About Suicide Prevention Australia

Suicide Prevention Australia (SPA) is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. SPA is supported by funding from the Australian Government under the National Suicide Prevention Strategy.

SPA Position Statements

SPA regularly publishes position statements on priority areas of suicide and self-harm prevention, intervention and postvention in Australia. These foundation documents provide a basis for understanding, discussion, teaching, delivery and research, and reflect the diversity of voices within the sector.

They are not intended to be specific to or limited to policy-makers alone, but are instead written with a general cross-section of the educated lay public in mind (ie. broader community, media, and other NGOs). SPA Position Statements therefore represent a starting point for policy and strategy development, while supporting SPA’s ongoing advocacy work and activities.

These documents are developed in close consultation with community and specialist reference groups and are ratified by the SPA Board. They are reviewed biannually with the intention of being reaffirmed, revised or retired, and generally do not refer to issues previously covered by other SPA Position Statements or by those currently in the process of being drafted.

The development of SPA Position Statements is supported by the Australian Government as part of its funding agreement with SPA. Position statements support and build on the Living Is For Everyone (LIFE) Framework developed under the National Suicide Prevention Strategy.

SPA Position Statements can be downloaded from the SPA website: http://www.suicidepreventionaust.org/PositionStatements.aspx

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Disclaimer

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To access accurate information about suicide and the portrayal of suicide in the media, please visit: http://www.mindframe-media.info/

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Glossary

First Response
First response to suicide is the initial contact with a person who considers, threatens or attempts suicide. It includes the discovery of a death suspected to be by suicide. The incidental care and the formal treatment that follow a suicide attempt at the first point of health care contact is part of the first response continuum and, for the purposes of this position statement, includes the referral of patients to appropriate secondary points of care. The analysis of treatment and outcomes following these initial stages of contact is beyond the scope of this position statement.

Please refer to SPA’s Position Statement, ‘Supporting Suicide Attempt Survivors’ (2009a), for more details of ongoing treatment following suicide attempts: http://suicidepreventionaust.org/PositionStatements.aspx

Mental Illness and Services
Mental illness has been recognised as the strongest contributing factor to suicide (World Health Organisation (WHO) 2009). While this position statement looks specifically at responses to suicide attempts, many issues relating to mental illness response remain relevant. In this regard, references to mental health policies, treatments and services are intended to refer to situations where mental health treatment and suicide attempt response overlap. While suicide attempts are not always necessarily mental illness related, suicidal crises may be a risk factor in the development of clinical disorders or may indicate the onset of a mental illness (Rosen 1998). Furthermore, the principles of appropriate response are conducive to situations where mental illness is present and where it is not. The use of the term ‘mental health services’ is also intended to include the myriad proxy services (e.g. drug and alcohol, addiction, assault, marriage counselling, youth, bereavement services etc) that are not mental illness services, but rather serve to safeguard mental wellbeing.

Please refer to SPA’s Position Statement, ‘Mental Illness and Suicide’ (2009b), for more details: http://suicidepreventionaust.org/PositionStatements.aspx

Suicide Attempts and Self-Harm
Self-harm is the deliberate injury of oneself, without suicidal intent. Self-harm is one of the leading risk factors for future suicide, and is a major public health concern (Martin et al. 2008). SPA recognises the links between crisis response to suicide attempts and crisis response to self-harm, but emphasises that suicide and self-harm are two different and multifaceted issues. This position statement does not attempt to address the unique and complex features of crisis response to self-harm, but does acknowledge that many of these issues overlap with those of responses to suicide attempts.

Guiding Principles

• The care and treatment that a suicide attempt survivor receives has the capacity to reduce their risk of future suicidality. Suicide attempt survivors should be treated with dignity and compassion.

• First response to suicide is everyone’s business and may involve anyone, anywhere. Awareness about suicide and how to respond must be widely disseminated, especially among community members most likely to become first responders. These ‘community gatekeepers’ include emergency services and medical professionals.

• First response to suicide is a difficult and often traumatic event for the responder whose needs must be supported.

• Crisis support helplines and web-based services are integral to community suicide prevention, reducing suicidality and facilitating access to help. Complemented by ancillary follow-up services, they should be formally recognised as a distinct, definable element in suicide prevention policy and programs.

• Mental health services need to be made available and accessible in the whole community—not just hospitals—to reduce the incidence of suicidality, and to provide crisis care for suicidal people.

• Coordination and interagency collaboration of mainstream, mental and allied health services are essential for effective and accessible care.

• Emergency services provide a critical response to suicide attempt survivors. Their capacity is dependent on many individual and service factors.

• Suicidal, suicide-bereaved people and suicide attempt survivors narrate experiences that are crucial to understanding suicide and informing suicide prevention. They need to be involved in all levels of policy development and service provision, and be supported in these roles.

• Suicide prevention and intervention activities require best practice guidelines and evidence-based frameworks. SPA recommends establishing a National Accreditation Body to monitor and accredit training providers, services and programs, enhance service quality and provide benchmarks for the development of new initiatives.
Background

Over 500,000 Australians attempt suicide during their lifetime. This equates to 3.3% of the population, and approximately 65,000 attempts a year (Slade et al. 2009). Nearly 3% of the total burden of disease and injury in Australia is attributed to suicide, suicide attempts, and self-harm (Begg et al. 2003). Suicide is a complex phenomenon that is influenced by a wide range of risk and protective factors. Many suicide attempts result from a culmination of mental illness, adverse life events and overburdened internal and external coping mechanisms, leading to acute desperation, despair and disassociation of emotions and thoughts from logic and memory. Often accompanying these are a loss of self-respect and value, and a belief that the only way to escape the unbearable mental pain is to die. Considering the toxic experience that precedes attempted suicide, it is important that first responders take into account the sufferer's emotional, cognitive and psychological wellbeing as well as their physical needs.

An emergency is a life threatening situation that requires immediate intervention, whereas a crisis is a psychological state that may be resolved more effectively with a longer term approach. The two often overlap, but are distinct (Rosen et al., 2008). A first responder to a suicide attempt needs to consider the crisis as well as the emergency; recognising that different timeframes may be needed for each.

A previous suicide attempt is the highest independent risk factor for eventual suicide (Hawton and Harriss 2007 and LIFE Framework 2007). Therefore, effective crisis response and initial care following an attempt are critical.

