Government of **Western Australia**
Mental Health Commission

Western Australian Suicide Prevention Framework 2021–2025

Needing help?

If you or someone you know is having thoughts of suicide or is distressed, please seek help.

Contacting your general practitioner (GP) could be a good starting point. However, if this is not possible or your needs are more urgent, please consider contacting one of the following services.

Help is available:	
Mental Health Emergency Response Line (MHERL)	Metro – 1300 555 788 Peel – 1800 676 822
Rurallink	1800 552 002
Lifeline	13 11 14 www.lifelinewa.org.au
Kids Helpline	1800 551 800 www.kidshelpline.com
Mensline	1300 789 978 www.mensline.org.au
Suicide Call Back Service	1300 659 467 www.suicidecallbackservice.org.au
Samaritans	13 52 47 www.thesamaritans.org.au
Open Arms – 24 hour helpline for Veterans & Families	1800 011 046 www.openarms.gov.au

In an emergency, call an Ambulance on 000

Other services that can provide assistance for people having thoughts of suicide include:	
Headspace	1800 650 890 www.headspace.org.au/eheadspace
QLife	1800 184 527 www.qlife.org.au
Beyond Blue	1300 224 636 www.beyondblue.org.au
Carers WA	1300 227 377 www.carerswa.asn.au
MATES In Construction	1300 642 111 www.matesinconstruction.org.au/wa/

If you are bereaved by suicide and need help, the following services can help:	
Suicide Call Back Service	1300 659 467 www.suicidecallbackservice.org.au
Children and Young People Responsive Suicide Support	1300 114 446 www.cypress.org.au
Active Response Bereavement Outreach (ARBOR)	1300 11 44 46
Lifeline	13 11 14 www.lifelinewa.org.au
Stand By – support after suicide	www.standbysupport.com.au

Government of **Western Australia**
Mental Health Commission

Western Australian Suicide Prevention Framework 2021–2025

This resource was prepared by:

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Accessibility

This publication can be made available in alternative formats for people with a disability, on request to the Mental Health Commission.

Disclaimer

The information in this document has been included in good faith and is based on sources believed to be reliable and accurate at the time the document was developed. While every effort has been made to ensure that the information contained within is accurate and up to date, the Mental Health Commission and the Western Australian Government do not accept liability or responsibility for the content of the document or for any consequences arising from its use.

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NOTE: All photographs within this document are for illustrative purposes only: people depicted are either models or may not have lived experiences dealing with suicide.

Contents

Acknowledgements

We remember those we have lost to suicide, and their families, friends, loved ones and others affected by their deaths.

We respectfully acknowledge and pay our respects to Aboriginal and Torres Strait Islander Elders, past, present and emerging; and acknowledge the diversity and strength of Aboriginal and Torres Strait Islander people and communities today.

The Western Australian Suicide Prevention Framework 2021–2025 (Suicide Prevention Framework 2025) is the result of contributions from many organisations and individuals from across the Western Australian community. These include:

- Members of the steering committee, who provided content expertise and also represented the voices of vulnerable populations;
- Suicide prevention coordinators, who were instrumental in bringing together service providers, local government, non-government, private sector, and community members from across the state, to ensure their needs were voiced; and
- Representatives of key state and federal government departments, who were involved in the advisory group and showed leadership and commitment to a whole-of-government approach to address suicide in our communities.

We sincerely thank the community, and everyone who contributed to the state-wide engagement and shared their experiences, for their commitment to address suicide in Western Australia.

Key terminology

Aboriginal People

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Reference to Aboriginal people throughout this document is respectfully inclusive of Torres Strait Islanders.

Social and Emotional Wellbeing

The traditional Aboriginal understanding of health is holistic and does not refer to the individual but encompasses the social, emotional and cultural wellbeing of the whole community. The social and emotional wellbeing (SEWB) of Aboriginal people is strongly influenced by their connection to family, Elders, community, culture, Country, and spirituality. These connections work together to provide a culturally safe environment for Aboriginal people, and helps individuals to maintain and enhance their SEWB.

Lesbian, Gay, Bisexual, Transgender and Intersex People

Throughout this document the acronym LGBTI is used to refer to lesbian, gay, bisexual, transgender and intersex people. However, it is recognised that many people and populations have additional ways of describing their distinct histories, experiences and needs beyond this acronym [1].

Community

The term community in this document represents groups of people living in or frequenting the same place such as a sporting club, neighbourhood, town, regional centre or metropolitan area. It can also represent a group of people with particular characteristics, attitudes or interests in common. These could also be referred to as communities of interest, communities of shared experience, and communities of people who self-identify.

Vulnerable Populations

In this document, vulnerable populations refers to communities who have been identified as having a higher risk of suicide and suicidal behaviour as a result of barriers they may experience due to social, economic, cultural, geographical, environmental and individual factors.

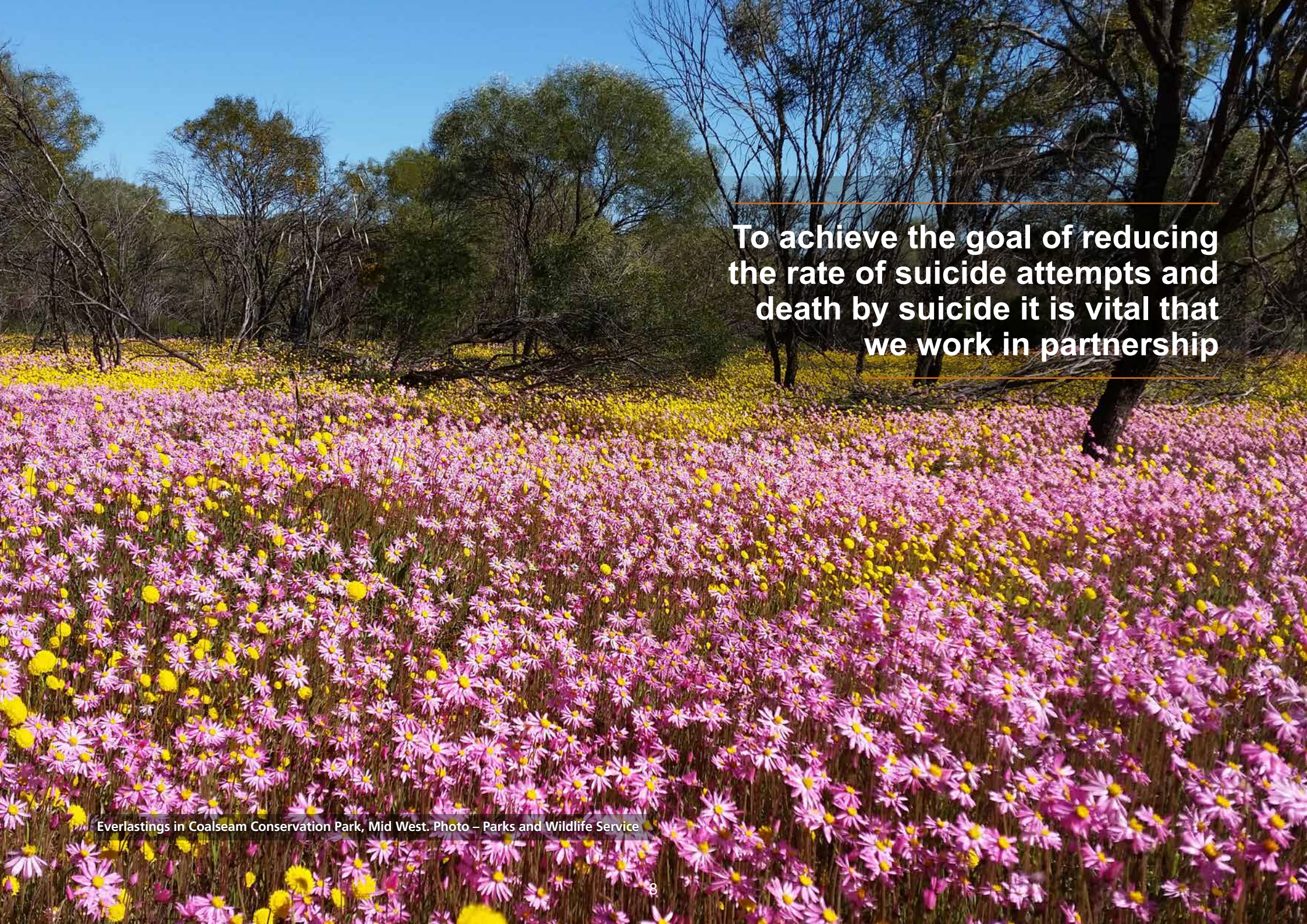
As reported by the World Health Organization (WHO), these include Aboriginal people; persons who have experienced abuse, trauma, conflict or disaster; refugees and migrants; prisoners and others in contact with the justice system; LGBTI persons; individuals who have made a previous suicide attempt and people suicide bereaved. In Western Australia this also includes children and young people and rural and remote communities.

However, it is acknowledged there are many additional communities who may also be at risk and the term 'vulnerable populations' used within this document is respectfully inclusive of these groups.

Language matters when talking about suicide

Please remember that suicide is a complex issue and arises from an interaction between many circumstances in a person's life. Using safe and inclusive language is helpful when talking about suicide [2].

Stigmatising Language	Why	Safe Language
'unsuccessful suicide'	So as to not glamorise or normalise a suicide attempt	**'non-fatal' or 'made an attempt on his/her life'**
'successful suicide'	So as to not present suicide as a desired outcome	**'took their life' or 'ended their own life'**
'committed' or 'commit suicide'	So as to avoid the association between suicide and 'crime' or 'sin'	**'died by suicide' or 'deaths by suicide'**
'suicide epidemic'	To avoid sensationalism and inaccuracy	**'concerning rates of suicide' or 'number of deaths'**
'suicide victim' or 'suicide attempter'	To avoid labelling, which hides the real complexity of someone's situation	**'person who has died by suicide' or 'person who has experienced a suicide attempt'**



To achieve the goal of reducing the rate of suicide attempts and death by suicide it is vital that we work in partnership

Everlastings in Coalseam Conservation Park, Mid West. Photo – Parks and Wildlife Service

Foreword

On average, approximately one person a day dies by suicide in Western Australia. This is a tragic loss of life. The devastating impacts of suicide are felt deeply and can affect entire communities. However, by supporting people, providing the appropriate interventions when required and working together we can change this.

Suicide is a complex issue that will take time to address. Preventing suicide and reducing suicidal behaviour is a key priority for the Western Australian Government.

Suicide Prevention is a whole-of-community issue, and as such requires a whole-of-community approach. This Western Australian Suicide Prevention Framework 2021-2025 (Suicide Prevention Framework 2025) has been developed in consultation with consumers, communities, peak bodies and a range of other stakeholders across Western Australia.

The overwhelming feedback received is that government cannot do it alone – suicide prevention requires a united front and it needs to be tailored to individual community needs.

The Suicide Prevention Framework 2025 takes into consideration the vast geographical distances between regions and allows for flexibility in delivery and for voices to be heard, so that programs and services have the greatest chance of success.

The guiding principles and priority areas in the Framework provide a roadmap, outlining the need for commonalities such as better data collection, support structures, capability and resources.

At its core is the need for government to draw on and be guided by the critical knowledge and strength of communities, service providers and people with lived experience.

This Framework was developed to be used as a guide by government, non-government, communities and private organisations, so that a coordinated approach can be taken to suicide prevention activity across Western Australia.

Suicide is preventable. To achieve the goal of reducing the rate of suicide attempts and deaths by suicide among Western Australians, it is vital that we work in partnership. We must do this together.

Hon. Roger Cook MLA
Deputy Premier and Minister for Mental Health

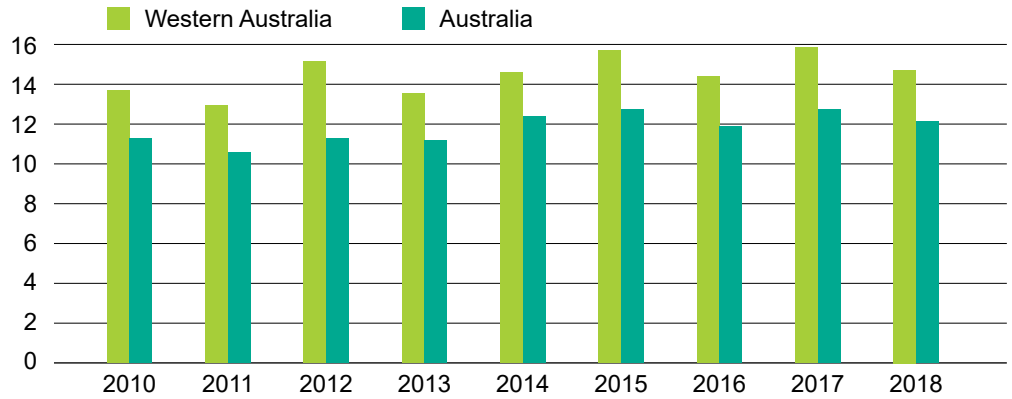
Introduction

Everyone has a role in suicide prevention. Reducing the rate and impact of suicide in our communities requires a whole-of-population commitment. It is not something any single agency, level of government, or community can do alone. The impact of suicide is far-reaching and long-lasting. It has a devastating effect on families, friends, and services, which ripples throughout communities. A 2016 Australian report indicated that 89% of respondents knew someone who had attempted suicide, and that 85% knew someone who had died by suicide [3]. For every person who takes their life, more than 135 people experience intense grief or are otherwise affected [4].

