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Report on Northern Beaches Suicide Postvention/Prevention Protocol Pilot.

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Prologue

From the Suicide Prevention Australia, Member Briefing 30/01/2020.

In response to a funding announcement by Minister Greg Hunt Suicide Prevention Australia CEO, Nieves Murray said,

“We’ve been calling for major reform for some time as suicide is more than a health issue.
We know the people at greatest risk of suicide in future are those who’ve made an attempt. People who have survived a suicide attempt are often given inadequate follow up, simply because our public health system is under pressure.
A person surviving a suicide attempt is at heightened risk of a future attempt, particularly in the first six months after the attempt was made. Despite this, the follow-up or ‘aftercare’ provided to people who are known to have attempted suicide is patchy at best. Our emergency departments and other acute care settings are overstretched, with demand for services often exceeding the resources available.
Connected, community-based suicide prevention interventions where agencies work together are a critical way of ensuring people who’ve survived a suicide attempt have the intensive, compassionate support they need.
We’ve seen this in the case of Scotland, where the Distress Brief Intervention Program has helped thousands of people in crisis to not only survive, but thrive into the future.
We welcome Minister Hunt’s decision to inject significant funding into community based mentoring and support programs.
Suicide prevention is complex. Global evidence shows that a fragmented and mental illness-specific approach doesn’t work.

Executive Summary-Community Care Northern Beaches

People can and do recover after a suicide attempt. Family, friends, the service system and an understanding community all play a pivotal role in a person's recovery.

The Northern Beaches Suicide Prevention Communication Protocol was a local initiative driven by service providers and the Northern Beaches Council. It was informed by those with lived experience of the local service system.

CCNB chose to pilot and resource the Communication Protocol because of:

- people dying by suicide in the local area is a significant and shared community concern;
- an uncoordinated, local service response following a death by suicide;
- a lack of unavailable or shared data regarding attempts was hindering service development initiatives and resourcing;
- people and their families were not linked into care and support in a timely way;
- the local Police calling out for better support for people following a suicide attempt, self-harm or death by suicide

CCNB's Care Navigation model of service is a good fit for this Communication Protocol Pilot Project. CCNB offers impartial and independent care navigation service ensuring that people can be easily and efficiently linked into a range of care and support.

It is noted that leveraging off our existing infrastructure was made possible by the dedication and expertise of our team, specifically Kerry Gleeson and Marika Kontellis. But the good client and family outcomes are attributable to the buy in and support of others. Most significantly, Superintendent Dave Darcy and his team at Northern Beaches Police Area Command, the team at Northern Beaches Council and the expertise and responsiveness of David Thomas and Barbara Rabbitts at Lifeline, Northern Beaches.

The results of the pilot project show promise. CCNB looks forward to supporting the next stage of development.

Dr. Gary Jacobson

CEO CCNB

Overall Summary

The Northern Beaches Postvention Protocol Pilot shows promise in three main areas:

1. A possible reduction in the number of deaths by suicide in the area
2. Support of the Local Area Command due to the positive effect on first responders
3. Better coordination and support for people affected by suicide in the Northern Beaches area.

It is suggested that these benefits alone are enough to warrant the continuation and development of the program in the area. Sustainability of the program was one of the main concerns that the people interviewed for the program spoke about. Lack of funding and dependence on specific people were at the centre of this concern. A lack of a fully integrated response with Northern Sydney Local Health District and Northern Beaches Hospital was something that became apparent to this researcher during the course of the interviews. The successes of the program are broadly aligned with the target postvention impact model and also with the broad range of the international academic literature referred to in this evaluation.

Further development of the program should be guided by the Steering Group and take into account the suggestions made by the international literature and the observations of people in a range of organisations contacted for this evaluation and outlined below.

In the contect of this report recommendation 25 of the National Mental Health Commission (National Mental Health Commission, 2019) should also be kept at front of mind in this process. That the people who are being supported are the focus of what we are doing, and in this case it also includes those indirectly supported, such as the first responders who are so often left to deal with the fallout from situations beyond their control or most of their training.

Summary of interview and data results:

Summary of Positives

The Northern Beaches Local Area Command (NBLAC) data monitoring shows a decrease in deaths by suicide that is particularly marked in the latter part of 2019 compared to the latter part of 2018. The timing in regard to other related activities in the Northern Beaches area, the direction and scale of the reduction in deaths suggests that the pilot protocol is responsible. The difference is not, however, statistically significant and there are difficulties to ascribing causality to any community wide intervention. However these promising results strongly indicate the potential benefit of further

investigation over a longer time span and a more direct assessment can be made when comparable statistics from the Northern Sydney Local Health District (NSLHD) become available.

This community response is broadly in line with the international academic literature which shows clearly the benefits of immediately offering support to people who have been discharged or who have not been admitted following a suicide or self-harm related incident.

Coordination of services in the area has greatly improved leading to lower distress and confusion amongst the people being supported.

Coordination has also improved the quality of support that people receive as those services with a surfeit of enthusiasm over skill are being better managed.

The police report better job satisfaction and lower distress as they feel that the people they judge to be in severe distress are being referred to support.

Police also report a lower number of people re-attempting suicide which improves job satisfaction and may be a part of what has led to fewer deaths by suicide.

The international literature suggests that healthcare workers can increase the perceived stigma of people with mental health issues (Ye et al., 2016) and it has been suggested that community workers might offer a ‘soft’ entry point for onward referral to both clinical and non-clinical healthcare workers (Rose, Hippel, Brener, & Hippel, 2018).

The international literature is clear on two points.

1. It is difficult or impossible to accurately define what is a suicide attempt or how serious the suicide attempt may have been.
2. It is impossible, with current knowledge, to accurately assess the suicide risk of an individual.

Therefore, to reduce the number of deaths by suicide and to reduce the resultant distress and contagion in the area it becomes necessary to respond to all suicide related incidents, including self-harm. The inclusion of self-harm is particularly important as the two problems of assessing exactly what is a suicide attempt and then assessing suicide risk are fraught with inaccuracy and confusion even at the level of international best practice.

Areas of improvement.

Many respondents were concerned about the sustainability of the project. It is currently funded by CCNB and has relied heavily on the work and good will of a small number of people. Suggestions for sustainability included tender applications and gaining the involvement of the NSLHD. The police

stated that they should not be leading this program. This author suggests that a resolution of the impasse within the NSLHD might represent a chance of sustainability for this project.

It was suggested that the protocol expanded and became confused as it developed and that perhaps splitting it into two protocols, one for notification and one for support might assist this impasse resolution and also provide greater clarity to the program.

The single point of contact is both a strength and weakness. The strength is that it provides easy coordination which all found to be an important improvement but it can leave to at least a perception that the outward referrals and notifications were not as broadly spread as they could be.

Some reported that boundaries might be being crossed due to the 'insular on the peninsular' phenomenon. That is people working in difference services know each other, perhaps too well, and that may interfere with quality service delivery from the optimum range of organisations and people.

Some organisations felt that they weren't being notified of incidents that were relevant to their service and felt 'out of the loop'.

It is suggested that, in the light of the difficulty of accurately assessing suicide risk and of accurately identifying the exact scale of the incident, that the low percentage of people being admitted to hospital following presentation by police be investigated and perhaps alternatives to emergency department presentations be pursued in addition to this community response.

Background:

In 2018 an incident involving the sudden death of a young person triggered wide distress in the community. The response by the various support organisations was uncoordinated and the result was both inefficient and less effective than a more coordinated response might have been. Northern Beaches Council, the Police, Community Care Northern Beaches and a broad range of support organisations collaborated on developing a protocol to form a more proactive and coordinated response to a young person's death by suicide. The overarching aim of the protocol was to reduce community distress and reduce the 'ripple effect' of a death by suicide that can potentially lead to more deaths. Although this response was initially targeted towards youth suicide responding to suicide attempts and serious self-harm in the community was also included to reduce community distress as the community response to those events were perceived to be similar. The academic literature also suggests that separately defining those events poses major difficulties.

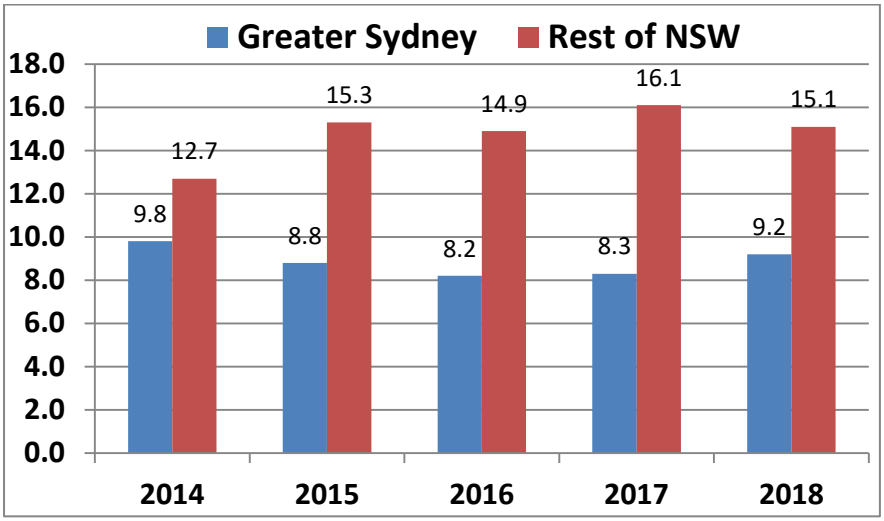
As the program developed the participant organisations recognised that it was not solely youth *suicide* that had the capacity to produce widespread community distress, a serious attempt by a young person also had the potential to cause widespread distress in the local community. Further, it was assumed that while the death of a young person caused a wider distress reaction in the community it was also recognised that the death by suicide, serious attempt or self-harm of a person

of any age has the potential to affect a network of people. An assumption which is supported in the academic literature at least in relation to suicide (Berman, 2011).

