

# Next steps Victoria's suicide prevention forward action plan 2006

A public statement

A Victorian  
Government  
initiative



**Next steps**  
**Victoria's suicide prevention forward action plan 2006**  
A public statement

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## 1 Introduction

Successive Victorian governments have supported initiatives to reduce suicide. Each year more than 500 Victorians choose to end their lives. For every male suicide there are an estimated 30 to 50 suicide attempts and for every female suicide there are an estimated 150 to 300 attempts. For each of these suicides many other people—family, friends, and work colleagues—are affected.

There is no single cause of suicide and no simple solution to prevent it. Suicide prevention requires the whole of government to work in partnership with the community—individuals, families, schools, community groups and non-government services.

In 1997, the Suicide Prevention Taskforce report outlined a comprehensive whole-of-government suicide prevention strategy. The taskforce developed an integrated framework which encompasses primary prevention, early intervention, intervention and postvention.

The government's response included a Suicide Prevention Strategy which aimed to minimise the impact of risk factors associated with suicide by funding a range of program initiatives (\$23.9 million recurrent and \$1.6 million one-off) along the intervention continuum. The strategy continued after the change of government in 1999.

An independent evaluation of the Suicide Prevention Strategy was undertaken in 2001. The evaluation found that while it was not possible to assess the collective impact of strategy initiatives on key risk factors, many individual initiatives were being well implemented. The evaluation made a number of recommendations for future action.

Because the strategy was implemented by the previous government many years ago, it was felt a re-examination of Victoria's Suicide Prevention Strategy was needed. Rather than develop a major new discrete suicide prevention strategy, a forward action plan that identifies and improves on existing suicide prevention activities embedded in universal and specialist services has been developed which:

- i. provides a coordinated state approach to ensure it benefits from the national structure and funding, and that new programs are effectively integrated with existing initiatives
- ii. identifies suicide prevention activities embedded in universal and specialist services and improves their contribution to relevant outcomes
- iii. proposes a modest program of targeted suicide prevention interventions and initiatives
- iv. focuses on a small number of specific priority areas for action.

The areas for potential action identified in the plan were informed by:

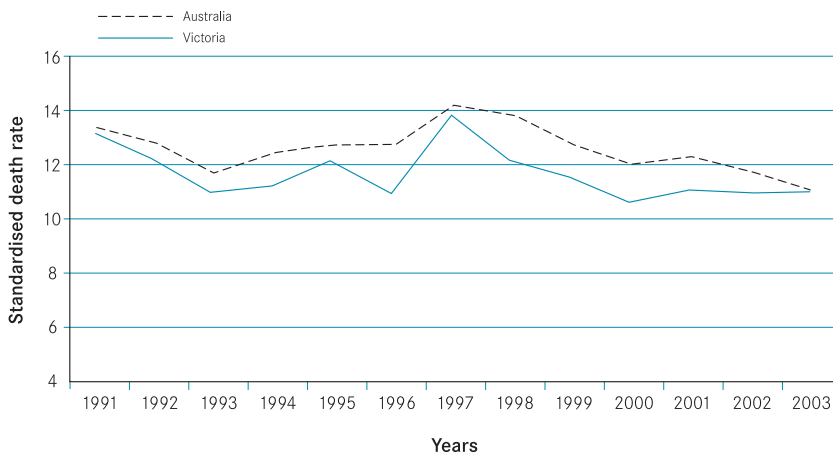
- the current focus of Victoria's suicide prevention activities using the Suicide Prevention Strategy Framework and the national LiFE framework
- current national and local suicide prevention effort
- the recommendations of the 2002 evaluation of the Victorian Suicide Prevention Strategy and further advice from departments
- the available evidence of effectiveness of suicide prevention activities.

## 2 Data and current trends

### Prevalence rate

In Victoria in 2003, there were 540 deaths by suicide (409 males and 131 females). Victoria's suicide death rate is 10.9 per 100,000 persons (the national average is 11.1 per 100,000 persons). Victoria's rate has been lower than the national average since 1991 (refer to Figure 1).

