



A Summary of Suicide Prevention Recommendations from Canada,
the United States and Australia

The mission of the Alberta Centre for Injury Control and Research is to reduce the frequency and optimize the treatment and rehabilitation of injuries in Alberta by providing coordination and support for injury control programming, research, information sharing and education. Currently, suicide is the leading cause of injury death among Albertans, and accounts for one third of all injury fatalities (Injury Prevention Centre, 1996). In comparison to the rest of the nation, Alberta's suicide rate (per 100,000) is ranked second among Canadian provinces behind Quebec (Suicide Information Centre, 1998) and historically Alberta has had a higher rate of suicide than the rest of Canada (Injury Prevention Centre, 1996). It is surprising that more Albertans die annually by suicide than by more publicly discussed causes of death such as infectious disease, HIV or homicide (ACICR, 2000). One form of injury control is injury prevention. Suicide prevention strategies are those measures, which can be taken to reduce the prevalence or probability of suicidal behavior (Health Canada, 1987). The following document summarizes suicide prevention recommendations suggested by various governments around the world in an attempt to shed light on possible strategies, which may be employed in Alberta.

Health Canada Report (1987)

In 1974, the federal Minister of Health for Canada identified suicide as a major public health problem for individuals under 35, where suicide was ranked second among causes for early death (Lalond, 1974). Following this declaration in June, 1979 Ottawa hosted the 10th International Association for Suicide Prevention Congress (Health Canada, 1987). This was an ironic point since although the Health Minister had previously cited suicide as a health problem little was known about the topic of suicide in Canada. In response to this realization, Health and Welfare Canada established the National Task Force on Suicide in Canada, which published reports both in 1987, and an update in 1994. The following recommendations regarding suicide prevention stemmed from the National Task Force:

1. Amelioration of Societal Conditions
2. The Requirement for Public Education
 - a. Improved Media Relations

- b. Public Education Programs
- 3. Reduction in the Availability and Lethality of Means
- 4. Education and Training for Health Care Professionals and Gatekeepers
 - a. Health Care Professionals
 - i. Nursing and Social Work
 - ii. Psychology
 - b. Gatekeepers (Clergy, Police, Custodial Officers and School Personnel)
 - i. Clergy
 - ii. Police
 - iii. Custodial Personnel
 - iv. School Personnel

Aboriginal

On a national level death due to suicide is one of the greatest disparities between First Nations peoples and other Canadians (Wadieh Yacoub, Medical Service Branch, 1996). More specifically in Alberta, between 1983 and 1996 a total of 365 First Nations deaths were attributed to suicide (Health Canada, 1999) making it the second leading cause of injury death among this group (Injury Prevention Centre, 1996). As a result Health Canada (1987) referred to this population as being at high-risk for suicide. Two specific recommendations regarding the prevention of suicide in First Nations were provided by the National Task Force, namely:

1. The development and implementation of suicide prevention strategies for Canadian Native people should be based on a comprehensive and culturally oriented approach.
2. A liaison and backup network of mental health consultants should be accessible to all community health workers delivering health, education and social services to Native peoples.

Health Canada Report (1994)

In 1991, following discussions between Health Canada and experts in suicidology in Canada, a decision was made to begin updating the Task Force report of 1987. The purpose of the update was to examine the original report and determine what information required updating in light of recent research as well as make recommendations relevant for today's society. The following recommendations regarding suicide prevention originated from this update as follows:

1. Improving Societal Conditions
2. Public Education
 - a. Improving Coping and Life Skills
 - b. Improved Media Relations
 - c. Public Education Programs
3. Reducing the Available and Lethality of Means

U.S. Department of Health and Human Services Report (2001)

In 1998, the Suicide Prevention Advocacy Network (SPAN) sponsored a National Suicide Prevention Conference of individuals from the United States Department of Health. The Centers for Disease Control and prevention, the National Institutes of Health, the Office of the Surgeon General, the Substance Abuse and Mental Services Administration, the Health Resources and Services Administration, the Indian Health Service and the Public Health Service Administrators. These individuals collectively developed a list of 81 recommendations for action to prevent suicide. In response to the conference in 1999, the United States Surgeon General issued a "Call to Action to Prevent Suicide" which noted suicide as being a serious public health concern. This call laid out a blueprint for a Nation Strategy regarding suicide prevention. The following recommendations and expected outcomes flowed from the United States National Strategy:

1. Promote Awareness that Suicide is a Public Health Problem that is Preventable
 - a. By 2005, increase the number of States in which public information campaigns designed to increase public knowledge of suicide prevention reach at least 50 percent of the State's population

- b. By 2005, establish regular national congresses on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.
- c. By 2005, convene national forums to focus on issues likely to strongly influence the effectiveness of suicide prevention messages.
- d. By 2005, increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complementary disseminations of information on the World Wide Web.

