A community response

South Australian Suicide Prevention Strategy 2012-2016

Every life is worth living

Government of South Australia

Seeking Help

Help is available.

If you or someone you know, are **having thoughts of suicide** please seek help.

In a crisis

Emergency Services	000
South Australian 24 hr Mental Health Triage 18 years +	13 14 65
Women's and Children's Hospital under 18 years	08 8161 7000
Lifeline	13 11 14
Kids Help Line	1800 551 800
Suicide Call Back Service	1300 659 467
Mensline Australia	1300 789 978

Seeking information

Your General Practitioner	....
Mental Illness Fellowship of South Australia	08 8378 4100
beyondblue info line	1300 224 636
Relationships Australia	1300 364 277
SANE Helpline	1800 187 263
PANDA (Postnatal and Antenatal Depression Association)	1300 726 306
Reach Out (for young people)	www.reachout.com
For Aboriginal and Torres Strait Islander people	www.vibe.com.au
For Culturally and Linguistically Diverse people	www.mmhja.org.au
Gay and Lesbian Counselling Service	www.glccs.org.au

If you are **bereaved by suicide** and need help, the following services are able to provide assistance.

Lifeline	13 11 14
Living Beyond Suicide	1300 761 193
Hopeline	1300 467 354
Healthdirect Australia	1800 022 222
MOSH (Minimisation of Suicide Harm)	08 8443 8369
Solace Association (SA) Inc.	08 8271 6366
Suicide Survivors (on-line)	www.casa.asn.au

Message from the Government of South Australia

The Honourable Jay Weatherill MP Premier

Every suicide is a tragedy and the Government of South Australia has significant concerns about the rate of suicide. That is why we are committed to implementing the South Australian Suicide Prevention Strategy 2012-2016.

The vast majority of South Australians have been touched in some way by the death of an individual who has taken their own life. Preventing suicide and the impact it has on individuals, families and the state is something the whole of community must take responsibility for. The personal circumstances and experiences that lead to a person to attempt suicide are complex and varied. They do not fall neatly within one area of government or community life. The Government of South Australia is committed to leading community efforts to tackle suicide through awareness, prevention, intervention and support for those affected by suicide.

The State Government is committed to supporting safe communities and healthy neighbourhoods that are strong and supportive, resilient in adversity and work together in times of need. The South Australian Suicide Prevention Strategy provides us with a way forward to reduce the impact of suicide.

Every life in South Australia is worth living and we are committed to working together to ensure lives are not lost to suicide.

The Honourable John Hill MP, Minister for Health and Ageing and Minister for Mental Health and Substance Abuse

Suicide prevention is important to the wellbeing of all South Australians.

SA Health has been privileged to play a lead role in the development of the South Australian Suicide Prevention Strategy and will work collaboratively with all government departments, the non-government sector, business and community groups to achieve the outcomes and objectives set out within.

We are committed to ensuring the provision of the best possible care to consumers, their families and carers. The South Australian Government's investments in mental health, in conjunction with our ongoing reform agenda, will continue to deliver accessible, responsive and accountable services throughout South Australia.

The South Australian Suicide Prevention Strategy 2012-2016 provides us with a way forward to support people in need.

Foreword

The Office of the Chief Psychiatrist was established under the Mental Health Act 2009 with a mandate to protect the rights and interests of vulnerable South Australians.

The Office had a lead role in the development of the South Australian Suicide Prevention Strategy; however, the task would not have been possible without the openness and willingness of the people and communities of our state to speak out.

The project has brought us into contact with people from all walks of life and across South Australia. Forums were held in Nuriootpa, Berri, Murray Bridge, Mount Gambier, Victor Harbor, Whyalla, Port Augusta, Wallaroo, Jamestown, Port Lincoln, Coober Pedy and Adelaide to discover the issues affecting South Australians. Over 750 people participated and shared their journey, to progress this Strategy. We thank you for the honesty of your involvement and willingness to participate in the consultation process.

The seven goals within this Strategy articulate the elements that emerged as important in preventing suicide in this state.

During the consultation process we found a vast amount of good work occurring in the space of suicide prevention. However, because of a lack of coordination there was a pervasive sense that little was being done.

The South Australian Suicide Prevention Strategy aims to pull this work together, identify priorities for action, and coordinate effective response across our state. Suicide prevention is everybody's business.

The Office of the Chief Psychiatrist will work with other government departments, non-government organisations, business and community groups to establish responsibility for the actions and activities detailed in the Strategy and Implementation Guide.

Collectively we will prioritise the work in 12 month cycles and over the next five years, setting clear targets which will allow monitoring and regular reporting on progress.

Oversight of the Strategy will be provided by the Minister's Suicide Prevention Advisory Committee in collaboration with the Office of the Chief Psychiatrist.

I would like to acknowledge the early work of my predecessor Dr Margaret Honeyman, Ms Lynne James for her tireless work on this project and Mr Tony Stavrou who assisted in the consultations.

I extend a call to all South Australians. Together we can work towards preventing suicide and improving the wellbeing of our community.

Dr Panayiotis Tyllis

Chief Psychiatrist
Director Mental Health Policy
Mental Health and Substance Abuse

In Memory

This Strategy is dedicated to the memory of those who have taken their own lives. We acknowledge the struggle, turmoil and hopelessness they experienced.

Condolences

To those bereaved by suicide we would like to acknowledge the pain and anguish felt for the loss of their loved ones.

To those that have attempted to take their own life, we would like to acknowledge the inner turmoil that led to the attempt, and your courage and strength in trying to give new meaning to life. To their carers, we would like to acknowledge your hard work at a time of personal uncertainty and anguish to remain, alongside your loved one to help them to overcome their suicidal thoughts and begin the journey to recovery.

Acknowledgments

To those who participated in the consultation forums and those that provided feedback in the preparation of this Strategy, we would like to thank you for your contribution. The amount of passion shown to addressing suicide in our community is very heartening and encouraging as we as a community work towards eliminating suicide in South Australia.

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Section 1 Introduction

1. To provide a socially inclusive community of resilient individuals and supportive environments.
2. To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.
3. To provide targeted suicide prevention initiatives, activities and programs.
4. To address, as a priority, the issues that affect regional South Australians.
5. To provide targeted postvention activities and programs.
6. To improve the evidence base and understanding of suicide and suicide prevention.
7. To implement standards and continuous practice improvement in suicide prevention.

Introduction

1. Executive Summary

The South Australian Government shares a deep concern for the rate of suicide in South Australia, with all South Australians. The development of the South Australian Suicide Prevention Strategy has been a priority over the past 12 months and will continue to be for the life of the Strategy and beyond.

The personal circumstances and experiences that lead a person to attempt suicide are complex and varied and are not neatly contained within one government sector. Many of the risk factors for suicide are outside the control of the health sector, as are many of the protective factors that strengthen individuals and protect against suicide.

The South Australian Suicide Prevention Strategy has resulted from wide consultation throughout South Australia and describes, a whole of community, whole of government approach to suicide prevention that maximises the capacity of health and community services, families and communities to work together to prevent suicide.

Suicide prevention in the context of this document is all encompassing of awareness, prevention, intervention and postvention.

The strategy has seven goals that encompass a whole community response.

1. To provide a socially inclusive community of resilient individuals and supportive environments.
2. To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.
3. To provide targeted suicide prevention initiatives, activities and programs.
4. To address, as a priority, the issues that affect regional South Australians.
5. To provide targeted postvention activities and programs.
6. To improve the evidence base and understanding of suicide and suicide prevention.
7. To implement standards and continuous practice improvement in suicide prevention.

From the South Australia Suicide Prevention Strategy will be drawn specific strategies for children and youth, Aboriginal and Torres Strait Islander communities, men and older persons.

An Implementation Guide has been included and over the next year work will be required to achieve a cross government response to the actions and activities identified to achieve the outcomes over the life of the strategy.

Over the next five years we will be working with Federal Government, State Government Departments and Local Governments to coordinate the local responses required.

2. The Context

The South Australian Suicide Prevention Strategy does not sit in isolation. It is supported and enabled by many existing acts, policies and South Australia's Strategic Plan. South Australia's Strategic Plan's (SASP) Primary Goal: *We assist people to deal with all forms of illness and to live a satisfying life where they can contribute to their community.* In particular it addresses SASP *Primary Target 86 Psychological Wellbeing: Equal or lower the Australian average for psychological distress by 2014 and maintain thereafter.*

It also aligns with target 79: *Aboriginal Healthy Life Expectancy* and target 6: *Aboriginal Wellbeing* of the South Australia's Strategic Plan.

Whilst the Strategy aligns with the following documents, these documents also provide the enablers to achieve the work required across the numerous departments and sectors of South Australia.

2.1 Nationally

> **Fourth National Mental Health Plan 2009-2014.**

> **The Living Is For Everyone (LIFE)**, a framework for prevention of suicide in Australia (Australia's national framework for suicide prevention).

> **National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003.**

2.2 South Australia

> **South Australia's Mental Health and Wellbeing Policy 2010-2015.**

> **SA Health – Primary Prevention Plan 2011-2016.**

> **SA Health – Mental Health Unit Summary Report**: Statewide Aboriginal Mental Health Consultation February 2009, which is based on consultations through South Australia in late 2008.

> **SA Health Service Framework for Older People 2011-2016.**

2.3 The supporting Acts

> **The Public Health Act 2011.**

> **The Mental Health Act 2009.**

> **Child Protection Act 1993.**

> **Australian Human Rights Commission Act 1986.**

> **Intervention Orders (Prevention of Abuse) Act 2009.**

2.4 The supporting Policies and Frameworks

- **The People and Community at the Heart of Systems and Bureaucracy; South Australia's Social Inclusion Initiative – Feb 2009** – South Australia's Social Inclusion Initiative (SII) brings together political, bureaucratic and community efforts into a strategic and policy format to drive change.
  - **A cultural inclusion Framework for South Australia.**
  - **One Guide to the Framework** – A guide to assist agencies in the public sector to deliver culturally inclusive programs to Aboriginal peoples in South Australia.
  - **Two Cultural Competency Self-**Assessment Instrument. A guide to assist agencies in the public sector to deliver culturally inclusive programs to Aboriginal peoples in South Australia.
  - **Three – Cultural Inclusion Checklist**. A guide to assist agencies in the public sector to deliver culturally inclusive programs to Aboriginal peoples in South Australia.
- **The South Australian Health in all Policies** provides new and innovative ways of thinking and working across government departments in dealing with issues whose causal factors does not lie within the area of outcome. The plan throws down the challenge to all South Australians to take action that will achieve a better future for the state.
- **Family Safety Framework** – the Framework involves an agreement across departments and agencies for a consistent understanding and approach to domestic and family violence that has a focus on women's and children's safety and the accountability of perpetrators.
- **National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013** – the overarching goal of the Framework is to ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.
- **Closing the Gap** – is a commitment by all Australian governments to improve the lives of Aboriginal and Torres Strait Islander people, and in particular provide a better future for Aboriginal and Torres Strait Islander children.
- ***Youth*connect Framework.**
- **South Australia's Vulnerable Youth Strategy (10-25 years)** – the *youth*connect policy is a four year strategy and its action plan provides a policy framework and outlines new initiatives that address key issues for young South Australians.

3. Statistics – What are we trying to solve?

3.1 Suicide data

Suicide is a major public health issue. Although death by suicide is relatively uncommon, the human costs are substantial and can impact broadly across communities. As such, suicide prevention is a key focus for both government agencies and non-government organisations.

There are several national and state sources that capture suicide data and these data are neither comparable nor definitive. The Australian Bureau of Statistics (ABS) provides a caveat that care must be taken in using and interpreting suicide data contained within their publications due to limitations in the data quality.

