IN THEIR WORDS:

HOW TO SUPPORT YOUNG PEOPLE IN SUICIDAL DISTRESS

Suicide Prevention Australia

August 2022

CEO's Foreword

As older adults we often forget the whole picture of what it was like to be a young person or young adult. We may remember the good times, the life-long friendships we made and the beginnings of journeys both literal and metaphorical. But we can forget that for many of us, being a young person is in some ways the most difficult time of our life.

Often it's a time of uncertainty, both internally and externally. We may not yet be sure exactly who we are or what we would like to be. Some of our most important relations, with parents and other family members, are in flux as we transition towards independence. At the same time our income may be lower and more unstable than at any other time of our life.

If we, for a moment, take off our rose-coloured glasses and think back, many of us will remember not just "the best days of our lives" but also times that were not so good either for ourselves or our friends.

The point of this is not to dwell on dark times, but to use those recollections as a reminder of the importance of supporting young people. We were all young once and we all needed support to thrive and grow. If we were fortunate, we got that support. But not everybody did. From these experiences we can all agree that as a nation we need to strive to ensure that when a young person is in distress, particularly when they are self-harming or have attempted suicide, they get the support that they need.

The common adage "nothing about us, without us" applies in youth suicide prevention as much as in any other area. So our efforts to address youth suicide should be guided by the insights of today's young people. As set out in this report, young people have said clearly that a key part of preventing youth suicides is addressing the support received by young people who present at hospital emergency departments (ED) after self-harming or a suicide attempt.

Emergency departments can, and should be, improved in the ways they respond in these situations. However, the key message from young people is that ideally in many cases they should not be going to an ED and do so only because there are no better options (or no other options at all).

What is needed is alternatives to ED. Young people need places or services that can address both the physical health consequences of self-harm and suicide attempts, while also addressing and not exacerbating suicidal distress and the wider range of factors that have led to the distress. Providing a safe environment to address both physical and mental needs is essential.

Such places and services will only be effective if they are designed in partnership with young people. As always, consultations need to start early and continue throughout the process. This report represents early steps in the process of creating a comprehensive set of supports for young people in circumstances of high risk. It has drawn on the insights of 85 young people to outline what reforms are needed to create these supports, and has developed recommendations for the process of reform.

Nieves Murray
CEO
Suicide Prevention Australia

Executive Summary

Suicide Prevention Australia

To address the critical issue of youth suicides effectively, we need to hear the voices of young people. This report is based on consultations with 85 young people, as well as input from 13 organisations that focus on youth suicide prevention and mental health, and a review of published research. These consultations with young people and experts, and the available data and research, make it clear that a key aspect of preventing youth suicides is addressing the too often negative experiences of young people attending ED after attempting suicide or self-harm or at a point of suicidal distress.

Young people have said they need alternatives to ED, and that these alternatives should have the following features:

- Both place-based and response team models are needed
- The staff must be able to provide both medical assistance and compassionate support
- There should be clear processes and choice
- They should be accessible to all and safe
- Place-based services should be designed and located to protect privacy, and have an environment that feels safe and focussed on mental health and wellbeing

Even with a system of alternatives, there will likely always be some level of presentations to ED of young people who have attempted suicide of self-harmed. Young people have given insights on how ED can better address the needs of these young people:

- Clearer processes
- Improved accessibility
- Further staff training on suicide and self-harm
- Specific suicide response staff including youth peer workers
- Reduce waiting times and provide support while waiting
- Create alternative waiting areas
- Increased privacy
- Improved follow-up support

The following recommendations outline steps governments can take to respond to these insights.

Recommendation 1: All state and territory governments should, in their 2023-24 budget, allocate funding for programs to design and trial a number of youth-specific alternatives to ED for young people in suicidal or mental health crisis.

Recommendation 2: The Australian Government should support state and territory efforts to develop youth-specific alternatives to ED by providing part of the funding and by forming a working group with state and territory governments under the new National Mental Health and Suicide Prevention Agreement to coordinate the sharing of lessons learned from these trials and investigate a national network of youth-specific alternatives.