2. Develop Broad-Based Support for Suicide Prevention

- a. By 2001, expand the Federal Steering Group to appropriate Federal agencies to improve Federal coordination on suicide prevention, to help implement the *National Strategy for Suicide Prevention*, and to coordinate future revisions of the *National Strategy*.
- b. By 2002, establish a public/private partnership(s) (e.g., a national coordinating body) with the purpose of advancing and coordinating the implementation of the National Strategy.
- c. By 2005, increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities.
- d. By 2005, increase the number of nationally organized faith communities adopting institutional policies promoting suicide prevention.

3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

- a. By 2005, increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.
- b. By 2005, increase the proportion of the public that views mental disorders as real illnesses that respond to specific treatments.

- c. By 2005, increase the proportion of the public that views consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.
 - d. By 2005, increase the proportion of those suicidal persons with underlying disorders who receive appropriate mental health treatment.
4. Develop and Implement Community-Based Suicide Prevention Programs
- a. By 2005, increase the proportion of States with comprehensive suicide prevention plans that
 - i. Coordinate across government agencies
 - ii. Involve the private sector
 - iii. Support plan development, implementation, and evaluation in its communities
 - b. By 2005, increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.
 - c. By 2005, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.
 - d. By 2005, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.
 - e. By 2005, increase the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders, with evidence-based suicide prevention programs.
 - f. By 2005, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.
 - g. By 2005, increase the proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs.

- h. By 2005, develop one or more training and technical resource centers to build capacity for States and communities to implement and evaluate suicide prevention programs.

5. Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

- a. By 2005, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.
- b. By 2005, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.
- c. By 2005, develop and implement improved firearm safety design using technology where appropriate.
- d. By 2005, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.
- e. By 2005, improve automobile design to impede carbon monoxide-mediated suicide.
- f. By 2005, institute incentives for the discovery of new technologies to prevent suicide.

6. Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

- a. By 2005, define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.
- b. By 2005, increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk and identification and promotion of protective factors.

- c. By 2005, increase the proportion of clinical social work, counseling and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors.
- d. By 2005, increase the proportion of clergy who have received training in identification of an response to suicide risk and behaviors and the differentiation of mental disorder and faith crises.
- e. By 2005, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.
- f. By 2005, increase the proportion of correctional workers who have received training on identifying and responding to persons at risk for suicide.
- g. By 2005, increase the proportion of divorce and family law and criminal defense attorneys who have received training in identifying and responding to persons at risk for suicide.
- h. By 2005, increase the proportion of countries (or comparable jurisdictions such as cities or tribes) in which education programs are available to family members and others in close relationships with those at risk for suicide.
- i. By 2005, increase the number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention.

7. Develop and Promote Effective Clinical and Professional Practices

- a. By 2005, increase the proportion of patients treated for self-destructive behavior in hospital emergency departments that pursue the proposed mental health follow-up plan.
- b. By 2005, develop guidelines for assessment of suicidal risk among person receiving care in primary health care settings, emergency departments, and

specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.

- c. By 2005, increase the proportion of specialty mental health and substance abuse treatment centers that have policies procedures and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.
- d. By 2005, develop guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings.
- e. By 2005, increase the proportion of those who provide key services to suicide survivors (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy) who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors.
- f. By 2005, increase the proportion of patients with mood disorders who complete a course of treatment or continue maintenance treatment as recommended.
- g. By 2005, increase the proportion of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
- h. By 2005, develop guidelines for providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide. Implement the guidelines in facilities (including general and mental hospitals, mental health clinics and substance abuse treatment centers).
- i. By 2005, incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings, hospice, and skilled nursing facilities for all Federally-supported healthcare programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).

- j. By 2005, include screening for depression, substance abuse and suicide risk as measurable performance items in the Health Plan Employer Data and Information Set (HEDIS).

8. Improve Access to and Community Linkages with Mental Health and Substance Abuse Services

- a. By 2005, increase the number of States that require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.
- b. By 2005, increase the proportion of counties (or comparable jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.
- c. By 2005, define guidelines for mental health (including substance abuse) screening and referral of students in schools and colleges. Implement those guidelines in a proportion of school districts and colleges.
- d. By 2005, develop guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of school districts.
- e. By 2005, increase the proportion of school districts in which school-based clinics incorporate mental health and substance abuse assessment and management into their scope of activities.
- f. By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.
- g. By 2005, define national guidelines for effective comprehensive support programs for suicide survivors. Increase the proportion of counties (or comparable jurisdictions) in which the guidelines are implemented.

- h. By 2005, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans.

9. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

- a. By 2006, establish an association of public and private organizations for the purpose of promoting the accurate and responsible representation of suicidal behaviors, mental illness and related issues on television and in movies.
- b. By 2005, increase the proportion of television programs and movies that observe promoting accurate and responsible depiction of suicidal behavior, mental illness and related issues.
- c. By 2005, increase the proportion of news reports on suicide that observe consensus reporting recommendations.
- d. By 2005, increase the number of journalism schools that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

10. Promote and Support Research on Suicide and Suicide Prevention

- a. By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers and advocates.
- b. By 2005, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice and for training of researchers in suicidology.
- c. By 2005, establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.
- d. By 2005, perform scientific evaluation studies of new or existing suicide prevention interventions.

11. Improve and Expand Surveillance Systems

- a. By 2005, develop and refine standardized protocols for death scene investigations and implement these protocols in counties (or comparable jurisdictions).
- b. By 2005, increase the proportion of jurisdictions that regularly collect and provide information for follow-back studies on suicides.
- c. By 2005, increase the proportion of hospitals (including emergency departments) that collect uniform and reliable data on suicidal behavior by coding external cause of injuries utilizing the categories included in the International Classification of Diseases.
- d. By 2005, implement a national violent death reporting system that includes suicides and collects information not currently available from death certificates.
- e. By 2005, increase the number of States that produce annual reports on suicide and suicide attempts, integrating data from multiple State data management systems.
- f. By 2005, increase the number of nationally representative surveys that include questions on suicidal behavior.
- g. By 2005, implement pilot projects in several States that link and analyze information related to self destructive behavior derived from separate data systems, including for example law enforcement, emergency medical services, and hospitals.

Australian Report (2001)

A total of more than 2,500 Australians die by suicide each year and several more deliberately harm themselves. In response to this crisis, the Australian government developed "Life is for Everyone (LIFE)" which provides a 4-year framework for national action to address suicide and its prevention. The document addresses the needs of all age groups, however special attention was paid to the needs of young people and young adults in its recommendations. This focus is due to the development of the framework by the National

Advisory Council on Youth Suicide Prevention. The following recommendations, strategies for implementation and proposed performance indicators were suggested by the Council:

1. Promoting well-being, resilience and community capacity across Australia
 - a. Increase community capacity and emotional well-being across Australia.

Strategies

- Ongoing review of the research into effective population strategies.
- Promote development of indicators and measures of community well being.
- Implement and evaluate evidence-based population approaches to improving mental health in settings and across the lifespan.
- Support community initiatives in life and health promotion consistent with national policy.
- Encourage wider implementation of effective parenting skills and support programs.
- Encourage implementation and evaluation of the MindMatters resources.

Performance Indicators

- Establishment of an infrastructure to facilitate ongoing review of the research into effective population strategies.
- Extent of dissemination of reviews into effective population strategies.
- Increased funding for the development of measures and indicators of community well-being and community capacity.
- Increased number of programs based on primary prevention approaches to mental health.
- Increased number of evaluations of programs based on primary prevention approaches to mental health.

- Increased number of community initiatives that are given support for life and health promotion projects.
 - Increased number of programs that teach parenting skills, number of recipients and total money spent on such interventions.
 - Increased level of family functioning within the Australian population.
 - Number of schools that have implemented the MindMatters resources.
 - Enhanced community capacity and emotional well-being.
- b. Improve social structural factors that promote well being, community capacity and mental health.

Strategies

- Establish partnerships in mental health promotion and suicide prevention across sectors including health, education, justice, media, welfare, drug and alcohol, sports and recreation, transport, roads and traffic, local councils.
- Implement and evaluate initiatives that address the health promoting features of local social and physical environments.
- Implement and evaluate initiatives that encourage learning communities.
- Advise, inform and report on policy and program direction in ways that support health promoting communities and a more connected social environment.

Performance Indicators

- Improved partnerships across sectors including health, education, justice, media, welfare, drug and alcohol, sport and recreation, transport, roads and traffic, local councils.
- Improved information exchange between sectors.
- Increased investment in the development of human, social and economic capital in communities.

- Improved problem solving abilities within community structures.
 - Improved local capacity to conduct needs assessment, rapid appraisal and evaluation of community practice and activity.
 - Increased contribution to the development of policy and programs.
 - Enhanced community capacity and emotional well being.
- c. Increase community acceptance of and support for marginalized groups, people with risk factors for suicide, and those affected by suicide.

Strategies

- Identify, review, and adapt safe, accurate and appropriate community education materials that address stigma and discrimination affecting specific population groups.
- Disseminate these project materials and implement community development strategies with influential community groups such as employers, schools, sports coaches, service clubs, churches, community organizations.
- Media strategies.

Performance Indicators

- Revision of community education materials including feedback form stakeholders.
 - Increased number of materials disseminated and extent of dissemination.
 - Increased number of community development strategies implemented that target influential community groups such as employers, schools, sports coaches, service clubs, churches, community organizations.
 - Increase tolerance and understanding of marginalized groups, people with risk factors for suicide and those affected by suicide.
2. Enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian community.