The findings of the ABS Report, ABS 3309.0 Suicide Australia 2010 as detailed in this section, support the premise that although suicide is a significant issue that requires greater understanding and collaboration across communities and services, the rates are improving as public awareness and service enhancement improves.

There were 22 526 suicide deaths registered in Australia over the 10 years between 2001 and 2010. Suicide accounts for 1.7% of the 1 357 537 deaths due to all causes which occurred over this period.

The suicide rate in Australia has decreased by 17% over the past decade, from 12.7 to 10.5 deaths per 100 000 people.

Table 1 Deaths and Death Rates by Jurisdiction in Australia 2010

Death rates by jurisdiction in Australia 2010 (2012 ABS)

State	Males 2010	Females 2010	Persons 2010	Standardised Death Rate per 100 000 2006-2010
New South Wales	456	144	600	8.6
Victoria	405	126	531	9.8
Queensland	429	143	572	12.2
South Australia	157	40	197	11.7
Western Australia	248	62	310	13.2
Tasmania	47	17	64	14.5
Northern Territory	39	6	45	21.2
Australian Capital Territory	35	7	42	20.2
Total	1 816	545	2 361	10.1

Source: ABS 3309.0 Suicide Australia 2010

Suicide remains the leading cause of death among Australians between 15 and 34 years of age. Suicide rates for males in this age group have decreased over the past 10 years, with decreases of 34% for 15-24 year olds, and 46% for 25-34 year olds, while for other age groups the suicide rate has remained more stable. There has been little change in the suicide rate for females across all age groups over the past decade. Males account for approximately three in four suicide deaths.

There are clear differences in suicide rates across states and territories, with Tasmania and the Northern Territory recording particularly high suicide rates in comparison to other jurisdictions. There are also consistent differences in suicide rates for urban and rural areas, with Capital City Statistical Divisions recording lower suicide rates than 'rest of state' areas.

Of the 22 526 suicide deaths reported for 2001-10, 22% were recorded as having an associated cause of death (a contributing condition, disease or injury involved in the events leading to death). Of that 22%, the associated cause was recorded as: mental and behavioural disorder (50.2%), circulatory system disease (19.4%), respiratory system disease (9.6%), nervous system disease (8.3%), cancer (7.1%) and unknown (18.2%), with smaller percentages for a number of other conditions.

3.2 The South Australian suicide rate

The standardised suicide death rate for South Australia for 2001-05 was 12.8 (deaths by suicide per 100 000 population) and for 2006-10 was 11.7, contrasting against the national averages of 11.4 and 10.7 respectively. SA has had a rate decrease of 8.6% compared to the national rate decrease of 6.1%.

South Australia has also experienced a decrease in the suicide death rate for regional people. Contrast the rates in 2001-05 for Adelaide (12.5) versus regional (14.0), with the rates in 2006-10 for Adelaide (11.7) and regional (11.9). In most other jurisdictions the difference between metropolitan and regional rates is on average 3.5, ranging from 0.7 for NSW to 6.3 in WA and QLD.

3.3 The Aboriginal and Torres Strait Islander people suicide rate

The Aboriginal and Torres Strait Islander rate of suicide for South Australia for 2001-2010 was 26.7 (deaths by suicide per 100 000 population, compared to the 21.4 national average), contrasting with the non-Indigenous rate for SA for 2001-10 of 11.2 (compared to the 10.3 national average).

Table 1 shows the most recent data of the distribution of suicide across Australia for the year 2010 and provides the Standardised Death Rate per 100 000 population for 2006-10.

Table 2 Aboriginal and Torres Strait Islander/Non-Indigenous comparison of rates per 100,000 Years 2001-10

Age Group	Aboriginal and Torres Strait Islander Rate per 100 000		Non- Indigenous Rate per 100 000	
2001-2010	**Males**	**Females**	**Males**	**Females**
15-19	43.4	18.7	9.9	3.2
20-24	74.7	21.8	19.2	4.0
25-29	90.8	18.1	22.1	5.4
30-34	75.0	13.1	25.0	5.8
35-39	60.1	15.7	25.4	6.6
40-44	44.7	7.9	25.2	6.6
45-49	25.5	7.1	23.3	6.6
50-54	18.3	5.6	20.3	6.6
55-59	13.6	-	16.2	5.5
60 and over (h)	17.6	n/a	19.2	5.0
All ages	33.0	8.7	16.5	4.5
(h) Includes under 15 yrs of age and age unknown.				

Source: ABS 3309.0 Suicide Australia 2010

Suicide rates for Aboriginal and Torres Strait Islander peoples are approximately twice those of non-Indigenous Australians. Suicide rates are particularly high among younger Aboriginal and Torres Strait Islander people. However, for Aboriginal and Torres Strait Islander people aged 45 and over, suicide rates align more closely with those recorded for the non-Indigenous population.

3.4 Young children

The ABS have not provided details on the number of deaths of young children below 15 years but there are children under the age of 15 years who self harm. *The Hidden Toll: Suicide in Australia*, the Senate Community Affairs Reference Committee June 2010 reported in recent decades, within Aboriginal and Torres Strait Islander communities, the number of children 14 years and under who die by suicide has been increasing.

3.5 Culturally and Linguistically Diverse communities

Suicide rates for Australian residents based on regional of birth show that people born in Australia, New Zealand, Europe and North America have similar rates of suicide (between 9.7 and 13.5 deaths per 100 000 people). However, suicide rates are comparatively lower for people born in Asia, Africa and the Middle East (ranging from 5.3 to 5.9 deaths per 100 000 people).

3.6 Suicidal ideation

There is no consistent way of measuring the phenomenon of suicidal ideation, or thoughts about suicidal acts. Usually, studies of suicidal ideation rely on the self-report of interviewees or respondents to questionnaires. In the 2007 *National Survey of Mental Health and Wellbeing*, 1.8% of males and 2.7% of females reported having experienced thoughts of suicide in the previous 12 months. Extrapolating to the whole population, an estimated 146 000 men and 222 000 women experienced suicidal thoughts in the previous 12 month period.

As documented in the Australian Bureau of Statistics (2007), National Survey of Mental Health and Wellbeing: Summary of Results, 0.3% of men and 0.5% of women (0.4% of the sample overall) reported that they had made a suicide attempt in the previous 12 month period. Based on this data it can be estimated that around 65 000 people make a non-fatal suicide attempt each year in Australia.

4. Reasons – Why do people engage in suicide and self-harm?

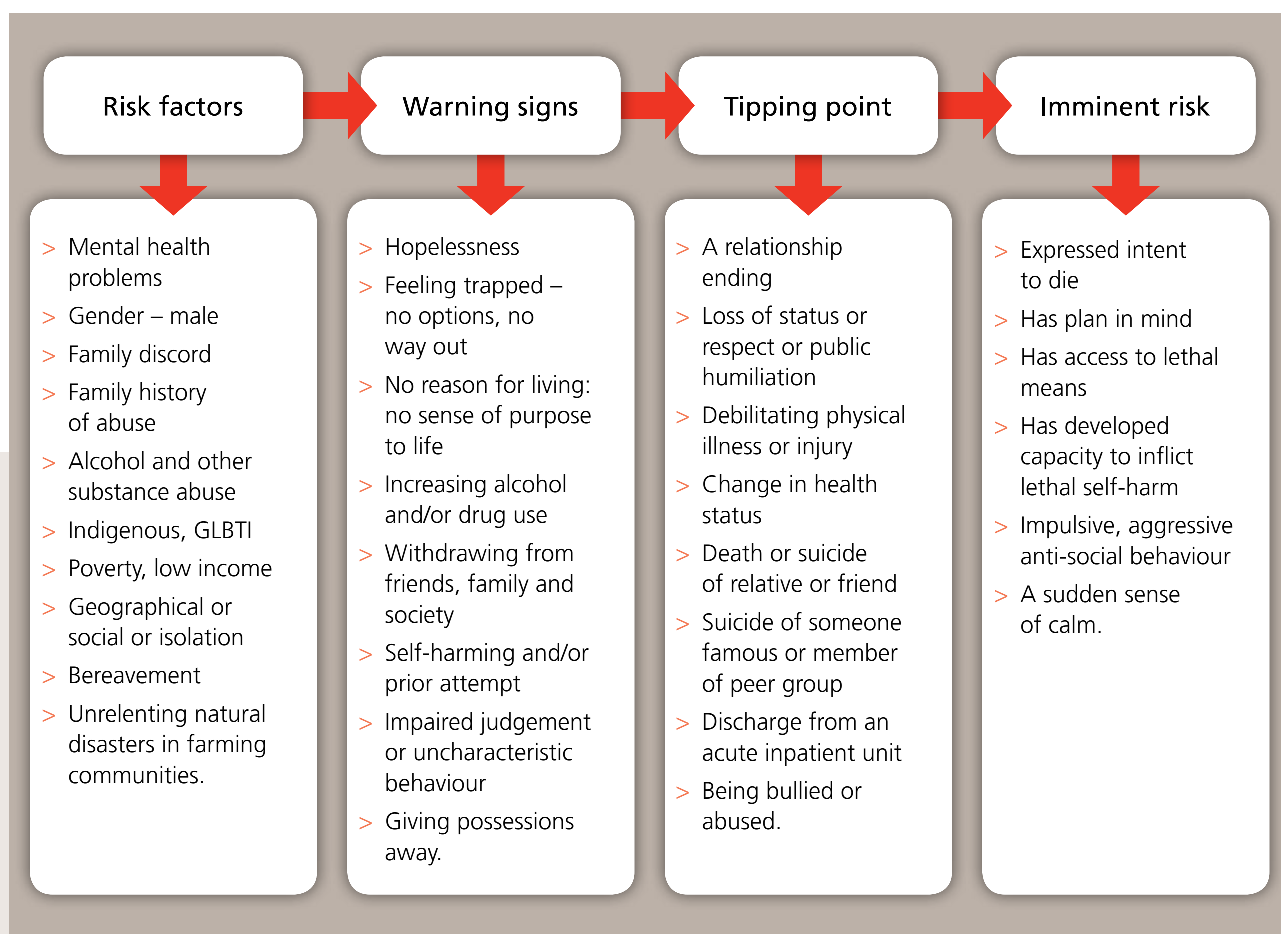
4.1 Contributing factors

Suicide is complex and does not result from one single cause. Our uniqueness provides a plethora of reasons that one might engage in suicidal or self-harming behaviours. There are several factors that may contribute to a person engaging in suicidal behaviour. Some of these factors are personal whilst others lie in the fabric of society. The persistent themes that came through the consultations were:

- A personal crisis often associated with the loss of a significant other through death or relationship breakdown or the loss of identity through the loss of job or poor choices. This will often lead to the person feeling overwhelmed, isolated, alienated and unable to cope.
- A family history of child abuse or exposure to poor coping mechanisms and self-harming behaviours.
- Social isolation or social exclusion.
- Mental Illness that can amplify or distort the degree of distress being experienced (schizophrenia, bipolar disorder, substance abuse disorders, personality disorders, depression and anxiety).
- Alcohol and substance use can cause a person to lose self control and engage in high risk behaviours and impulsive suicidal behaviour.

4.2 The transition from risk factors to the point of imminent risk

Figure 1 The transition from risk factors to the point of imminent risk. After Bycroft 2010.



5. Responses to Suicide

The things that push a person from having a risk factor through to being at imminent risk are numerous. The South Australian Suicide Prevention Strategy was developed to strengthen the communities response at all stages of the spectrum of distress.

Responses to suicide fall into the three categories of universal, selective and indicated and can be utilised at the various stages to prevent transition to a person being at imminent risk. Universal initiatives are designed to address risk factors and selective initiatives are designed to address risk factors and early warning signs, whilst the indicated interventions are designed to address imminent risk.