However, crisis and first response services are not integrated under the National Suicide Prevention Strategy (NSPS). Suicide response by emergency services falls under the auspices of mental and general health responsibilities, and is not targeted by suicide specific funding. Emergency services (ambulance, police and emergency departments (EDs)) should be recognised as key suicide prevention providers under the NSPS.

First response to suicide is relevant in community and public spheres as well as medical and emergency settings. The opportunities for and barriers to effective care reside in three related domains:

- Individual factors;
- Community factors; and
- Service factors.

Individual compassion and understanding of suicide and mental illness are necessary to providing effective response. This applies to family and community responders as well as professionals and carers. Community responses are restricted by a lack of awareness and skills and the reluctance to get involved together with residual mental illness stigma, which also restricts the public drive for service provision for suicidal and mentally ill people. Correspondingly, mental health services are often characterised by resource shortages and policy under-sight—issues that negatively contribute to the service response to people who attempt suicide.

Within mental health services, two themes dominate: the lack of coordination and over-emphasis on inpatient care. Since the 1990s and the deinstitutionalisation of mental health care, inpatient acute care in mainstream hospitals has replaced the institutional system, albeit without the necessary level of investment in community care to address unmet need. This contradicts international principles affirming “the right to be treated and cared for, as far as possible, in the community in which the patient lives” (The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, United Nations General Assembly 1991: 7.1). An ongoing resource crisis threatens coordinated and accessible community services for mentally ill and suicidal people (Mental Health Council Australia (MHCA) 2005). In 2003, mental illness contributed to 13.3% of the overall burden of disease in Australia, yet only 7.5% of the health budget was spent on mental health care and services (Begg et al. 2003). This has slightly improved in recent years, but is still far from equitable (SPA 2009c). The provision of appropriate and accessible mental health services and care with quarantined funding and accountability mechanisms is central to reducing suicidal behaviour and to treating those who have attempted suicide.

This position statement reviews current pathways to care for people who consider or attempt suicide. It does not comprehensively analyse all sites of first response, but addresses the most common and likely situations, providing recommendations to increase the capacity of individuals and services to provide appropriate care.
SPA’s Position

SPA supports the Living Is For Everyone (LIFE) Framework, developed under the NSPS and calls for the extension of this strategy to become a national government policy. SPA strongly recommends that crisis response policies are enacted and sustainably resourced to improve the care and outcomes for people who attempt suicide. It advises that crisis and emergency services are integral to responding to suicide, and need to be supported under the NSPS.

Crisis Response

Community and Family Response and Gatekeeper Training

Over half of all people who attempt suicide do not initially seek professional or medical help for their attempt. It is estimated that there are many more whose suicidality is never recognised, and who therefore are not included in these statistics (SPA 2009a). Most often the point of first response is with a family member, friend, bystander or community member. The person may self-identify or their crisis may be recognised by another. A study by SANE Australia (2010) found that, of the participants who reported suicidality, nearly three quarters had spoken to someone about their feelings, which often led to them getting further help. For this reason, the LIFE Framework under the NSPS, “aims to build: the capacity for communities and individuals to identify and respond quickly and appropriately to people in need” (2007: 3).

A suicide crisis or attempt may take place in any setting and may be unexpected, distressing and stressful for a first responder. To react appropriately to the needs of the person who has attempted or threatened suicide, a first responder needs to understand and have empathy for the complex causes and effects of suicidality and mental illness. A source of formal understanding may include community training, such as Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid or LivingWorks. The Salvation Army also provides online QPR (Question, Persuade, Refer) training to the general public to disseminate information on suicide warning signs and how to effectively respond. Kitchener and Jorm (2002) and Jorm et al. (2005) found Mental Health First Aid Training to be effective at improving real and perceived abilities to respond to someone with a mental illness or suicidality. The quality and content of the training are intimately related to trainees’ capacity to respond effectively to suicidal crises.

Dissemination of mental health awareness and suicide prevention training should occur universally. However, ‘community gatekeepers’ (i.e. those serving in sectors more likely to be first responders than the general population) need targeted training. They include medical, social, emergency and crisis services staff, but also representatives of other relevant groups, such as teachers, youth workers, human resource managers, military personnel, rural and Indigenous service providers, Centrelink workers, clergy, State Emergency Services and prison personnel. Effective training and formalised roles and structures for gatekeepers have been shown to reduce suicidal behaviour in contact populations (Mann et al. 2005, Isaac et al. 2009).

Suicidal or distressed people are more likely to ask for help if they can recognise and identify with someone who understands what they are going through and has some skills to assist. For example, the evaluation of the NSPS found the school-based crisis help-seeking behaviours of young people increased following a corresponding increase in access to mental health and suicide prevention training by teachers and school counsellors (Department of Health and Ageing (DoHA) 2006).

Gatekeeper training can be moulded to suit the environment and suicide prevention needs of each target population; increasing its effectiveness and transferability across occupations and regions (Isaac et al. 2009). OzHelp’s suicide training and support service for construction industry workers exemplifies a successful gatekeeper training initiative (OzHelp Foundation 2007). Similarly, targeted gatekeeper training effectively reduces high military suicide rates (Dreazen 2009, Selby et al. 2009, Rozanov et al. 2002).

For those not accessing specific programs, social marketing, stigma reduction and general awareness campaigns may provide basic understanding for an effective response.
A public health approach to suicide and mental health awareness should develop suicide prevention and intervention understanding among the general public (King et al. 2009).

The Council Of Australian Government’s (COAG) National Action Plan for Mental Health 2006-2011 (2006) prioritised investment in community awareness strategies to safeguard people at risk of mental illness and suicide. Culturally and socially specific strategies directed towards at-risk groups, as well as the general population, increase the reach of awareness-raising campaigns. Multicultural Mental Health Australia’s (MMHA) Stepping Out of the Shadows anti-stigma initiative for culturally and linguistically diverse (CALD) communities is an example of this. In a review of 15 suicide and depression public awareness campaigns, Dumesnil and Verger (2009) found public campaigns to be effective at increasing awareness and reducing stigma. The goal of public awareness is to elevate suicide prevention and mental health first aid to levels of acceptance and understanding similar to that which currently exists for heart attacks or drowning (LIFE 2007:3).