- a. Enhance factors that protect the adverse social conditions associated with suicide risk.

Strategies

- Support research to explore and identify protective factors for suicide and self-harm.
- Work in parallel with other strategies in particular, national strategies, to address drug and alcohol problems, child abuse, criminal and juvenile justice issues.
- Develop and evaluate pilot programs or build on existing approaches to increase protective factors for suicide.

Performance Indicators

- Increased financial investment in research exploring the protective factors for the spectrum of suicidal behavior.
- Increased number of research studies to explore protective factors for the spectrum of suicidal behavior.
- Increase in the number of joint national initiative and intersectoral action plans that address drug and alcohol problems, child abuse, criminal and juvenile justice issues.
- Increased number of programs implemented that address protective factors, money spent and number of recipients involved in these programs.
- Improved support relationships with significant adults; connectedness to family, work or school; interpersonal skills, support networks and social participation.
- Extent of the dissemination of the evaluation findings from programs designed to address protective factors.

- b. Reduce the prevalence of the known risk factors for suicide and self-harm.

Strategies

- Use/adapt approaches of demonstrated effectiveness, or develop and evaluate pilot programs, to modify factors that are common antecedents for suicide and other mental health, drug and alcohol or social problems.

Performance Indicators

- Decreased rate of depressive symptomatology and other mental disorders.
 - Decrease in social alienation and social exclusion (in particular among those with psychosis).
 - Decrease in social isolation (in particular among older Australians after loss).
 - Decreased rate of child abuse and neglect.
 - Decreased rate of sexual abuse.
 - Decreased rate of antisocial and aggressive behavior.
 - Decreased rate of crime.
 - Decreased rate of substance abuse.
 - Decreased rate of domestic, marital and parental conflict.
 - Decreased rate of social inequity.
 - Decreased rate of unemployment.
 - Increase in the availability and dissemination of credible evaluation reports of projects designed to reduce risk factors for suicide and self-harm.
- c. Increase awareness of early signs and symptoms of mental health problems and mental disorders.

Strategies

- Implement early intervention initiatives under the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health for groups at increased risk of suicide.
- Disseminate throughout the community information about early signs and symptoms of mental health problems and mental disorder, where to get help, and how to provide support.

Performance Indicators

- Increased range of appropriate materials providing information on mental disorders and sources of help for age groups and cultures.
 - Increased number of media articles or segments conveying positive mental health messages.
 - Increased availability of information on mental health, mental disorders and services, from sources including GP's, media and youth and community services.
 - Increased level of mental health literacy within the community.
- d. Increase the acceptability of help seeking to respond to mental health problems and other issues.

Strategies

- Ongoing review of the research programs and current initiatives associated with increasing help-seeking behavior and its acceptability.
- Consult young people (particularly young males) and youth agencies, older people and aged care agencies on possible strategies, with particular attention to gender, culture and effectiveness with disadvantaged groups.
- Implement and evaluate evidence-based programs that aim to increase help-seeking in education and community settings including

families, schools, universities, workplaces, employment and training agencies, and community organizations.

- Media campaigns and community education on issues relating to traditional notions of masculinity, and to healthy aging including retirement planning, adaptation to physical disability, and maintaining independence.
- Raise awareness of the available services for relevant groups.

Performance Indicators

- Increased number of research studies designed to explore help-seeking behavior.
 - Increased number of evidence-based programs designed, implemented and evaluated to enhance the acceptability of help-seeking for mental health problems.
 - Increased levels of knowledge about help-seeking options in the community.
 - Improved attitudes towards help-seeking in the community (in particular among males).
 - Increased proportion of people in high risk groups who are aware of services available.
 - Increased rate of help-seeking among groups with low rates of help-seeking.
- e. Identify and promote good practice in the portrayal, in the media and artistic productions (school and other drama, film, painting, etc.) of young people, high-risk groups, suicide, mental disorder and related issues.

Strategies

- Establish media reference groups to provide expert advice on media strategies.

- Monitor media coverage of young people, risk groups, suicide, mental disorders and related issues, and assess its impact on young people and people at risk of suicide.
- Joint strategies between the media and health and welfare agencies that reduce the risk for imitation suicide, including development of media resources, codes of practice and policies in media organizations.
- Promote media coverage and artistic portrayal of positive mental health, understanding of mental health issues and supportive attitudes towards marginalized groups.
- Raise awareness of risks involved in normalizing and romanticizing suicide through media and artistic productions.