**Figure 1: All Victorian suicides compared with national standardised death rate (deaths per 100,000)**



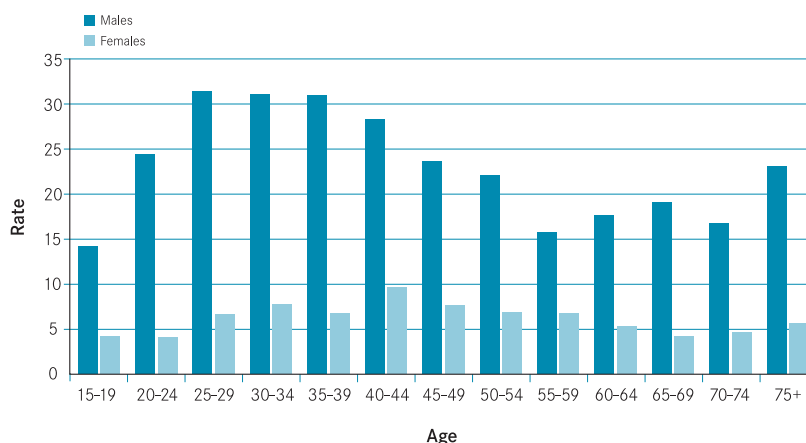
Source: Australian Bureau of Statistics (2004) *Suicides: Recent Trends, Australia, 1993-2003, Cat. No. 3309.0.55.001, Canberra.*

### Suicide rates by gender

Nationally, more than half (56 per cent) of all suicide deaths in 2002 occurred in age groups between 25 and 49 years. In Victoria, people aged between 25 and 34 years had the highest rate of suicide, closely followed by those aged 35–44 years. These two age groups accounted for 37 per cent of total suicide deaths in 2001.

While age-specific suicide rates for both genders tend to decrease across adulthood, suicide rates increase markedly for men in late life over the age of 80 years. Overseas research has found that a high proportion of older men who had suicided had seen their general practitioner in the month before their suicide. It has been suggested that this may imply that the visit revealed news of a terminal condition.

**Figure 2: Victorian male and female age-specific suicide rates, 2001 (deaths per 100,000)**



*Source: Australian Bureau of Statistics (2002) Causes of Death Australia, 2001, Cat. No. 3303.0, Canberra.*

The trends for female suicide rates follow a similar longitudinal pattern as for males, but at a much lower rate. Although suicide rates for males are higher than for females, the research evidence indicates that females attempt suicide more frequently and engage in higher levels of self-harm. Lower rates of completed suicide in females owes more to the less lethal means adopted in attempting suicide than to lower levels of emotional distress. When developing policy and programs, any analysis of the statistical information on suicide needs to take this into account.

## Rural suicide rates

Rural communities experience higher suicide rates than urban areas. These communities often have greater access to firearms and often experience limited confidence in using specialist services compared with urban communities. Access to services in rural areas is also more limited than in metropolitan areas as a result of service availability and a lack of public transport. Suicide rates for males in these communities have increased steadily over the past 20 years, with rates for young males consistently higher in small rural communities than in metropolitan and regional areas. More specifically, rural inland towns with populations of less than 4,000 people have experienced the most significant increases in male youth suicide. Given this evidence, suicide prevention targeted at young men continues to be an appropriate focus for some small communities.

## Suicide means

Table 1 details means of suicide by gender, based on 2002 national data.

**Table 1: Means of suicide by gender, 2002**

Means	Male (%)	Female (%)
Poisoning by drugs	8.6	26
Poisoning by other (include solids, gas, car emissions)	19.9	15.3
Hanging	46.6	39.6
Firearms and explosion	14.4	2.21
Other (drowning, jumping, cutting)	13.5	16.9

## 3 At risk groups

### Key at risk groups

Current research and trends on suicide prevention have identified the following demographic groups as having a heightened risk of suicide:

- young people
- people with domestic and family violence and intimate relationship problems
- middle aged men
- offenders/prisoners
- Aboriginal people.

### Young people at risk

Risk factors that contribute to suicide in young people include socioeconomic disadvantage, childhood physical or sexual abuse, poor parent-child relationships, loss of a parent through divorce, suicide or violence in the family, experience within the family of imprisonment, mental health problems and drug use. Other factors are often present, although the way they relate to suicide risk is not clear. These factors include same sex attraction, homelessness, unemployment, incarceration in the juvenile justice system, and having a Vietnam veteran parent.<sup>1</sup>

### People with domestic and family violence and intimate relationship problems

Victorian research has found:

- women reporting intimate partner violence were nine times more likely to report having harmed themselves or having recent thoughts of doing so than women who had never experienced violence<sup>2</sup>
- 13 per cent of women experiencing intimate partner violence suicided<sup>3</sup>
- nearly 10 per cent of those who committed suicide during 2000 were known to have been abused either physically, sexually or both.<sup>4</sup>

Furthermore, data from the Victorian State Coroner's Office indicate that around 75 per cent of people who committed suicide in the year 2000 were reported to have had an intimate relationship problem prior to their death. This figure comprises 45 per cent relationship problems with a marital partner and 30 per cent with a de facto (non-married) partner.

