LIFE in the South West of Western Australia: A study of existing suicide prevention services

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EXECUTIVE SUMMARY

The aim of the present report is to provide information that can be used to improve outcomes for people in the South West (SW) region of Western Australia (WA) at risk of suicide. The executive summary provides an overview of the conceptual framework for the research, the information collection strategies used, research questions and findings, and the implications of these findings for services development.

Conceptual framework for the research

Suicide is the defined as self-inflicted death where there is evidence that the person intended to die. Its prevention presents a significant challenge not only for Australia but internationally. The Living is for Everyone (LIFE) framework has been adopted across Australia in response to this challenge. In WA the State Suicide Prevention Strategy 2009-2013 uses this framework to guide future suicide prevention initiatives. Two of the 'action areas' identified in the LIFE framework and the State Suicide Prevention Strategy provided a focal point for the present research, viz., 'the provision of targeted suicide prevention activities', and 'taking a coordinated approach to suicide prevention'. Three outcomes were of interest in relation to the action areas (1) improved access to a range of support and care for people feeling suicidal, (2) improved understanding, skills and capacity of front-line workers, and (3) local services linking effectively so that people experience a seamless service. A second key element of the LIFE framework refers to eight domains of intervention ranging from universal interventions which aim to engage all Australians in reducing suicide (e.g., gun control measures) to ongoing care and support where the emphasis is on assisting individuals to get back into life after a suicide attempt. The six domains for individual services provided the second focal point for the present study, viz., 'indicated intervention', symptom identification', 'early treatment', standard treatment', longer-term treatment and support' and 'ongoing care and support'. Bringing these two elements together ('action areas' and 'domains of intervention') generated a number of research questions which the present study set out to answer with the intention of improving outcomes for people in the SW at risk of suicide.

Information collection strategies

There were three research phases. Information was sought in Phase 1 about suicidal behaviour in the SW and psychosocial stressors associated with completed suicides. Sources of data included the Health and Wellbeing Surveys conducted by the WA Department of Health and routine file audits of completed suicides from the WA Coroner's Office. The aim of Phase 2 of the research was to identify service providers in the SW who could be reasonably assumed to play an important role in suicide prevention. These included government providers, specifically the Western Australian Country Health Service (WACHS), private sector general practitioners (GPs), private sector allied health professionals (AHPs), and finally allied health professionals employed in the non-government sector (NGOs). A list of these providers was obtained

from the internet and by consulting people in the SW with knowledge about local services. An assessment of the appropriateness of these services was conducted in Phase 3. There were two steps in this phase for WACHS staff, AHPs and NGOs. In the first step, providers were sent a brief survey to complete and return to the researchers. A follow-up face-to-face interview was conducted as the second step. In contrast, GPs provided information by way of the brief survey; face-to-face interviews could not be arranged. Response rates ranged from 25.6% (general practices) to 65.9% (WACHS) for the brief surveys, and around 75% for the face-to-face interviews across the three sectors.

Research questions and findings

The following questions were addressed with a view to providing data that could be used to improve access to a range of support and care for people feeling suicidal in the SW, viz., what is the extent of suicide and suicidal behaviour in the SW; what psychosocial stressors are associated with completed suicides; who provides suicide prevention services; what part/s of the spectrum of interventions do these service providers engage with; what services are provided and what professions are represented; how accessible are these services; and, what 'duty-of-care' issues arise in the provision of services to people at risk of suicide?

In Australia, the annual incidence of completed suicides for the year 2004 ('age-standardised') was 10.4 per 100,000 persons. The rate /100,000 persons (age adjusted) for completed suicides in the SW from 2003-2007 inclusive was estimated to be 10.5. Males complete suicide approximately four times more frequently than females in WA. Mortality rates /100,000 (age-adjusted) from 2003-2007 in the SW for intentional self harm/ suicide for males was 16.9 compared to 3.9 for females. The Kimberley, Wheatbelt and Goldfields had the highest rates of male suicide in 2007, whereas the Pilbara had the lowest rate. The SW, Great Southern, Goldfields and the Midwest had similar rates of male suicide, higher than the Pilbara (12.4) but lower than the Kimberley (39.1), Wheatbelt (24.1) and Goldfields (24.1). Rates /100,000 (age-adjusted) for hospital admissions in the SW for intentional self harm from 2004-2008 inclusive for males was 1.1 compared to 1.9 for females.

There are seven health districts in the SW: Bunbury, Blackwood, Warren, Wellington, Busselton, Leeuwin and Leschenault. An analysis of differences between each district by sex and the State suggests the rate of hospital admission for self harm is higher for females in Bunbury and lower for females in Leschenault. Analysis of differences for males suggests hospital admission rates for self harm are higher in Busselton and lower in Leschenault. Mortality rates for suicide and self harm are higher for males in Warren.

A number of psychosocial stressors associated with completed suicides in WA from 1998-2008 have been identified. Around 38% of people in the SW who completed suicide during this period had a diagnosed psychiatric disorder; 29% experienced a relationship breakdown; around 22% had drug/ alcohol problems; 21% experienced

issues with their family/ friends; around 18% were dealing with physical illness/other medical issues; 15% had financial problems; around 14% were involved in legal issues; and around 12% were dealing with the death of someone close. An examination of differences between the seven health districts in the SW in terms of these stressors in a recent 12-month period revealed they have a similar profile in terms of current mental health problems, diagnosis of depression by a doctor, relationship breakdown, high risk short term alcohol use, serious illness, financial hardship or the death of someone close. The exceptions were that a higher proportion of females in the Wellington health district reported they had experienced the death of someone close in the past 12 months, a higher proportion of males in the Wellington health district had been diagnosed with depression in the past 12 months, and a higher proportion of males in the Blackwood health district reported high risk drinking associated with short-term harm.

Three service sectors assumed to have a role in suicide prevention were identified: government services –specifically the WA Country Health Service (WACHS) in the SW; for-profit services – general practitioners (GPs) and allied health practitioners providing mental health services (AHPs) working in the private sector in the SW; and not-for-profit services (NGOs) providing care and support to people who, in light of known risk factors (e.g., severe financial stress, unemployment, social isolation), may be at risk of suicide. Eleven WACHS services (comprising hospital-based and community-based services) considered to have a role in suicide prevention were identified, for example, the Bunbury Regional Hospital Emergency Department, the SW Primary Health Service, the SW Mental Health Service and the SW Aged Care Assessment Team. One-hundred and thirty-eight SW GPs from 43 practices, along with 50 AHPs, and 39 NGOs were identified. Bunbury, Busselton and Leeuwin were found to have the highest ratio of GPs to residents (1 GP to around 900 residents); Warren and Wellington appear to have the lowest ratios (1 GP to around 2000 residents). By way of comparison, Bunbury, Leeuwin and Blackwood were found to have the highest ratio of AHPs to residents (around 1 to 1700 for Bunbury and around 1 to 1500 for Leeuwin and Blackwood); Leschenault and Warren appear to have the lowest ratios (around 1 to 8700 and 1 to 5000 respectively). Turning to NGOs, of the total number, 76.9% provide services in Bunbury which accounts for 29.4% of the total population in the SW compared to around 36% of the total number of NGOs who provide services in Leschenault and 38% who service the Blackwood and Leeuwin health districts which account for 22.8%, 4.8% and 7.8% of the total SW population respectively.

The majority of WACHS hospital-based and community-based mental health services, GPs, AHPs and NGOs take action in response to early signs of suicide risk/ tipping points. In contrast, the majority of WACHS hospital-based mental health services and GPs reported being a first point of professional contact for people who had attempted suicide. Further, the majority of WACHS community-based mental health services, GPs and AHPs provide longer-term support for people in the recovery stage and provide support to carers/ families of people at risk of suicide. Putting these services to individuals to one side, it was found that less than half of WACHS staff, GPs, AHPs and

NGOs reported that reducing suicide through community education was their responsibility. However, the majority of WACHS community-based mental health staff, GPs and NGOs reported that working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility. In contrast, around half of WACHS hospital-based staff and AHPs considered this was their responsibility.

Most WACHS hospital-based and community-based staff, GPs, AHPs and NGOs provide advice about mental health/ make referrals, and provide counselling/ psychological therapy in response to early signs of suicide risk/ tipping points, at the first point of professional contact after a suicide attempt and for people who have attempted suicide and are in the recovery stage. Needs assessment/ case management along with mental/ behavioural/ psychological assessment is undertaken to a lesser extent. WACHS hospital-based and community-based mental health services employ practitioners from a wide range of professions including psychiatrists, emergency medicine, mental health nurses, critical care nurses, psychologists, social workers and occupational therapists. Few GPs employ AHPs. The majority of AHPs work as sole practitioners many of which are psychologists or counsellors; AHPs working with other practitioners were generally psychologists some of which work in general practice with GPs; and social workers and counsellors were employed more often than psychologists, mental health nurses or occupational therapists by NGOs.

The usual wait time for a consult with a mental health professional for WACHS hospital-based services is less than 2 hours. However wait times after hours at Bunbury Regional Hospital are longer because mental health liaison staff are available from 8am to 11pm. Children/ adolescents may have extended wait times as CAMHS services are limited. The usual wait time for a consult with a mental health professional for WACHS community-based services is reported to be within 24 hours. These services typically do not operate out-of hours or over the weekend. GPs reported that all patients would be seen the same day if not immediately if they were regarded as at-risk of suicide. GPs typically provide an out-of-hours/ weekend service. Around 40% of people at risk of suicide would be seen on the same day by AHPs. However, this typically applies to existing clients only. Around 50% of AHPs provide an out-of-hours/ weekend service. Similarly, around one-third of NGOs reported that clients at risk of suicide would be seen the same day. Around 36% of the NGOs reported they provide an out-of-hours/ weekend service.

A wide range of considerations emerged regarding the duty of care to people at risk of suicide in the SW. If the risk is not imminent the patient's wishes regarding confidentiality would be respected. However, if the risk is deemed sufficiently high then the patient's refusal to involve others would be over-ridden. The need for patients to always sign a confidentiality agreement/ release of information form regarding information sharing with other agencies/ practitioners was highlighted as was the need to involve the patient's GP when the patient is admitted to hospital; if the patient is < 16 the requirement to involve their parents/ guardian was also emphasized. The requirement to keep patients/ practitioners/ carers and others safe, particularly where violence to others is a risk was also underlined.

The following questions were addressed with a view to providing data that could be used to improve the understanding, skills and capacity of front-line workers involved in suicide prevention in the SW, viz., what suicide risk factors are salient for service providers given their target population; what is the level of awareness amongst service providers involved in suicide prevention of 'early signs', 'tipping points' and 'clinical indicators on ongoing risk' of suicide; what is the level of awareness amongst service providers involved in suicide prevention of the known barriers that males face in accessing treatment and support and how these barriers might be addressed; and what professional development activities have service providers recently participated in regarding suicide prevention?

Understanding of suicide prevention in the SW was examined in terms of perceptions of risk factors, knowledge of early signs of suicide risk/ tipping points, knowledge of indicators of ongoing risk, and barriers experienced by males in accessing services. Alcohol/ other substance abuse, family discord/ violence or abuse, social/ geographical isolation, mental health problems/ disorders and separation/ loss were reported. Known suicide risk factors infrequently reported as apparent in the SW were prior suicide attempts, low self esteem, hopelessness, homelessness, social/ cultural discrimination, chronic pain/ illness, little sense of control over life's circumstances, a lack of meaning and purpose in life, family history of suicide/ mental illness, imprisonment, and access to lethal means for people with suicidal ideation.

Knowledge of the known early signs of suicide risk/ tipping points appeared to be sketchy. Frequently mentioned early signs/ tipping points by WACHS staff were suicidal ideation, substance abuse, anxiety/ agitation, hopelessness, withdrawal, mood fluctuations, relationship ending and death/ suicide of a relative/ friend. None of the known early signs/ tipping points were identified by 50% or more of GPs and only two of the known early signs/ tipping points were identified by 50% or more of AHPs (suicidal ideation and relationship ending). Suicidal ideation was the only early signs/ tipping point identified by 50% or more of NGOs. Known early signs of suicide risk/ tipping points infrequently identified were purposelessness, feeling trapped, recklessness, debilitating physical illness/ accident, suicide of someone famous/ member of peer group, anger, a serious argument at home, media report on suicide/ suicide methods. Knowledge of known clinical indicators of ongoing risk for people in the SW who have attempted suicide also appeared to be sketchy. Frequently mentioned indicators by WACHS staff were frequent thoughts of suicide, access to suicide means, a significant change in circumstances/ loss, depressive symptoms/ hopelessness/ helplessness and substance abuse. Depressive symptoms/ hopelessness/ helplessness was the only clinical indicator identified by 50% or more of GPs and clinical indicators identified by 50% or more of AHPs were a significant change in daily routine, depressive symptoms/ hopelessness/ helplessness and alienation/ lack of support networks. Clinical indicators identified by 50% or more of NGOs were a significant change in daily routine and depressive symptoms/ hopelessness/ helplessness. Known clinical indicators of ongoing risk less frequently identified were a detailed suicide plan, the lethality of intended suicide method or an interest in being rescued for those

with suicidal ideation, recency/ frequency/ severity of recent attempts, and chronic, painful medical problem/ perceived medial problem.

Relatively few of the known barriers to access to service by males were identified. Those commonly mentioned were that males are reluctant to talk about their problems, the male stereotype of being tough and strong, the use of destructive coping mechanisms and the perceived stigma of mental illness. Known barriers infrequently identified were males don't know what help is available, the cost of services, a lack of understanding regarding treatments, long wait lists, lack of social network support, males without partners are harder to reach, lack of time and not recognizing emotional symptoms of distress, only physical symptoms. Barriers perceived as difficult to address included providing access to services for isolated men, referral pathways and knowledge of available services, lack of trained staff, the need to educate males that it's OK to have mental health problems, provision of out-of-hours services, getting males 'in the door', the cost of services, time constraints that men have, difficulties building family support, accessing male staff and child care services for single-fathers.

Turning to professional development, 50% of the WACHS community-based staff surveyed had undertaken suicide prevention PD in the past three years. Around half of AHPs and 70% of NGOs had undertaken suicide prevention PD in the past three years. In contrast around 85% of the WACHS hospital-based staff surveyed had not undertaken any suicide prevention PD in the past three years. Similarly around 75% of GPs had not undertaken any suicide prevention PD in the past three years. Suggestions for future PD included assessment of risk during the first 24 hour critical period after a suicide attempt, legal training in detaining psychiatric patients, drug/ alcohol education, self harm assessment and management, acute psychosis treatment/ care, the link between psychopharmacology and suicidality, information about referral pathways to mental health practitioners, case analysis, integrated strategies for managing suicide risk, working with families, types of longer-term intervention, and domestic violence/ drug abuse and the link with suicide.

The following questions were addressed with a view to providing data that could be used to more effectively link local services so that people at risk of suicide experienced a seamless service, viz., how effective is inter-agency collaboration in the SW in the opinion of service providers; how effective is the coordination of services across agencies for individuals at risk of suicide in the opinion of these providers; and do providers consider they have timely access to mental health practitioners outside their agency?

Less than half of the providers rated the collaboration with external agencies/ practitioners they needed to work with in relation to patients/ clients at risk of suicide as effective. Of particular note, 8% of GPs and none of the WACHS hospital-based staff rated collaboration as effective. More generally, whilst more than half of the GPs, AHPs and NGOs agreed there was a high level of interest in working collaboratively across agencies, only WACHS community-based staff agreed there is a clear commitment to

working collaboratively. Few of the providers agreed the areas of shared responsibility are clear and understood by all concerned, or there are clear arrangements to monitor and review the success of working collaboratively. Further, less than half of the providers agreed there is sufficient trust to survive any mistrust that may arise from collaboration. More than half of the WACHS hospital-based staff agreed that co-locating agencies would facilitate working collaboratively. This view was not shared amongst the other providers.

The main barriers to effective service coordination were regarded as limited availability of services outside Bunbury, access to services only during office hours, lack of adequate interagency referral and follow-up protocols, difficulties in accessing CAMHS, lack of acute care psychiatric beds, poor case management, not enough mental health professionals to provide a rapid response, professional silos, lack of community agencies willing to provide treatment after recovery, a lack of communication between agencies/ practitioners, a lack of understanding about suicide/ suicide risk, too much emphasis on managers when addressing interagency issues, client transport issues, multiple medical records/ problems in addressing confidentiality issues across agencies, a lack of support agencies for young people at risk, difficulties in maintaining ongoing contact with people at risk of suicide, a lack of inter-agency networking opportunities and staff shortages.

The majority of providers considered they had timely access to practitioners with the training and experience to work with people at risk of suicide, particularly GPs and psychologists. The majority of WACHS community-based staff and NGOs reported timely access to mental health nurses. NGOs reported timely access to social workers.

Conclusions and implications of the research for services development

What conclusions can be drawn from the study findings that have implications for improving access to a range of support and care for people feeling suicidal, particularly in locations of greatest need? As reported in the present study, suicide and suicidal behaviour in the SW appears to be no more prevalent in one health district or another, with the exception of completed suicides for males in the Warren district. However, differences were found in the range and type of services across these districts. Bunbury, Busselton and Leeuwin districts have the highest ratio of GPs per head of population (1 GP to around 900 residents). Warren and Wellington appear to have the lowest ratios (1 GP to around 2000 residents). Similarly, Bunbury, Leeuwin and Blackwood appear to have the highest ratio of private sector AHPs per head of population (around 1 to 1700 in Bunbury and around 1 to 1500 in Leeuwin and Blackwood). Leschenault and Warren appear to have the lowest ratios (around 1 to 8700 and 1 to 5000 respectively). Of the total number of NGOs, around 77% provide services in Bunbury which accounts for about 29% of the SW population. By way of comparison, around 46% of the NGOs in the SW provide services to Warren and Wellington which account for around 6.6% and 9.4% of the population respectively. Taken on face value, this might suggest that these districts are relatively well served by NGOs. Further investigation, however, is needed to confirm this. It may be that NGO

services (along with WACHS and AHPs) operate more infrequently at these locations. As highlighted in the LIFE framework, services need to be proactively developed in communities where suicide and suicidal behaviour is prevalent. It can be concluded from the data obtained in the present study that access to services for people at risk of suicide is not spread evenly across health districts in the SW. Of particular concern is access to GPs in some of the inland health districts, given the pivotal role GPs have in ameliorating the risk of suicide. As highlighted in the LIFE framework, regardless of the lack or otherwise of services, all services for people at risk of suicide should be highly visible. Included here, for example, would be information about support that is available at the service itself as well as other services in the local area.

A second issue that emerged from the present research regarding services for people at risk of suicide centred on wait-times, including the provision of services after-hours and over the weekend. On a positive note, it was found that SW service providers give a high priority to people at imminent risk of suicide and those who have attempted suicide - during normal business hours. In the case of AHPs the added stipulation is 'provided they are existing clients'. In the case of NGOs the added stipulation is 'provided they meet the eligibility criteria for the service'. Services out-of-hours (including over the weekend) appear to be less quick to respond. Mental health liaison staff at Bunbury Regional Hospital, for example, are only on-duty from 8am to 11pm each day. Further, CAMHS services were also reported to be limited resulting in extended wait times for children and adolescents.

A third issue to emerge from the present study regarding treatment and support for people at risk of suicide was the wide range views on patient/ client confidentiality. In some services, the usual practice appears to be to require the person to sign a release of information form (once they are able to do so). In other services, if the risk of suicide is regarded as sufficiently high then any refusal by the patient to involve others would be over-ridden regardless of what may or may not have been agreed. In contrast, in other services it was reported this right would always be respected regardless of the circumstances. There can be little doubt that these practices need further investigation to ensure all service providers helping people at risk of suicide conform with generally accepted ethical and legal requirements in these circumstances, including when they are working with children and adolescents.

What conclusions can be drawn from the study findings that have implications for improving understanding, skills and capacity of front-line workers in the SW? Data obtained from file audits routinely conducted using data from the Coroner's office indicated that important psychosocial stressors for people in the SW who completed suicide were a diagnosed psychiatric disorder, relationship breakdown, drug/ alcohol problems, issues with family/ friends, physical illness/other medical issues, financial problems, involvement in legal issues, and the death of someone close. Around half of these were identified by providers, viz., mental health problems/ disorders, separation/ loss, alcohol/ other substance abuse, and family discord/ violence or abuse, were reported. However, a number of other extremely important suicide risk

factors were infrequently reported such as prior suicide attempts, a family history of suicide/ mental illness, social/ cultural discrimination and chronic pain/ illness.

Of further concern was the lack of a comprehensive knowledge of the early signs of the risk of suicide and tipping points. It was found that few of the known early signs/ tipping points were identified by 50% or more of the GPs, AHPs and NGOs. WACHS staff, by contrast, appeared to be better informed. A similar picture emerged regarding knowledge of the known clinical indicators of ongoing risk for people who had attempted suicide. Knowledge of the known barriers to services for males and strategies for addressing these also appeared to be sketchy amongst these service providers including amongst WACHS staff. In light of these findings, professional development regarding suicide prevention would be of benefit and a range of suggestions were offered by providers regarding topics of interest. That said, knowledge of population risk factors, early signs of suicide risk/ tipping points, and clinical indicators of ongoing risk for people who have attempted suicide will need to be a high priority. Printed guidelines and succinct risk assessment tools may be of particular help if they can be provided in an easily understood and accessible format.

What conclusions can be drawn from the study findings that have implications for linking local services effectively so that people experience a seamless service? An encouraging finding was that SW service providers appear to have a high level of interest in working collaboratively. Equally encouraging was the finding that the majority of providers considered they had timely access to practitioners with the training and experience to work with people at risk of suicide. Both of these findings are extremely important in light of data that indicated important differences between providers in which part of the spectrum of interventions they consider is their responsibility and in which they therefore provide services. GPs and WACHS hospital-based mental health services, for example, reported being a first point of professional contact for people who had attempted suicide. This is not generally the case for WACHS community-based providers, private sector AHPs and NGOs, each of which take action in response to early signs of suicide risk/ tipping points, as well as providing longer-term support for people in the recovery stage. As more fully discussed in relation to the LIFE framework, developing an understanding of peoples' journeys to find services, and encouraging cross-agency coordination of services is critical when different service sectors have responsibility for different parts of the spectrum of interventions for people at risk of suicide. A finding of particular concern in the present study therefore was that few providers agreed that areas of shared responsibility are clear and understood by all. Moreover, less than half of the providers agreed there is sufficient trust to survive any mistrust that may arise from collaboration. Building trust is therefore an important first step in improving inter-agency collaboration and taking a coordinated approach to suicide prevention. Indeed, many of the strategies identified in the present study and in the LIFE framework to more effectively link local services, such as developing practical tools for information sharing, dealing with privacy and confidentiality requirements, and agreeing on joint service/ client protocols, are unlikely to succeed in a climate of mistrust.

In conclusion, many of the findings of the present research are encouraging, especially the finding that WACHS, GPs, private sector AHPs, and allied health practitioners working in NGOs, provide services and support ranging from taking action in response to early signs of the risk of suicide through to longer-term support for people recovering after a suicide attempt. Nonetheless there is room for improvement. Areas of concern where improvements to services and their organisation are needed include the accessibility of services in specific health districts in the SW, as well as after-hours and over the weekend, important gaps in knowledge about suicide risk factors, known signs/ tipping points/ clinical indicators on ongoing risk for suicide, along with inter-agency collaboration and the coordination of services, particularly for those at imminent risk of taking their own life.

CONTENTS

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SUICIDE IN REGIONAL AUSTRALIA

Overview of suicide in Australia

Despite recent questions being raised about the possible underestimate of suicide deaths in Australia (particularly in relation to the analysis of trends) there can be little doubt that it is an area of major concern. Based on ABS data, the total number of suicides in Australia in 2006 was 1799. The age-adjusted suicide rates for males was 17.0/100,000 and 4.8/100,000 for females; the median age of death for males was 43.7 years, for females it was 45.1years. The most frequent method of suicide in 2006 was hanging accounting for 52.2% of all suicides in Australia in 2006. The next most frequent method was poisoning by either drugs or other methods such as carbon monoxide poisoning, accounting for 24.1% of all suicides in 2006 followed by firearms which accounted for 8.6% of suicides across Australia in 2006 (Harrison, Pointer & Abou Elnour, 2009).

In a recent paper, Judd, Cooper, Fraser and Davis (2006) point out that based on ABS data rural communities experience higher rates of suicide than urban areas. Further, the rate of suicide for males in rural communities has increased steadily over the past 20 years. They underline, however, the need to go beyond overly-simplistic comparisons between urban and rural centres and argue for the importance of understanding the nature of issues that may be specific to or of particular importance in rural settings. Their view is that one broad set of factors that impact on suicide rates is 'place'; another broad factor is 'people'. The present research has been conducted in this spirit.

Overview of suicide in WA

In their 2010 report the Senate Community Affairs Committee[1] noted that suicide was the 14th leading cause of death in Australia – 1.5% of all deaths in 2008 of which 78% were male and 22% female. Whilst concern has been raised that the number of deaths by suicide may have been underestimated, (e.g., revised data from 2007 released by the ABS showed a 9.2% increase from 1,881 previously reported for 2007 to 2,054), at least six Australian lives are taken by suicide every day.

The Coroner determined there were 4,787 deaths by suicide in WA between 1982 and 2006. Suicide rates have been decreasing since a peak of 313 deaths in 1998. Over the period 1986-2006 the most common methods of suicide amongst WA men were hanging and carbon monoxide poisoning. Since 1986, there has been a significant increase in suicide by hanging and a decrease in the use of carbon monoxide poisoning. Increasingly, women are using more 'active' methods of self-inflicted injury. Prior to 1995, the most commonly used method of suicide by women was self-poisoning. Since 1995, there has been a significant increase in the rates of hanging.

For every death by suicide it is estimated that at least 6-8 people are intimately affected. There are many more people, such as workmates, teachers, neighbours who

[1] http://www.aph.gov.au/senate/committee/clac_ctte/suicide/report/report.pdf

are affected by what has become known as the 'ripple effect' (Lukas & Seiden, 1987; McIntosh, 1993). In WA it has been estimated there are between 1500-2000 people intimately affected by suicide each year.[2]

Suicide in the South West

Completed suicides 1998-2007

Table 1 presents the number of completed suicides for the SW for the period 1998-2002 and 2003-2007. Comparative data is presented for other regional areas in WA. As shown in this table the number of completed suicides was similar for these two 5-year periods despite any population increases for the Wheatbelt, Great Southern, Pilbara and the Kimberley. In contrast the number of suicides in the Midwest and Goldfields decreased; the total population in both regions increased marginally. The number of suicides in the SW decreased although there was an increase in the population.

Table 1

Number of suicides in regional WA (1998-2002 and 2003-2007)

	# suicides 1998 -2002	Estimated resident pop 2002	# suicides 2003 -2007	Estimated resident pop 2007
South West	73	131,305	71	146,830
Wheatbelt	49	73,996	49	74,000
Gt Southern	31	53,964	27	56,271
Midwest	44	60,777	33	61,999
Goldfields	56	55,054	34	56,589
Pilbara	26	40,176	20	45,026
Kimberley	51	32,682	36	33,158

Data Source: Epidemiology Branch, Department of Health, accessed October 2010.

In WA, males complete suicide approximately four times more frequently than females. Table 2 presents the 2007 estimates (age-adjusted) /100,000 for male suicides for each WA region. As shown in this table the Kimberley, Wheatbelt and Goldfields had the highest rates of male suicide based on data from 2003-2007 inclusive, whereas the Pilbara had the lowest rate. The SW and Great Southern, had similar rates of male suicide, higher than the Pilbara but lower than the Kimberley, Wheatbelt and Goldfields.