Performance Indicators

- Increased number of media reference groups in the community.
- Decreased number of inappropriate portrayals of suicide and mental disorders in the Australian media.
- Decreased number of negative portrayals of young people in the Australian media.
- Decreased number of negative portrayals of high-risk groups in the Australian media.
- Decreased number of inappropriate portrayals of suicide and mental disorders in artistic productions in the Australian community.
- Increased availability of information to support media in appropriate portrayals of suicide and mental disorders.
- Increased number of media agencies that have codes of practice and policies relating to the portrayal of suicide and mental disorders.
- Increased awareness among journalists of issues relevant to the portrayal of suicide and mental disorders.

- Fewer and less prominent portrayals of methods of suicide.
- Fewer and less prominent portrayals of suicide as normal or glamorous.
- Increased publication of research on media portrayals of suicide in Australia.

f. Reduce access to identified lethal methods of suicide.

Strategies

- Increase awareness of research findings and recommendations on effective methods of reducing access to means of suicide.
- Legislative approaches, including limiting pack sizes of potentially lethal medications.
- Education on prescribing and dispensing of potentially lethal medications for people of all age groups.
- Reduce the lethal potential of motor vehicle exhaust emissions.
- Encourage safe storage and use of firearms.
- Encourage erection of barriers on potential jumping points.
- Address cultural presentations of hanging in Aboriginal and Torres Strait Islander communities.
- Explore alternatives to custodial care.

Performance Indicators

- Reduced availability of lethal means of suicide in specific populations.
- Reduced availability of hanging points in detention centers and prisons.
- Increased education about the dispensing of potentially lethal medications.
- Improved range and use of alternatives to custodial care, in particular for young people.
- Reduced lethal potential of motor vehicle exhaust emissions.

- Increased number of initiatives that address the safe storage and use of firearms.
 - Increase in the number of barriers on common jumping points.
 - Reduced injury and death arising from self-harming behaviors using these means.
3. Services and support within the community for groups and increased risk.
- a. Enhance the response of services in the community to the full range of needs of groups who are at increased risk of suicide.

Strategies

- Service providers identify groups within their local community who are at higher risk of suicide, and increase awareness of the specific needs of these groups and capacity to respond to those needs.
- Develop, implement and evaluate models for service delivery that are realistic and achievable and can be adapted within the local context.
- Increase service provider's awareness of and links with other services available, and the referral criteria of such services.
- Develop training programs, support materials and policies for staff to promote openness to and acceptance of groups who tend to be marginalized and awareness of the range of approaches available to meet their needs.

Performance Indicators

- Increased training and education for service providers about appropriate process for conducting needs assessment and rapid appraisal.
- Increased proportion of service providers who have access to the results of needs assessment and rapid appraisal.
- Increased number of model service delivery programs adapted to the local context and used by a range of community organizations.

- Increased proportion of service providers aware of the referral criteria of other services available for groups at increased risk of suicide.
 - Increased proportion of services that have incorporated appropriate support materials and policies for staff to promote openness to and acceptance of groups who tend to be marginalized.
 - Increased proportion of service providers trained in the importance of openness to and acceptance of groups who tend to be marginalized and awareness of appropriate approaches to meet the needs of these groups.
- b. Enhance the capacity of services in the community to recognize, respond to and refer individuals showing signs of high suicide risk.

Strategies

- Implement and evaluate and where not available, develop, qualify suicide prevention training appropriate to a range of specific service provider groups.
- Develop and implement protocols for service delivery based on identified population need and service use.
- Develop information systems for help-seeking, advice and referral, with a range of access points including local services, internet providers, telephone counseling services and resource guides.
- Increase service provider's awareness of and links with other services available, and awareness of the referral criteria of such services.

Performance Indicators

- Increase proportion of service providers who have received appropriate and quality suicide prevention training.
- Increased number of quality information systems for help-seeking, advice, and referral for individuals showing signs of high suicide risk.

- Improved access to information systems for service providers regarding help-seeking advice and referral for individuals showing signs of high suicide risk.
 - Increased proportion of service providers with access to data on frequency of suicidal behavior and thinking specific to their service type.
 - Increased proportion of service providers aware of other services available for individuals showing signs of high suicide risk.
 - Increased proportion of service providers aware of the referral criteria of other services available for individuals showing signs of high suicide risk.
 - Increased numbers of regions with suicide prevention plans, networks and intersectoral protocols in place and endorsed by service providers and governments.
- c. Increase awareness and implementation in rural and remote communities of models of suicide prevention and response suitable for such communities.

Strategies

- Collect, collate, interpret and disseminate data and information on suicide in all age groups in rural and remote communities.
- Develop, pilot and evaluate models of suicide prevention suitable for a diverse range of rural and remote communities.
- Implement and evaluate a trial of a coordinated intersectoral approach to suicide prevention in at least one rural region.
- Ensure the availability of suicide prevention and mental health materials, support and resources to community workers in rural and remote communities.