<sup>1</sup> Commonwealth Department of Health & Aged Care (2000) *LiFE: A framework for prevention of suicide and self-harm in Australia*, Canberra.

<sup>2</sup> VicHealth (2004) *The health costs of violence - measuring the burden of disease caused by intimate partner violence*, Victorian Health Promotion Foundation, Carlton South, Victoria.

<sup>3</sup> Ibid.

<sup>4</sup> Graham, A. & Yip, P. (2003) *Victorian and Hong Kong suicides during the year 2000*, Victorian State Coroner's Office, Melbourne (unpublished report).

## Middle aged men

Although males aged 25–45 years constitute the largest single age and gender group at risk of suicide in most developed Western countries, concern about suicide in adults has been relatively neglected in recent years. Unlike many other at-risk groups, men in the 25–45 years age group are not easily accessible and tend to seek help less.

## Offenders/prisoners

A State Coroner's Office report in 2000 found that approximately 10 per cent of those who committed suicide were known to have had criminal related problems; in all these activities the deceased was the perpetrator. Ex-prisoners are also at higher risk of suicide following their release from prison. Corrections Victoria data indicate that during the period 2001–02 to 2003–04 people under the supervision of Community Correctional Services were between 18 and 22 times more likely to die from suicide compared with the general population.

## Aboriginal people

Although the available data on suicide and self-harm in Aboriginal and Torres Strait Islander communities are scant and often unreliable, it is estimated that overall suicide rates within these communities may be around 40 per cent higher than in the general population. These rates are believed to vary considerably across areas and age groups, with young males particularly at risk.<sup>5</sup> This suggests that suicide is a significant social issue in Aboriginal communities which links to both the cycle of ongoing chronic disadvantage (linked to socioeconomic disadvantage, disproportionate rates of imprisonment, family violence and drug misuse) and the historic injustice experienced by Aboriginal people (including dispossession, assimilation and cultural disruption, and removal of children from their families and communities).

## Risk factors contributing to suicide

Individuals are more vulnerable to suicide if they have:

- a history of prior attempts and deliberate self-harm
- a mental illness
- been discharged from mental health services
- a history of drug and alcohol abuse and unemployment.

The risk of suicide is thought to increase with the clustering of a range of risk factors. The most important of these risk factors appears to be a history of mental illness—notably depression—particularly where more than one mental illness is present or a mental illness is combined with harmful drug use. Other risk factors may include sexual abuse; homelessness; chronic poverty; very early school leaving; family breakdown and separation; survival of torture and trauma, marginalisation and bullying (including as a consequence of sexual preference); impulsivity; and post traumatic stress disorder.

<sup>5</sup> Commonwealth Department of Health & Aged Care (2000) *LiFE: A framework for prevention of suicide and self-harm in Australia*, Canberra.

It is important to note that although the research literature on suicide identifies a broad range of risk factors for suicide, almost all of the assumptions made about causality are based on ‘association’ of factors. The available evidence needs to be strengthened through improved data collection and research, primarily at a national level, to gain a better understanding of the complex relationships between cultural, community and sociopolitical issues as risk factors for suicide.<sup>6</sup>

### Prior suicide attempt/deliberate self-harm

One of the strongest predictors of future death by suicide is a past history of attempted suicide. The research evidence indicates that females attempt suicide more frequently than males and engage in high levels of self-harm. There is also evidence of an increasing incidence range of deliberate self-harm and risk-taking behaviours other than overdose in the 15–24 year age group.

The State Coroner’s Office research found that in 2000:

- an estimated 30 per cent of suicide victims were reported to have harmed themselves at least once prior to their death
- 19.3 per cent of suicide victims had been previously hospitalised as a result of self-harm
- approximately 13 per cent of those who suicided had been involved in a self-harm incident during the 12 months prior to their death.