In 2018, 3,046 people died by suicide in Australia. For every suicide death, as many as 25 people will attempt suicide, meaning approximately 78,000 Australians [5] require appropriate, timely and critical care to support their recovery each year. Suicide was estimated to account for 108,035 years of potential life lost in Australia in 2017 [6].

In 2018, 383 individuals died by suicide in Western Australia (WA). On average, this is more than one person a day. WA had the third-highest rate of suicide for all Australian states and territories (14.7 deaths per 100,000 people) and its rate has been consistently higher than the national average (12.1 deaths per 100,000 people) since 2008 [7], **Table 1** demonstrates this trend over time.

Table 1 [6] **– Standardised death rates for suicide, Western Australian and Australia 2010 - 2018**



Between 2014 and 2018, WA had the highest age-standardised rate of suicide among Aboriginal people (37.9 deaths per 100,000 people). This was considerably higher than the national average for Aboriginal people over the same period (23.7 deaths per 100,000).

Suicidal behaviour is complex. Many factors and pathways may lead a person to attempt to take their life. In the pursuit of effective suicide prevention strategies, no single activity stands out above others. With the implementation of a range of strategies that focus on lowering the risks and increasing the protective elements many suicide deaths can be prevented.

To support the creation of a community that experiences optimal mental health and wellbeing individuals, communities, government and non-government need to work together to implement ongoing and coordinated evidence-informed activities across WA. The Suicide Prevention Framework 2025 is inclusive of all Western Australians across the lifespan. It aims to create a platform for the WA community to be better educated about suicidal behaviours and considers that anyone can become suicidal, anyone can lose someone to suicide, and everyone has a role in suicide prevention.

The impact of suicide is far-reaching and long-lasting. It has a devastating effect on families, friends, and services, which ripples throughout communities

Photo: Omar Lopez

Building on existing programs and aligned with State and Commonwealth policy directions, the Suicide Prevention Framework 2025 supports the WA Government's existing commitments to tackling the complex issues of suicide and sets the direction for future action. It brings the voices of the community together to provide understanding and guidance for individuals, communities, private and non-government organisations and the government.

Facts about suicide

The rate of suicide among males is more than three times greater than that for females [4]

Aboriginal people have a rate of suicide three times higher than non-Aboriginal people in WA [6]

For young people aged 15-24 suicide is the leading cause of death [8]

15.5% of LGBTI young people in the Growing up Queer study reported attempting suicide at some point in their life [9]

48.1% of young transgender people in the Trans Pathways study reported attempting suicide at some point in their life [10]

Problems related to substance use were present in 29.4% of deaths by suicide in Australia in 2018 [6]

Mood disorders, including depression, were present in 43.9% of deaths by suicide in Australia in 2018 [6]

The Suicide Prevention Framework 2025 at a glance

Vision

All Western Australians experience optimal mental health and wellbeing and work together to prevent suicide in the community

Goal

To reduce the rate of suicide attempts and death by suicide in Western Australia

Purpose

To provide the framework for a coordinated approach to address suicide prevention activity in Western Australia from 2021 to 2025

Guiding Principles

- Everyone has a role in suicide prevention
- Recognition that lived experience is essential to inform suicide prevention activity
- Community wellbeing and resilience are fundamental
- Evidence-informed, integrated, cross-sectoral approaches are needed
- Quality and timely interventions are available across the lifespan
- Earlier intervention to prevent and manage crisis
- Support and care is matched to individual needs and preferences
- Care is culturally appropriate and compassionate
- Communities are empowered to lead local efforts tailored to local circumstances and priorities
- Individuals, families and communities are supported to recover
- A sustainable service system, which takes into account the limited resources available

Streams	Priority Areas
Prevention / Early Intervention	Community engagement and awareness to support positive change
	Mental health and wellbeing education, and suicide prevention training for communities and health professionals
	Responsible reporting of suicide in the media
Support / Aftercare	Options for people experiencing suicidal crisis
	Competent and confident assistance for people who are suicidal
	Restricting the means of suicide
	Appropriate aftercare support following a suicide attempt
Postvention	Support for people and communities affected by a suicide death
	Streamlined notification processes
	Build community capacity to respond to the needs of those affected by a suicide death
Aboriginal People	Facilitate the development of a Western Australian Aboriginal Suicide Prevention Strategy prioritising culturally secure approaches to social and emotional wellbeing and suicide prevention, with dedicated regional plans

Success Factors

- Better use of data, information and evidence to support suicide prevention
- Partnerships, collaboration, and coordination of activities for better outcomes
- Acknowledgment of the role that trauma and the social determinants of health have in suicide prevention

In 2020, contemporary research supports implementing multiple strategies, delivered simultaneously across a range of areas; this is referred to as a systems-based approach

Cows grazing, South West

The Western Australian approach

The WA State Government has supported two previous suicide prevention strategies, covering the period from 2009 to the present. The Suicide Prevention Strategy – One Life, 2009 to 2013, was developed from an analysis of almost 20 years of data on suicide and self-harm in WA, a comprehensive literature review of contemporary suicide prevention research, and an extensive state-wide consultation process. It was aligned with the former National Suicide Prevention Strategy: Living is for Everyone (LIFE).

One Life was succeeded by Suicide Prevention 2020: together we can save lives (Suicide Prevention 2020). Suicide Prevention 2020 was organised under six key action areas and provided services and activities to at-risk populations in locations across the state.

During the implementation of Suicide Prevention 2020 there were significant developments in the Australian and international suicide prevention literature and research. During this time, the Commonwealth and State and Territory governments committed to a more coordinated approach to address suicide prevention across Australia.

In 2020, contemporary research supports implementing multiple strategies, delivered simultaneously across a range of areas; this is referred to as a systems-based approach [11]. Systems-based approaches that have emerged in Australia since the launch of Suicide Prevention 2020 include the Alliance Against Depression (AAD) model [13, i], the LifeSpan Integrated Suicide Prevention (LifeSpan) model [13], and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) framework [14].

To ensure consistency and a focus on a systems-based approach to address deaths by suicide, the National Mental Health Commission (NMHC) supported the development of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). The Fifth Plan has been endorsed by the Council of Australian Governments (COAG) Health Council and sets a clear direction for coordinated action by the Commonwealth, State and Territory governments. The Fifth Plan also acknowledges the unique challenges faced by Aboriginal people, with the recommendation to develop a National Aboriginal and Torres Strait Islander Suicide Prevention Plan. The Fifth Plan outlines a commitment from governments to develop a National Suicide Prevention Strategy for Australia's Health System: 2020-2023 (NSPS).

The Suicide Prevention Framework 2025 was developed within a framework focusing on the whole population and closely aligns with the Fifth Plan, the NSPS and some of the systems-based approaches mentioned previously. The Suicide Prevention Framework 2025 has four major streams: Prevention / Early Intervention, Support / Aftercare, Postvention and Aboriginal people. **Table 2** summarises the Suicide Prevention Framework 2025 approach across the suicide prevention continuum.

i. The Alliance Against Depression (formally the Nuremberg Alliance Against Depression) was initially implementated in 2004 in the trial region of Nuremberg. WA Primary Health Alliance (WAPHA) utilised this model in WA since 2017.

Table 2 – Suicide Prevention 2025 approach – The WA Suicide Prevention Continuum
(adapted from: Prevention First (Adapted): A Framework for Suicide Prevention) [15]

STREAM	PREVENTION / EARLY INTERVENTION	SUPPORT / AFTERCARE	POSTVENTION	ABORIGINAL PEOPLE
PURPOSE	To promote wellbeing and prevent the development of suicidal behaviour	To provide early and effective support to reduce suicide and quality care following a suicide attempt	To reduce the impact of a death by suicide and assist people who are bereaved and affect to recover from trauma, manage loss and grief and cope with major stressors	To promote SEWB in Aboriginal Western Australians and prevent the development of suicidal behaviour
POPULATION	The whole population or groups in the community Groups with higher risk Individuals showing early signs of suicidal behaviour	Individuals who are showing early signs of suicidal behaviour Individuals experiencing a suicidal crisis. This includes those who have recently been suicidal, and the people who support them	Individuals (family, friends, professionals, peers) and communities who have been affected by the death of someone from suicide	Aboriginal people across WA Aboriginal Youth
ACTIVITIES	Focusses on promoting wellbeing. Reducing risk factors and enhancing the protective factors for whole populations Timely support for those showing early warning signs of suicidal behaviour	Focusses on early identification of individuals showing signs of suicidal behaviour and providing clear pathways for appropriate support Appropriate support (care, treatment, help or supervision) to lower the severity and duration of a suicidal crisis and/or attempt. This extends to family and carers	Strategies meet bereavement-related needs that may occur over a lifetime and focus on providing timely support to limit the ongoing harmful consequences of a suicide death for others	Use a SEWB approach to address suicide prevention for Aboriginal People. SEWB acknowledges that connections to land, culture, spirituality, family and community impact on the wellbeing of Aboriginal people
EXAMPLES	Community awareness campaigns about suicide prevention Programs to promote community connectedness School-based programs to build resilience	Training for para-professionals to help detect the early signs of suicide behaviour Clear referral pathways between community organisations primary care and specialist services Effective community follow-up following a suicide attempt	Practical support such as providing meals, transport, bedding etc Peer-support groups for those with a lived experience of suicide Community education and awareness raising about suicide, stigma, trauma, loss and grief	Develop a Western Australian Aboriginal Suicide Prevention Strategy Recognise and empower Aboriginal youth voices in suicide prevention discussion and decision-making Develop and deliver a culturally appropriate public awareness-raising campaign aimed to support Aboriginal people

The Suicide Prevention Framework 2025 aims to build on the work of the previous strategies and considers strategic documents, such as:

- The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025
- The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018–2025
- Gayaa Dhuwi (Proud Spirit) Declaration
- The State Public Health Plan for Western Australia 2019-2024
- Commitment to Aboriginal wellbeing
- ATSISPEP

The Framework was designed in consultation with the community, government and non-government organisations, and the mental health sector. It was developed using the most current data, research, evaluation and reports, and the expertise of various working and steering groups. It takes into consideration and includes the voices of vulnerable populations as well as the lived experiences of those who have been bereaved by suicide, and those who have experienced being suicidal.

It takes into account the complexities of WA, including the vast distances between regions and diversity of populations, the rapidly changing social, economic and environmental landscape, and the emerging evidence. It recognises the need for a mix of place-based and state-wide activities and promotes flexibility for programs and services to be tailored for local communities.

The Suicide Prevention Framework 2025 provides the framework for a coordinated approach to address suicide prevention activity in Western Australia from 2021 to 2025 under the four streams of Prevention / Early Intervention, Support / Aftercare, Postvention and Aboriginal people.

It can be used by state and local governments, non-government and private organisations and communities to help identify their role in suicide prevention and guide the investment, development, implementation and evaluation of suicide prevention activities.

Everyone has a role in suicide prevention

The Suicide Prevention Framework 2025

Vision

All Western Australians experience optimal mental health and wellbeing and work together to prevent suicide in the community

Goal

To reduce the rate of suicide attempts and death by suicide in Western Australia

Purpose

To provide the framework for a coordinated approach to address suicide prevention activity in Western Australia from 2021 to 2025

Guiding Principles

These principles underpin and guide all activities outlined in the Western Australian Suicide Prevention Framework 2021–2025. They are drawn from the draft National Suicide Prevention Implementation Strategy for Australia's Health System: 2020–2023, modified to present a Western Australian perspective. In the development, commissioning, and implementation of suicide prevention activity, it is important these principles are consistently applied.

Everyone has a role in suicide prevention

Having a role in suicide prevention activities is in every person's, community's and government's interest, because suicide impacts the entire community. It is far-reaching and long-lasting, with the potential to touch everyone directly and indirectly. Whilst the reasons for suicide are complex and multifaceted, many suicides are preventable. Everyone is encouraged to take a role in suicide prevention, no matter how great or small.

Recognition that lived experience is essential to inform suicide prevention activity

People with a lived experience of attempted suicide or who have been bereaved by suicide have great knowledge and expertise through their experiences. This includes their families, carers and communities. The development and implementation of strategies must include their voice, and suicide prevention activities should be co-designed including people with a lived experience.

Community wellbeing and resilience are fundamental

Connection to community, a sense of belonging, equity and inclusion, engagement and safe gathering places all contribute to community wellbeing and resilience. Fostering social connections, creating community safety and protecting against adversity will enable communities to adapt, recover and thrive through times of change and unpredictability.

Guiding Principles (continued)

Evidence-informed, integrated, cross-sectoral approaches are needed

It is preferable for activities to be developed and implemented on the basis of evidence and of what does and does not work. Where evidence is unavailable, programs informed by evidence and best practice methods in similar fields can be implemented. The insights of people with lived experience of suicide; traditional forms of knowledge, such as from Aboriginal people; and unique cultural perspectives can form part of the evidence base for effective suicide prevention. Continual development, implementation and evaluation of existing and future initiatives is crucial. However, it is also important that any evaluations of suicide prevention programs or activities are open to trialling new, innovative and non-traditional initiatives.