Performance Indicators

- Improved access to appropriate data, information, resources and training on mental health and suicide prevention for service providers in rural and remote communities.
- Completion and dissemination of a comprehensive evaluation report of a coordinated intersectoral approach to suicide prevention in at least one rural region.

4. Services for individuals at high risk.

- a. Improve emergency response and provision of follow up support for incidents of attempted suicide and self-harm.

Strategies

- Build effective links between services responding to incidents of attempted suicide and self-harm, including emergency departments, ambulance services, police, community mental health, GP's, community health, general hospital, psychiatric in-patient, drug treatment and prevention services.
- Provide appropriate training and support to staff responding to suicide, self-harm, drug harm or mental health crisis, to enable them to respond in culturally appropriate ways and take account of issues such as age and gender.
- Develop, implement and review protocols and procedures for emergency services that demonstrate commitment to the response and follow-up process after an incident of attempted suicide or self-harm, including linkages with community and hospital based services.
- Develop, implement and review protocols and procedures for all health services and other relevant services that demonstrate commitment to follow-up and continuity of care after incidents of attempted suicide and self-harm.

- Improve the quality and consistency of data on incidents of attempted suicide and self-harm presenting to hospital emergency departments and other services.

Performance Indicators

- Quality and use of data systems.
 - Availability of agreed/approved protocols and procedures in departments/agencies providing emergency response to attempted suicide and self-harm.
 - Evidence in case studies and practice audits of link with community based services, mental health services and drug treatment and prevention services.
 - Feedback form emergency service users after attempted suicide or self-harm.
 - Compliance by service providers with guidelines and protocols.
- b. Reduce the risk of suicide and self-harm among people with or at high risk of mental disorder.

Strategies

- Increase access to appropriate and non-stigmatizing mental health support and early intervention for people with mental disorders.
- Enhance discharge protocols and improve community support and follow-up after hospital discharge with mental disorders.
- Review, disseminate and implement protocols for suicide risk assessment within health services.
- Develop, implement and review good practice (including guidelines) for working with groups with mental disorders at particularly high risk of suicide.
- Develop, implement and review protocols and procedures to reduce and respond to incidents of suicide and self-harm.

Performance Indicators

- Reduced rate of suicide and self-harming behavior among people with mental disorders.
 - Increased access to evidence based early interventions for people at risk of mental disorders.
 - Increased proportion of hospitals with appropriate discharge protocols for people with mental disorders.
 - Improved community support and follow-up after discharge for people with mental disorders.
 - Development and guidelines and training in evidence-based guidelines for discharge from hospital of people with mental disorders, for use by those involved in the discharge process.
 - Development of guidelines and training in evidence-based practice for use by those involved (through government, non-government and private sector) in the provision of community support and follow-up care for people with mental disorders.
 - Development of good-practice guidelines for working with people with a mental disorder who are at high risk of suicide.
 - Improved assessment of suicide risk within health services.
 - Improved knowledge and skills among government and non-government service providers about working with people with a mental disorder who are at high risk of suicide.
- c. Enhance support for people who are involved with, or likely to become involved with, the criminal justice or juvenile justice system.

Strategies

- Collect, collate, interpret and disseminate accurate data on prevalence, type and severity of mental health problems and drug and alcohol

problems in people in the criminal and juvenile justice systems and correctional services.

- Review policies and practices in suicide prevention within the criminal and juvenile justice systems and correctional services in consultation with staff, prisoners, parolees and those awaiting trial.
- Establish partnerships between police, criminal and juvenile justice systems, correctional services, mental health services and drug and alcohol services for policy development and staff training on suicide prevention.
- Establish partnerships and joint initiatives for the more appropriate management and care of people with mental health and related problems who are in the juvenile or criminal justice systems.
- Develop, implement and evaluate programs to support the children and siblings of prisoners, parolees and those awaiting trial.

Performance Indicators

- Increase data on prevalence and severity of mental health problems and drug and alcohol problems of people in the criminal and juvenile justice systems and correctional services.
- Increased percentage of services with access to data on prevalence and severity of mental health problems and drug and alcohol problems of people in the criminal and juvenile justice systems and correctional services.
- Increase percentage of practice audits of suicide prevention policies and practices within the criminal and juvenile justice systems and correctional services, which involved consultation with staff, prisoners, parolees, and those awaiting trial.
- Increased percentage of police, criminal and juvenile justice systems, correctional services, mental health services and drug and alcohol

services with suicide prevention policies that emphasize partnership approaches to policy development and staff training.