[2] This is based on an estimate of 250 suicides each year which significantly impacts on 6-8 people for each completed suicide.

Table 2

2010 estimates /100,000 (age-adjusted) based on data from 2003-2007 for male suicide in regional WA

	Est pop 2007	Rate/ 100,000
South West	74,844	16.9
Wheatbelt	38,606	24.1
Gt Southern	28,768	17.3
Midwest	32,301	21.0
Goldfields	30,209	24.1
Pilbara	25,250	12.4
Kimberley	17,380	39.1

Data Source: Epidemiology Branch, Department of Health, accessed October 2010.

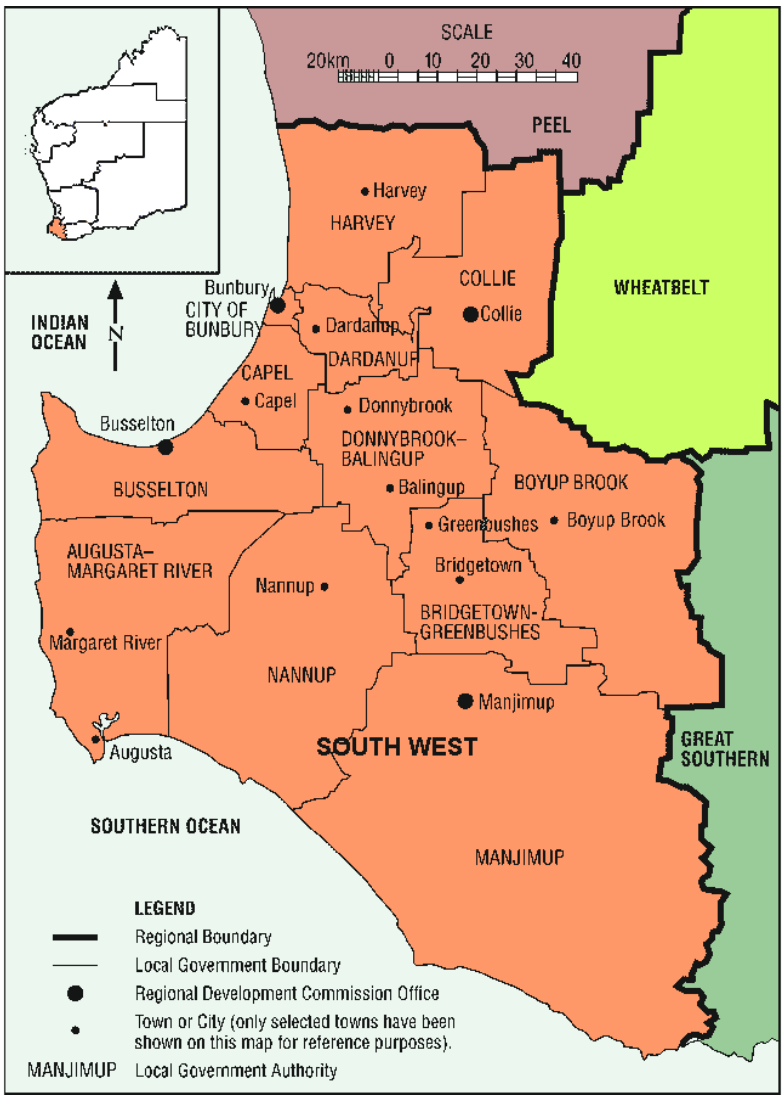
SW Health Districts

There are seven South West Health Districts. These cover the following local government areas (see Figure 1):

- Bunbury – includes the City of Bunbury and the Shire of Capel
- Busselton – includes the Shire of Busselton
- Leschenault – includes the Shires of Harvey and Dardanup
- Leeuwin – includes the Shire of Augusta-Margaret River
- Blackwood – includes the Shires of Boyup Brook, Bridgetown-Greenbushes and Nannup
- Wellington – includes the Shires of Collie area and Donnybrook-Balingup, and
- Warren – includes the Shire of Manjimup.

Figure 1

Map – Regional Map of the South West, Department of Regional Development and Lands



Risk factors for suicide for SW Health Districts

Two types of data were utilised to develop suicide risk profiles for each SW Health District (i) data on suicidal behaviour, and (ii) data regarding psychosocial stressors associated with suicides in the SW. Data are presented separately for males and females. Due to lower numbers and the need to present meaningful data Age Standardised Rates (ASR) cannot be used as a measure for each of the Health Districts. The State rate is not significantly different to the Australian rate for suicide so a Standardised Rate Ratio (SRR) is used to measure hospitalization and Standardised Mortality Ratio (SMR) is used to measure mortality. In each of these measures the Standardised State Rate is 1.

Suicidal behaviour in the SW

Table 3 presents rates for hospital admissions for intentional self harm (2004-08) and mortality rates associated with suicide and intentional self-harm (2003-07) for each SW health district. Analysis of differences between each district by sex and the State (based on 95% confidence intervals) suggests the rate of hospital admission for self harm is higher for females in Bunbury and lower for females in Leschenault. Analysis of differences for males suggests hospital admission rates for self harm are higher in Busselton and lower in Leschenault. Mortality rates for suicide and self harm are higher for males in Warren.

Table 3

SRR for Hospital admissions for intentional self-harm (2004-08) and SMR for suicide and intentional self harm (2003-07)

	Hospital admission rates 2004-08		Mortality rates 2003-07	
	Female	Male	Female	Male
Bunbury	1.18**	0.98	0.43	0.79
Blackwood	0.86	1.13	1.29	1.09
Warren	0.97	1.36	1.9	3.6**
Wellington	1.01	0.8	0.66	1.3
Busselton	0.81	1.8**	1.70	0.89
Leeuwin	0.82	1.05	1.60	0.87
Leschenault	0.76*	0.71*	0	6.9

Data Source: Epidemiology Branch, Department of Health, accessed October 2010.

** indicates a significantly higher than expected number of cases compared to the State Rate Ratio (=1)

* indicates a significantly lower number of cases compared to the State.

Table 4 presents the percentage of residents who have experienced suicidal ideation within the past twelve months for each SW health district based on self-report data obtained from 2005-2009 by the Health and Wellbeing Survey. Analysis of differences between each district by sex and the State (based on 95% confidence intervals) found no significant differences regarding 'serious thoughts about ending their own life' over the past 12 months except for Leeuwin where a significantly lower proportion of males reported suicidal ideation and Warren where a significantly lower proportion of females and males reported suicidal ideation.

Table 4

Percentage of SW residents who experienced suicidal ideation 2005-2009 (WA Health and Wellbeing Survey)

	Female	Male
State	4.6	3.8
Bunbury	6.2	3.3
Blackwood	2.7	5.0
Warren	1.0*	0.5*
Wellington	5.8	2.6
Busselton	5.4	3.9
Leeuwin	6.8	0.9*
Leschenault	3.0	2.7

Data Source: Epidemiology Branch, Department of Health, accessed October 2010.

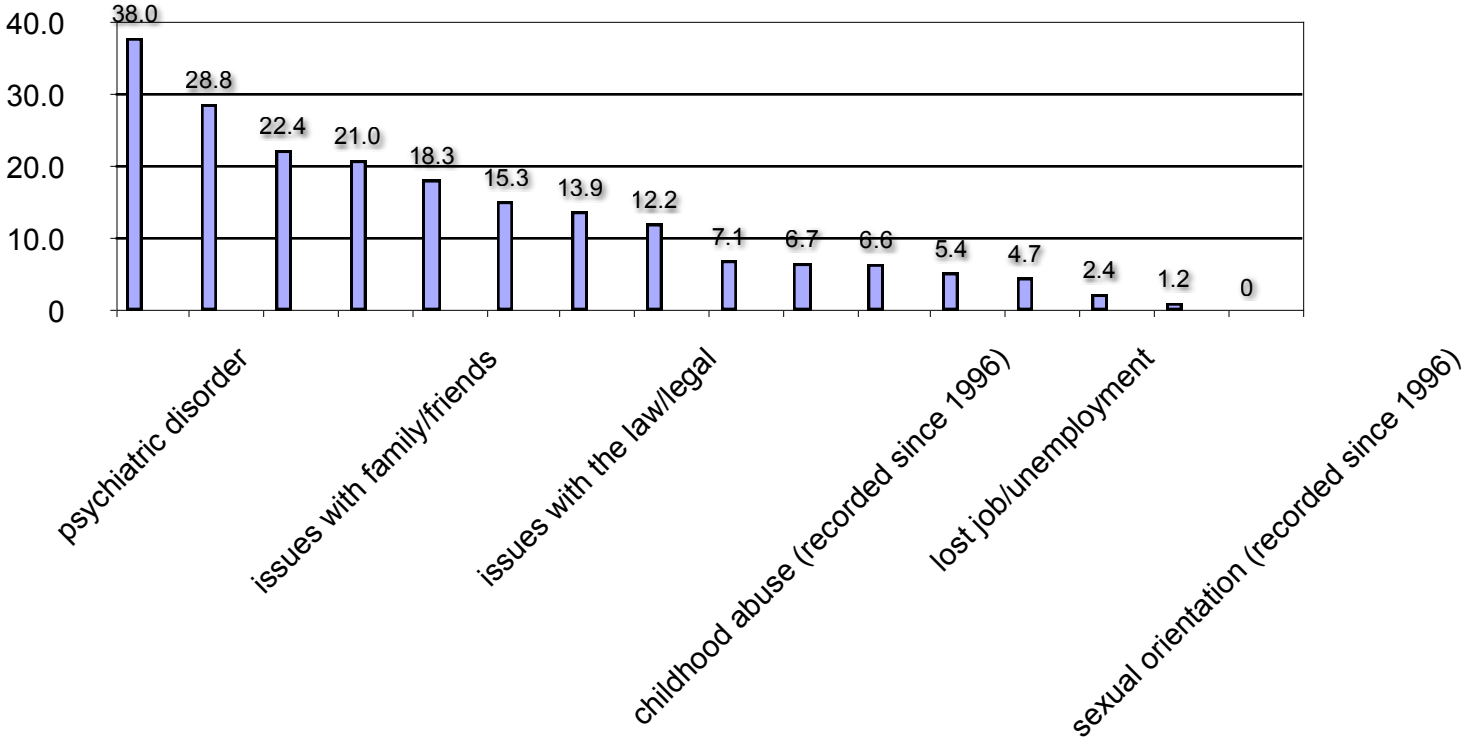
* indicates a significantly lower number of cases compared to the State.

Psychosocial stressors associated with completed suicides in the SW

Figure 2 presents the psychosocial stressors associated with completed suicides in the SW from 1998-2008. As shown, around 38% of people (34% for males) who completed suicide during this period had a diagnosed psychiatric disorder; 29% (32% for males) experienced a relationship breakdown; around 22% (25% for males) had drug/ alcohol problems; 21% (18% for males) experienced issues with their family/ friends; around 18% (16% for males) were dealing with physical illness/other medical issues; 15% (15% for males) had financial problems; around 14% (17% for males) were involved in legal issues; and around 12% (11% for males) were dealing with the death of someone close. Given the relatively high weight given to psychosocial stressors for males resulting from the higher proportion of males who complete suicide, it is important to treat these findings with caution when drawing conclusions for females who complete suicide.

Figure 2

Psychosocial stressors associated with completed suicides in the SW health Region 1986-2008



Prevalence of psychosocial stressors known to be associated with completed suicides in the SW

Data was obtained about the prevalence in each SW health district of the psychosocial stressors most frequently associated with suicides in the SW: current mental health problems, relationship breakdown, high risk short-term alcohol use, serious illness, financial hardship and death of someone close.

Table 5 presents the prevalence of these stressors based on self-report data obtained from 2005-2009 by the Health and Wellbeing Survey. Analysis of differences between these districts and the State for females found:

- a significantly higher proportion of females in the Wellington health district reported they had experienced the death of someone close in the past 12 months
- a significantly lower proportion of females in the Blackwood and Warren health districts reported they had experienced a relationship breakdown in the past 12 months
- a significantly lower proportion of females in the Leeuwin health district reported they had experienced financial hardship in the past 12 months, and
- a significantly lower proportion of females in the Blackwood health district reported high risk drinking associated with short-term harm.

Analysis of differences between these districts and the State for males found:

- a significantly higher proportion of males in the Wellington health district had been diagnosed with depression in the past 12 months, and
- a significantly higher proportion of males in the Blackwood health district reported high risk drinking associated with short-term harm.

There were no other statistically significant differences between the seven health districts and the State in relation to self-reported 'diagnosis of depression by a doctor', 'relationship breakdown', 'high-risk short term alcohol use', 'serious illness', 'financial hardship', or 'death of someone close'.

Table 5

Percentage of SW residents reporting psychosocial stressors most frequently associated with suicides in the SW 2005–2009

		State	Bunbury	Blackwood	Warren	Wellington	Busselton	Leeuwin	Leschenault
Diagnosed depression last 12 months	Female	9.4	9.7	11.2	5.3	11	10.1	4.4	9.4
	Male	5.3	8.1	6.8	1.6	10.8**	6.8	2.3	5.0
Relationship breakdown	Female	9.3	9.6	4.5*	4.4*	4.9	9.9	7.5	8.5
	Male	7.6	7.6	7.4	3.3	7.0	5.2	8.1	6.8
Alcohol consumption (high short-term risk)	Female	10.5	12.4	2.4*	9.1	11.1	11.1	7.7	12.5
	Male	23.9	23.4	36.3**	23.4	31.0	21.0	17.3	27.7
Serious illness	Female	13.1	14.6	19.1	12.1	11.1	14.8	8.1	13.0
	Male	9.3	12.3	11.7	11.6	10.3	10.9	9.1	10.4
Financial hardship	Female	11.1	12.2	15.8	10.4	14.9	9.9	6.4*	13.9
	Male	10.3	10.1	10.6	5.3	6.0	10.4	14.4	6.9
Death of someone close	Female	26.1	25.4	23.7	22.0	35.8*	24.2	28.5	27.2
	Male	23.4	25.3	28.0	21.5	29.8	22.8	22.8	24.8

Risk profiles for suicide in SW health districts

To sum up, as shown in Table 6 (when comparisons are made with the State), Bunbury has a higher rate of hospital admissions for self harm for females, whereas Busselton has a higher rate of hospital admissions for self harm for males. Warren has a higher suicide/ self harm mortality rate. As shown in Table 7 (again when comparisons are made with the State), a higher proportion of females in the Wellington health district reported they had experienced the death of someone close in the past 12 months, a higher proportion of males in the Wellington health district had been diagnosed with depression in the past 12 months, and a higher proportion of males in the Blackwood health district reported high risk drinking associated with short-term harm.

Table 6

Suicide risk profiles for SW Health Districts – suicidal behaviour

	Females			Males		
	Hospital admission – self harm 04-08 (SSR)	Suicide/ self harm mortality rates 03-07 (SMR)	Suicidal ideation 05-09	Hospital admission – self harm 04-08 (SRR)	Suicide/ self harm mortality rates 03-07 (SMR)	Suicidal ideation 05-09
Bunbury	1.18**	0.43	6.2	0.98	0.79	3.3
Blackwood	0.86	1.29	2.7	1.13	1.09	5.0
Warren	0.97	1.9	1.0*	1.36	3.6**	0.5*
Wellington	1.01	0.66	5.8	0.8	1.3	2.6
Busselton	0.81	1.70	5.4	1.8**	0.89	3.9
Leeuwin	0.82	1.60	6.8	1.05	0.87	0.9*
Leschenault	0.76*	0	3.0	0.71*	6.9	2.7

** indicates a significantly higher than expected number of cases compared to the State.
* indicates a significantly lower number of cases compared to the State.

Table 7

Suicide risk profiles for SW Health Districts – psychosocial stressors

	Females						Males					
	Diag of depressn 05-09	Relationsh breakdown 05-09	High-risk short-term alcohol use 05-09	Serious illness 05-09	Financial hardship 05-09	Death of someone close 05-09	Diag of depressn 05-09	Relationsh breakdown 05-09	High-risk short-term alcohol use 05-09	Serious illness 05-09	Financial hardship 05-09	Death of someone close 05-09
State	9.4	9.3	10.5	13.1	11.1	26.1	5.3	7.6	23.9	9.3	10.3	23.4
Bunbury	9.7	9.6	12.4	14.6	12.2	25.4	8.1	7.6	23.4	12.3	10.1	25.3
Blackwood	11.2	4.5*	2.4	19.1	15.8	23.7	6.8	7.4	36.3	11.7	10.6	28.0
Warren	5.3	4.4*	9.1	12.1	10.4	22.0	1.6	3.3	23.4	11.6	5.3	21.5
Wellington	11.0	4.9	11.1	11.1	14.9	35.8**	10.8	7.0	31.0	10.3*	6.0	29.8
Busselton	10.1	9.9	11.1	14.8	9.9	24.2	6.8	5.2	21.0	10.9	10.4	22.8
Leeuwin	4.4	7.5	7.7	8.1	6.4*	28.5	2.3	8.1	17.3	9.1	14.4	22.8
Leschenault	9.4	8.5	12.5	13.0	13.9	27.2	5.0	6.8	27.7	10.4	6.9	24.8

** indicates a significantly higher than expected number of cases compared to the State.
* indicates a significantly lower number of cases compared to the State.

SW MENTAL HEALTH SERVICES/ SUPPORT

Formal services/ support are vital to minimize the risk of suicide. Estimates of the investment in government-provided mental health services in WA are encouraging. Similarly, access to GPs and psychologists has improved as a result of the Commonwealth government's investment in mental health programs such as 'Better Access'. Investment in mental health services/ support provided by the NGOs in WA has also increased in recent years. Our research question was what SW services have a role in minimizing the risk of suicide in this region?

Mapping of existing services

The LIFE framework[3] is a national policy initiative in Australia. Eight 'domains' of suicide activities are identified to assist providers to locate their services within a broader context of effort by other stakeholders. We utilised the LIFE framework to assist in the development of a comprehensive list of existing mental health service providers in the SW organised by the following six 'service domains' targeting individuals (Table 8).

[3] http://www.livingisforeveryone.com.au/LIFE-Framework.html

Table 8

Example service providers for the six domains of the LIFE framework that target individuals

Service domains	Service focus	Types of service providers
Indicated intervention	Indicated interventions require that service providers are aware of the early signs of suicide risk as well as symptoms of an illness known to heighten the risk of suicide (e.g., depression). Recognition of these early warning signs and taking appropriate action is paramount.	Community service organisations, GPs, police, rehabilitation providers, emergency workers, specialist physicians, education providers
Symptom identification	Symptom identification requires that service providers are knowledgeable and alert to signs of high or imminent risk, adverse circumstances and potential tipping points. Recognition of these signs of imminent risk and potential tipping points and taking appropriate action is paramount.	GPs, help lines, police, rehabilitation providers, emergency workers, specialist physicians, teachers
Early treatment	Early treatment refers to the first point at which service providers offer targeted and integrated support and care. Interventions are monitored with the aim of facilitating access to standard treatment when specialized care is needed.	GPs, psychologists, allied mental health professionals, Aboriginal Health Workers, hospital emergency departments, police, emergency workers, specialist physicians, community mental health services, school counsellors
Standard treatment	Standard treatment refers to integrated, professional care to manage suicidal behaviours and comprehensively treat and manage any underlying conditions.	Psychiatrists, psychologists, GPs, allied mental health professionals, Aboriginal Health Workers
Longer-term treatment and support	Longer-term treatment and support entails the provision of continuing integrated care to consolidate recovery from attempted suicide. Addressing risk factors and improving protective factors are important.	Psychiatrists, psychologists, GPs, allied mental health professionals, community service providers
Ongoing care and support	Ongoing care and support aims to support people to adapt, cope and build resilience within an environment of self-help to prevent recurrences of attempted suicide.	GPs, allied mental health professionals, Aboriginal Health Workers, community service providers

Service providers were categorised as those provided by 'the state', 'for-profit private providers' and 'not-for-profit providers'. The service providers for each sector in the SW who participated in the present research are shown in Table 9. These providers were deemed to have a key role in suicide prevention in terms of the six service domains of the LIFE framework that target individuals (see Table 8).[4]

[4] Secondary schools in the SW were approached to participate in the research. Of the 33 schools approached only 8 agreed to take part. This was considered an insufficient sample of schools from which to draw conclusions. Secondary schools were therefore excluded from the present research.

Table 9

Service providers for the six domains of the LIFE framework that target individuals

Services provided by government	'For-profit private' providers	'Not-for-profit' providers
State health services - WACHS	General practitioners Allied health professionals	Non-government, non-profit human service agencies

Internet searches of the following websites were conducted to identify existing services in the SW. We searched for the types of service providers listed in the six domains of the LIFE framework that target individuals (see Table 10) including those provided by the WACHS, 'private for-profit' services (e.g., services provided by SW general practitioners and allied health practitioners such as psychologists), and 'not-for-profit services'.

Table 10

Websites searched to locate service providers

Services provided by government	For-profit private providers
http://www.wacountry.health.wa.gov.au/	http://www.gpdownsouth.com.au/
http://www.harvey.wa.gov.au/	http://www.gbdgp.com.au/
http://www.bunbury.wa.gov.au/	http://www.otauswa.com.au/
http://www.busselton.wa.gov.au/	http://www.aasw.asn.au/
http://www.manjimup.wa.gov.au/	http://www.psychology.org.au/
http://www.dardanup.wa.gov.au/	http://www.psychboard.wa.gov.au/
http://www.capel.wa.gov.au/	http://www.beyondblue.org.au/index.aspx?link_id=107.1007
http://www.nannup.wa.gov.au/	
http://www.amrsc.wa.gov.au/	**Not-for-profit private providers**
http://www.boyupbrook.wa.gov.au/	http://www.sjog.org.au/
http://www.collie.wa.gov.au/	http://www.swams.com.au/site/index.php
http://www.donnybrook-balingup.wa.gov.au/	http://www9.health.gov.au/ccsd/usr_general/gen_home.cfm
http://www.bridgetown.wa.gov.au/	http://www.familyrelationships.gov.au/
	http://www.deewr.gov.au/Employment/JSA/EmploymentServices/Pages/serviceProviders.aspx
General websites	http://www.harvey.wa.gov.au/
http://www.whitepages.com.au/wp/	http://www.bunbury.wa.gov.au/
http://www.yellowpages.com.au/	http://www.busselton.wa.gov.au/
http://www.google.com.au/	http://www.manjimup.wa.gov.au/
http://www.hotfrog.com.au/	http://www.dardanup.wa.gov.au/
http://www.startlocal.com.au/	http://www.capel.wa.gov.au/
http://www.truelocal.com.au/	http://www.nannup.wa.gov.au/
http://www.aussieweb.com.au/	http://www.amrsc.wa.gov.au/
http://mysouthwest.com.au/	http://www.boyupbrook.wa.gov.au/
http://www.mybunbury.com.au/	http://www.collie.wa.gov.au/
Directory	http://www.donnybrook-balingup.wa.gov.au/
	http://www.bridgetown.wa.gov.au/

Government provided health services - WACHS

Table 11 presents the WACHS that were considered to have a role in suicide prevention in terms of the six service domains of the LIFE framework that target individuals.

Table 11

Government service providers in the SW considered to have a role in suicide prevention

Types of services provided by government	Existing SW services

WACHS health services, including mental health	Bunbury Regional Hospital Acute Psychiatric Unit Bunbury Regional Hospital AHP Department Bunbury Regional Hospital Emergency Department SW Primary Health Service SW Mental Health Service Busselton Community Health Centre Yarloop Community Health Centre Warren-Blackwood Primary Health Care Unit Warren-Blackwood Child Health SW Aged Care Assessment Team SW District Hospitals

'For-profit private' services

Table 12 presents the number and type of 'for-profit private' service providers (GPs and AHPs) for each health district in the SW. There are 138 GPs from 43 practices and 50 AHPs. As shown in this table Bunbury, Busselton and Leeuwin have the highest ratio of GPs to residents; Warren and Wellington have the lowest ratios. By way of comparison, Bunbury, Leeuwin and Blackwood have the highest ratio of AHPs to residents; Leschenault and Warren have the lowest ratios.

Table 12

Number of persons/ GP and AHPs in the SW

Heath district	Population	No. of general practitioners	No. of persons/ GP	No. of AHP providers	No. of persons/ AHP
Coastal					
Bunbury	44,776	51	877	27	1658
Busselton	29,183	33	884	14	2084
Leschenault	34,696	25	1388	4	8674
Leeuwin	11,830	12	986	8	1479
Inland					
Blackwood	7,258	5	1452	5	1452
Warren	9,995	5	1999	2	4997
Wellington	14,349	7	2050	6	2391

'Not-for-profit' services

Table 13 presents the number of 'not-for-profit' service providers considered to have a role in suicide prevention for each health district in the SW. There were 39 in total providing services to an estimated 152,087 residents. As shown in this table, of the total number of NGOs, 76.9% provide services in Bunbury which accounts for 29.4% of the total population in the SW. By way of comparison, around 36% of the total number

of NGOs provide services in Leschenault and around 38% in the Blackwood and Leeuwin health districts, which account for 22.8%, 4.8% and 7.8% of the total SW population respectively. These data suggest that all health districts have access to a wide range of NGOs considered to have a role in suicide prevention. However, it should be noted that the number of NGO services in each health district (as presented in Table 13) does not differentiate between services operating on a full-time basis with a range of staff members and a service operating with one staff member one day a month. NGOs were considered to provide a service to residents in the health district if they had a part-time, permanent presence or operated on an outreach basis.

Table 13

Prevalence of NGOs in the SW considered to have a role in suicide prevention

Health district	No. of NGOs	% of total NGOs	Population	% total population
Coastal				
Bunbury	30	76.9	44,776	29.4
Busselton	19	48.7	29,183	19.2
Leschenault	14	35.9	34,696	22.8
Leeuwin	15	38.5	11,830	7.8
Inland				
Blackwood	15	38.5	7,258	4.8
Warren	18	46.2	9,995	6.6
Wellington	18	46.2	14,349	9.4

OVERVIEW OF SUICIDAL BEHAVIOUR AND SERVICE PROVIDERS IN THE SW

Suicide remains a problem across Australia. The number of completed suicides in the SW in the five year period (2003-2007) was 82. The rate /100,000 persons (age adjusted) for completed suicides in the SW from 2003-2007 inclusive was estimated to be 10.5. Males complete suicide approximately four times more frequently than females in WA. Mortality rates /100,000 (age-adjusted) from 2003-2007 inclusive in the SW for intentional self harm/ suicide for males was 16.9 compared to 3.9 for females. The Kimberley, Wheatbelt and Goldfields had the highest rates of male suicide in 2007, whereas the Pilbara had the lowest rate. The SW, Great Southern, Goldfields and the Midwest had similar rates of male suicide, higher than the Pilbara (12.4) but lower than the Kimberley (39.1), Wheatbelt (24.1) and Goldfields (24.1). Rates / 100,000 (age-adjusted) for hospital admissions in the SW for intentional self harm from 2004-2008 inclusive for males was 1.1 compared to 1.9 for females. There are seven health districts in the SW: Bunbury, Blackwood, Warren, Wellington, Busselton, Leeuwin and Leschenault. An analysis of differences between each district by sex and the State (based on confidence intervals) suggests the rate of hospital admission for self harm is higher for females in Bunbury and lower for females in Leschenault.

Analysis of differences for males suggests hospital admission rates for self harm are higher in Busselton and lower in Leschenault. Mortality rates for suicide and self harm are higher for males in Warren.