Quality and timely interventions are available across the lifespan

Evidence shows that early identification and effective management for the support of individuals who are seeking help is key to reducing suicides. A variety of services and programs need to be equipped to deliver evidence-informed and culturally secure prevention and interventions that prevent and respond to psychological distress and suicide-related experience for people of all ages.

Earlier intervention to prevent and manage crisis

Shifting focus to early interventions, such as addressing risk and protective factors, can have significant advantages for the whole population. For individuals, early intervention is critical for those showing signs of suicidal crisis, as is a holistic SEWB approach for Aboriginal people.

Support and care is matched to individual needs and preferences

It is essential that individuals, their families and communities have a voice. Care must be tailored to the person's circumstances, needs and underlying causes of distress. For some people this will involve person or family centric mental health treatment or cultural healing. For others, relationship counselling, employment or housing support could be what is needed most.

Care is culturally appropriate and compassionate

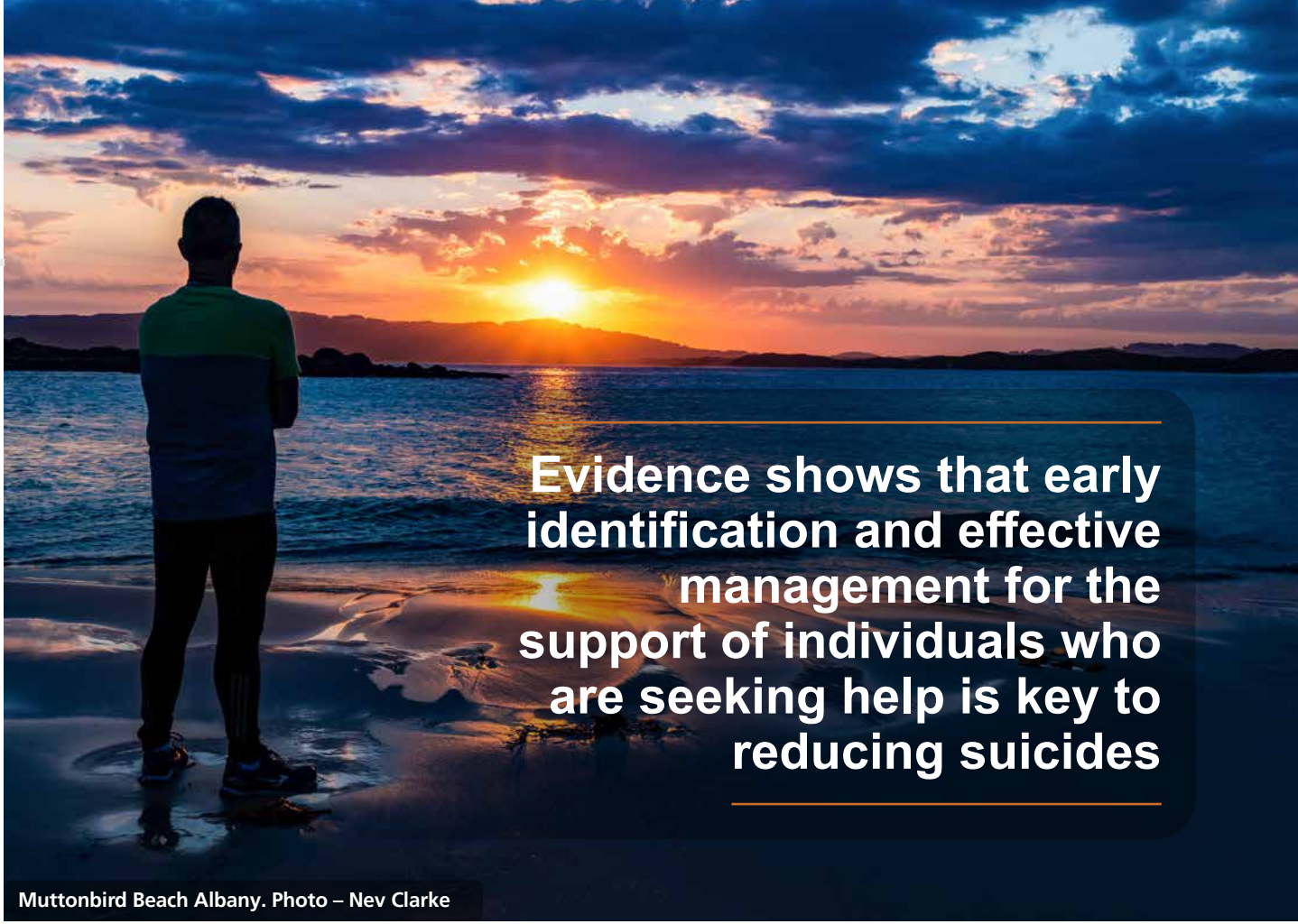
The diversity of individuals and communities needs to be valued and respected. Care which is kind and compassionate, without prejudice, racism, stigma or judgement, is essential. A compassionate approach requires an understanding of where the person came from, what they are connected to, how they got to where they are now and how they can move forward. People with lived experience report culturally secure, compassionate care as vital to their successful recovery.

Communities are empowered to lead local efforts which are tailored to local circumstances and priorities.

Suicide prevention approaches are more effective when they are community-driven and led, and reflect the social, emotional, cultural, socio-economic and spiritual needs of the community. WA is an expansive and diverse state, with each region having its own unique circumstances and challenges. Local people are best placed to determine what is required for their community, and their expertise must be respected and prioritised. Within an evidence-informed context their local knowledge, experiences and stories are essential for making a difference.

Individuals, families and communities are supported to recover

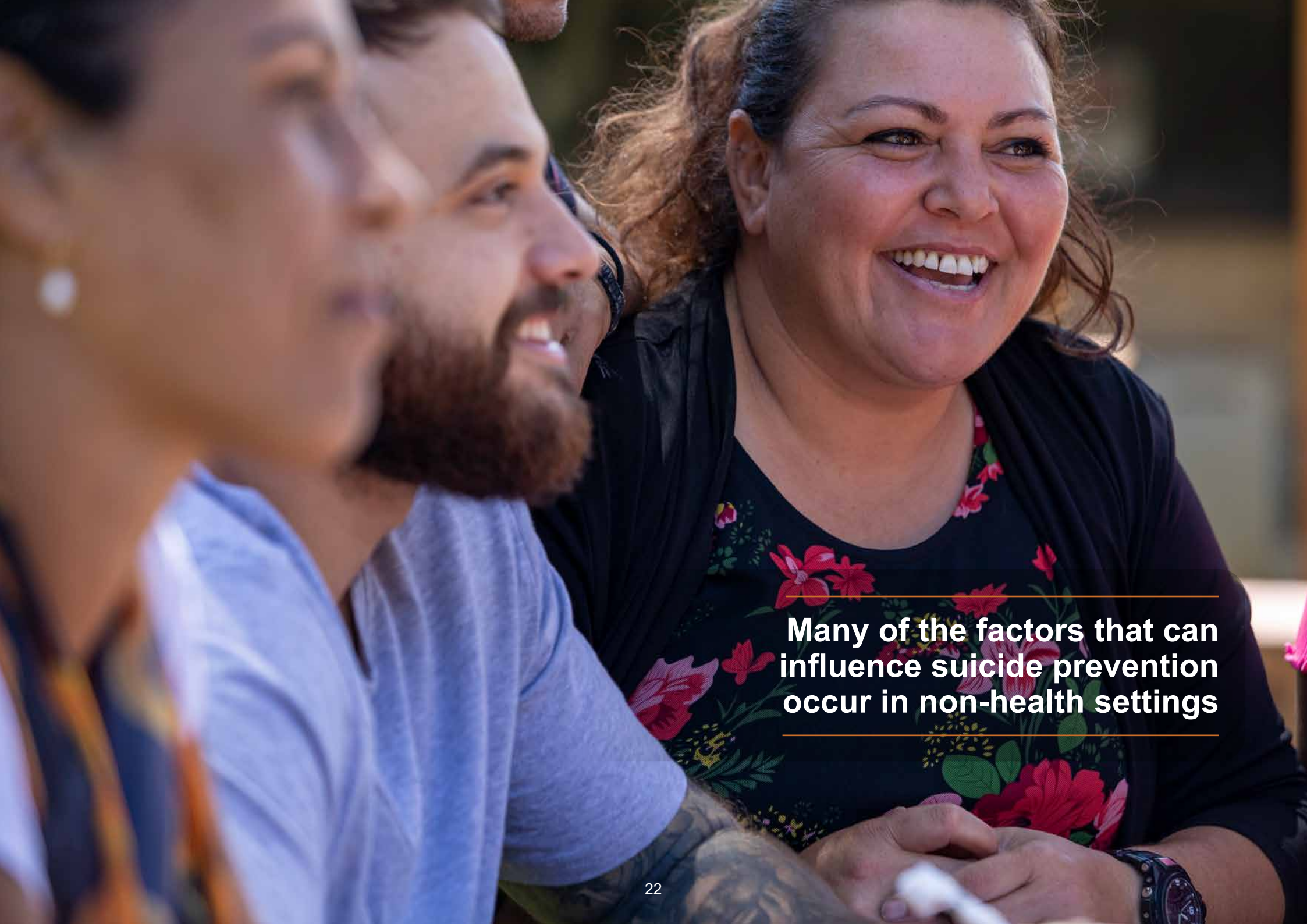
The ripple effect of suicide and suicidal behaviour has diverse and long-term impacts for individuals, families, friends and communities. Sustained compassion, understanding, coordinated and practical support are required over the long term to aid healing and recovery from the impact of suicide.



Muttonbird Beach Albany. Photo – Nev Clarke

A sustainable service system, which takes into account the limited resources available

Governments, services providers and communities must acknowledge that resources for suicide prevention programs and initiatives will fluctuate over time. Strategies for sustainability must be prioritised, including the sharing of information, collaboration across services and a commitment by government agencies to work together.



Many of the factors that can influence suicide prevention occur in non-health settings

Success factors

The following factors are required and must function well for the success and sustainability of the Suicide Prevention Framework 2025.

Partnerships, collaboration, and coordination of activities for better outcomes

Many of the factors that can influence suicide prevention originate and occur in non-health settings. Close working relationships across multiple settings between governments at the local, state and national level, private and non-government sectors, research institutions and key community groups is essential. This includes funding models for suicide prevention activities to promote collaboration, including the efficient pooling of resources and a commitment to investment from various agencies over the long-term.

Success factor examples:

- Lead government agencies with appropriate resource allocation, will commit to facilitating, leading and/or being part of a coordinated whole-of-government response to suicide in Western Australia, utilising the Suicide Prevention Framework 2025 as a guiding document
- Defining the roles and responsibilities of federal, state, local and non-government organisations regarding suicide prevention, early intervention, support, aftercare and postvention to address duplication and/or service gaps
- Commitment by federal, state, local and non-government organisations to genuinely collaborate on suicide prevention initiatives including the establishment of (pathways) to support systemic advocacy in suicide prevention
- Provision of opportunities for MHC-funded service providers to engage with each other regularly to support a more cohesive approach to strategy delivery and an improved consumer pathway
- Provision of appropriately qualified metropolitan and regionally based staff who engage with local service providers, community and stakeholders to coordinate and support suicide prevention initiatives
- Greater alignment with Local Public Health Plans on practical initiatives

Better use of data, information and evidence to support suicide prevention

Improving the quality of evidence about suicide and suicide prevention activities is fundamental for the continuous improvement of community outcomes. Improved reporting of and learning from deaths by suicide needs to occur to help inform future suicide prevention activities. Promoting evidence-informed innovation, accompanied by thorough evaluation, will help build the evidence for new approaches.

Success factor examples:

- Improved data collection, particularly at the community and population levels, to measure increased personal and community resilience
- More consistent and timely reporting and notification of WA Police Force and hospital data on self-harm, suicidal ideation and suicide attempts
- Collection of both qualitative and quantitative data, including descriptive narratives from service providers and people with lived experience
- More academic research and practical information sharing between suicide prevention professionals and communities with lived experience

Acknowledgment of the role that addressing historical and current trauma and the social determinants of health have in suicide prevention

Action on suicide prevention is more effective when integrated with broad responses to the social and cultural determinants of poor health and wellbeing. This includes childhood trauma, family violence, poverty, insecure housing, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use. For Aboriginal people the impact of colonisation and systemic racism also needs to be acknowledged.

Success factor examples:

- Collaboration across governments in equitable partnerships with local communities to address the social contexts and determinants that drive feelings of hopelessness
- Addressing homelessness, violence, child neglect, alcohol and other drug related-harms, poverty, etc.

Stigma, Myths and Misconceptions about suicide

If someone or something is stigmatised, they are unfairly regarded as having something to be ashamed of. A stigma refers to a social attribute or characteristic, which when present is viewed (by some) as undesirable or discrediting of an individual or group [16]. Social stigmas though physically invisible, may be identified through our expressed attitudes or behaviours toward certain groups or individuals.

