2021

Crisis support and suicide prevention

Needs Assessment

phn GOLD COAST

An Australian Government Initiative

Crisis support and suicide prevention

A mental health crisis is defined as any non-life-threatening situation in which people experience an intensive behavioural, emotional, or psychiatric response triggered by a precipitating event and whose behaviour puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community (NAMI, 2020).

Although individuals with a diagnosed mental illness are at greater risk, a mental health crisis is not synonymous with mental illness. A prolonged mental health crisis can however lead to a mental illness.

The risk of experiencing a mental health crisis may be impacted by individual or societal factors, including economic disadvantage, poor housing, lack of social support and the level of access to, and use of, health services.

Whilst having poor mental health is a known risk factor for suicide, not all persons with mental illness will experience suicidality, nor do all suicides and ideation occur in the context of mental illness.

Suicide is a complex issue with long-lasting impacts on individuals, families, and communities. Causes of suicide ideation and behaviour can stem from a mix of factors such as adverse life events, trauma, social and geographical isolation, socio-economic disadvantage, mental and physical health, lack of support structures and individual levels of resilience.

Summarised local health needs and service issues

- Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified and people do not receive the care or follow up support they need at this critical time.
- Limited supports are available for people in distress who end up in ED by default or on a mental health trajectory, but many times their distress is related to a situational crisis in their lives.
- Carers are at the frontline of suicide prevention and many sit daily with this risk and responsibility but may not having any training or skills to equip them for this. In addition, they may not know where to go for help or how to access the unique supports they require at this time.
- Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated.
- When challenges occur during a crisis, it is often at the points of intersection between different sectors. These entities have their own points of entry, and staff with significant variation in skills, training, and experience in mental health crisis. It can be unclear who should take the lead for certain situations and how information is communicated between agencies.
- Service providers do not always know what the best evidence- based treatments are for people experiencing suicidal thoughts and behaviours or how to access local services and supports.
- Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without receiving the care they need.
- Many mental health clinicians do not have specific training in suicide prevention or know what the best evidence-based treatments are for people experiencing suicidal thoughts and behaviours.

- Many people in the community lack the confidence and skills to address people in suicidal distress or crisis.
- Representations and portrayals of suicide in the media can be sensationalised and can increase the risk of suicide for vulnerable people and can perpetuate stigmatising attitudes towards people experiencing suicidal thoughts or behaviours, or towards people who have died by suicide.
- Many General Practitioners are unaware of referral points and current best practice care and treatment.
- Default referral options for suicide prevention and crisis may not match the person to the right level of care.
- People with a lived experience of suicide have the potential, to inform, influence and enhance local suicide prevention solutions but may lack the confidence, skills and readiness to participate.
- Confidentiality and legal concerns along with lack of formal arrangements limit information sharing between providers.
- Limited understanding of which evidence-based suicide prevention treatments are being delivered in the region, by whom or what the quality of these services is.
- Consultation and data identified the below groups/regions are at elevated risk of suicide:
    - males (Gap is shortening of gender of those dying by suicide in Gold Coast Primary Health Network region)
    - northern Gold Coast
    - LGBTIQAP+
    - Aboriginal and Torres Strait Islander population
    - culturally and linguistically diverse population
- With lived experience workers a central component of new service models to address crisis, the region needs to ensure there are enough lived experience workers and appropriate support systems are in place.

Summarised key findings

- Gold Coast Primary Health Network (GCPHN) suicide rate is consistent with the state rate, while greater than the national rate.
- The Gold Coast has one of the busiest EDs in Queensland, a large percentage of these are people presenting with mental health issues.
- Males accounted for 65 per cent of suspected deaths by suicide on the Gold Coast in 2017-2019 compared to 35 per cent for females in the same period.
- Mental illness, including depression, and trauma are associated with a large portion of suicide attempts.
- Those who are affected or bereaved by suicide have an increased risk of suicide.
- Suicide prevention is the most common cause for referral by General Practitioners (GP) to the Psychological Services Program.
- Hangings and poisoning are the most common methods of suicide in Queensland.

- National data indicates the Lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others, Aboriginal and Torres Strait Islander and culturally and linguistically diverse community is particularly vulnerable.
- The risk of suicide remains high risk for up to 12 months following the attempt, once discharged from ED/psychiatric wards.
- Services that support people struggling with relationship and family breakdowns, financial problems and bereavement are essential elements of the suicide prevention system.
- Safe communication about suicide actively promotes help-seeking, reduces stigma and encourages collaboration.

Prevalence, service usage and other data

Deaths by suicide

Suicide was the leading cause of death for young Queenslanders in 2018 with 129 deaths among people aged 15-24 years[1] . It was also the leading cause of death for people aged 25-34 years with 139 deaths and 35-44-year-olds with 149 deaths in Queensland.

In the 2019 calendar year, there were 757 suspected suicides of Queensland residents. This is just under 15 suspected suicides for every 100,000 people. The number of male suspected suicides decreased by 23 from 593 in 2018 to 570 in 2019. Female suspected suicides increased by 12, from 175 in 2018 to 187 in 2019. Hangings and poisoning were the most common methods of suicide in Queensland.

Suspected suicide rates of Queensland residents have decreased since 2017 with a 2.8 per cent decrease from 2018 to 2019 in Queensland. It reduced by 5.6 per cent for males but increased by 7.4 per cent for females. Suspected suicide numbers and rates were highest in males aged 40-49 and females aged 45-49.