Recent research from the United Kingdom investigating suicide rates up to four years after a deliberate self-harm episode found that an approximately 30-fold increase in risk of suicide was observed for the whole cohort in comparison with the general population, with the greatest risk during the first six months. The predictors of subsequent suicide included avoiding discovery at the time of self-harm, not living with a close relative, previous psychiatric treatment, self-mutilation, alcohol misuse and physical health problems. The authors recommended treatment focused on these independent predictors.<sup>7</sup>

### Mental illness

People who have been diagnosed with a psychiatric disorder face a statistically higher risk of suicide than the general population. Depression, schizophrenia, bipolar disorder, and conduct and personality disorders have strong links with suicide and suicide attempts. A recent overview of coronial data found that 57 per cent of individuals who committed suicide in Victoria during 2000 were recognised prior to death as having had at least one psychiatric disorder.

### Discharge and service transition

There is a large body of research that identifies the first month following discharge from acute and correctional settings as being a high risk period for suicide. Key service transition points include being discharged from mental health inpatient services, after an emergency department presentation related to intentional self-harm or suicide, and being released from prison.

<sup>6</sup> Commonwealth Department of Health & Aged Care (2000) *LiFE: A framework for prevention of suicide and self-harm in Australia*, Canberra.

<sup>7</sup> Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K. & Appleby, L. (2005) *Suicide after deliberate self-harm: a four-year cohort study*, *Am J Psychiatry* 162:297-303.

## Alcohol and drug abuse

People who abuse drugs and alcohol have higher rates of suicide than the general population, with substance abuse often immediately preceding suicidal behaviour. While substance abuse alone is not necessarily translated into suicide, this behaviour does increase risk for people with other vulnerabilities. Victorian State Coroner's Office research found that in 2000:

- 26.9 per cent of Victorian suicide victims had alcohol present in their blood
- 61.3 per cent of suicide victims had one or more drugs other than carbon monoxide and alcohol present in their blood. These drugs included analgesics (generally heroin), sedatives and hypnotics, and antidepressants and antipsychotics.<sup>8</sup> Heroin users die at a rate 13 times greater than those who do not use heroin, with one in ten deaths of heroin users estimated to be suicide.<sup>9</sup>

## Unemployment

Victorian coronial data suggest a strong relationship between unemployment and suicide. The peak suicide rate is among unemployed males aged between 30 and 34 years. Research has found that underemployment and unemployment are both linked to increased rates of attempted suicide.

## 4 Current suicide prevention activity

While suicide prevention activity in Victoria covers the breadth of the intervention continuum there is currently an emphasis on the primary prevention and intervention stages. The Victorian Government has invested in a range of programs targeting high risk groups, including:

- primary prevention and intervention for young people through generic programs in schools and specialist services
- primary and early intervention for Indigenous, gay and lesbian, and rural and regional Victorians
- early intervention for those affected by mental illness
- intervention for offenders.

Victoria invests in research on depression through the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders. Additionally, there is embedded activity across government which addresses suicide prevention indirectly. Much of this activity relates to community strengthening and resilience-building in a diverse range of program areas, including primary health, corrections and programs within the Department for Victorian Communities relating to youth, Aboriginal people and senior Victorians. Appendix 1 details recent and current Victorian Government funding for suicide prevention activity.

<sup>8</sup> Graham, A. & Yip, P. (2003) *Victorian and Hong Kong suicides during the year 2000*, Victorian State Coroner's Office, Melbourne (unpublished report).

<sup>9</sup> Darke, S. (2002) *Suicide among heroin users: the silent killer*, *CentreLines* (7):3.

## 5 Evidence base

### Summary of available evidence

To date, most suicide prevention strategies, including Victoria's, have not been determined by a solid evidence base and rely largely on assumed efficacy with little or no evidence.

There is a growing body of evidence examining the effectiveness of interventions that directly treat known risk factors, such as depression and substance abuse. Conversely, there is little empirical evidence that demonstrates the effectiveness of interventions to enhance protective factors.<sup>10</sup> While the theoretical assumption relating to the reduction of suicide by enhancing protective factors appears sound, it needs to be more rigorously tested.