If we think negatively of, or stigmatise someone because they have a particular attribute (such as skin colour, cultural background, a disability or a mental health condition), this 'labelling' sets them apart from others in connection to the stigmatised quality. It is through this process of labelling that an individual becomes part of a stereotyped group.

Another consequence of stigma can be self-stigma [17], which is the process by which members of stigmatised populations come to internalise and self-identify with the stigma to which they are exposed, that is, agreeing that the way they are is abnormal, shameful or undesirable. This often leads to self-isolation or other difficulties in coping, potentially adding to their vulnerability.

Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who are left behind following a loss, or who have attempted suicide often face considerable stigma within their communities, which may prevent them from seeking help.

> *…having to confront the negative attitudes of others can be one of the biggest and most isolating obstacles for people experiencing suicide related issues.*
> – Bathje & Marston, 2014

Exploring the **myths** [18] **and misconceptions** around suicide is one way to help reduce the development and impact of stigma.

Challenging stigma

Challenging stigma is a whole-of-population responsibility, and everyone has a role to play in creating inclusive, non-discriminatory communities. Some of the ways to challenge stigma around suicide and mental health are:

- Build knowledge about suicide and mental health conditions, and share learnings with others
- Be mindful not to judge, label or discriminate when meeting people affected by suicide or mental health conditions
- Treat all people with respect and dignity
- Avoid use of stigmatising language
- If you hear people around you making stereotypical or incorrect comments about suicide or mental health, speak up and correct them [19].

MYTH: "Everyone who engages in suicidal behaviour has a mental illness."

FACT:

Thoughts of suicide can happen to anyone, including those who have no history of mental health conditions. People living with mental health conditions, however, are at increased risk of suicide.

MYTH: "A person living with suicidal thoughts wants to die."

FACT:

Most people who are suicidal don't really want their lives to end, they just want the pain to end. The understanding, support, and hope that you offer can be their most important lifeline [20].

MYTH: "People who talk about suicide are just attention seeking."

FACT:

People who talk about suicide are often thinking about taking their own life. Talking about suicide may be a way to indicate they need support so it needs to be taken seriously.

MYTH: "People who think about suicide are weak or selfish"

FACT:

Anyone who thinks about suicide is experiencing intense and overwhelming negative feelings and cannot see any other solution – they need support, not judgement.

Asking someone if they are feeling suicidal may seem difficult, but it shows that you care

MYTH: "It is impossible to stop suicide."

FACT:

Suicide is not inevitable and is often preventable.

MYTH: "Someone who has attempted suicide will never try again."

FACT:

A previous suicide attempt is a recognised risk factor and will increase with each subsequent attempt.

MYTH: "People who are living with thoughts of suicide think about taking their life all the time."

FACT:

Suicidal thoughts can come and go, a person living with suicidal thoughts most likely will not be suicidal forever.

MYTH: "Asking someone if they are suicidal puts 'ideas' in their head."

FACT:

Experts generally agree that asking is unlikely to make the situation worse. One of the only ways to really know if a person is contemplating suicide is to ask. Asking someone if they are feeling suicidal may seem difficult, but it shows that you care.

Streams:

Prevention / Early Intervention

Support / Aftercare

Postvention

Aboriginal People

Blue skies over the Pilbara

Prevention / Early Intervention

The prevention / early intervention stream aims to promote wellbeing and prevent the development of suicidal behaviour. Initiatives may occur across the whole population or within specific communities. Activities focus on promoting wellbeing, and reducing the risk factors while enhancing the protective factors for communities. This can include strategies to address social determinants of health as well as public awareness raising campaigns and engaging communities in suicide prevention action.

"Empowering local people to determine those methods of suicide prevention that are most appropriate for their community will ensure local buy-in, innovation, social inclusion and a sense of belonging. Every community appears to have the 'right' answer for addressing suicide in their context and all display great levels of insight and innovation in methods. These methods often manifest in community and social engagement activities, and whilst these initiatives may not always be evidence-based, they are critical to providing local ownership, hope and the necessary community dialogue to support more evidence-based prevention."

– Engagement summary 2019
(WA Suicide Prevention Action Plan 2021-2025 Engagement Report)

1. Community engagement and awareness to support positive change

Communities play a critical role in suicide prevention. They are able to access knowledge to identify and implement specific suicide prevention strategies relevant to their situation [21]. This may include enhancing broad government strategies by localising them and/or coming up with specific activities unique to their community.

Activities required to ensure this priority is achieved include:

1.1 Empowering local people to determine and deliver those methods of suicide prevention that are most appropriate for their community through increased and more accessible localised suicide prevention resourcing

1.2 Addressing the stigma of mental health and suicide in communities by leveraging national and state health promotion initiatives at regional and community levels

1.3 Expanding public awareness campaigns to assist communities to connect with the best mental health and suicide (prevention) information, support, and services, with the capacity to be localised as required

1.4 Celebrating those with diverse cultures, languages, genders and sexualities within the community and at the service provision level

1.5 Recognising and empowering youth voices in suicide prevention discussions and leadership through greater participation in decision-making, co-production of prevention initiatives, and advice to services

1.6 Providing dedicated peer-based mental health and wellbeing education and support for vulnerable populations as directed by local needs

1.7 Enhancing the broader Western Australian community's understanding of the SEWB approach to suicide prevention taken by Aboriginal people and their communities, to ensure culturally secure responses and support

1.8 Investigating community-based initiatives to reduce loneliness and increase social connections for high-risk populations [ii]

ii. The literature points to young people aged 15-25 years and individuals aged 75 and older as being at the highest risk of loneliness. This document acknowledges the unique challenges within some workplaces and communities and provides scope for loneliness initiatives to be implemented as identified.

2. Mental health and wellbeing education, and suicide prevention training for communities

Many people who are experiencing suicidal thoughts communicate distress through their words or actions, but these warning signs may be missed or misinterpreted. Education and training can provide people with the knowledge and skills to identify warning signs that someone may be suicidal, talk to them about suicidal thoughts, and connect them with professional care [24].

Activities required to ensure this priority is achieved include:

2.1 Expanding mental health and suicide prevention training and education to a wider cross-section of the community through easily accessible and culturally appropriate formats

2.2 Coordinate a cross-government, placed-based approach to expand mental health and suicide prevention training for all health professionals and frontline staff in relevant service areas such as policing, justice and child protection

2.3 Empowering peer support groups and networks that deal with mental health and suicidal ideation through appropriate recognition, supervision and resourcing

2.4 Providing education and training that addresses the wider social context within which mental health and suicidal ideation develops, and focusing on building stronger protective behaviours in at-risk populations

2.5 Providing mental health and wellness education and suicide prevention training in schools, and tertiary institutions to both staff and students

2.6 Facilitating opportunities for reconnection to culture and country for Aboriginal people

3. Responsible reporting of suicide in the media

Suicidal behaviour can be influenced through the media. Media guidelines supporting the responsible reporting of suicide can reduce suicide rates, influence stigma and improve awareness and help-seeking [25].

Activities required to ensure this priority is achieved:

3.1 Working with journalists to increase their competency with respect to the Mindframe reporting guidelines

3.2 Educating communities, particularly school-aged youth and parents, about identifying distress and cries for help on social media and the application of Mental Health First Aid-style principles in online environments

Helpful ways to present information

(adapted from ***Reporting suicide and mental illness: A Mindframe resource for media professionals***, 2014) [26]

- Covering suicide sensitively and accurately to challenge public misconceptions and myths, increase community awareness and encourage community discussion and prevention activities
- Informing community about the risk factors of suicide, including warning signs, the importance of taking suicidal thoughts seriously and providing information about where people can get support
- Coverage that focuses on personal stories and overcoming suicidal thinking can promote hope and may encourage others to seek help
- Reporting that focuses on suicide as a health and community issue helps to increase community awareness and reduce stigma
- Reports that show the impact that suicide has on individuals and communities can increase understanding about the experiences of those affected by suicide

Case Study – Think Mental Health

The Think Mental Health Program (TMH) was built on the premise that strategies developed for mental health promotion have a flow-on effect for suicide prevention. For example, building protective behaviours that promote mental health and wellbeing, or seeking early support when mental health is compromised, will translate into fewer incidents of suicidal behaviour. Think Mental Health focuses on helping people connect with the best information, support and services for their particular situation. To achieve effective outcomes for mental health and suicide prevention, a broader focus has been taken to model the success achieved by other high-profile population-based behaviour change campaigns, such as tobacco control.

A new Think Mental Health Men's Campaign (the campaign) was developed in response to consistently high suicide rates among men in WA. In 2017, over 70% of suicide deaths in WA were men [22]. The highest prevalence of suicide was among men aged 25 to 54 years, who were consequently chosen as the primary target audience for the current phase of the campaign. The secondary target audience is people who support men, such as partners, friends, family, or colleagues.

The main communication messages of the campaign were designed to motivate people who may be experiencing mental health issues, or family and friends of these people, to talk to each other when things aren't going so well and connect them with mental health information, support and help appropriate to their situation and needs. They included:

- what to look out for when you or someone else isn't doing very well
- how to start the conversation and what to say
- options on getting help and support
- what to do in a crisis situation

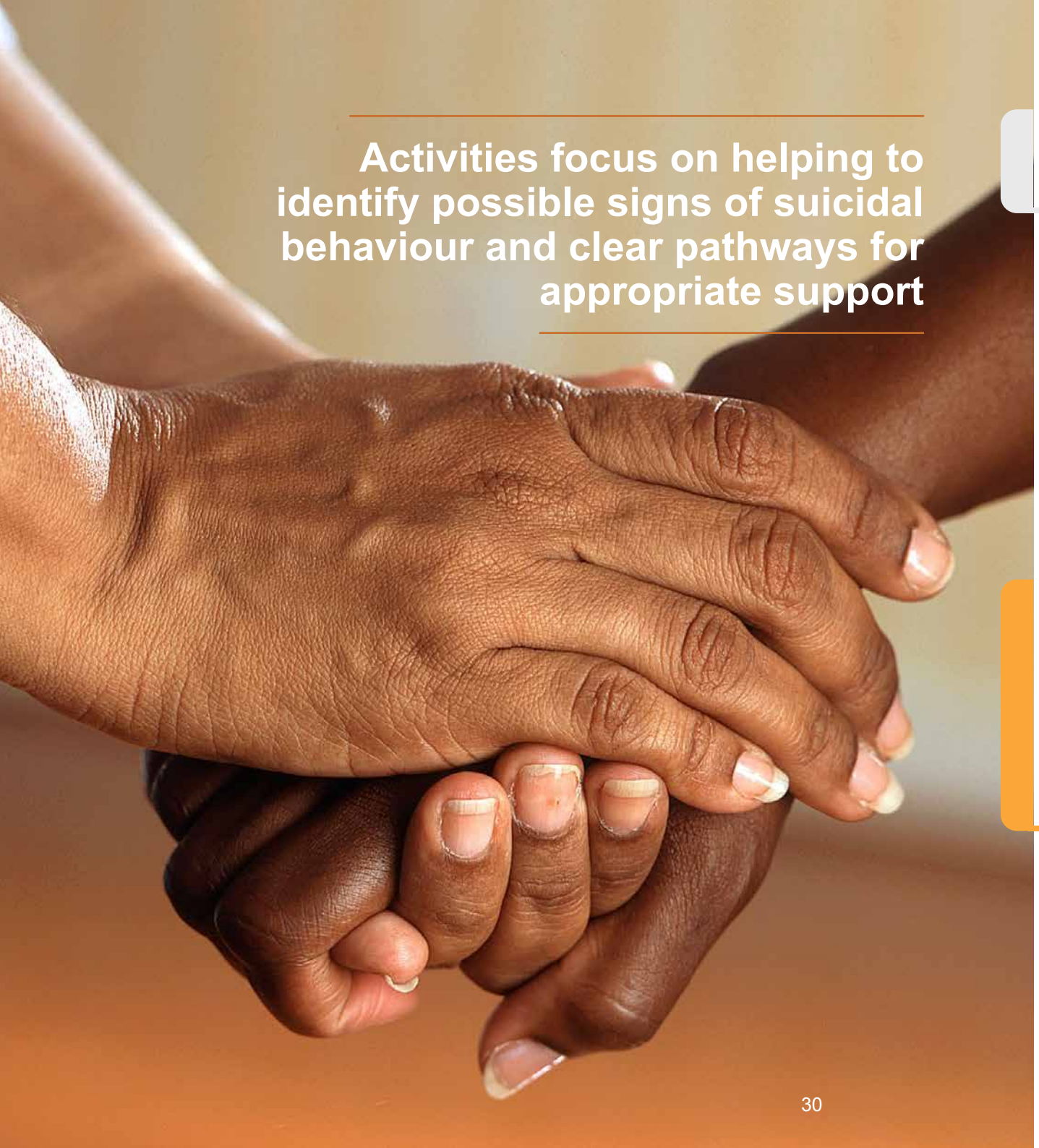
Baseline research was conducted prior to the launch of the campaign to understand trends in community knowledge, beliefs, attitudes, intentions and behaviours in relation to mental health and wellbeing, mental health issues, help-seeking, and barriers to help-seeking (stigma). Research will be conducted to monitor and track attitudinal measures over time.