During the period 2017-2019, there were 278 suicides in the Gold Coast Primary Health Network catchment area, representing an age - standardised suicide rate of 14.5 per 100,000 people[2].

Table 1. Suicides and age-standardised suicide rates per 100,000 people in regions covered by Primary Health Network catchment areas in Queensland, 2017–2019

Primary Health Network Catchment area	Suspected Suicides	2017-19 ASR
Northern Queensland	423	20.6
Western Queensland	35	20
Darling Downs and West Moreton	303	18.3
Central Queensland, Wide Bay, Sunshine Coast	424	16.8
Gold Coast	278	14.5
Brisbane North	407	13.1
Brisbane South	545	12.9

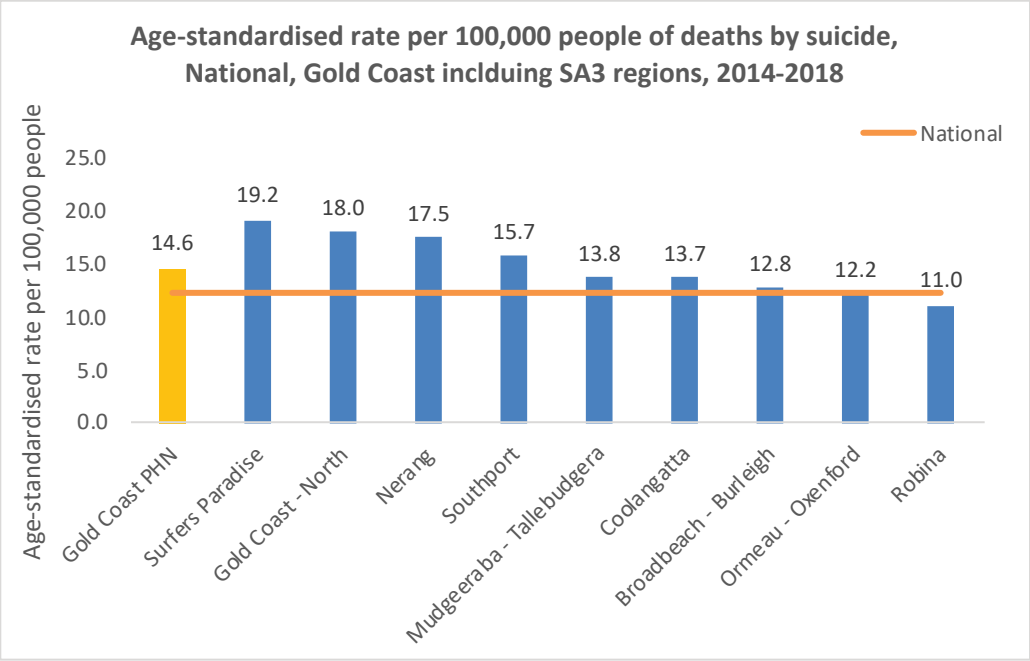
Source. Leske, S., Adam,G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

1 Australian Bureau of Statistics, 3303.0-Cause of Death.
2 Leske, S., Adam,G., Schrader, l., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith

The release of the 2014-2018 leading cause of death in Australia by Australian Institute of Health and Welfare indicated suicide was the 11th leading cause of death in this period with 15,100 deaths (12.3 per 100,000 age standardised rate) in Australia. Suicide was the 8th leading cause of death on the Gold Coast in the same reporting period with 438 deaths (14.6 per 100,000 age standardised rate).

As can be seen in Figure one, the Gold Coast rate of deaths by suicide from 2014 to 2018 was above the national rate while Surfers Paradise had the largest rate of deaths by suicide with 19.2. Although the age-standardised rate of deaths by suicide identified that Ormeau-Oxenford had the second lowest rate the GCPHN region, the region did have the highest total number of deaths by suicide from 2014 to 2018 as can be seen below in table two.

Figure 1. Age-standardised rate per 100,000 people of deaths by suicide, National, Gold Coast including SA3 regions, 2014-2018



Source. Deaths in Australia/Grim MORT Books, Australian Institute of Health and Welfare, 2020

Table two identifies the number of deaths by suicide on the Gold Coast including Statistical Area Level 3 (SA3) regions between 2014 and 2018. SA3 regions in the northern corridor of the Gold Coast had the highest number of suspected suicides in the period.