Recommendation 3: The programs to fund the designs and trials should be implemented to ensure that:

- All trials are co-designed with young people
- The trials are conducted at sufficient scale to have the potential of a measurable reduction in presentations to nearby ED
- All trials are evaluated to determine the extent to which they are diverting young people from ED, and the effectiveness of the support provided

Recommendation 4: Following evaluation of the youth-specific alternatives to ED, state and territory governments should select one or more of the trialled models to be rolled out to provide state- or territory-wide coverage with funding equivalent to the savings of anticipated diversions from ED.

Recommendation 5: All state and territory governments should, in their 2023-24 budget, allocate funding to upgrade ED's capacity to address the needs of young people who are presenting after having made a suicide attempt or self-harmed. Each hospital ED should be resourced to investigate options for improved accessibility, creating alternate waiting areas, and creating spaces for private conversations.

Recommendation 6: All state and territory governments should, in their 2023-24 budget, allocate funding to trial a program of increased training for ED staff on responding to young people who have attempted suicide or self-harm, and the introduction of an ED Suicide Response Team which includes youth peer workers.

Recommendation 7: All state and territory health departments should consult broadly with young people on where they would search for information on ED and what information they need. Based on this they should co-design with young people clear and accessible information on ED processes.

Introduction

Suicide is the most common cause of death for young people.[1] Over the past ten years an average of around 400 young people died each year from suicide, and the rate of youth suicide is increasing.[2] It's therefore critical to ensure that effective supports are available to young people at high risk of suicide.

Young people who have previously attempted suicide, and young people who have self-harmed without an intention to take their own life, are at substantially higher risk of dying by subsequent suicide attempts.[3] Each year across Australia over 10,000 of these young people attend hospital ED following their self-harm or suicide attempts.[4]

A substantial body of research, as well as the young people consulted in this project, make it clear that too often the young people who attend ED following self-harm or suicide attempts do not receive the support they need.[5] The indications are that those in suicidal distress who have poor experiences in an ED are less likely to return to the ED or attend follow-up appointments.[6]

So it is clear that improving supports received by young people in these situations is an important part of reducing youth suicide. Drawing on the insights of 85 young people, experts in youth wellbeing, and published research, this report examines what is needed for young people who attend ED following self-harm or suicide attempts.

What the young people who were consulted with have said about improving ED aligns closely with previous research. However, one of the key insights from young people has not previously been sufficiently highlighted. There was strong consensus that ED are fundamentally unsuited to meeting the needs of young people who have made a suicide attempt, have self-harmed, or are at a point of suicidal distress.

What the young people who were consulted with have said about improving ED aligns closely with previous research. However, one of the key insights from young people has not previously been sufficiently highlighted. There was strong consensus that ED are fundamentally unsuited to meeting the needs of young people who have made a suicide attempt, have self-harmed, or are at a point of suicidal distress. What is needed is effective youth-specific alternatives to ED.

However, even with a system of alternatives to ED, there will likely always be some presentations of young people who have self-harmed or made a suicide attempt. This means improvements to ED should also be undertaken. Many of the insights around the design of alternatives can be to some extent incorporated into ED, and young people's insights on such improvements are also outlined.

Providing alternatives to ED not only gives more suitable support to young people in suicidal distress, it also has wider benefits in relieving the pressure on ED that are being additionally burdened by the ongoing impacts of Covid-19. This report concludes by setting out recommendations for a process to develop youth-specific alternatives to ED. Such a process is effectively an investment in strengthening our emergency care system, as well as an investment in the health and wellbeing of our young people.

Consultations and Research

This report draws on insights from young people, from stakeholders in organisations with a focus on youth suicide prevention and mental health, and from published research. The process of consultations and research review is briefly outlined here.

The project's intention was to examine an aspect of youth suicide prevention and make recommendations for policy reform. The aspect of youth suicide prevention that would be the focus of the project was to be determined by consultations with young people and other stakeholders.