5.1 Universal initiatives

Universal initiatives are aimed at the general public or specific groups and are pre-emptive. These initiatives promote social inclusion and positive mental health and provide information and education on mental health related topics.

Examples of universal initiatives are RU OK Day, World Suicide Prevention Day, World Mental Health Day and the LIFE Living is for Everyone National Suicide Prevention Strategy. They involve large numbers of people raising the issue of mental health related topics globally to reduce stigma and encourage help-seeking behaviour.

5.2 Selective interventions

Selective interventions are aimed at the people whose risk of suicidal behaviour is higher than the average person. Specific strategies may be used to assess and help people who could be at a somewhat higher risk of suicidal behaviour. Initiatives might include selective interventions to increase problem solving skills, coping skills and help-seeking behaviours or programs might screen for indicators of suicidal ideation or mental illness.

Selective interventions are those that affect local communities providing opportunities to up-skill in areas of problem solving, coping strategies or programs for screening groups of people for early warning signs of suicidal ideation or mental illness. There is a role for many local services to provide early intervention programs as selective interventions to reduce the risk for people in the selected community. The community may be rural, those experiencing a mental illness, Aboriginal and Torres Strait Islander or children.

An example of a selective intervention is the development of postvention guidelines for schools, as this deals with a specific community to address the risk of suicide. Another example is the Mates in Construction Model for industry and mining sectors. A final example would be the local church or a community group working with a vulnerable group perhaps in the development of a community garden to bring about connectedness.

5.3 Indicated interventions

Indicated interventions are used for individuals whose behaviour indicates that they may be at imminent risk of suicide. In these circumstances an indicated intervention may be the face to face delivery of care, either by a professional or a family member, friend or colleague, in getting alongside the individual and supporting them through the crisis to professional longer-term support.

Indicated interventions can occur anywhere at anytime by individuals who are prepared to listen and assist the person to stay connected with life. Every one of us is able to offer this support to someone close.

Section 2

Principles and Goals

1. To provide a socially inclusive community of resilient individuals and supportive environments.
2. To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.
3. To provide targeted suicide prevention initiatives, activities and programs.
4. To address, as a priority, the issues that affect regional South Australians.
5. To provide targeted postvention activities and programs.
6. To improve the evidence base and understanding of suicide and suicide prevention.
7. To implement standards and continuous practice improvement in suicide prevention.

Principles and Goals

1 The Guiding Principles

Suicide prevention is a shared responsibility of the whole of the South Australian community.

The South Australian Suicide Prevention Strategy must encompass **awareness, intervention and postvention initiatives** in a holistic and comprehensive way.

This is most effectively achieved through **adequate and appropriate training** to meet the needs of clinicians and community members.

Do no harm. It is imperative that initiatives are carefully developed, informed by best practice, assessed to be safe, are comprehensively evaluated to ensure they are effective and most importantly, do not place vulnerable people at an increased risk of suicide.

The first door is the right door. Services need to be widely promoted and easily accessible through a wide range of entry points with the first service responsible for finding the best fit that meets the vulnerable person's needs.

Individuals need compassion and understanding when experiencing psychological or physical distress.

Suicide prevention initiatives should be based on best practice. Empirically supported approaches and best practice models should be utilised where available. Where robust evidence is lacking, collaborations with and amongst researchers should be developed to build the evidence base.

Promote personal resilience and strengthen environments in which people work and play. Develop resilience during early life experiences and continue through the life span. Personal resilience is seen as the individual's capacity to navigate their way to resources that sustains wellbeing, physical and social environments in a manner that is culturally meaningful.

Develop partnerships between government and non-government organisations to meet community needs through a comprehensive approach to suicide prevention. Services are most effective when they are coordinated, integrated and supported by collaboration across sectors and communities.

Provide responsiveness to the needs of those in psychological distress. Listen to the needs expressed by stakeholders and modify programs to meet their needs. There is a responsibility to provide alternative ways of addressing psychological or physical distress.

Recognise and respect diversity within the community. To be effective, the design and delivery of suicide prevention (programs, interventions and services) must be responsive to, and respectful of, the realities and needs of the population they target such as those based on ethnicity, culture, gender, sexual orientation and age.

Demonstrate sustainability and long-term commitment. Suicide prevention is a complex issue and requires sustained action at a range of levels, supported by a commitment to long-term investment.

1

To provide a socially inclusive community of resilient individuals and supportive environments

Strategic direction

The South Australian Social Inclusion Initiative is 'about participation': it is a method of social justice. It is about increasing opportunities for people, especially the most disadvantaged people, to engage in all aspects of community life (Government of South Australia, 2006). Social inclusion emphasises community wide participation, integration, cohesion and access to connections.

Key focus

Awareness programs; community connectedness; community organisations; development of help seeking behaviours; education and training; families; Government services; lifespan health and emotional wellbeing; media; schools and workplaces.

Outcomes

1.1 Increased responsiveness to social determinants of wellbeing.

1.2 Improved community and individual awareness.

1.3 Improved individual strengths, resilience and increased help seeking behaviour.

1.4 Improved education and training, across the community.

1.5 Balanced and considered portrayal of suicide in all media genre.

2

To provide a sustainable, coordinated approach to service delivery and resources and information within communities to prevent suicide

Strategic direction

The community is increasingly diverse and services need to be able to cater for the diversity of the population they serve. Improving the coordination and sustainability of services, programs and interventions involved in suicide prevention, intervention and postvention to make them more accessible to consumers is critical to good outcomes. Services need to be culturally sensitive and evaluated to ensure the needs of consumers are met across the age continuum. It is also important that the withdrawal of a service does not compromise regional care and treatment.

Key focus

Awareness; criminal justice; evaluations; emergency services; funding sources; health services; mental health services; prevention, intervention and postvention; referral pathways; schools; services of non-government organisations; industry groups; professional bodies; social venues; sporting groups and workplaces.

Outcomes

2.1 Public policy supports suicide prevention.

2.2 Transparent resourcing and partnerships between Federal, State and Local Governments to prevent suicide.

2.3 Joint ownership of suicide prevention enabling partnerships between governments, industry, professional bodies and non-government organisations.

2.4 Agencies and departments linking effectively so that people experience a seamless service.

3

To provide targeted suicide prevention initiatives, activities and programs

Strategic direction

The issues that lead to a person contemplating suicide are complex and a wide range of initiatives are necessary to tailor responses to the individual's needs.

Key focus

Children (victims of abuse, social disadvantage); young people (particularly those questioning their sexuality, bullying, carers); men; Indigenous men and peoples; people of rural farming and remote communities; people with a mental illness and co-morbidities; people in contact with the criminal justice system; culturally and linguistically diverse people (CALD); Lesbian, Gay Bisexual, Transgender, Intersex people (LGBTI) and those questioning their sexuality; peri-natal woman; older persons experiencing, chronic pain, terminal illness or disability; adult survivors of trauma, sexual abuse, child abuse or bullying; relationship breakdown; people who have made a previous suicide attempt; people bereaved by suicide; carers and vicarious and bystander trauma.

Outcomes

3.1 Provision of selective and indicated programs and interventions available for all high risk groups.

3.2 Reduced access to means for suicide.

4

To address, as a priority, the issues that affect regional South Australians

Strategic direction

All areas of the South Australian Suicide Prevention Strategy apply equally to regional SA. Regional SA comprises 28% of the state's population and this population is located in communities ranging from 25 000 through to populations of 10 or less. The regions are vastly different from metropolitan Adelaide. Each region has a diversity of strengths and unique challenges. Providing services to such a diverse population group is difficult and costly; and often resource poor. Addressing the many issues that increase the risk of suicide is prevention in action. Community action plans that address specific needs in these areas will be critical to the success of the suicide prevention strategy.

Goal 4 focuses on regional South Australia and the diversity of the population, industry and community needs, as well as the resources available to service those needs. Collaboration and communication between services is the key to maximising the resources available, and to develop strong communities.

Key focus

Access to services; agricultural community resilience; early intervention; education; government interagency collaboration; government and industry collaboration; Aboriginal and Torres Strait Islander communities; Local Government; men; mining; planning; training and youth.

Outcomes

4.1 Improved capacity of regional communities to address the issues associated with suicide.

4.2 Improved capacity of Aboriginal and Torres Strait Islander communities to address the issues underlying suicide.

4.3 Increased community awareness of what is needed to prevent suicide in rural areas.

4.4 Provision of support during times of physical and emotional crisis in a community.

5

To provide targeted postvention activities and programs

Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description. (Jamison K. R, Night Falls Fast: Understanding Suicide 1999, New York Alfred A Knoft p. 24).

Strategic direction

Suicide is devastating for those left behind; impacting family, friends, workmates and the community in profound ways. Goal 5 focuses on improving the care and support for those who have made a suicide attempt, and supporting the partners, carers, family, friends and community affected by a suicide or suicide attempt.

Key focus

Bystanders; clinicians; individuals; partners, carers, families, peers and communities impacted by a suicide attempt(s); partners, carers, families, friends and peers bereaved by suicide; response to suicide data; schools; survivors of attempted suicide and workplaces.

Outcomes

5.1 Provision of effective support to those who are affected by suicidal behaviour or a suicide.

5.2 Appropriate care for those people who present with behaviour identified as suicidal.

5.3 Increased understanding of factors that facilitate recovery after a suicide attempt.

6

To improve the evidence base and understanding of suicide and suicide prevention

Strategic direction

Suicide prevention initiatives should be based on best practice gathered from a range of methodologies, and inclusive of the evaluation of existing therapies and programs. Where robust evidence is lacking, local research should be fostered to build an evidence base and greater understanding of suicide.

Links with national and international research groups should be encouraged to create opportunities for large-scale significantly funded, research programs.

Key focus

Prevention programs and research and evaluation of suicide.

Outcomes

6.1 Accuracy is achieved in the reporting of suicide in South Australia.

6.2 Research activities are coordinated and targeted at knowledge gaps.

6.3 Expanded knowledge and understanding contributing to the evidence base for suicide prevention.

6.4 The application of evidence into practice across all areas of suicide prevention.

7

To implement standards and continuous practice improvement in suicide prevention

Strategic direction

Goal 7 of the South Australian Suicide Prevention Strategy ensures best practice is occurring across all sectors of the community in relation to suicide prevention, supported by standards, policy and memorandums of understanding (MoU) between partners. Evaluation of current programs and interventions is critical to the knowledge base to reach best practice.