Table 2. Suicides in Gold Coast PHN including SA3 regions, 2014–2018

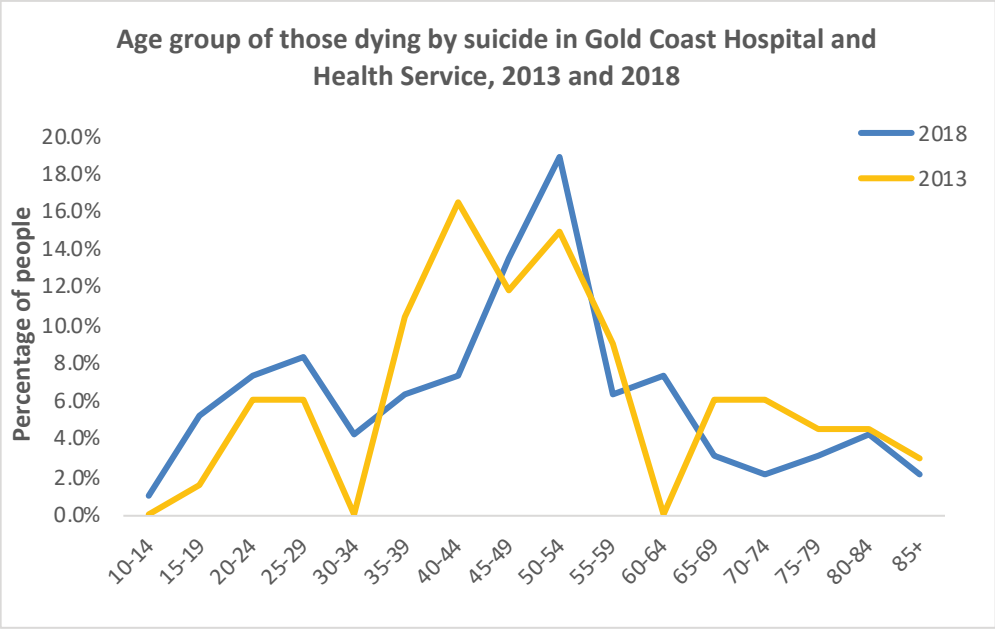
	Number of deaths
Gold Coast PHN	438
Ormeau - Oxenford	69
Gold Coast - North	62
Nerang	61
Southport	51
Surfers Paradise	45
Broadbeach - Burleigh	45
Coolangatta	38
Robina	28
Mudgeeraba - Tallebudgera	24
Gold Coast Hinterland	15

Source. Deaths in Australia/Grim MORT Books, Australian Institute of Health and Welfare, 2020

Suicide rates by age and gender

In 2018, the age group of 50-54 had the highest number people dying of suicide in the Gold Coast Hospital and Health Service compared to 2013, which the age group of 40-44 had the highest number of people dying by suicide as can be seen in figure two.

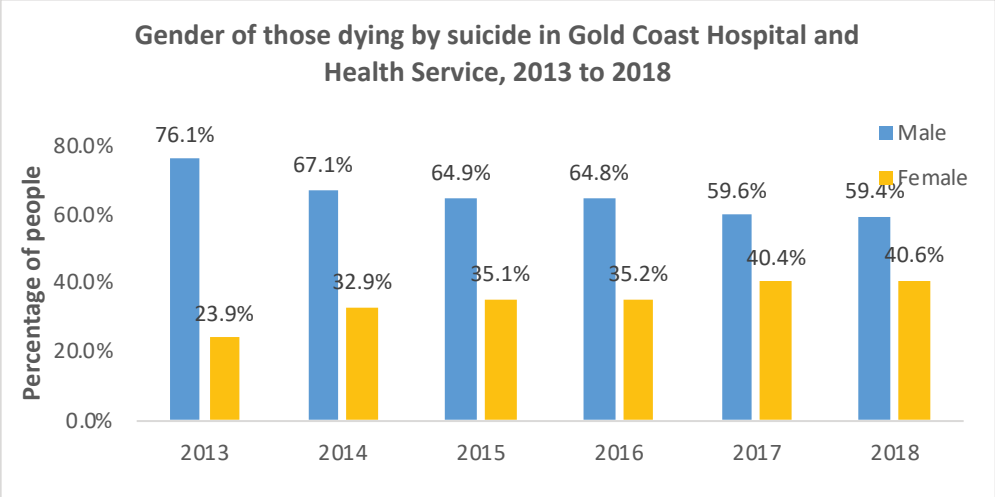
Figure 2. Age group of those dying by suicide in Gold Coast and Hospital and Health Service, 2013 and 2018



Source. Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

The male rate of deaths by suicide has been decreasing on the Gold Coast in recent years while the female rate has been increasing. Males accounted for 59.4 per cent of deaths by suicide on the Gold Coast in 2018 compared to 76.1 per cent in 2013. In 2018, the female rate of deaths by suicide was 40.6 per cent which has increased from 23.9 per cent in 2013.

Figure 3. Gender of those dying by suicide in Gold Coast and Hospital and Health Service, 2013 to 2018



Source. Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

Aboriginal and Torres Strait Islander peoples

The suicide rate in Queensland Aboriginal and Torres Strait Islander peoples is twice that of the non-Indigenous population, and suicide occurs at a much younger age. Intentional self-harm is the fifth highest cause of death for Indigenous people, with males representing the vast majority (83 per cent) of suicide deaths[3].

Of the 757 suicides reported in 2019 in Queensland. Aboriginal and Torres Strait Islander females living in Queensland accounted (11.9 per cent) of all female suicides while males accounted for 8.3 per cent of all male suicides[4] . The age group of 20-24 had the highest number of suspected suicides by Aboriginal and Torres Strait Islander Queenslanders.

Gold Coast recorded the lowest number of suicides by Aboriginal or Torres Strait Islander people in Queensland for the 2011-13 period. True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems. (Please see Mental Health & Suicide Aboriginal & Torres Strait Islander needs assessment).

3 Australian Bureau of Statistics (2018). Catalogue 3303.0—Causes of Death. Canberra. Australia
4 Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith

Lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)

LGBTIQAP+ are far more likely to attempt suicide than heterosexual people. LGBTIQAP+ people are between 3.5 and 14 times more likely to try and die by suicide compared to heterosexual people[5] .