**Crisis Services**

De Leo et al.’s (2005) survey of help-seeking behaviour by suicidal Australians found that only 36.7% of people who had planned a suicide attempt and 42.1% of those who attempted suicide sought help for their suicidality. In a review of the 2007 National Mental Health and Wellbeing Survey, Johnson et al. (2009) concluded that, of the respondents who reported suicidality in the previous 12 months, up to 73.4% had some contact with a mental health service in the previous 12 months. These studies indicate a need for improved service delivery (as many who accessed help later attempted suicide) and also a need to increase help-seeking behaviour by suicidal people.

De Leo et al. (2005) also found that, of those who did seek formal help for acute suicidal ideation, 11.1% phoned a crisis helpline such as Lifeline or Kids Helpline. Crisis helplines aim to ameliorate a crisis and stem the psychological decline of an individual. As people in crisis are at greatest risk of suicide, crisis helplines may reduce risk by providing evidence-based first response. Crisis helplines are supported under the NSPS, but despite the positive evidence base, funding is still limited. They are especially vital in rural and remote areas where face-to-face services are restricted.

Currently, in Australia, approximately 20 organisations provide crisis helpline services. Many of these aim to meet the needs of a particular age, geographic or social group. Demand for crisis helplines is high, evidenced by the large number of calls received by the provider organisations every day, yet resources and capacity for these services are limited by technology and resource issues. For example, funding is not provided by the Government on a continuing basis.

Crisis helplines need to be funded by the Government to increase their capacity to respond to demand. An independent body needs to monitor service quality and provide accreditation.

Mobile phone calls to crisis helplines have increased dramatically, yet some mobile phone providers charge for these calls. Service providers recommend that the Australian Communications and Media Authority (ACMA) mandate the provision of free crisis service access from all phones through the establishment of a national 1800 crisis line. Another barrier is the unstructured service network, which hinders navigation for people trying to find a helpline for their needs. Underpinned by increased service capacity, public health campaigns need to promote services and inform on how to access appropriate helplines.

It is well documented that, in general, women are more likely to call crisis helplines (Mishara et al. 2007a, Gould et al. 2006, Mitchell 2000), and that some young people are deterred from calling by feelings of shame and the perceived need for self-reliance (Gould et al. 2006, Gilat and Shahar 2007). Crisis helpline counselling needs to be responsive to the cultural and social variations in callers’ expectations of support, with particular sensitivity to Indigenous and gay, lesbian, bisexual and transgender (GLBT) callers, and CALD communities.
Importantly, studies of crisis helplines by King et al. (2003), Gould et al. (2007) and Paterson et al. (2009) found that helplines do receive calls from suicidal people and provide a therapeutic medium of communication for reducing the suicidality of many callers, saving lives. Kalafat et al. (2007) found that callers had reduced levels of confusion, depression, anger, anxiousness, helplessness and hopelessness at the end of a crisis call. In the sister study by Gould et al. (2007), evidence showed reduced hopelessness for suicidal callers.

Due to the complex and distressing nature of suicidal ideation, brief one-off phone calls are not expected to be effective (nor are they) at reducing long-term depression or distress (Mishara and Diagle 1997). Providing subsequent phone-based psychotherapy following initial helpline contact may therefore benefit some callers experiencing depression, anxiety and suicide ideation (Rhee et al. 2005). Phone-based cognitive behaviour therapy (CBT), combined with antidepressants, is more effective than antidepressants alone at reducing self-reported depressive symptoms (Tutty et al 2000; Simon et al 2004). The Suicide Call Back Service and Kids Helpline provide repeat counselling services over the phone and internet. Internal evaluations by Crisis Support Services have found that the Suicide Call Back Service benefits callers’ emotional state and reduces suicidality (Crisis Support Services 2009). In light of service resource shortages, phone-based psychotherapy is a cost effective treatment for suicidal callers needing support.

Rhee et al.’s (2005) comparison of psychotherapy techniques concluded that compassionate listening and empathy are the most effective strategies for reducing the suicidality of callers. This correlates with the modification of the ASIST program to reduce the emphasis on therapists assessing caller risk; instead actively and empathetically listening to callers (Ramsay 2004). Mishara et al. (2007b) found that empathy and respect were the most essential qualities for crisis helpline staff, and that using these qualities to facilitate problem solving increased the likelihood of positive outcomes. More research is needed to add to the evidence base of crisis helplines and their methods (Leach and Christensen 2006).

Internet-based crisis services are becoming more popular among young people and those who do not feel comfortable with phone-based counselling. Comparing phone and internet help-seeking, Gilat and Shasher (2007) found that internet users were more likely to express their feelings and experiences of suicidality. Kids Helpline provides web- and email-based counselling, through which youths disclose mental health and serious personal problems more often than phone-based counselling (Urbis Keys Young 2002). The Inspire Foundation’s Reach Out internet mental health support service has been accessed by over 7 million young people since its inception in 1998. Inspire’s self-evaluation found that young people aged 16 to 24 were the most likely age group to use the site for support, with 37% of their users visiting the site at least once a week. Their principal reason for visiting was that they were going through a hard time. Importantly, Reach Out was rated by users as their primary source of support (Durkin and Burns 2008).

Recognising the important contribution of crisis phone and web services for suicidal and mentally ill clients, the COAG (2006) National Action Plan on Mental Health 2006-2011 provided $56.9 million to non-government service providers to continue and expand their services. The funding of Lifeline phone booths at suicide hotspots, such as The Gap in Sydney, further recognises the value of crisis phone services for suicidal people.

The network of crisis phone and internet services in Australia remains disjointed. Funding systems are inconsistent, target populations differ, and the network is hard to navigate for those trying to make referrals. Comprehensive mapping of services could identify gaps and collect data to streamline referrals. To address the need for improved structure and quality of services, DoHA and sector representatives developed the Quality Framework for Telephone Counselling and Internet-based Support Services (2008b). The framework, whose guidelines for services are optional and based on self-assessment and evaluation, is an important step towards eventually achieving quality assurance and accreditation of crisis services.

Based on the National E-Health Strategy (Deloitte 2008), phone and web-based crisis sector experts have collaboratively developed E-Mental Health: A 2020 Vision and Strategy for Australia (Christensen et al. 2008). An E-Mental Health Portal for consumers will provide a complementary or alternate crisis intervention pathway to telephone and web-based services, as well as information on how to access general mental health and crisis services.
General Practitioners (GPs) and Allied Health Services

GPs are a common source of care for people who plan and attempt suicide. For example, De Leo et al. (2005) found that 58.9% and 19.2% of individuals respectively used GPs as their primary point of help-seeking. GP contact is associated with reduced suicide risk (O’Brien et al. 2009). Yet, patients at risk of suicide who contact a GP are reliant on the GP recognising their risk and diagnosing and treating the underlying mental illness that causes it. GPs require detailed and structured training to effectively treat patients at risk of suicide, and this capacity can diminish without regular refresher training (Rutz 2001 and Rihmer et al. 1995). Such training has been shown to increase the accuracy of diagnoses of depression and other mental illnesses, and leads to a subsequent reduction in suicide attempts (Mann et al. 2005).