A number of psychosocial stressors associated with completed suicides in WA from 1998-2008 have been identified. Around 38% of people in the SW who completed suicide during this period had a diagnosed psychiatric disorder; 29% experienced a relationship breakdown; around 22% had drug/ alcohol problems; 21% experienced issues with their family/ friends; around 18% were dealing with physical illness/other medical issues; 15% had financial problems; around 14% were involved in legal issues; and around 12% were dealing with the death of someone close. An examination of differences between the seven health districts in the SW in terms of these stressors in a recent 12-month period revealed they have a similar profile in terms of current mental health problems, diagnosis of depression by a doctor, relationship breakdown, high risk short term alcohol use, serious illness, financial hardship or the death of someone close. The exceptions were that a higher proportion of females in the Wellington health district reported they had experienced the death of someone close in the past 12 months, a higher proportion of males in the Wellington health district had been diagnosed with depression in the past 12 months, and a higher proportion of males in the Blackwood health district reported high risk drinking associated with short-term harm.

Whilst there appear to be few major differences between the health districts in the SW when suicidal behaviour and psychosocial stressors associated with completed suicides are examined, there are some differences in the number of service providers considered to have a role in suicide prevention. Three categories of service providers were included: services provided by government (the WA Country Health Service – WACHS), services provided by the 'for-profit' sector (SW GPs and AHPs), and services provided by the 'not-for-profit' sector. Eleven WACHS services considered to have a role in suicide prevention were identified, for example, the Bunbury Regional Hospital Emergency Department, the SW Primary Health Service, the SW Mental Health Service and the SW Aged Care Assessment Team. One-hundred and thirty-eight SW GPs were identified. Bunbury, Busselton and Leeuwin were found to have the highest ratio of GPs to residents (1 GP to around 900 residents); Warren and Wellington appear to have the lowest ratios (1 GP to around 2000 residents). By way of comparison, Bunbury, Leeuwin and Blackwood were found to have the highest ratio of AHPs to residents (around 1 to 1700 for Bunbury and around 1 to 1500 in Leeuwin and Blackwood); Leschenault and Warren appear to have the lowest ratios (around 1 to 8700 and 1 to 5000 respectively). Turning to NGOs, of the total number, 76.9% provide services in Bunbury which accounts for 29.4% of the total population in the SW compared to around 36% of the total number of NGOs who provide services in Leschenault and around 38% in the Blackwood and Leeuwin health districts, which account for 22.8%, 4.8% and 7.8% of the total SW population respectively. These data suggested that all health districts have access to a wide range of NGOs considered to have a role in suicide prevention.

APPROPRIATENESS OF EXISTING SERVICES

Services planning and development to minimise the risk of suicide highlights an important question – how appropriate is the service mix and endeavour in the SW if the aim is to minimise the risk of suicide? For example, are the existing services in the SW appropriately targeting (1) early detection of suicidal behaviour (e.g., people thinking about suicide and/or people at potential 'tipping points'), (2) treatment for people who have attempted suicide, and/or (3) follow-up support for those who have attempted suicide and are in the recovery stage?

Survey of service providers

Sampling framework

WACHS

Identification of WACHS sites/ services occurred via the WACHS website. After discussion with the WACHS South West Regional Mental Health Manager, it was determined that 44 nurses, doctors and allied health staff from the District Hospitals, the Bunbury Regional Hospital, Community Health Services and Mental Health Service would be approached to participate in the research. WACHS managers were responsible for deciding which staff members were approached.

Private-sector GPs

Web-based searches resulted in 43 GP practices being identified in the SW. A decision was made to sample the GPs working in the region by GP practice rather than approaching the GPs on an individual basis. As a result, participation of at least one GP per practice was sought through the practice managers. This decision was largely based on a belief that the GP sector was going to be difficult to engage given their workload. It was hoped that by having practice managers discuss the research with the GPs to find one person willing to participate that the response rates may be increased.

Private-sector AHPs

As the AHP sector encompasses a wide variety of professions a decision was made to focus on those professions who would most frequently come into contact with people at risk of suicide. As a result, only psychologists, social workers, OTs and counsellors were included in the sample of private-sector AHPs. The majority of private AHPs work as sole practitioners so as many practitioners as possible were invited to participate. Managers of AHP practices were approached to either participate themselves or to nominate a senior practitioner within the practice. Finding the names, addresses and contact phone numbers for private AH practitioners proved difficult at times and in some cases, different websites had conflicting contact information about the practitioners. Given the high proportion of sole practitioners within this sector the contact details of practitioners and indeed, the number of practitioners, can more easily change than a GP Practice. Consequently, the information provided in Table 12 presents a 'best estimation' of the number and location of the private AH practitioners operating in the SW.

NGOs

As with the search for private AHPs, the search to find NGOs to approach to participate was time consuming. Given the (often) time-limited duration of funding for services or specific programs the services can cease to exist, merge with other providers and/or can change over time. The contact details for the NGOs also were at times difficult to confirm as different websites had differing information. Because of this, the information provided in Table 13 presents a 'best estimation' of the number and location of NGOs operating in the SW. The sampling method for this sector was to invite the senior manager of the NGOs to either participate themselves or to nominate a senior practitioner within the agency. As many NGOs operate multiple sites and/or on an outreach basis it was decided that only one senior person from the agency would be asked to participate to discuss whole-of-organisation practices and procedures; staff from each site/outreach location were not approached to participate.

Table 14 summarises the sampling framework for each of these sectors.

Table 14

Sampling framework used in the practitioner survey for three SW service sectors

WACHS		GPs and AHPS	NGOs
Hospital services		GPs	Counsellors
Bunbury Regional Hospital	Doctors	Psychologists	Service managers
Emergency	Nurses	Social Workers	Program
Allied Health	Psychologists	OTs	coordinators
Psychiatric Unit	Social Workers		Client advocates
SW District hospitals	OTs		
Community services			
SW Primary Health Service	Doctors		
SW Mental Health Service	Nurses		
Busselton Community Health Centre	Psychologists		
Yarloop Community Health Centre	Social Workers		
Warren-Blackwood Primary Health Care	OTs		
Warren-Blackwood Child Health			
SW Aged Care Assessment Team			

Information collection strategies

WACHS

Survey packs, which included a letter to participants, an information sheet about the research project, a consent form and the survey, were provided to relevant WACHS Executive staff (covering District Hospitals, the Bunbury Regional Hospital, Community Health Services and Mental Health Service) in August 2010. The Executive staff then gave the packs to relevant line managers, who were responsible for their distribution to individual staff members. The distribution of packs aimed to ensure the opinions of a wide range of personnel was included. Packs were distributed to 44 WACHS staff (13 doctors, 25 nurses and 6 allied health practitioners) working in the four areas detailed above. Participants were asked to return their completed surveys and consent forms to ECU within a two week period. Follow-up of WACHS staff regarding participation in the research was made internally by WACHS management. The response rate for WACHS staff was 65.9% (29/44 returned).

Private-sector GPs

Survey packs were sent to the practice manager of each SW GP practice identified during the services mapping process. A letter to the practice managers sought the participation of at least one GP at the practice with knowledge of the treatment/ support provided to patients who may be at risk of suicide. Forty-three packs were posted in February 2010. Participants were asked to return their completed surveys

and consent forms to ECU within a two week period. Follow-up phone calls were made to each of the non-responsive Practices one week after this deadline. At this point, the response rate for GPs in the SW was 11.4% (5/43 returned). During the follow-up phone calls it became apparent that some GPs were finding it difficult to find the time to participate in the interview component of the research. In light of this, a decision was made to send GPs a second self-completion questionnaire in March 2010 which incorporated questions from the initial survey and some of the interview questions. This meant that interviews were no longer required for GPs. A letter from the Val Lishman Health Research Foundation was also posted to the Practice Managers at this time urging SW GPs to participate in the research. Participants were asked to return their completed surveys and consent forms within a two week period. A further two follow-up phone calls were made to the non-responders until May 2010. A further 8 surveys were received (from GPs from 6 different Practices) over this period making the response rate for GPs 25.6% (11/43 returned). It has been estimated that there are around 138 GPs working in the South West; when looking at the response rate in terms of the number of GPs who participated out of the total GP population, the response rate is extremely low with only around 9% (13/138) of SW GPs participating. The reasons provided by practice managers/ receptionists at the GP practices who did not participate included they were not interested in participating, they were unable to participate as the doctors were too busy, or the research was not relevant to the work of their Practice (i.e. the Practice has a particular client focus and they were unlikely to come across suicide issues within their patient group).

Private-sector AHPs

Survey packs were sent to AHP sole practitioners or the practice manager of AHP practices in the SW identified through the service mapping process. The letter sought the participation of managers/ senior practitioners with knowledge of the treatment/ support provided to clients who may be at risk of suicide. Fifty packs were posted to AHP sole practitioners/ practices in February 2010. Participants were asked to return their completed surveys and consent forms within a two week period. Follow-up phone calls were made to each practitioner/ practice who had not returned their surveys one week after this deadline. A further two follow-up phone calls were made to the non-responders over subsequent weeks until May 2010. The response rate for AHPs was 40% (20/50 returned). Feedback regarding non-participation included being too busy/ not having enough time to participate, not wishing to participate, not coming across the issue of suicide in their work, or recently finishing a research project and not wishing to participate in more research.

NGOs

Survey packs were sent to the manager of SW NGOs identified as part of the mapping of existing services. The letter to managers asked for the participation of managers/ senior practitioners with knowledge of services their agency provides to clients who may be at risk of suicide. Thirty-nine packs were posted in December 2009. Participants were asked to return their completed surveys and consent forms within a

two week period. Follow-up phone calls were made to each organisation that had not returned their surveys one week after this deadline. A further two follow-up phone calls were made to the non-responders until February 2010. The response rate for SW NGOs was 59% (23/39 returned). Feedback from those who chose not to participate in the research included comments that the research was not relevant to their work, or they did not wish to participate.

Table 15 presents the response rate for providers in each of the three service sectors. As shown in this table the response rates varied from 25.6% for GPs to 65.9% for WACHS staff.

Table 15

Survey response rates for service providers in the SW deemed to have a role in suicide prevention

Providers	Number surveyed	Number responded	Survey response rate %
WACHS	44	29	65.9
hospital based			
doctors	11	6	54.5
nurses	20	13	65.0
allied health staff	2	0	0
community based			
doctors	2	2	100
nurses	5	5	100
allied health staff	4	3	75.0
General practices	43	11	25.6
AHPs	50	20	40
NGOs	39	23	59

Key stakeholder consultations

Face-to-face consultations were conducted with practitioners who participated in the mail-out survey. Table 16 shows the response rate for these consultations. As shown in this table the response rates varied from 72.4% for WACHS staff to 78.3% for NGOs.

Table 16

Response rates for consultations with SW service providers deemed to have a role in suicide prevention

Providers	Number who participated in the mail-out survey	Number who participated in face-to-face interviews	Face-to-face consultations response rate %
WACHS	29	21	72.4
hospital based			
doctors	6	3	50.0
nurses	13	9	69.2
allied health staff	0	0	-
community based			
doctors	2	1	50.0
nurses	5	5	100
allied health staff	3	3	100
General practices	NA	NA	NA
AHPs	20	15	75.0
NGOs	23	18	78.3

WACHS

Service provision

WACHS play an important role in minimising the risk of suicide. We applied the following criteria from Action Area 5 of the LIFE framework (outcome 5.1 - improved access to a range of support and care for people feeling suicidal) to examine the appropriateness of WACHS in the SW viz:

- an appropriate mix of services (treatment/ support) is provided to individuals (i) showing early signs/ tipping points, (ii) at ongoing and imminent risk of suicide, and (iii) who have attempted suicide and are in the recovery stage.
- an appropriate mix of mental health practitioners are employed to provide treatment/ support.
- services are accessible in terms of location, wait times for appointments/ priority and out-of-hours service arrangements for individuals at risk of suicide, and
- barriers to services for males are addressed.

A stratified (by hospital vs community, and by occupation – doctors, nurses, AHP) random sample of staff who work with patients with mental health problems was

selected. Of the hospital-based doctors and nurses who agreed to take part, 19 returned their survey and 12 were able to be contacted for a follow-up interview (63.1%). Of the community-based doctors, nurses and AHPs who agreed to take part, 10 returned their survey and nine were able to be contacted for a follow-up interview (90%). Of the total of 21 interviewees, 19 (90.5%) indicated their role was to treat/ support patients showing early signs of suicide/ at potential tipping points; of these 94.7% had done so in the past 12 months. Of the 17 of 21 interviewees (81%) who indicated their role was to treat/ support patients at the first point of contact after a suicide attempt, 88.2% indicated they had done so in the past 12 months. Of the seven of 21 interviewees (33.3%) who indicated their role was to treat/ support patients requiring longer-term support for their recovery after a suicide attempt, 85.7% indicated they had done so in the past 12 months. Caution is required in generalising the findings to WACHS given the sample size, particularly differences that may or may not exist between hospital-based and community-based services.

Services mix

Hospital-based (HB) and community-based (CB) staff were surveyed about the services they provide to individuals at risk of suicide. As shown in Table 17, 89.5% of HB staff indicated their role was to treat/ support patients showing early signs of suicide/ at potential tipping points, 100% indicated their role was to treat/ support patients after a suicide attempt, 25% indicated their role was to treat/ support patients requiring longer-term support for their recovery after a suicide attempt, and 50% indicated their role was to provide support/ information to carers/ families of people at risk of suicide. By way of comparison, all CB staff indicated their role was to treat/ support patients showing early signs of suicide/ at potential tipping points, 44.4% indicated their role was to treat/ support patients after a suicide attempt, 90% indicated their role was to treat/ support patients requiring longer-term support for their recovery after a suicide attempt, and 89.9% indicated their role was to provide support/ information to carers/ families of people at risk of suicide.

Table 17

Services provided by WACHS to individuals at risk of suicide

Suicide prevention service	**% HB**	**% CB**
Being alert to the early signs of the risk of suicide/ potential tipping points and taking action	89.5	100
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/support	100	44.4
Being a provider of longer-term treatment/ support for people who have received acute treatment/ support for a suicide attempt and are in the recovery stage	25.0	90.0

Being a provider of support/ information to carers/ families of people at risk of suicide to build resilience and create an environment that supports help-seeking	50.0	89.9

Accessibility of services

Table 18 presents information about the usual wait time for a consult with a mental health professional for patients at imminent risk of suicide/ made a suicide attempt at WACHS hospitals. As shown the majority are seen within two hours (62.6%).

Table 18

Usual wait time for a mental health consult for patients at risk of suicide at WACHS hospitals

Service attribute	Immediate	Within 1 hour	1-2 hours -4	Hours	> 4 hours
Usual wait time for a consult	6.3	12.5	43.8	6.3	31.3

Table 19 presents information about the usual wait time for a consult with a mental health professional for patients at imminent risk of suicide/ made a suicide attempt at a WACHS community-based service. As shown around 33% are seen the same day or within 24 hours (44.4%).

Table 19

Usual wait time for a mental health consult for patients at risk of suicide at community-based service

Service attribute	Immediate	Same day	Within 24 hrs	Within 1 wk	More than 1 wk
Usual wait time for a consult	0	33.3	44.4	11.1	11.1

Identified concerns about the usual wait time for a consult with a mental health professional were:

- mental health staff are not always on site at district hospitals
- wait time after hours is longer as mental health liaison staff are available 8am-11pm only
- patients under 18 years of age have extended waits – limited CAMHS services and general psychiatry refuse to assess anyone under 18, and
- usual wait times can be variable - sometimes up to 1 hr, other times 12 hours or more depending on the time of day, staff availability and patients overall condition (patient needs to be stabilized; drug/ alcohol out of system).

Community-based staff were asked whether patients at risk of suicide can access their service out-of-hours/ weekend. Only one of the staff surveyed (10%) indicated this was the case.

Treatment and support

Table 20 presents information about the types of treatment and support provided to people at risk of suicide by hospital-based and community-based services.[5]

All hospital-based staff indicated they provided information about available services/ advice about mental health/ referrals to other mental health professionals to patients showing early signs, as well as at the first point of contact after a suicide attempt. Needs assessment/ case management is provided by 60% of these staff to patients showing early signs/ tipping points compared to 16.7% at the first point of contact after a suicide attempt. Less than half provide mental/ behavioural/ psychological assessment after a suicide attempt to patients showing early signs (20%), as well as at the first point of contact after a suicide attempt (41.7%). Counselling/ therapy is infrequently provided to patients showing early signs (0%), as well as at the first point of contact after a suicide attempt (8.3%). None of the staff interviewed indicated they prescribed medication to these patients. Further, none of the hospital based staff indicated they provided longer-term treatment/ support to patients in the recovery stage after a suicide attempt.

By way of comparison, all community-based staff indicated they provided information about available services/ advice about mental health/ referrals to other mental health professionals to patients showing early signs, as well as at the first point of contact after a suicide attempt. Around 83% provided these services to patients needing longer-term support after a suicide attempt. Needs assessment/ case management is provided by 88.9% of these staff to patients showing early signs/ tipping points compared to 60% and 66.7% at the first point of contact after a suicide attempt and to patients needing longer-term support respectively. Similarly, mental/ behavioural/ psychological assessment is provided by 66.7% of these staff to patients showing early signs/ tipping points compared to 40% and 33.3% at the first point of contact after a suicide attempt and to patients needing longer-term support respectively and 44.4%, 60% and 66.7% respectively for counselling/ therapy services. Few of the staff interviewed indicated they prescribed medication to patients: 11.1% and 20% respectively to patients showing early signs and those requiring longer-term support.

[5] Excludes cases where the staff member does not provide treatment/ support to patients showing early signs, those who attempt suicide or those needing longer-term support after a suicide attempt. For example emergency room nurses were not asked questions about longer term treatment/ support for patients recovering after a suicide attempt.

Table 20

Types of treatment and support provided to people at risk of suicide by WACHS

	Hospital-based services			Community-based services		
Type of treatment	% early signs/ tipping points	% first point of contact after attempt	% recovery after suicide attempt	% early signs/ tipping points	% first point of contact after attempt	% recovery after suicide attempt
General service availability information, advice, referral	100	100	-	100	100	83.3
Needs assessment and case management	60.0	16.7	-	88.9	60.0	66.7
Mental, behavioural or psychological assessment	20.0	41.7	-	66.7	40.0	33.3
Psychosocial counselling/ psychological therapies	0	8.3	-	44.4	60.0	66.7
Prescribe medication	0	0	-	11.1	20.0	0

Hospital-based staff were asked to describe their current practices in relation to patients who may be at risk of suicide/ have attempted suicide. Current practices include calling the police if restraint is necessary (where there is a local police station), organising ambulance transport to the regional hospital if admitted to a district hospital, keeping patients in the ED if they have been drinking as hospital wards won't accept them until they are below the legal limit, sending patients to Perth if they require intubation, sedating patients where necessary, performing a psychosocial risk assessment, admitting patients to the psychiatric extended care unit, referral to the mental health liaison team after sorting out initial injuries/ overdose (which enables access to outpatient mental health services) and referral to the patient's GP. Children are referred to CAMHS; however as there is no after-hours CAMHS service they sometimes need to be admitted to the Bunbury Regional Hospital or PMH in Perth. A risk alert (for self-harm) is recorded on file for all patients and staff are alerted to the potential for aggression based on previous admissions/ records. A psychiatric nurse is available at Bunbury Regional Hospital until 11pm each day.

Community-based staff were also asked to describe their current practices in relation to patients who may be at risk of suicide/ have attempted suicide. Current practices include referral to GPs/ hospital/ mental health service where appropriate, increased contact with patient (e.g., telephone calls, additional appointments), more involvement of carers/ advising the school when dealing with children/ adolescents (e.g., how to support them), carrying out risk assessments (e.g., HEADSS), the setting up of a contract not to self-harm including contingency plans for the family, strengthening community agency support for the patient and providing case management. There is a

strong preference not to admit children to hospital as they are likely to be sent to Perth (PMH).

A range of views emerged regarding duty of care for someone at risk of suicide. The views of hospital-based staff included:

- we have to keep patients safe from themselves and keep other patients and members of staff safe as we have a duty of care to everyone
- we will usually involve significant others with/ without the patient's consent if the circumstances require it – most patients don't seem to care one way or the other
- we will involve the patients' GP and family straight away if admitted
- we will involve social work if the patient refuses to involve significant others
- we consider issues such as competence to make informed decisions, for example when substance abuse is a factor
- there is a legal requirement under the mental health act to detain patients for their own protection
- in some cases it is very difficult to know how much information is appropriate to divulge to family members
- we're not equipped/ staffed/ trained at district hospitals to negotiate such issues with patients so they are referred to Bunbury as soon as this is possible
- our duty of care is to protect life
- if the patient is < 16 we can't treat without a guardian present; if > 16 we need the patient's permission, and
- if the patient is conscious, we respect their request for privacy; if the patient is unconscious, information is provide to parents/ carers.

The views of community-based staff regarding duty-of-care issues included:

- we have a duty of care to everyone (staff, patient etc) and will not accept the referral if acute treatment is required
- we make a judgment call based on age/ maturity/ past attempts of person, if risk is not imminent then would respect the patient's wishes regarding confidentiality
- confidentiality will be broken if there is a moderate to high risk of suicide and we will inform the patient's family to facilitate appropriate protective factors
- we require patients to sign a confidentiality agreement permitting sharing of information within the agency
- if the risk deemed sufficiently high, then patients refusal to involved significant others is over-ridden
- we will involve the family, other professionals, the DCP and/or the mental health team immediately if children/ adolescents attempt suicide, and
- we have a duty of care to the many, for example, if there is a likelihood of violence to others.

Understanding of suicide prevention

Service providers should have an adequate understanding of suicide prevention. We applied criteria from Action Area 5 of the LIFE framework (outcome 5.4 – improved understanding, skills and capacity of front-line workers) to examine the extent to which SW State government providers:

- have adequate knowledge of known suicide risk factors
- have adequate knowledge of (i) the early signs/ tipping points for suicide, and (ii) the clinical indicators of ongoing and imminent risk for people who have attempted suicide, and
- access up-to-date professional development regarding suicide prevention.

Knowledge of suicide risk factors

Table 21 presents the suicide risk factors hospital-based (HB) and community-based (CB) staff perceived as relevant to their patients. As shown the individual risk factors identified by 50% or more of HB or CB staff were alcohol or other substance abuse (75% HB and 77.8% CB) and age (58.3% HB); situational risk factors identified by more than 50% of HB or CB staff were family discord, violence or abuse (58.3% HB and 77.8% CB) and social or geographical isolation (50% HB and 66.7% CB). Two known individual risk factors were not mentioned viz., prior suicide attempt (HB) and low self esteem (HB); one situational risk factor was not mentioned viz., imprisonment (HB and CB).

Table 21

Percent of WACHS staff who identified known risk factors for suicide

Risk factors	% HB	% CB
Individual		
Male gender	41.7	22.2
Age	58.3	33.3
Mental health problems/disorders	25.0	55.6
Prior suicide attempt	0	11.1
Alcohol or other substance abuse	75.0	77.8
Chronic pain or illness	8.3	22.2
Low self-esteem	0	44.4
Little sense of control over life circumstances	8.3	22.2
Lack of meaning and purpose in life	8.3	11.1
Poor coping skills	25.0	11.1
Hopelessness	0	33.3
Access to lethal means	16.7	22.2
Situational		
Family discord, violence or abuse	58.3	77.8
Separation/ loss/relationship breakdown	33.3	33.3
Family history of suicide or mental illness	8.3	11.1
Social or geographical isolation	50.0	66.7
Imprisonment	0	0
Financial stress	33.3	22.2
Poverty	16.7	44.4
Unemployment or economic uncertainty	16.7	44.4
Homelessness	16.7	44.4
Social or cultural discrimination	8.3	11.1
Exposure to environmental stressors	8.3	33.3
Lack of support services	41.7	22.2

Knowledge of the early signs/ tipping points for suicide

Table 22 presents the percent of HB and CB staff who identified known early signs/ tipping points for suicide. As shown six of the known early signs were identified by 50% or more of those interviewed viz., suicidal ideation (50% HB and 66.7% CB), substance abuse (55.6% CB), anxiety/ agitation (60% HB), hopelessness (66.7% CB), withdrawal (50% HB and 55.6% CB) and mood fluctuations (80% HB and 88.9% CB); only two of the known tipping points were identified by more than 50% of those interviewed viz., relationship ending (60% HB and 66.7% CB) and the death or suicide of a relative/ friend (66.7% CB). One known early sign was not mentioned viz., feeling trapped (CB), and four known tipping points were not mentioned viz., a debilitating physical illness or accident (CB), the suicide of someone famous or member of a peer group (HB), a serious argument at home (HB) and a media report on suicide/ suicide methods (HB and CB).

Table 22

Percent of WACHS staff who identified known early signs/ tipping points for suicide

Early signs/ tipping points for suicide	% HB	% CB
Early signs		
Suicidal ideation	50.0	66.7
Substance abuse	40.0	55.6
Purposelessness	10.0	33.3
Anxiety and agitation	60.0	44.4
Feeling trapped	10.0	0
Hopelessness	40.0	66.7
Withdrawal	50.0	55.6
Anger	20.0	11.1
Recklessness	10.0	22.2
Mood fluctuations	80.0	88.9
Tipping points		
Relationship ending	60.0	66.7
Loss of status or respect	10.0	55.6
Debilitating physical illness or accident	30.0	0
Death or suicide of relative/ friend	30.0	66.7
Suicide of someone famous or member of peer group	0	22.2
	0	11.1
Serious argument at home	30.0	33.3
Being abused or bullied	0	0
Media report on suicide or suicide methods		

Knowledge of the clinical indicators of ongoing and imminent risk for people who have attempted suicide

Table 23 presents the percent of HB and CB staff who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide and are in the recovery stage.[6] As shown five of the known indicators were identified by 50% or more of those interviewed viz., frequent thoughts of suicide (50% HB and 66.7% CB), access to suicide means (58.3% HB), a significant change in circumstances or loss (CB), depressive symptoms/ hopelessness/ helplessness (83.3% HB and 100% CB) and substance abuse (50% HB and 66.7% CB). Indicators that were not mentioned were whether a person has a detailed suicide plan (CB), the lethality of an intended method of suicide (CB), an interest in the likelihood of being found/rescued (HB and CB) and chronic, painful medical conditions/ perceived medical problem (CB).

[6] These data apply to HB staff who indicated they provided services to people who had made an attempt and were being provided acute care and CB who indicated they provide services to people who had made an attempt and were in the recovery stage being provided longer term support.

Table 23

Percent of SW government providers who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide

Clinical indicators of ongoing and imminent risk	% HB	% CB
Frequent thoughts of suicide	50.0	66.7
Detailed suicide plan	25.0	0
Lethality of intended suicide method	16.7	0
Access to suicide means	58.3	33.3
An interest in the likelihood of being found/rescued	0	0
Recency/ frequency/ severity of recent attempts	25.0	16.7
Significant change in circumstances or loss	25.0	50.0
Significant change in daily routine	16.7	33.3
Chronic, painful medical problems or perceived medical problem	8.3	0
Depressive symptoms/ hopelessness/ helplessness	83.3	100
Psychiatric disorder – depression, psychotic disorder, eating	41.7	33.3
disorder, panic	50.0	66.7
Substance abuse	41.7	16.7
Alienation or lack of support networks		

Knowledge of barriers to services for males

WACHS staff were also asked about services to males at risk of suicide, specifically what they regarded as the main barriers males face in accessing treatment/ support. As shown in Table 24 the most frequently mentioned barriers by HB staff were that males are reluctant to talk about their problems (preferring to deal with them alone) (75%), the use of destructive coping mechanisms (66.7%), and the male stereotype of being tough and strong (66.7%). The most frequently mentioned barriers by CB staff were that males are reluctant to talk about their problems (preferring to deal with them alone) (77.8%), the male stereotype of being tough and strong (77.8%) and the perceived stigma of mental illness (55.6%). Barriers less frequently mentioned by HB staff were that generally males don't know what help is available (8.3%), cost of services (0%), lack of understanding regarding treatments (0%) and long wait lists (0%). Barriers less frequently mentioned by CB staff lack of social network support (11.1%), cost of services (11.1%) and males without partners are header to reach (0%).