Of the 757 suicides reported in 2019 in Queensland, 36 (1.5 per cent of all) suspected suicides by persons identifies as LGBTIQAP+ [6]. Australian Bureau of Statistics data indicates a heightened risk of poor mental health that may lead to suicidal behaviour in LGBTIQAP+ communities[7] . This increased risk of poor mental health and suicidality among LGBTIQAP+ people is not attributable to sexuality, sex, or gender identity, but rather due to experiences of discrimination and exclusion[8]

One in six young LGBTIQAP+ people has attempted suicide and one third have harmed themselves. 16 per cent of LGBTIQAP+ Australians aged between 16 and 27 have attempted suicide and 33 per cent have self-harmed[9] . Looking at transgender young people, around 3 in every 4 transgender young people have experienced anxiety or depression, 4 out of 5 transgender young people have ever engaged in self-harm and almost 1 in 2 have ever attempted suicide (48 per cent)[10]

Culturally and linguistically diverse (CALD)

Australia's CALD communities have diverse views of suicide and suicidal thinking, and vary in the way that their community, family, and friends respond to suicide. Multicultural differences, past trauma and experiences of discrimination are acknowledged and related to effective suicide prevention strategy. Limited data is available on this group although stigma around mental health and the topic of suicide, as well as language barriers and the difficulty of maintaining privacy and confidentiality can affect people in CALD communities.

Prevalence of life events

There are multiple factors recognised as contributing to suicidal behaviour or someone being at risk of suicide. These include personal hardship, difficult life events, poor physical and mental health such as depression and trauma, harmful substance use and previous self-harm or suicide attempts. It is important to understand these factors when considering suicide prevention.

Data from the Australian Institute for Suicide Research and Prevention identified the prevalence of life events among people who died by suicide (2013-2015). Relationship separation was the most frequently recorded life event (32.5 per cent) among all ages and for both women and men. This was followed by financial problems (27.3 per cent), recent or pending unemployment (19.5 per cent).

5 Suicide Prevention Australia Position Statement, Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities 2009
6 Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith
7 Skerrett, D., Kolves, K., De Leo, D (2015). Are LGBT Populations at a Higher Risk for Suicidal Behaviors in Australia? Research Findings and Implications. Journal of Homosexuality. Vol. 62. Issue 7.
8 Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance: Sydney.
9 Robinson, KH, Bansel, P, Denson, N, Ovenden, G & Davies, C 2014, Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse, Young and Well Cooperative Research Centre, Melbourne
10 Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., Lin, A. (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, Perth, Australia

Table 3. Life events reportedly experienced by those dying by suicide in Gold Coast Hospital and Health Service, 2013 to 2015

		2013	2014	2015
Relationship problems	**Conflict**	17.9%	14.1%	18.2%
	Separation	22.4%	29.4%	32.5%
Bereavement	**Spouse**	9.0%	3.5%	3.9%
	Family	6.0%	7.1%	5.2%
	Other	1.5%	1.2%	3.9%
	Multiple	1.5%	0.0%	0.0%
Conflict	**Familial**	6.0%	8.2%	10.4%
	Interpersonal	7.5%	3.5%	7.8%
Other	**Pending legal matters**	4.5%	8.2%	5.2%
	Financial problems	14.9%	20.0%	27.3%
	Recent or pending unemployment	9.0%	8.2%	19.5%
	Work/school problems (not financial)	4.5%	7.1%	5.2%
	Child custody dispute	6.0%	4.7%	6.5%
	Childhood trauma	6.0%	0.0%	3.9%
	Sexual abuse	1.5%	0.0%	2.6%

Source. Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

Emergency Department Presentations

EDs are frequent places for people in mental health crisis to present, with 69,585 presentations in 2019/20 by Gold Coast residents. Of these presentations, 59 per cent the emergency service episode is completed and discharged, 19 per cent are admitted, 16 per cent are admitted to short stay unit, 4 per cent transferred to another hospital, 2 per cent left at own risk after treatment commenced and 1 per cent did not wait.

In general people presenting with mental health issues wait longer to be seen initially in EDs than other consumers with a similar severity of physical illness and of concern, they were twice as likely as other ED presentations to leave before their treatment and care was complete. Crisis responses do not respond well to the needs of individuals and emergency mental healthcare is frequently compared unfavorably to emergency physical care, raising issues of lack of equality.

Presentations to Gold Coast University Hospital and Robina Hospital Emergency Department for suicidal ideation between June 2019 to July 2020 was slightly above 2,000 presentations. Of these, 49 per cent were males while 51 per cent were females with 7 per cent of presentations identifying as Aboriginal and or Torres Strait Islander. People aged between 20 to 29 years old had the largest rate of presentation of people for suicidal ideation with 29 per cent followed by people aged 7 to 19 with (23 per cent).

Intentional self-harm

Intentional self-harm is often defined as deliberately injuring or hurting oneself, with or without the intention of dying. Intentional self-harm comes in many forms, and affects people from different backgrounds, ages and lifestyles. The reasons for self-harm are different for each person and are often complex. Most people who self-harm does not go on to end their lives- but previous self-harm is a strong risk factor for suicide. Therefore, monitoring of intentional self-harm is key to suicide prevention.