Thus the project broadened the focus from purely youth suicide to suicide and serious attempts for anyone in the community as it was recognised that the wider community is affected by all of these events and that distinguishing those events in real time was difficult. The term serious attempt, while adding a prevention component to the protocol and therefore further potential for a reduction in the number of suicide deaths, also introduces an issue of how the first responders might recognise what is and what is not a serious attempt, a problem that even the theoretical academic literature has yet to successfully grapple with (Kattimani, 2015; Lester, 2009; Lucas Giner, 2016; O'Carroll, 1996; Silverman, 2016) let alone the first responder arriving on the scene of a crisis situation. Thus serious self-harm needs to be included to ensure the best support in the community.

Based on the data provided by the Australia Bureau of Statistics (Figure 1) it can be seen that the rates of suicides has stayed relatively stable since 2014 in the greater Sydney area, whereas there was a sudden increase in the suicide rate in regional areas between 2014-2015 which has been relatively stable since that time.

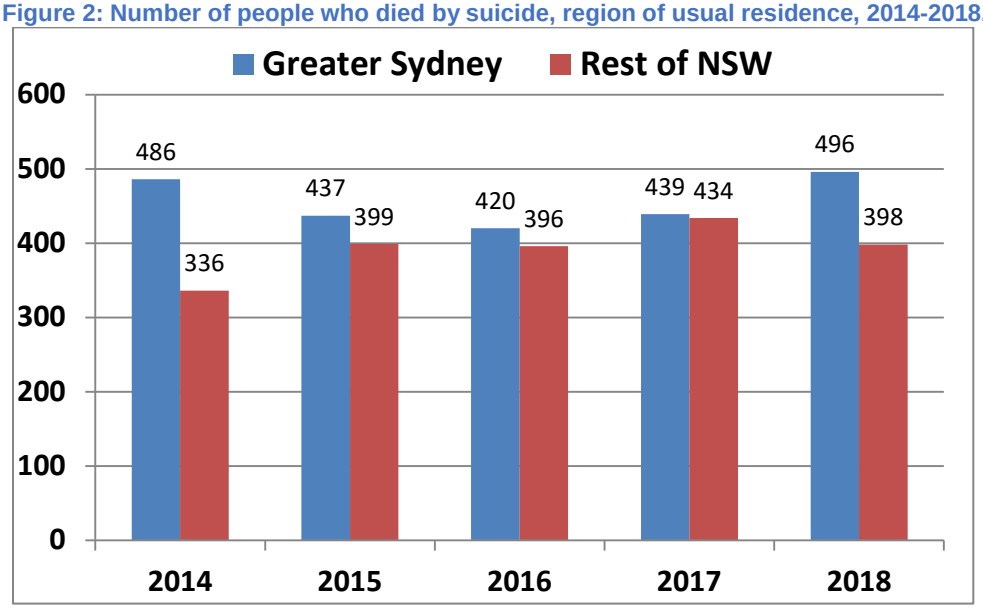
Figure 1: Standardised suicide death rates per 10000 by region of usual residence 2014-2018.



(Australian Bureau of Statistics, 2019a)

Lest we forget that these standardised rates represent people's deaths we can see that the number of deaths has risen in the greater Sydney area between 2016 and 2018 though the rate remained stable (Figure 2).

Figure 2: Number of people who died by suicide, region of usual residence, 2014-2018.



(Australian Bureau of Statistics, 2019a)

Without being drawn into too wide a discussion it has been reported that the rate of deaths by suicide have increased substantially since 2008. Note that the standardised rate of deaths by suicide in 2018 was 12.1 deaths per 100,000 people. Death rates across Australia recorded over the five years from 2014 to 2018 have been between 11.9 (2016) and 12.9 (2015) deaths per 100,000 people. This contrasts with rates of between 10.5 (2011) and 11.2 (2010 and 2012) in the five years from 2009 to 2013 (Australian Bureau of Statistics, 2019b). The rate and number of people who are taking their own lives is then, increasing or relatively stable across the state and country depending on the time frame and region examined.

Suicide itself is a complex phenomenon. People may, for example, have suicidal ideation, attempt, make a serious attempt, have deliberate self-harm without intent, or deliberate self-harm with intent and while better evidence would be produced if there were standardised terms used to described a self-harm there is as yet no universally recognised nomenclature (Kattimani, 2015; Lester, 2009; Lucas Giner, 2016; O'Carroll, 1996; Silverman, 2016).

That said, however the events are going to be classified, or responded to we must move beyond process and staffing related variables as primary outcome measures and focus on meaningful outcomes for consumers and carers as a primary outcome measure as stated in recommendation 25 in relation to emergency departments and suicide (National Mental Health Commission, 2019).

Quantitative findings:

Methods

De-identified raw data was provided by Community Care Northern Beaches in Excel format and data analysis was conducted in SPSS 25, with the exception of the χ^2 analysis and the Poisson Timed Events Test which were carried out using the Graphpad online calculator, Stattreck Poisson Events Calculator, and the Decision Tree online chi square power calculator.

Results.

The principal measure of any project that seeks to reduce the impact of suicide is the reduction in the number of deaths by suicide. The involvement of the Northern Beaches Local Area Command has been invaluable in providing quite accurate monitoring of suicide deaths in the area as they have worked hard to improve monitoring. Unfortunately the change to more accurate monitoring means that there are few comparable years, counts of suicide attempts, for example have increased by 400% over the last 2 years purely as a result of a change in the way that they have been counted. There is however comparable data on deaths by suicide between 2018 and 2019 and the results show that there has been a dramatic decline in the number of deaths by suicide between 2018 and 2019. The great majority of this reduction in deaths occurred in the second half of 2019, when the pilot project was running (Figure 3). This reduction was not statistically significant (χ^2= 1.581, p=0.21, Cumulative Poisson $p \leq 12$=0.06) but the number of people who died by suicide in the Northern Beaches Local Command gives barely sufficient power for the statistical test to find even a large difference (power = 0.76, acceptable power =0.8 (Cohen, 1988) and each test has it's limitatons due to the type and availability of data. Table 1 below shows the degree of change in the statistics across the Northern Sydney Local Health District (NSLHD) for the period 2001-2017 the latest date that statistics were publicly available. While these statistics reinforce the non-significant finding in the LAC statistics by showing that there have been wide variations in the past, they also show that a year on year change on the scale of 37% as occurred comparing the second half of 2019 with the second half of 2018 has only occurred once across the NSLHD since 2001. Similarly a year on year change of 30% as occurred between 2018 and 2019 would also be highly unusual. Further, other factors that could have contributed to a reduction in the number of deaths by suicide were investigated, such as the installation of barriers at known suicide 'hot spots' and the opening of the New hospital but no factor was found that occurred in the relevant time period. These factors combine to imply that the probable cause of this reduction in deaths by suicide in the area is due to

the intervention of this protocol pilot. A future useful comparison, when the 2019 statistics for the NSLHD become available, would be to compare changes in the NSLHD monitored change with the NBLAC monitored change. As the NSLHD has not been referring people into the pilot the statistics that the LHD has gathered, while including the NBLAC figures, will also incorporate deaths by suicide of people and communities who have not been directly involved in the pilot and there may be a difference in the rate between those two groups. If there is a difference it points directly to the result of the pilot intervention, if there is no difference the reduction may be related to community activities and the fact that the NBLAC deaths are also incorporated in the NSLHD statistics.

Figure 3: Deaths by suicide as recorded by the Local Area Command 2018-2019.