Australian GPs commonly treat clinical depression with a combination of psychosocial and pharmacological interventions; reducing suicide rates, particularly in older people (Hall et al. 2003). SANE Australia’s recent (2010) study of people who have experienced suicidality found coping strategies such as physical exercise, spending time with friends, and calling helplines improved mental health and reduced suicidality. GPs and other health professionals can incorporate these strategies into crisis plans for patients experiencing suicidality. Complementing prescribed pharmacological and other psychosocial interventions, these plans contain simple reminders and advice, including what coping mechanisms may work for them, who to contact, and how to stay safe. SANE’s study found that only 20% of people who have received treatment for a suicide attempt were provided with this simple intervention (SANE Australia 2010).

GPs need to access specific suicide prevention training so that they can effectively and compassionately treat patients experiencing suicidality. This training should be a regular part of GP professional development and accredited by an independent body.

Since 2001, GPs have been able to refer patients at risk of suicide to a psychologist under the Access to Allied Psychological Services (ATAPS) component of the Government’s Better Outcomes project. ATAPS aims to meet the needs of people with high prevalence mental health disorders and the large majority of patients receiving ATAPS services have a depression or anxiety diagnosis (Fletcher et al. 2009). A pilot project under the ATAPS program prioritises the referral of patients at risk of suicide. This project includes unlimited access to services and active follow-up. Additional specialised training for allied health professionals who receive GP referrals is also included. Recent evaluations have extended the pilot period through to 2011.

As part of the COAG National Action Plan on Mental Health 2006 -2011, DoHA established the Better Access initiative. Complementing ATAPS, this program uses Medicare to extend access to psychologist treatment for patients needing mental health support, and also provides financial incentives for GPs to access Mental Health Training. A GP referral entitles patients to receive up to 12 psychologist sessions annually. Evaluation of the Better Access program found that over 1.4 million Australians accessed primary mental health care through the system over a two year period, yet 80% of these were in urban areas; indicating restricted access in rural and remote areas (DoHA 2009). The reasons for lower uptake of Better Access-related services in rural and remote areas needs to be understood, and similar analysis needs to be undertaken to ensure equity of access for economically disadvantaged communities and the rest of the population. Many Better Access-related services are being utilised by patients already accessing mental health support, while other people desperately in need are still not approaching their GPs for help in the first place (MHCA 2010c). Studies by Hawton and Harriss (2007) show how a population-based approach to suicide prevention is necessary to meet the needs of individuals who do not present to GPs or hospitals when suicidal.

For example, male adolescents are among those at high risk of suicide, yet they are also the least likely to attend specialised mental health services (Dudley 2004). Similarly, many men who feel that they should be more self-reliant avoid GPs and formal psychological services. CALD communities also require targeted approaches as they are at high risk of suicide and experience low levels of service utilisation. More appropriate, alternative services should be explored and resourced to meet these gaps and encourage help-seeking. Targeted anti-stigma campaigns increase help-seeking among certain populations of young men. For example, a US Air Force program promoting help-seeking behaviour for suicidal personnel contributed to reduced suicide levels (Knox et al 2003). OzHelp’s program has been cited above.


Similarly, the youth mental health program Headspace has increased the accessibility and use of mental and allied health support for adolescents by providing services in an appropriate and stigma free environment (Muir et al. 2009).
Targeted campaigns should promote help-seeking and awareness through anti-stigma measures and information on services available. This will contribute to the increased access of services, which need to be supported to respond to the demand.

Nurses, paramedics, aero-medical workers, social workers, youth workers, counsellors, drug and alcohol workers and other allied services are also commonly first points of contact for suicidal people. Increased understanding and awareness of suicide among these groups, including knowledge of pathways to care, can stop vulnerable people falling through the cracks. The suicide prevention training available to GPs under the Better Access scheme should be available for all health and allied service workers.

The NSW Mental Health Sentinel Events Review Committee estimated that one third of suicides are preventable with more optimum primary care (NSW Health 2007). Yet, under the current pathways to care, GPs generally refer suicidal patients who need acute or community care through EDs rather than directly to inpatient or community services. Community-based crisis assessment and emergency intervention services, despite being a core component of DoHA’s National Mental Health Policy (2008a), are not widely available. State health departments and non-government organisations provide a variety of community mental health services, such as Extended Hours Teams (EHTs), Community Assessment and Treatment Teams (CATTs) and Crisis Resolution Teams (CRTs). Resources, location, awareness, diagnostic criteria and a lack of interagency collaboration, however, limit access. Referral to specialist psychiatric crisis intervention services, rather than to general EDs, is economically cost effective as it reduces the rate of hospital admissions (Damsa et al 2005). Despite this, and evidence that mobile community services generate better outcomes (Rosen et al 2010), Mental Health Crisis Assessment Teams (MHCAIs), which provide mobile emergency mental health care, have recently had their funding reduced and been relocated to EDs.

Fully resourced crisis assessment and emergency intervention services need to be established in every community as per the 2008 National Mental Health Policy. Improved service coordination and collaboration that allows GPs to refer patients to a variety of different services, depending on their need, would not only be more cost effective, it is also in the best interests of the patient.

Additionally, “pathways to care should be seamless with continuity of care maximised” (National Hospital and Health Review Committee (NHHRC) 2008: 195).

**Triple Zero, Ambulance and Police Services**

Triple Zero, police and ambulance workers are often first responders to suicide attempts or threats. In this capacity, they should be equipped to recognise and respond to the emotional, cognitive, behavioural and physiological needs of suicidal individuals (Suicide Prevention Resource Centre (SPRC) 2005).

Emergency personnel often have to respond to the needs of family members, witnesses and bystanders as well as the patients. Without training and support, this can be very challenging. Ambulance services usually include basic mental health treatment in their training, but for police and firefighters, training is on an ad hoc basis and is not a professional requirement. Specific suicide response training is even more sporadic and often subsumed under mental health response.