Key focus

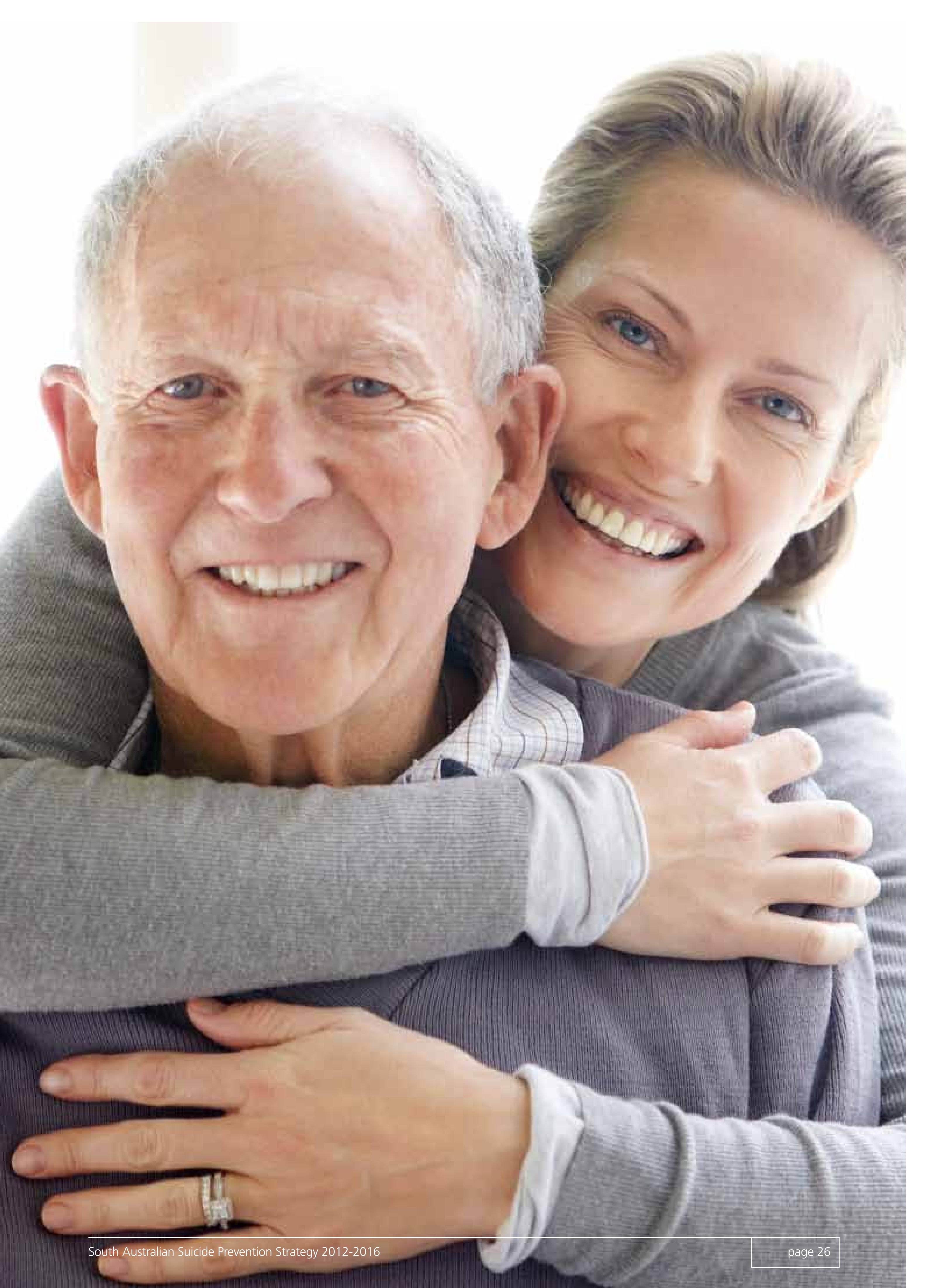
Access to means; care and treatment in Emergency Departments; community and community groups; crisis call outs; evaluation; media; medication; palliative care; pathways of care; risk assessments; safe environments; transfer of care and training.

Outcomes

7.1 Systematic and continuous improvement in suicide prevention practices.

7.2 Provision of MoUs where partnerships require a shared, understanding of roles and responsibilities in meeting standards of care.

7.3 Continuous evaluation of strategies, therapies and programs to enhance their value and effectiveness over time.



Section 3

Implementation Guide

1. To provide a socially inclusive community of resilient individuals and supportive environments.
2. To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.
3. To provide targeted suicide prevention initiatives, activities and programs.
4. To address, as a priority, the issues that affect regional South Australians.
5. To provide targeted postvention activities and programs.
6. To improve the evidence base and understanding of suicide and suicide prevention.
7. To implement standards and continuous practice improvement in suicide prevention.

1 The Implementation Guide

The Implementation Guide provides the outcomes and objectives for achieving the South Australian Suicide Prevention Strategy 2012-2016.

The Guide was developed to capture all activity that was considered to be important in prevention of suicide. The reader should be aware that the presentation of the actions and activities comprising each goal is not intended to imply priority.

The Guide was informed by and built upon the consultation feedback, the submissions received and the activity identified through the position statements of the Australian and New Zealand College of Psychiatrists and suicide prevention peak body, Suicide Prevention Australia (SPA).

Much work has been occurring in the space of suicide prevention by dedicated volunteers and innovative program providers. There was inconsistency in service provision with gaps in several areas and duplication in others. Coordination of the activity and identification of the gaps is much needed. The Implementation Guide is an attempt at identifying what needs to be occurring at all levels in order for us to achieve the seven goals of the Strategy.

It is a living document and activity will be measured against the agreed targets. The actions and activities may change and develop over the life of the Strategy. During the next six months we will prioritise the activity and produce timelines against the priorities set.

The enormity of the task at hand is evident in the Implementation Guide. The willingness, for all government departments, the private sector, non-government organisations, media, consumers and carers to come together to address suicide in this state is significant. Each individual and organisation will focus on different priorities to bring about the realisation of the strategy.

The Implementation Guide is an honest representation of consultation with South Australians, and what they wanted for this state and the people who reside here.

Goal 1

A socially inclusive community of resilient individuals and supportive environments.

	Action	Activity
1.1	Outcome: Increased responsiveness to social determinants of wellbeing.	
1.1.1	Objective: Improved community connectedness and social inclusion.	
	1. Develop structures to ensure that all policies and programs are socially inclusive.	1. Develop and promote progressive policies to enable important features of social inclusion (including engagement and empowerment).
		2. Ensure mental health is included in the Health in all Policies model.
	2. The development of mechanisms for social inclusion for people with a mental illness.	1. Strengthen interagency collaboration and cooperation to ensure that issues relating to suicide are recognised and incorporated into policies and programs and related research.
	3. Whole of community interventions are developed and supported by and with local community that build community empowerment through access of information, support and services.	1. Promote and support well designed neighbourhoods which facilitate safe, walkable access to services, recreation facilities and community meeting places that enable community connectedness.
		2. Increase opportunities for young people to participate in and contribute to all aspects of community life particularly decision making processes which impact them directly.
		3. Develop broad community education programs targeted at all age groups, cultures, gender, schools, sporting clubs, religious groups, workplaces and media.
		4. Communities to engage in generating solutions to issues that are of concern to them; need to develop opportunities to foster caring for another.
		5. State Government planning to include emotional impact studies on communities impacted by development.
1.1.2	Objective: Develop and promote universal programs that build life skills that enhance individual resilience.	
	1. Use a social inclusion approach to targeting the social determinants of suicide, generating long term outcomes and protecting people from risk of suicidality.	1. Support and strengthen Child Adolescent Mental Health Service (CAMHS) Child protection / Guardianship of the Minister (GOM) services.
		2. Community education regarding impact of childhood neglect, abuse, loss and trauma on the development of psychological problems and suicide.
		3. Increase the understanding of mental health needs of children in out of home care by other health professionals.
		4. Address the issues of homelessness with adequate housing and support services to reclaim lives.
		5. Promote full citizenship and inclusion, including addressing discrimination on grounds of age, gender, race, religion and sexual preference.
		6. Increased support for first time peri-natal women to enhance parenting skills.
	2. Use government legislation, regulation and policy to address areas that lead to increased suicide risk.	1. Consider regulation in areas such as poker machines and alcohol licensing to address problem gambling and alcohol use.
1.2	Outcome: Improved community and individual awareness.	
1.2.1	Objective: Reduce the stigma in the community by breaking the silence on emotional and mental health.	
	1. Invest in Mental Health Awareness programs to address stigma, mental health literacy and mental health promotion.	1. Link into National and International Days that promote positive ways of thinking about mental health. RU OK Day, World Mental Health Day, International Suicide Day and White Wreath Day.
		2. 'Let's think positive' campaign.
		3. Increase awareness of warning signs for suicide and how they differ between groups.
	2. Focus on the attitudes and behaviours of community leaders, professional bodies and service providers.	1. Reduce stigma and enhance responsiveness in places where people in distress may seek assistance in a last bid for help. These places will develop ways to engage with individuals so that hope will not be lost.

	Action	Activity
1.2.2	Objective: To encourage people to discuss suicide and how to seek help.	
	1. Seek advice and information from experts from high risk groups in how best to discuss suicide with them.	1. Foster discussion amongst high risk groups to promote help seeking in ways that are culturally, age and gender specific.
	2. Provide information to community members.	1. Provide information regarding services on a variety of mediums: pamphlets, fridge magnets, resource centres, books, one on one and phone centres and information technology.
		2. Utilise social media platforms to provide access to information and support.
1.3	Outcome: Improve individual strengths, resilience and help seeking behaviour.	
1.3.1	Objective: Develop and promote universal programs that build life skills that enhance individual resilience.	
	1. Promote wellbeing for children and young people across all levels of the community.	1. Every Chance For Every Child policy development: > Building strong foundations for Indigenous children, families and communities > Continue to develop and implement early childhood initiatives.
		2. The protection of children from neglect and abuse.
	2. Develop flourishing communities.	1. Promote the principles of Positive Psychology across all levels of government and community life.
1.4	Outcome: Improved education and training, across the community.	
1.4.1	Objective: Develop community capacity to respond.	
	1. Develop a society that is able to help out and respond.	1. Skill development across the wider community to build confidence, including: > Skills to respond > Knowledge to refer.
		2. Develop a more compassionate community.
	2. Develop a set of principles for how best to take further action.	1. Enable people to identify and help another in need.
		2. Provide targeted education to people whose jobs place them in positions of 'confidante' – like hairdressers, barbers, taxi drivers, charity store staff, housing, Centrelink staff and hotel staff.
1.4.2	Objective: Provide support, education and training to all professions engaged in suicide prevention or trauma response.	
	1. Develop consistent training approach across service providers' workforce development.	1. Provide training and support in the workplace through the Mental Health First Aid Training, and Applied Suicide Intervention Skills Training (ASIST).
	2. Improve targeted training in mental health, suicide risk, awareness and management.	1. Specific training and curriculum for professionals, to meet the mental health needs of children and adolescents (including those in care).
		2. Specific training in the risks and ways of reducing the risk of suicide in the elderly
		3. Training education and support provided to frontline staff, for example health professionals, service providers, school teachers, family, friends, and the wider community to recognise and assist people who are experiencing suicidal crisis.
	3. Increased numbers of appropriately trained health professionals to provide general and mental health care to high risk groups are required.	1. Ongoing education regarding identification and appropriate treatment of the different types of depressive disorders provided to general practitioners.
		2. General Practitioners to provide evidence that they have maintained basic competency in mental health assessment.
		3. Those training at all medical schools or undertaking training as other health professionals be given suicide prevention education to ensure good literacy in general physicians and health care professionals early in their careers.

	Action	Activity
	4. Develop pathways of care suitable for all General Practitioner Surgeries, Emergency Departments, and crisis lines to make the required care easy to access.	*1. To be developed by partners during implementation.*
	5. Develop culturally and linguistically sensitive resource packs that are to be given to people at the point of contact.	*1. To be developed by partners during implementation.*
1.5	Outcome: Balanced and considered portrayal of suicide in all media genre.	
1.5.1	Objective: Responsible reporting of suicide and how stories reach the community.	
	1. Increased media accountability for responsible and balanced reporting of suicide.	1. Mainstream and multi-lingual media to improve community knowledge and understanding of suicide and suicide prevention through responsible reporting.
		2. Encourage professional bodies, including journalism and media, to include treatment of suicide and mental illness in the code of ethics for the profession.
		3. Engage South Australian media, advertising, film and television in the Mindframe resources and professional development.
		4. Introduce Mindframe curriculum in tertiary journalism, public relations, film and television academic courses.
	2. Monitor the media for responsible reporting.	1. Report to SANE Australia Stigma Watch any irresponsible reporting and seek corrections.

Goal 2

To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.