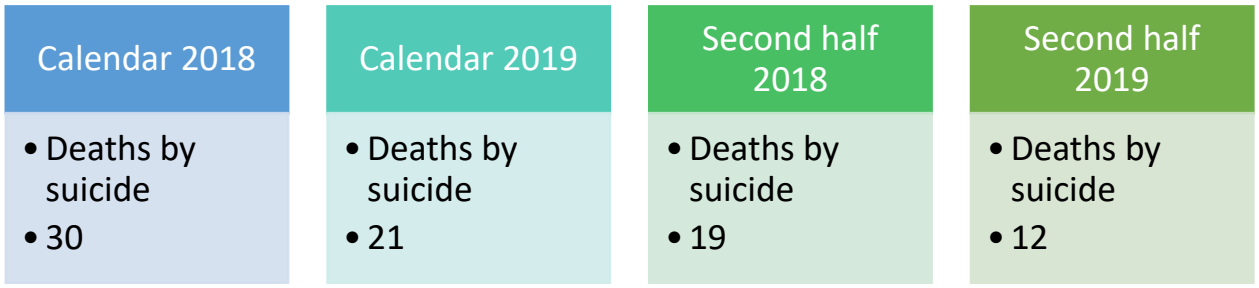


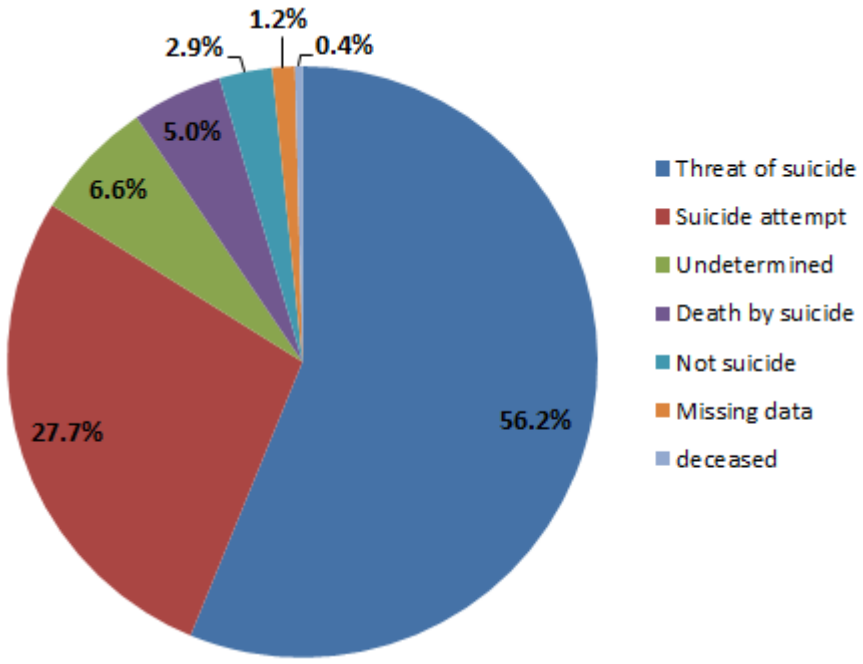
Table 1: Deaths by suicide (persons- all ages) 2001-2017 in the Northern Sydney Local Health District.*

Year	Deaths by suicide	Change on previous year	Percentage change on previous year
2001	78		
2002	73	-5	-6.4%
2003	63	-10	-13.7%
2004	56	-7	-11.1%
2005	50	-6	-10.7%
2006	50	0	0.0%
2007	73	23	46.0%
2008	59	-14	-19.2%
2009	71	12	20.3%
2010	68	-3	-4.2%
2011	60	-8	-11.8%
2012	76	16	26.7%
2013	72	-4	-5.3%
2014	82	10	13.9%
2015	71	-11	-13.4%
2016	57	-14	-19.7%
2017	68	11	19.3%

* Source: http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_lhn_trend

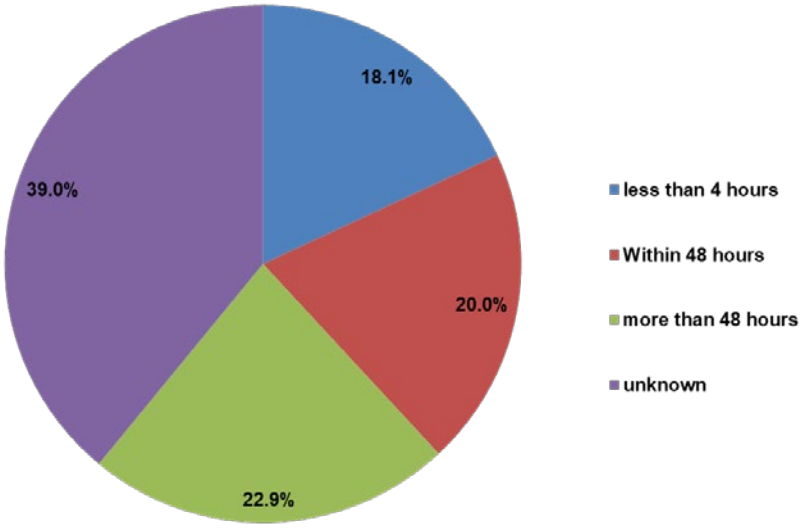
There were 242 people who were referred into the service, 23 people who declined to take part in the service. There were two people for whom the deaths were prior to July 8th 2019 and thus were outside the scope of this evaluation and were removed from the data analysis. A total of 4 people did not live in the Northern Beaches LGA 1 of whom had attempted suicide and 3 who had threatened suicide. Of the 219 people who consented to receive support 50% were younger than 29, 25% were aged between 29 and 47 and 25% of people were aged over 47. There were 2 people for whom age was not recorded. The oldest person who received support was 93 years old and the youngest was 12. The majority of responses were to threat of suicide or suicide attempts, bearing in mind that as previously discussed it is difficult to separate categories based on the limited observation of the first responders and the complexity of the response of the person themselves. The other large category of responses was of those who had attempted suicide, nearly 28% of responses and sadly 5% of incidents were related to a death by suicide (Figure 4).

Figure 4: Incident type by percentage



All the following statistics include the 23 people who declined the service thus the reported statistics are on an 'intention to treat' basis. Of the people referred to the service 45% identified as having previously received some form of mental health support. Of those who had previously received mental health support 59% had received support from the Local Health District, 26% from private counsellors with the complement receiving support from psychiatrists, Headspace, Lifeline or a PHN. 239 of the 242 referrals came from the Northern Beaches Local Area Command, 1 referral came from the Northern Beaches Hospital and 2 from other sources. All referrals were responded to within 24 hours, in 75% of instances the person or next of kin were contacted directly, in 22% of instances the next of kin were contacted with 3% of contacts being categorised at 'other' contacts. 40% of people contacted were engaged in the service within 24 hours of the incident with a further 14% engaged within 5 days. 11% of people could not be engaged into the protocol within 7 days and for 34% of the incidents there was no information available on engagement (numbers do not sum to 100 due to rounding). All of the people included in the notifications to the pilot were taken to the hospital of the 242 people taken to the hospital 105 were admitted. That is, approximately 43% of people who were judeged by the police to be in severe distress were admitted to hospital. 40% of those people were discharged within 48 hours. For nearly 40% of people the time to discharge is unknown (Figure 5).

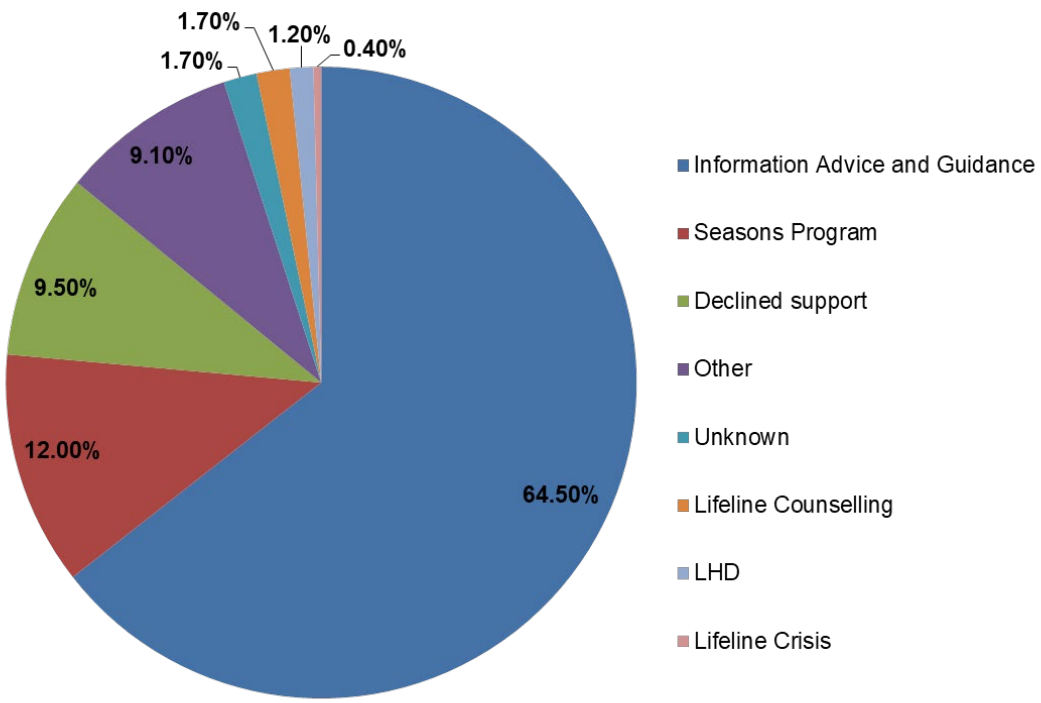
Figure 5: Time to discharge after admission.



less than 4 hours	19	7.9
Within 48 hours	21	8.7
more than 48 hours	24	9.9
unknown	41	16.9
Not admitted	45	18.6
	92	38

Most people were given information advice and guidance after contact with the service, with 12% of people being referred into the Seasons the PHN commissioned program run by Community Care Northern Beaches (Figure 6).

Figure 6: Type of support offered.



Dissecting the type of support offered by the type of client shows that the type of support offered is similar for all types of clients, with the two main supports across client type being information advice and guidance (IAG) and access to the Seasons program (Table 2).

Table 2: Action taken by client type crosstabulation

Follow up	Missing	Death by suicide	Deceased	Not suicide	Suicide attempt	Threat of suicide	Undetermined	Total
Missing data	0	0	0	0	1	3	0	4
Declined support	0	0	0	0	9	14	0	23
IAG	3	11	0	7	36	90	7	154
LHD	0	0	0	0	0	3	0	3
Lifeline Counselling	0	0	0	0	1	3	0	4
Lifeline Crisis	0	1	0	0	0	0	0	1
Other	0	0	1	0	6	9	6	22
Seasons	0	0	0	0	14	14	1	29
	3	12	1	7	67	136	14	240

In the vast majority of instances, no matter what the referring event was it was either the person or next of kin who was contacted by the service (Table 3).