Table 24

Perceived barriers males at risk of suicide face in accessing treatment/ support identified by WACHS staff

Barriers that males face	% HB	% CB
Not talking about problems/deal with them alone	75.0	77.8
Talking won't help fix the problem	25.0	22.2
Lack of social network support	33.3	11.1
Males without partners harder to reach	16.7	0
Lack of time	25.0	44.4
Not recognising symptoms of distress, only physical symptoms	25.0	22.2
Cost of services	0	11.1
Perceived stigma of mental illness	33.3	55.6
Lack of understanding regarding treatments	0	33.3
Use of destructive coping mechanisms to deal with problems	66.7	44.4
Don't know what help is available	8.3	22.2
Traditional views of masculinity, of being tough and strong	66.7	77.8
Long waiting lists	0	33.3

WACHS staff were asked how the barriers had been addressed at their service. As shown in Table 25 apart from clear referral pathways (25%) and ensuring staff diversity (e.g., employing male and female staff and/or a cultural mix) (25%), few of the other known strategies for addressing barriers that males at risk of suicide face are currently being employed by WACHS hospital based services. As also shown apart from ensuring staff diversity (e.g., employing male and female staff and/or a cultural mix) (33.3%), promotion of healthy lifestyles/ coping mechanisms (22.2%), understanding emotional/ economic/ social factors increasing suicide risk (22.2%), provision of educational materials on mental health issues (22.2%), few of the other known strategies for addressing barriers that males at risk of suicide face are currently being employed by WACHS community-based services.

Table 25

Strategies WACHS providers have used to address barriers that males at risk of suicide face when accessing treatment/ support

Strategies used to address barriers	% HB	% CB
Promotion of healthy lifestyles/ coping mechanisms	16.7	22.2
Build and strengthen the support networks of male clients	16.7	0
Understand the emotional/economic/social factors increasing suicide risk	0	22.2
Use physical symptoms to ask questions about what else may be going on	16.7	0
Gather enough information to be aware of what's really going on	8.3	0
Completed appropriate training courses	0	0
The service/ practice is male-friendly	16.7	0
Service is well publicised	8.3	0
Practical and solution focused service to develop life skills	0	11.1
Educational materials on mental health issues provided	0	22.2
Clear referral pathways	25	0
Male and female staff and/or a cultural mix	25	33.3
Specialist support services for at-risk groups	16.7	0
Service aimed at times of high need	8.3	0
Free service/ bulk bill/ publicise Medicare rebates	8.3	0
High quality and well-trained staff	8.3	0
Continuity of care	8.3	0
Information sharing protocols developed	0	0
The service/ program is for males only	8.3	0
Hours of operation	16.7	0

Specific barriers for males that HB providers have found difficult to address include educating nurses about the suicide risks for men, providing access to services for isolated men, referral pathways and knowledge of available services, and difficulties faced by female staff in working Aboriginal males (cultural issues). Specific barriers for males that CB providers have found difficult to address include not enough staff, a lack of understanding by other agencies regarding what WACHS can/ can't provide, information sharing between agencies, the need to educate males that it's OK to have mental health issues and that help is available, provision of an out-of-hours service, and difficulties in accessing families for counselling.

Professional development regarding suicide prevention

WACHS staff were asked about the professional development regarding suicide prevention they had undertaken in the past 3 years. Around 85% of HB staff indicated they had not undertaken this type of PD within the past 3 years. Suggestions for future PD were included:

- assessment of risk during first 24 hr critical period
- triaging suicidal patients
- how to deal with acute phase of suicidal ideation
- legal training in detaining psychiatric cases
- options regarding available support/ treatment
- drug/ alcohol education
- self harm assessment/ education
- acute psychosis treatment and care – clinical pathways, and
- evidence-based treatment options.

By way of comparison, around 50% of CB staff had undertaken this type of PD in the past three years including Gatekeeper workshops, Map of Loss workshops and workshops on suicide risk management. Suggestions for future PD were included:

- options regarding available support/ treatment
- suicide risk assessment
- building inter-agency collaboration
- refresher courses along lines of Gatekeeper workshops
- writing postvention community plans, and
- the link between psychopharmocology and increased risk of suicidality.

Coordination of services

The coordination of WACHS services with other services is important to minimise the risk of suicide. We applied criteria from Action Area 4 (outcome 4.1 – linking local services effectively so that people experience a seamless service) of the LIFE framework to examine the extent to which WACHS hospital-based and community-based services:

- accept appropriate responsibility for the early detection of suicidal behaviour, treatment of individuals who have attempted suicide, and/or follow-up support for those who have attempted suicide and are in the recovery stage
- collaborate effectively with other providers involved in suicide prevention/ treatment, and
- have timely access to mental health providers with the training and experience to work with individuals at-risk of suicide.

Responsibility for suicide prevention services

Table 26 presents the percent of hospital-based staff who considered they have a responsibility for suicide prevention services to individuals along with the percent who currently provide these services. As shown, all staff reported they felt a responsibility to be alert to the early signs of the risk of suicide as well as the signs of high risk and tipping points, and taking action, as well as being a first point of contact and treatment/ support for people who have attempted suicide. Seventy-five percent also felt they had a responsibility as a provider of support/ information to carers/ families of people with evidence of suicidal behaviour; 16.7% considered they had responsibility for ongoing care for people in the recovery stage. The sense of responsibility for these services is generally reflected in the services currently provided by HB staff. Around 33% felt that reducing suicide through community education was their responsibility and around 45% considered working with at-risk groups/ communities to build resilience/ promote help seeking was their responsibility.

Table 26

Percent of hospital-based staff who considered they had a responsibility for, and who provide, particular suicide prevention services

Suicide prevention services	% responsible for services	% provide services
Being alert to the early signs of the risk of suicide/ tipping points and taking action	100	89.5
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/ support	100	100
Being a provider of ongoing care for people who have had treatment/ support for a suicide attempt and are in the recovery stage	16.7	25.0
Being a provider of support/ information to carers/ families of people with evidence of suicidal behaviour to build resilience and create an environment that supports help-seeking	75.0	50.0

Table 27 presents the percent of community-based staff who considered they have a responsibility for suicide prevention services to individuals along with the percent who currently provide these services. As shown, all staff reported they felt a responsibility to be alert to the early signs of the risk of suicide as well as the signs of high risk and tipping points, and taking action, as well as being a provider of ongoing care for people who had attempted suicide and were in the recovery stage. Around 73% felt they had a responsibility as a first point of contact and treatment/ support for people who have attempted suicide, along with 78% who felt they had a responsibility as a provider of support/ information to carers/ families of people with evidence of suicidal behaviour. The sense of responsibility for these services is generally reflected in the services currently provided by CB staff with the exception of being the first point of contact and treatment/ support for people who have attempted suicide. Around 44% felt that reducing suicide through community education was their responsibility and around 78% considered working with at-risk groups/ communities to build resilience/ promote help seeking was their responsibility.

Table 27

Percent of community-based staff who considered they had a responsibility for, and who provide, particular suicide prevention services

Suicide prevention services	% responsible for services	% provide services
Being alert to the early signs of the risk of suicide/ tipping points and taking action	100	100
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/ support	73.0	44.4
Being a provider of ongoing care for people who have had treatment/ support for a suicide attempt and are in the recovery stage	100	90.0
Being a provider of support/ information to carers/ families of people with evidence of suicidal behaviour to build resilience and create an environment that supports help-seeking	77.8	90.0

Services coordination

Table 28 presents the perceptions of hospital-based staff regarding the effectiveness of services coordination in the SW for people at risk of suicide based on items from the Nuffield Partnership Assessment Tool (Halliday, Asthana & Richardson, 2004). As shown less than half agreed:

- there is interest in working collaboratively to address suicidal behaviour in the SW (36.8%)
- there is a clear commitment to working collaboratively (22.2%)
- there had been substantial past achievements when agencies had collaborated (16.7%)
- there is sufficient trust to survive any mistrust that might arise from collaboration (31.6%)
- that areas of shared responsibility are clear and understood by all concerned (16.7%), and
- there are clear arrangements to monitor and review the success of working collaboratively (0%).

Around 68% agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

Table 28

Perceptions of hospital-based staff regarding the effectiveness of services coordination in the SW for people at risk of suicide

Services coordination	% SD	% D	% Neutral	% A	% SA
Interest in working collaboratively among agencies/practitioners involved in addressing suicidal behaviour in the South West is generally high	5.3	26.3	31.6	36.8	0
There is a clear commitment to working collaboratively from the most senior levels of these agencies/ independent practices	0	33.3	44.4	22.2	0
There have been substantial past achievements when agencies/ practitioners involved in addressing suicidal behaviour in the South West have collaborated	0	16.7	66.7	16.7	0
There is sufficient trust among agencies/ practitioners involved in addressing suicidal behaviour in the South West to survive any mistrust that might arise from collaboration	5.3	26.3	36.8	31.6	0
The areas of responsibility of agencies/ independent practitioners involved in addressing suicidal behaviour in the South West are clear and understood by all concerned	15.8	52.6	21.1	10.5	0
Co-location of agencies/ practitioners involved in addressing suicidal behaviour in the South West is an important facilitator of working collaboratively	0	15.8	15.8	52.6	15.8
There are clear arrangements to monitor and review how agencies/ practitioners involved in addressing suicidal behaviour in the South West work collaboratively	22.2	33.3	44.4	0	0

HB staff were asked how they would rate their collaboration with external agencies/ practitioners they needed to work with in relation to suicidal clients. None rated collaboration as ‘extremely effective’ or ‘very effective’, whereas 85.7% rated collaboration as ‘somewhat effective’ or ‘minimally effective’. 14.3% rated their collaboration as ‘not at all effective’.

The main barriers to effective inter-agency coordination were described as:

- limited availability of services outside Bunbury
- access to services only during office hours
- lack of adequate inter-agency referral protocols
- a lack of follow up after referral
- difficulties in accessing to CAMHS – there is no out-of-hours service
- lack of beds at Bentley and PMH
- a lack of case conferences
- not enough mental health professionals to provide a rapid response
- a lack of psychiatrists
- professional silos, and
- a lack of community agencies willing to provide treatment after recovery.

Suggestions for addressing these barriers included:

- cooperation from all sides
- better access to the WACHS mental health team
- increase child and adolescent mental health services
- proper on-call psychiatric services for all ages
- increase in mental health liaison staff
- acute services within the community not just counselling and support groups
- MOU with all service providers
- relevant people/ practitioners making themselves known to hospital staff, and
- facilitation of case conferences.

Interviewees were also asked about issues that needed to be addressed to improve the coordination of services for individuals.

Around 70% of hospital-based staff who indicated they provided support to patients showing early signs/ tipping points, indicated they were kept well-informed by other wards/ units compared to 50% who were the first point of contact after a suicide attempt. Suggestions for improvement included the need for a more supportive relationship between ED and social work, ED should be informed by other wards/ units of discharge/ treatment, and 24 hour access to mental health professionals.

Table 29 presents the perceptions of community-based staff regarding the effectiveness of services coordination in the SW for people at risk of suicide. More than half agreed there is a clear commitment to working collaboratively (60%) and there had been substantial past achievements when agencies had collaborated (70%). Less than half agreed:

- there is interest in working collaboratively to address suicidal behaviour (44.4%)
- there is sufficient trust to survive any mistrust that might arise from collaboration (20%)

- that areas of shared responsibility are clear and understood by all concerned (10%), and
- there are clear arrangements to monitor and review the success of working collaboratively (0%).

Around 40% agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

Table 29

Perceptions of community-based staff regarding the effectiveness of services coordination in the SW for people at risk of suicide

Services coordination	% SD	% D	% Neutral	% A	% SA
Interest in working collaboratively among agencies/practitioners involved in addressing suicidal behaviour in the South West is generally high	11.1	0	44.4	33.3	11.1
There is a clear commitment to working collaboratively from the most senior levels of these agencies/ independent practices	10	0	30	60	0
There have been substantial past achievements when agencies/ practitioners involved in addressing suicidal behaviour in the South West have collaborated	0	0	30	70	0
There is sufficient trust among agencies/ practitioners involved in addressing suicidal behaviour in the South West to survive any mistrust that might arise from collaboration	10	10	60	20	0
The areas of responsibility of agencies/ independent practitioners involved in addressing suicidal behaviour in the South West are clear and understood by all concerned	10	50	30	10	0
Co-location of agencies/ practitioners involved in addressing suicidal behaviour in the South West is an important facilitator of working collaboratively	0	10	50	30	10
There are clear arrangements to monitor and review how agencies/ practitioners involved in addressing suicidal behaviour in the South West work collaboratively	0	55.6	44.4	0	0

CB staff were asked how they would rate their collaboration with external agencies/ practitioners they needed to work with in relation to suicidal clients. Twenty-five percent rated collaboration as 'very effective' whereas 75% rated collaboration as 'somewhat effective' or 'minimally effective'. None rated their collaboration as 'not at all effective'.

The main barriers to effective inter-agency coordination were described as:

- a lack of MOUs and clear referral processes
- a lack of clear understanding of roles/ responsibilities of each agency
- a lack of mental health staff
- a lack of communication between different agencies e.g., information needs to be given to school nurses about students who attempt suicide
- a lack of understanding about suicide
- consent forms to release information are not always completed
- inappropriate use of 'suicidal' by referrer in the hope that the patient will receive quicker response
- too much emphasis on managers when addressing inter-agency issues – practitioners feel disconnected
- a lack of understanding that suicide prevention is the responsibility of all not just mental health services
- a loss of autonomy to work across agencies locally now that managed from Bunbury
- transport issues to access services by other agencies
- everyone works defensively trying to protect their territory
- multiple medical records – clients poor historians of their medical history
- lack of trust between some workers in different agencies, and
- poor case management.

Suggestions for addressing these barriers included:

- clearer processes
- better training
- more coal face workers
- easier access to GPs and mental health services in shorter time
- improved communication between agencies
- community education regarding suicide
- improved inter-agency discussion amongst practitioners not just managers
- improved information sharing including the management of privacy
- better collaboration between acute and community practitioners
- a concerted effort to work collaboratively, and
- the use of electronic medical records.

Around 33.3% of community-based staff who indicated they provided support to patients showing early signs/ tipping points, indicated they were kept well-informed by other agencies compared to 50% who provided longer term support after a suicide attempt. Suggestions for improvement included sharing of medical information with consent, improved compatibility between and access to medical databases, better case conferencing systems, improved feedback from GP/ hospital/ school/ parents, more resources so that practitioners can spend time building cross-agency networks and protocols, consistent assessment across agencies and better collaborative case management.

Timely access to external mental health providers

Timely access to external mental health providers with appropriate training and experience is an important feature of effective coordination of services for individual clients/ patients at risk of suicide. Around 90% of community-based staff considered they had timely access to providers with appropriate training and experience.[7]

Table 30 presents the percent of community-based staff who considered they had timely access to different types of external mental health professionals with the training and experience to work with people at risk of suicide. As shown more than half reported they have timely access to GPs (88.9%), psychologists (55.6%) and mental health nurses (55.6%). Less than half reported that have timely access to psychiatrists (44.4%), social workers (44.4%), occupational therapists (22.2%) and counsellors (22.2%).

Table 30

Percent of community-based staff who considered they had timely access to external mental health professionals with the training and experience to work with people at risk of suicide

Mental health professional	% CB
Psychiatrist	44.4
General practitioner	88.9
Psychologist	55.6
Social worker	44.4
Mental health nurse	55.6
Occupational therapist	22.2
Counsellor	22.2

[7] HB staff were not asked this question.

Summary of findings –WACHS

Services for people at risk of suicide

1. The majority of hospital-based staff take action in response to early signs of suicide/being at potential tipping points (90%), and all are the first point of contact for people who attempt suicide. Fifty percent provide support to carers/ families of people at risk of suicide and 25% support patients in the recovery stage. Around 33% felt that reducing suicide through community education was their responsibility. Around 45% considered working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility.

2. For patients showing early signs of suicide risk/ tipping points, all hospital-based staff reported they provide information about available services and make referrals to mental health professionals. Around 60% undertake needs assessment/ case management whilst around 20% undertake mental/ behavioural/ psychological assessment. For patients at the first point of contact after a suicide attempt again all hospital-based staff reported they provide information about available services and make referrals to mental health professionals. Around 40% undertake mental/ behavioural/ psychological assessment.

3. For hospital-based services, around 63% of patients are seen within two hours by a mental health professional. Wait times after hours are longer as mental health liaison staff are available from 8am to 11pm only. Children and adolescents may have extended wait times as CAMHS are limited. Mental health staff are not always on site at district hospitals.

4. All community-based staff take action in response to early signs of suicide/being at potential tipping points. Similarly a majority of staff indicated they support patients in the recovery stage (90%) and provide support to carers/ families of people at risk of suicide (90%). Around 44% indicated they were the first point of contact after a suicide attempt. Around 44% felt that reducing suicide through community education was their responsibility. Around 78% considered working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility.

5. For patients showing early signs of suicide risk/ tipping points, all community-based staff reported they provide information about available services and make referrals to mental health professionals. Around 89% undertake needs assessment/ case management whilst around 67% conduct mental/ behavioural/ psychological assessment. Around 44% provide counselling/ psychological therapy. For patients at the first point of contact after a suicide attempt, again all community-based staff reported they provide information about available services and make referrals to mental health professionals. Around 60% undertake needs assessment/ case management and provide counselling/ psychological therapy. Around 40% conduct mental/ behavioural/ psychological assessment. For patients in the recovery stage after a suicide attempt, around 83% provide information about available services

and make referrals to mental health professionals. Around 67% undertake needs assessment/ case management and provide counselling/ psychological therapy. Around 33% conduct mental/ behavioural/ psychological assessment.

6. For community-based services, around 77% of patients are seen within 24 hours by a mental health professional. Community-based services do not typically operate after hours or during weekends.

7. A range of views emerged regarding duty of care for someone at risk of suicide. The views of hospital-based staff included we have to keep patients safe from themselves and keep other patients and members of staff safe as we have a duty of care to everyone, we will usually involve significant others with/ without the patient's consent if the circumstances require it, we will involve the patients' GP and family straight away if admitted, we consider issues such as competence to make informed decisions, for example when substance abuse is a factor, we're not equipped/ staffed/ trained at district hospitals to negotiate such issues with patients, if the patient is < 16 we can't treat without a guardian present; if > 16 we need the patient's permission, and if the patient is conscious, we respect their request for privacy; if the patient is unconscious, information is provide to parents/ carers.

8. The views of community-based staff regarding duty-of-care issues included we have a duty of care to everyone (staff, patient etc) and will not accept the referral if acute treatment is required, we make a judgment call based on age/ maturity/ past attempts of person, if risk is not imminent then would respect the patient's wishes regarding confidentiality, we require patients to sign a confidentiality agreement permitting sharing of information within the agency, if the risk is deemed sufficiently high, then the patients refusal to involved significant others is over-ridden, we will involve the family, other professionals, the DCP and/or the mental health team immediately if children/ adolescents attempt suicide, and we have a duty of care to the many, for example, if there is a likelihood of violence to others.

<u>Knowledge of suicide prevention</u>

9. There are a number of agreed-upon risk factors for suicidal behaviour. Those identified by more than 50% of hospital-based or community-based staff were alcohol/ other substance abuse (75% HB and 78% CB), age (58% HB) family discord/ violence or abuse (58% HB and 78% CB) and social/ geographical isolation (50% HB and 67% CB%).

10. Six of the known early signs of suicidal risk were identified by 50% or more hospital-based or community-based staff, viz., suicidal ideation (50% HB and 66.7% CB), substance abuse (55.6% CB), anxiety/ agitation (60% HB), hopelessness (66.7% CB), withdrawal (50% HB and 55.6% CB) and mood fluctuations (80% HB and 88.9% CB). Only two of the known tipping points were identified by more than 50% of those interviewed viz., relationship ending (60% HB and 66.7% CB) and the death or suicide of a relative/ friend (66.7% CB). One known early sign was not

mentioned viz., feeling trapped (CB), and four known tipping points were not mentioned viz., a debilitating physical illness or accident (CB), the suicide of someone famous or member of a peer group (HB), a serious argument at home (HB) and a media report on suicide/ suicide methods (HB and CB).

11. Of the known clinical indicators of the imminent risk of suicide for someone who has attempted suicide in the past, five were identified by 50% or more hospital-based or community-based staff viz., frequent thoughts of suicide (50% HB and 66.7% CB), access to suicide means (58.3% HB), a significant change in circumstances or loss (50% CB), depressive symptoms/ hopelessness/ helplessness (83.3% HB and 100% CB) and substance abuse (50% HB and 66.7% CB). Known indicators that were not mentioned were whether a person has a detailed suicide plan (CB), the lethality of an intended method of suicide (CB), an interest in the likelihood of being found/rescued (HB and CB) and chronic, painful medical conditions/ perceived medical problem (CB).

12. The most frequently mentioned barriers by HB staff were that males are reluctant to talk about their problems (preferring to deal with them alone) (75%), the use of destructive coping mechanisms (66.7%), and the male stereotype of being tough and strong (66.7%). The most frequently mentioned barriers by CB staff were that males are reluctant to talk about their problems (preferring to deal with them alone) (77.8%), the male stereotype of being tough and strong (77.8%) and the perceived stigma of mental illness (55.6%). Barriers less frequently mentioned by HB staff were that generally males don't know what help is available (8.3%), cost of services (0%), lack of understanding regarding treatments (0%) and long wait lists (0%). Barriers less frequently mentioned by CB staff were the lack of social network support (11.1%), cost of services (11.1%) and males without partners being header to reach (0%). Areas difficult to address by hospital-based staff include educating nurses about the suicide risks for men, providing access to services for isolated men, referral pathways and knowledge of available services, and difficulties faced by female staff in working Aboriginal males (cultural issues). Specific barriers for males that CB providers have found difficult to address include not enough staff, a lack of understanding by other agencies regarding what WACHS can/ can't provide, information sharing between agencies, the need to educate males that it's OK to have mental health issues and that help is available, provision of an out-of-hours service, and difficulties in accessing families for counselling.

13. Around 85% of hospital-based staff indicated they had not undertaken professional development regarding suicide prevention within the past 3 years. Suggestions for future PD included assessment of risk during first 24 hr critical period, legal training in detaining psychiatric cases, drug/ alcohol education, self harm assessment/ education, and acute psychosis treatment and care. By way of comparison, around 50% of community-based staff had undertaken this type of professional development in the past three years including Gatekeeper workshops, Map of Loss workshops and workshops on suicide risk management. Suggestions

for future PD were included suicide risk assessment, writing postvention community plans, and the link between psychopharmocology and increased risk of suicidality.

Services coordination

14. Less than half of the hospital-based staff interviewed agreed: there is interest in working collaboratively to address suicidal behaviour in the SW (36.8%); there is a clear commitment to working collaboratively (22.2%); there had been substantial past achievements when agencies had collaborated (16.7%); there is sufficient trust to survive any mistrust that might arise from collaboration (31.6%); that areas of shared responsibility are clear and understood by all concerned (16.7%); or there are clear arrangements to monitor and review the success of working collaboratively (0%). Around 68% agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

15. None of the hospital-based staff interviewed rated collaboration with external agencies/ practitioners they needed to work with in relation to patients at risk of suicide as 'extremely effective' or 'very effective'. The main barriers to effective inter-agency coordination were described as limited availability of services outside Bunbury, access to services only during office hours, lack of adequate inter-agency referral protocols, a lack of follow up after referral, difficulties in accessing CAMHS, lack of beds at Bentley and PMH, a lack of case conferences, not enough mental health professionals to provide a rapid response, a lack of psychiatrists, professional silos, and a lack of community agencies willing to provide treatment after recovery. Suggestions for addressing these barriers included cooperation from all sides, better access to the WACHS mental health team, increase child and adolescent mental health services, proper on-call psychiatric services for all ages, increase in mental health liaison staff, acute services within the community not just counselling and support groups, MOU with all service providers, relevant people/ practitioners making themselves known to hospital staff, and facilitation of case conferences.

16. More than half of the community-based staff interviewed agreed there is a clear commitment to working collaboratively (60%) and there had been substantial past achievements when agencies had collaborated (70%). Less than half agreed: there is interest in working collaboratively to address suicidal behaviour (44.4%); there is sufficient trust to survive any mistrust that might arise from collaboration (20%); that areas of shared responsibility are clear and understood by all concerned (10%); and there are clear arrangements to monitor and review the success of working collaboratively (0%). Around 40% agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

17. Twenty-five percent of the community-based staff interviewed rated collaboration with external agencies/ practitioners they needed to work with in relation to patients at risk of suicide as 'very effective. The main barriers to effective inter-

agency coordination were described as a lack of MOUs and clear referral processes, a lack of clear understanding of roles/ responsibilities of each agency, a lack of mental health staff, a lack of communication between different agencies e.g., information needs to be given to school nurses about students who attempt suicide, a lack of understanding about suicide, consent forms to release information are not always completed, inappropriate use of 'suicidal' by referrer in the hope that the patient will received quicker response, too much emphasis on managers when addressing inter-agency issues, a lack of understanding that suicide prevention is the responsibility of all not just mental health services, a loss of autonomy to work across agencies locally now that managed from Bunbury, transport issues to access services by other agencies, everyone works defensively trying to protect their territory, multiple medical records, lack of trust between some workers in different agencies, and poor case management. Suggestions for addressing these barriers included clearer processes, better training, more coal face workers, easier access to GPs and mental health services in shorter time, improved communication between agencies, community education regarding suicide, improved inter-agency discussion amongst practitioners not just managers, improved information sharing including the management of privacy, better collaboration between acute and community practitioners, a concerted effort to work collaboratively, and the use of electronic medical records.

18. Around 33.3% of community-based staff who indicated they provided support to patients showing early signs/ tipping points, indicated they were kept well-informed by other agencies compared to 50% who provided longer term support after a suicide attempt. Suggestions for improvement included sharing of medical information with consent, improved compatibility between and access to medical databases, better case conferencing systems, improved feedback from GP/ hospital/ school/ parents, more resources so that practitioners can spend time building cross-agency networks and protocols, consistent assessment across agencies and better collaborative case management.

19. Around 90% of community-based staff considered they had timely access to providers with appropriate training and experience to address suicide risk. More than half reported they have timely access to GPs (88.9%), psychologists (55.6%) and mental health nurses (55.6%). Less than half reported that have timely access to psychiatrists (44.4%), social workers (44.4%), occupational therapists (22.2%) and counsellors (22.2%).

SW general practices

Service provision

Along with WACHS, GPs can play an important role in minimising the risk of suicide. We applied the following criteria from Action Area 5 of the LIFE framework (outcome 5.1 – improved access to a range of support and care for people feeling suicidal) to examine the appropriateness of GP services in the SW:

- an appropriate mix of services (treatment/ support) is provided to individuals (i) showing early signs/ tipping points, (ii) at ongoing and imminent risk of suicide, and (iii) who have attempted suicide and are in the recovery stage
- an appropriate mix of mental health practitioners are employed to provide treatment/ support
- services are accessible in terms of location, wait times for appointments/ priority and out-of-hours service arrangements for individuals at risk of suicide, and
- barriers to services for males are addressed.