- Increase number of partnerships between these services for policy development and staff training.
- Improved range and use of alternatives to custodial care.
- Increased percentage of people involved with the criminal justice of juvenile justice systems who are identified as experiencing mental health problems and mental disorders.
- Increased percentage of people involved with the criminal justice of juvenile justice systems and experiencing mental health problems and disorder, who receive treatment.
- Improved suicide prevention practice within the criminal justice system.
- Improved cross-departmental response for mental health issues concerning people involved with the legal systems.
- Improved information available to support policy and planning on suicide prevention within the criminal justice, juvenile justice and legal systems.
- Increased number of programs designed, implemented and evaluated that support the children and siblings of prisoners, parolees and people awaiting trial.

d. Reduce the risk of suicide and self-harm associated with harmful drug and alcohol use.

Strategies

- Establish partnerships between, drug and alcohol services/programs, primary care services/programs and mental health services/programs.
- Develop, implement and evaluate in consultation with consumers, carers and service providers (government and non-government) programs that reduce the risk of suicide and accidental or deliberate

self-harm including overdose among those who engage in harmful drug use.

- Develop, implement and evaluate pathways of care for those with drug and alcohol problems combined with another mental disorder.

Performance Indicators

- Increased number of partnerships between drug and alcohol services/programs, primary care services/programs, and mental health services/programs.
 - Increased number of programs developed, implemented and evaluated that reduce the risk of suicide and accidental or deliberate self-harm, including overdose, among people who engage in harmful drug use.
 - Decreased rate of overdose.
 - Decreased rate of substance abuse.
 - Decreased rate of heavy drinking episodes.
 - Improved information exchange, referral pathways, joint case management, shared care and discharge planning between drug services, GP'S, and mental health services.
 - Improved access to services for people with combined mental health/drug and alcohol problems.
- e. Provide prompt and effective support for people bereaved or directly affected by suicide.

Strategies

- Review the availability and quality of support and information for people bereaved or affected by suicide including families, partners, ex-partners, friends, peers, agencies and service providers.
- Establish partnerships between police, ambulance, hospitals, church groups, community organizations, and funeral parlors to improve support in the community for people bereaved or affected by suicide.

- Develop, implement and evaluate protocols for responding to suicide within settings including schools, workplaces, jails, mental health services, drug and alcohol services, residential services and other agencies to support people bereaved by suicide.

Performance Indicators

- Increased access to support and information for families and friends bereaved by suicide.
 - Improved information exchange, problem solving and linking between police, ambulance, hospitals, church groups, community organizations and funeral parlors after a suicide.
 - Increased percentage of schools, workplaces, jails, mental health services, drug and alcohol services, residential services and other agencies with appropriate plans for action after a suicide.
5. Partnerships with Aboriginal and Torres Strait Islander peoples.
- a. Share information about and implement life-affirming and suicide-prevention programs that are community based and grounded in the culture of Aboriginal and Torres Strait Islander peoples.

Strategies

- Identify effective and culturally acceptable life promotion and suicide prevention approaches.
- Develop mechanisms for inter-community dialogue and exchange about these projects.
- Ensure capacity for timely linkages between communities with recognized expertise and those in crisis.
- Encourage wider implementation and local adaptation of these approaches in other urban, rural and remote settings.
- Ensure recurrent funding for proven programs.

- Encourage community control of these programs and related activities.
- Ensure cross-sectoral support for such programs.
- Enhance mainstream support for community based programs and communities in need.
- Support programs to provide alternatives to custodial care for younger Aboriginal and Torres Strait Islander men.

Performance Indicators

- Increased resources for suicide prevention programs in Aboriginal and Torres Strait Islander communities, and feedback and evaluation of services developed by people involved in the program.
 - Feedback by training participants on the cultural appropriateness of training.
- b. Increase the relevance of mainstream services and suicide prevention programs and services to the culture, needs and strengths of Aboriginal and Torres Strait Islander peoples.

Strategies

- Enhance information and training support to mainstream and Aboriginal and Torres Strait Islander health and community agencies on suicide and self harming behaviors.
- Increase the input of Aboriginal and Torres Strait Islander peoples into service and program development.
- Develop effective mechanisms for disseminating information on services and programs to all Aboriginal and Torres Strait Islander communities.
- Enhance linkages with protocols between services working with Aboriginal and Torres Strait Islander people at risk of suicide.

- Ensure consideration of the needs of Aboriginal and Torres Strait Islander people in mainstream services and suicide prevention programs, including primary care, mental health services, drug and alcohol services, correctional services programs and custodial care.
- Work in partnership with Aboriginal and Torres Strait Islander agencies and communities to develop strategies on media responses to suicide related issues.