Table 3: Person contacted by client type crosstabulation.

Contacted	Missing data	Death by suicide	Deceased	Not suicide	Suicide attempt	Threat of suicide	Undetermined	Total
Person/ next of kin	2	8	1	3	33	74	8	129
Next-of-kin	0	3	0	2	16	27	3	51
Other	1	0	0	1	1	4	0	7
Person directly	0	1	0	1	17	31	3	53
	3	12	1	7	67	136	14	240

Qualitative Discussions

Method

The short time period allowed for the evaluation review, budget constraints and the need for anonymity amongst a very small group of participants who are known to each other meant that typical qualitative analysis of transcribed interviews and using direct quotes from participants was not the optimal approach. The discussion below is a synthesis of the main points raised in a mix of group and individual face to face meetings and individual telephone discussions with a range of stakeholders. Those consulted by interview in this way included representatives from: Sydney North Primary Health Network, Headspace, New Horizons, Lifeline, Community Care Northern Beaches, The Great Group, Northern Beaches Council, Northern Beaches Police Area Command and one person who received support from the program. Between 1 and 5 people from each organisation took part, the interviews were recorded after asking permission and the interviewer took notes during the interview then re-listened to each interview taking more notes before synthesising the results below. Unfortunately after attempts to contact both the Northern Beaches Hospital/Healthscope and the Northern Sydney Local Health District the only response was 3 short bullet points from the NSLHD. (Appendix 3: North Sydney Local Health District evaluation response.) and an email referring the interviewer to other contacts in Healthscope.

Results.

Respondents' principal positive response, which was virtually universal, is that the implementation of the pilot has introduced a degree of service coordination to the area that was lacking prior to this program. This was a benefit for both the services in the Northern Beaches area as well as people receiving support in the area. A number of service providers commented that it has helped reduce

the problem of response by providers who had a surfeit of enthusiasm over experience. People accessing support benefited from a lack of confusion in being contacted by a number of services in a time of crisis. Particularly, again, the people accessing this service are being protected from services with a surfeit of enthusiasm over expertise.

A principal area commented on for improvement was in regard to notifications to services in the area. People from some major service providers in the area did not feel that they were notified of incidents that were of direct interest to their organisations and therefore a recommendation for improvement is to review the protocol for notification of incidents and which organisations would need to be notified in case of an incident. Headspace, for example, would best be informed of a suicide related incident where a young person might be affected not just directly but also by the attempt of a parent. Private providers and psychologists in the area were also mentioned as those who would benefit from a more structured notifications process. An area related to this, and one that came from more than one person, was that people are 'insular on the peninsular' and this has resulted in perhaps some boundaries being crossed and relationships becoming too close in some instances resulting in a limited response network. It is suggested that the protocol be reviewed by the Steering Group and agreement as to who should be notified in what circumstances be confirmed and key contacts agreed upon.

Another area was notifications and communication in that there is a single point of contact and notification. This is both a strength and a weakness of the protocol. It is a strength in that it is an efficient communication with first responders but notifications and referrals are dependent on the skills, knowledge and perhaps biases of the single point of contact organisation. A review of notifications and referrals would lessen the perception or occurrence of a limited range of notifications and referrals. It was also suggested that more than one organisation be involved in that first 24 hours and this was mentioned in relation to an early model that according to the participant, used a tiered model with more than one provider initially involved.

Slightly tangential to that point is the limited number of people at that single contact point is that there is a small number of people responding to a large number of incidents and there is thus the possibility of workplace trauma for people working in that area. Some participants stated that it is essential that there be a formal supervision and debriefing be in place if it is not already being adequately being addressed.

A major positive benefit mentioned was the effect on the police in the area of having this service available. There is no quantitative data but the police are reporting that they are feeling less distressed as they feel that the people that they have been attending in crisis situations are getting better support than previously. They also report seeing a reduction in the number of people reattempting suicide. Those people, commonly referred to as 'frequent flyers' in the emergency response community, cause particular distress to the psyche of police and emergency services as

their work can seem pointless. Thus a reduction in people re-attempting has positive benefits for first responders as well as the people themselves and the community through lower distress. One area of particular distress to the police was the experience of police making the judgement that a person was at risk of suicide, taking that person to the emergency department and the person not being admitted, the distress of this occurrence has been reduced by this program as there is still support available. Further support for the benefits of timely and widespread response comes from a large study investigating suicides in Denmark between 1996 and 2009 which found that compared with a matched cohort of people who had not received any psychiatric support, people who had contact with a psychiatric emergency department and were not admitted had 27.9 times the risk of suicide (Hjorthøj, Madsen, Agerbo, & Nordentoft, 2014). A startling statistic and one that strongly suggests follow up support for people who are not admitted after presentation at emergency departments even though the Australian emergency department system is different to the Danish system.

Another area suggested for improvement was generalising the protocol to attempted suicide and self-harm which changed a part of the program into suicide prevention, which was not the original intention and has created confusion and disagreement about the program. The rationale for this change, however was that the response to a serious suicide attempt and a completed suicide was virtually the same in the community and that the single best predictor of death by suicide is a previous suicide attempt. Given the confusion, however, one suggested solution was to have two separate protocols, one for postvention and one for prevention. One comment which, as the NSLHD did not take part in the interviews was not made by anyone in the NSLHD, was that conflation of the communication protocol with the support protocol may have stopped the NSLHD involvement.

Related to this were references to a duplication of services in the region. The Northern Sydney Local Health District already has a postvention/prevention service which is presumably, as they did not meaningfully take part in this evaluation, led by clinically trained personnel. A number of counter arguments to the duplication argument were discussed. The NSLHD and Northern Beaches Hospital have, presumably again due to a lack of engagement in the evaluation process, a KPI for contacting people within 7 days of an incident. A number of people mentioned that there might be triaging based on a risk profile and those found to be at higher risk would be contacted earlier in the 7 day period. Even if this is the case it is still problematic. Suicide risk is notoriously difficult to accurately measure. As stated in the LIFE Framework: “A list of risk and protective factors can provide a guide at the community level and can inform effective local action. However, it tells us little about individuals and can never provide an individual checklist” (Department of Health and Ageing, 2007)p14. Suicide risk is complex, and difficult to assess (Large, Sharma, Cannon, Ryan, & Nielssen, 2011). Studies dating back over 100 years have shown that the risk of suicide in the general population is associated with low income, unemployment, educational underachievement, and singleness. However a large study of people who have been admitted to psychiatric hospitals that involved nearly 100,000 people, over 250,000 admissions and nearly 3000 suicide deaths found that high income, postgraduate education,

marriage and employment were the major risk factors for death by suicide after hospitalisation (Agerbo, 2007). Further, a case controlled study from the U.K found that 43% of suicides occurred within a month of discharge, 47% of whom died before their first follow up appointment. The first week, **and the first day** *(this author's emphasis),* were found to be the high risk periods (Hunt et al., 2009). Due to their limited involvement in this evaluation it is impossible to know if the health services are taking findings such as this into account in triaging, or indeed if there is any triaging is being done. Whatever the outcome and also in regard to the difficulty of classifying serious attempts/self-harm/suicide attempt it would seem that the best way to prevent further suicide attempts and would be to respond to all serious incidents and in as short a time frame as is possible. It was mentioned more than once in the interviews that the acute care teams in the area are understaffed and stretched, this is not uncommon, and that an appropriately coordinated service such as tested in this pilot might be able to relieve some of the load from acute care.

As mentioned by some in the interviews the ideal response to suicide, attempt or serious self harm, response is not only a clinical response but needs to be a community response. There are a number of factors that could affect this decision here. Firstly a recent study by WentWest PHN in Sydney (Page et al., 2018) found that the three most important factors in reducing deaths by suicide were all factors which are addressed amongst the aims of the protocol.

1. Post suicide attempt assertive aftercare
2. Improved community support and reduction in community distress
3. A reduction in the proportion of people lost to follow-up.

The factors associate with suicide are not only mental health issues. The predictors of suicide include social factors such as housing, employment and even internet access (Downing, 2016; Law, Snider, & De Leo, 2014). The response, therefore, needs to be more extensive than a mental health support response. Mental health issues are definitely predictive of suicide risk, a health response is an essential part of any response to suicide, attempted suicide or serious self-harm, but a health response by itself is not enough for the individual or particularly for the community.

A further reason for involving community organisations as an entry point for suicide prevention is that there is ample research demonstrating that the stigma surrounding suicide and or mental illness prevents people, particularly men and young people, from seeking help in suicidal crisis (Niederkrotenthaler, Reidenberg, Till, & Gould, 2014) or for mental health issues generally (Clement et al., 2015; Corrigan, 2004). It has also been found that past experiences with health professionals, good or bad, are predictive of help seeking (Gulliver, Griffiths, & H., 2010). It has been suggested that an initial point of contact that does not have a direct mental health focus may be less stigmatising to the individual and that an initial contact other than a clinical mental health service could serve as a 'soft' entry point for navigation to other clinical or community support services (Rose et al., 2018). One comment in the interviews was that seeing a psychologist or other clinician was a self-diagnosis

that ‘I’m crazy’ but support from a community organisation doesn’t carry the same stigma and can still lead to referral to an acute pathway. However, another suggestion from those interviewed in relation to the current project was that the first point of contact into the program after the first responder should be a clinically trained person, which may be part of a solution the current observed impasse between organisations, and may present an opportunity for clinically trained staff to work alongside community staff, which may address the issues of stigma and also referral pathways and clinical governance. If that degree of cooperation can be achieved and if clinical staff, who are both expensive and stretched, can be funded to provide the level of response that the current program give to the large number of people referred then this could be a recommended pathway. .