Thirteen of 138 GPs (9.4%) from 43 general practices in the SW agreed to participate in the study. Two were 'sole practitioners', the remaining 11 worked at general practices with 'multiple practitioners'. Ninety-two percent indicated they had treated patients showing early signs of suicide/ at potential tipping points in the past 12 months; 38.5% indicated they had treated patients who had made a suicide attempt; 61.5% indicated they had treated patients requiring longer-term support for their recovery after a suicide attempt. Caution is also required in generalising the findings to all SW general practices given the relatively small number of GPs who agreed to participate in the study.

Services mix

GPs were asked about the services they provide to individuals at risk of suicide. As shown in Table 31, the majority provided services ranging from taking action in response to early signs of suicide/ being at potential tipping points, being a first point of professional contact for people who had attempted suicide, being a provider of support for people in the recovery stage, and being a provider of support to carers/ families of people at risk of suicide.

Table 31

Services provided by general practices to individuals at risk of suicide

Suicide prevention service	% GPs
Being alert to the early signs of the risk of suicide/ potential tipping points and taking action	100
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/support	84.6
Being a provider of longer-term treatment/ support for people who have received acute treatment/ support for a suicide attempt and are in the recovery stage	92.3
Being a provider of support/ information to carers/ families of people at risk of suicide to build resilience and create an environment that supports help-seeking	92.3

GPs were also asked if they regarded reducing suicide through improving media coverage, reducing access to means of suicide or providing community education as their responsibility. Around 46% indicated this was their responsibility as a GP. They were also asked whether working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility; around 67% indicated this was their responsibility as a GP.

Mix of mental health practitioners

Table 32 presents information about the mix of mental health professionals employed to provide treatment/ support at general practices[8]. As shown few practices employed AHPs. Psychologists and mental health nurses were employed in some practices (18.2% and 9.1% respectively).

[8] N = 11 as two of the GPs who participated in the survey were 'sole practitioners'.

Table 32

Mix of mental health professionals employed to provide treatment/ support by general practices

Mental health professional	% GPs
Psychiatrist	0
Psychologist	18.2
Social worker	0
Mental health nurse	9.1
Counsellor	0
Occupational therapist	0

Accessibility of services

Table 33 presents information about the usual wait time for an appointment and the priority given to patients at risk of suicide. As shown 46.2% of patients would normally be offered an appointment the same day or within 24 hrs; 53.9% would be seen within one week or more than one week. In contrast, all patients at risk of suicide would be offered an appointment the same day, if not immediately. The urgency of the appointment for patients at risk of suicide was typically assessed by the practice nurse, and in some cases the receptionist.

Table 33

Usual wait time for an appointment and the priority given to patients at risk of suicide for general practices

Service attribute	Immediate	Same day	Within 24 hrs	Within 1 week	More than 1 week
Usual wait time for an appointment	0	38.5	7.7	38.5	15.4
Priority given to patients at risk of suicide for appointments	46.2	53.8	0	0	0

Table 34 presents information about the capacity to take on new patients and whether an out-of-hours/ weekend service for patients at high risk of suicide is provided by general practices. As shown 61.5% of the GPs indicated their practice had the capacity to take on new patients; 38.5% had the capacity to take on new patients subject to certain conditions, e.g., they were local residents. Almost all practices provide an out-of-hrs/ weekend service for patients at risk of suicide. The availability of telephone contact with a GP at the practice arrangement was frequently mentioned as the standard arrangement, for example, the patient calls the surgery and is given a GPs mobile phone number via a recorded message.

Table 34

Capacity to take on new clients and whether an out-of-hours/ weekend service is provided for general practices

Service attribute	% GPs
Capacity to take on all new patients	61.5
Capacity to take on new patients subject to certain conditions	38.5
Provision of an out-of-hours/ weekend service for patients at risk of suicide	92.3

Treatment and support

Table 35 presents information about the types of treatment and support provided to people at risk of suicide for general practices. As shown the majority of GPs indicated they provided referrals to mental health professionals, psychological/ mental/ behavioural assessment, counselling, advice about mental health, prescription of medication and regular follow-up.

Table 35

Types of treatment and support provided to people at risk of suicide by general practices

Mental health professional	% GPs
Referral to mental health professional	92.3
Mental, behavioural or psychological assessment	92.3
Psychosocial counselling/ psychological therapies	61.5
Advice/education regarding mental health	69.2
Prescribe medication	92.3
Regular follow-up	100

Knowledge of suicide prevention

Service providers should have adequate knowledge of suicide prevention. We applied the following criteria from Action Area 5 of the LIFE framework (outcome 5.4 – improved understanding, skills and capacity of front-line workers) to examine the extent to which GPs from SW general practices:

- have adequate knowledge of (i) the early signs/ tipping points for suicide, and (ii) the clinical indicators of ongoing and imminent risk for people who have attempted suicide
- have adequate knowledge of the barriers to accessing services for males and strategies for addressing them, and

- access up-to-date professional development regarding suicide prevention.

Table 36 presents the percent of GPs who identified known early signs/ tipping points for suicide. As shown none of the known early signs/ tipping points was identified by 50% or more of the GPs. Early signs that were not mentioned were a sense of purposelessness, feeling trapped, anger, recklessness; tipping points that were not mentioned were the suicide of someone famous or member of a peer group, a serious argument at home, or a media report on suicide or suicide methods.

Table 36

Percent of SW general practices who identified known early signs/ tipping points for suicide

Early signs/ tipping points	**% GPs**
Early signs	
Suicidal ideation	46.2
Substance abuse	15.4
Purposelessness	0
Anxiety and agitation	15.4
Feeling trapped	0
Hopelessness	38.5
Withdrawal	7.7
Anger	0
Recklessness	0
Mood fluctuations	15.4
Tipping points	
Relationship ending	23.1
Loss of status or respect	7.7
Debilitating physical illness or accident	15.4
Death or suicide of relative/ friend	30.8
Suicide of someone famous or member of peer group	0
Serious argument at home	0
Being abused or bullied	7.7
Media report on suicide or suicide methods	0

Knowledge of the clinical indicators of ongoing and imminent risk for people who have attempted suicide

Table 37 presents the percent of GPs who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide. As shown, only one of the known indicators was identified by 50% or more GPs viz., depressive symptoms/ hopelessness/ helplessness (53.8%). Indicators that were not mentioned were an interest in the likelihood of being found/rescued when suicidal ideation is present and chronic, painful medical problems or perceived medical problems.

Table 37

Percent of general practices who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide

Clinical indicators of ongoing and imminent risk	% GPs
Frequent thoughts of suicide	30.8
Detailed suicide plan	23.1
Lethality of intended suicide method	15.4
Access to suicide means	7.7
An interest in the likelihood of being found/rescued	0
Recency/ frequency/ severity of recent attempts	30.8
Significant change in circumstances or loss	0
Significant change in daily routine	7.7
Chronic, painful medical problems or perceived medical problem	0
Depressive symptoms/ hopelessness/ helplessness	53.8
Psychiatric disorder – e.g., depression, eating disorder, panic	23.1
Substance abuse	30.8
Alienation or lack of support networks	23.1

Knowledge of barriers to services for males

GPs were asked about services to males at risk of suicide, specifically what they regarded as the main barriers males face in accessing treatment/ support. As shown in Table 38 the most frequently mentioned barriers were the male stereotype of being tough and strong (53.8%) and that males are reluctant to talk about their problems (preferring to deal with them alone) (46.2%). Barriers less frequently mentioned were the perceived stigma of mental illness (15.4%), the use of destructive coping styles (15.4%), the lack of social network support (8%) and a lack of time (8%). Barriers that were not mentioned were that males without partners are more difficult to reach, males don't typically recognise psychological symptoms of distress, the cost of services, a lack of understanding regarding treatments, and a lack of knowledge about what help is available.

Table 38

Perceived barriers males at risk of suicide face in accessing treatment/ support identified by general practices

Barriers that males face	% GPs
Not talking about problems/deal with them alone	46.2
Talking won't help fix the problem	0
Lack of social network support	7.7
Males without partners harder to reach	0
Lack of time	7.7
Not recognising symptoms of distress, only physical symptoms	0
Cost of services	0
Perceived stigma of mental illness	15.4
Lack of understanding regarding treatments	0
Use of destructive coping mechanisms to deal with problems	15.4
Don't know what help is available	0
Traditional views of masculinity, of being tough and strong	53.8
Long waiting lists	7.7

Barriers that the GPs participating in the study have found difficult to address are the reluctance of males to seek help prior to crisis point, the male attitude of 'I can deal with it alone,' limited time to access services during working hours, overcoming the notion that seeking help is weak, and a lack of publically-funded services.

Professional development regarding suicide prevention

GPs were asked about professional development regarding suicide prevention they had undertaken in the past 3 years. Around 23% had undertaken this type of PD in this period. PD activities included:

- GP Mental Health Standards Collaboration accredited Mental Health Skills training
- primary mental health care training
- clinical adult mood disorders training
- training for Level 2 Mental Health qualification, and
- an online course provided by Australian College of Rural and Remote Medicine on mental health in general and suicide prevention in part.

Suggestions for future PD were:

- inter- and intra-disciplinary mental health meetings to discuss roles and network
- information about referral pathways to mental health/ psychologists/ counsellors/ support groups with contact details of services
- education on suicide prevention best practice
- suicide risk assessment, and
- deliberate self harm management.

Coordination of services

The coordination of services is important to minimise the risk of suicide. We applied the following criteria from Action Area 4 of the LIFE framework (outcome 4.1 – linking local services effectively so that people experience a seamless service) to examine the extent to which GPs from SW general practice:

- collaborate effectively with other providers involved in suicide prevention/ treatment, and
- have timely access to mental health providers with the training and experience to work with individuals at-risk of suicide.

Services coordination

Table 39 presents GPs' perceptions regarding the effectiveness of services coordination in the SW for people at risk of suicide. As shown whilst more than half (53.8%) agreed there was a high level of interest in working collaboratively across agencies/ practitioners to address suicidal behaviour in the SW, only 30.8% agreed there had been substantial past achievements when agencies/ practitioners had collaborated. Further, only 15.4% agreed that the areas of shared responsibility are clear and understood by all concerned. None of the GPs agreed there are clear arrangements to monitor and review the success of working collaboratively, whilst 41.6% agreed there was sufficient trust to survive any mistrust that might arise from collaboration. Less than half (38.5%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

Table 39

Perceptions of general practices regarding the effectiveness of services coordination in the SW for people at risk of suicide

Services coordination	% SD	% D	% Neutral	% A	% SA
Interest in working collaboratively among agencies/practitioners involved in addressing suicidal behaviour in the South West is generally high		7.7	38.5	53.8	
There is a clear commitment to working collaboratively from the most senior levels of these agencies/ independent practices	7.7	15.4	38.5	38.5	
There have been substantial past achievements when agencies/ practitioners involved in addressing suicidal behaviour in the South West have collaborated		30.8	38.5	30.8	
There is sufficient trust among agencies/ practitioners involved in addressing suicidal behaviour in the South West to survive any mistrust that might arise from collaboration		33.3	25.0	33.3	8.3
The areas of responsibility of agencies/ independent practitioners involved in addressing suicidal behaviour in the South West are clear and understood by all concerned	7.7	61.5	15.4	15.4	
Co-location of agencies/ practitioners involved in addressing suicidal behaviour in the South West is an important facilitator of working collaboratively	7.7	30.8	23.1	38.5	
There are clear arrangements to monitor and review how agencies/ practitioners involved in addressing suicidal behaviour in the South West work collaboratively	15.4	38.5	46.2		

GPs were asked how they would rate the collaboration of GPs at their practice and the external agencies/practitioners they needed to work with in relation to suicidal patients. Around 8% rated collaboration as ‘extremely effective’ or ‘very effective’, 69% rated collaboration as ‘somewhat effective’ and 23% rated collaboration as ‘minimally effective’ or ‘not at all effective’. Around 54% indicated they were kept well-informed by other agencies treating/ supporting their patients.

The main barriers to effective coordination identified by GPs were:

- a lack of understanding about referral protocols between general practice and other agencies/ practitioners providing mental health services
- frustration among GPs with the requirement to refer patients at risk of suicide to the ED of hospitals rather than directly to South West Mental Health Service
- the need for additional private psychiatrists in the SW
- a lack of timely communication between GPs and mental health providers
- a lack of 'psychological mindedness' of GPs, and
- a shortage of time to address multi-disciplinary issues.

GPs were asked if they involved 'significant others' (carers/ family members) in treatment/ support of patients at risk of suicide: 23.1% indicated this was the case 'with no exceptions', 61.5% indicated this was the case 'with some exceptions'; 15.4% indicated this was the case 'but only with the agreement of the patient'.

Timely access to external mental health providers

Timely access to external mental health providers with appropriate training and experience is an important feature of effective coordination of services for individual clients/ patients at risk of suicide. Around 69% of GPs from SW general practices considered they had timely access to external mental health professionals with appropriate training and experience. Table 40 presents the percent of these GPs who considered they had timely access to different types of external mental health professionals. As shown the majority (75%) indicated they had timely access to psychologists with the training and experience to work with people at risk of suicide. Less than half considered they had timely access to other practitioners (psychiatrists (44.4%), other general practitioners (37.5%), social workers (44.4%), mental health nurses (44.4%), occupational therapists (25%) and counsellors (33.3%)) with the training and experience to work with people at risk of suicide.

Table 40

Percent of general practices who considered they had timely access to external mental health professionals with the training and experience to work with people at risk of suicide

Mental health professional	% GPs
Psychiatrist	44.4
General practitioner	37.5
Psychologist	75.0
Social worker	44.4
Mental health nurse	44.4
Occupational therapist	25.0
Counsellor	33.3

Summary of findings –general practices

Services for people at risk of suicide

1. The majority of GPs provide a wide range of services viz., taking action in response to early signs of suicide/being at potential tipping points (100%), being a first point of professional contact for people who had attempted suicide (84.6%), being a provider of support for people in the recovery stage (92.3%), and being a provider of support to carers/ families of people at risk of suicide (92.3%). Around half felt that reducing suicide through community education generally speaking was their responsibility as a GP. In contrast, working with at-risk groups/ communities to build resilience and promote help seeking was seen to be their responsibility by two-thirds of the GPs.

2. The majority of GPs make referrals to mental health professionals (92.3%), conduct psychological/ mental/ behavioural assessments (92.3%), provide counselling (61.5%) and advice about mental health (69.2%), prescribe medication (92.3%) and conduct regular follow-ups (100%).

3. Few general practices employ AHPs (e.g., social workers, mental health nurses, counsellors, occupational therapists). Psychologists and mental health nurses are employed in some practices.

4. General practices have the capacity to take on new patients in some cases subject to certain conditions. Whilst around 38% of patients would normally be given an appointment the same day as requesting it, all patients at risk of suicide would be seen the same day if not immediately. General practices typically provide an out-of-hrs/ weekend service. The usual arrangement is the patient calls the surgery and is given a contact phone number for a GP via a recorded message.

Knowledge of suicide prevention

5. None of the known early signs/ tipping points of suicidal risk were identified by 50% or more of the GPs. Known early signs that were not mentioned by any GP were a sense of purposelessness, feeling trapped, anger and recklessness. Known tipping points that were not mentioned by any GP were the suicide of someone famous/ member of a peer group, a serious argument at home, or a media report on suicide or suicide methods.

6. Of the known clinical indicators of the imminent risk of suicide for someone who has attempted suicide in the past only depressive symptoms/ hopelessness/ helplessness was identified by 50% or more of the GPs (54%). Known indicators that were not mentioned by any GP were an interest in the likelihood of being found/ rescued when suicidal ideation is present, and chronic, painful medical problems/ perceived medical problems.

7. The most frequently mentioned barriers to services for males were the male stereotype of being tough and strong (54%) and that males are reluctant to talk about their problems (preferring to deal with them alone) (46%). Barriers less frequently mentioned were the perceived stigma of mental illness (15%), the use of destructive coping styles (15%), the lack of social network support (8%) and a lack of time (8%). Barriers not mentioned were that males without partners are more difficult to reach, males don't typically recognise psychological symptoms of distress, the cost of services, a lack of understanding regarding treatments, and a lack of knowledge about what help is available.

8. Professional development activities undertaken by GPs in the past 3 years regarding suicide prevention included 'GP Mental Health Standards Collaboration' accredited Mental Health Skills training, primary mental health care training, clinical adult mood disorders training, training for Level 2 Mental Health qualification, and an online course provided by Australian College of Rural and Remote Medicine on mental health in general and suicide prevention in part. Suggestions for future PD were inter- and intra-disciplinary mental health meetings to discuss roles and network, information about referral pathways to mental health/ psychologists/ counsellors/ support groups with contact details of services, education on suicide prevention best practice, suicide risk assessment, and deliberate self harm management.

Services coordination

9. Whilst more than half (54%) of the GPs agreed there was a high level of interest in working collaboratively across agencies/ practitioners to address suicidal behaviour, only 31% agreed there had been substantial past achievements when agencies/ practitioners had collaborated. Further, only 15% agreed that the areas of shared responsibility are clear and understood by all concerned. None of the GPs agreed there are clear arrangements to monitor and review the success of working collaboratively. Around 42% agreed there was sufficient trust to survive any

mistrust that might arise from collaboration. Less than half (38%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

10. Only 8% of the GPs rated collaboration with external agencies/ practitioners they needed to work with in relation to patients at risk of suicide as 'extremely effective' or 'very effective'. Around half (54%) indicated they were kept well-informed by other agencies treating/ supporting their individual patients. The main barriers to effective coordination appear to be a lack of understanding about referral protocols between general practices and other agencies/ practitioners providing mental health services, frustration among GPs with the requirement to refer patients at risk of suicide to the ED of hospitals rather than directly to South West Mental Health Service, a lack of timely communication between GPs and mental health providers, and a lack of 'psychological mindedness' of GPs.

11. Around 69% of GPs considered they have timely access to providers with appropriate training and experience to address suicide risk. More than half (75%) considered they had timely access to psychologists. Less than half considered they had timely access to other practitioners (psychiatrists (44%), other general practitioners (37%), social workers (44%), mental health nurses (44%), occupational therapists (25%) and counsellors (33%)) with the training and experience to work with people at risk of suicide.

12. Relatively few GPs (23%) indicated they involved 'significant others' (carers/ family members) in treatment/ support of patients at risk of suicide 'with no exceptions'. Around 61% indicated they would do this 'with some exceptions'.

SW AHPs

Service provision

Services provided by AHPs (along with WACHS and GPs) can play a key role in suicide prevention. The same criteria from Action Area 5 of the LIFE framework (outcome 5.1 – improved access to a range of support and care for people feeling suicidal) were applied to examine the appropriateness of SW AHP services viz:

- an appropriate mix of services (treatment/ support) is provided to individuals (i) showing early signs/ tipping points, (ii) at ongoing and imminent risk of suicide, and (iii) who have attempted suicide and are in the recovery stage
- an appropriate mix of mental health practitioners are employed to provide treatment/ support
- services are accessible in terms of location, wait times for appointments/ priority and out-of-hours service arrangements for individuals at risk of suicide, and
- barriers to services for males are addressed.

A senior practitioner from 20 of the 50 allied health practices identified in the SW agreed to participate in the survey phase of the study. Seventy-two percent indicated they had treated/ supported clients showing early signs of suicide/ at potential tipping points in the past 12 months; 22.2% indicated they had treated/ supported clients in the past 12-months requiring acute treatment for a suicide attempt; 66.7% indicated they had treated/ supported clients requiring longer-term support for their recovery after a suicide attempt. Fifteen (of the 20 AHPs who participated in the survey) were 'sole practitioners'. The remaining five worked at allied health practices with 'multiple practitioners'. Of the 15 AHPs working as sole practitioners 46.6% were psychologists, 33.4% were counsellors (33.4%) and 20% were occupational therapists. All five of the practices with multiple practitioners employ psychologists; two of these five practices also employ GPs and counsellors. Caution is required in generalising the findings to all SW AHPs.

Services mix

AHPs were asked about the services they provide to individuals at risk of suicide. As shown in Table 41, the majority provided services in response to early signs of suicide/ being at potential tipping points (95%); being a provider of support for people in the recovery stage (80%), and being a provider of support to carers/ families of people at risk of suicide (75%). Around one-third (35%) of AHPs reported being a first point of professional contact for people who had attempted suicide.

Table 41

Services provided by AHPs to individuals at risk of suicide

Suicide prevention service	% AHPs
Being alert to the early signs of the risk of suicide/ potential tipping points and taking action	95.0
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/support	35.0
Being a provider of longer-term treatment/ support for people who have received acute treatment/ support for a suicide attempt and are in the recovery stage	80.0
Being a provider of support/ information to carers/ families of people at risk of suicide to build resilience and create an environment that supports help-seeking	75.0

Accessibility of services

Table 42 presents information about the usual wait time for an appointment and the priority given to clients at risk of suicide for AHPs. As shown 20% of clients would normally be offered an appointment within 24 hrs; 35% would be seen within one week; 45% would not be seen for more than one week. In contrast, 50% of AHPs indicated that clients at risk of suicide would be offered an appointment within 24 hours. The urgency of the appointment for clients at risk of suicide was typically assessed by the AHP based on client self-report, information provided by a referring GP or by family/friends of the client. Around one-third of AHPs indicated they do not provide services to people at risk of suicide.

Table 42

Usual wait time for an appointment and the priority given to clients at risk of suicide for AHPs

Service attribute	Immediate	Same day	Within 24 hrs	Within 1 week	More than 1 week	Not applicable
Usual wait time for an appointment	0	0	20.0	35.0	45.0	-
Priority given to clients at risk of suicide for appointments	5.0	35.0	10.0	15.0	5.0	30.0

Table 43 presents information about the capacity to take on new clients and whether an out-of-hours/ weekend service for clients at high risk of suicide is provided by AHPs. As shown 73.7% of the AHPs indicated their practice had the capacity to take on new clients; 26.3% had the capacity to take on new clients subject to certain

conditions, e.g., they were referred by arrangement from a GP, the AHP could see the person within two weeks, they did not work with children. Around half of the AHPs provide an out-of-hrs/ weekend service for clients who may be at risk of suicide. Typically this applies to existing clients who are provided with an after-hours contact number. AHPs who do not provide an out-of-hrs/ weekend service generally provide their existing clients with the contact details for crisis call-centres.

Table 43

Capacity to take on new clients and whether an out-of-hours/ weekend service is provided for AHPs

Service attribute	% AHPs
Capacity to take on all new clients	73.7
Capacity to take on new clients subject to certain conditions	26.3
Provision of an out-of-hours/ weekend service for clients at high risk of suicide	56.3

Treatment and support

Table 44 presents information about the types of treatment and support provided to people showing early signs/ being at potential tipping points and people who have received acute treatment for a suicide attempt and are in the recovery stage. As shown AHPs indicated they provided information about available services, advice about mental health, referrals to other mental health professionals and psychosocial counselling/ psychological therapy. Around one-fifth of AHPs provide mental/ behavioural/ psychological assessment.

Table 44

Types of treatment and support provided to people at risk of suicide by AHPs

Types of treatment/ support	% AHPs – early signs/ tipping points	% AHPs – suicide attempt	% AHPs – recovery stage after a suicide attempt
General service availability information, advice, referral	100	100	64.3
Mental, behavioural or psychological assessment	23.5	25	21.4
Psychosocial counselling/ psychological therapies	76.5	100	92.9

AHPs were asked to describe who they refer to, the hand-over process, and the nature of client follow up for clients at risk of suicide. Most AHPs contacted the client's GP regarding referral to the ED of the local hospital, government-provided mental health services, or psychiatrists where this was necessary. Arrangements were also made with family members to accompany the client to the ED of the local hospital. In some cases the AHP took the client to the ED themselves. Depending on the circumstances, clients were given contact details for Rural-link', Lifeline, Beyond-Blue, and/ or referrals were made to other AHPs. Many AHPs indicated they would conduct a follow-up with the client, family member, and/ or GP as appropriate. A strong support network was regarded as vital given that allied health services are typically 1-hour sessions and that clients in these circumstances can be 'bounced around by the system'.

A range of views emerged regarding duty of care for someone at risk of suicide, viz:

- confidentiality stands in the way to get help, however we will break it if needed – for example we will call the client's GP in front of them
- it's a real dilemma – want to hand-over to WACHS but we're not confident that our client's needs will be met
- we have a duty of care to inform carers/ a responsible other, if self harm is a risk
- we do a written/ verbal agreement not to self harm based on a risk assessment
- we sometimes refer to hospital even though it may break trust in the therapeutic relationship
- we will involve significant others depending on level of risk – to self or others and will follow up with the client
- we will warn significant others if the client is in peril including the police
- our duty of care is to inform the GP and family members as well as put safeguards in place for the client by providing other avenues of support

- we won't contact others without the client's consent
- the limitations to confidentiality are clearly explained at the first contact with the client and a release-of-information form is signed
- our ethical obligations drive appropriate the involvement of others, and
- we provide reassurance that involving others will not cause the client harm.

Understanding of suicide prevention

Service providers should have adequate knowledge of suicide prevention. We applied the following criteria from Action Area 5 of the LIFE framework (outcome 5.4 – improved understanding, skills and capacity of front-line workers) to examine the extent to which SW AHPs:

- have adequate knowledge of the risk factors for suicide
- have adequate knowledge of (i) the early signs/ tipping points for suicide, and (ii) the clinical indicators of ongoing and imminent risk for people who have attempted suicide
- have adequate knowledge of the barriers to accessing services for males and strategies for addressing them, and
- access up-to-date professional development regarding suicide prevention.

Suicide risk factors

Table 45 presents the suicide risk factors AHPs perceived as relevant to their client group. As shown the individual risk factors identified by 50% or more of those interviewed were alcohol or other substance abuse (58.8%) and mental health problems/ disorders (52.9%); situational risk factors identified by more than 50% of those interviewed were family discord, violence or abuse (58.8%), social or geographical isolation (58.8%), separation or loss (52.9%). None of the known individual risk factors were not mentioned; imprisonment was the only situational risk factor not mentioned.

Table 45

Percent of AHPs

who identified known risk factors for suicide

Risk factors	%
Individual	
Male gender	17.6
Age	35.3
Mental health problems/disorders	52.9
Prior suicide attempt	17.6
Alcohol or other substance abuse	58.8
Chronic pain or illness	23.5
Low self-esteem	23.5
Little sense of control over life	41.2
circumstances	23.5
Lack of meaning and purpose in life	35.3
Poor coping skills	29.4
Hopelessness	11.8
Access to lethal means	
Situational	58.8
Family discord, violence or abuse	52.9
Separation or loss	29.4
Family history of suicide or mental illness	58.8
Social or geographical isolation	0
Imprisonment	41.2
Financial stress	17.6
Poverty	35.3
Unemployment or economic uncertainty	5.9
Homelessness	5.9
Social or cultural discrimination	35.3
Exposure to environmental stressors	17.6
Lack of support services	

Knowledge of the early signs/ tipping points for suicide

Table 46 presents the percent of AHPs who identified known early signs/ tipping points for suicide. As shown only one of the known early signs was identified by 50% or more of those interviewed viz., suicidal ideation (70.6%); only one of the known tipping points was identified by 50% or more of those interviewed viz., when a relationship ended (76.5%). There were no early signs that were not mentioned by at least one AHP; two tipping points not mentioned were a serious argument at home and a media report on suicide or suicide methods.