A post-campaign evaluation [23] indicated that men found the messages highly relevant, with the availability of help and encouragement of help-seeking registering strongly. As a result of seeing the campaign, more than a quarter (28%) of all men had taken some form of action. In terms of cut-through and effectiveness, the campaign performed extremely well on Novelty, Affective Impact, and Relevance – within the top 25% of all Australian campaigns tracked to date.

think MENTAL HEALTH

At-risk men were those with a diagnosed mental health condition or who had experienced a significant life event in the previous two years. The campaign was particularly effective in reaching at-risk men, with 70% recognising it when prompted. At- risk men were significantly more likely to talk about their mental health needs with a professional as well as with family/friends as a result of seeing the campaign.

Awareness of the campaign was also high amongst family and friends with 29% of family and friends spontaneously aware of the campaign and 69% demonstrating awareness when prompted. The campaign was also felt to strongly educate family and friends: 57% said it made them think about the mental health and wellbeing of males close to them; 49% were made aware of the TMH website; 48% were provided advice on how to approach someone they are concerned about; 38% were made aware of the support tools and tips available; and 37% were made aware of the symptoms of a mental health issue.



Activities focus on helping to identify possible signs of suicidal behaviour and clear pathways for appropriate support

Support / Aftercare

The Support /Aftercare Stream aims to provide early and effective support to reduce suicide and quality care following a suicide attempt. Initiatives are aimed at individuals who are showing early signs of suicidal behaviour or experiencing a suicidal crisis. This includes those who have recently been suicidal, and the people who support them. Activities focus on helping to identify possible signs of suicidal behaviour ensuring clear pathways to appropriate support. This also includes appropriate support to lower the severity and duration of a suicidal crisis and/or attempt.

“Suicide and self-harm are not black and white but the responses always are – ED or not, medication or not. You can still have those thoughts every day and self-harm but not want to act on them. ED shouldn’t be the first and only option.”

– Regional LGBTI Teenager

4. Options for people experiencing suicidal crisis

Suicidal behaviour is complex, and there are many reasons why someone may be having suicidal thoughts. The early identification and providing people with a range of support and/or treatment options can reduce the risk of someone taking their life.

Activities required to ensure this priority is achieved include:

4.1 Providing culturally appropriate, increased and equitable access to mental health and SEWB services for people in mental distress and/or with suicidal ideation

4.2 Addressing the critical lack of after-hours support for people in suicidal crisis outside of emergency departments (EDs) and anonymous helplines, especially in rural and remote settings

4.3 Providing alternatives to EDs for those in mental distress and/or suicidal crisis

4.4 Redesigning existing ED settings to more compassionately care for those in mental distress

4.5 Increasing access to appropriate mental health and support services for the specific needs of targeted vulnerable populations and including those relating to family and domestic violence, homelessness, alcohol and other drug use and/or trauma

4.6 Expanding access to specific services for children [iii] and young people in mental distress and suicidal crisis across WA

iii. In this context, children are those aged 8-to-12 years.

5. Competent and confident assistance for people who are suicidal

Those who support people in suicidal crisis need to have the knowledge and skills to enable them to provide care that will make the person seeking help feel safe and reduce their risk of suicide.

Activities required to ensure this priority is achieved include:

5.1 Build capacity through appropriate professional development opportunities relating to identification, assessment, treatment and response to suicide for GPs, frontline workers, health, mental health and primary care staff

5.2 Embedding culturally secure, trauma-informed and compassionate procedures and responses into EDs as well as crisis and support services

5.3 Implementing consistent assessment and early intervention frameworks and services for suicidal ideation and behaviour

5.4 Recognising and supporting peer support and response models for people in acute mental distress and suicide crisis

5.5 Acknowledging the high burnout rates of staff, in particular those in community prevention, isolated rural and remote counselling roles, and outreach and volunteer workers

5.6 Providing local services with access to more timely and accurate regional self-harm, suicide attempt and death by suicide data

6. Reducing access to the means of suicide

A key challenge for suicide prevention is how to support individuals who may be at risk when the signs are less obvious, or support for those who may avoid or are less likely to seek help. One effective population level strategy strongly supported by evidence that does not depend on individual level help-seeking or risk identification is means restriction.

Means restriction is the modification of the environment or the creation of physical deterrents to create safer community settings. By making it more difficult for a person to access means, or by interrupting a person's immediate physical method for taking their life, (critical) time is gained which can allow for the suicidal crisis to pass. This, coupled with encouraging help-seeking and the intervention of a third party, significantly reduces the potential for someone to take their life [27].

Some examples of means restriction include: carbon monoxide emission controls in vehicles; barriers on bridges and railways; firearm safety (lockable storage, licensing restrictions); blister

Stars, Scooters, Songs and Butterflies

In 2018/19 Metropolitan Suicide Prevention Coordinators partnered with Anglicare WA's CYPRESS program to develop a book of stories told by children and young people bereaved by suicide. Thirty CYPRESS clients aged between 6-18 years volunteered to share a piece of writing connected to their experience of being suicide bereaved to support other children and young people bereaved through suicide. Many stories were created as part of the therapeutic process and a few were created by young people specifically for the booklet.

The main objectives of creating the booklet were to help young people bereaved in this way to know they are not alone, and also to share ideas on how writing and creating can help young people work through their grief.

The stories are compiled in different sections: Memories, Significant Objects, Creative Stories, Letters and Grieving Experiences. Some stories are heavy with loss and grief to acknowledge and validate the bereavement journey. Other stories share growth, meaning making, and even celebrate and inspire hope for those who are working through a loss.

The impact of the book has been larger than expected. Parents, helping professionals, and other adults are impacted by the depth of insight and honesty of the young writers. Others bereaved through suicide have found commonalities, points of connection and assurances through the stories. Some children have been inspired to try new ways of writing and creating based on the examples in the booklet. The contributing writers feel acknowledged, understood and valued by the book being printed. They have also expressed pride and amazement at the impact their words can have on others.

Some workshops have been facilitated by CYPRESS to support helping professionals in schools use this resource to explore and express suicide bereavement with other young people.

packaging of medications and liquor restrictions. Training focused on building capacity of clinicians, individuals and families to identify and remove means as part of a safety plan is also useful.

Activities required to ensure this priority is achieved include:

6.1 Coordinating multi-agency collaboration across government to identify and establish barriers or mechanisms that can interrupt the suicidal process

6.2 Establishing cross-functional working groups on suicide means restriction as part of suicide prevention planning

6.3 Assisting communities to identify and create safer settings within their community

7. Appropriate aftercare support following a suicide attempt

Aftercare refers to the care, treatment, help or supervision received by people after a suicide attempt[28], and extends to family and carers. Evidence tells us that a suicide attempt is the strongest risk factor for a subsequent suicide, and the period of highest risk is following release from hospital or medical treatment. Appropriate aftercare responds holistically and in a timely manner to each individual's circumstances in their social, emotional and wider health concept, providing the factors needed to stabilise people's lives and prevent further attempts.

Activities required to ensure this priority is achieved include:

7.1 Rigorous safety planning including established referral pathways to ensure seamless and supported transitions from hospital or medical treatment post discharge

7.2 Empowering, equipping and supporting families and carers to successfully navigate mental health and suicide prevention networks and systems

7.3 Providing families and carers with accessible and formal peer support, community-based support and education, and respite opportunities in the ongoing recovery phase

7.4 Facilitating access to culturally appropriate healing-centred practices and recovery options for migrant and refugee populations

The Mental Health Co-Response Program

The Mental Health Co-Response Program (MH-CR) was implemented in metropolitan Perth in January 2016 in response to increased demand on the WA Police Force to attend and manage incidents that involved a mental health element. This increase in demand coincided with national concerns about the ability of police officers to respond appropriately to mental health incidents.

The MH-CR is a joint initiative between the WA Police Force, the MHC and Health Service Providers, and enables police and mental health clinicians to share information and jointly attend crisis situations when mental illness is identified as a likely factor. The MH-CR model provides a distinct multiagency service that responds to particular mental health-related circumstances, including calls for assistance when a mental health or welfare concern has been indicated; requests for advice, guidance or assistance from frontline police officers who suspect a member of the community is experiencing a mental health episode; and the admission of arrested people with mental health issues or a history of mental health intervention to the Perth Watch House for guidance, assessment, monitoring and diversion pathways.

The MH-CR trial, which incorporated mental health expertise at each stage of police contact, was the first of its kind in Australia. Four components support the delivery of the MH-CR model:

1. A police operations centre with a co-located mental health practitioner to enable sharing of relevant information from health databases
2. MH-CR mobile teams which include an authorised mental health practitioner and uniformed police officers in an unmarked vehicle to respond to incidents involving a mental health crisis
3. Perth Watch House, where an authorised mental health practitioner is on duty to observe and screen detainees as they are processed and provide further assessment if needed
4. An MH-CR Unit that co-locates WA Police Force and Department of Health personnel and provides managerial oversight

Over the course of the two-year trial, the following results were achieved:

Police operations centre

- 20,149 tasks reviewed by the mental health practitioner including welfare checks, missing persons and mental health incidents

Mobile teams

- Co-response teams engaged or assessed 2,907 mental health consumers (1,318 by the South East Metropolitan District mobile team and 1,589 by the North West Metropolitan District mobile team)
- The South East Metropolitan District mobile team and the North West Metropolitan District mobile team made 328 and 389 referrals respectively to mental health and other community services

Perth Watch House

- The mental health practitioner screened 8,671 detainees
- A total of 705 referral episodes (139 to mental health court liaison services, 383 to external mental health services and 183 to other community services)

An independent evaluation of the trial showed benefits for resource allocation, the safety and wellbeing of officers and mental health consumers, and interagency collaboration at each stage of the model. Findings also indicated that although police are being called to a growing number of mental health incidents, most are not criminal incidents. Interviews revealed that mental health consumers and their carers engaged positively with the MH-CR model and saw it as a significant improvement over the police's traditional crisis response. The MH-CR has strengthened the partnership between the WA Police Force and mental health services, leading to improved overall mental health and wellbeing outcomes for consumers. In response to the success of the trial, the MH-CR has since been expanded to cover the whole Perth metropolitan area.

Postvention

Postvention refers to activities or interventions which occur after a death by suicide aimed to support and assist those bereaved or affected (family, friends, professionals, peers, responders, community) to recover from trauma, cope with additional stressors, and to manage the experiences of loss and grief.

Postvention priorities target people and communities impacted by suicide loss, including strategies for responding to differences in need across a lifetime, and aimed to reduce the potential for further harm, for example, individual, family and community-based education, counselling or psychotherapy, material and social supports, peer-support groups and support coordination. [29]

"In the immediate aftermath of a suicide, the bereaved need immediate practical and financial support in order to be allowed the time to grieve. This includes meals, extended leave from workplaces and assistance preparing memorials. Person-centred care is required as there is no universal answer to postvention support."

– Engagement summary 2019 *(WA Suicide Prevention Action Plan 2021-2025 Engagement Report)*

8. Support for people and communities affected by a suicide death

Individuals bereaved by suicide are considered at heightened risk for suicide [30] and poorer mental health outcomes, such as major depression and post-traumatic stress disorder, as well as complicated grief due to the intensity of the grief experience, combined with complexities of the suicide loss.

The sudden and often unexpected nature of the death can be extremely traumatic, and in addition to grief, the bereaved individuals can experience shock, isolation, questioning why, anger, rejection and guilt. It is important that people and communities are supported appropriately following a suicide to prevent further harm and to ensure improved outcomes are promoted for those impacted.

Activities required to ensure this priority is achieved include:

8.1 Establishing clear scope of service and protocols for suicide postvention coordination between existing federal, state and community-based services and roles

8.2 Providing ongoing practical and financial support to families directly affected by a suicide in locally and culturally relevant ways

"As well as increasing public awareness of the impact of suicidal behaviour we must look to educate and empower individuals and communities in how to get help, give help and save lives."

– Maple et al (2016) (T*he Ripple Effect: Understanding the exposure and impact of suicide in Australia*)

8.3 Increasing access to dedicated and ongoing postvention and bereavement services for families, communities, children and young people bereaved by suicide

8.4 Educating service providers on suicide postvention evidence, best practice models and available pathways to access support (such as the Postvention Australia Guidelines [31])

9. Build community capacity to respond to the needs of those affected by a suicide death

The painful experience of grief and bereavement following suicide loss is further complicated by the effects of stigma and trauma. Increasing the skills

and knowledge of communities to be able to respond safely, appropriately and in a manner that does not inadvertently cause harm is essential.

Activities required to ensure this priority is achieved include:

9.1 Enhancing whole of community understanding of and capacity to respond to suicide bereavement and effects in areas of grief and loss, trauma and crisis support

9.2 Providing dedicated resources to enable opportunities for ongoing healing through peer-lead group based and community level activities

9.3 Facilitating the development of community supported activities to better meet the identified needs of people and communities bereaved and impacted by suicide loss.

10. Streamlined notification processes

Prompt access to validated data at the stakeholder and community level will help to enable provision of timely and appropriate suicide postvention services and supports.