A frequently voiced concern was the sustainability of the project. Currently there is no specific long-term funding for the core response and this author is unsure of funding for the more community based responses, such as liaison with surf clubs etc. One participant also stated that it would be impossible for clinicians to have the time to spend the amount of time in the local clubs and community groups as the local Community Managed Organisations (CMOs) are able to. CMOs, however, are reliant on short funding cycles and given two limitations expressed thus far sustainability may hinge on two factors.

1. At present the program is dependent on individuals’ good will to stay funded and to have workable processes. The framework of a system is in place in the protocol however if the program is to continue then arrangements between as many organisations in the area as possible should be formalised to support continuity. The greater involvement of clinicians might strengthen the sustainability of the project.
2. Of the two organisations on the steering committee with guaranteed virtually eternal funding, the police and the NSLHD, the involvement of the latter is minor. The police have commented that this is not their main role, further the Northern Beaches Local Area Command will shortly have a change of leadership to someone who may have different priorities. It may be crucial, therefore, to resolve the impasse with the NSLHD to keep this program viable. Splitting the protocols into two as previously mentioned or demonstrating the value of the program in reducing deaths by suicide as conclusively as possible are two ways that this might happen. It is easy to recommend but difficult to implement but this impasse must be navigated for the good of all people in the area. The comparison of 2018-2019 deaths by suicide as compiled by NSLHD compared with the data compiled by the NBLAC would be a reasonably strong comparison that will shed further light on whether the program is reducing deaths in addition to the evidence that it is reducing stress in the community and resulting more coordinated better targeted support. A quantitative survey of the community organisations might also provide evidence of the perceptions of distress in relation to the protocol.

Discussion and Conclusions:

The principal outcome for any program aiming to improve the health and wellbeing of the participants. In the case of a suicide postvention/prevention protocol such as the one evaluated in this report the two most important outcomes would be a reduction in the number of suicides and a reduction in the number of re-attempts. Other factors might be a reduction in community distress and/or the distress of the individuals' directly involved in the types of events that come to the attention of the program. Death by suicide is notoriously difficult to measure and all measures have their weaknesses. The Northern Beaches Local Area Command has strengthened their monitoring of suicide deaths to include deaths that were previously missed. The timing of this change in monitoring means that the only comparable years are 2018 and 2019. Deaths in 2019 show a marked decrease compared with deaths in 2018, and most of this improvement is concurrent with the commencement of the protocol pilot. This reduction and timing of the reduction, however, looks promising and on its own suggests that continuing the pilot would be worth the time, effort and expense involved. The basic experimental design is a before and after design with an intervention. This is a generally robust design though, again, there are many variables that could interplay in a community setting and thus there is no certainty at this time that this pilot has been the cause of this reduction.

Re-attempts are also a strong indicator of success and unfortunately in this case no statistics have been collected beyond the anecdotal. However the anecdotal evidence is positive. The police in the Local Area Command report a reduction in people who are re-attempting suicide and an increase in job satisfaction as a result. Increased wellbeing of first responders, by itself, is a useful and needed outcome as the effect of repeated exposure to suicide related incidents has a profoundly negative effect on the people who provide the necessary service of first response to these incidents.

The bulk of the quantitative data collected to day have been 'process variables', how many occurrences of service where the person was referred to, etc. There has been no attempt to collect quantitative measures of distress reduction amongst next of kin, for example, the person or community. It is suggested that some thought be put into how outcome variables such as these might best be collected and analysed.

A further indicator of success is the broadness of participation in the project. While there are only qualitative indicators available to this author it appears that the results in this case are mixed. While there are major services in the area who have spoken very favourably about the service and in particular the efficiency and distress lowering effects of coordinating services at times of great community and personal distress, there have been major services who have not been involved, who feel that the service is a duplication and who feel left out. It is a recommendation that, in the best interests of the community, the broadest range of services find a path to involvement in this protocol or a similar protocol in the area.

The results, such as are available, look promising. There has been a reduction in deaths by suicide as monitored by the principal, almost sole, referrer to the service. The NBLAC is reporting reduced distress amongst officers attending suicide related incidents and major services in the region were very pleased with the efficiency, professionalism and coordination of the program. The people working in these services believe that the program has reduced distress and confusion in the community. There is no program that cannot be improved upon however, and some of these same major service providers in the region also thought that they were not being notified of all incidents pertinent to their organisation, that there was inherent to the Northern Beaches area a certain kind of insularity that resulted in sometimes too close collaboration between some parties to the exclusion of others. Some were also concerned that there was only one point of contact, CCNB, and asked questions about clinical supervision and debriefing of the people working directly in the program.

There was also a suggestion that the lead should be clinically trained, but it is possible that this might reduce help seeking behaviour due to the stigma attached to clinical health professions. Referral pathways and whether this service was a duplication of an existing service were also raised as concerns and these concerns also relate to the training of the people in the organisation who take the notifications and make the referrals. The principal function of a program such as this is to link people to appropriate support as quickly as practicable. There is no valid way to assess an individual's risk of suicide in these situations. Further, if people do not make contact in the first place then it is impossible to refer appropriately. However, if people do make contact then it is crucial that the best and most appropriate supports be made available. Those supports should include as broad a range of the best services available in the area whether they are clinical or community services is relevant only in the contact of the need of the person accessing the program. Better coordination between clinical and community support organisations would provide the best possible range of referral options.

Pilot projects like this do more than provide a one-off service. They help local service systems build cooperation, and capability. The relationships between local council, police, CCNB, and Lifeline – in particular, have been strengthened through the operation of the program. The identification of local services and support have been mapped and a list of resources, fact sheets, communication templates has been developed. This base can be used to build a further level of service innovation locally and to use these and further results to generalise to other localities and thus lower suicide related behaviour and distress in the wider Australian context. .

Finally, it is noted that CCNB did not wait for funding. The police came to the local service system for support. Council responded by bringing players together and CCNB responded by funding and delivering a pilot. What happens next is up to the local service system.

References:

Agerbo, E. (2007). High Income, Employment, Postgraduate Education, and Marriage: A suicidal cocktail among psychiatric patients. *Archives of General Psychiatry, 64*(12), 1377-1384.

Australian Bureau of Statistics. (2019a). 3303.0 Causes of Death, Australia, 2018.

Australian Bureau of Statistics. (2019b). Causes of Death, Australia, 2018.

Berman, A. L. (2011). Estimating the Population of Survivors of Suicide: Seeking an Evidence Base. *Suicide and Life-Threatening Behavior, 41*(1), 110-116. doi:10.1111/j.1943-278X.2010.00009.x

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. . *Psychological Medicine, 45*(1), 11-27.

Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd Edition ed.). New York, New York: Lawrence Erlbaum and Associates.

Corrigan, P. W. (2004). How Stigma Interferes With Mental Health Care. *American Psychologist, 59*(7), 614-625. doi:10.1037/0003-066X.59.7.614

Department of Health and Ageing. (2007). *Living Is For Everyone (LIFE) Framework*. Canberra Australia: Commonwealth Government of Australia

Downing, J. (2016). The health effects of the foreclosure crisis and unaffordable housing: A systematic review and explanation of evidence. *Social Science & Medicine, 162*, 88-96. doi:https://doi.org/10.1016/j.socscimed.2016.06.014

Gulliver, A., Griffiths, K. M., & H., C. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10*(113).

Hjorthøj, C. R., Madsen, T., Agerbo, E., & Nordentoft, M. (2014). Risk of suicide according to level of psychiatric treatment: a nationwide nested case–control study. *Social Psychiatry and Psychiatric Epidemiology, 49*(9), 1357-1365. doi:10.1007/s00127-014-0860-x

Hunt, I. M., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw, J., & Appleby, L. (2009). Suicide in recently discharged psychiatric patients: a case-control study. *Psychological Medicine, 39*(3), 443-449. doi:10.1017/S0033291708003644

Kattimani, S. B., Balaji ; Sarkar, Siddharth ; Mukherjee, Aniruddha. (2015). Interrater Reliability of the Silverman et al. Nomenclature for Suicide-Related Ideations, Behaviors, and Communications. *Crisis: Journal of Crisis Intervention & Suicide., 26*(61-64).

Large, M., Sharma, S., Cannon, E., Ryan, C., & Nielssen, O. (2011). Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis. *Australian and New Zealand Journal of Psychiatry*, 1-10. doi:doi:10.3109/00048674.2011.590465

Law, C.-k., Snider, A.-M., & De Leo, D. (2014). The influence of deprivation on suicide mortality in urban and rural Queensland: an ecological analysis. *Social Psychiatry and Psychiatric Epidemiology, 49*(12), 1919-1928. doi:10.1007/s00127-014-0905-1

Lester, D. (2009). A Proposal for a Nomenclature for Suicide. *Psychological Reports, 105*(3), 685-686. doi:10.2466/pr0.105.3.685-686

Lucas Giner, J. A. G., Christopher W. Root, Enrique Baca-Garcia,. (2016). Nomenclature and Definition of Suicidal Behavior. In P. Courtet (Ed.), *Understanding Suicide: From Diagnosis to Personalized Treatment,* (pp. 3-17). Cham Switzerland: Springer International.