Initially a short list of potential focus areas for the project were derived from a search of published research and media reports over the past five years. Then a series of consultations were undertaken with young people and with representatives of government agencies and non-government organisations that focus on youth suicide prevention and mental health. These consultations included four workshops with 38 young people, as well as meetings with experts in nine different organisations. All consultations were undertaken via videoconferencing due to Covid-19 restrictions.

In all cases the broad structure of the consultations was the same. After a brief outline of the project (and for the workshops with young people, some information on safe language, self-care, and support services), participants were informed that some pre-prepared ideas for the project focus areas would be presented to them, but they were first invited to give any initial thoughts they had on potential focus areas. The pre-prepared focus area ideas were then outlined, followed by a discussion on each of the ideas and any additional ideas they had raised.

Participants were then given another opportunity to raise and discuss any further ideas. Finally, participants were asked to nominate which of the ideas should be the focus of the project.

There was support for a number of focus areas and many of the participants struggled to nominate a single idea as their preference. However, there was a clear majority of support, amongst both the young people and the other stakeholders, for a focus on improving the experience, or providing alternatives, for young people who present to a hospital ED after a suicide attempt.

Having established a focus area for the project, the next stage was to conduct further consultations focused on this area. Two young people were engaged to co-design and co-facilitate further consultations with young people. A review of the published research on this area was undertaken to help inform consultations.7 And a series of six workshops with 27 young people were conducted, as well as meetings with other stakeholders. In all consultations both alternatives to ED and improvements to ED were discussed. These consultations were a mix of videoconference and face-to-face.

Based on the results of these consultations a survey was co-designed with the two young people engaged in the project and it was made available online to those who were not able to attend the remote or face-to-face consultations. A further 20 young people responded to this survey.

In total, 13 different organisations and 85 young people were consulted. The young people in consultations were asked to give demographic information separately to the consultations, but not all elected to do so. From the demographic data, we know that the consultations included young people from regional areas, Aboriginal and Torres Strait Islander young people, LGBTIQ+ young people, young people with disability, and young people from culturally and linguistically diverse backgrounds.

Findings

ALTERNATIVES TO EMERGENCY DEPARTMENTS

As mentioned above, although young people acknowledged the importance of improvements to ED, their strong view was that there were limits as to how much ED could be made to address their needs when they were suicidal or had been self-harming.

This was not expressed as a criticism of ED staff. Some young people recounted stories of ED staff going to great lengths to provide support. And even many of those young people who had had negative experiences acknowledged that this was likely due to high workloads and they were supportive of increased resources for ED.

However, a consistent view amongst young people was that ED were inherently focused on physical health crises and would always struggle to create an environment that felt safe and focussed on mental health and wellbeing.

Young people clearly expressed the view that they needed alternatives to ED.

There are a number of services which offer an alternative to ED, but most cover a very limited area and none are youth-specific. It is important that youth-specific alternatives to ED exist in order to address the risk factors unique to young people, and to match their help-seeking behaviours and needs. For example, research indicates that adolescent suicides have a higher prevalence of family conflicts, school-related problems and suicides in social groups.[8] Other research demonstrates that school students experience particular barriers in help-seeking, such as embarrassment, concern at breaking the trust of a friend, and feeling as though the situation would become worse if an adult was involved.[9]

The operating models of some of the currently available alternatives to ED could potentially be adapted to be youth-specific. Examples include:

- Safe Havens[10]
- Crisis Assessment and Treatment Teams[11]
- Crisis Stabilisation Unit[12]
- Urgent Mental Health Care Centre[13]

It was notable in consultations that as the young people discussed alternatives to ED, they became less focussed on suicide and self-harm and spoke in more general terms about young people in acute mental distress as well as suicidal crisis. Therefore such alternatives to ED should be structured to also provide support to young people in crisis, but who have not self-harmed or made a suicide attempt.