The World Health Organisation (WHO 2009) has produced guidelines for police, ambulance workers and other first line responders that aim to reduce suicidal deaths; decrease the incidence, severity and affects of suicide attempts; and protect emergency personnel through appropriate first response. These guidelines are available at: http://whqlibdoc.who.int/publications/2009/9789241598439_eng.pdf

Triple Zero, the national emergency services phone line is often the first point of contact for emergency services to a suicide crisis. Protocols for emergency service response to calls transferred from Triple Zero vary across each state and territory and across services, but commonly follow the systems provided by organisations such as the Priority Dispatch Corporation in the United States. Operators are not trained in mental health or suicide response, and operators’ guidelines when receiving calls relating to suicide are limited to asking about medical needs and keeping a suicidal caller on the line. Yet, without mental health or suicide prevention training, operators are ill equipped to divert from standard questions or to maintain communication with a suicidal caller in a safe manner.
The decision-making and communication skills required for calls involving suicidal emergencies must be supported by specific and detailed suicide training that is nationally accredited, regularly reviewed and based on international best practice. States and territory governments have a responsibility to ensure that emergency call services effectively respond to the needs of suicidal people, and are in a position to mandate mental health and suicide training for emergency service and Triple Zero call takers.

In cases of suicide attempts where medical intervention is required, an ambulance is dispatched to the scene. In rural and remote areas, a local service provider or community responder will often attend the patient prior to medical or psychiatric response. Some areas have MHCATs that support ambulance personnel or precede them to the scene. However, in recent years, these have been scaled back in favour of in-hospital assessments (see above).

In the absence of MHCATs, mental health assessment and response skills at point of contact are provided by ambulance staff. There are state and territory jurisdictional variations in legislation governing ambulance response and, while staff education involves basic mental health training, ambulance staff have reported that the level of ethical decision-making involved in responding to suicide attempts is only achieved through experience and/or extensive training (Personal communication Council of Ambulance Authorities 2010). Ambulance staff need the skills to assess suicide risk and provide immediate management, but they also need support and training to safeguard their personal needs and to deal with the trauma associated with crisis response. Knowledge of local mental health legislation, involuntary admission laws and mental health or support services, facilitates ambulance workers’ decision-making about suicidal patients.

In cases where the patient has a weapon or dangerous implement or their intentions are not clear, the police will also be dispatched to the scene. Police have discretionary powers to divert suicidal people who may have committed a crime from the criminal justice system to appropriate mental health services, yet the ability to make appropriate decisions under this power is dependent on police understanding of mental health and suicide prevention, as well as access to information on the appropriate referral pathways in each jurisdiction. Drug or alcohol misuse by people with a mental illness and lack of police confidence in pathways to care may prevent police diverting patients to mental health care rather than through the criminal justice system (Lamb et al. 2002). Police attendance at suicidal crises may also add to the stigma of suicide by giving the impression that the person is socially deviant and even criminal. Police training must consider the possibility of police-assisted suicide, when an individual intentionally provokes deadly force from police and, importantly, must give police tools and support to deal with the personal effects of traumatic incidents.

In line with the Memphis model of police crisis response, several state police departments have mental health intervention or similar training for officers and Suicide Negotiation Teams within their Critical Incident or Rescue Squads. These projects train individuals to effectively respond to mental health and suicide crises, but are not universally available or resourced to respond to every situation.

Currently, the few mental health crisis services that are available in the community are generally modelled as case management and continuity of care safeguard services, rather than having a strong emergency focus (Rosen et al. 2008). While this is a useful model for community care, these services are not widespread and have a weak ability to respond to suicide crises.

Police will inevitably be required to respond to incidences that involve mental illnesses (including attempted suicide, family violence, public disturbances etc). However, using police vehicles to transport patients and relying on police as frontline mental health responders is not appropriate in place of adequate mental health crisis response (Burgess 2007). The transfer of individuals from police care to psychiatric services or EDs can be problematic due to the nature of suicidal patients’ distress; the stigma sometimes associated with such involvement; and the lack of clarity of responsibility for patient safety and supervision (Steadman et al. 2001). In rural and remote areas, and during after hour periods, police experience further delays in referring patients for mental health assessment; lengthening the stressful period for the patient. In some cases, the urgency of the crisis may dissipate and the subsequent treatment may not address previous symptoms.

The Memorandum of Understanding (MOU) between NSW Health, the Ambulance Service of NSW, and the NSW Police for Mental Health Emergency Response is an example of an effective measure to promote safe and coordinated systems of care (2007). Similar MOUs exist in Queensland and Tasmania as well as some other jurisdictions. Burgess (2007) advocates the inclusion of transitional handover mental health services as a component of MOU collaboration to reduce the risks associated with patient handovers. MOUs also need to be established with aero-medical services and Aboriginal and remote health services to ensure emergency pathways to care for suicidal people in remote areas are seamless and efficient.
Current accredited paramedic education curricula should be reviewed and developed to place a greater emphasis on the mental health and suicide prevention training of ambulance staff.

Increased funding and training for all members of the police force could facilitate further dissemination of appropriate intervention strategies for frontline responders. Training should be accredited by an independent body and include refresher courses. Suicide attempt survivors should be involved in the development and implementation of training.

In addition to police training, fully resourced MHCATs should attend crises with emergency services and help to assess the situation and reduce the criminalisation of mental illness. The funding issues that have led to the scaling back of MHCATs have reduced the capacity of the emergency services to provide optimum care and response to vulnerable people.

The development of clear guidelines, protocols and relationships between services should address the lack of inter-organisational coordination.

The Role of Emergency Departments (EDs) and Community Care

Nearly one third of people who attempt suicide access the first point of treatment at an ED (De Leo et al. 2005), and nearly 60% of people who have died by suicide had previously presented to an ED (Salter and Pielage 2000). EDs are therefore vital sites for suicide prevention, yet up to 25% of people who present to the ED following a suicide attempt will make another attempt and up to 10% eventually die by suicide (Larkin and Beutrais 2010).