As can be seen in table four, the GCPHN region was below the Queensland rate per 100,000 people for all intentional self-harm for all age cohorts except males aged 0-24 and females aged 65 years and over in 2018-19.

Table 4. Number of intentional self-harm hospitalisations and rate per 100,000 people, Gold Coast and Queensland, 2018-19

		Gold Coast	Queensland	Gold Coast	Queensland
	Number			Rate per 100,000 people	
Male	0-24	102	856	103.5	102.4
	25-44	142	1,308	170.9	194
	45-64	70	736	95	122
	65+	21	181	43.8	49.4
	All ages	335	3,081		
Female	0-24	230	2,351	238.9	293.6
	25-44	167	1,747	189.8	251.6
	45-64	110	1,058	136.5	167.4
	65+	35	197	65	48.8
	All ages	542	5,353		

Source. National Hospital Morbidity Database, Australian Institute of Health and Welfare, 2020

Psychological Services Program

The Psychological Services Program (PSP) provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program targets seven underserviced and priority groups including children, people at risk of homelessness and suicide prevention.

From the 1st of July 2020 to 30th April 2021 there were 826 referrals to the Adult Suicide Prevention Psychological Services Program (PSP) stream leading to 3,656 sessions. Suicide prevention is by far the most common cause for referral by GPs and services users include a range of people in distress.

Table 5. Number of persons accessing Psychological Services Program on the Gold Coast, suicide prevention 1 July 2020 to 30 April 2021.

FY 2020/April 2021	Referrals	Rate of referrals from specified group	Sessions	Rate of total sessions delivered from referrals from specified group
Adult Suicide Prevention	826	51%	3,656	55%
Children	264	16%	884	56%
Aboriginal and Torres Strait Islander	112	7%	319	47%
Homeless	30	2%	92	51%
CALD	46	3%	200	72%
Perinatal	57	4%	144	42%
LGBTIQAP+	27	2%	121	75%
General (COVID19 Response)	243	15%	1,180	81%
Total	1,605		6,596	58%

Of those referred to the adult suicide prevention stream, 16 per cent came from clients located in Coomera, Pimpama, and Upper Coomera followed by 15 per cent from Labrador and Southport.

The Way Back

People who have attempted suicide or experienced a suicidal crisis often experience severe distress in the days and weeks immediately afterwards, and they are at high risk of attempting again within 12 months from being discharged. Beyond Blue developed The Way Back Service to support them through this critical risk period. The Way Back provides non-clinical, tailored support for up to three months following discharge from hospital after a suicide attempt.

The Gold Coast Way Back Service receives the largest number of referrals compared to other PHN regions. Between 1st July to 30th March 2021, 432 people accessed the service which exceeds the expected number of people accessing the service of 261 (166 per cent of target).

Suicide Prevention Pathway

The Gold Coast Mental Health and Specialist Services Suicide Prevention Pathway assist patient's recovery from suicidal thoughts and behaviors. Between January and November 2019, a total of 1,681 placements on the Suicide Prevention Pathway (on average, 153 placements per month). This represented a total of 1,498 persons (average of 136 / month). Of these people, 84.2 per cent were aged 18 years and over.

COVID-19 Impacts

There is much uncertainty around the medium- and long-term impacts of the COVID-19 pandemic on suicide mortality in Australia. Duration and intensity of restrictions, timeframe of economic recovering and the impact of state and federal government interventions to reduce the economic and social effects will all affect suicide mortality. As the Gold Coast is a region dependent on tourism this may have more of an impact on the Gold Coast compared to other regions depending on ongoing social distancing practices.

As previously mentioned, suicide is not influenced or caused by one factor but results from complex interaction between multiple risk factors, consequently it is difficult to understand the impact COVID-19 on suspected suicides. As can be seen in table six, the year-to-date comparisons for suicides from January to July in 2020 is comparable to 2019.

Table 6. Year to date comparisons for suicides from January to July, by sex, 2015-2020, Queensland

Year	Males	Females
2015	315	106
2016	290	92
2017	340	116
2018	341	89
2019	343	102
2020	352	102

Source. Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University

The Wesley Mission Queensland COVID-19 Recovery Service was established to provide responsive wellbeing support for people aged 16 years and over living in the GCPHN region whose wellbeing has been impacted by the ongoing effects of COVID-19. Below are some of the common presentations to the service:

- loneliness and social isolation
- suicidal ideation
- problems with secure housing
- financial barrier's such as loss of employment/struggles to secure adequate ongoing employment
- overall anxiety and depressive presentations – low mood and lack of motivation
- struggles with accessing services such as Centrelink and NDIS
- loss of routine
- grief and Loss
- difficulties in accessing appropriate services in a timely manner due to long waitlists