During consultations questions were asked about the design of alternatives to ED for young people who have self-harmed or attempted suicide. The following common themes and points of broad agreement were identified:

Both place-based and response team models are needed:

When asked about whether an alternative to ED should be a place to go to or some form of crisis response team that goes to young people, there was often initial disagreement in the consultation workshops, with some young people supporting a place and others a team. In all groups consensus emerged that both place and response team alternatives were needed as different young people in different circumstances would need one or the other. In some cases young people will feel most safe in their own home, and so a crisis response team would be appropriate, and would avoid difficulties some might have in travelling to place-based service. In other cases young people will be safest when leaving their home environment, and the ability to go to a place-based service enables them to keep their help-seeking confidential from their family or others they live with.

Staff able to provide both medical assistance and compassionate support:

Young people were asked what staff should be in a crisis response team or at an alternative place. Although this question was structured around their professional role (i.e. whether there should be nurses, counsellors, doctors social workers etc.), most young people felt that the primary consideration was that staff should be compassionate and supportive.

A range of views were expressed about the professions of the staff in alternative services. However, there was clear general support for having youth peer-workers as part of staff. Even young people who were unaware of the term "peer-worker" expressed that it would be beneficial to have young people present who had experienced suicidal thoughts or behaviours and had had training in supporting others.

Most young people also strongly supported that qualified nurses should be available. This aligns with the data available on medical needs of those attending ED for self-harm. For example, previous research on NSW ED data shows the majority of self-harm presentations (55.6%) were categorised as having a "potentially life threatening condition",[14] a triage category that includes those suffering from severe illness, bleeding heavily from cuts, have major fractures or are severely dehydrated.[15] We also know that the majority of youth intentional self-harm hospitalisations are due to poisoning by pharmaceutical drugs.[16]

Clear processes and choice:

Young people felt they were more likely to make use of a service, or go to a place, if they had a clear idea of what would happen and what would be expected of them. This information should be readily available online; and should also be given to them on engaging with the service or arriving at the location. However, clear processes does not mean the processes should be inflexible. Young people also wanted to have a choice on different processes. For example, on entry to a location they could be given the choice of either talking to someone immediately to be assessed, or be able to fill out a survey.

Accessible and safe:

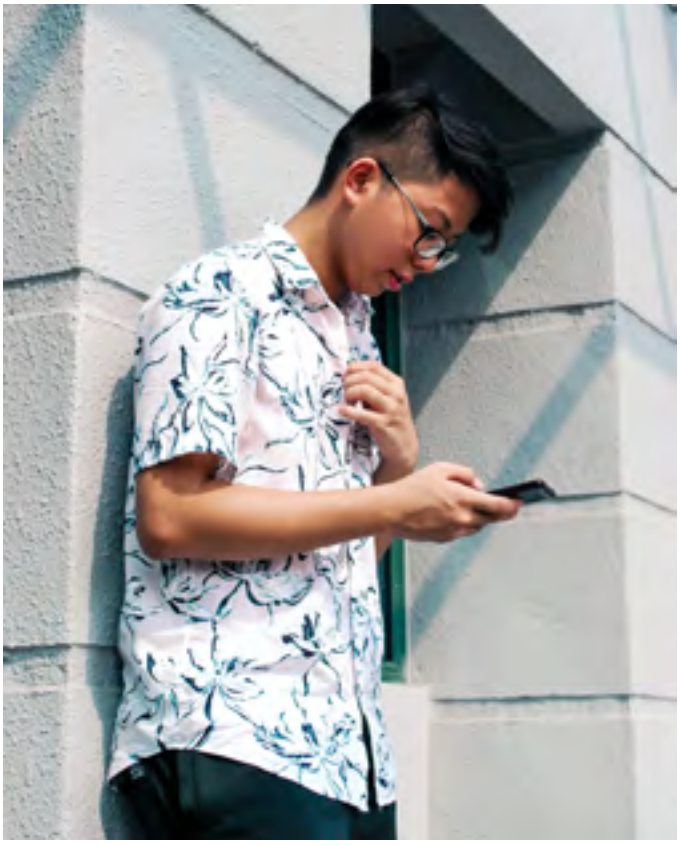
Access was a key theme of discussions with strong agreement that the alternatives must be available 24/7. Crisis response teams were seen as removing a number of barriers for young people who would have difficulty traveling to a place. Place-based alternatives need to be accessible for those with a disability, close to public transport, and distributed so that getting to them does not require extended travel time. The majority of young people consulted thought that place-based alternatives to ED should ideally be no more than 10 minutes' walk from public transport, and less than 30 minutes total travel time for the majority of young people.