Activities required to ensure this priority is achieved include:

10.1 Improving the timely, accurate reporting and notification of suicide deaths in Western Australia

Metropolitan Suicide Prevention Coordinator (SPC) Postvention Project

In 2018, members of the Metropolitan SPC Postvention Development Group (over 30 key government, community and lived experience representatives) agreed to develop and trial a community postvention model in Perth. The proposed community postvention model would be informed by international and Australian evidence and be flexible enough to be adapted to 'best-fit' by the broad range of potential stakeholders in the metropolitan area.

The first group which identified an interest in trialling such an approach was Bowra & O'Dea Funeral Directors. Their staff of over 100 perform approximately 3 500 funerals in the metropolitan area per annum. In Australia, funeral service staff are the most prevalent service used following a bereavement. While they are on the frontline with families and friends following a suicide, there has been little acknowledgement of the role of funeral service staff or their potential for playing an important part in community postvention.

In an Australian first, the Metropolitan SPC team has been working with Bowra & O'Dea to co-design and pilot a community-based postvention model which will equip staff to work appropriately with suicide bereavement funerals, including:

- a training package covering: the use of appropriate language; de-mystifying stigma and myths around suicide; understanding complex grief; and self-care for staff
- a range of client and staff resources providing information about the experience of suicide bereavement, referral and support services
- a range of organisational interventions around workflow and communication to further support good practice around suicide bereavement funerals

The process of trialling and reviewing this postvention model will continue into 2021. It is being academically evaluated by the University of Western Australia and informed by a group of experts with experience of working with people bereaved by suicide. The findings will consider the potential application of this model to broader community contexts.

Men of the `Karjanarna Jaru` perform a traditional dance depicting an initiation ceremony for a young man. Purnululu National Park in The Kimberley

Aboriginal People

For Aboriginal people and their communities, SEWB is the foundation for a holistic concept of physical and mental health. The SEWB of Aboriginal people is strongly influenced by their connection to family, Elders, community, culture, Country, and spirituality. These connections work together to provide a culturally safe environment for Aboriginal people, and help individuals to maintain and enhance their SEWB.

Aboriginal SEWB:
For Aboriginal peoples, health itself is not understood as the concept often assumed by non-Aboriginal people, rather it is a culturally informed concept, conceived of as 'social and emotional wellbeing' – a term that is increasingly used in health policy but in this context carries a culturally distinct meaning: it connects the health of an Aboriginal individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine [32].

The wellbeing of Aboriginal people is influenced by physical health, mental health, cultural wellbeing and other social determinants of health including education, employment, economic engagement and cultural wellbeing.

Addressing the ongoing impacts of colonisation including trauma, grief, loss, discrimination, societal racism and the violation of the human rights of Aboriginal people are also critical elements influencing factors on the SEWB of Aboriginal people.

Diagram 1 – A Model of Social and Emotional Wellbeing

11. Social and Emotional Wellbeing

While the experience of SEWB varies between Aboriginal people and groups, and by location, some common elements help to enhance it. These include:

- A holistic approach which extends further than mental health, and focuses on the broader context and life pathways of individuals and families
- A strong link between collective and individual wellbeing
- Recognition and promotion of the importance of family support, prioritising the need to work with the whole family and where appropriate the community, not just the individual
- An understanding and acknowledgement of connection to Country and community
- Acceptance and understanding of the legacy of history and contemporary impacts on health and wellbeing
- Flexible delivery of services, including outreach, home support, care on Country and in schools
- Promotion of an 'open door policy' where there is no judgement or exclusion
- Understanding the importance of language, cultural healers, and traditional medicines that are trusted by the community

> **"Creating a suicide prevention framework that is inclusive of youth perspectives is extremely significant and beneficial as it creates a unique take on matters about youth from youth themselves.**
>
> **The young people of today are the leaders of tomorrow and this is why we not only have to empower them to have a voice in important matters, but also take into consideration that they may have the answers to some of the most important questions."**
>
> – Aboriginal Health Council of Western Australia (AHCWA) Youth Committee, 2019

The following recommended activities aim to support the healing and restoration to wellbeing and mental health, both individually and collectively for Aboriginal people [33] (Gayaa Dhuwi Declaration).

11.1 Facilitate the development of a Western Australian Aboriginal Suicide Prevention Strategy prioritising a culturally secure SEWB approach to suicide prevention with dedicated regional plans

11.2 Facilitate access to culturally appropriate healing-centred practices and opportunities for reconnection to culture and Country for Aboriginal people

11.3 Develop and deliver a culturally appropriate public awareness-raising campaign aimed to support Aboriginal people

11.4 Recognise and empower Aboriginal youth voices in suicide prevention discussions and leadership through greater participation in decision-making, co-production of prevention initiatives and advice to services

11.5 Provide increased and equitable access to SEWB services for Aboriginal people in mental distress and/or with suicidal ideation, including the engagement of Elders and Traditional Healers where required

11.6 Empower Aboriginal Community Controlled Health Services (ACCHSs) and other community organisations to provide culturally appropriate suicide prevention, intervention and postvention services for Aboriginal people

11.7 Embed culturally secure, trauma-informed and compassionate procedures and responses into crisis and support services

11.8 Provide ongoing practical and financial support to families directly affected by a suicide in locally and culturally relevant ways

Family Wellbeing Program

The Aboriginal Health Council of Western Australia (AHCWA) delivers the Family Wellbeing Program across Western Australia. The program aims to increase awareness of all the contributing social and emotional determinants that impact on family wellbeing, and identify culturally appropriate strategies to help build stronger foundations for overcoming these issues, and enhance social and emotional wellbeing.

As part of the Family Wellbeing Program, AHCWA delivers a culturally appropriate version of the Certificate II in Family Wellbeing to Aboriginal Communities. The training brings together Aboriginal health professionals, and others who work with Aboriginal people, to gain the necessary skills to support individuals, families and communities to overcome social and emotional challenges, and create stronger community and family environments.

During 2019, over 120 Aboriginal men and women participated in culturally appropriate Family Wellbeing training which has given them the opportunity to reflect on barriers to, and solutions for, improving and maintaining their own wellbeing. Participants have voiced that they are now able to recognise and identify triggers and stressors that impact social and emotional wellbeing, and feelings and behaviours that may lead to an increased risk of suicide for themselves or people in their communities. They also reported increased confidence in talking about emotions, and have learned how to help others manage stress and negative feelings. In addition, they have a better understanding of the holistic determinants of social and emotional wellbeing for Aboriginal people, and that, to be able to help others, social and emotional wellbeing is essential in their own lives as well.

Image © Mary-Lou Divilli, Camera Story

The program continues to evolve and grow with AHCWA now delivering the training course to community groups to build their capabilities to share skills with their communities. The program is also focussing on the needs of particular groups, for example, men's health groups.

How we developed the Suicide Prevention Framework 2025

Plan Consultation

Who we engaged	554 individuals in 110 separate face-to-face engagements (yarns, focus groups, workshops)
	431 individuals via an online survey
	Revision and analysis of 19 previous consultation reports and papers published between January 2015 and June 2019 that related to Suicide Prevention activity
	Steering committee with representatives from key agencies and community groups who provided advice and guidance and helped to represent the voices of vulnerable populations, sector and academic experts
	Individuals with a lived experience of being bereaved by suicide, and those who have experienced being suicidal
	Government advisory group included a mix of representatives from federal and state government
What we heard	Social determinants of health and wellbeing need to be addressed – housing, education, employment and health care etc
	Culture and country are important
	We need to empower local communities for community-led suicide prevention activities
	Suicide prevention education should be expanded to a wide cross-section of the community
	There is a need for a greater range of options for people experiencing suicidal crisis
	Pro-active follow up aftercare following a suicide attempt is needed

Emerging evidence and literature

New Frameworks and literature	Alliance Against Depression (AAD) model Black Dog LifeSpan Integrated Suicide Prevention (LifeSpan) model
	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)
	Review of 15 strategic government documents that have direct or indirect involvement in addressing suicide within WA (**Appendix 1**)
From the literature we learnt	A systems-based approach is essential; this means multiple strategies, delivered simultaneously, that focus on individuals, high-risk groups and the whole population
	Social determinants of health need to be addressed
	An Aboriginal-specific Suicide Prevention Plan must be developed
	Cross-government collaboration is required

Evaluation of Suicide Prevention 2020

How we evaluated	Internal ongoing evaluation and monitoring of Suicide Prevention 2020
	Independent evaluation of Suicide Prevention 2020
Key Findings from the evaluation	We need better coordination at the local level and of community-led activities
	Aftercare (following a suicide attempt) should be addressed as a separate issue to postvention (following a suicide death)
	Longer-term funding agreements for service providers are needed
	Collection of quantitative and qualitative community-level data is important
	Suicide prevention activity needs to be coordinated across government, non-government organisations and community groups

Perth, Western Australia

Everyone has a role in suicide prevention

“Suicide is often caused by situational events, not mental health conditions and this needs to be recognised and addressed in a holistic, not siloed, approach. In fact, in some regions and communities, addressing the social determinants that drive hopelessness and have a marked impact on an individual’s social connections, mental health and suicidality is seen as the most pressing activity for suicide prevention in the near and long term. These social determinants include, but are not limited to, domestic and family violence, alcohol and other drug use, homelessness and overcrowding, unemployment, poverty and hunger and require a whole of government response.”

– Engagement summary 2019 *(WA Suicide Prevention Action Plan 2021-2025 Engagement Report)*

The MHC acknowledges the vision of the Suicide Prevention Framework 2025 cannot be achieved in isolation. Identifying the roles of government, non-government organisations and community efforts is important.

Many services and agencies which do not have suicide prevention as part of their core business may not recognise they are engaged with some of the most vulnerable members of the community. They have an important role in identifying and responding to those who may be vulnerable to suicidal behaviour due to risk factors such as financial hardship, relationship loss, historic and current trauma, legal issues, and social isolation.

Every individual’s life highlights the need for suicide prevention activities to be embedded into the core business of all agencies.

Commonwealth Government

The Commonwealth Government is responsible for the development and implementation of national frameworks, including the delivery of funds, programs and services. For example, the WA Primary Health Alliance coordinates the development of Joint Regional Plans in collaboration with the MHC, the WA Department of Health and the State-based Health Service Providers.

Western Australian Government

The WA Government is responsible for the development of state-wide strategies and plans and includes the delivery and funding of programs and services that improve wellbeing at the community, organisational and individual levels. These include housing, employment, health, disability and financial support, transport assistance, workplace supports, the justice system and education programs.

Local Government

Local Government is the closest level of government to the community and plays an essential role in the provision of community programs and the built environment. They are responsible for developing the local community and creating supportive environments through the provision of local infrastructure, parks and recreation facilities, community services, building and planning, licensing and cultural facilities and events. Local Governments can contribute to improving mental health in their communities, but not in a formal service role.

Non-government organisations, and the private sector

The non-government and private sector delivers a range of face-to-face and online services and plays a large role in supporting individuals and the community in advocating for change. These sectors include peak bodies such as AHCWA, The WA Association for Mental Health and the Youth Advocacy Council of WA and the AHCWA Youth Committee. Non-government and private sector organisations are also responsible for providing employment and workplaces that are safe and healthy.

Individuals and communities

Individuals, families and groups that make up our community share the responsibility of providing safe and secure environments and building supportive positive relationships between friends, families, neighbourhoods and community groups.

Shining Hope

Shining Hope is a suicide prevention peer support group located in Bunbury. It was formed by community members to reduce the stigma of suicide and to support those who have been affected by a suicide loss. The group was established from the need for grieving members of the community to join together in support to share their stories, and the lives of the people they had lost.

They meet every second Thursday evening with founder Dylan Oakey describing how they work as, “We chat, we cry, we remember, we drink coffee and eat doughnuts. But mostly we are just there to listen to the grief, the loss, and the hope of each individual who attends”. All groups are facilitated by a qualified and experienced counsellor and members consistently report an increase in feeling emotionally and mentally supported. The facilitator also moderates a closed Facebook page to further assist group members.

When they are not meeting for support and to listen, Shining Hope offer practical assistance for families such as providing meals and offer general home assistance to those who are in the midst of their grief.