National Mental Health Commission. (2019). *National Mental Health Commission. Monitoring mental health and suicide prevention reform*. Sydney, Australia

Niederkrotenthaler, T., Reidenberg, D. J., Till, B., & Gould, M. S. (2014). Increasing Help-Seeking and Referrals for Individuals at Risk for Suicide by Decreasing Stigma: The Role of Mass Media. *American Journal of Preventive Medicine, 47*(3, Supplement 2), S235-S243. doi:https://doi.org/10.1016/j.amepre.2014.06.010

O'Carroll, P., W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the tower of babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26*(3).

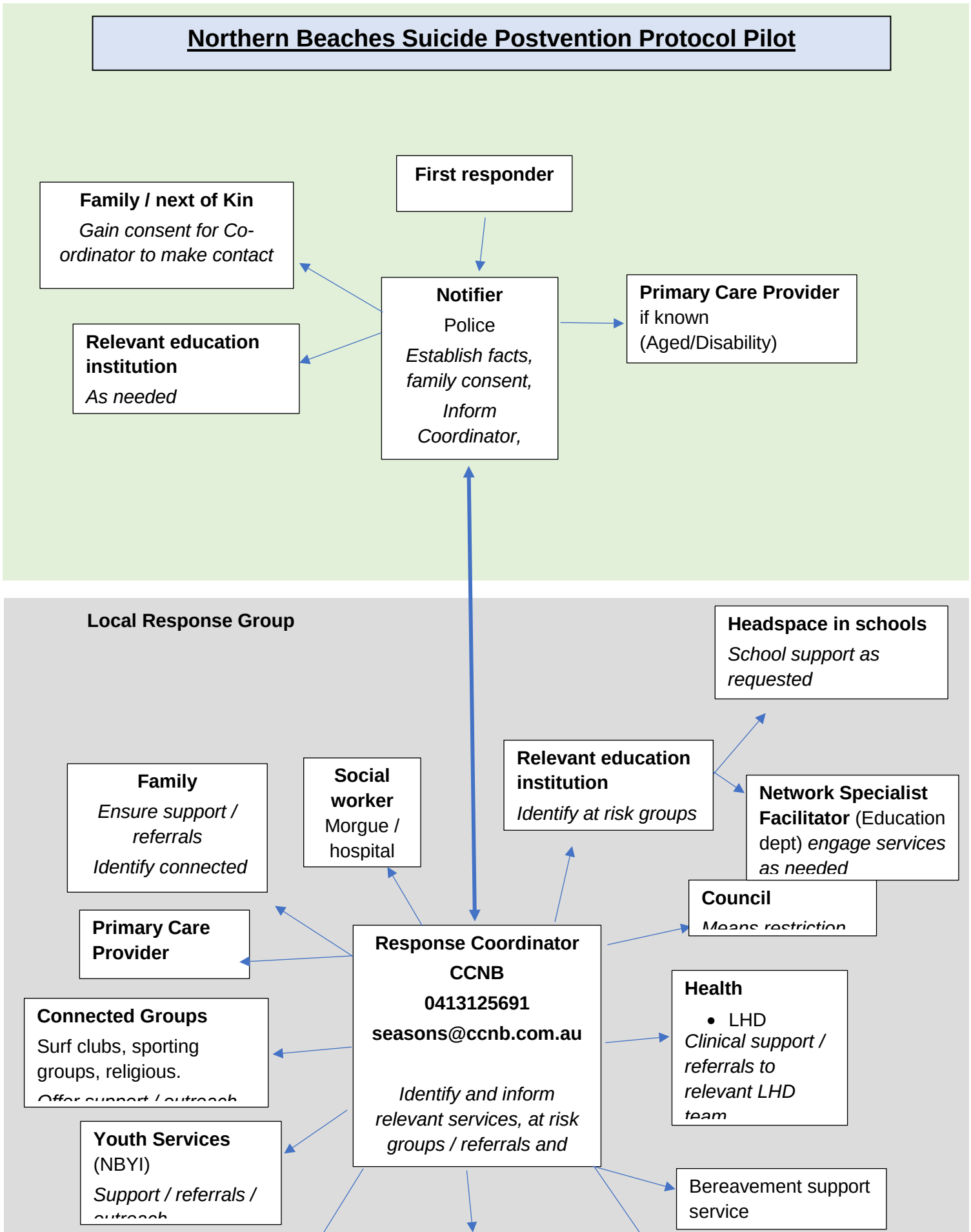
Page, A., Atkinson, J.-A., Campos, W., Heffernan, M., Ferdousi, S., Power, A., . . . Hickie, I. (2018). A decision support tool to inform local suicide prevention activity in Greater Western Sydney (Australia). *Australian & New Zealand Journal of Psychiatry, 52*(10), 983-993. doi:10.1177/0004867418767315

Rose, G., Hippel, C. v., Brener, L., & Hippel, B. v. (2018). Attitudes of people working in mental health non-governmental organisations in Australia: A comparison with other mental health professionals. *Health Psychology Open, 5*(1), 2055102918765413. doi:10.1177/2055102918765413

Silverman, M. M. D. L., Diego. (2016). Why There Is a Need for an International Nomenclature and Classification System for Suicide. *Crisis: Journal of Crisis Intervention & Suicide., 32*, 83-87.

Ye, J., Chen, T. F., Paul, D., McCahon, R., Shankar, S., Rosen, A., & O'Reilly, C. L. (2016). Stigma and discrimination experienced by people living with severe and persistent mental illness in assertive community treatment settings. *International Journal of Social Psychiatry, 62*(6), 532-541. doi:doi:10.1177/0020764016651459

Appendix 1: Northern Beaches Suicide Postvention Protocol Pilot



COMMUNICATION PROTOCOL KEY CONTACTS AND ROLES

Table 1.

Agency	Contact	Role	Email	Telephone
Northern Beaches Police Area Command	Supt Dave Darcy	Police response	darc1dav@police.nsw.gov.au	0416 213 960
Northern Beaches Council	Kylie Walshe	Means restriction (signage / fencing) Notify if incident is on public land	Kylie.Walshe@northernbeaches.nsw.gov.au	0419 205 238
Schools	Relevant school principal.	Activate school response Contact district director – related schools	Police hold list of school Principals	
Department of Education	Wendy Pike	Network Specialist Facilitator - support school by referring services	Wendy.pike2@det.nsw.edu.au	
NB TAFE	Ngaire Young Timothy Fletcher	Customer and stakeholder relations Early School leavers program	Ngaire.Young@tafensw.edu.au timothy.fletcher5@tafensw.edu.au	0447 240 421
ICMS	James Brady Val McMorran	Head of Student Wellness	jbrady@icms.edu.au vmcmorran@icms.edu.au	
Youth Worker in Schools	Lynda Roberge	Youth worker in Pittwater High School	Lynda.roberge@det.nsw.edu.au	0425211852
Headspace in Schools	Adrian Larkin	Support school staff in response Lead agency in Organising support within school	ALarkin@headspace.org.au	0475 383 049
Headspace Brookvale	Michael Cummings	Support for young people as needed	MCummings@newhorizons.net.au	0409 418 860
Lifeline NB	David Thomas	Counselling / telephone support Bereavement support Mobilise support in school if	david.thomas@lifelinenb.org.au	0405 422 437

Agency	Contact	Role	Email	Telephone
		requested		
Lifeline NB Head of counselling	Barbra Rabbitts	Head of counselling	barbara.rabbitts@lifelinenb.org.au	
CCNB	Marika Kontellis Kerry Gleeson	Seasons program – care coordination - support after suicide attempt	Marika.Kontellis@ccnb.com.au seasons@ccnb.com.au	0413125691
NS LHD	Andrea Taylor	Clinical support / referrals CYMHS / MHDA / OPMH	Andrea.Taylor@health.nsw.gov.au	0417 699 208
Youth Services (NBYI exec)	Sam King or Anita Mangan	Mobile outreach as needed and youth support services	sam.king@theben.org.au anita.mangan@det.nsw.edu.au	TBC
Surf Life Saving Clubs	Clinton Rose and Steve McInnes	Notify surf clubs if needed Rescue response and/or support for surf club members	Clinton.Rose@northernbeaches.nsw.gov.au Steve@surflifesaving.net.au	0408 469 269
Media	Police Lifeline	All media inquiries to be directed to Police for comment Positive messaging – lifeline then distributed to all relevant groups		
Glebe Morgue	Social worker			
Hospital	Social worker			

The Response Coordinator when notifying the relevant Local Response Group personnel as per incident circumstances should use discretion, only on an as needed basis to reduce risk of over-exposure.

Northern Beaches Suicide Postvention Protocol

Information is to be provided /shared on a need to know basis only, in line with confidentially policies and only once it is confirmed as factual.

Primarily, responses relating to this protocol will address potential publicity from the incident and risk of community distress. Individual organisational responses should progress in line with organisational policy and procedures.

If possible, the Police will obtain permission from the family for the Response Coordinator to be involved and protocol activated. The Communication Protocol can be activated without family/guardian consent if deemed necessary by Police and Response Coordinator.

The decision to activate the Communication Protocol will be made by the Response Coordinator, who will use discretion when contacting the relevant and appropriate Local Response Group (LRG) members. Not every incident will require all LRG members to be notified. Other agencies to be invited as appropriate.