Design of place-based alternatives:

Some points of discussions concerned the design of alternative places:

Privacy and location – Some young people stated that, especially in small towns, the entrance should be located so that it is not obvious that a young person is going to this place. And it should be located to easily "mask" attending, for example by being at or near a shopping centre or other place where young people might go for a variety of reasons. Some young people suggested that place-based alternatives to ED should be co-located with medical centres, or with youth services or hubs. Others felt that it being located near to, but not in, a hospital would provide benefits.

Environment – Suggestions from young people included, having comfortable seats, blankets and cushions available, and headphones that can be borrowed to listen to music. In addition, suggestion were made that the place could have activities available such as game or arts supplies, tools for personal/sensory engagement and could incorporate a garden or green space, and perhaps even have animals that you could interact with. Most young people acknowledged that some of these suggestions may be impractical in most cases, but they were encouraged to think creatively in the consultations.



IMPROVEMENTS TO EMERGENCY DEPARTMENTS

Suicide Prevention Australia

Young people recognised that even if a system of alternatives to ED was put in place, there would still likely be some level of presentations to ED of young people who had attempted suicide or self-harm. In the consultations they were asked about changes to ED to reduce further distress and improve the overall experience. The following common themes were evident across the consultations:

Clearer processes:

As with alternatives to ED, young people expressed the need for clear information about the processes at ED. A number of young people reported being at ED as an isolating experience with a lack of communication about what was expected of them and a sense of "not knowing what the rules are". Emergency departments were perceived as "scary" or "overwhelming" spaces by many. However, some young people who had attended ED on multiple occasions expressed the view that they liked their predictability. It was clear that having experience of the processes of ED made them a less intimidating space. More information could be made available about the processes in ED; so young people know what will happen and what is expected of them. This information should be available online and in the ED.

Improved accessibility:

Emergency departments being open at all hours made them a highly accessible space and this was often the reason why young people attended them after a suicide attempt or self-harming, because they were no other services open at that time. However, some young people did report difficulties with accessibility for those with specific needs. Some ED were difficult to access for those with particular disabilities, and young people reported having to ask for assistance. Other young people reported particular ED as not being culturally safe.

Further staff training on suicide and self-harm:

Across all the groups consulted young people reported instances of ED staff having approaches that were described as "no sympathy", "uncaring", or a "why are you here attitude". Some young people did report instances where staff had been deeply compassionate. However in general, young people felt that ED staff too often took an approach that was stigmatising and dismissed their distress. This aligns with previous research where young people have reported staff often seem disinterested and lack empathy which contributes to feelings of guilt and shame and can increase distress.[17] Research has also indicated that ED staff can feel unequipped to deal with self-harm or suicidal behaviour beyond providing immediate physical care.[18]

Young people acknowledged that ED could be extremely busy and high-pressure environments, but they felt that more could be done to provide a supportive, compassionate response that demonstrates understanding and awareness of the seriousness of self-harm and the distress it indicates. Many expressed the view that there should be increased training for ED staff on suicide, on mental health, and on culturally safe behaviour. Research indicates that providing appropriate training would not only improve the quality of care provided, it may also help to decrease stigma.[19] Training to increase awareness, empathy and sensitivity, and increase knowledge to perform culturally appropriate and sensitive assessments has been previously recommended.[20]

Specific suicide response staff including youth peer workers:

Some young people suggested that there should be additional staff available in the ED to support the wellbeing of those who had attempted suicide or self-harmed. The idea of a dedicated Suicide Response Team has been suggested in the literature.[21] Young people envisioned this support being provided by councillors or youth peer-workers. There was strong support amongst young people for having youth peer-workers in the ED, and this has also been found in previous research.[22]