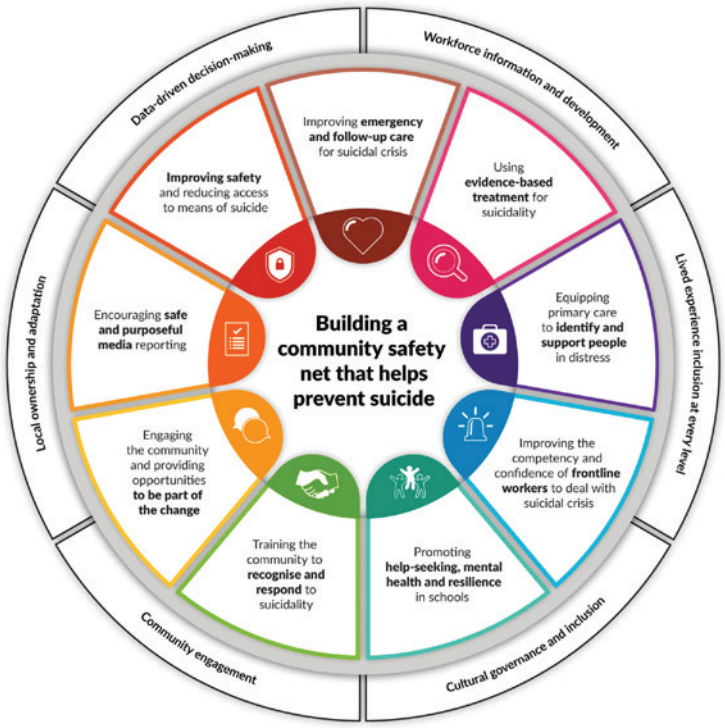
In addition to the above, very early on in the rollout of this service it became apparent that schools needed support as children's anxiety levels had increased; anecdotally home-schooling had a massive impact on some students finding it difficult to re-engage in face-to-face learning. Parents were also struggling with how to deal with the impact of COVID-19 on the mental health and wellbeing of their children.

Community Approach to Suicide Prevention

Reducing the rate and impact of suicide in the Gold Coast community is not something any single agency or level of government can do alone. The health system plays a vital role in suicide prevention, particularly through the delivery of specialised mental healthcare. However, equally important roles are played by a wide range of social and human services, law enforcement agencies, industry bodies, education providers, private and non-government service providers, community services and workplaces. Community events can also provide people with clear opportunities to be actively involved in suicide prevention.

Recognising the need for a community approach to suicide prevention, as part of the Joint Regional Planning process a Suicide Prevention Leadership Group was formed in August 2019. This group advised on the suicide prevention components of the Joint Regional Plan and developed a more in-depth Community Action Plan for Suicide Prevention using the LifeSpan framework developed by Black Dog Institute. This framework includes nine evidence-based strategies and six overarching principles and when implemented together, this approach is predicted to reduce suicide death by 20 per cent and suicide attempts by 30 per cent.

Figure 4. LifeSpan: Integrated Suicide Prevention



Through the development of the Suicide Prevention Community Action Plan, the following issues were identified, in alignment with the nine LifeSpan strategies

Improving emergency and follow up care for suicidal crisis:

- A suicide attempt is the strongest risk factor for subsequent suicide.
- People who present in emergency department in crisis or for suicidal thinking or attempts often do not receive the care and support they need. This may be related to staff experience and skills to deal with suicide and crisis.
- The emergency department environment can be fast paced and traumatising environment.
- Police and ambulance may not have the level of experience/skills or time to deal with mental health related call outs effectively.
- Current resource material to support crisis and suicide is outdated to changes in the sector.

Using evidence-based treatment for suicidality:

- Mental illness, including depression, and trauma are associated with a large portion of suicide attempts.
- Currently it is unclear what evidence-based treatments are being delivered, by whom or what the quality of these services is.
- Mental health professionals are not aware of the latest evidence and best practice care and treatment options for suicide.
- The Gold Coast has some of the highest use of MBS billings in the country for the private sector, but it is not clear who is accessing these services, what services are available and the quality of these services.
- There is a lack of urgency for evidence-based treatment options to address suicide within the mental health sector.

Equipping primary care to identify and support people in distress:

- Primary care providers are often visited by suicidal persons in the weeks or days before suicide but due to fear, stigma or time pressures, do not receive the care they need.
- GPs encounter numerous barriers and competing priorities which impacts GP uptake and access to suicide prevention training.
- Traditional GP training does not necessarily equip GPs with the skills and confidence to address mental health concerns and suicidal ideation.
- Many GPs are unaware of referral points and current best practice care and treatment.
- Issues with GPs being able to access forms for referral pathways other than Mental healthcare Plan e.g., Psychological Service Providers.

Improving the competency and confidence of frontline workers to deal with suicidal crisis:

- Frontline workers can play a key role in de-escalating a crisis and improving safety.
- Existing training for frontline workers (mental health services, police, paramedics, and hospital staff) may not include specific suicide prevention skills.
- Barriers to training such as funding, time of day, endorsement and approval by workplaces can limit uptake and participation in training.

Promoting help-seeking, mental health and resilience in schools:

- Schools are overwhelmed with options and pressure from multiple bodies/sectors to include additional content in their curriculum and programs.
- Schools are keen to support their students but often do not know how to choose quality programs or integrate programs with other student wellbeing activities and referral pathways.
- A focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children, but also creates a solid foundation for health outcomes later in life.
- Training initiatives are often fragmented, parents, teachers, and young people may all receive different training, resources and information about how to respond to mental health issues and suicidal crisis resulting in fragmentation and diffusion of responsibility.
- Currently the communication between hospitals and schools to is not being optimised to support young people post discharge and in the recovery process or to help children and youth remain engaged with school.
- Clinicians in schools often operate in silos and at the discretion of school principals. Involvement in the planning of school activities could facilitate and enhance coordination of activities.
- Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without getting the care they need.