Performance Indicators

- Involvement of Aboriginal and Torres Strait Islander organizations and communities in the design of mainstream strategies and programs.
- Increased presence of Aboriginal and Torres Strait Islander professionals in mainstream services and suicide prevention programs.
- Presence of support services and activities for Aboriginal and Torres Strait Islander employees within mainstream services.
- Increased numbers of people in Aboriginal and Torres Strait Islander services and communities, and mainstream services, who have received training in prevention of suicide and self-harm.
- Increased number of services which have an ongoing training strategy in the prevention of suicide and self-harm.
- Increased mainstream services with defined training programs for working in Aboriginal and Torres Strait Islander settings and with Aboriginal and Torres Strait Islander clients, and increased numbers of employees completing these courses.
- Participation of community members, service providers and organizations in approaches to suicide prevention.
- Positive feedback from Aboriginal and Torres Strait Islander groups on the appropriateness of activities.

6. Progressing the evidence base for suicide prevention and good practice.

- a. Support strategic research and evaluation of programs, ongoing and longitudinal research and the dissemination of knowledge gained to facilitate good practice.

Strategies

- Conduct epidemiological and sociological studies of suicide and self-harm risk and protective factors, effectiveness of strategies and legal and ethical issues.
- Conduct epidemiological and sociological studies of suicide and self-harm in specific groups of interest.
- Support evaluation of suicide prevention initiatives through publication and dissemination of evaluation resources.
- Investigate the feasibility of a longitudinal study in conjunction with a range of other programs.
- Disseminate research and evaluation findings.

Performance Indicators

- Increase in the number of relevant strategic research projects funded and completed.
 - Improved availability of research and evaluation research reports.
 - Increase in the number of relevant publications in peer-reviewed journals.
 - Enhanced dissemination of research and evaluation reports, including implications for practice, to service providers and community agencies that may be involved in implementing the outcome.
 - Appraisal of the resources developed for the evaluation of suicide prevention projects.
 - Completion of a feasibility study on the design and conduct of a relevant collaborative longitudinal study.
- b. Provide timely access to accurate and up to date data on suicide, self-harm, risk factors and good practice initiatives.

Strategies

- Establish and support partnerships between coronial and health information systems, and population and mental health surveillance systems, including mental health services, GP's, private psychiatrists and Aboriginal medical services.
- Develop data systems to underpin suicide prevention activities across the health, welfare justice and education sectors.
- Collect, collate and disseminate information about good practice in suicide prevention through education, peer-reviewed and other publications, professional associations, networks, conferences, the internet and clearing house services.

Performance Indicators

- Increased number and types of primary care workers provided with appropriate suicide prevention training, where possible accredited by their professional or vocational training system.
 - Increased number of relevant workers who participate in suicide prevention training.
 - Increased number of tertiary education providers for relevant professions that include modules on suicide prevention.
 - Inclusions of suicide prevention in the competency standards for relevant occupations.
 - Increased number of suicide prevention training activities that use strategies to improve sustainability of training outcomes.
 - Improved evaluation of suicide prevention training activities.
 - Increased number of tertiary education providers for relevant professions that include modules on evaluation strategies.
- c. Increase the percentage of the health, welfare, education and other human services workforce that has undertaken training in suicide prevention.

Strategies

- Provide pre-vocational and in-service education to a range of professions including, clinicians, staff of emergency services, correctional services, drug treatment and prevention services, community accommodation and welfare services, pharmacists, the education and employment sector, media and local government.
- Develop accredited training to ensure quality and integrity of pre-vocational and in-service education, and adequate support for and supervision of students.
- Ensure that such training is integrated with education and training structures for the occupation.
- Ensure that training is included in the development of regional plans and protocols for suicide prevention.

Performance Indicators

- Increase number and types of primary care workers provided with suicide prevention training where possible accredited by their professional or vocational training system.
- Increased number of relevant workers who participate in suicide prevention training.
- Increased number of tertiary education providers for relevant professions that include modules on suicide prevention.
- Inclusion of suicide prevention in the competency standards for relevant occupations.
- Increased number of suicide prevention training activities that use strategies to improve sustainability of training outcomes.
- Improved evaluation of suicide prevention training activities.
- Increased number of tertiary education providers for relevant professions that include modules on evaluation strategies.

- d. Implement guidelines and protocols consistent with good practice identified through research, evaluation, consumer consultation and expert consensus.

Strategies

- Develop guidelines for good practice in a range of promotion, prevention and service delivery work based on research evidence, consumer feedback and consultation with workers.
- Liaise with professional and industry associations, government and major community and private providers to disseminate and implement guidelines including adaptation to local policy and program levels and to review guidelines and implementation.

Performance Indicators

- Increased number of regions, organizations and professions with guidelines and protocols consistent with good practice in suicide prevention.
- Increase review of regional, organizations and professional guidelines and protocols consistent with good practice in suicide prevention.
- Report by staff that relevant guidelines and protocols are routinely used.
- Increased number of case studies and practice audits that indicate that relevant guidelines and protocols are adhered to.
- Inclusion of guidelines and protocols on suicide prevention in the National Standards for Mental Health Services standards and accreditation processes.

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