Reduce waiting times and provide support while waiting:

One issue identified by young people is long waiting times. This has also been noted in previous consultations with young people, where they have reported waiting up to 12 hours in ED before being seen.[23] In our consultations, young people suggested that waiting times should be reduced by increasing staff in ED. They also suggested that while young people are waiting there should be regular check-ins to ensure their distress is not increasing. Previous consultations have included the suggestion of improving the communication and transparency of wait times to ensure young people are not left waiting for hours without any updates as to when they will be seen.[24] This could potentially be included in the role of the above discussed Suicide Response Team. Some young people felt that suicide should be treated more seriously in triage assessments.

Create alternative waiting areas:

Young people suggested that the environment of the ED could be made more comfortable, or perhaps have a separate quieter space for those needing a calmer environment to wait in. Many of the above suggestions for the environment of place-based alternatives to ED were considered to be applicable, such as more comfortable seats, blankets and cushions available, and headphones that can be borrowed.

Previous research on the experiences of young people presenting to ED with suicidal thoughts or behaviours has also identified the need for alternative waiting areas with environments designed to minimise additional distress.[25] And health and allied health workers including nurses, social workers and ED staff have also identified this as an area to be addressed.[26] Separate waiting areas to provide young people experiencing significant psychological and suicide related distress with a calm and safe space have been previously suggested,[27] with features including less harsh lighting, less noise, supervision and having means of self-harm and suicide removed.[28]

There is also some research in psychiatric care settings into the use of sensory tools to help reduce psychological distress in young people experiencing severe mental illness. One study looked at the impacts of a sensory modulation room,[29] and another at a variety of sensory tools and equipment including a rocking chair, weighted blankets, fidget toys, scented oils, music, projected images and teas.[30]

Increased privacy:

A number of young people stated that giving information relating to a suicide attempt can be very difficult in the open setting of most ED. This has also been identified in previous research, and there is evidence to suggest it can impact on the information that young people give to ED staff.[31]

The separate waiting areas discussed above could address this, but the young people consulted expressed that there should at least be the ability to go to a semi-private corner or space to answer questions from ED staff.

Improved follow-up support:

A consistent theme across the consultation workshops was a lack of adequate follow-up support arranged by ED. Previous consultations with young people have also indicated that the majority of young people discharged from hospital following a suicide attempt do not receive follow-up or aftercare.[32] Young people stated that there should be improved follow-up, with processes that ensure young people are connected with supports that will help them.

Young people in the consultations were unaware that this issue was addressed in the 2021-22 Federal Budget where $158.6 million was announced for delivering universal aftercare and that implementation of this is currently being planned.[33]

Conclusion and Recommendations

Suicide Prevention Australia

The insights from young people provide a starting point for a process of addressing a significant aspect of youth suicide prevention. Future steps will require the continued input of young people to ensure that actions are effective. Below are a set of recommendations outlining steps to respond to the insights of young people.

Recommendation 1:
All state and territory governments should, in their 2023-24 budget, allocate funding for programs to design and trial a number of youth-specific alternatives to ED for young people in suicidal or mental health crisis.

Recommendation 2:
The Australian Government should support state and territory efforts to develop youth-specific alternatives to ED by providing part of the funding and by forming a working group with state and territory governments under the new National Mental Health and Suicide Prevention Agreement to coordinate the sharing of lessons learned from these trials and investigate a national network of youth-specific alternatives.

Recommendation 3:
The programs to fund the designs and trials should be implemented to ensure that:

- All trials are co-designed with young people
- The trials are conducted at sufficient scale to have the potential of a measurable reduction in presentations to nearby ED
- All trials are evaluated to determine the extent to which they are diverting young people from ED, and the effectiveness of the support provided

Recommendation 4:
Following evaluation of the youth-specific alternatives to ED, state and territory governments should select one or more of the trialled models to be rolled out to provide state- or territory-wide coverage with funding equivalent to the savings of anticipated diversions from ED.