Several international and Australian studies have reported negative staff attitudes experienced by suicidal and self-harm patients in EDs and acute care (see Pajonk et al. 2002, Mackay and Barrowclough 2005, McCann et al. 2006, Allen 2007, Wheatly and Payne 2009, Hadfield et al. 2009, Michel et al. 2009). King et al. (2004) found evidence in Australian EDs that some staff have negative attitudes to mental health and drug and alcohol patients, although this was improved with effective training. Australian EDs have experienced a huge increase in demand for emergency mental health care in recent years, corresponding to increased awareness of mental health and suicide issues by ED staff (DoHA 2006). Under the COAG National Action Plan on Mental Health 2006-2011, Western Australia, South Australia, New South Wales, Victoria and Tasmania committed to allocating considerable resources to improve mental health care in EDs, while the other state and territories dedicated increased funds to community mental health care (COAG 2006). Further improvements include new models of care such as Psychiatric Emergency Care Centres, Short Stay Units, and dedicated mental health and drug and alcohol workers in EDs across the country (Commonwealth of Australia 2009).

Despite these improvements, challenges remain in the recruitment and retention of quality staff in EDs and carers and consumers have reported difficulties with access to and the quality of emergency care (Commonwealth of Australia 2009).

Training, support and resources are needed to overcome the barriers that remain with staff and ensure that suicide attempt survivors are treated effectively and with dignity. A public health approach to reduce community stigma surrounding suicide, would also contribute to medical staff attitudes and understandings of suicide.

The skill needs of ED staff to deliver interventions to suicidal patients have been recognised by state governments, who have implemented some training programs and increased access to specialised mental health staff in EDs (State Government Victoria 2009 and NSW Health 2008). Yet, conversely, mental health is not a compulsory component of nurses training in all states (e.g. Victoria). Skills and treatment training for suicidal patients has proven value; staff who feel professionally equipped to treat suicidal patients are more likely to have positive attitudes towards these patients and to treat them with dignity and respect (King et al. 2004, Wheatly and Payne 2009).
Apart from the ethical imperative for good care, the quality of emergency acute care may reduce further suicidality (Australian College for Emergency Medicine (ACEM) 2000). EDs offer an opportunity for cost effective approaches such as suicide screening, brief interventions, suicide registers, promoting referrals and enhancing engagement (Larkin and Beautrais 2010). However, they are structured, albeit with varying degrees of success, to refer patients’ psychological needs to other care providers.

Many EDs have treatment guidelines for suicide attempt patients. However, they often refer to medical treatment only, and McCann et al. (2006) found that 21.4% of nurses did not know of their existence and, even among those who did, 33.3% had never read or utilised them.

There is a strong need for more concentrated training to address staff attitudes to mental health and suicidal behaviour as a requisite component of skills and knowledge training (Ramsay 2004). Clear and visible guidelines for staff treatment of suicidal patients, including attitudinal, ethical and practical components, ought to be supported by compulsory, regular, detailed and accredited staff training.

Importantly, the capacity of EDs to respond to the emergency and crisis needs of a suicidal patient are reliant on many more factors than staff attitudes. When mental health care was mainstreamed in 1992, the pathways to care for patients with mental illness were largely diverted through the emergency room doors (Australian Health Ministers 1992). The responsibility for assessment and intake into psychiatric departments has moved from mental health teams to ED clinicians, and mental health staff encourage the thorough physical assessment of patients before they respond to the psychiatric or psychological needs of patients.

The consistent use of Mental Health Triage scales has been recommended to overcome delays in mental health treatment for patients presenting to EDs and to improve referral timeliness (Broadbent et al. 2007, National Institute for Clinical Excellence 2004, ACEM 2000).

EDs are generally under resourced and over capacity and, under the current model of health care, typically respond to the need for immediate, short-term, emergency treatment. This is not always a suitable environment or pathway to care for a person who is suffering a mental illness, experiencing alcohol or drug problems or suffering emotional turmoil, and may exacerbate the crisis situation that a suicidal person experiences. The medical model of treatment that dominates is effective for most emergency cases, but reliance on it as a site for an effective mental health or suicide attempt response may be misguided. “Community treatment should be the treatment of choice wherever appropriate” (DoHA 2008a: 17).

EDs should be recognised for what they currently are: emergency care and stabilisation, case identification and referral sites. Opportunities for alternative models in which people experiencing crises can receive the range of care they need outside of the physical emergency spectrum should be considered. Mental health crisis care, in EDs or preferably in inpatient or community settings, should be available for patients from the point of Mental Health Triage.

Recognising the resourcing issues that face EDs, SPA advocates for the consideration of the recruitment of non-medical personnel to accompany and support suicidal patients through their respective pathways to care. This should not replace medical or mental health staff contact, but would ensure that patients are not left alone and are emotionally supported. Established crisis services, such as Lifeline, are already well positioned to coordinate and administer this type of service. The contributions of people with lived experience of suicide, as consultants, paid staff or volunteers, would add to their effectiveness and appropriateness.
In July 2007, the suicide of a young man hit the headlines as he had been waiting for 22 hours in Wagga Wagga Base Hospital ED for a bed in an acute psychiatric unit. He had been assessed as at high risk of suicide and emergency staff were eager to get him a bed where he could be properly and effectively treated. No bed was available and the young man suicided before he could get the care he needed.

This case highlights the need for suicidal persons to be continuously monitored and referred out of an ED to a suitable site of care. This site may be acute psychiatric care or community-based intermediate care. The latter may include mental health and psychological care, GPs, Mental Health Nursing Practitioners (MHNPs), drug and alcohol, sexual assault and family violence services, as well as services addressing employment, parenting, youth or housing concerns and culturally and socially appropriate services for minority groups. The pathway to care for these services is currently disjointed and in need of reform.

For patients in need of acute psychiatric care, there is a nationwide shortage of inpatient psychiatric beds, creating a tension between the need for mental health staff to prioritise patient intake and discharge.

The patient and, where appropriate, family and other relevant individuals should be involved in making decisions on where a referral is actioned (Mitchell 2000).

The effective management and funding of community mental health care could alleviate the tension on acute services and extend the current model of community care to new and alternative services.

Community care leads to more positive outcomes and is more cost effective than inpatient care, yet has been eroded by the competitive funding structures throughout the health system in recent years (Rosen et al 2010). It is estimated that 40% of people in acute beds could be more effectively treated in community care. Since the mid 1990s, however, over half of community care beds have disappeared (MHCA 2010a). Community care models such as Parakaleo in Tasmania (www.parakaleo.org.au/suicideint_training.htm) and Maytree in England (www.maytree.org.uk) should be considered to divert patients away from the traditional path through acute care to a more appropriate environment for their needs. These short-term residential models have been found to be effective at reducing suicidality and providing long-term benefits (Briggs et al. 2007). Similarly, a formalised, structured and adequately resourced Mental Health Nursing Practitioner outpatient service, integrated within the ED treatment and referral system, has the potential to address some of the gaps in care for people who do not need acute mental health care, but do need additional treatment (Wand and White 2007, Currier et al. 2010).