In its synthesis of current suicide prevention research, the World Health Organization reported that in the general school population, suicide prevention programs based on behavioural change and coping strategies were found to be effective. In adolescents at high risk, school-based suicide prevention programs based on skill training and social support appeared to be effective in reducing risk factors and enhancing protective factors.<sup>11</sup>

While acknowledging the limitations of intervention effectiveness studies relating to treatment, it appears that interventions, such as cognitive behavioural therapy, life and social skills training, and therapeutic group interventions, are effective in reducing the incidence of repeat self-harm in the target group. In addition, the use of group support techniques appears effective in responding to the needs of those bereaved by suicide.<sup>12</sup> In a meta-analysis of numerous treatment studies, Hawton et al. (1998) reported that promising results were found with problem solving therapy and with dialectical behaviour therapy. Home-based treatment was found to increase the rate of take-up of treatment, and the article suggests that assertive outreach for poorly compliant patients may be necessary to maximise the delivery of effective treatment options.<sup>13</sup>

<sup>10</sup> Australian Institute of Primary Care (2003) *State-wide evaluation of the national suicide prevention strategy community initiatives projects*, La Trobe University, Melbourne (unpublished progress report).

<sup>11</sup> World Health Organisation (2004) *For which strategies of suicide prevention is there evidence of effectiveness?* WHO Regional Office for Europe, Copenhagen.

<sup>12</sup> WestWood Spice (2002) *National suicide prevention strategy strategic development projects (Victoria)*, Literature Review, East Balmain, New South Wales (unpublished).

<sup>13</sup> Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owens, D., Sakinofsky, I. & Trademan-Bendz, L. (1998) Deliberate self-harm: Systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition, *BMJ* 317: 441-447.

Although it is recognised that many of the known at-risk groups are difficult to reach and engage in programs, there is emerging evidence that for some at least, participation in sports appears to be protective. Both Australian and international research demonstrates that sports participation and physical activity programs are associated with, or contribute to, lower levels of suicide and suicide attempts for adolescents and Aboriginal communities<sup>14,15</sup>. For older men, research undertaken in New South Wales indicates that high intensity strength training has proven effective in reducing depression, which may in turn reduce suicidal thoughts and behaviours in this group.

An evaluation of the Victorian Rural Suicide Prevention Strategy, completed by the Centre for Rural Mental Health, may be instructive in implementing suicide prevention action plans in rural community service settings.

## Implications for Victoria

To enable future program and policy development in line with an evidence base about efficacy, especially where limited published research exists, monitoring and evaluation of the quality and effectiveness of current suicide prevention programs and services are required. Further activity is also needed to better inform the targeting of effort.

Appropriate data collection and research methodology is particularly important at the primary prevention end, where causal relationships between activity and outcomes are more difficult to establish. The variety and frequency of program monitoring needs to be relevant to suicide prevention data collection across the intervention continuum in order to enhance knowledge of what embedded activity in particular works effectively in reducing suicidal thoughts and behaviours.

14 Miller, K.E., Sabo, D.F., Melnick, M.J., Farrell, M.P., & Barnes, G.M. (2000). *The Women's Sports Foundation Report: Health risks and the teen athlete*, Women's Sports Foundation, East Meadow, New York; Minneapolis Department of Health and Family Support (2002) *Benefits associated with participation in school sports and other extracurricular activities in adolescence*, Research Brief, Minneapolis, USA; Morris, L., Sallybanks, J., Willis, K., & Makkai, T. (2003) Sport, physical activity and antisocial behaviour in youth, *Australian Institute of Criminology Trends and Issues in Crime and Criminal Justice*, No. 249, Canberra.

15 Tatz, C. (1994) *Aborigines: sport, violence and survival*, Criminology Research Council, Canberra.

## 6 The way forward

### Overview of proposed areas for targeted action

The *Next steps* suicide prevention action plan has been developed based on priorities participating departments identified. Table 2 summarises proposed areas for targeted action which are detailed in the following sections of the plan. These proposed areas build on current and ongoing suicide prevention activity.