Recommendation 5:
All state and territory governments should, in their 2023-24 budget, allocate funding to upgrade ED's capacity to address the needs of young people who are presenting after having made a suicide attempt or self-harmed. Each hospital ED should be resourced to investigate options for improved accessibility, creating alternate waiting areas, and creating spaces for private conversations.

Recommendation 6:
All state and territory governments should, in their 2023-24 budget, allocate funding to trial a program of increased training for ED staff on responding to young people who have attempted suicide or self-harm, and the introduction of an ED Suicide Response Team which includes youth peer workers.

Recommendation 7:
All state and territory health departments should consult broadly with young people on where they would search for information on ED and what information they need. Based on this they should co-design with young people clear and accessible information on ED processes.

References

1. Australian Bureau of Statistics. 2020. Causes of Death, Australia, 2020. [online] Available at: <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release>.
2. Ibid.
3. Zubrick, S. R., Hafekost, J., Johnson, S. E., Lawrence, D., Saw, S., Sawyer, M., Ainley, J. & Buckingham, W. J. 2016. Self-harm: prevalence estimates from the second Australian child and adolescent survey of mental health and wellbeing. Australian & New Zealand Journal of Psychiatry, 50(9), 911-921.
4. Australian Institute of Health and Welfare. 2022. Intentional self-harm hospitalisations by age groups. [online] Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/intentional-self-harm-hospitalisations-by-age-sex>.
5. Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J. 2021. A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health, 18(6), 2892.
6. Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F. 2021. Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation. Crisis: The Journal of Crisis Intervention and Suicide Prevention. [online] Available at: <https://doi.org/10.1027/0227-5910/a000812>.
7. Suicide Prevention Australia. 2022. Foundations Paper: Improvements and Alternatives to Emergency Departments for Young People who have Attempted Suicide or Self-harmed. [online] Available at: <https://www.suicidepreventionaust.org/wp-content/uploads/2022/07/Foundations-Improvements-and-alternatives-to-ED-1.pdf>.
8. Kolves, K. & De Leo, D. (2015). Child, adolescent and young adult suicides: A comparison based on the Queensland Suicide Registry, Journal of Child & Adolescent Behavior, 3(3), 209.
9. NSW Commission for Children and Young People, and Mental Health Commission of NSW. 2014. Support in tough times: Encouraging young people to seek help for their friends, [online] Available at: <https://apo.org.au/node/41967>.
10. Consumers of Mental Health WA. 2019. Alternatives to Emergency Departments Project Report. [online] Available at: <https://www.mhc.wa.gov.au/media/2993/alt-to-ed-and-safe-havens-final-report-2019.pdf>.
11. Health Direct. 2021. CATT – The Crisis Assessment and Treatment Team. [online] Available at: <https://www.healthdirect.gov.au/crisis-management>.
12. Gold Coast Health. 2021. Queensland's first Crisis Stabilisation Unit opens at Robina Hospital. [online] Available at: <https://www.goldcoast.health.qld.gov.au/about-us/news/queenslands-first-crisis-stabilisation-unit-opens-robina-hospital>.
13. Neami National. 2022. Urgent Mental Health Care Centre (UMHCC). [online] Available at: <https://www.neaminational.org.au/find-services/umhcc/>.
14. Perera, J., Wand, T., Bein, K.J., Chalkley, D., Ivers, R., Steinbeck, K.S., Shields, R. and Dinh, M.M., 2018. Presentations to NSW emergency departments with self-harm, suicidal ideation, or intentional poisoning, 2010–2014. Medical journal of Australia, 208(8), 348-353.
15. NSW Health. 2022. Hospital triage. [online] Available at: <https://www.health.nsw.gov.au/Hospitals/Going_To_hospital/Pages/triage.aspx>.
16. Australian Institute of Health and Welfare. 2022. Intentional self-harm hospitalisations by method. [online] Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/self-harm-hospitalisations-by-mechanism>.
17. Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J. 2021. A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health, 18(6), 2892.