Building blocks for a cross-government approach

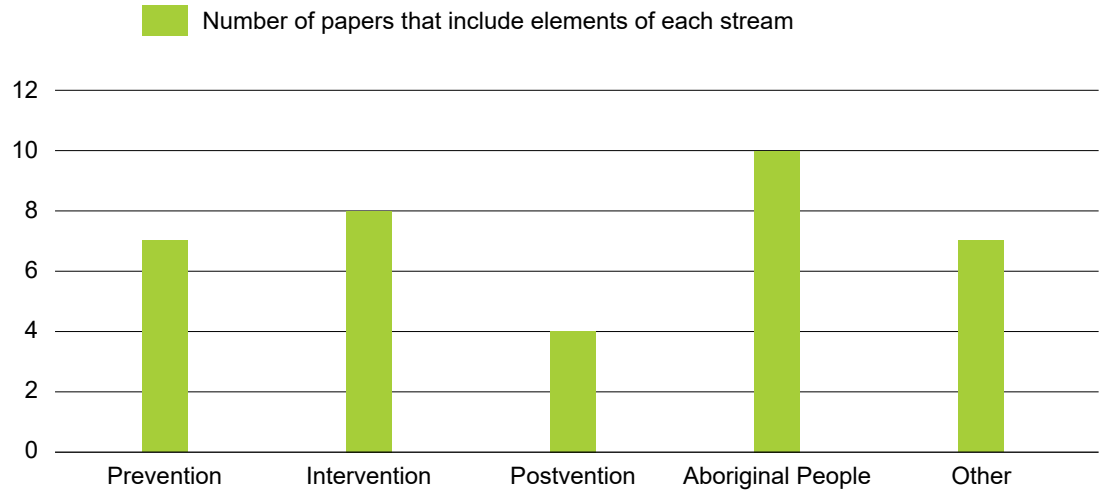
To reduce the potential for duplication of services and to further understand the interaction between government departments in relation to suicide prevention activity, the MHC commissioned a desktop review of 15 key government documents. Suggestions, recommendations, strategies, priorities and actions from within these documents were cross-referenced against the Priority Areas of the Suicide Prevention Framework 2025:

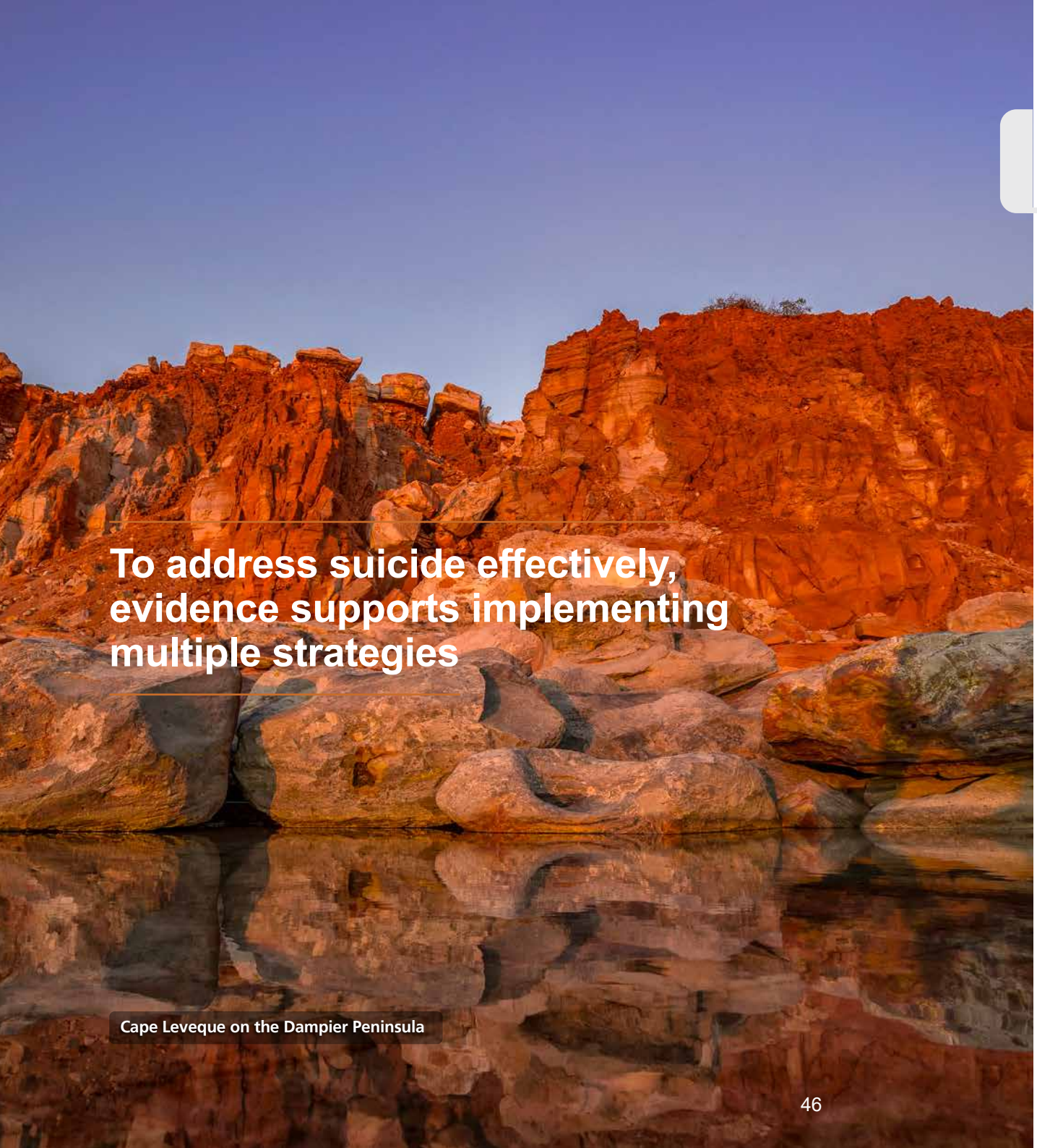
- Suicide Prevention
- Suicide Intervention
- Suicide Postvention
- Aboriginal People
- Social Determinants
- Other (Governance Issues and Research)

Table 3 identifies the key documents as they relate to each priority area in the Suicide Prevention Framework 2025.

The desktop review identified suicide prevention, suicide intervention and Aboriginal people as the priority areas covered in the highest numbers of documents. The areas of postvention and social determinants of health were covered in the fewest documents. Aboriginal suicide prevention and intervention experts strongly recommended culturally secure strategies that recognise and utilise the knowledge within Aboriginal communities, with many recommending collaborative works or Aboriginal-led initiatives. Several authors discussed the need for Government leadership in collaborative approaches.

Table 3 – Key documents as they relate to each priority area





To address suicide effectively, evidence supports implementing multiple strategies

Cape Leveque on the Dampier Peninsula

What works well

To address suicide effectively, accumulating evidence supports implementing multiple strategies, delivered simultaneously across a range of areas. This spans from individual-level to public health interventions in localised regions [34]. This is referred to as a systems-based approach. The WHO has identified the following 11 elements as priority areas to focus on when addressing suicide:

1. **Surveillance** – increase the quality and timeliness of data on suicide and suicide attempts
2. **Means restriction** – reduce the availability, accessibility and attractiveness of the means to suicide
3. **Media** – promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media
4. **Access to services** – promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care
5. **Training and education** – maintain comprehensive training programs for identified gatekeepers
6. **Treatment** – improve the quality of clinical care and evidence-based clinical intervention, especially for individuals who present to hospital following a suicide attempt

7. **Crisis intervention** – ensure that communities have the capacity to respond to crises with appropriate interventions
8. **Postvention** – improve responses to, and care for, those affected by suicide and suicide attempts
9. **Awareness** – establish public information campaigns to support the understanding that suicides are preventable
10. **Stigma reduction** – promote the use of health services
11. **Oversight and coordination** – utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours

In Australia, the LifeSpan Model (**Appendix 2**) developed by the Black Dog Institute is an evidence-based, integrated approach that combines multiple strategies that have strong evidence for suicide prevention into one community-led approach. The AAD (formally the European Alliance Against Depression, **Appendix 3**) is another systems-based model focusing on an integrated community-based approach focused on improving care for people living with depression and preventing suicidal behaviour.

The Kimberley Deliberate Self-Harm and Suicidal Behaviours Protocol

The Kimberley Deliberate Self-Harm and Suicidal Behaviours Protocol (the Protocol) was developed by members of the Drug, Alcohol and Mental Health Subcommittee of the Kimberley Aboriginal Health Planning Forum (KAHPF).

The KAHPF identified that there were multiple Social and Emotional Wellbeing and Mental Health agencies funded at varying levels to provide support for people with mental health conditions; concurrent with a lack of uniformity of service delivery within and across the different regional areas and communities in the Kimberley.

The protocol aimed to assist local staff with identifying and helping people who experience or display self-harming or suicidal tendencies and to make an accessible pathway for agencies to support their clients to access appropriate care.

A training package to support the use of the protocol was developed and piloted by the Kimberley Suicide Prevention Coordinator in nine different towns and communities across the Kimberley. Feedback was collected from 66 training participants (of which 61% were Aboriginal) in the form of pre- and post-tests to help evaluation the training.

The feedback received was very encouraging, indicating that:

- understanding of what is meant by deliberate self-harm & suicidal behaviours, including cultural factors, increased by 33%
- understanding of current mental health and WA Police Force processes increased by 50%;
- confidence in identifying risk factors and warning signs increased by 41%
- confidence in screening and assessing risk increased by 48%
- confidence in completing a risk assessment increased by 40%
- confidence in managing risk and safety planning increased by 23%
- understanding of which agencies to refer to dependent on risk increased by 26%

Feedback from participants was highly valued by local agency staff in the co-design process. As a result changes were made to the final protocol to make it more ‘user friendly’ for frontline staff. It was also identified that a separate protocol for community members would be advantageous. The community version is currently being developed in collaboration with the Kimberley Aboriginal Suicide Prevention Trial.

The protocol is being used by local agency staff across the region and is available online via the KAHPF website.

Factors that influence suicidal behaviour

Many factors influence a person to attempt to take their life. Most commonly, several risk factors accumulate over time which can increase an individual's vulnerability to suicide. These risk factors can occur at the individual, community, or structural level and often interact with one another.

For Aboriginal people, health and wellbeing is directly related to holistic determinants of health. Any disturbance to these determinants can impact an Aboriginal person's SEWB which, in turn, may result in them being at increased risk of experiencing suicidal behaviour. These determinants include connection to community, family, land, culture and Country, and physical, emotional and spiritual wellbeing.

Although not exhaustive, **Table 4** provides a list of known risk factors for suicidal behaviour, grouped into categories demonstrating the multiple levels at which risk factors can operate. It also helps to reinforce the role that everyone has in suicide prevention.

Some populations and groups are more vulnerable to suicide and suicidal behaviour[28]. These include:

- Aboriginal people
- persons who have experienced abuse, historical or current trauma, conflict or disaster
- refugees and migrants
- prisoners and others in contact with the justice system
- LGBTI persons
- individuals who have made a previous suicide attempt and people suicide bereaved
- children and young people
- rural and remote communities

At the other end of the spectrum, protective factors can help reduce a person's vulnerability to suicidal behaviours and increase their capacity to cope with particularly difficult circumstances. Known protective factors[32, 36], include:

Table 4 – Risk factors for suicidal behaviour (adapted from WHO, 2014)[35]

HEALTH SYSTEMS	• Barriers to accessing health care	
SOCIETY	• Access to the means of suicide • Inappropriate media reporting	• Stigma associated with suicide and help-seeking behaviour
COMMUNITY	• Disaster, war and conflict • Stresses of acculturation and dislocation	• Discrimination • Historical or current trauma or abuse
RELATIONSHIPS	• Sense of isolation and lack of social support	• Relationship conflict, discord or loss
INDIVIDUAL	• Previous suicide attempt • Mental disorders • Harmful use of alcohol and other drugs • Job or financial loss	• Hopelessness • Chronic pain • Family history of suicide • Genetics and biological factors

- employment
- social support and connectedness in stable relationships
- children under 18 living at home
- balanced physical health and general wellbeing
- having future plans and a sense of purpose
- engaging in meaningful activities
- strong reasons for living
- access and availability to effective mental health care
- life skills (problem solving, coping skills and adaptability to change)
- cultural beliefs that discourage suicide
- religious beliefs that discourage suicide

In addition, for Aboriginal people there is a growing body of evidence demonstrating that protection and promotion of traditional knowledge, family, culture and kinship contribute to community cohesion and personal resilience.

It is important to acknowledge that the presence of risk factors does not necessarily mean a person will take their life. Similarly, a person may experience suicidal behaviour even if there are multiple protective factors in their life. It is also important to understand that risk and protective factors are not simply opposites of each other.

Upstream Approaches

Use of "upstream approaches" such as addressing risk and protective factors early in the life course has the potential to "shift the odds in favour of more adaptive outcomes" over time. Additionally upstream approaches may simultaneously impact a wide range of health and societal outcomes such as suicide, substance misuse, violence and crime [35]

The literature continues to reference the social determinants of health as a factor in suicidal behaviour. The social determinants of health sit outside the health system but have the potential to significantly affect the health of populations.

Across WA, communities identify social determinants as one of the most important factors that needs to be addressed to prevent suicides and suicidal behaviour. Whilst the MHC can influence some of the direct factors influencing suicidal behaviour, there needs to be a commitment across government, industry and community to acknowledge and address issues that affect the social determinants of health.

Aboriginal people and their communities play an important role in identifying their health needs and shaping innovative local responses to strengthen their SEWB and mental health. Central to Aboriginal health and wellbeing are cultural connections to family, community, language and culture, spiritual, physical and emotional wellbeing. Disconnection from these elements can cause an individual to experience an imbalance in their overall health and wellbeing, not only from a medical point of view but from an Aboriginal and cultural perspective. This holistic approach to health recognises that for Aboriginal people and their communities, good health is more than just the absence of disease or illness.

Social Determinants of Health

Our health is determined by a number of factors outside the health system, including our environment, the choices we make and broader social factors. Social determinants of health can be defined as, 'the circumstances in which people grow, live, work, and age. The social determinants of health are mostly responsible for health inequities [37]. Social determinants of health include socio-economic position, foundations built in early life, social exclusion, social capital, employment and work, housing and residential environment. The physical environment also has the potential to influence our health. 'Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions' [38]

Evaluating activities is crucial to determining if what is being implemented is making a difference

The Pinnacles Desert, Nambung National Park, Wheatbelt

Monitoring and Evaluation

Ongoing monitoring and evaluation is central to the successful implementation of the Suicide Prevention Framework 2025. Activities delivered as part of the Framework need to be informed by evidence, promote safe practice, and aim to achieve their intended outcomes.