	Action	Activity
2.1	Outcome: Public policy supports suicide prevention.	
2.1.1	Objective: To provide policies that enables the efforts of suicide prevention.	
	1. Develop public policy that supports health promotion, disease prevention and the ability for individuals to make healthy choices.	1. Promote Government policy on healthy lifestyle and healthy self-management.
		2. Develop Government policy in early childhood development, child protection and family support.
		3. Ensure policy supports equity of service for aboriginal people and is developed in partnership with the community including the Aboriginal Health Council of SA and the Aboriginal Health Advisory Committees in SA.
	2. Develop a health and wellbeing strategy for men, which is grounded in valuing men, their contribution to society and positive male identities, promoting men's health.	1. Ensure a focus on men in Aboriginal and Torres Strait Islander populations especially communication between males (younger males) and their ability to talk on their issues.
	3. Develop a comprehensive suicide incidence and prevention report every three years.	1. Reporting to include; incidence of suicide; cross references against standard demographic breakdowns; evidence of co-morbidities inclusive of drug and alcohol use; mental health, gambling behaviour; homelessness; prevention activities and other data deemed useful.
		2. Linking data bases to increase understanding.
2.2	Outcome: Transparent resourcing and partnerships between Federal, State and Local Governments to prevent suicide.	
2.2.1	Objective: To ensure that services available in South Australia are well known and service gaps are able to be identified.	
	1. Develop greater coordination, linkage and accountability between Federal, State and local government funding departments.	1. Develop Local Government action plans on suicide prevention activities.
	2. Stand alone APY mental health plan that addresses social determinants of suicide.	1. People identified in Anangu Pitjantjatjara Yankunytjatjara (APY) lands as 'go to people' for health. Leaders identified to spread the word.
2.3	Outcome: Joint ownership of suicide prevention enabling partnerships between governments, industry, professional bodies and non-government organisations.	
2.3.1	Objective: To ensure that partnerships are developed to achieve positive outcomes for the community the partnerships serve.	
	1. Develop partnerships between governments, business, and industry, industrial and professional bodies to achieve sustainable services.	1. Develop opportunities for partnerships such as The Help Seeking Program at General Motors Holden Ltd, a partnership with Adelaide Northern Division of General Practice and the Mates in Construction example in the construction and mining industry.
	2. Develop and inform people on the threshold signs for care to be accessed and available to communities.	1. Develop an analysis of community need for times when the community is under stress.
	3. Systemic issues need to be addressed to improve risk assessment and management in health care in particular mental health care, including an improved and timely response to those people presenting as mentally ill and/or acutely suicidal.	*1. To be developed by partners during implementation.*
	4. Develop partnership models to assist groups to commence work.	1. Promote self-supported programs for industry. Education response guidelines could be used as a template.
		2. Create and support opportunity to promote successful partnerships.

	Action	Activity
2.4	Outcome: Agencies and departments linking effectively so that people experience a seamless service.	
2.4.1	Objective: To ensure improved linkages and coordination of services.	
	1. upport and collaboration between the mental health system and crisis hotlines or telephone outreach programs and follow-up to ensure individuals at risk of suicide, including those who have made a suicide attempt, can readily access quality crisis support services.	1. Improved, integrated IT and systems of advice and support for ambulance, police and fire brigade.
		2. Develop systems for tracking individuals through services to ensure no abandonment of consumer occurs.
	2. Develop cross-government partnerships to improve service delivery.	1. Define the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assist people at risk of suicide.
	3. Improve inter-agency communication.	1. Ensure smooth transition between services from child to adolescent and adolescent to adulthood.
	4. Linkage between agencies are improved so that all service providers are able to refer to specialist programs where they identify risks or become aware of suicide attempts among their respective client group.	1. Develop integrated service models between services to provide the greatest possible support for respective client groups.
		2. Develop an updated service directory for people seeking help including: > Online service/resources > Target audience > Geographical.
	5. Develop central coordination of suicide awareness, prevention, intervention and postvention programs, interventions or services offered in South Australia.	1. *To be developed by partners during implementation.*

Goal 3

To provide targeted suicide prevention initiatives, activities and programs.

	Action	Activity
3.1	Outcome: Provision of, selective and indicative programs and interventions for all high risk groups.	
3.1.1	Objective: To ensure that best practice occurs across the spectrum of selective and specific strategies for suicide prevention.	
	1a. Children.	
	1. Ensure services are readily accessible.	1. Enable opportunities for children to access emergency and related services 24 hours per day.
		2. Ensure access to services for children in regional areas is a priority.
		3. The implementation of family sensitive practice approaches enabling family members to be involved in service provision and for relationships to develop between the individual, their family and their workers.
		4. Children in the care of the State to receive priority care and follow-up.
		5. Service allocation to take account of developmental and individual needs other than age and diagnosis.
		6. Support children and young people through advocacy in an adult system. Provide an advocate for children entering an adult service.
	2. Improved detection and management of childhood depression, grief and loss.	1. On-going education regarding identification and appropriate treatment for the different types of depressive disorders in children should be provided to general practitioners, teachers and student counsellors.
		2. School leaders to be educated and supported in suicide prevention strategies and grief and loss programs for use in schools.
	3. Ensure service connection partnerships and improved transfer of care between services.	1. Improved communication between service providers such as education, social services, health, mental health and non-government agencies to ensure no gaps occur.
		2. Ensure children presenting with mental health problems or a suicide attempt receive follow-up care.
	1b. Children in out of home care are particularly vulnerable.	
	1. Access to competent, comprehensive, multi-disciplinary mental health services needs to be a priority for children in out-of-home care.	1. Increase the understanding of the mental health needs of children in out-of-home care by health professionals to allow effective and cost-effective ways of providing accessible and timely mental health care to this vulnerable group.
	2. Address the mental health issues of children in out-of-home care to reduce their vulnerability to suicide.	1. Increase the understanding of the aetiology and manifestation of mental health problems in Aboriginal and Torres Strait Islander children in out of home care needs to be well understood and translated into the policies and practices of services providing care to these populations.
		2. Increase the understanding of the aetiology and manifestation of mental health problems in Culturally and Linguistically Diverse children in out-of-home care needs to be well understood and translated into the policies and practices of services providing care to these populations.
		3. Increase the understanding of the aetiology and manifestation of mental health problems in unaccompanied minors (refugees) in out of home care needs to be well understood and translated into the policies and practices of services providing caret to these populations.

Action	Activity
2. Adolescents (young people particularly socially disadvantaged, those questioning sexual identity, those bullied and those who are carers).	
1. Access to services that are youth appropriate, accessible, affordable and confidential.	1. Young people in rural areas to be given access to appropriate services that are confidential, provide choice and are bulk-billed.
	2. Young people questioning their sexual identity to be provided with opportunities to explore resources and services with confidentiality to develop their sense of dignity and self-efficacy.
	3. On-line forums and technologies utilised to enhance accessibility.
2. Integrated and coordinated pathways to care.	1. Coordinate consistent and effective pathways of care for youth.
	2. Homeless adolescents provided with an integrated approach utilising General Practitioner, nurse, social worker, drug and alcohol counselling, family support and independent living skills within a youth friendly, flexible service delivery. Collaborative service partnerships, be established to address at risk youth with high and complex needs.
	3. Specific suicide prevention strategies identified and implemented for adolescents. Indicated programs, crisis support services, early intervention programs and mental health services.
	4. Ensure follow-up care is provided for youth from all mental health services.
3. Young people to be supported and encouraged to be involved in the design, implantation and evaluation of services that are targeted	1. Listen to the needs expressed by young people and develop or modify programs to meet their needs.
4. Develop and implement early intervention programs and supports for young people in order to decrease the manifestation of mental health problems in adulthood.	1. Curriculum content in health and physical education to include mental health and wellbeing and developing of resiliency skills in addition to anti-bullying programs, physical health promotion and drug and alcohol programs.
	2. Extend appropriate early intervention programs to other forums dealing with young people such as tertiary education, apprentice and early career–based programs, online and new media information and education programs.
	3. Commit to understanding and addressing the needs of young people in contact with the juvenile justice system.
3. Men.	
1. SA to develop a health and wellbeing strategy for men, which is grounded in valuing men, their contribution to society and, promoting men's health.	1. Develop action plans for high risk groups such as Aboriginal and Torres Strait Islander men, Culturally and Linguistically Diverse men, farmers, regional communities, mining, construction industries and older men.
	2. Focus on the special needs of older men who are isolated or disabled, with a particular focus on older men's psychological health.
	3. Link with clinical research groups who are identifying determinants of help seeking in men.
	4. Link with existing clinical research groups to develop strategies for example, Florey Adelaide Male Ageing Study.
2. Develop programs that engage men in help-seeking.	1. Provide opportunities for men to meet with each other to discuss issues affecting them and receive information.
3. Understand and respond to the points of vulnerability for men.	1. Develop policies and programs that anticipate and improve the consequences of social changes such as retrenchment, unemployment, bereavement, relationship breakdown and forced loss of breadwinner role (eg drought effect on farmers) on men's health and mental health.
4. Aboriginal and Torres Strait Islander communities with a focus on men.	
1. Services are accessible, culturally responsive and appropriate.	1. Increase the availability of tailored mental health services to Aboriginal and Torres Strait Islander men.
	2. Design and market programs in ways that are appealing, relevant and accessible to Aboriginal and Torres Strait Islander communities.

Action	Activity
2. Build the capacity of the Aboriginal and Torres Strait Islander workforce and workers working with Aboriginal and Torres Strait Islander people.	1. Increase the Aboriginal and Torres Strait Islander workforce.
	2. Ensure that all mental health professionals have the opportunity to complete Indigenous specific mental health training on a regular and on-going basis.
3. Understanding the cultural needs of Aboriginal and Torres Strait Islander communities.	1. Involve Aboriginal and Torres Strait Islander people in service design, implementation and evaluation.
	2. Work with the cultural differences in families.
5. People of rural, farming and remote communities.	
1. Ensure availability of services across all geographic areas.	1. Provide joined up services to regional communities.
2. Breakdown the stigma associated with depression and coping mechanisms in farmers.	1. Debunk the myths regarding men and depression.
	2. Occupational Health and Safety training for farmers to include mandatory self-help and first responder training. For example inclusion of mental health and wellbeing module in agricultural studies curriculum.
3. Develop men's networks for the farming community that encourage men to talk about issues affecting them.	1. Develop strong farming networks with Men's Health, first responder training incorporated into field days.
4. Take services to the community.	1. Tailor counselling to the issues faced by farmers.
	2. Take services to men.
6. People with a mental illness.	
1. A system of care focused on prevention and early intervention, and designed to meet the holistic and long-term needs of consumers.	1. Mental health services must be person-centred and adapted to individual need.
	2. Continued workforce development in mental health services.
2. Investment in collaborative stepped care services to ensure that the level of care needed is provided promptly and that all consumers discharged from acute inpatient care have access to appropriate and effective support in the community.	1. Improved education, training and resources for primary care physicians, general practitioners and general practice teams to enhance the primacy of team-based, multidisciplinary (mental) health care and early interventions to mental illness and suicidal ideation.
	2. Coordinated services designed around the needs of consumers and the consumer journey.
7. People with co-morbidities.	
1. Develop pathways to care that are inclusive of follow-up and drug and alcohol specific after care.	1. Enable opportunities for clinicians to share their clinical expertise in key community sectors should be increased, such as the alcohol and drug sector, especially in non-acute settings.
	2. Ensure continuity of care and active follow-up, following treatment to ensure that suicide risk does not remain and the risk of Alcohol or Drug (AOD) abuse relapse is reduced.
	3. Support the difficult roles that professionals play at the interface between Alcohol or Drug abuse and suicidality, supported by training professional care and adequate debriefing practices.
	4. Implement the philosophy of 'every door is the right door' philosophy to prevent people falling through the gaps.