1. AIMS

The Northern Beaches Suicide Postvention Protocol has two aims

1. To ensure a coordinated and effective response to suicide, serious attempt of suicide or sudden death
2. To foster community capacity in minimising of contagion following a suicide, serious attempt of suicide or sudden death

2. TARGET CATCHMENT

The Northern Beaches Suicide Postvention Protocol covers the Local Government Area of Northern Beaches of Sydney

3. CONFIDENTALITY AND STORAGE OF DATA

All documents and templates used for the purpose of collection and planning responses are strictly confidential and are not to be shared publicly or with any non-authorised personnel. It is the responsibility of all members of the Local Response Group (LRG) to ensure confidentiality is maintained.

4. PROTOCOL ACTIVATION

This protocol will only be activated in response to an incident that has the potential to impact the community and lead to community distress and possible contagion. Critical incidences in this protocol include three types of incidents

1. (Suspected) Death by Suicide*

2. Serious attempt suicide**

* Note: Cause of death is determined by the Coroner and ruling about cause of death can take some time. Hence, until that time all deaths by suicide are suspected deaths by suicide.

** Definition: An incident that had the potential to cause harm but didn't, due to timely intervention and/or luck and/or chance

This protocol will only be activated in the event of factual confirmation from Police of a critical incident as outlined above.

4.1 Criteria for Protocol Activation

The following criteria will be assessed and documented to inform the decision to activate the protocol.

- Potential for community distress, particularly amongst children and young people
- Potential; for media interest
- Circumstances surrounding the death
- Perception of risk of suicide contagion in the community
- Statistics indicate a cluster may be developing
- Family agreement sought, but not required to activate plan

A Protocol Incident and Activation Report will be completed by the Response Coordinator for each incident, regardless of whether the Protocol is activated or not. The Response Coordinator will be responsible for documenting and holding these records. All decisions must be clearly documented in the Protocol Activation Criteria. The LRG should convene within 48 hours of notification of an incident by the Response Coordinator, phone, text, email or face-to-face is acceptable. The Response Coordinator will document key factual information and contact relevant LRG members as soon as reasonable.

4.2 Protocol Activities

The following activities should be undertaken throughout the Protocol activation period.

- Obtain accurate and factual information
- Response Coordinator notify essential key stakeholders that a critical incident has occurred
- Evaluate the need for other services for individual/groups as appropriate
- Inform individuals/groups of services available as appropriate and assist access to services
- Liaise with media as required
- Convene meetings or communicate with the Local Response Group as required (phone, email, face-to-face)
- Record details on Incident and Activation Report (Appendix A)
- Plot response on Response Action Plan as details emerge (Appendix B)

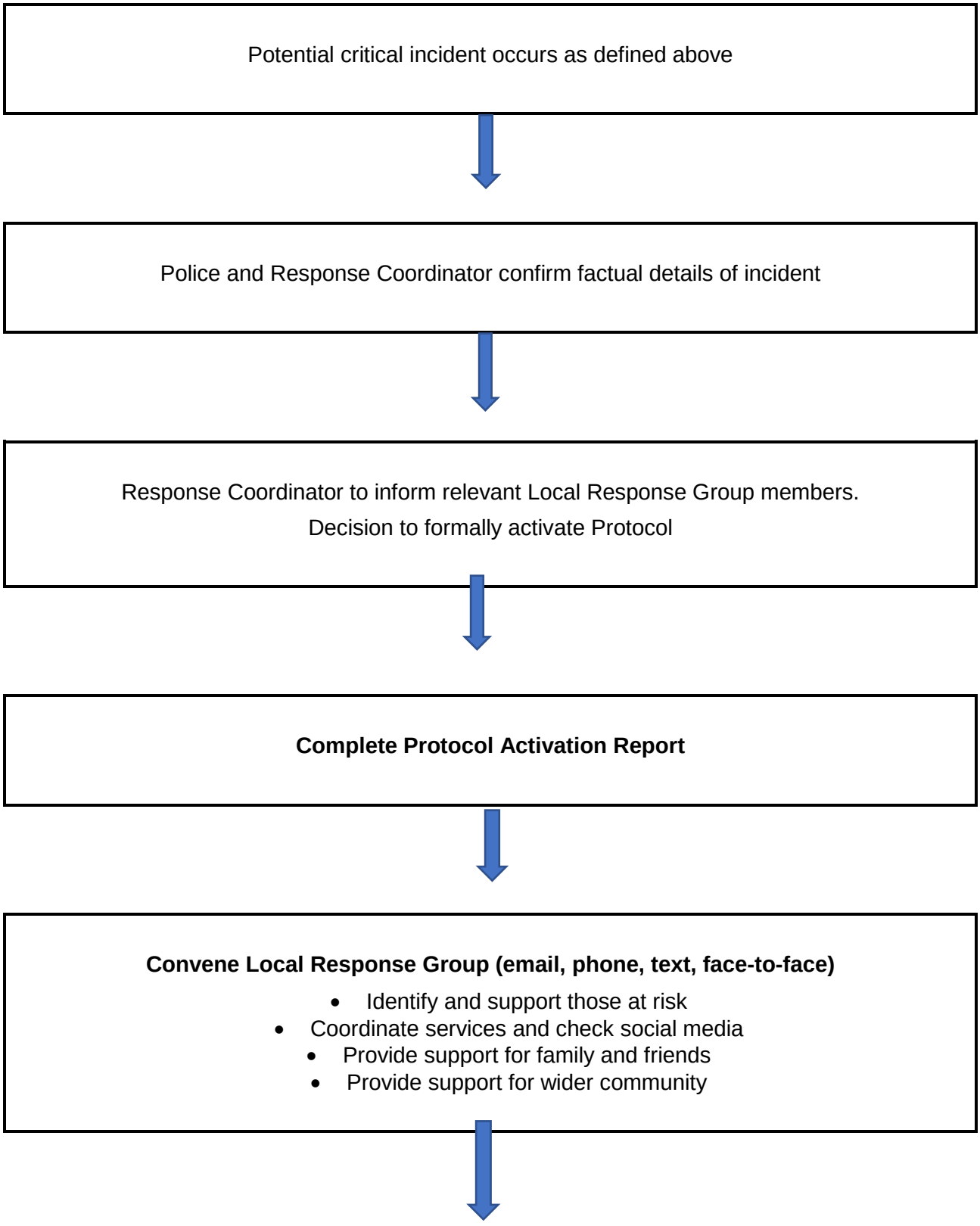
4.3 Protocol De-Activation

The Communication Protocol should be formally deactivated at an appropriate time. The LRG will decide when to deactivate the Protocol via a deactivation meeting (phone, email, face-to-face) using the following agenda:

- Review Response Action plan (Appendix B) - follow up any outstanding issues
- Amend protocol based on lessons learned
- Identify ongoing services / resources and who will supply them
- LRG to review roles, responsibilities
- Debrief of all LGR members

4.5 Protocol Response Pathway

In the event that a critical incident occurs, the following pathway will be followed



Stand down Local Response Group

Operational debrief with Response coordinator, Police and Local Response Group (phone, email, text, face-to-face)

Document / Report

5. LOCAL RESPONSE GROUP (LRG)

A Local Response Group (LRG) will be convened by the Response Coordinator in consultation with Police if deemed necessary. The Local Response Group will be responsible for:

- Oversight and implantation of the Protocol
- Monitor reports from the Response Coordinator
- The decision to deactivate the Protocol
- Ensuring Protocol is reviewed to incorporate lessons learnt

The Local Response Group (LRG) will be specific to an incident, but will include the following representatives as required. Discretion should be used by the Response Coordinator when notifying the members of the LRG, depending on the circumstances of each incident.

- Response Coordinator
- Police
- Local Government representative
- Department of Health representative
- Department of Education / Independent Schools / TAFE representative
- Lifeline representative
- Community Care Northern Beaches (CCNB) representative / postvention support service

- Youth Services representative
- Headspace in school support
- Headspace Brookvale
- Bereavement Support services

Other representatives will be by invitation from the response coordinator on a case by case basis.

6. PROTOCOL KEY CONTACTS AND ROLES

This Protocol has been designed to compliment existing organisational processes and procedures in the event of a critical Incident and to promote coordination between agencies. It is not intended to duplicate or take the place of existing protocols in any way.

All agencies must notify the Response Coordinator if there are staff changes and contact details changes in your organisation.

Key contacts and their roles and responsibilities in the implementation of the Protocol are outlined in Table 1

6.1 Response Coordinator

- The Response Coordinator is an allocated staff member from CCNB
- The Response Coordinator takes on the main contact and co-ordination role in the response to suicide incidents
- The Response Coordinator provides a direct link between health services and other relevant local community service providers.

6.2 Police

- Attending Police members to a suicide event, serious attempt or sudden death confirm details of the incident and seek permission to contact the Response Coordinator.
- They will provide information available and relevant with consideration to confidentiality.
- Police may not be able to clarify in all instances specific detail; however, where concern exists around risks and community welfare, the Protocol can be activated.