18. Lee, J., Bang, Y., Min, S., Ahn, J., Kim, H., Cha, Y., Park, I. and Kim, M. 2019. Characteristics of adolescents who visit the emergency department following suicide attempts: comparison study between adolescents and adults. BMC Psychiatry, 19(1) 1-9.
19. McCann, T., Clark, E., McConnachie, S. and Harvey, I. 2006. Accident and emergency nurses' attitudes towards patients who self-harm. Accident and Emergency Nursing, 14(1), 4-10.
20. Hill, N., Halliday, L. and Reavly, N. 2017. Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings. Black Dog Institute. [online] Available at: <https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/delphi-guidelines-clinical-summary_web.pdf>.
21. Ibid.
22. Glowacki, K., Whyte, M., Weinstein, J., Marchand, K., Barbic, D., Scheuermeyer, F., Mathias, S. and Barbic, S. 2022. Exploring How to Enhance Care and Pathways Between the Emergency Department and Integrated Youth Services for Young People with Mental Health and Substance Use Concerns. BMC Health Services Research, 22(1), 1-15.
23. Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J. 2021. A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health, 18(6), 2892.
24. Ibid.
25. Asarnow, J., Babeva, K. and Horstmann, E., 2017. The emergency department: Challenges and opportunities for suicide prevention. Child and Adolescent Psychiatric Clinics, 26(4), 771-783.; Rosebrock, H., Batterham, P., Chen, N., McGillivray, L., Rheinberger, D., Torok, M. and Shand, F. 2021. Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-Up Care Arrangements Following an Initial Suicide-Related Presentation. Crisis: The Journal of Crisis Intervention and Suicide Prevention. [online] Available at: <https://doi.org/10.1027/0227-5910/a000812>; Liddicoat, S. 2019. Designing a supportive emergency department environment for people with self harm and suicidal ideation: A scoping review. Australasian Emergency Care, 22(3), 139-148.
26. True, G., Pollock, M., Bowden, C., Cullen, S., Ross, A., Doupnik, S., Caterino, J., Olfson, M. and Marcus, S. 2021. Strategies to Care for Patients Being Treated in the Emergency Department After Self-harm: Perspectives of Frontline Staff. Journal of Emergency Nursing, 47(3), 426-436.
27. Consumers of Mental Health WA, 2019. Alternatives to Emergency Departments Project Report. Cannington.
28. Hill, N., Halliday, L. and Reavly, N. 2017. Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings. Black Dog Institute. [online] Available at: <https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/delphi-guidelines-clinical-summary_web.pdf>.
29. Bobier, C., Boon, T., Downward, M., Loomes, B., Mountford, H. and Swadi, H. 2015. Pilot Investigation of the Use and Usefulness of a Sensory Modulation Room in a Child and Adolescent Psychiatric Inpatient Unit. Occupational Therapy in Mental Health, 31(4), 385-401.
30. West, M., Melvin, G., McNamara, F. and Gordon, M. 2017. An evaluation of the use and efficacy of a sensory room within an adolescent psychiatric inpatient unit. Australian Occupational Therapy Journal, 64(3), 253-263.
31. Byrne, S., Bellairs-Walsh, I., Rice, S., Bendall, S., Lamblin, M., Boubis, E., McGregor, B., O'Keefe, M. and Robinson, J. 2021. A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm. International Journal of Environmental Research and Public Health, 18(6), 2892.
32. Ibid.
33. The Commonwealth of Australia, 2021. Budget 2021-22. [online] Available at: <https://archive.budget.gov.au/2021-22/index.htm>.

Suicide Prevention Australia

®2022

For general enquiries
02 9262 1130
admin@suicidepreventionaust.org
www.suicidepreventionaust.org

There are crisis services available 24/7 if you or someone you know is in distress

Lifeline: 13 11 14
www.lifeline.org.au

Standby Support After Suicide: 1300 727 247
www.standbysupport.com.au

Suicide Call Back Service: 1300 659 467

www.suicidecallbackservice.org.au

Acknowledgement Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. As set out in this report, consultations with young people guided all aspects of this report from the choice of topic, the research, insights discussed and recommendations.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our reports. Suicide Prevention Australia thanks all involved in the development of this report.