Critically, appropriate community care facilities act as an important service to reduce the need for patients to get to the stage where they need emergency care. Early intervention and prevention is a much more cost effective and person-centred approach to care (Access Economics 2008), and is already the dominant model in parallel medical areas, such as skin or breast cancer. Headspace youth mental health services demonstrate the early intervention model of mental health care, which provides accessible community-based services to youth at risk of suicide.

The restructuring and adequate resourcing of community services is part of the current drive to overhaul the mental health system. The NHHRC recommends the “expansion of sub-acute services in the community and propose[s] that all acute mental health services have a ‘rapid response outreach team’, available 24 hours a day, which can provide intensive community treatment and support, as an alternative to hospital-based treatment” (NHHRC 2009: 4). For individuals who are unable to access community mental health care because of its cost or inaccessibility at the initial onset of their suicidality, the current system necessitates their deterioration to an emergency or crisis point before they can access timely care in an ED. This system lacks compassion and logic. Community mental health care is currently a state and territory responsibility, yet the resources and capacity to create the necessary improvements are largely unavailable at state level. Therefore, the proposed Commonwealth takeover of community-based mental health care may be necessary (MHCA 2010b).

Johnson et al. (2009: 642) recommend that suicide interventions should “straddle the interface between clinical and population based approaches”. In this regard, the COAG National Action for Mental Health 2006-2011 (2006: 4) commits to “developing ways of coordinating and linking the range of care that is provided across the continuum of primary, acute and community services by public, non-government and private sector providers”.

A properly funded, multi-tiered, inter-sectoral approach would ensure that appropriate services for suicidal people are available and accessible at their time of need, and would help to ensure that people who are experiencing emotional turmoil do not get to the stage of suicidality.
Prisons

As a unique location for suicidality, prisons require specialised crisis response. Suicide is the leading cause of death in prisons in Australia (McArthur et al. 1999). Suicide rates for pre-trial and sentenced prisoners are 10 and three times that of the general population respectively (WHO 2000).

Compared to the general population, prisoners experience extremely high prevalence and complexity of mental disorders; often combined with suicide risk factors such as substance abuse, homelessness, and a history of abuse (Paton and Jenkins 2002 and Kellam 2006).

The deinstitutionalisation of mental health care and the subsequent gaps in care have resulted in an increasing number of mentally ill people ending up in the criminal justice system (MHCA 2005, Kellam 2006).

Prisoner access to crisis and mental health support are critical suicide prevention measures in prisons. Peer support systems, staff awareness, visitor access, shared accommodation, restriction of means and effective prison education and social programs can contribute to safeguarding the mental wellbeing of inmates (McArthur et al. 1999).

Suicide risk screening and intervention is a part of some prison health systems, depending on resources and state practice. Fazel et al. (2008) found several risk factors for suicide among prisoners, which importantly included potentially modifiable clinical and institutional factors. Mental illness and alcohol problems were significant risk factors, reduced by effective treatment and interventions, while single cell occupancy and lack of visitors were also strongly correlated with suicide risk. The first week of incarceration is an elevated period of risk. Hanging is the most frequent method of suicide in prisons. While new cells are generally designed without potential hanging points, the modification of existing accommodation may well contribute to a reduction in suicides.

Considering the risk and prevalence of suicide in prisons, prison staff often need to provide emergency care by delivering initial first aid and responding to ongoing personal and health needs. Procedures for health response must be planned and pathways to appropriate care should be timely and should take prisoner needs into account.

A comprehensive psychological assessment of the prisoner, examining underlying problems, precipitating issues and planning treatment, should be undertaken as soon as possible following a suicide attempt (WHO 2007). The segregation of suicidal prisoners and restricting access to means of suicide are not appropriate responses without appropriate social support and psychosocial treatment (WHO 2000). Following a suicide or suicide attempt in a prison, there is a high risk of contagion suicides. Other inmates need to be psychosocially supported and have access to counselling, if appropriate (WHO 2007).

Due to the prevalence of suicidality in prisons, suicide prevention and intervention training is a regular component of correctional staff training with some states making it a compulsory requirement.

The content, quality and application of staff training needs to be assessed to ensure that it follows best practice guidelines and is accredited through a national body. Further attention needs to be given to reducing suicide attempts and addressing the needs of correctional staff and other prisoners who witness suicide attempts.

Support for Witnesses and Bereaved

Please see the SPA Position Statement, ‘Suicide Bereavement and Postvention’ (2009d), for a comprehensive analysis of the support needs of people bereaved by suicide:
http://suicidepreventionaust.org/PositionStatements.aspx

A suicide or suicide attempt often has a profound impact on family members, friends and other individuals. Confusion, guilt, anger, denial and shock are just some of the complex emotions that may accompany the worry and concern that a bereaved individual may feel.
A suicide or suicide attempt is potentially a site of suicide prevention and intervention for family or friends and other associates of the patient, as family history of suicide is a known risk factor for future suicide (LIFE Framework 2007). The role of a first responder to suicide needs to include a responsibility to support family, friends and bystanders as much as possible (WHO 2009). This should include sensitivity to family needs at point of first response and referral information for appropriate services. This is known as postvention.

Andriessen (2009) found that those bereaved by suicide were more likely to suffer long-term mental health problems compared to the general population, and that postvention in the form of early intervention and treatment by health professionals, support groups or telephone helpline services can reduce this risk.

Cerel and Campbell (2008) found that active postvention, including the attendance of trained volunteers with personal experiences of suicide at the scene of death or soon after at the family home, gave families initial support and comfort and encouraged them to engage with support services. Coronial counsellors offer personal support and information for families bereaved by suicide—a service that is particularly necessary considering the increased distress that can be caused by the police investigation that follows a suicide. Services such as StandBy Response Service provide telephone and face-to-face counselling for bereaved people, which can reduce the compounded long-term complications of bereavement by suicide. StandBy also provides individualised practical support that recognises the varied and complex needs of people bereaved by suicide. Evaluations of StandBy services found that they reduced suicide ideation of suicide bereaved people to levels lower than that of the general population (Corporate Diagnostics 2009). Similarly, the Salvation Army National Hope Line provides a telephone counselling service that offers comfort and support, and also information and skills to help equip bereaved people with the tools to get through their devastating experience. Bereavement support services can deliver positive outcomes for family members of suicide victims, but need to be gender, socially and culturally specific (Clark 2001).