Table 2

Proposed actions for suicide prevention in Victoria	
<b>Primary prevention</b>	
1.	Strengthen efforts to promote positive mental health and resilience, by:
	<ul style="list-style-type: none"> <li>improving social participation through community capacity building, volunteering, neighbourhood renewal and neighbourhood houses</li> </ul>
	<ul style="list-style-type: none"> <li>enhancing mentoring strategies</li> </ul>
	<ul style="list-style-type: none"> <li>further coordinating state and national school-based initiatives.</li> </ul>
2.	Reduce the availability and lethality of suicide methods, with a focus on pharmaceutical drugs and car exhausts systems.
<b>Early intervention</b>	
3.	Improve early intervention by education, health and welfare professionals through:
	<ul style="list-style-type: none"> <li>training to improve capacity to identify and developed targeted responses to known at-risk groups and risk factors, especially clustering of risk factors</li> </ul>
	<ul style="list-style-type: none"> <li>improving coordination and communication between education, health, welfare and community groups through existing mechanisms and networks</li> </ul>
4.	Formalise accountabilities of relevant departments in relation to roles and responsibilities for responding to high risk groups, including policies, protocols and performance indicators.
<b>Intervention</b>	
5.	Improve crisis intervention and support services delivered by primary, community and specialist mental health services, and links and referral arrangements between these services.
6.	Develop training to ensure relevant professionals are aware of newly identified at-risk groups, including domestic violence victims and 'middle aged men', and efficacious treatment models.
7.	Improve specialist suicide telephone services and their responsiveness to people with suicide related issues, including improved referral arrangements and linkages with primary and specialist services. <sup>16</sup>
8.	Improve procedures and follow-up for people at key service transition points, including people being discharged from mental health inpatient services, people who have just had an emergency department presentation related to intentional self-harm or suicide, people entering the criminal justice system and people leaving prison.
9.	Enhance protocols and professional development strategies for teachers and welfare coordinators in working with support services.
<b>Postvention</b>	
10.	Provide better access to and coordination of support and follow-up for families and friends of suicide victims, involving centre-based, telephone-based and outreach responses.
11.	Develop new postvention guidelines and procedures for after a suicide to minimise the harmful flow-on effects to schools, families, workplaces and communities.
<b>Research and information monitoring</b>	
12.	Improve the capacity of the Coroner's Office and other research bodies to research, monitor and identify new trends, evaluate specific initiatives and disseminate this information to service providers.
13.	Improve suicide prevention data collection practices and the quality of suicide related data.

<sup>16</sup> Further evaluation of the characteristics of telephone crisis services might enhance their effective use, especially by target groups.

## Key principles

The following **key principles** underpin implementation of priority actions across the intervention continuum:

<b>Key principles for suicide prevention in Victoria</b>	
<b>1. Embedding</b>	That activities and processes (including coordination wherever possible) are embedded within existing community and service delivery networks and structures
<b>2. Coordinated planning</b>	That coordinated planning occurs to maximise available resources and minimise duplication of effort
<b>3. Adaptability</b>	That priority actions are adaptable for implementation in a diverse range of locations and service settings
<b>4. Role clarity</b>	That the respective roles and responsibilities of all stakeholders at the local, state and national levels are clear
<b>5. Evidence</b>	That a concerted effort is made towards improved data collection and the development of best practice and evidence-based approaches
<b>6. Diversity</b>	That responses to suicide prevention take into account the needs and experiences of Victorians from diverse backgrounds and communities, including Indigenous communities, culturally and linguistically diverse communities, those from different geographic locations, those with a disability, and those of all ages and sexual preferences

## Primary prevention

The evaluation of Victoria's suicide prevention response identified Victoria's investment in primary prevention and early intervention as a significant strength in current initiatives. Recent research has also found that Victoria's significant investment in primary prevention and targeting risk factors will not only reduce suicide but other types of premature death as well.

Primary prevention strategies can include strengthening families; creating positive relationships; promoting the role of education; strengthening local communities; and promoting help seeking, professional training, research, evaluation and data collection, access to means and the media.

## Future directions

Proposed actions – primary prevention
<b>Reduce the availability and lethality of suicide methods</b>
<p><b>Pursue national action on restricting access to toxic and lethal drugs</b> by promoting the use of clinically safer drugs and limiting the amount of potentially lethal drugs prescribed at any one time.</p> <p><b>Implement the outcomes of the national project to decrease the lethality</b> of carbon monoxide emissions from vehicle exhausts through design modification or use of catalytic converters.</p>
<b>Improve social participation</b>
<p>Ensure groups that appear most at risk are participating in the government's Community Capacity Building initiatives (that is, employment, sport and recreational programs).</p> <p>Ensure the government's programs and initiatives (Neighbourhood Renewal, Community Capacity Building, Neighbourhood Houses, Volunteering Strategy) also address, where possible, people with risk factors known to be associated with suicide and self-harm.</p>
<b>Enhance mentoring strategies</b>
<p>Enable supportive mentoring relationships and connections between young people at risk and adults in positions of respect.</p>
<b>Coordinate school-based programs</b>
<p>Further coordinate state and national school-based initiatives, including MindMatters, <i>beyondblue</i> schools research initiative, School Focused Youth Service, and Secondary School Nursing Program, and seek complementarity.</p>

**Example indicators** of the effective implementation of primary prevention activities include:

1. improvement in the psychosocial wellbeing of the Victorian population as a whole
2. continued reduction in access to means.