Action	Activity
2. Develop more specialised dual diagnosis services across the state.	*1. To be developed by partners during implementation.*
3. Develop understanding of drug and alcohol issues as it relates to high risk groups.	1. Culturally and socially appropriate services should be made available especially for Aboriginal and Torres Strait Islander peoples.
4. General Practitioners and Mental Health workers to do first line assessment on the level of gambling occurring in peoples lives.	1. Ensure the staff are trained and aware of the issues in relation to gambling.
	2. Work with gambling help services, industry through the Office of Problem Gambling.
5. Equitable care for people experiencing a mental illness and chronic or terminal illness.	1. Ensure equitable palliative care services for people experiencing a terminal illness and mental illness.
	2. Ensure equitable physical health care for those people with a mental illness.
6. Improve data on physical co-morbidity and suicide.	1. Routine suicide and suicide attempt data should record physical health conditions and their possible influences allowing greater understanding of risk in chronic pain and disability.
8. People in contact with the criminal justice system.	
1. The prison system ensures prisoners are supported through their incarceration.	1. Recognise and work with the complexities facing people in prison that are experiencing bereavement with specific consideration of Aboriginal and Torres Strait Islander people.
2. Prisoners are screened for the risk of suicidal ideation within the first seven days of imprisonment.	1. Maintain screening of all prisoners upon admission to identify risk of suicide or self-harm.
3. Prisoners are observed for any risk of self-harm during imprisonment.	1. Ensure prisoners are monitored throughout their imprisonment and any risk of self-harm during this time is responded to as soon as possible.
4. Support for the bereaved following a death in a prison.	1. Ensure that appropriate mechanisms are in place for staff and prisoners following a death in custody. This support includes the Department's Employee Assistance Program.
5. Prison officers to receive specific training in the identification of suicidal behaviour and self-harm.	1. Ensure appropriate training and policies for the management of prisoners at risk of suicide or self-harm.
6. Peer support programs are established in the prison system to ensure that prisoners are supported.	*1. To be developed by partners during implementation.*
7. People receive follow-up after release from prison.	*1. To be developed by partners during implementation.*
9. Culturally and Linguistically Diverse people (CALD).	
1. Increase the number of mental health trained interpreters and develop a sustainable bilingual mental health workforce.	*1. To be developed by partners during implementation.*
2. Culturally appropriate services for asylum seekers and migrants available in the community and detention centres.	*1. To be developed by partners during implementation.*
10. Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) and those questioning their sexuality.	
1. Suicide prevention strategies must be inclusive and relevant to the diversity within and between LGBTI communities recognising that some groups may be at higher risk than others and that different approaches may be required for different groups.	1. Provide greater capacity for the delivery of resources and support services for parents and families dealing with sexuality and gender issues.

	Action	Activity
		2. Generic mental health and suicide prevention initiatives be proactively inclusive of LGBTI people and their diverse issues and demonstrate this in order to reduce access barriers and provide appropriate services.
		3. Enable approaches to building resilience, help-seeking and capacity for self-help in LGBTI community.
	11. Perinatal women.	
	1. Improve the detection of mental distress and illness in the perinatal period.	1. Adopt a specific focus on first time mothers and those with a history of depression or other mental illness.
		2. Universal home visiting and screening of perinatal women.
		3. Education pre-birth for signs and symptoms of depression.
	12. The older person high risk groups (older people in pain, socially isolated migrants and rural elders, history of depression, older persons recently diagnosed with life-threatening illness such as cancer or dementia, those experiencing grief or loss).	
	1. Service collaboration across governments is required to develop a strategy for older Australians to have adequate access to specific mental health and dementia care services.	1. Develop partnerships that support continuity of care.
		2. To be developed by partners during implementation.
	2. Primary suicide prevention to be incorporated as part of healthy ageing.	1. Build capacity across community services for example, aged and community care services and volunteer programs.
	3. Training gatekeepers about the risks faced by the elderly and ways of reducing these risks.	1. Ensure mental health first aid training specific to the elderly.
		2. Focus on the detection of depression in the elderly with training to be provided to better treat people with depression.
	4. Protect the older people from exploitation and various forms of abuse.	1. Policy to support the mandatory reporting, knowledge and policies pertaining to abuse prevention of vulnerable older adults and improved knowledge of this policy.
	13. Carers.	
	1. Carers to be supported in the task of caring.	1. Promote state-wide respite services rather than regional.
		2. Personal and social supports, compassionate and quality psychosocial support programs, practical assistance and psychiatric care.
	14. Victims of trauma, sexual abuse, child abuse, or bullying.	
	1. Supporting development of partnerships between child protection services (Families SA), Education and CAMHS.	1. Develop MoU with partners in care involved in child protection, education and CAMHS.
		2. Share learning and transparency between services.
		3. Identify of people with cumulative harm (including across the developmental lifespan).
		4. Identify and promote services that can support people with exposure to abuse.
		5. Reduce the stigma for people with trauma in childhood presenting as adults.
3.2	Outcome: Reduced access to means for suicide.	
3.2.1	Objective: To reduce the ease of access to means.	
	1. Access to means of suicide needs to be reduced through specific legislation.	1. Enable data collection on suicide/attempts to include access to identify trends.
		2. Where possible legislate to reduce access to means identified, for example paracetamol, nitrogen and helium asphyxiation.
	2. dentify 'hot spots' and address as necessary.	1. 'Keeping us Safe' Project with Transport SA.

Goal 4

To address, as a priority, the issues that affect regional South Australians

	Action	Activity
4.1	Outcome: Improved capacity of regional communities to address the issues associated with suicide.	
4.1.1	Objective: To improve the capacity of regional communities to address the issues of suicide.	
	1. Improve community capacity.	1. Develop employment opportunities in the community.
		2. Community engagement to be led by members of the community working together to find solutions. Debunking of myths about suicide still active in regional communities.
		3. Mentoring system implemented for General Practitioners, nurses, allied health and other support workers to enable regular debriefing during the establishment and implementation of suicide prevention strategies in regional areas.
		4. Identify the unique characteristics of suicide factors and preventative factors in regional SA.
		5. Develop and implement strategic responses to social stigma in regional communities.
	2. Address access issues and gaps in service.	1. Examine the parity of access between urban and regional SA to quality education, housing, transport and social services as well as other community services and professional resources.
		2. Develop programs or collaboration to address service gaps identified.
		3. Hosting bi-monthly meetings allowing networking and support – linking people. Case review learning – tangible practice what we are doing well.
	3. Strengthen primary care.	1. Develop online communication and information technologies to greatly reduce the barriers of distance that typically disadvantage regional areas of South Australia.
4.2	Outcome: Improved capacity of Aboriginal and Torres Strait Islander communities to address the issues underlying suicide.	
4.2.1	Objective: Develop the strengths of the Aboriginal and Torres Strait Islander communities.	
	1. Strengthen cultural protective factors. Those elements of culture if strengthened could be a protective factor.	1. Work with Aboriginal and Torres Strait Islander elders to support their role in community capacity.
		2. Draw from the Aboriginal and Torres Strait Islander culture elements that can make the people stronger as a community and individually.
		3. Develop a mentoring program for Aboriginal and Torres Strait Islander men.
	2. Aboriginal and Torres Strait Islander health networks to be established in all regions where Aboriginal and Torres Strait Islander populations are greater than 1.5% of total population.	1. Aboriginal Health Council utilised to support other councils. Ensure links are made to other agencies providing services to Aboriginal and Torres Strait Islander people.
	3. Develop opportunities for community led initiatives.	1. Review pre-existing community intervention and capacity building programs so that potentially important lessons about Aboriginal and Torres Strait Islander suicide prevention are valued and understood.
		2. Local suicide prevention programs represent the culture and occur in partnership with the Aboriginal and Torres Strait Islander community.
		3. Suicide risk to be addressed at a community and extended family level.
		4. Develop opportunities for community-led initiatives for pre and postvention programs.

	Action	Activity
4.2.2	Objective: To improve the care of Aboriginal and Torres Strait Islander people.	
	1. Improve health outcomes for Aboriginal and Torres Strait Islander communities.	1. Improve health outcomes for Aboriginal and Torres Strait Islander communities through the Closing the Gap programs.
		2. Increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islander people that are proficient in identification of mental health issues.
	2. Improve access to care and support for those at risk. Improve the care for Aboriginal and Torres Strait Islander people who feel suicidal.	1. Support programs that target child abuse, domestic violence, gambling, drug and alcohol in Aboriginal and Torres Strait Islander communities.
		2. Improve detection and management of youth depression; on-going education regarding identification and appropriate treatment of the different types of depressive disorders should be provided to GP and mental health workers involved with Aboriginal and Torres Strait Islander communities.
		3. Provide incentives to mental health practitioners to live and practice in rural areas, including access to peer support and continuing professional development.
	3. Address social determinants of suicide with specific programs for Aboriginal and Torres Strait Islander people.	1. Enable greater access to local sobering up units in areas such as Coober Pedy, Port Augusta, Mount Gambier, Berri, Ceduna and Port Lincoln.
		2. Develop grief and loss programs with Aboriginal and Torres Strait Islander communities that are culturally appropriate and recognise the enduring grief experienced in Aboriginal and Torres Strait Islander communities.
	4. Timely culturally appropriate postvention responses to suicide in Aboriginal and Torres Strait Islander communities.	1. Postvention activities to be informed by local custom and culture.
		2. All regional services to be culturally competent for the Aboriginal and Torres Strait Islander community
		3. Funeral services to be culturally appropriate and sensitive to indigenous culture, traditions and spirituality.
4.3	Outcome: Increased community awareness of what is needed to prevent suicide in regional areas.	
4.3.1	Objective: To develop community awareness to improve access to services and reduce stigma.	
	1. Early identification and intervention in the community.	1. Improve mental health literacy for community, nursing staff, consumers and carers.
		2. Increase mental health capacity through workforce development, organisational development, partnerships and resource allocation.
		3. Provide early intervention in schools though a program of increased monitoring evidenced based programs related to promotion, prevention and early intervention for all priority groups.
	2. Improve the access to government and non-government services in regional South Australia (improved care).	1. Improve the coordination of care of people with a mental illness.
		2. Use new technologies to provide services to regional South Australia.
		3. Improved mental health literacy amongst farmers, men and youth.
	3. Address the social determinants of health.	1. Address child abuse, domestic violence, problem gambling, illicit drug and harmful alcohol use.
		2. Address issues affecting youth.
		3. Families Safety Framework to be initiated in all areas of need.
	4. Develop environment that encourages and supports help seeking.	1. Rural Counsellors to go to farmers in the paddock and other home based locations to normalise the contact and reduce stigma.
		2. Involve farmers, men and youth in ways of connecting with the community.
4.4	Outcome: Provision of support during times of physical and emotional crisis in a community.	
4.4.1	Objective: To provide early intervention in the community during community crisis.	
	1. Early postvention responses in regional communities.	1. Communities to be supported by a team which provides resources, counselling and assistance to move beyond the suicide and contain potential contagion effect.
	2. Action plans to be developed for events such as fire, drought, flood and pestilence.	1. Enable a coordinated preventative health response that is community wide and prepared to swiftly mobilise information and opportunities. Draw on and bring to the fore social capital in the community.

Goal 5

To provide targeted suicide postvention activities and programs.