Research by Maple et al. (2009) found that following initial support available post-bereavement, it became harder for family members to maintain the level of social support they needed. Therefore, bereavement and support services must take a long-term approach to helping family and friends and other individuals bereaved by suicide.

Analysis by Ratnarajah and Schofield (2008) of the narratives of children who had lost parents to suicide showed the sense of abandonment that parental suicide creates in children and the need for bereavement counsellors to understand the history of the relationships and the family dysfunction that may have contributed to or culminated in the suicide. In this sense, bereavement counselling can be an opportunity for intervention to support family functioning.

De Leo and Heller (2008) found suicide contagion risks can be even higher for friends than for family members. For this reason, they recommend that “postvention activities should have targets that go beyond the immediate family circle, but encompass all emotionally affected proxies/peers of the deceased person” (De Leo and Heller 2008: 17). This is especially the case for young people and is also true of situations of attempted suicide (De Leo and Heller 2008). Crisis plans for postvention in schools can address some of the issues of peer trauma and give students strategies to deal with their grief safely (Clark 2001). There is evidence that some poorly designed or administered support services can have negative effects on bereavement; necessitating evidence-based practices, guidelines and accreditation (Clark 2001).

Families, friends and significant others of people who suicide or attempt suicide, have much to contribute to the understanding of suicidal behaviours. Professionals and bereaved people working together can begin to “explore and ultimately find some of the answers” to suicide issues (Myers and Fine 2007: 122).
Support Needs of First Responders

First responders to suicide and suicide attempts are exposed to high risk, stressful and challenging situations and need to be trained and supported to manage their own needs as well as the needs of those they respond to (Johnson et al. 2009).

The needs of incidental first responders, such as family, community gatekeepers and members of the public, should be addressed through the provision of counselling services, referral information and follow-up support.

First responders who are exposed to crisis situations and suicide attempts as part of their job should have formal structures of support and debriefing embedded in their work practices (Paterson et al. 2009). Police and ambulance personnel are at risk of stress-related anxiety and depression, as well as post traumatic stress disorder, due to the nature of the situations that they respond to. Ambulance personnel report repeat suicide attempt attendances as being especially difficult to deal with and as a contributing factor to burnout (Personal Communication CAA 2010). Hadfield et al. (2009) found that ED doctors distance themselves from patients’ emotions in an effort to contain the personal impact of being a first responder to suicide. Similarly, Wistrand et al. (2007) found that, in order to manage personal feelings, nurses set up boundaries between themselves and suicide attempt patients in ways not typical to other patients. This has negative implications for patient care and needs to be counteracted with effective support and training for all first responders that address their own needs, as well as those of their patients.

Clinicians and carers who treat or interact with suicidal people prior to their suicide attempt or death may feel professionally or personally responsible (Clark 2001). Professionals need to be supported to accept that their efforts may not be absolute or 100% effective (Myers and Fine 2007). They are also often called on for bereavement support for family and friends following a death by suicide, while concurrently being involved in the legal proceedings of a coroner’s report.

Strategies for debriefing and support embedded in organisational practice should safeguard the professional’s own needs to reduce distress and burnout. This is also true and especially compelling for teachers whose students experience suicidality, and should be addressed through school crisis plans (Clark 2001).

Kinzel and Nanson (2000) track the pathway to crisis helpline responder burnout through the stages of emotional exhaustion, de-personalisation and diminished personal accomplishment. This leads to a high staff turnover; increasing the resources needed for training and retention of volunteers and staff. Lifeline volunteers reported the difficulty of responding to mentally ill clients who saw them as a last resort when other services were not available (Urbs Keys Young 2002). Kinzel and Nanson (2000) recommend ongoing support and debriefing to reduce staff burnout.

Barron (2007) found that police were at a higher risk of suicide than the general population, and that most police officers who suicided had previously been referred to an organisational psychologist or similar support person. This suggests the need for increased suicide screening and support for distressed officers—especially those who have responded to a suicide or suicide attempt.

Professional first responders need support and training to safeguard their emotional needs and enable them to continue to undertake their important roles. All care and support provided to first responders should be of best practice standards and accredited by an independent body.
Key Recommendations

- Since first response to suicide is everyone’s business and not restricted to health or related services, gatekeeper training should be provided widely in the community. Gatekeeper training should involve personnel like emergency services and medical professionals but also other ‘community gatekeepers’ who are most likely to become first responders and carers (families and friends) of suicidal persons.

- Crisis response services should be recognised as vital infrastructure for suicide prevention in Australia, because of the evidence that exists regarding their effectiveness in attracting suicidal persons who are seeking help and their ability to provide appropriate crisis response, including linkages to safety interventions for persons in suicidal crisis.

- Mental health services, including step up and step down care, need to be available and accessible in the community to reduce incidences of suicidality and also to provide appropriate sites of crisis care for people who become suicidal. The coordination and interagency collaboration of mainstream, mental and allied health services are essential for the provision of effective and accessible care.

- Emergency services such as Triple Zero operators, police, ambulance and emergency departments should be recognised as service providers in suicide prevention on the basis of their involvement in interventions to uphold personal safety, and should accordingly operate within national protocols to define the intersection of emergency services and other suicide crisis support services.

- The establishment of personal support services in emergency departments and hospitals and during transitions between care should be considered. These services would work alongside mental health and medical care, ensuring suicidal patients receive emotional support and are not left alone. Established crisis services are well positioned to administer this type of service.

- Investment should be made into trials of short-term residential community care for suicidal people, following models developed in other countries.

- First responders to suicide and suicide attempts are exposed to high risk, stressful and challenging situations and need to be trained and supported to manage their own needs as well as the needs of those they respond to.

- All suicide prevention and intervention activities need to be based on best practice guidelines and evidence-based frameworks. SPA advocates for the establishment of a National Accreditation Body that will monitor and accredit training providers, services, and programs. This will increase and maintain the quality of all suicide prevention activities.

- Suicidal, suicide-bereaved people and suicide attempt survivors narrate experiences that are crucial to understanding suicide and informing suicide prevention. They need to be involved in all levels of policy development and service provision, and be supported in these roles.
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