## Early intervention

Early intervention strategies are targeted at individuals displaying general disorganisation in coping skills, stress reactions, depressive symptoms, and other personal and social vulnerabilities for suicide. Early intervention excludes those engaging in suicide attempts or other deliberately self-harming or life-threatening behaviours. Early intervention is often described as secondary intervention in public health models. It is focused on groups that are at risk of self-harm.

## Future directions

Proposed actions – early intervention
<p><b>Improve local area coordination</b></p> <p><b>Improve</b> communication and processes between education, health and welfare providers and key community groups. While there has been improved community coordination in some rural areas, this is not yet the case in metropolitan areas.</p> <p><b>Facilitate</b> the planning of coordinated local responses to high suicide risk through existing mechanisms, such as School Focused Youth Services, primary care partnerships, and regional youth affairs networks.</p> <p><b>Develop</b> information packages and community response kits to support coordinated planning.</p>
<p><b>Pursue ongoing training opportunities</b> and improved supervision in the use of risk frameworks for professionals in all service settings.</p> <p><b>Develop</b> improved risk assessment frameworks and associated support activities as part of embedded strategies for the mental health workforce, drug treatment services and primary mental health team services.</p> <p><b>Seek</b> national support and incentives for specific general practitioner training initiatives.</p> <p><b>Develop</b> a tool to assist correctional staff in identifying prisoners at risk of suicide or self-harm.</p>
<p><b>Target strategies at at-risk groups, specifically:</b></p> <ul style="list-style-type: none"> <li>• young people</li> <li>• people who have experienced domestic and family violence and intimate relationship problems</li> <li>• middle aged men</li> <li>• offenders/prisoners</li> <li>• Aboriginal people</li> </ul> <p>especially where they have:</p> <ul style="list-style-type: none"> <li>• a history of prior attempts and deliberate self-harm</li> <li>• a mental illness</li> <li>• been discharged from mental health services</li> <li>• a history of drug and alcohol abuse and unemployment.</li> </ul>

**Provide** enhanced capacity in hospitals and community-based primary care services to undertake assertive follow-up and referral following emergency department presentation.

**Seek** formal accountability from relevant departments for improved responses to high risk groups, specifically:

- policy on roles and responsibilities for respective departments responding to high risk groups
- the development of risk assessment tools and possible protocols that govern responses across different departments and programs
- explicit performance indicators in the Mental Health Strategy regarding suicide prevention as part of core business.

**Example indicators** of the effective implementation of early intervention activities include:

1. reduced number of suicides in high risk groups
2. better cross-sector training on suicide risk factors and methods for intervening, and early detection of depression.

## Intervention

Intervention involves providing effective treatment support to those people engaging in suicidal behaviour. Intervention is often referred to as tertiary prevention in a public health model.