Training the community to respond to suicidality/Gatekeeper training:

- Many people who are experiencing suicidal thoughts communicate distress through their words or actions, but these warning signs may be missed or misinterpreted.
- Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated.
- Inconsistent approaches to increasing Mental Health and Suicide Prevention literacy across the community through workplaces.
- Many gatekeepers are in roles that might encounter people in suicidal crisis, however since this is not their primary role, they may lack skills and confidence to respond to suicidality.
- There is a lot of training available, but people are not always aware of what is available and relevant to them, this may result in duplication and inefficiency.
- There are limited evidence around which programs are most effective and relevant to local stakeholders.

Engaging the community and providing opportunities to be a part of change:

- Suicide prevention activity is frequently fragmented. There are opportunities to improve awareness of how we can work together better.
- Suicide prevention services and approaches need to be more culturally inclusive and responsive to diversity.
- Service eligibility criteria/thresholds often limits access to services. In addition, many services do not provide afterhours support.
- Stigma associated with suicide and help-seeking is a significant barrier to prevention. Greater acknowledgment and recognition of community suicide prevention activity is required to raise the profile of suicide prevention and postvention in a positive way.
- There is often stigma attached to mental health and suicide. Some people don't identify with these labels and will not access support for conditions that they don't relate to.
- Safe communication about suicide actively promotes help-seeking, reduces stigma and encourages collaboration.
- People do not know how to be actively involved in suicide prevention and are not always aware of opportunities or ways they can contribute.

Encouraging safe and purposeful media reporting:

- Representations of suicide in the media can be sensationalised/or stigmatised and unsafe leading to copycat behaviour.
- The graphic nature of news can be traumatising and cause fear and anxiety.
- People with a lived experience of suicide are often not empowered or provided with opportunities to become agents of system change or to share messages of hope and recovery with others.
- Suicide prevention activities and campaigns could be better coordinated to maximise impact.

Improve safety and the means of suicide:

- Currently timely (up to date) regional data is not available which limits our ability to use data to drive decision making.
- Safety plans are held by providers and individuals have to develop new safety plans with multiple providers.
- Carers are often not aware of/informed of details of safety plans and how they can support people to implement their safety plans.

Mental Health Crisis Reform

Gold Coast Health commenced the Mental Health Crisis Reform initiative in the second half of 2019 with a consideration of the Crisis Now framework[11], which emphasises a number of care elements including: regional or state-wide crisis call centres coordinating in real time: centrally deployed, 24/7 mobile crisis teams; short-term, "sub-acute" residential crisis stabilization programs; and essential crisis care principles and practices including recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Feedback was obtained through a range of stakeholder meetings held on the Gold Coast across the second half of 2019 and through 2020. There was a very positive response to the core elements as outlined in the Crisis Now framework. However, it was felt by many stakeholders that it was important to emphasise other aspects of the system and go beyond those presented within Crisis Now. There was strong feedback that any plans around crisis reform on the Gold Coast needed to have due consideration of the whole continuum of care, and to be well integrated into the community, and recovery focused. The Gold Coast Crisis Reform Framework has been developed[12] in response to the following issues identified by local stakeholders:

- There is a need for health services (physical health, mental health, alcohol and other drugs services), social services and emergency response services (e.g., police and ambulance) to work together on coordinated and strategic approaches to transforming mental health crisis care across the GCPHN region. When challenges occur during a crisis, it is often at the points of intersection of these agencies. These entities have their own points of entry, and staff with significant variation in skills, training, and experience in mental health crisis. There are complex questions regarding who takes the lead for certain situations and how does integration and communication occur.
- While principles related to best practice crisis care have been driving reform at a regional level for many years, there is a need to continue to embed these principles in our service and system, both existing and new initiatives:
    - trauma-informed care
    - lived experience and involvement of families central to all models of care
    - adopting a Journey to Zero Seclusion and Restraint
    - integrated mental health, alcohol and other drug and physical healthcare
    - cultrually safe, responding to diversity
- A narrow focus on how we respond once a significant crisis has developed will not meet the needs of our community, nor will it align with a growing evidence base internationally. Only with an adequate continuum of service will we be able to prevent crises from developing or reduce likelihood of re-presentations in the future. A comprehensive system needs to include social and housing support to enable recovery and prevent a cycle of repeated crises.

11 Crisis Now: Transforming Services is Within our Reach (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016)
12 Gold Coast Crisis Reform: A Strategic Approach to Transforming Mental Health Crisis Care Published by the State of Queensland (Queensland Health), December 2020

- There is a need for real-time displays of data to inform rapid decision making and tracking of consumers during their crises.
- There is a need to develop a data-driven quality improvement approach to inform clinical, cultural and system changes that will lead to improved outcomes for people in crisis on the Gold Coast.
- There is a need to add to the local evidence base through research and evaluation of crisis reform initiatives.
- New models of service to respond to mental health crisis will require training and support to ensure success.
- With lived experience workers a central component of the crisis service models, there are specific needs to ensure enough peer workers and appropriate support systems are in place.
- Opportunities for shared training across organizations can assist in achieving a consistent approach and shared language, attitudes and beliefs which will be important in an integrated network of care and include:
    - training developed to support all underlying principles and new models of service
    - opportunities to enhance connections of networks of services through shared training
    - lived experience workforce training
    - all staff receive training on crisis intervention, trauma-informed care, lived experience principles.