	Action	Activity
5.1	Outcome: Provision of effective support to those who are affected by suicidal behaviour or a suicide.	
5.1.1	Objective: Support families, friends, and community members, bereaved by suicide.	
	1. Develop postvention guidelines	1. Promote quality assurance and training of bereavement support groups, and the promotion of evidenced based 'best practice principles' as the foundation for all suicide bereavement outreach services and postvention initiatives.
	2. Provide an appropriate and immediate crisis response that delivers consistent, highly skilled suicide postvention and a range of comprehensive services for the bereaved.	1. Establish response teams through training and formal partnerships and agreements between available services.
		2. Establish current information packs for those bereaved by suicide that are culturally appropriate.
		3. Coordinate a clean-up service to clean the site of a suicide preventing further distress to the family and relatives.
		4. Provide greater flexibility in the delivery of support and outreach services to individuals, families and communities bereaved by suicide.
		5. Standardise follow-up support and compassionate response during the coronial process and police investigations.
		6. Improve support in the workplace, including greater accessibility to information and resources for emotional and practical support.
	3. Create age appropriate, Culturally and Linguistically Diverse services for those bereaved by suicide.	1. Enable more inclusive interventions (including friends and family) and integrated pathways of 'shared care', including better communication and common engagement points.
		2. Department of Education and Child Development to maintain guidelines for addressing post-suicide or suicide attempt in schools for dissemination across all schools.
5.1.2	Objective: Provide support to those affected vicariously by suicide.	
	1. Recognition of traumatic stress. Continue to support workers in roles that may bring about a vicarious trauma.	1. Employee assistance programs to assist where a vicarious trauma may occur.
	2. Provide support, training and education for people in roles that may be affected by vicarious trauma, for example health; education; emergency; corrections; legal and transport services.	1. Improve mechanisms for mental health staff, clinicians and General Practitioners following patient suicide.
5.2	Outcome: Provide appropriate care for those people who present with behaviour identified as suicidal.	
5.2.1	Objective: To ensure people displaying suicidal behaviour are supported through their crisis and beyond.	
	1. Improved access and services for consumers following a suicide attempt.	1. Address service stigma around 'frequent presenters' and suicide attempt so as to minimise the physical and emotional effects of a suicide attempt.
		2. Provide guidelines for those dealing with a suicide attempt to ensure referral to appropriate services for follow-up care.
		3. Develop pathways to care that provide assistance to people transitioning in and out of specialist mental health services, suicide attempt survivors, and those who self-harm, by offering post-discharge support, particularly for those presenting to emergency department, crisis services and psychiatric inpatient units. This must include support for interventions that maintain contact and follow-up after an event, for example follow-up postcards.
		4. Establish partnerships with Aboriginal and Torres Strait Islander communities to assist mainstream services in their responsiveness to high risk communities.
		5. Ensure the person is provided with adequate care to overcome any physical problems resulting from the suicide attempt.

	Action	Activity
	2. Address the stigma of a suicide attempt within medical services particularly Emergency Departments (develop compassionate services).	1. Develop and implement strategies aimed at de-stigmatising those affected by suicide behaviours, including promotion of improved understanding of the suicidal state by health care professionals.
		2. Education and training in dealing with a suicide attempt.
		3. Ensure equality of care to those at risk.
	3. Strategies that assist reintegration of the individual into their community following a suicide attempt.	1. Implement and strengthen strategies that allow children and adolescents to be reintegrated into the school system, and their friendship and peer groups, after a suicide or suicide attempt.
		2. Improve the understanding of the suicidal state by health care professionals and the wider community.
		3. Enable greater involvement of suicide attempt survivors in the planning, implementation and evaluation of all suicide prevention efforts.
	4. The dissemination of best practice in continuing education on surviving suicide attempts for healthcare professionals.	1. Implement training to understand the nature of the suicidal state and how to assist suicide attempt survivors, and in identifying helpful resources.
		2. Provide pre-service training.
		3. Implement training and support of first responders to suicide attempt survivors.
5.3	Outcome: Increased understanding of factors that facilitate recovery after a suicide attempt.	
5.3.1	Objective: Support families, friends, and communities, post suicide attempt.	
	1. Ensure family / carer involvement and support following a suicide attempt.	1. Dependent upon consent, involve loved ones in the history taking process, provision of treatment and interventions, as well as the development of discharge plans.
		2. Implement strategies and resources that assist family members and friends in understanding the suicide state and supporting suicidal people.
	1. Implementation of suicide postvention guidelines: a framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide.	1. Implement the Postvention Guidelines developed by South Australia Department of Education and Children’s Services, Catholic Education South Australia and Association of Independent Schools of South Australia (2010).

Goal 6

To improve the evidence base and understanding of suicide and suicide prevention.

	Action	Activity
6.1	Outcome: Accuracy is achieved in the reporting of suicide in South Australia.	
6.1.1	Objective: Improved reporting of suicide data.	
	1. Work with state and national bodies to gain better access to timely information and data on suicide and suicide attempts.	1. Establish regular reporting of suicide attempt and suicide ideation data from existing data base on a state (SA Health) and national (Medicare) level.
		2. Develop mechanisms for information sharing and data collection gaps.
		3. Report on information and data collection.
6.2	Outcome: Research activities and coordinated and targeted at knowledge gaps.	
6.2.1	Objective: Provide coordinated and collaboration to suicide research and evaluation in South Australia.	
	1. Develop and maintain a suicide research register.	1. Identify current suicide research programs. Topic areas: suicide; postvention; prevention; precipitating factors in collaboration with regard to funding research in suicide prevention
		2. Adopt a 'united research group' to identify research areas for targeted research.
		3. Promote a collaborative research model involving community, lived experience and researchers.
		4 Publish the suicide research register in an annual report.
6.3	Outcome: Expanded knowledge and understanding contributing to the evidence base for suicide prevention.	
6.3.1	Objective: Improve the understanding and evidence base for suicide prevention.	
	1. Develop the evidence base to better understand the warning signs of suicide and most effective interventions for at risk groups.	1. Create opportunities to share current knowledge about the neurobiology of maltreatment with other disciplines and organisations as a way of increasing the understanding of mental health needs of children in out of home care by other health professionals, and promoting further research.
		2. Undertake research on the aetiology and manifestations of mental health problems in Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse children in out of home care.
		3. Enable further clinical research into the psychological and pharmacological treatment of the complex psychopathology of children in out of home care.
		4. Promote further research into strategies to address adolescent suicide attempters.
		5. Support research into effective suicide prevention strategies for older populations.
		6. Enable research into the lived experience of suicide attempt survivors.
	2. Develop greater understanding in increasing community capacity and resilience.	1. Support community action research that addresses male suicide.
		2. Undertake further research into the benefits of reporting suicide in relation to reducing suicide rate and increasing mental health literacy.
6.4	Outcome: The application of evidence into practice across all areas of suicide prevention.	
6.4.1	Objective: To ensure that research results in the translation of evidence into practice.	
	1. Develop the evidence base to better understand suicide prevention and the implications to future government planning.	1. Ensure policy/funding is informed by evidence/research.
	2. Develop a priority of therapeutic approaches that are empirically and clinically based.	1. Ensure service development informed by evidence/research.
6.4.2	Objective: Ensure that lived experience is informing best practice.	
	1. Ensure that lived experience is informing practice.	1. Improve understanding of the lived experience of suicide attempt survivors and carers in all suicide prevention efforts, including a strong focus on incorporating views and experience in policy research, the development of mental health services and in the development of interventions and evaluation for suicide prevention.

Goal 7

To implement standards and continuous practice improvement in suicide prevention.

	Action	Activity
7.1	Outcome: Service delivery governed by agreed standards.	
7.1.1	Objective: To develop and promote standards for suicide prevention, intervention and postvention.	
	1. Develop standards and guidelines in accordance with best practice for prevention and intervention and postvention.	1. Implement standards for access and wrapping services around people seeking assistance or identified by others as requiring assistance.
		2. Standards adopted for intervention, postvention attempt and suicidal ideation across a spectrum of care from primary to tertiary services.
		3. Standards implemented for transferring between levels of care that is inclusive of clinical handover and follow-up procedures.
		4. Ensure standards for postvention response to families bereaved by suicide for use by mental health services, South Australian Police, South Australian Ambulance Service, and Emergency Departments.
7.2	Outcome: Provision of MoUs where partnerships required shared, understanding of roles and responsibilities in meeting standards of care.	
7.2.1	Objectives: Development of care partnerships between services.	
	1. Develop memorandums of understanding where partnerships in care are required between organisations.	1. MoU implemented between South Australian Police (SAPOL), South Australian Ambulance Service (SAAS), Mental Health Services and Emergency Departments. Define the appropriate roles and effectiveness of agencies.
		2. MoU adopted between organisations such as Medicare Locals, Mental Health Services, non-government organisations and Department of Communities and Social Inclusion and Correctional Services around topics of housing, welfare, child protection, disability, corrections and Immigration.
	2. Systemic and continuous improvement in collaboration and communication practices.	*1. To be developed by partners during implementation.*
7.3	Outcome: Continuous evaluation of strategies, therapies and programs to enhance their value and effectiveness over time.	
7.3.1	Objective: To add to the evidence base of strategies, therapies and programs and progress programs that are working well and improve, change or modify those that are not.	
	1. Suicide prevention services and programs are evaluated against empirical evidence.	1. State funded programs to be evaluated prior to funding renewal.
		2. All suicide prevention programs be properly evaluated with at least 15% of all funding allocated to suicide prevention programs being spent on evaluation.
7.4	Objective: The South Australian Suicide Prevention Strategy is evaluated annually.	
	1. The Strategy should be reviewed and monitored with a commitment to evaluation and publication of data reflecting the effectiveness of the strategy.	1. The evaluation of the Strategy be inclusive of outcome and process based evaluation as both are important in measuring the effectiveness of the strategy.

Appendix 1

Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ASIST	Applied Suicide Intervention Skills Training
ATAPS	Access to Allied Professional Services
ATSI	Aboriginal Torres Strait Islander
APY	Anangu Pitjantjatjara Yankunytjatjara
CALD	Culturally and Linguistically Diverse
CAMHS	Child Adolescent Mental Health Services
DECD	Department of Education and Child Development
GOM	Guardianship of the Minister
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LIFE	Living is for Everyone
MoU	Memorandum of Understanding
NSW	New South Wales
NT	Northern Territory
OH&S	Occupational Health and Safety
SA	South Australia
SASPS	South Australian Suicide Prevention Strategy
SPA	Suicide Prevention Australia
VIC	Victoria
QLD	Queensland
WA	Western Australia

Glossary of Terms and Definitions

Attempted suicide (also suicide attempt): A non-fatal self-injury, but with an intention to cause death.

Postvention: Interventions to support and assist the bereaved after a suicide has occurred.

Suicide: The act of purposely ending one's life.

Suicidal behaviour: Includes the spectrum of activities related to suicide and self-harm, including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Also deliberate recklessness and risk-taking behaviours.