### Future directions

<p><b>Proposed actions – intervention</b></p> <p><b>Improve continuity of care, especially at key discharge and transition points</b> for people who do not require ongoing specialist mental health services post-crisis.</p> <p><b>Enhance</b> capacity in hospital and primary care settings for assertive follow up.</p> <p><b>Create</b> additional capacity in community health services to undertake counselling and case management services in order to provide structured support, minimise compounding secondary factors and link to primary health services for other treatment needs.</p> <p><b>Improve</b> discharge processes to ensure provision of information to families and primary care providers.</p> <p><b>Provide</b> case management information to the Suicide Help Line where referral is part of the discharge plan.</p> <p><b>Seek</b> nationally to improve the Victorian uptake of general practitioner Better Outcomes, the More Allied Health Services program and new Medical Benefits Schedule items relevant to this purpose.</p> <p><b>Establish</b> clear protocols for assessment, treatment and assertive follow-up of those who present at emergency departments following suicide attempts.</p> <p><b>Seek</b> formal accountability from specialist mental health services for improved continuity of care and reduced suicide rates among patients following discharge from mental health inpatient services to ambulatory services.</p> <p><b>Improve</b> access to community-based services for offenders at risk of suicide and self-harm.</p>
<p><b>Enhance and streamline counselling and support telephone services</b></p> <p><b>Develop</b> standards for the Suicide Help Line which make reference to assertive outreach and case management practices to support follow-up of high risk callers.</p> <p><b>Improve</b> links and referral arrangements with primary and specialist services.</p>
<p><b>Pursue ongoing training opportunities and improved supervision in treatment and support options for relevant professionals</b></p> <p><b>Develop</b> training and associated support activities as part of embedded strategies for the mental health workforce and primary mental health team services.</p> <p><b>Conduct</b> regular training of Community Correctional officers in identifying and responding to suicide risk.</p> <p><b>Seek</b> national support and incentives for specific general practitioner training initiatives.</p>
<p><b>Review the Student Support Services Framework</b></p> <p><b>Enhance</b> protocols and professional development strategies for teachers and welfare coordinators which:</p> <ul style="list-style-type: none"> <li>• clarify the range of treatment and support services that can be involved</li> <li>• identify the key triggers for bringing these services into play.</li> </ul>

**Example indicators** of the effective implementation of intervention activities include:

1. reduced number of suicides particularly for people who are recently discharged from hospital or mental health services or are at key transition points, including entry into the criminal justice system and release from prison
2. increased responsiveness of generalist services to meet the needs of those who do not require ongoing specialist services.

## Postvention

Postvention involves support for the bereaved. Postvention activity recognises those bereaved (the friends, family and peers of a person who has died) may be particularly vulnerable to suicidal behaviours of their own and may be more likely to develop complicated grief reactions.

Research indicates that in Victoria the person most likely to find the body of someone who has suicided is a family member of the deceased.<sup>17</sup> The research literature also indicates that survivors of sudden or violent traumatising losses, including suicide, are likely to benefit from specialist grief and bereavement interventions.

## Future directions

### Proposed actions – postvention

#### Improve generic and specialist postvention bereavement counselling

Improve counselling services so that they can:

- develop trauma/debriefing plans
- undertake postvention coordination
- provide capacity for on-call service and flexible outreach for urgent cases.

Develop standards for the Suicide Help Line which make reference to assertive outreach and case management practices to support follow-up with bereaved families.

#### Develop postvention guidelines and procedures for after a suicide

New guidelines and procedures will be:

- incorporated into suicide prevention information kits
- targeted to families, schools, workplaces, and communities
- designed to limit the potentially contagious impact of suicide death, particularly for young people
- monitored and responded to in a timely way to minimise the risk of copycat suicide or suicide clusters.

**Example indicators** of the effective implementation of postvention activities include:

1. reduced number of suicides over time in families and friendship groups where a suicide has previously occurred
2. increased responsiveness of services to requests for grief and loss counselling from bereaved friends and families (95 per cent of all requests for service met within 24 hours).

<sup>17</sup> Graham, A. & Yip, P. (2003) *Victorian and Hong Kong suicides during the year 2000*, Victorian State Coroner's Office, Melbourne (unpublished report).

## Research and information monitoring

Quality research and data collection improves the capacity to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention. There is a well acknowledged need for accurate, timely systemic data collection for suicide and attempted suicide.

### Future directions

<b>Proposed actions – research and information monitoring</b>
<b>Collate and analyse clinical reviews</b> undertaken by hospitals as a result of suicide.
<b>Improve research, monitoring and identification</b> of new trends and disseminate this information to service providers.
<b>Research design and evaluation of intervention programs</b>
There is very little evaluation of the overall effectiveness of programs which identifies what works in a variety of settings. A priority for suicide prevention is the design and evaluation of a variety of intervention programs to prevent suicide and suicide attempt behaviour.
<b>Develop guidelines for police investigating suicide on behalf of the Coroner</b> to ensure better data collection.
<b>Develop best practice models</b>
Focus on approaches along the intervention continuum.
<b>Pursue national data collection</b>
Seek at a national level to align data collection relating to efficacy of interventions.

**Example indicators** of the effective implementation of suicide prevention research and monitoring include:

1. expansion and strengthening of the available evidence base
2. improved data collection practices.