Service system

Services	Number in GCPHN region	Distribution	Capacity discussion
GCPHN funded Psychological Services Program (PSP) suicide prevention	Of the 20 contracted organisations, 16 are contracted to provide suicide prevention services	Providers are distributed across the region	Dedicated suicide prevention services on the Gold Coast appear to be limited; however, some mental health services provide information and referral advice on suicide prevention. A 2018 review of clients accessing Psychological Services Program (PSP) suicide prevention service stream indicates strong use but those using the service tend to be females and younger people, which are not the most at risk cohorts in the region. Crisis services on the Gold Coast are available through the public health system in the form of hospital emergency departments and specific crisis support (Acute Care Treatment team, 24hr phone line). There are numerous well-known national suicide prevention and crisis services that are likely to be accessed by the Gold Coast community. For example, Lifeline (phone and online), Suicide call back service (phone and online) and Beyond blue (phone and online). There are no specialised suicide prevention or crisis services for Aboriginal and Torres Strait Islander people on the Gold Coast although the Acute Care Team does employ an Aboriginal and Torres Strait Islander Mental Health Worker.
Gold Coast Health crisis helpline	1 phone hotline (13 MH CALL) for the Acute Care Treatment (ACT) Team	ACT team telephone service available 24hrs	
Emergency Departments (ED)	5	Southport and Robina (public) Southport, Benowa and Tugun (private)	
Support and Transition Program - Suicide Prevention (coordination support for those at-risk of suicide, recently attempted or are recently discharged	1	Accessible via contact with public hospitals in Robina and Southport	
Crisis helplines	4 national (Lifeline, Suicide Call Back Service, Mensline, Kids Helpline)	24-hour, 7-day telephone services. Public knowledge of these services would drive uptake/demand.	
Counselling helplines and websites	12 national help lines (Mensline, Kids Helpline, Open Arms formerly Veterans and Veterans Families Counselling Service, QLife, Carers Australia, eheadspace, 1800 Respect, Relationships Australia, SANE Australia, ReachOut, BeyondBlue, Counselling Online, Child abuse prevention service)	Online and telephone services.	

Consultation

GCPHN and Gold Coast Health have been working collaboratively over the past two years through the development of three separate but complementary regional strategies: Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services (JRP), Crisis Reform Strategy (CRS), and the Suicide Prevention Community Action Plan (SP CAP). While there are different drivers for each of these strategies, many of the underlying issues and longer-term outcomes are similar resulting in the interrelated nature of the three strategies and their contributing activities.

A range of consultation activities have occurred over the past two years to support the development of these strategies as well as the needs assessment process, service design, implementation and evaluation. Community members, clinicians and service providers have been engaged through various mechanisms including workshops, advisory groups, consumer journey mapping, one-to-one interviews, sector presentations, working groups and co-design processes. In addition to the findings mentioned above aligned to the LifeSpan framework, the following insights have emerged from consultation activities:

Service provider consultation

- People presenting to hospital feeling at risk of self-harm but whose mental health issues are not seen as serious enough for admission with limited follow up provided.
- Training and skills development for school staff will support early identification, intervention and referrals.
- Need for enhancing the skills of mainstream services, GPs, and clinicians to work with at risk and vulnerable populations.
- Limited community support systems and services available for those that have attempted suicide
- Early identification of at-risk people who identify as LGBTIQAP+ is key to suicide prevention.
- Lotus staff have described emerging impacts of COVID-19 on service delivery. This includes increased number of people requiring supports and connections to Centrelink and additional time required to support clients in the use of technology to facilitate connections and access to other services and supports during this time.
- The Social and Economic fallout of COVID-19 is anticipated to have significant impacts on service demand and need.
- Responses for 45-56-year age demographic remains a definite gap. People are left highly vulnerable due to unplanned/unforeseen circumstances with little support from the community.
- Access to Domestic Violence services have been an issue especially with carers and violence orders, gaps evident and challenges with this sector.
- GPs refer to the PSP program on “need”, usually distress rather than personal attributes (such as being LGBTIQAP+ or CALD)
- The GCPHN region would benefit greatly from a Safe Space/Safe Haven Service located within walking distance to one of the major hospitals such as Robina
- The current After Hours Model is limited in its reach (location wise) and capacity to focus around crisis intervention/ED presentation reduction rather than a broader catchment model which includes much of homelessness supports/drop ins.

Service user consultation

- Inadequate response for individuals presenting to hospital feeling unsafe/at risk of self-harm but who are not admitted as their immediate health issues are not seen as serious or acute enough.
- Limited community support systems or services for those that have attempted suicide
- People who have survived suicide attempts want more support, particularly with non-health related issues such as financial support, relationships and housing.
- Individuals being discharged feel excluded from the hospital discharge planning process.
- Due to high numbers of persons presenting with high mental health needs and/or risk of suicide there are periods of increased length of response times from the Acute Care Team.
- When describing their experience of care, consumers frequently express a lack of empathy and compassion from primary care providers.

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Gold Coast Primary Health Network

"Building one world class health system for the Gold Coast."

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Primary Care Gold Coast (ABN 47152953092), trading as the Gold Coast Primary Health Network. Gold Coast Primary Health Network gratefully acknowledges the financial and other support from the Australian Government Department of Health.

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.