7.3 Roles

7.3.1 Police

POLICE **Number:** **Email:** **24 hours, 7 day per week** **Name: Superintendent Dave Darcy** **Position:** **Organisation: NSW Police**	**Roles and Responsibilities:** • **Contact Response Coordinator immediately with factual information (via email, text or phone).** • **Obtain agreement from family / next of Kin (if possible) to involve Response Coordinator.** Police can determine if family agreement is a requirement, but where possible, family agreement should be obtained • Contact school or education institution if required

Phone Number: **Back up Number:** **Email:**	• Contact Primary Care Provider (Aged / Disability) if required • Identify at-risk individuals for referral and advise Response Coordinator • Provide witness contact details if available

7.3.2 Response Coordinator

RESPONSE CORDINATOR **Number: 0413 125 691** **Email: seasons@ccnb.com.au** **24 hours, 7 days per week** **Name: Kerry Gleeson** **Position: Senior Care Coordinator** **Organisation: CCNB** **Phone Number:** **Back up Phone Number:** *(Business hours)*	**Roles and Responsibilities (Business hours)** • **Confirm facts of incident with Police** • **Complete Incident and Activation report** • **Determine if Protocol should be activated** • Convene within 48 hrs relevant Local Response Group members via email or text. • Provide early notification (no action necessary) to key groups such as headspace, lifeline, via email or text • Document all discussions and referrals • Identify at-risk individuals and/or groups and notify relevant LRG members • Advise CHYMS/MHDA/OPMH of identified at-risk individuals • Follow up contact with all agencies in the response • Assist in the follow up of identified at-risk individuals/groups (contact relevant agencies only with relevant information only)

8. MEDIA

All media inquiries relating to an incident are to be directed to Police for comment.

9. PROTOCOL REVIEW MEETINGS

Key stakeholders should meet as needed to update stakeholder contact details, reflect on activated events and to critically review the relevance of the protocol. Changes will be made to reflect decisions made in these meetings and with direct feedback to the Northern Beaches Suicide Prevention Steering Group. It is the responsibility of each individual agency to review their internal protocols relating to suicide postvention to ensure they remain current and effective.

Appendix A

Northern Beaches Suicide Postvention Protocol

Incident and Activation Report

Confidential Document - not to be shared

Date ___/__/__

Name of Response Coordinator _____

Checklist for Northern Beaches Suicide Postvention Protocol Activation				
Potential for community distress	Yes	No	Unknown	Details
Possibility of risk of contagion / cluster	Yes	No	Unknown	Details
Potential for media interest	Yes	No	Unknown	Details
Circumstances surrounding death increase risk to others	Yes	No	Unknown	Details
Decision to activate Communication Protocol	Yes	No	Unknown	Details

Incident Report	
Date /Time and Source of initial notification (e.g. School, family member, community, emergency services)	
Incident Level A. Suspected death by suicide B. Serious attempt	
Name	

Age	
Gender	
School / Educational facility connections	
Identification with marginalised group (e.g. LGBTI, ATSI)	
Mode / Method (e.g. Drug or alcohol related, hanging, cliff top, other, unknown)	
Location of incident	
Witness Present	
Next of kin informed of death	Yes / No
Next of kin aware that suicide is suspected	Yes / No / Unsure
Next of kin agreed to call death a suspected suicide	Yes / No / Unsure
Have next of kin given consent for contact from Local Response Group	Yes / No / Unsure

Northern Beaches Suicide Postvention Protocol

Response Action Report

Response Action Plan

Risks Identified	Action / follow Up	By Whom

Identified At-Risk Individuals and Groups

Name	Age	Relationship	Risk factors	Supports

Agencies involved in Response

Local Response Group	
Mental Health Services	
GP (if Known)	
Education Institution (if relevant)	
AOD organisation	
Allied Health Provider (Counsellor / Psychiatrist)	
Community groups (church, surf clubs, sports clubs)	
Workplace	
Other	

Protocol Deactivation Report

	Comment / Decision
Incident ID Number	
Date of Initiation	
LRG Participants	
Review Response Action Plan – follow up on all outstanding issues	
Amend Communication Protocol bases on lessons learnt	
Decision to Deactivate	**Yes / No**
Date of Deactivation **Completed by: Name and signature**	

This document is credited to Frankston Headspace from the document:

Youth Mental Health Suicide Postvention and Prevention Project. Community Response Plan, Communication Protocol 2017, from Frankston and Mornington Peninsula Local Government Area.

References

Australian Institute for Suicide Research and Prevention and Postvention Australia (2017) Postvention Australia Guidelines: A resource for organisations and individuals providing services to people bereaved by suicide. Brisbane: Australian Institute for Suicide Research and Prevention

Black Dog Institute (2017), Regional Suicide Response: Implementation Tool, Sydney, Black Dog Institute

Mental Health Commission (2018), Strategic Framework for Suicide Prevention in NSW 2018 – 2023

California Health Services Authority (2016), After Rural Suicide: A Guide for Coordinated Community Postvention Response

NSW Government department of Education (2015), Responding to Student Suicide, Support Guidelines for Schools,

Appendix 2: Suicide Postvention Coordination Pilot - Target Operating Model

Current Situation	• The number and characteristics of people attempting suicide in the Northern Beaches region is unknown. First responders(Police) report that they respond to approximately 60 suicide attempts every month • Approximately 30 people die by suicide every year in the region. The impact of every death has a significant impact on loved ones, neighbours, colleagues, peers and their communities • There is a high level of commitment(from communities and the formal care sector) to support people and their families following a suicide attempt or death by suicide • There are many services in the region (public, not for profit and private) that interface with people affected by suicide • An apparent lack of coordination of postvention support drives poor service access and outcomes for individuals, families and communities • Hospital planning processes do not always link people to care and support when they are discharged following a suicide attempt • First responders do not always get the support they need from health and community services
Participants	• People who have had a recent suicide attempt, their families and friends • Families and friends of people who die by suicide • Police - Northern Beaches Police Area Command • NB Suicide Prevention Steering group • Key service providers including Northern Beaches Hospital, GPs, Lifeline, Headspace,
Activities	• Notifications of suicide related incidents • Data collection and analysis • Individual safety plans • Timely assessment of needs • Information, advice and guidance • Referral and linkage • Community education
Outputs	• People, their family and friends are linked to services and support • Police are provided with outcome information regarding their notification • People receive timely information, advice and linkage to services • Data is collected and analysed • Partnerships between services are strengthened • Integrated care Coordination is delivered

Outcomes	**…for people and their families**	**…for the local service system**	**…for local communities**
	• Receive support at their point of need - support within 24 hours of notification • Do not attempt suicide again • Family and friends feel	• A co-ordinated and integrated care system exists for people that have attempted or died by suicide • Effective and value-added partnerships are in place	• Increased confidence in supporting people at risk of suicide or those bereaved by suicide • Suicide attempts and deaths by suicide decrease

	• supported in their grief • Choices about recovery and grief management	• Resources are shared for mutual benefit • Data is collected and analysed • There is greater expertise in generic services that interface with people who are at risk of suicide	
Impact	People get access to the right care and support to get the most out of life		

Data Points

Outputs (outputs are consequences of the activities)

Output	Measure
People, their family and friends are linked to services and support	Number of people and families linked to services and support
Police are provided with outcome information regarding their notification	Number of notification feedback reports to Police
People receive timely information, advice and linkage to services	100% of people notified are connected with within 24 hours
Data is collected and analysed	Type of information collated The actions taken with that information
Partnerships between services are strengthened	Number of partnerships that are explored during the pilot project Number of new partnerships developed throughout the project
Integrated Care	Hospital discharge advice given to PV Coordinator 100% of the time People linked and referred to key services

Outcomes (changes that occur as a consequence of the outputs)

Outcome	Measure	Data Points
Receive support at their point of need - support within 24 hours of notification	The amount of people notified to the Project Amount of people connected to within 24 hours of notification	Monthly reports Length of time between notification and first contact
Do not attempt suicide again	Re- notifications	Number of re-notifications
Family and friends feel supported in their grief	Number of family and friends connected	Care notes indicate number of contacts

		Self-reported
Choices about recovery and grief management	Person and or family members provided with choice about services	Care Note assessment Monthly report shows number of services people are linked into
A co-ordinated and integrated care system exists for people that have attempted or died by suicide	Postvention protocol stakeholders accept and act on referrals The person's experience with the service system and their ease of access and effective use of services	Monthly reports Self-reported
Effective and value-added partnerships are in place	Number of partners trained and participating in protocol	Attendance at stakeholder briefing session
Resources are shared for mutual benefit	Number of new resources shared across the region	Collateral log developed and updated
Data is collected and analysed	Notifications and action data collected	Monthly reports Final evaluation report
There is greater expertise in generic services that interface with people who are at risk of suicide	Number of service staff and volunteers trained	Council
Increased confidence in supporting people at risk of suicide or those bereaved by suicide	Number of people who take up local community training	Self-reported
Suicide attempts and deaths by suicide decrease	Number of people who attempt or die by suicide	Monthly reports

Appendix 3: North Sydney Local Health District evaluation response.

Below is the complete response from the Northern Sydney Local Health District

The Northern Beaches Suicide Postvention Protocol Pilot is an important initiative.

In addition to the contribution made at the December 2019 NB Suicide Response Steering Group; I note that as an LHD we support the development , integration and coordination of effective postvention strategies; which requires strong networks and referral pathways between agencies that takes into consideration the following principles:

1. Peoples first experiences with services has an impact on their bereavement journey (assistance from frontline workers could normalise grief reactions and link them to other specialised services)'
2. One size does not fit for all -there is a diverse range of needs of people impacted by suicide and the changes in those needs at different stages of bereavement (including emotional and practical needs, such as counselling, employment, legal advice);
3. There is a 'No wrong door' approach –which requires the facilitation of referrals to the most appropriate services, ensuring that the bereaved are supported in finding the right services.

We are currently awaiting Ministry advice in relation to clinical information sharing following notifications from police to CCNB to address privacy concerns.