Suicidal ideation: This refers to thoughts about attempting or completing suicide.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of suicide. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

Bibliography

1. Australian Bureau of Statistics (2007). *National Survey of Mental Health and Wellbeing: Summary of Results.* ABS Cat No. 4326.0 (Mindframe Statistics from ABS 2007)
2. Australian Government. Department of Health and Ageing. *Life Living is for Everyone. A framework for prevention of suicide in Australia* (2007)
3. Australian Government *National Strategic Framework for Aboriginal and Torres Strait Islander health 2003-2012 Australian Government Implementation Plan 2007-2013*
4. Australian Government Dept of Health and Ageing. *Towards good practice: Standards and Guidelines for Suicide Bereavement Support Groups* Lifeline Australian and Australian Government DoHA
5. beyondblue, *beyondblue: the national depression initiative. South Australia Profile of Activity January 2011 Government of South Australia and beyondblue*
6. House of Representatives, Standing Committee on Health and Ageing. July 2011 *Before it's too late: Report on early intervention programs aimed at prevention youth suicide*
7. Bebbington PE, Cooper C, Minot S, Brugha TS, Jenkins R, Meltzer H, Dennis M. *Suicide attempts, gender, and sexual abuse: data from the 2000 British Psychiatric Morbidity Survey.* Department of Mental Health Sciences, UCL, London W1W 7EJ, UK. Am J Psychiatry. 2009 Oct;166 (10):1135-40. Epub 2009 Sep 1
8. Bradley C, Harrison J, Elnour AA, *Editorial Appearances may deceive: what's going on with Australian suicide statistics?* MJA Vol 192 Number 8 428-429, April 2010
9. Burns J, Maling CM, Thomson N (2010) *Review of Indigenous female health, 2010.* Perth, WA Australian Indigenous Health/ infonet
10. Bycroft, P *Perspectives on Suicide and Suicide Prevention*. National Mental Health Summit, University of Sunshine Coast
11. Commonwealth of Australia 2009 *Reporting suicide and mental illness, A Mindframe resource for media professionals*
12. *Chronic Pain Conditions and Suicidal Ideation and Suicide Attempts:* An Epidemiologic Perspective
13. Regional Health SA, Sept 2008 *Framework for Suicide Risk Assessment and Management, Project Implementation Plan*
14. De Leo, D et al *Achieving standardised reporting of Suicide in Australia rationale and program for change.* MJA Vol 192 No 8, 452 – 456, 19 April 2010
15. De Leo D, Hickey P, Neulinger K, Cantro C, *A Hidden Problem, Suicide in Older Men in Queensland, Maximising social justice and economic independence through partnerships in service excellence.* Families Youth & Community Care Queensland. Griffith University
16. De Leo, D *Editorial Australia revises its Mortality Data on Suicide*, Crisis 2010; Vol 31 (4): 169-173
17. De Leo, D, Evans R: *International Suicide Rates, Recent Trends and Implications for Australia Australian Institute for Suicide Research.* Commonwealth of Australia 2003
18. De Leo D, Dudley, M, Aebersold C, Mendoza J, Barnes M, Harrison J, Ranson D, *Achieving standardised reporting of suicide in Australia: rationale and program for change.* MJA Vol 192 Number 8 19 April 2010
19. Department of Health and Human Services Dec 2010 *Tasmania's Suicide Prevention Strategy 2010-2014* A literature Review Statewide and Mental Health Services
20. Dunt D, *Review of Mental Health Care in the ADF and Transition through Discharge*. Department of Defence January 2009
21. Fleming, G, *An approach to Rural Suicide,* Department of Psychiatry Faculty of Health Science University of Adelaide. April 2007
22. Form A, Kitchener B, *Giving support to a suicidal person*. Editorial BMJ 2011;343:d5680 doi: 10.1136/bmj.d5680
23. Gunnell, David, Olive Bennewith, Keith Hawton, Sue Simkin and Nav Kapur. *The epidemiology and prevention of suicide by hanging: a systematic review*. International Journal of Epidemiology 2005, 34:433 -442
24. Gliatto, MD, Anil K, *Evaluation and treatment of Patients with Suicidal Ideation*. The American Family Physician March 1999
25. Goldney, R D. *Antidepressants and suicide in young people*, MJA 2007: 187 (10): 586-587
26. Goldney, R D *Suicide Prevention*, Oxford Press 2008
27. Goldney, R D Elonora Dal Grande, Anne Taylor. *Population-attributable risk of childhood sexual abuse for symptoms of depression and suicidal ideation in adulthood.* International Journal of Psychiatry in Clinical Practice, 2009: 13: 285 -291

28. Goldney, R D, Dunn KI, Air M, Dal Grande E, Taylor A W, *Relationships between body mass index, mental health, and suicidal ideation: population perspective using two methods.* Australian and New Zealand Journal of Pyschiatry 2009: 43 652 – 658

29. Government of South Australia Dec 2011 *Information booklet for people bereaved by suicide.* Attorney-General's Department – ISBN 9780987241900

30. Government of South Australia 2010 *Suicide postvention Guidelines. A framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide*. Department of Education and Children's Services and Catholic Education, Association of Independent Schools

31. Government of SA 2010 *The health status of people living in the South Australian Health Regions January 2004 to December 2009,* South Australian Monitoring and Surveillance System (SAMSS) Population Research and Outcome studies Health System Information and Performance Operations Division

32. H M Government (2011) *Consultation on preventing suicide in England: A cross-government outcomes strategy to save lives. Consultation document*

33. HM Government *National Suicide Prevention Strategy for England Annual Report National Institute for Mental Health in England*

34. HSC Southern Health and Social Care Trust March 2010 *Bereaved by Suicide – A useful guide following loss.* London

35. Large M, S Sharma, E Cannon, C Ryan, O Nielssen, *Risk Factors for suicide within a year of discharge from psychiatric hospital: a systematic meta analysis*, The Royal Australian and New Zealand College of Psychiatrists. 2011

36. Large M , Nielssen O *Suicide in Australia: meta-analysis of rates and methods of suicide between 1988 and 2007,* MJA Volume 192 Number 8 432- 437 April 2010

37. Larkin, Gregory Luke Annette L Beautrais *Emergency Departments are underutilized sites for Suicide Prevention Crisis* 2010; Vol. 31 (1); 1-6

38. Lawrence, David Stephen Kisely, Joanne Pais, *The epidemiology of Excessive mortality in People with mental illness.* The Canadian Journal of Psychiatry, Vol 55. No 12 December 2010

39. Australian Government Department of Health and Ageing Life Living is for everyone .com.au *A Framework for prevention of suicide in Australia*

40. Martin, Graham, Andrew Page, *National Suicide Prevention Strategies A Comparison 2009*: The University of Queensland

41. Morris A, Bdargaddi N. 'Evaluation of Rural Community Counsellor Program 2008-2010' *2nd National Regional Conference* 28-30 September 2010

42. New Zealand Government *New Zealand Suicide Prevention Action Plan 2008-2012 The Summary for Action*

43. NSW Government NSW Suicide Prevention Strategy 2010-2015 A whole of government strategy promoting a whole of community approach

44. NSW Health Jan 2005 *Policy Directive, Suicidal Behaviour – Management of Patients with Possible Suicidal Behaviour*

45. Owens C, Owen G, Belam J, Lloyd K, Rapport F, Donovan J, Lambert H, *Recognising and responding to suicidal crisis within family and social networks: qualitative study, BMJ 2011:* 343:d5801 doi: 10.1136/bmj.d5801

46. Parslow, Ruth Anthony F. Jorm. *Predictors of partially met or unmet need reported by consumers of mental health services: an analysis of data from the Australian National Survey of Mental Health and Wellbeing.* Australian and New Zealand Journal of Psychiatry 2001; 35:455 – 463

47. Pirkis, Jane Philip Burgess, David Dunt, *Suicidal Ideation an Suicide Attempts Among Australian Adults,* Crisis, 21/1 (2000)

48. Ratciffe GE, Enns MW, Belik S, Sareen J *Chronic pain conditions and suicidal ideation and suicide attempts: An epidemiologic Perspective*

49. Rosenstreich, G, *LGBTI People Mental Health and Suicide, Briefing Paper,* 2011 National LGBTI Health Alliance

50. Rudd, D, Berman A, Joiner T, Nock M, Silverman M, Mandrusiak M, Van Orden K, Witte T, *Warning Signs for Suicide: Theory, Research and Clinical Applications, Suicide and Life-Threatening Behaviour* 36 (3) June 2006 The American Association of Suicidology

51. SA Health 2011 *A review of Deaths July 2007 – December 2009 In the community by Suicide or Undetermined Cause*

52. SA Government *Successful partnerships: A brief guide. Learning from the South Australian Social Inclusion Initiative.* A publication of the Social Inclusion Board

53. Smith, David P, Malcolm Battersby, Peter W Harvey, Rene G Pols, Michael F Baigent, Jane E Oaks. *The influence of depression and other co-occurring conditions on treatment outcomes for problem gamblers:* a cohort study, MJA Vol 195 Number 3, 1 August 2011

54. Stacey, Kathleen, Nicole Keller, Bonnie Gibson, Ron Johnson, Leanne Jury, David Kelly, Ann Newchurch, Lyn Newchurch, Bronwyn Ryan and Tanya Short. *Promoting mental health and wellbeing in Aboriginal contexts: Successful elements of suicide prevention work.* Regional Health SA

55. Lifeline et al 2011 *Suicide and Suicide prevention in Australia, Breaking the Silence – A seminal report*

56. Department of Human Services South Australia, April 1998 Suicide Prevention Task force Report, Mental Health Unit

57. Suicide Prevention Australia (SPA) Position Statements
    - *Men and Suicide: Future Directions* April 2008
    - Suicide Prevention and Capacity Building in Australian Indigenous Communities April 2008 Reviewed September 2010
    - Responding to suicide in rural Australia September 2008
    - *Suicide Bereavement and Postvention* May 2009
    - *Suicide and Self-harm among Gay, Lesbian, Bisexual and Transgender Communities.* August 2009
    - *Supporting Suicide Attempt Survivors* September 2009
    - *Mental Illness and Suicide* June 2009
    - Crisis Response and the Role of Emergency Services and First Responders June 2010
    - *Overcoming the Stigma of Suicide* September 2010
    - *Youth Suicide Prevention* December 2010
    - *Alcohol, Drugs and Suicide Prevention* June 2011
    - *Social Inclusion and Suicide Prevention* September 2011
    - *Chronic Illness, Chronic Pain and Suicide Prevention* April 2012

58. Taylor, Anne Eleonora Dal Grande, Tiffany Gill, Laura Fisher, Robert Goldney. *Detecting determinants of suicidal ideation: South Australian surveillance system results.* Int J Public Health 52 (2007) 142 – 152

59. Thomson N, Midford R, Debuyst O, MacRae A (2010) *Review of Indigenous male health. Australian Indigenous Health/infonet*

60. Thomson N, Midford R, Debuyst O, MacRae A et al(2010) *Summary of Indigenous health.* Perth WA Australian Indigenous Health/infonet

61. Substance abuse and Mental Health Services Administration (SAMHSA) Centre for Behavioural Health Statistics and Quality, (8 March 2011). *The DAWN report; Emergency Department Visits fro Drug Related Suicide attempts Involving Antidepressants by Adolescents and Young Adults:* 2004 to 2008 Rockville, MD

62. Australian Government 2010 *The health of Australia's prisoners*, Australian Institute of Health and Welfare. Cat. No. PHE 149

63. The Hidden Toll: Suicide in Australia June 2010 – The Senate Community Affairs References Committee

64. The Royal Australian and New Zealand College of Psychiatrists, *Inquiry into Early Intervention Aimed at Preventing Youth Suicide; Response to the House of Representatives Discussion Paper* March 2011

65. The Royal Australian and New Zealand College of Psychiatrists, *Inquiry into Youth Suicide Prevention, Working with the Community, Submission to the House of Representatives Standing Committee on Health and Ageing – April 2010*

66. The Royal Australian and New Zealand College of Psychiatrists, *Position Statements on Suicide*

67. Tidemalm, Dag, Stig Elofsson, Claes-Goran Stefansson, Margda Waern, Bo Runeson, *Predictors of suicide in a community-based cohort of individuals with severe mental illness.* Soc Psychiatry Psychiatric Epidemiology (2005) 40: 595 – 600

68. US Department of Health and Human Services *To Live to see the Great Day that Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults.* Substance Abuse and Mental Health Services Administration Centre for Mental Health Services

69. Victorian Institute of Forensic Medicine 2 March 2011; Updated Report: *Suicides in South Australia by Statistical Division and remoteness of residential address,* National Coroners Information System

70. Wilson, Anne, Clark Sheila, *South Australian Suicide Postvention Project: Report to Mental Health Services,* Department of Health, Department of General Practice University of Adelaide. December 2005.

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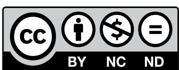

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