The Suicide Prevention Framework 2025 has been developed with a program logic approach. Each stream has several associated short and intermediate-term outcomes, to assist with a more consistent approach for the planning, delivery and evaluation of suicide prevention activities. Over time, these activities will help to influence the long-term community and state-wide population outcomes of the Framework.

Stakeholders, including other government departments, non-government agencies, organisations in the private sector and local communities are all encouraged to identify what parts of their core business may impact suicide-related risk and protective factors. Where appropriate, stakeholders are further encouraged to adopt or reorient their activities to align with the short and intermediate outcomes of the Suicide Prevention Framework 2025. **Table 5** identifies program and/or

service outcomes for consideration by stakeholders when planning suicide prevention activities.

Evaluating activities as they relate to the outcomes is crucial to determining if what is being implemented is making a difference. The MHC will monitor progress towards the short and intermediate-term outcomes identified as part of the delivery of funded programs as they relate to the Framework.

The long-term community and state-wide population outcomes are influenced by a variety of additional factors external to the MHC. The MHC will work in collaboration with key agencies re surveillance, data collection and the development of appropriate indicators to measure the long-term outcomes of the Suicide Prevention Framework 2025.

Table 5 – Suicide Prevention Framework 2025 Outcomes

	PREVENTION / EARLY INTERVENTION	SUPPORT / AFTERCARE	POSTVENTION	ABORIGINAL PEOPLE
*** SHORT AND INTERMEDIATE-TERM OUTCOMES**	Increased literacy surrounding mental health and wellbeing and suicide prevention Decreased stigma associated with mental health issues and suicide Increased ability to seek help for oneself or for someone else Increased coping skills and ability to manage difficult life experiences	Improved care and support for individuals in crisis Improved care and support for those assisting individuals in crisis Improved functioning following crisis Decreased symptoms following crisis Improved response to suicidal behaviours Increased quality of data on suicidal behaviours Increased timeliness of data on suicidal behaviours	Improved care and support for those affected by a suicide Increased quality of data on suicide Increased timeliness of data on suicide	Each regional Aboriginal suicide prevention plan will outline it's own outcomes as part of their plan development
LONG-TERM OUTCOMES	Increased personal and community resilience Decreased instances of intentional self-harm in Western Australia Decreased deaths due to suicide in Western Australia			

*** NOTE**: It is important to acknowledge short and intermediate-term outcomes are program dependent and identified as part of the service or program development. The establishment of data collection procedures to monitor and evaluate the program provides evidence that the outcomes have been achieved or that progress towards their achievement has been made. Measuring outcomes is the responsibility of those implementing the program/s and need to be identified prior to implementation.

Glossary

Key terms and preferred language when taking about suicide are explained below.

Aftercare: The care, treatment, help, or supervision given to persons following a suicide attempt with hospitalisation or medical treatment, this extends to family and carers acknowledging that a suicide attempt is the strongest risk factor for subsequent suicide, and highest risk period following release.

Attempted suicide: Attempted suicide refers to any non-fatal suicidal behaviour. In some cases it can be difficult to determine if a person intended their actions to result in death.

Complicated grief: a syndrome where normal grief is unusually prolonged because of complications in the normal healing process, with symptoms including separation distress and traumatic distress, characterised by an inability to accept death, intense yearning, avoidance, social withdrawal and suicidal ideation.

Intentional self-harm: Engaging in an act of self-harm with the intention of suicide. Intentional self-harm will result in either a non-fatal suicide attempt or a suicide death.

Lived experience: having experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crisis, or been bereaved by suicide.

Mental health promotion: Involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

Mental illness prevention: Initiatives which focus on reducing risk factors for mental ill-health and enhancing protective factors.

Non-suicidal self-injury (NSSI): Engaging in an act of self-injury without the intention of it resulting in suicide. Although suicide is not the intention of NSSI, there is an independent association between NSSI and increased suicide risk.

Placed-based approach: A place-based approach targets an entire community and aims to address issues that exist at the neighbourhood level. By using a community engagement approach to address complex problems, a place-based approach seeks to make families and communities more engaged and connected.

Postvention: Activities or interventions which occur after a death by suicide, aimed to support and assist those bereaved or affected (family, friends, professionals, peers, responders, community) to recover from trauma, cope with additional stressors, and to manage the experience of loss and grief.

Primary prevention: Strategies aimed at preventing illness by maintaining and/or enhancing the wellbeing of the general population.

- **Universal** – interventions targeted at the whole population.
- **Selective** – Interventions targeting subgroups of population who are at increased risk.
- **Indicated** – Interventions targeting high risk groups and those showing early signs of suicidal behaviour.

Resilience: The capacity and dynamic process of adaptively overcoming stress and adversity [39].

Secondary prevention/intervention: Seeks to lower the number of cases of a disorder or illness in the population through early detection and treatment.

Stigma: The WHO defines stigma as a major cause of discrimination and exclusion; it affects people's self-esteem, helps disrupt their family relationships and limits their ability to socialise and obtain housing and jobs.

Suicide: A death resulting from an act of self-harm with the intention of ending one's own life; a death resulting from an act of self-harm, without the intention of ending one's own life, is considered an accidental death.

Suicidality: Thoughts and behaviours related to suicide.

Suicidal crisis: A situation in which an individual is engaging in intentional self-harm with the intent to die, or is seriously contemplating or planning to make an attempt on their own life.

Suicidal ideation: Having thoughts about suicide. Suicidal ideation can range from momentary passing thoughts of ending one's own life to extensive contemplation and detailed planning.

Suicidal behaviour: Engaging in actions that have the potential to lead to suicide. Suicidal behaviour can range from role-playing an intended suicide to making an attempt.

Tertiary prevention/postvention: Interventions that reduce disability enhance rehabilitation and prevent reoccurrences of the illness.

Years of potential life lost: Is an estimate of the average years a person would have lived if he or she had not died prematurely. It takes into account the age at which deaths occur, giving greater weight to deaths at a younger age and lower weight to deaths at older age.

Kalgoorlie rooftops, Goldfields

Appendices

Appendix 1: Desktop review

Desktop review of strategic government documents with direct or indirect involvement in addressing suicide within Western Australia

COAG Health Council, 2017. *The Fifth National Mental Health and Suicide Prevention Plan*. Department of Health, Commonwealth of Australia

Department of Health, 2018. *National Foetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028*. Commonwealth of Australia

Department of Health (WA), 2019. *State Public Health Plan for Western Australia: Objectives and Policy Priorities for 2019-2024*. Government of Western Australia

Department of Premier and Cabinet, 2019. *Statement of Intent on Aboriginal Youth Suicide*. Government of Western Australia

Dudgeon, P., Darwin, L., McPhee, R., Holland, C., von Helle, S., and Halliday, L., 2018. *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for Primary Health Networks*. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute

Government of Western Australia, 2019. *Our Priorities: Sharing Prosperity*

Kimberley Aboriginal Law and Cultural Centre (KALACC), 2019 (Draft), *KALACC Feedback on the 22nd May 2019 Statement of Intent on Aboriginal Youth Suicide*. KALACC May 2019

Mental Health Commission, 2018. *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025*. Mental Health Commission, Government of Western Australia

Mental Health Commission, 2019. *Full Government Response to the Western Australian Methamphetamine Taskforce Report*. Mental Health Commission, Government of Western Australia

Mental Health Commission, 2019(a). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018*. Mental Health Commission, Government of Western Australia

National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), 2015. *Gayaa Dhuwi (Proud Spirit) Declaration: A Companion Declaration to the Whareārātā Declaration for Use By Aboriginal and Torres Strait Islander Peoples*

NATSILMH, 2017. *Co-Designing Health in Culture: Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide*

National Mental Health Commission, 2019. *Monitoring Mental Health and Suicide Prevention Reform: National Report 2019*. NMHC Sydney

National Suicide Prevention Project Reference Group (NSPPRG), 2019 (Draft). *National Suicide Prevention Implementation Strategy for Australia's Health System 2020-2023*. Draft for Comment as at 12 August 2019. Mental Health Principle Committee

Sustainable Health Review, 2019. *Sustainable Health Review: Final Report to the Western Australian Government*. Department of Health, Western Australia

Appendix 2: Lifespan

What is Lifespan?

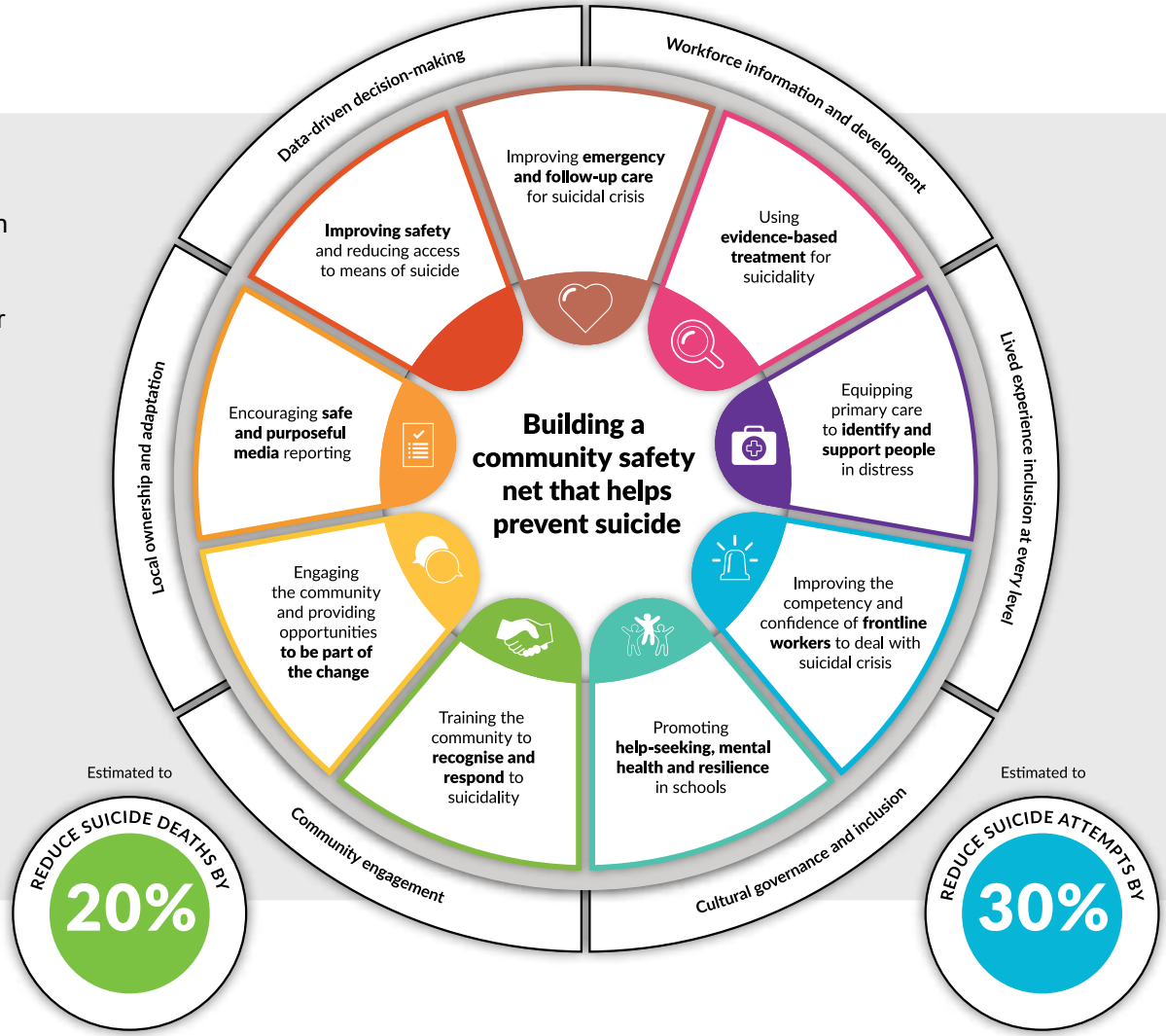
LifeSpan is a new, evidence-based, integrated approach to suicide prevention.

It combines nine strategies that have strong evidence for suicide prevention into one community-led approach.

Lifespan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis.

Get involved

- Undertake suicide prevention training
- Familiarise yourself with the services and support available in the community
- Look after yourself and support others when they need help.



Appendix 3: The Alliance Against Depression Framework

The Alliance Against Depression is considered to be a best practice model for the prevention of depression and suicide globally.

Establishing a local Alliance Against Depression helps a community work together to improve the care of people living with depression and preventing suicide and comprises of four levels of community-based interventions:

- Public awareness campaigns to reduce the stigma associated with depression and suicide;
- Support for high-risk groups, patients and their families;
- Localised training for health professionals, including GPs; and
- Education activities on depression and suicide for community members and leaders.

While each intervention has inherent value, real impact occurs when integration between all four components occur.

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