Table 46

Percent of AHPs who identified
known early signs/ tipping points for suicide

Early signs/ tipping points	% AHPs
Early signs	
Suicidal ideation	70.6
Substance abuse	35.3
Purposelessness	29.4
Anxiety and agitation	35.3
Feeling trapped	29.4
Hopelessness	76.5
Withdrawal	17.6
Anger	29.4
Recklessness	11.8
Mood fluctuations	41.2
Tipping points	
Relationship ending	76.5
Loss of status or respect	29.4
Debilitating physical illness or accident	35.3
Death or suicide of relative/ friend	17.6
Suicide of someone famous or member of peer group	5.9
Serious argument at home	0
Being abused or bullied	41.2
Media report on suicide or suicide methods	0

Knowledge of the clinical indicators of ongoing and imminent risk for people who have attempted suicide

Table 47 presents the percent of AHPs who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide and are in the recovery stage. As shown three of the known indicators were identified by 50% or more of those interviewed viz., a significant change in daily routine (58.3%), depressive symptoms/ hopelessness/ helplessness (75%), and alienation or lack of support networks (75%). Indicators that were not mentioned were an interest in the likelihood of being found/rescued when suicidal ideation is present or the recency/ frequency/ severity of recent attempts.

Table 47

Percent of AHPs who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide and are in the recovery stage

Clinical indicators of ongoing and imminent risk	% AHPs
Frequent thoughts of suicide	33.3
Detailed suicide plan	16.7
Lethality of intended suicide method	16.7
Access to suicide means	16.7
An interest in the likelihood of being found/rescued	0
Recency/ frequency/ severity of recent attempts	0
Significant change in circumstances or loss	25.0
Significant change in daily routine	58.3
Chronic, painful medical problems or perceived medical problem	16.7
Depressive symptoms/ hopelessness/ helplessness	75.0
Psychiatric disorder – e.g., depression, eating disorder, panic	33.3
Substance abuse	33.3
Alienation or lack of support networks	75.0

Knowledge of barriers to services for males

AHPs were also asked about services to males at risk of suicide, specifically what they regarded as the main barriers males face in accessing treatment/ support. As shown in Table 48 the most frequently mentioned barriers were that males are reluctant to talk about their problems (preferring to deal with them alone) (94.4%), the male stereotype of being tough and strong (88.9%) and the perceived stigma of mental illness (55.6%). Barriers that were less frequently mentioned were that males without partners are harder to reach (11.1%), a lack of time (11.1%), a lack of understanding regarding treatments (11.1%) and long wait lists (5.6%). A known barrier not mentioned was the cost of services.

Table 48

Perceived barriers males at risk of suicide face in accessing treatment/ support identified by AHPs

Barriers that males face	% AHPs
Not talking about problems/deal with them alone	94.4
Talking won't help fix the problem	27.8
Lack of social network support	16.7
Males without partners harder to reach	11.1
Lack of time	11.1
Not recognising symptoms of distress, only physical symptoms	27.8
Cost of services	0
Perceived stigma of mental illness	55.6
Lack of understanding regarding treatments	11.1
Use of destructive coping mechanisms to deal with problems	33.3
Don't know what help is available	16.7
Traditional views of masculinity, of being tough and strong	88.9
Long waiting lists	5.6

AHPs were asked how the barriers had been addressed at their service. As shown in Table 49 apart from the promotion of healthy lifestyles/ coping mechanisms (38.9%), ensuring clear referral pathways (33.3%), and building/ strengthening the support networks of males (27.8%), few of the other known strategies for addressing barriers that males at risk of suicide face are currently being employed by AHPs.

Table 49

Strategies AHPs have used to address barriers that males at risk of suicide face when accessing treatment/ support

Strategies used to address barriers	% AHPs
Promotion of healthy lifestyles/ coping mechanisms	38.9
Build and strengthen the support networks of male clients	27.8
Understand the emotional/economic/social factors increasing suicide risk	5.6
Use physical symptoms to ask questions about what else may be going on	0
Gather enough information to be aware of what's really going on	16.7
Completed appropriate training courses	0
Service is well publicized	5.6
Practical and solution focused service to develop life skills	16.7
Educational materials on mental health issues provided	22.2
Clear referral pathways	33.3
Male and female staff and/or a cultural mix	16.7
Specialist support services for at-risk groups	5.6
Service aimed at times of high need	5.6
Free service/ bulk bill/ publicise Medicare rebates	5.6
High quality and well-trained staff	11.1
Continuity of care	5.6
Information sharing protocols developed	11.1
The service/ program is for males only	5.6
Hours of operation	11.1

Specific barriers that AHPs have found difficult to address include getting males in the door in the first place, a reluctance to maintain therapy, finances to pay for therapy, a belief that therapy won't work, time constraints that men have, difficulties in building family support, the stigma of mental illness, a lack of services coordination, the paperwork associated with Medicare rebates, and a lack of availability of appointments.

Professional development regarding suicide prevention

AHPs were asked about the professional development regarding suicide prevention they had undertaken in the past 3 years. Around 45% indicated they had undertaken this type of PD. PD activities included:

- semi-regular peer de-briefing and supervision
- a one-day workshop conducted by Lifeline
- a one-day 'advanced skills course' run by the MCSP
- a Gate-keeper workshop, and
- trauma counselling.

Suggestions for future PD were:

- the formation of an inter-agency network with a focus on suicide prevention
- written guidelines that all professionals can refer to as a best practice protocol
- access to up-to-date information regarding community resources for clients
- information about client needs
- 2-day gatekeeper workshop
- refresher on suicide risk assessment
- referral protocols and care pathways for access to community mental health services, CAMHS etc
- case analysis
- stress reduction techniques
- how to run a men's group as a woman, and
- integrated strategies for managing suicide risk – GPs, AHPs, police, psychiatrists, emergency team.

Coordination of services

The coordination of services is important to minimise the risk of suicide. We applied the following criteria from Action Area 4 of the LIFE framework (outcome 4.1 – linking local services effectively so that people experience a seamless service) to examine the extent to which SW AHPs:

- accept appropriate responsibility for the early detection of suicidal behaviour, treatment of individuals who have attempted suicide, and/or follow-up support for those who have attempted suicide and are in the recovery stage
- collaborate effectively with other providers involved in suicide prevention/ treatment, and

- have timely access to mental health providers with the training and experience to work with individuals at-risk of suicide.

Responsibility for suicide prevention services

Table 50 presents the percent of AHPs who considered they have a responsibility for suicide prevention services for individuals along with the percent who currently provide these services. Except for being one of the first points of professional contact for people who had attempted suicide (47.1%), the majority of AHPs considered they had a responsibility for a wide range of services, ranging from being alert to the early signs (100%), being a provider of ongoing care for people who have had treatment/ support for a suicide attempt (82.4%), through to being a provider of support to carers/ families of people with evidence of suicidal behaviour (76.5%). This sense of responsibility is generally reflected in the services currently provided.

Table 50

Percent of AHPs who considered they had a responsibility for, and who provide, particular suicide prevention services

Suicide prevention services	% responsible for services	% provide services
Being alert to the early signs of the risk of suicide/ potential tipping points and taking action	100	95.0
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/ support	47.1	35.0
Being a provider of ongoing care for people who have had treatment/ support for a suicide attempt and are in the recovery stage	82.4	80.0
Being a provider of support/ information to carers/ families of people with evidence of suicidal behaviour to build resilience and create an environment that supports help-seeking	76.5	75.0

AHPs were also asked if they regarded reducing suicide through improving media coverage, reducing access to means of suicide or providing community education as their responsibility. Around 47% indicated this was their responsibility as an AHP. They were also asked whether working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility; 50% indicated this was their responsibility as an AHP.

Services coordination

Table 51 presents the perceptions of AHPs regarding the effectiveness of services coordination in the SW for people at risk of suicide. As shown whilst more than half (52.6%) agreed there was a high level of interest in working collaboratively to address

suicidal behaviour in the SW, only 26.3% agreed there had been substantial past achievements when agencies/ practitioners had collaborated. Further, only 15.8% agreed that areas of shared responsibility are clear and understood by all concerned. None of the AHPs agreed there are clear arrangements to monitor and review the success of working collaboratively, whilst only 21.1% agreed there was sufficient trust to survive any mistrust that might arise from collaboration. Less than half (44.4%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

Table 51

Perceptions of AHPs regarding the effectiveness of services coordination in the SW for people at risk of suicide

Services coordination	% SD	% D	% Neutral	% A	% SA
Interest in working collaboratively among agencies/practitioners involved in addressing suicidal behaviour in the South West is generally high	5.3	10.5	31.6	52.6	
There is a clear commitment to working collaboratively from the most senior levels of these agencies/ independent practices	5.3	15.8	47.4	31.6	
There have been substantial past achievements when agencies/ practitioners involved in addressing suicidal behaviour in the South West have collaborated		5.3	68.4	26.3	
There is sufficient trust among agencies/ practitioners involved in addressing suicidal behaviour in the South West to survive any mistrust that might arise from collaboration	10.5	10.5	57.9	21.1	
The areas of responsibility of agencies/ independent practitioners involved in addressing suicidal behaviour in the South West are clear and understood by all concerned	10.5	42.1	31.6	15.8	
Co-location of agencies/ practitioners involved in addressing suicidal behaviour in the South West is an important facilitator of working collaboratively		11.1	44.4	22.2	22.2
There are clear arrangements to monitor and review how agencies/ practitioners involved in addressing suicidal behaviour in the South West work collaboratively	15.8	52.6	31.6		

AHPs were asked how they would rate their collaboration with external agencies/ practitioners they needed to work with in relation to suicidal clients. Around 22% rated collaboration as 'extremely effective' or 'very effective', 61.1% rated collaboration as 'somewhat effective', and 16.7% rated collaboration as 'minimally effective' or 'not at all effective'.

The main barriers to effective inter-agency coordination identified by AHPs were:

- a lack of clear interagency referral and follow-up protocols particularly for acute admissions and discharge
- difficulties in contacting staff in other agencies
- a lack of awareness of the indicators of suicide risk
- a lack of support agencies for young people at risk
- a lack of awareness of SW services for people at risk of suicide
- difficulties in retaining ongoing contact with clients at risk of suicide
- a lack of inter-agency networking opportunities
- too much emphasis on individual relationships between mental health providers- it's who you know
- a lack of time for coordinating services across the professionals and agencies involved, and
- structures within WACHS which do not acknowledge the expertise of private practitioners, e.g., private practitioners do not have admitting rights.

Suggestions for addressing these barriers to effective inter-agency coordination were:

- more opportunities for psychologists in private practice to meet other professions
- community based forums to discuss local issues pertaining to suicide
- clear referral guidelines so people don't slip through the cracks
- physical co-location of agencies where this is appropriate
- regular case conferencing
- smaller caseloads – more resources
- more beds/ in-patient resources for self harm assessment
- breaking down status hierarchies between agencies
- coordination between case manages in acute health services and practitioners in the community
- equal referral rights for admission to WACHS, and
- suicide intervention counsellors at WACHS.

AHPs were asked whether they were kept well informed by other agencies involved with their clients. Around 65% indicated they were not kept well-informed by other agencies treating/ supporting clients showing early signs of the risk of suicide/ at potential tipping points. A further 11.8% indicated that this depended on the agency concerned. Similarly around 61% indicated they were not kept well-informed by other agencies treating/ supporting clients who were in the recovery stage after making a suicide attempt.

Suggestions for improving the coordination of services for individuals were:

- using whatever type of communication is convenient e.g., telephone, email, letters etc
- increasing respect private providers by providing feedback
- improving immediate access to practitioners
- being informed when a client is discharged from hospital
- the need to improve case reports
- inclusive practices across all AH groups beyond the government mental health system
- better access to confidential client information particularly whether the client is also seeing other practitioners/ involved with other agencies
- the appointment of liaison officers for each client to manage handovers and information flow between agencies, GPs and the person concerned
- the need to strengthen links between GPs and AHPs
- mandatory follow-up especially after acute phase
- policies and procedures for follow up across all agencies/ practitioners, and
- increasing the accessibility of the WACHS mental health team.

Timely access to external mental health providers

Timely access to external mental health providers with appropriate training and experience is an important feature of effective coordination of services for individual clients/ patients at risk of suicide. Around 85% of the AHPs considered they had timely access to external mental health professionals with appropriate training and experience. Table 52 presents the percent of AHPs who considered they had timely access to different types of external mental health professionals. As shown the majority reported they have timely access to GPs and psychologists. Less than half consider they have timely access to psychiatrists (41.2%), social workers (17.6%), mental health nurses (35.3%), occupational therapists (11.8%) and counsellors (11.8%) with the training and experience to work with people at risk of suicide.

Table 52

Percent of AHPs who considered they had timely access to external mental health professionals with the training and experience to work with people at risk of suicide

Mental health professional	% AHPs
Psychiatrist	41.2
General practitioner	94.1
Psychologist	100
Social worker	17.6
Mental health nurse	35.3
Occupational therapist	11.8
Counsellor	11.8

Summary of findings –AHPs

Services for people at risk of suicide

1. The majority of AHPs (95%) take action in response to early signs of suicide/being at potential tipping points, are a provider of support for people in the recovery stage (80%) and to carers/ families of people at risk of suicide (75%). Around 35% reported being a first point of professional contact for people who had attempted suicide. Around half felt that reducing suicide through community education and working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility (47% and 50% respectively).

2. The majority of AHPs make referrals to other mental health professionals for clients showing early signs of suicide risk, at the first point of contact following a suicide attempt, and working with clients in the recovery stage after a suicide attempt (100%, 100% and 64% respectively). The majority also provide counselling and advice about mental health when working with clients showing early signs of suicide risk, at the first point of contact, and for clients in the recovery stage (76%, 100% and 93% respectively). Around 24% conduct psychological/ mental/ behavioural assessments.

3. Around 75% of AHPs work as sole practitioners of which around half were psychologists; the remainder being counsellors or occupational therapists. AHPS working with other practitioners were generally speaking psychologists, some of which also worked with GPs.

4. The majority of AHPs have the capacity to take on new clients (74%), in some cases subject to certain conditions (26%). None of the AHPs reported clients would normally be given an appointment on the same day as requesting it. By

comparison, around 40% of clients at risk of suicide would be seen on the same day. Around half of the AHPs (56%) provide an out-of-hrs/ weekend service for clients who may be at risk of suicide. These clients are provided with an after-hours contact number. AHPs who do not provide out-of-hrs/ weekend service generally provide their clients with contact details for crisis call centres.

5. A range of views emerged amongst AHPs regarding duty of care for someone at risk of suicide, viz., we have a duty of care to inform carers/ a responsible other, if there is a risk of self harm, the limitations to confidentiality are clearly explained at the first contact with the client and a release-of-information form is signed, and we won't contact others without the client's consent.

Knowledge of suicide prevention

6. There are a number of agreed-upon risk factors for suicidal behaviour. Those identified by more than 50% of AHPs were alcohol/ other substance abuse (59%), family discord/ violence or abuse (59%), social/ geographical isolation (59%), mental health problems/ disorders (53%) and separation/ loss (53%).

7. Two of the known early signs/ tipping points of suicidal risk were identified by 50% or more of the AHPs, viz., suicidal ideation (71%) and a relationship ending (76%). Known tipping points that were not mentioned by any AHP were a serious argument at home, and media reports on suicide or suicide methods.

8. Of the known clinical indicators of the imminent risk of suicide for someone who has attempted suicide in the past, a significant change in daily routine (58%), depressive symptoms/ hopelessness/ helplessness (75%), and alienation/ lack of support networks (75%) were identified by 50% or more of the AHPs. Known indicators that were not mentioned by any AHP were an interest in the likelihood of being found/ rescued when suicidal ideation is present and the recency/ frequency/ severity of recent attempts.

9. The most frequently mentioned barriers to services for males were that males are reluctant to talk about their problems (preferring to deal with them alone) (94%), the male stereotype of being tough and strong (90%) and the perceived stigma of mental illness (56%). Barriers that were less frequently mentioned were that males without partners are harder to reach (11%), a lack of time (11%), a lack of understanding regarding treatments (11%) and long wait lists (6%). A known barrier not mentioned by any AHP was the cost of services. Areas difficult to address include getting males in the door, a reluctance to maintain therapy, finances to pay for therapy, a belief that therapy won't work, time constraints that men have, difficulties in building family support, the stigma of mental illness, a lack of services coordination, the paperwork associated with Medicare rebates, and a lack of availability of appointments.

10. Professional development activities undertaken by AHPs in the past 3 years regarding suicide prevention included peer supervision, workshops (e.g.,

Gatekeeper), a one-day 'advanced skills course' run by the MCSP and trauma counselling. Suggestions for future PD included the formation of an inter-agency network with a focus on suicide prevention, best practice guidelines, refresher courses on suicide risk assessment, referral protocols and care pathways for access to community mental health services, case analysis and integrated strategies for managing suicide risk.

Services coordination

11. Whilst more than half (53%) of the AHPs agreed there was a high level of interest in working collaboratively across agencies/ practitioners to address suicidal behaviour, only 26% agreed there had been substantial past achievements when agencies/ practitioners had collaborated. Further, only 16% agreed that the areas of shared responsibility are clear and understood by all concerned. None of the AHPs agreed there are clear arrangements to monitor and review the success of working collaboratively. Around 21% agreed there was sufficient trust to survive any mistrust that might arise from collaboration. Less than half (44%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

12. Around 22% of the AHPs rated collaboration with external agencies/ practitioners they needed to work with in relation to patients at risk of suicide as 'extremely effective' or 'very effective'. The main barriers to effective coordination appear to be a lack of clear interagency referral and follow-up protocols particularly for acute admissions and discharge, difficulties in contacting staff in other agencies, a lack of awareness of the indicators of suicide risk, a lack of support agencies for young people at risk, a lack of awareness of SW services for people at risk of suicide, difficulties in retaining ongoing contact with clients at risk of suicide, a lack of inter-agency networking opportunities, too much emphasis on individual relationships between mental health providers, a lack of time for coordinating services across the professionals and agencies involved, and structures within WACHS which do not acknowledge the expertise of private practitioners. Suggestions for addressing these barriers were more opportunities for psychologists in private practice to meet other professions, community based forums to discuss local issues pertaining to suicide, clear referral guidelines so people don't slip through the cracks, physical co-location of agencies where this is appropriate, regular case conferencing, smaller caseloads, more beds/ in-patient resources for self harm assessment, breaking down status hierarchies between agencies, coordination between case manages in acute health services and practitioners in the community, equal referral rights for admission to WACHS, and suicide intervention counsellors at WACHS.

13. Around 65% of AHPs indicated they were not kept well-informed by other agencies treating/ supporting clients showing early signs of the risk of suicide/ at potential tipping points. A further 12% indicated that this depended on the agency concerned. Similarly around 61% indicated they were not kept well-informed by

other agencies treating/ supporting clients who were in the recovery stage after making a suicide attempt. Suggestions for improvement were using whatever type of communication is convenient, increasing respect private providers by providing feedback, improving immediate access to practitioners, being informed when a client is discharged from hospital, the need to improve case reports, inclusive practices across all AH groups beyond the government mental health system, better access to confidential client information particularly whether the client is also seeing other practitioners/ involved with other agencies, the appointment of liaison officers for each client to manage handovers and information flow between agencies/ practitioners, the need to strengthen links between GPs and AHPs, mandatory follow-up especially after acute phase, policies and procedures for follow up across all agencies/ practitioners, and increasing the accessibility of the WACHS mental health team.

14. Around 85% of AHPS considered they had timely access to providers with appropriate training and experience to work with people at risk of suicide. All AHPs considered they had timely access to psychologists. Around 94% considered they had timely access to GPs. Less than half considered they had timely access to other practitioners (psychiatrists (41%), social workers (18%), mental health nurses (35%), occupational therapists (12%) and counsellors (12%)) with the training and experience to work with people at risk of suicide.

'Not-for-profit' services

Service provision

Along with WACHS, GPs and AHPs, NGOs can play an important role in minimising the risk of suicide. Again, we applied the following criteria from Action Area 5 of the LIFE framework (outcome 5.1 – improved access to a range of support and care for people feeling suicidal) to examine the appropriateness of SW NGO services, viz:

- an appropriate mix of services (treatment/ support) is provided to individuals (i) showing early signs/ tipping points, (ii) at ongoing and imminent risk of suicide, and (iii) who have attempted suicide and are in the recovery stage
- an appropriate mix of mental health practitioners are employed to provide treatment/ support
- services are accessible in terms of location, wait times for appointments/ priority and out-of-hours service arrangements for individuals at risk of suicide, and
- barriers to services for males are addressed.

A senior practitioner from 23 of the 39 NGOs who were approached to take part in the research agreed to participate in the survey phase of the study. Eighteen were able to be contacted for a follow-up interview. Sixteen of the 18 interviewees (88.9%) indicated they had treated/ supported clients showing early signs of suicide/ at potential tipping points in the past 12 months; none of the NGOs indicated they had treated/ supported clients in the past 12-months requiring acute treatment for a suicide attempt; 22.2% indicated they had treated/ supported clients requiring longer-term support for their recovery after a suicide attempt. Social workers (36.4%) and counsellors (27.3%) were employed more often by NGOs than psychologists (9.1%), mental health nurses (4.5%) or occupational therapists (4.5%) to provide mental health support. Youth workers (9.1%) were also employed. Caution is required in generalising the findings to all SW NGOs.

Services mix

NGOs were asked about the services they provide to individuals at risk of suicide. As shown in Table 53, the majority provided services in response to early signs of suicide/ being at potential tipping points (80%), and being a provider of support to carers/ families of people at risk of suicide (63.6%). Around 39% reported being a provider of support to people in the recovery stage; none reported being a first point of professional contact for people who had attempted suicide.

Table 53

Services provided by NGOs to individuals at risk of suicide

Suicide prevention service	%
Being alert to the early signs of the risk of suicide/ potential tipping points and taking action	80.0
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/support	0
Being a provider of longer-term treatment/ support for people who have received acute treatment/ support for a suicide attempt and are in the recovery stage	39.1
Being a provider of support/ information to carers/ families of people at risk of suicide to build resilience and create an environment that supports help-seeking	63.6

Accessibility of services

Table 54 presents information about the usual wait time for an appointment and the priority given to clients at risk of suicide by NGOs. As shown around 27% of clients would normally be offered an appointment within 24 hrs; 18% would be seen within one week; 27% would not be seen for more than one week. In contrast, 44% of NGOs indicated that clients at risk of suicide would be offered an appointment within 24 hours. The urgency of the appointment for clients at risk of suicide was typically assessed by the NGO based on client self-report, information provided by a referring GP or by family/friends of the client. Around 50% of NGOs indicated they would not offer appointments to people at imminent risk of suicide.

Table 54

Usual wait time for an appointment and the priority given to clients at risk of suicide by NGOs

Service attribute	Immediate appointment	Same day	Within 24 hrs	Within 1 week	More than 1 week	Not applicable
Usual wait time for an appointment	0	27.3	0	18.2	27.3	27.3*
Priority given to clients at risk of suicide for appointments	20.0	12.0	12.0	4.0	0	48.0**

* The NGO does not operate on an appointment basis.

** Appointments are not usually offered to people at imminent risk of suicide

Table 55 presents information about the capacity to take on new clients and whether an out-of-hours/ weekend service for clients at high risk of suicide is provided by SW AHPs. As shown 77.3% of the NGOs indicated they had the capacity to take on new clients; 22.7% had the capacity to take on new clients subject to certain conditions, e.g., they must meet the agency's eligibility criteria (for example, they must be referred by Centrelink). One NGO indicated they would always offer an initial appointment even though they may not have the means to help the person. Around 36% of the NGOs provide an out-of-hrs/ weekend service for clients who may be at risk of suicide. Types of out-of-hours services included a 24-hour 'hot-line' where the client may be referred on to an emergency service, or a weekend drop-in centre with support services available. Some agencies work on an as-needed basis which includes weekends and evenings. NGOs who do not provide an out-of-hrs/ weekend service generally provide their existing clients with the contact details for crisis call-centres.

Table 55

Capacity to take on new clients and whether an out-of-hours/ weekend service is provided by NGOs

Service attribute	% Yes
Capacity to take on new clients	100
Provision of an out-of-hours/ weekend service for clients at high risk of suicide	35.7

Treatment and support

Table 56 presents information about the types of treatment and support provided to people showing early signs/ being at potential tipping points and people who have received acute treatment for a suicide attempt and are in the recovery stage. As shown the majority of NGOs indicated they provided information about available services/ advice about mental health/ referrals to other mental health professionals for clients showing early signs, as well as those in the recovery stage after a suicide attempt (100% and 71.4% respectively). Needs assessment/ case management and psychological/ mental/ behavioural assessments are provided less frequently (around 15% and 33% respectively). Counselling/ therapy is more frequently provided to clients in the recovery stage than to clients showing early signs (71.4% and 44.4% respectively).

Table 56

Types of treatment and support provided to people at risk of suicide by NGOs

Types of treatment/ support	% – early signs/ tipping points	% – recovery after suicide attempt
General service availability information, advice, referral	100	71.4
Needs assessment and case management	16.7	14.3
Mental, behavioural or psychological assessment	33.3	0
Psychosocial counselling/ psychological therapies	44.4	71.4

NGOs were asked to describe who they refer to, the hand-over process, and the nature of client follow up for clients who may be at risk of suicide. Current practices include referrals to GPs, the local hospital, SW drug service, other NGO services such as Waratah, and/ or WACHS mental health services. An ambulance or the police may be called depending on circumstances. Some NGOs indicated they drive clients to hospital or organise a taxi and contact their clients to make sure they attended their referral appointment. Others continue to provide support, e.g., by taking people to appointments for one-on-one counselling. The PET (psychiatric emergency team) is called in some cases, as is the WACHS mental health team or Rural Link.

A range of views emerged regarding duty of care for someone at risk of suicide, viz:

- our duty of care remains with client – would not divulge info without their consent, if < 16 will contact DCP
- our duty of care is to provide information to relevant people
- we will only contact parents with young clients
- we will always encourage clients to talk to significant others
- confidentiality boundaries are clearly explained at our first contact with the client and a release of information form signed
- we have a duty of care to inform and support carers/ responsible other if self harm is a risk
- our agency accepts full responsibility for our clients' welfare unless the client refuses a service – that said we will involve police/ hospital if deemed necessary
- our duty of care means that where suicide is a risk we need to inform everyone concerned up to the State operations manager
- we have a duty of care to inform the student's school which in turn has a duty of care to inform the parents

- we have a duty of care to keep our clients safe until the appropriate person takes responsibility
- we will physically take clients to hospital if required, but if they won't agree the police are called if the situation is serious
- we will only involve significant others with the permission of the client
- our agency will call police/ emergency if the client in imminent danger and is not cooperating, and
- we have a duty of care to workers to keep them safe as well as our clients.

Understanding of suicide prevention

Service providers should have adequate understanding of suicide prevention. We applied criteria from Action Area 5 of the LIFE framework (outcome 5.4 – improved understanding, skills and capacity of front-line workers) to examine the extent to which SW NGOs:

- have adequate knowledge of known suicide risk factors
- have adequate knowledge of (i) the early signs/ tipping points for suicide, and (ii) the clinical indicators of ongoing and imminent risk for people who have attempted suicide, and
- access up-to-date professional development regarding suicide prevention.

Knowledge of suicide risk factors

Table 57 presents the suicide risk factors NGOs perceived as relevant to their client group. As shown the individual risk factors identified by 50% or more of those interviewed were alcohol or other substance abuse (82.4%) and mental health problems/ disorders (52.9%); situational risk factors identified by more than 50% of those interviewed were family discord, violence or abuse (58.8%), and social or geographical isolation (58.8%). One individual risk factor was not mentioned viz., access to lethal means when suicidal ideation is present; none of the known situational risk factors were not mentioned by at least one NGO.

Table 57

Percent of NGOs
who identified known risk factors for suicide

Risk factors	%
Individual	
Male gender	23.5
Age	11.8
Mental health problems/disorders	52.9
Prior suicide attempt	11.8
Alcohol or other substance abuse	82.4
Chronic pain or illness	5.9
Low self-esteem	17.6
Little sense of control over life	23.5
circumstances	11.8
Lack of meaning and purpose in life	11.8
Poor coping skills	23.5
Hopelessness	0
Access to lethal means	
Situational	58.8
Family discord, violence or abuse	47.1
Separation or loss	11.8
Family history of suicide or mental illness	58.8
Social or geographical isolation	5.9
Imprisonment	35.2
Financial stress	17.6
Poverty	29.4
Unemployment or economic uncertainty	11.8
Homelessness	11.8
Social or cultural discrimination	11.8
Exposure to environmental stressors	35.3
Lack of support services	

Knowledge of the early signs/ tipping points for suicide

Table 58 presents the percent of NGOs who identified known early signs/ tipping points for suicide. As shown only one of the known early signs was identified by 50% or more of those interviewed viz., suicidal ideation (66.7%); none of the known tipping points were identified by more than 50% of those interviewed. There were no early signs that were not mentioned by at least one NGO; tipping points that were not mentioned were the suicide of someone famous or member of a peer group, a serious argument at home, and a media report on suicide or suicide methods.

Table 58

Percent of interviewees representing 'not-for-profit' providers who identified known early signs/ tipping points for suicide

Early signs/ tipping points for suicide	%
Early signs	
Suicidal ideation	66.7
Substance abuse	44.4
Purposelessness	5.6
Anxiety and agitation	38.9
Feeling trapped	5.6
Hopelessness	33.3
Withdrawal	27.8
Anger	11.1
Recklessness	5.6
Mood fluctuations	16.7
Tipping points	
Relationship ending	38.9
Loss of status or respect	38.9
Debilitating physical illness or accident	5.6
Death or suicide of relative/ friend	22.2
Suicide of someone famous/ member of peer group	0
	0
Serious argument at home	44.4
Being abused or bullied	0
Media report on suicide or suicide methods	

Knowledge of the clinical indicators of ongoing and imminent risk for people who have attempted suicide

Table 59 presents the percent of NGOs who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide and are in the recovery stage. As shown only two of the known indicators were identified by 50% or more of those interviewed viz., a significant change in daily routine (50%) and depressive symptoms/ hopelessness/ helplessness (50%). Indicators that were not mentioned were whether a person has a detailed suicide plan, the lethality of an intended method of suicide, access to suicide means, or an interest in the likelihood of being found/rescued, when suicidal ideation is present. Other indicators not mentioned were the recency/ frequency/ severity of recent attempts and the presence of chronic, painful medical problems/ perceived medical problems.

Table 59

Percent of interviewees representing 'not-for-profit' providers who identified known clinical indicators of ongoing and imminent risk for people who have attempted suicide and are in the recovery stage

Clinical indicators of ongoing and imminent risk	%
Frequent thoughts of suicide	33.3
Detailed suicide plan	0
Lethality of intended suicide method	0
Access to suicide means	0
An interest in the likelihood of being found/rescued	0
Recency/ frequency/ severity of recent attempts	0
Significant change in circumstances or loss	16.7
Significant change in daily routine	50.0
Chronic, painful medical problems/ perceived medical problem	0
Depressive symptoms/ hopelessness/ helplessness	50.0
Psychiatric disorder – e.g., depression, eating disorder, panic	33.3
Substance abuse	33.3
Alienation or lack of support networks	33.3

Knowledge of barriers to services for males

NGOs were also asked about services to males at risk of suicide, specifically what they regarded as the main barriers males face in accessing treatment/ support. As shown in Table 60 the most frequently mentioned barriers were that males are reluctant to talk about their problems (preferring to deal with them alone) (83.3%), the perceived stigma of mental illness (44.4%), and the associated male stereotype of being tough and strong (44.4%). Barriers less frequently mentioned were the idea that males have that talking won't help fix the problem (33.3%) and a lack of a social support network (22.2%). The cost of services and that males without partners are more difficult to reach, were not mentioned.

Table 60

Perceived barriers males at risk of suicide face in accessing treatment/ support identified by NGOs

Barriers that males face	%
Not talking about problems/deal with them alone	83.3
Talking won't help fix the problem	33.3
Lack of social network support	22.2
Males without partners harder to reach	0
Lack of time	11.1
Not recognising symptoms of distress, only physical symptoms	11.1
Cost of services	0
Perceived stigma of mental illness	44.4
Lack of understanding regarding treatments	5.6
Use of destructive coping mechanisms to deal with problems	16.7
Don't know what help is available	16.7
Traditional views of masculinity, of being tough and strong	44.4
Long waiting lists	5.6

NGOs were asked how the barriers had been addressed at their service. As shown in Table 61 apart from ensuring staff diversity (e.g., employing male and female staff and/or a cultural mix) (33.3%), the promotion of healthy lifestyles/ coping mechanisms (27.8%) and ensuring clear referral pathways (27.8%), few of the other known strategies for addressing barriers that males at risk of suicide face are currently being employed by NGOs.

Table 61

Strategies NGOs have used to address barriers that males at risk of suicide face when accessing treatment/ support

Strategies used to address barriers	%
Promotion of healthy lifestyles/ coping mechanisms	27.8
Build and strengthen the support networks of male clients	0
Understand the emotional/economic/social factors increasing suicide risk	11.1
Use physical symptoms to ask questions about what else may be going on	5.6
Gather enough information to be aware of what's really going on	11.1
Completed appropriate training courses	5.6
Service is well publicized	0
Practical and solution focused service to develop life skills	11.1
Educational materials on mental health issues provided	11.1
Clear referral pathways	27.8
Male and female staff and/or a cultural mix	33.3
Specialist support services for at-risk groups	0
Service aimed at times of high need	5.6
Free service/ bulk bill/ publicise Medicare rebates	0
High quality and well-trained staff	0
Continuity of care	11.1
Information sharing protocols developed	0
The service/ program is for males only	5.6
Hours of operation	0

Specific barriers that NGOs have found difficult to address include transport to Bunbury to access services (men at risk may have lost their licence) because of a lack of services available locally, getting appropriate intervention in a timely manner, accessing male staff, male isolation, that men are less likely to discuss problems than women, a lack of

referral options including a lack of options that males are willing to use, and child care services for single-parent men.

Professional development regarding suicide prevention

NGOs were asked about the professional development regarding suicide prevention they had undertaken in the past 3 years. Around 70% indicated they had undertaken this type of PD. PD activities included:

- Gate-Keeper workshop
- Map of Loss workshop
- applied suicide intervention skills training
- mental health conference workshops
- WACHS suicide intent and self-harm workshop
- Lifeline suicide counselling
- acute trauma counselling
- suicide prevention workshop, and
- mental health first aid.

Suggestions for future PD were:

- knowledge about available services and referral protocols in the SW
- working with families
- suicide risks and tipping points (e.g., in the family dispute resolution context)
- employee assistance programs for staff working with people at risk of suicide/ self care
- suicide risk assessment tools
- types of longer-term intervention
- domestic violence and drug abuse and the link with suicide
- counselling and grief workshops for new ideas/ strategies, and
- next step after suicide first aid training.

Coordination of services

The coordination of NGO services with other services is important to minimise the risk of suicide. We applied criteria from Action Area 4 of the LIFE framework (outcome 4.1 – linking local services effectively so that people experience a seamless service) to examine the extent to which NGOs:

- accept appropriate responsibility for the early detection of suicidal behaviour, treatment of individuals who have attempted suicide, and/or follow-up support for those who have attempted suicide and are in the recovery stage
- collaborate effectively with other providers involved in suicide prevention/ treatment, and
- have timely access to mental health providers with the training and experience to work with individuals at-risk of suicide.

Responsibility for suicide prevention services

Table 62 presents the percent of NGOs who considered they have a responsibility for suicide prevention services to individuals along with the percent of providers who currently provide these services. As shown all NGOs reported they felt a responsibility to be alert to the early signs of the risk of suicide as well as the signs of high risk and tipping points, and taking action. Around 77% also felt they had a responsibility as a provider of support/ information to carers/ families of people with evidence of suicidal behaviour, and 58.8% considered they had responsibility for ongoing care for people in the recovery stage. The sense of responsibility for these services is generally reflected in the services currently provided by NGOs. The exception is that whilst 27.8% considered they had a responsibility for being one of the first points of professional contact/ targeted support for people who have attempted suicide, none currently provides this service.

Table 62

Percent of NGOs who considered they had a responsibility for, and who provide, particular suicide prevention services

Suicide prevention services	% responsible for services	% provide services
Being alert to the early signs of the risk of suicide/ tipping points and taking action	100	80.0
Being one of the first points of professional contact for people who have attempted suicide and providing acute treatment/ support	27.8	0
Being a provider of ongoing care for people who have had treatment/ support for a suicide attempt and are in the recovery stage	58.8	39.1
Being a provider of support/ information to carers/ families of people with evidence of suicidal behaviour to build resilience and create an environment that supports help-seeking	76.5	63.6

NGOs were also asked if they regarded reducing suicide through improving media coverage, reducing access to means of suicide or providing community education as their responsibility. Around 33% indicated this was their responsibility as an NGO. They were also asked whether working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility; 94% indicated this was their responsibility as an NGO.

Services coordination

Table 63 presents the perceptions of NGOs regarding the effectiveness of services coordination in the SW for people at risk of suicide. As shown whilst more than half indicated there is interest in working collaboratively to address suicidal behaviour in the SW (66.7%), fewer than half considered there had been substantial past achievements when agencies had collaborated (41.6%). Only 8.3% agreed that areas of shared responsibility are clear and understood by all concerned. Similarly, only 4.2% agreed there are clear arrangements to monitor and review the success of working collaboratively. Around 38% agreed there was sufficient trust to survive any mistrust that might arise from collaboration. Less than half (37.5%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

Table 63

Perceptions of NGOs regarding the effectiveness of services coordination in the SW for people at risk of suicide

Services coordination	% SD	% D	% Neutral	% A	% SA
Interest in working collaboratively among agencies/practitioners involved in addressing suicidal behaviour in the South West is generally high	0	8.3	25.0	62.5	4.2
There is a clear commitment to working collaboratively from the most senior levels of these agencies/ independent practices	0	12.5	33.3	50.0	4.2
There have been substantial past achievements when agencies/ practitioners involved in addressing suicidal behaviour in the South West have collaborated	0	4.2	54.2	33.3	8.3
There is sufficient trust among agencies/ practitioners involved in addressing suicidal behaviour in the South West to survive any mistrust that might arise from collaboration	4.2	8.3	50.0	29.2	8.3
The areas of responsibility of agencies/ independent practitioners involved in addressing suicidal behaviour in the South West are clear and understood by all concerned	4.2	50.0	37.5	8.3	0
Co-location of agencies/ practitioners involved in addressing suicidal behaviour in the South West is an important facilitator of working collaboratively	0	20.8	41.7	20.8	16.7
There are clear arrangements to monitor and review how agencies/ practitioners involved in addressing suicidal behaviour in the South West work collaboratively	8.3	25.0	62.5	4.2	0

NGOs were asked how they would rate their collaboration with external agencies/ practitioners they needed to work with in relation to suicidal clients. Around 33% rated collaboration as ‘very effective’, around 42% rated collaboration as ‘somewhat effective’, and 25% rated collaboration as ‘minimally effective’ or ‘not at all effective’.

The main barriers to effective inter-agency coordination identified by NGOs were:

- too few staff/ staff shortages
- distance between providers
- more appropriate responses when referring to other agencies – our agency contacted SW24 and were told to contact police which would have inflamed the situation
- a lack of awareness of SW services and referral protocols for people at risk of suicide
- lack of inclusion in regional consultation/ engagement (financial problems are not viewed as a major issue in suicidal behaviour)
- lack of interaction amongst agencies involved in a common case
- problems addressing privacy/ confidentiality issues in across-agency referrals – the need for signed consent forms regarding confidentially can slow things down
- a lack of available appointments, support and follow-up when referring to other agencies
- lack of case managers particularly GPs who can act as case managers
- competing interests of agencies
- high case loads resulting in a lack of time for coordinating services across the professionals and agencies
- too much emphasis on individual relationships between mental health providers- it's who you know
- a lack of agreed referral protocols
- WACHS is not sufficiently involved in inter-agency networking meetings
- A lack of appreciation of what NGOs have to offer, and
- individual differences between what types of issues practitioners are willing to take on which makes it difficult to know who to approach.

Suggestions for addressing these barriers to effective inter-agency coordination were:

- information sheets for all SW agencies involved in suicide prevention including their role, referral protocols and contact information
- annual network meetings and information sessions – for service providers and the general community
- more funding for services
- better case management
- standardized protocols and processes for cross-agency coordination
- greater involvement of mental health services with NG sector

- the development of MOUs (roles/ responsibilities) between NGOs and non NGOs
- more engagement across agencies with the Mental Health Network and the SW Youth Coordinating Network
- services available in each town/ area, and
- better protocols regarding access to ED and SW mental health.

Interviewees were also asked about issues that needed to be addressed to improve the coordination of services for individuals. Around 50% who currently take action when alerted to the early signs/ tipping points for suicide indicated they were kept well-informed by other agencies treating/ supporting their clients/ patients; however, half of these said it depended on the agency concerned. Around 60% who currently provide support to people who had attempted suicide and were in the recovery stage indicated they were kept well-informed by other agencies treating/ supporting their clients/ patients; however, in most cases again this depended on the agency concerned.

Suggestions for addressing identified concerns were:

- being kept informed of other agency's treatment plans and treatment cessation
- case management that extends beyond the immediate crisis
- developing an agreed format for coordination of services for individuals
- keeping lines of communication open, and
- inclusion of all relevant practitioners in case conferences

Timely access to external mental health providers

Timely access to external mental health providers with appropriate training and experience is an important feature of effective coordination of services for individual clients/ patients at risk of suicide. Around 64% considered they had timely access to providers with appropriate training and experience. Table 64 presents the percent of NGOs who considered they had timely access to different types of external mental health professionals. As shown half reported they have timely access to GPs, psychologists, social workers and mental health nurses. Less than half consider they have timely access to psychiatrists (14.3%), occupational therapists (15.4%) and counsellors (21.4%) with the training and experience to work with people at risk of suicide.

Table 64

Percent of NGOs who considered
they had timely access to external mental health professionals
with the training and experience to work with people at risk of suicide

Mental health professional	%

Psychiatrist	14.3
General practitioner	50.0
Psychologist	50.0
Social worker	50.0
Mental health nurse	53.8
Occupational therapist	15.4
Counsellor	21.4

Summary of findings –NGOs

Services for people at risk of suicide

1. The majority of NGOs take action in response to early signs of suicide/being at potential tipping points (80%) and provide support to carers/ families of people at risk of suicide (64%). Around 39% are a provider of support for people in the recovery stage. No NGO reported being a first point of professional contact for people who had attempted suicide. Around 33% felt that reducing suicide through community education was their responsibility. Around 94% considered working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility.

2. The majority of NGOs make referrals to mental health professionals for clients showing early signs of suicide risk and working with clients in the recovery stage after a suicide attempt (100% and 71% respectively). The majority (71%) also provide counselling and advice about mental health when working with clients in the recovery stage, compared to 44% for clients showing early signs of suicide risk. Around 33% conduct psychological/ mental/ behavioural assessments for clients showing early signs of suicide risk. Around 15% conduct needs assessment and case management for clients showing early signs and those in the recovery stage.

3. Social workers (36.4%) and counsellors (27.3%) were employed more often than psychologists (9.1%), mental health nurses (4.5%) or occupational therapists (4.5%) to provide mental health support. Youth workers (9.1%) were also employed.

4. Around 77% reported they have the capacity to take on new clients, in some cases subject to certain conditions (23%). Around 27% of clients would normally be given an appointment on the same day of requesting it. By comparison, around 32% of clients at risk of suicide would be seen on the same day. Around 36% of the NGOs provide an out-of-hrs/ weekend service for clients who may be at risk of suicide. Types of out-of-hours services included a 24-hour 'hot-line' and a weekend drop-in centre. Some agencies work on an as-needed basis including weekends and evenings. NGOs who do not provide an out-of-hrs/ weekend service provide contact details for crisis call-centres.

5. A range of views emerged amongst NGOs regarding duty of care for someone at risk of suicide, viz., our duty of care remains with the client – would not divulge info without their consent, if < 16 will contact DCP, our duty of care is to provide information to relevant people, we will only contact parents with young clients, we will always encourage clients to talk to significant others and confidentiality boundaries are clearly explained at our first contact with the client and a release of information form signed.

Knowledge of suicide prevention

6. There are a number of agreed-upon risk factors for suicidal behaviour. Those identified by more than 50% of NGOs were alcohol/ other substance abuse (82%),

family discord/ violence or abuse (59%), social/ geographical isolation (59%) and mental health problems/ disorders (53%).

7. Only one of the known early signs of suicidal risk was identified by 50% or more of the NGOs, viz., suicidal ideation (67%). No known tipping points were mentioned by 50% or more of the NGOs. Known tipping points that were not mentioned by any NGO were the suicide of someone famous/ member of peer group, a serious argument at home, and media reports on suicide or suicide methods.

8. Of the known clinical indicators of the imminent risk of suicide for someone who has attempted suicide in the past, a significant change in daily routine (50%) and depressive symptoms/ hopelessness/ helplessness (50%) were identified by 50% or more of the NGOs. Known indicators that were not mentioned by any NGO were a detailed suicide plan, lethality of intended suicide method, access to suicide means, an interest in the likelihood of being found/ rescued when suicidal ideation is present, the recency/ frequency/ severity of recent attempts and chronic painful medical problems/ perceived medical problems.

9. The most frequently mentioned barriers to services for males were that males are reluctant to talk about their problems (preferring to deal with them alone) (83%), the perceived stigma of mental illness (44%), and the male stereotype of being tough and strong (44%). Barriers that were less frequently mentioned were a lack of time (11%), not recognizing emotional symptoms of distress, only physical symptoms (11%), a lack of understanding regarding treatments (6%), and long wait lists (6%). Known barriers not mentioned by any NGO were males without partners harder to reach and the cost of services. Areas difficult to address include transport to Bunbury to access services because of a lack of services available locally, getting appropriate intervention in a timely manner, accessing male staff, male isolation, that men are less likely to discuss problems than women, a lack of referral options including a lack of options that males are willing to use, and child care services for single-parent men.

10. Professional development activities undertaken by NGOs in the past 3 years regarding suicide prevention included workshops (e.g., Gatekeeper, Map of Loss), WACHS suicide intent and self-harm workshop, counselling (e.g., Lifeline suicide counselling), and mental health first aid. Suggestions for future PD included improving knowledge about available services and referral protocols, working with families, suicide risks and tipping points, suicide risk assessment tools, types of longer-term intervention, domestic violence and drug abuse and the link with suicide, counselling and grief workshops for new ideas/ strategies, and next step after suicide first aid training.

<u>Services coordination</u>

11. Whilst more than half (67%) of the NGOs agreed there was a high level of interest in working collaboratively across agencies/ practitioners to address suicidal behaviour, only 42% agreed there had been substantial past achievements when

agencies/ practitioners had collaborated. Further, only 8% agreed that the areas of shared responsibility are clear and understood by all concerned. Around 4% agreed there are clear arrangements to monitor and review the success of working collaboratively. Around 38% agreed there was sufficient trust to survive any mistrust that might arise from collaboration. Less than half (37%) agreed that co-locating agencies involved in addressing suicide would be an important facilitator of working collaboratively.

12. Around 33% of the NGOs rated collaboration with external agencies/ practitioners they needed to work with in relation to patients at risk of suicide as 'extremely effective' or 'very effective'. The main barriers to effective coordination appear to be too few staff/ staff shortages, distance between providers, the need for more appropriate responses when referring to other agencies, a lack of awareness of SW services and referral protocols for people at risk of suicide, a lack of inclusion in regional consultation/ engagement, a lack of interaction amongst agencies involved in a common case, problems addressing privacy/ confidentiality issues in cross-agency referrals, a lack of available appointments, support and follow-up when referring to other agencies, a lack of case managers particularly GPs who can act as case managers, competing interests of agencies, high case loads resulting in a lack of time for coordinating services across the professionals and agencies, too much emphasis on individual relationships between mental health providers, a perception that WACHS is not sufficiently involved in inter-agency networking meetings, a lack of appreciation of what NGOs have to offer, and individual differences between what types of issues practitioners are willing to take on which makes it difficult to know who to approach. Suggestions for addressing these barriers to effective inter-agency coordination included the need for information sheets for all SW agencies involved in suicide prevention including their role, referral protocols and contact information, annual network meetings and information sessions, more funding for services, better case management, standardized protocols and processes for cross-agency coordination, greater involvement of mental health services with the NG sector, the development of MOUs (roles/ responsibilities) between NGOs and non NGOs, more engagement across agencies with the Mental Health Network and the SW Youth Coordinating Network, an increase in the services available in each town/ area, and better protocols regarding access to ED and SW mental health.

13. Around 50% of NGOs indicated they were not kept well-informed by other agencies treating/ supporting clients showing early signs of the risk of suicide/ at potential tipping points. Around half of these NGOs indicated that this depended on the agency concerned. Similarly around 40% indicated they were not kept well-informed by other agencies treating/ supporting clients who were in the recovery stage after making a suicide attempt. Suggestions for improvement included being kept informed of other agencies' treatment plans and treatment cessation, case management that extends beyond the immediate crisis, developing an agreed

format for coordination of services for individuals, keeping lines of communication open, and inclusion of all relevant practitioners in case conferences.

14. Around 64% of NGOs considered they had timely access to providers with appropriate training and experience to work with people at risk of suicide. Around 50% considered they had timely access to psychologists, GPs, social workers and mental health nurses. Less than half considered they had timely access to other practitioners (psychiatrists (14%), occupational therapists (15%) and counsellors (21%)) with the training and experience to work with people at risk of suicide.

OVERVIEW OF SERVICE APPROPRIATENESS IN THE SW

The central goal of the LIFE framework is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour. Six 'action areas' are identified (1) improving the evidence base and understanding of suicide prevention, (2) building individual resilience and the capacity for self help, (3) improving community strength, resilience and capacity in suicide prevention, (4) taking a coordinated approach to suicide prevention, (5) providing targeted suicide prevention activities, and (6) implementing standards and quality in suicide prevention. The present research has focused on:

- the extent to which an appropriate range of required support and care for people at risk of suicide is available in the SW (Action Area 5: Providing targeted suicide prevention activities)
- the understanding amongst service providers of suicide prevention risk factors, early signs/ tipping points and clinical indicators of ongoing risk (Action Area 5: Improving understanding, skills and capacity of front-line workers), and
- the extent of inter-agency collaboration including the extent to which existing services are appropriately coordinated (Action Area 4: Taking a coordinated approach to suicide prevention).

Information was obtained four groups of service providers: WACHS, GPs, AHPs and NGOs. The key issues examined were:

… the extent to which

- an appropriate mix of services (treatment/ support) is provided to individuals (i) showing early signs/ tipping points, (ii) at ongoing and imminent risk of suicide, and (iii) who have attempted suicide and are in the recovery stage
- an appropriate mix of mental health practitioners are employed to provide treatment/ support
- an appropriate mix of treatment/ support is provided to people at risk of suicide
- services are accessible in terms of location, wait times for appointments/ priority and out-of-hours service arrangements for individuals at risk of suicide, and
- duty of care issues are appropriately resolved.

… the extent to which providers

- have adequate knowledge of known suicide risk factors
- have adequate knowledge of (i) the early signs/ tipping points for suicide, and (ii) the clinical indicators of ongoing and imminent risk for people who have attempted suicide
- barriers to services for males are addressed, and
- access up-to-date professional development regarding suicide prevention.

… and the extent to which providers

- accept appropriate responsibility for the early detection of suicidal behaviour, treatment of individuals who have attempted suicide, and/or follow-up support for those who have attempted suicide and are in the recovery stage
- collaborate effectively with other providers involved in suicide prevention/ treatment, and
- have timely access to mental health practitioners from other agencies with the training and experience to work with individuals at-risk of suicide.

Support and care for people at risk of suicide in the SW

Support and care for people at risk of suicide in the SW was examined in terms of the mix of services currently provided, the mix of mental health practitioners employed to provide services, the treatment/ support provided, and the accessibility of services.

Mix of services

Key findings regarding the mix of suicide prevention services in the SW are:

- the majority of WACHS hospital-based and community-based mental health services, GPs, AHPs and NGOs take action in response to early signs/ tipping points
- the majority of WACHS hospital-based mental health services and GPs, and to a lesser extent AHPs and WACHS community-based mental health services, reported being a first point of professional contact for people who had attempted suicide
- the majority of WACHS community-based mental health services, GPs and AHPs, and to a lesser extent WACHS hospital-based mental health services and NGOs, provide longer-term support for people in the recovery stage, and
- the majority of WACHS community-based mental health services, GPs, AHPs, and to a lesser extent WACHS hospital-based mental health services and NGOs, provide support to carers/ families of people at risk of suicide.

Less than half of WACHS staff, GPs, AHPs and NGOs reported that reducing suicide through community education was their responsibility. The majority of WACHS community-based mental health staff, GPs and NGOs reported that working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility. In contrast, around half of WACHS hospital-based staff and AHPs considered this was their responsibility.

Mix of mental health practitioners

Key findings regarding the mix of mental health practitioners working in suicide prevention services in the SW are:

- WACHS hospital-based and community-based mental health services employ practitioners from a wide range of professions including psychiatrists, emergency medicine, mental health nurses, critical care nurses, psychologists, social workers and occupational therapists
- few GPs employ AHPs, however some practices employ psychologists and mental health nurses
- the majority of AHPs work as sole practitioners many of which are psychologists or counsellors; AHPs working with other practitioners were generally psychologists some of which work in general practice with GPs, and

- social workers and counsellors were employed more often than psychologists, mental health nurses or occupational therapists by NGOs – youth workers were also employed.

Treatment/ support provided by mental health practitioners

Key findings regarding treatment/ support provided to people at risk of suicide in the SW are:

- the majority of WACHS hospital-based and community-based mental health services, GPs, AHPs and NGOs provide advice about mental health/ make referrals in response to early signs of suicide risk/ tipping points; needs assessment/ case management along with mental/ behavioural/ psychological assessment is undertaken to a lesser extent; counselling/ psychological therapy is conducted more frequently
- the majority of WACHS hospital-based and community-based mental health services, GPs and AHPs provide advice about mental health/ make referrals at the first point of professional contact for people who had attempted suicide; needs assessment/ case management along with mental/ behavioural/ psychological assessment is undertaken to a lesser extent; counselling/ psychological therapy is conducted more frequently amongst WACHS community-based mental health staff, GPs and AHPs, and
- the majority of WACHS community-based mental health services, GPs, AHPs and NGOs provide advice about mental health/ make referrals for people who have attempted suicide and are in the recovery stage; needs assessment/ case management along with mental/ behavioural/ psychological assessment is undertaken to a lesser extent; counselling/ psychological therapy is conducted more frequently amongst WACHS community-based mental health staff, GPs, AHPs and NGOs.

Accessibility of services

Key findings regarding the accessibility of services in the SW for people at risk of suicide are:

- the usual wait time for a consult with a mental health professional for WACHS hospital-based services is less than 2 hours; however wait times after hours at Bunbury Regional Hospital are longer because mental health liaison staff are available 8am to 11pm; children/ adolescents may have extended wait times as CAMHS services are limited; as mental health staff are not always on site at district hospitals wait times are likely to be longer
- the usual wait time for a consult with a mental health professional for WACHS community-based services is reported to be within 24 hours; these services typically do not operate out-of hours or over the weekend
- all patients would be seen the same day if not immediately by GPs; GPs typically provide an out-of-hours/ weekend service, the usual arrangement is that the patient calls the surgery and is given a contact phone number for a GP via a

recorded message; GPs have the capacity to take on new patients however this can be subject to certain conditions, for example, they need to live in the local area

- around 40% of people at risk of suicide would be seen on the same day by private AHPs, generally speaking this applies to existing clients; around 50% provide an out-of-hours/ weekend service whereby existing clients are provided with an after-hours contact number, otherwise clients are provided details of crisis-call centres; the majority have the capacity to take on new clients, in some cases subject to certain conditions, for example, practitioners may restrict their practice to adults, and
- around one-third of clients at risk of suicide would be seen the same day by NGOs; around 36% provide an out-of-hours/ weekend service for example a 24 hour hot-line, a weekend drop-in centre; otherwise clients are provided details of crisis-call centres; the majority have the capacity to take on new clients, in some cases subject to certain conditions, for example, clients need to meet eligibility criteria set by the funding body.

Duty of care

A wide range of considerations emerged regarding the duty of care to people at risk of suicide in the SW including:

- if the risk is not imminent the patient's wishes regarding confidentiality would be respected; if the risk is deemed sufficiently high then the patient's refusal to involve others would be over-ridden
- the need for patients to always sign a confidentiality agreement/ release of information form regarding information sharing with other agencies/ practitioners
- the need to involve the patient's GP when the patient is admitted to hospital; if the patient is < 16 there is also a requirement to involve their parents/ guardian, and
- the requirement to keep patients/ practitioners/ carers and others safe, particularly where violence to others is a risk.

Understanding of suicide prevention

Understanding of suicide prevention in the SW was examined in terms of perceptions of risk factors, knowledge of early signs of suicide risk/ tipping points, knowledge of indicators of ongoing risk, and barriers experienced by males in accessing services.

Suicide risk factors

Key findings regarding perceived risk factors in the SW are:

- factors identified by 50% or more of WACHS hospital-based or community-based mental health services were alcohol/ other substance abuse, age, family discord/ violence or abuse, social/ geographical isolation

- factors identified by 50% or more of AHPs were alcohol/ other substance abuse, family discord/ violence or abuse, social/ geographical isolation, mental health problems/ disorders and separation/ loss
- factors identified by 50% or more of NGOs were alcohol/ other substance abuse, family discord/ violence or abuse, social/ geographical isolation and mental health problems/ disorders.

Known suicide risk factors infrequently reported by WACHS, AHPs or NGOs as apparent in the SW were prior suicide attempts, low self esteem, hopelessness, homelessness, social/ cultural discrimination, chronic pain/ illness, little sense of control over life's circumstances, a lack of meaning and purpose in life, family history of suicide/ mental illness, imprisonment, and access to lethal means for people with suicidal ideation.

Knowledge of early signs of suicide risk/ tipping points

Key findings regarding knowledge of the known early signs of suicide risk/ tipping points in the SW are:

- early signs/ tipping points identified by 50% or more of WACHS hospital-based or community-based mental health staff were suicidal ideation, substance abuse, anxiety/ agitation, hopelessness, withdrawal, mood fluctuations, relationship ending and death/ suicide of a relative/ friend
- none of the known early signs/ tipping points were identified by 50% or more of GPs
- early signs/ tipping points identified by 50% or more of AHPs were suicidal ideation and relationship ending, and
- suicidal ideation was the only early signs/ tipping point identified by 50% or more of NGOs.

Known early signs of suicide risk/ tipping points infrequently identified by WACHS, GPs, AHPs or NGOs were purposelessness, feeling trapped, recklessness, debilitating physical illness/ accident, suicide of someone famous/ member of peer group, anger, a serious argument at home, media report on suicide/ suicide methods.

Knowledge of indicators of ongoing risk

Key findings regarding knowledge of known clinical indicators of ongoing risk for people in the SW who have attempted suicide are:

- indicators identified by 50% or more of WACHS hospital-based or community-based mental health staff were frequent thoughts of suicide, access to suicide means, a significant change in circumstances/ loss, depressive symptoms/ hopelessness/ helplessness and substance abuse
- depressive symptoms/ hopelessness/ helplessness was the only clinical indicator identified by 50% or more of GPs
- clinical indicators identified by 50% or more of AHPs were a significant change in daily routine, depressive symptoms/ hopelessness/ helplessness and alienation/ lack of support networks, and

- clinical indicators identified by 50% or more of NGOs were a significant change in daily routine and depressive symptoms/ hopelessness/ helplessness.

Known clinical indicators of ongoing risk less frequently identified by WACHS, GPs, AHPs or NGOs were a detailed suicide plan, the lethality of intended suicide method or an interest in being rescued for those with suicidal ideation, recency/ frequency/ severity of recent attempts, and chronic, painful medical problem/ perceived medial problem.

Barriers to males

Key findings regarding known barriers that males at risk for suicide face in accessing in the SW are:

- relatively few of the known barriers were identified except for males are reluctant to talk about their problems, the male stereotype of being tough and strong, the use of destructive coping mechanisms and the perceived stigma of mental illness.

Known barriers infrequently identified by WACHS, GPs, AHPs or NGOs were males don't know what help is available, the cost of services, a lack of understanding regarding treatments, long wait lists, lack of social network support, males without partners are harder to reach, lack of time and not recognizing emotional symptoms of distress, only physical symptoms. Barriers perceived as difficult to address included providing access to services for isolated men, referral pathways and knowledge of available services, lack of trained staff, the need to educate males that it's OK to have mental health problems, provision of out-of-hours services, getting males 'in the door', the cost of services, time constraints that men have, difficulties building family support, accessing male staff and child care services for single-fathers.

Professional development

Key findings regarding professional development in the SW are:

- 50% of the WACHS community-based staff surveyed had undertaken suicide prevention PD in the past three years
- around half of AHPs had undertaken suicide prevention PD in the past three years
- around 70% of NGOs had undertaken suicide prevention PD in the past three years
- around 85% of the WACHS hospital-based staff surveyed had not undertaken any suicide prevention PD in the past three years
- around 75% of GPs had not undertaken any suicide prevention PD in the past three years

Suggestions for future PD included assessment of risk during the first 24 hour critical period after a suicide attempt, legal training in detaining psychiatric patients, drug/ alcohol education, self harm assessment and management, acute psychosis treatment/

care, the link between psychopharmocology and suicidality, information about referral pathways to mental health practitioners, case analysis, integrated strategies for managing suicide risk, working with families, types of longer-term intervention, and domestic violence/ drug abuse and the link with suicide.

Inter-agency collaboration

Inter-agency collaboration in the SW was examined in terms of the perceived responsibility for suicide prevention services versus services currently provided, coordination of services and access to practitioners with the training and experience to work with people at risk of suicide.

Responsibility for suicide prevention services

Key findings regarding the responsibility for suicide prevention services felt by practitioners compared to the services they currently provide in the SW are:

- the majority of WACHS hospital-based and community-based mental health services, AHPs and NGOs believe they have a responsibility to respond to early signs of suicide risk/ tipping points and currently provide this support to patients/ clients
- the majority of WACHS hospital-based mental health staff believe they have a responsibility as a first point of professional contact for people who had attempted suicide along with the provision of acute treatment/ support and currently provide this to patients; around 70% of the WACHS community-based mental health staff believe they have this responsibility but only 44% currently provide this service; around half of the AHPs believe they have this responsibility and around 35% currently provide this service; around 30% of the NGOs believe they have this responsibility, however few reported they currently provide this service
- the majority of WACHS community-based mental health services and AHPs believe they have a responsibility to provide longer-term treatment/ support to people who have attempted suicide and are in the recovery stage and currently provide this support; 17% of WACHS hospital-based mental health services believe they have this responsibility and 25% currently provide this support; 59% of NGOs believe they have this responsibility and 39% currently provide this support, and
- the majority of WACHS hospital-based and community-based mental health services, AHPs and NGOs believe they have a responsibility to provide support/ information to carers/ families of people with evidence of suicidal behaviour and currently provide this support.

Services coordination

Key findings regarding the perceived effectiveness of services coordination for people at risk of suicide in the SW are:

- more than half of the GPs, AHPs and NGOs agreed there was a high level of interest in working collaboratively
- more than half of the WACHS community-based staff agreed there is a clear commitment to working collaboratively and there had been substantial past achievements when agencies had collaborated, and
- more than half of the WACHS hospital-based staff agreed that co-locating agencies would facilitate working collaboratively.

Generally few of these providers agreed the areas of shared responsibility are clear and understood by all concerned or there were clear arrangements to monitor and review the success of working collaboratively. Further, less than half of these providers agreed there is sufficient trust to survive any mistrust that may arise from collaboration. Moreover, less than half of these providers rated collaboration with external agencies/ practitioners as effective. Of particular note, 8% of GPs and none of the WACHS hospital-based staff rated collaboration as effective.

The main barriers to effective service coordination included limited availability of services outside Bunbury, access to services only during office hours, lack of adequate interagency referral and follow-up protocols, difficulties in accessing CAMHS, lack of acute care psychiatric beds, poor case management, not enough mental health professionals to provide a rapid response, professional silos, lack of community agencies willing to provide treatment after recovery, a lack of communication between agencies/ practitioners, a lack of understanding about suicide/ suicide risk, too much emphasis on managers when addressing interagency issues, client transport issues, multiple medical records/ problems in addressing confidentiality issues across agencies, a lack of support agencies for young people at risk, difficulties in maintaining ongoing contact with people at risk of suicide, a lack of inter-agency networking opportunities and staff shortages.

Access to mental health professionals from other agencies

The majority of WACHS hospital-based and community-based staff, GPs, AHPs and NGOs considered they had timely access to practitioners with the training and experience to work with people at risk of suicide, particularly GPs and psychologists; the majority of WACHS community-based staff and NGOs reported timely access to mental health nurses; NGOs reported timely access to social workers.

KEY FINDINGS AND CONCLUSIONS OF THE RESEARCH

Suicide prevention presents a significant challenge. The Living is for Everyone (LIFE) framework has been adopted across Australia in response to this challenge. In WA the 'State Suicide Prevention Strategy 2009-2013' uses this framework to guide future suicide prevention initiatives. Two of the 'action areas' identified in the LIFE framework and the State Suicide Prevention Strategy provided a focal point for the present research, viz., 'the provision of targeted suicide prevention activities', and 'taking a coordinated approach to suicide prevention'. Three outcomes were of interest in relation to the action areas (1) improved access to a range of support and care for people feeling suicidal, (2) improved understanding, skills and capacity of front-line workers, and (3) local services linking effectively so that people experience a seamless service. A second key element of the LIFE framework refers to 'domains of intervention' ranging from universal interventions which aim to engage all Australians in reducing suicide (e.g., gun control measures) to ongoing care and support where the emphasis is on assisting individuals to get back into life after a suicide attempt. Bringing these two elements together generated a number of research questions which the present study set out to answer with the intention of improving outcomes for people in the SW at risk of suicide.

The extent of suicide and suicidal behaviour in the SW

The rate /100,000 persons (age adjusted) for completed suicides in the SW from 2003-2007 inclusive was estimated to be 10.5. Males complete suicide approximately four times more frequently than females in WA. Mortality rates /100,000 (age-adjusted) from 2003-2007 in the SW for intentional self harm/ suicide for males was 16.9 compared to 3.9 for females. The Kimberley, Wheatbelt and Goldfields had the highest rates of male suicide in 2007, whereas the Pilbara had the lowest rate. The SW, Great Southern, Goldfields and the Midwest had similar rates of male suicide, higher than the Pilbara (12.4) but lower than the Kimberley (39.1), Wheatbelt (24.1) and Goldfields (24.1). Rates /100,000 (age-adjusted) for hospital admissions in the SW for intentional self harm from 2004-2008 inclusive for males was 1.1 compared to 1.9 for females.

There are seven health districts in the SW: Bunbury, Blackwood, Warren, Wellington, Busselton, Leeuwin and Leschenault. An analysis of differences between each district by sex and the State suggests the rate of hospital admission for self harm is higher for females in Bunbury and lower for females in Leschenault. Analysis of differences for males suggests hospital admission rates for self harm are higher in Busselton and lower in Leschenault. Mortality rates for suicide and self harm are higher for males in Warren.

A number of psychosocial stressors associated with completed suicides in WA from 1998-2008 have been identified. Around 38% of people in the SW who completed

suicide during this period had a diagnosed psychiatric disorder; 29% experienced a relationship breakdown; around 22% had drug/ alcohol problems; 21% experienced issues with their family/ friends; around 18% were dealing with physical illness/other medical issues; 15% had financial problems; around 14% were involved in legal issues; and around 12% were dealing with the death of someone close. An examination of differences between the seven health districts in the SW in terms of these stressors in a recent 12-month period revealed they have a similar profile in terms of current mental health problems, diagnosis of depression by a doctor, relationship breakdown, high risk short term alcohol use, serious illness, financial hardship or the death of someone close. The exceptions were that a higher proportion of females in the Wellington health district reported they had experienced the death of someone close in the past 12 months, a higher proportion of males in the Wellington health district had been diagnosed with depression in the past 12 months, and a higher proportion of males in the Blackwood health district reported high risk drinking associated with short-term harm.

Range and type of suicide prevention services in the SW

Whilst there appear to be few major differences between the health districts in the SW when suicidal behaviour and psychosocial stressors associated with completed suicides are examined, there appear to be some important differences in the number of service providers considered to have a role in suicide prevention. Eleven WACHS services considered to have a role in suicide prevention were identified, for example, the Bunbury Regional Hospital Emergency Department, the SW Primary Health Service, the SW Mental Health Service and the SW Aged Care Assessment Team. One-hundred and thirty-eight SW GPs from 43 practices were identified. Bunbury, Busselton and Leeuwin were found to have the highest ratio of GPs to residents (1 GP to around 900 residents); Warren and Wellington appear to have the lowest ratios (1 GP to around 2000 residents). By way of comparison, Bunbury, Leeuwin and Blackwood were found to have the highest ratio of AHPs to residents (around 1 to 1700 for Bunbury and around 1 to 1500 for Leeuwin and Blackwood); Leschenault and Warren appear to have the lowest ratios (around 1 to 8700 and 1 to 5000 respectively). Turning to NGOs, of the total number, 76.9% provide services in Bunbury which accounts for 29.4% of the total population in the SW compared to around 36% of the total number of NGOs who provide services in Leschenault and around 38% in the Blackwood and Leeuwin health districts, which account for 22.8%, 4.8% and 7.8% of the total SW population respectively. Taken on face value, this might suggest that these districts are relatively well served by NGOs. Further investigation, however, is needed to confirm this. It may be that NGO services (along with WACHS and AHPs) operate more infrequently at these locations. As highlighted in the LIFE framework, services need to be proactively developed in communities where suicide and suicidal behaviour is prevalent. It can be concluded from the data obtained in the present study that access to services for people at risk of suicide is not spread evenly across health districts in the SW. Of particular concern is access to GPs in some of the inland health districts, given the pivotal role GPs have in ameliorating the risk of suicide. As highlighted in the LIFE

framework, regardless of the lack or otherwise of services, all services for people at risk of suicide should be highly visible. Included here, for example, would be information about support that is available at the service itself as well as other services in the local area.

Appropriateness of existing SW mental health services/ support

The central goal of the national policy framework (LIFE) is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour. The present research focused on the extent to which an appropriate range of required support and care for people at risk of suicide is available in the SW; the level of understanding amongst SW service providers of suicide prevention risk factors, early signs/ tipping points and clinical indicators of ongoing risk; and the extent of inter-agency collaboration including the extent to which existing services are appropriately coordinated.

Support and care for people at risk of suicide was examined in terms of the mix of services currently provided, the mix of mental health practitioners employed to provide services, the treatment/ support provided, and the accessibility of services. The majority of WACHS hospital-based and community-based mental health services, GPs, AHPs and NGOs take action in response to early signs of suicide risk/ tipping points. The majority of WACHS hospital-based mental health services and GPs reported being a first point of professional contact for people who had attempted suicide. The majority of WACHS community-based mental health services, GPs and AHPs provide longer-term support for people in the recovery stage and provide support to carers/ families of people at risk of suicide. Less than half of WACHS staff, GPs, AHPs and NGOs reported that reducing suicide through community education was their responsibility. The majority of WACHS community-based mental health staff, GPs and NGOs reported that working with at-risk groups/ communities to build resilience and promote help seeking was their responsibility. In contrast, around half of WACHS hospital-based staff and AHPs considered this was their responsibility. Most WACHS hospital-based and community-based staff, GPs, AHPs and NGOs provide advice about mental health/ make referrals, and provide counselling/ psychological therapy in response to early signs of suicide risk/ tipping points, at the first point of professional contact after a suicide attempt and for people who have attempted suicide and are in the recovery stage. Needs assessment/ case management along with mental/ behavioural/ psychological assessment is undertaken to a lesser extent.

The accessibility of services was also examined. The usual wait time for a consult with a mental health professional for WACHS hospital-based services is less than 2 hours; however wait times after hours at Bunbury Regional Hospital are longer because mental health liaison staff are available 8am to 11pm; children/ adolescents may have extended wait times as CAMHS services are limited. The usual wait time for a consult with a mental health professional for WACHS community-based services is reported to be within 24 hours and these services typically do not operate out-of hours or over the weekend. All patients would be seen the same day if not immediately by GPs and they

typically provide an out-of-hours/ weekend service. Around 40% of people at risk of suicide would be seen on the same day by AHPs. However, this applies to existing clients. Around 50% of AHPs provide an out-of-hours/ weekend service. Around one-third of the NGOs clients at risk of suicide would be seen the same day. Around 36% provide an out-of-hours/ weekend service. In short, SW service providers give a high priority to people at imminent risk of suicide and those who have attempted suicide - during normal business hours. In the case of AHPs the added stipulation is 'provided they are existing clients'. In the case of NGOs the added stipulation is 'provided they meet the eligibility criteria for the service'. Services out-of-hours (including over the weekend) appear to be less quick to respond. Mental health liaison staff at Bunbury Regional Hospital, for example, are only on-duty from 8am to 11pm each day. Further, CAMHS services were also reported to be limited resulting in extended wait times for children and adolescents.

A wide range of considerations emerged regarding the duty of care to people at risk of suicide in the SW. If the risk is not imminent the patient's wishes regarding confidentiality would be respected. However, if the risk is deemed sufficiently high then the patient's refusal to involve others would be over-ridden. The need for patients to always sign a confidentiality agreement/ release of information form regarding information sharing with other agencies/ practitioners was highlighted as was the need to involve the patient's GP when the patient is admitted to hospital; if the patient is < 16 there is also a requirement to involve their parents/ guardian. The requirement to keep patients/ practitioners/ carers and others safe, particularly where violence to others is a risk was also underlined. In short, there appears to be a wide range of views on patient/ client confidentiality. These practices need further investigation to ensure all service providers helping people at risk of suicide conform with generally accepted ethical and legal requirements in these circumstances, including when they are working with children and adolescents.

Understanding of suicide prevention in the SW was examined in terms of perceptions of risk factors, knowledge of early signs of suicide risk/ tipping points, knowledge of indicators of ongoing risk, and barriers experienced by males in accessing services. Alcohol/ other substance abuse, family discord/ violence or abuse, social/ geographical isolation, mental health problems/ disorders and separation/ loss were reported. Known suicide risk factors infrequently reported as apparent in the SW were prior suicide attempts, low self esteem, hopelessness, homelessness, social/ cultural discrimination, chronic pain/ illness, little sense of control over life's circumstances, a lack of meaning and purpose in life, family history of suicide/ mental illness, imprisonment, and access to lethal means for people with suicidal ideation. Knowledge of the known early signs of suicide risk/ tipping points appeared to be sketchy. Frequently mentioned early signs/ tipping points by WACHS staff were suicidal ideation, substance abuse, anxiety/ agitation, hopelessness, withdrawal, mood fluctuations, relationship ending and death/ suicide of a relative/ friend. None of the known early signs/ tipping points were identified by 50% or more of GPs and only two of the known early signs/ tipping points were identified by 50% or more of AHPs

(suicidal ideation and relationship ending). Suicidal ideation was the only early sign/ tipping point identified by 50% or more of NGOs. Known early signs of suicide risk/ tipping points infrequently identified were purposelessness, feeling trapped, recklessness, debilitating physical illness/ accident, suicide of someone famous/ member of peer group, anger, a serious argument at home, or a media report on suicide/ suicide methods. Knowledge of known clinical indicators of ongoing risk for people in the SW who have attempted suicide also appeared to be sketchy. Frequently mentioned indicators by WACHS staff were frequent thoughts of suicide, access to suicide means, a significant change in circumstances/ loss, depressive symptoms/ hopelessness/ helplessness and substance abuse. Depressive symptoms/ hopelessness/ helplessness was the only clinical indicator identified by 50% or more of GPs and clinical indicators identified by 50% or more of AHPs were a significant change in daily routine, depressive symptoms/ hopelessness/ helplessness and alienation/ lack of support networks. Clinical indicators identified by 50% or more of NGOs were a significant change in daily routine and depressive symptoms/ hopelessness/ helplessness. Known clinical indicators of ongoing risk less frequently identified were a detailed suicide plan, the lethality of intended suicide method or an interest in being rescued for those with suicidal ideation, recency/ frequency/ severity of recent attempts, and chronic, painful medical problem/ perceived medical problem. Similarly relatively few of the known barriers to accessing services by males were identified. Those commonly mentioned were that males are reluctant to talk about their problems, the male stereotype of being tough and strong, the use of destructive coping mechanisms and the perceived stigma of mental illness. Known barriers infrequently identified were males don't know what help is available, the cost of services, a lack of understanding regarding treatments, long wait lists, lack of social network support, males without partners being harder to reach, lack of time and not recognizing emotional symptoms of distress, only physical symptoms. Barriers perceived as difficult to address included providing access to services for isolated men, referral pathways and knowledge of available services, lack of trained staff, the need to educate males that it's OK to have mental health problems, provision of out-of-hours services, getting males 'in the door', the cost of services, time constraints that men have, difficulties building family support, accessing male staff and child care services for single-fathers.

Data obtained from file audits routinely conducted using data from the Coroner's office indicated that important psychosocial stressors for people in the SW who completed suicide were a diagnosed psychiatric disorder, relationship breakdown, drug/ alcohol problems, issues with family/ friends, physical illness/other medical issues, financial problems, involvement in legal issues, and the death of someone close. Around half of these were identified by providers, viz., mental health problems/ disorders, separation/ loss, alcohol/ other substance abuse, and family discord/ violence or abuse, were reported. However, a number of other extremely important suicide risk factors were infrequently reported such as prior suicide attempts, a family history of suicide/ mental illness, social/ cultural discrimination and chronic pain/ illness. Of further concern was the lack of a comprehensive knowledge of the early signs of the

risk of suicide and tipping points. It was found that few of the known early signs/ tipping points were identified by 50% or more of the GPs, AHPs and NGOs. WACHS staff, by contrast, appeared to be better informed. A similar picture emerged regarding knowledge of the known clinical indicators of ongoing risk for people who had attempted suicide. Knowledge of the known barriers to services for males and strategies for addressing these also appeared to be sketchy amongst these service providers including amongst WACHS staff. In light of these findings, professional development regarding suicide prevention would be of benefit and a range of suggestions were offered by providers regarding topics of interest. That said, knowledge of population risk factors, early signs of suicide risk/ tipping points, and clinical indicators of ongoing risk for people who have attempted suicide will need to be a high priority. Printed guidelines and succinct risk assessment tools may be of particular help if they can be provided in an easily understood and accessible format.

Inter-agency collaboration in the SW was also examined in the present study. More than half of the GPs, AHPs and NGOs agreed there was a high level of interest in working collaboratively. However, only WACHS community-based staff agreed there is a clear commitment to working collaboratively and there had been substantial past achievements when agencies had collaborated. More than half of the WACHS hospital-based staff agreed that co-locating agencies would facilitate working collaboratively. Generally few of these providers agreed the areas of shared responsibility are clear and understood by all concerned or there were clear arrangements to monitor and review the success of working collaboratively. Further, less than half of these providers agreed there is sufficient trust to survive any mistrust that may arise from collaboration. Moreover, less than half of these providers rated collaboration with external agencies/ practitioners as effective. Of particular note, 8% of GPs and none of the WACHS hospital-based staff rated collaboration as effective. The main barriers to effective service coordination included limited availability of services outside Bunbury, access to services only during office hours, lack of adequate interagency referral and follow-up protocols, difficulties in accessing CAMHS, lack of acute care psychiatric beds, poor case management, not enough mental health professionals to provide a rapid response, professional silos, lack of community agencies willing to provide treatment after recovery, a lack of communication between agencies/ practitioners, a lack of understanding about suicide/ suicide risk, too much emphasis on managers when addressing interagency issues, client transport issues, multiple medical records/ problems in addressing confidentiality issues across agencies, a lack of support agencies for young people at risk, difficulties in maintaining ongoing contact with people at risk of suicide, a lack of interagency networking opportunities and staff shortages. The majority of providers considered they had timely access to practitioners with the training and experience to work with people at risk of suicide, particularly GPs and psychologists. The majority of WACHS community-based staff and NGOs reported timely access to mental health nurses. NGOs reported timely access to social workers. In short, SW service providers appear to have a high level of interest in working collaboratively. Equally encouraging, the majority of providers considered they had timely access to practitioners with the training and experience to work with people at

risk of suicide. Both of these findings are extremely important in light of data that indicated important differences between providers in which part of the spectrum of interventions they consider is their responsibility and in which they therefore provide services. GPs and WACHS hospital-based mental health services, for example, reported being a first point of professional contact for people who had attempted suicide. This is not generally the case for WACHS community-based providers, private sector AHPs and NGOs, each of which take action in response to early signs of suicide risk/ tipping points, as well as providing longer-term support for people in the recovery stage. As more fully discussed in relation to the LIFE framework, developing an understanding of peoples' journeys to find services, and encouraging cross-agency coordination of services is critical when different service sectors have responsibility for different parts of the spectrum of interventions for people at risk of suicide. A finding of particular concern in the present study therefore was that few providers agreed that areas of shared responsibility are clear and understood by all. Moreover, less than half of the providers agreed there is sufficient trust to survive any mistrust that may arise from collaboration. Building trust is therefore an important step in improving inter-agency collaboration and taking a coordinated approach to suicide prevention. Indeed, many of the strategies identified in the present study and in the LIFE framework to more effectively link local services, such as developing practical tools for information sharing, dealing with privacy and confidentiality requirements, and agreeing on joint service/ client protocols, are unlikely to succeed in a climate of mistrust.

In conclusion, many of the findings of the present research are encouraging, especially the finding that WACHS, GPs, private sector AHPs, and allied health practitioners working in NGOs, provide services and support ranging from taking action in response to early signs of the risk of suicide through to longer-term support for people recovering after a suicide attempt. Nonetheless there is room for improvement. Areas of concern where improvements to services and their organisation are needed include the accessibility of services in specific health districts in the SW, as well as after-hours and over the weekend, important gaps in knowledge about suicide risk factors, known signs/ tipping points/ clinical indicators on ongoing risk for suicide, along with inter-agency collaboration and the coordination of services, particularly for those at imminent risk of taking their own life.

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