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Intentional self-harm and suicidal behaviour - How children and young people can be better protected

A submission for the National Children's Commissioner of Australia prepared by the United Synergies Ltd and the National StandBy Response Service, a program of United Synergies Ltd.

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BACKGROUND

The National Children's Commissioner is examining how children and young people under 18 years can be better protected from intentional self-harm and suicidal behaviour.

This document provides a response to the request for submissions on the issue of children and young people under 18 years of age engaging in intentional self- harm and suicidal behaviour. This submission provides evidence from United Synergies experience and practice in working with children, young people, families and communities and identifies key activities, partnerships and a case study example which may assist toward making a difference in the tragedy of intentional self-harm as the leading cause of death for Australian children and young people aged 15 to 24.

United Synergies acknowledges those many communities and individuals who have supported and contributed to the service and seeks to respectfully provide contribution gained from supporting children, young people, families and communities including those Aboriginal and Torres Strait Islander individuals and communities impacted by suicide.

ABOUT UNITED SYNERGIES LTD

United Synergies is a leading provider of programs addressing the areas of suicide prevention and postvention, including the National StandBy Response Service and Headspace Maroochydore. This submission reflects practice experience, analysis of available data, evolving thinking and insight in the areas of intentional self-harm and suicidal behaviour in children and young people and the impact on Australian communities.

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STANDBY RESPONSE SERVICE

PREFACE

"Each year the lives of too many of our children and young people are lost. The impact of intentional self-harm on children and young people is felt all through the community and leaves a lasting legacy of grief, loss, disability and poor health."
National Children's Commission 2014

"There is no way to describe the loss of any child"
USA Senator Gordon Smith
Private Sector Co-Chair USA National Action Alliance for Suicide Prevention USA
President and CEO National Association of Broadcasters
Bereaved father.

"It's like in the movies where everything is quiet and in slow motion - that bus going past, that man walking over there…..the pain was just too much for me… I just wanted to get out … and help other bereaved parents with the loss of their children …."
Julie Turner
Wakka Wakka woman from Cherbourg, Queensland living in Northern Territory
Member NT Mental Health and Suicide Prevention Steering Committee
Member Darwin Region Indigenous Suicide Prevention Network
Bereaved mother.

'When I think of my Dad and all the good times we had and the times I'll never get to have with him all I can do is just breathe….if I can get my breathing back to normal then when my throat swells and aches, my stomach churns and all I can think is I'm going to be sick … I just breathe and know I will be OK.. maybe not today… but maybe some day very soon…."
Samantha Harrison
Founder of Head High Support Group for Young People Bereaved by Suicide
Bereaved daughter.

'The programs from the National Youth Suicide Prevention Strategy which have endured, and have continued to have long term impact, are about resilience, connectedness, increased awareness, clear information for when crises occurs, and help-seeking'
Professor Graham Martin Professor OAM, MD, MBBS, FRANZCP, DPM
Professor of Child and Adolescent Psychiatry, The University of Queensland
Advisor to the Australian Government National Suicide Prevention Strategy

OVERVIEW

Suicide is a major cause of mortality, both internationally and in Australia. Across Australia 2,535 people of all ages died by suicide in 2012. This translates to seven people dying by suicide in this country every day. Almost 75% of those were men. Suicide remains the leading cause of death for males 15 - 44 and has risen 60% in young females 16-19 years old (Australian Bureau of Statistics 2014).

The latest available data shows that intentional self-harm was the leading cause of death among Australian children and young people aged 15 to 24(ibid). In addition Aboriginal youth suicide and attempted suicide are of significant and increasing concern (Taylor et al 2012) with recent ABS data indicating that Aboriginal and Torres Strait Islander young people aged 15-24 are 5.2 times more likely to die by suicide than other children or young people of similar ages (ABS 2012:5:12.4:27; ABS 2012:5:12.4:106). Internationally data from the World Health organisation in 2012 indicates that deaths by suicide are among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group with suicide deaths in younger age groups continuing to rise despite reductions in other age groups. These figures do not include suicide attempts which are up to 20 times more frequent internationally than completed suicide. Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. In the last 45 years suicide rates have increased by 60% worldwide. Suicide worldwide was estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2012 (World Health Organization 2012)

THE IMPACT OF SUICIDE FOR CHILDREN & YOUNG PEOPLE

When considering the number of people bereaved by the loss of loved ones to suicide the impact today is considered greater than previously thought especially in relation to bereavement from loss of children and young people. While Shneidman's (1969) postulation of six people bereaved by each suicide has taken on a mythical status, Wrobleski's (Crosby & Sacks 2002) estimation that for every completed suicide at least 10 people are directly affected, translates to approximately 25,350 Australians directly impacted by suicide and

therefore on today's statistics, at least 70 Australians impacted each day. However more recently, Cerel and Campbell (2008, p. 30) suggested "each suicide creates at least five and as many as a hundred survivors". In this way, the number of people potentially affected following a suicide may be much larger than currently reported or traditionally envisioned (Maple & Fisher 2013: in publication).

Many of those affected by suicide are children and young people and the uptake of new technologies such as social media mean the 'ripples' of suicide impact spread to far greater populations than ever before increasing both the population of children and young people bereaved by suicide themselves as well as the population of those bereaved by the suicide deaths of children and young people. As early as 1988 the risks of diverse behaviour problems, morbidity and suicide were noted for those adolescents exposed to suicide loss as they simultaneously try to establish identities and values whilst trying to understand the death of a loved one or friend to suicide (Valente et al 1988).

It must also be noted that due to the cumulative nature of suicide loss with additional suicides each year the population of those 'first time' affected expands so that within five years numbers of those newly exposed and experiencing significant health and wellbeing impacts could exceed 1,267,500 thus a population health problem. This does not include those with pre-exiting negative health impacts from historic experiences of suicide loss whose numbers would further increase this total. Many of these also are children and young people and determining population numbers for this group has not occurred.

Many people, such as relatives, friends, colleagues, teachers and acquaintances are also impacted by suicide of children and young people, experiencing substantial feelings of grief and loss along with many community members who must deal with suicide events when they occur. Additionally emergency services personnel (e.g. police and ambulance), funeral directors, counsellors, health workers and community services personnel are also directly exposed to suicide and self harming behaviours by young people and, not surprisingly, feature among those professions at high risk of suicide themselves (Loo 2001).

Deaths amongst these professionals severely impact affected communities especially in rural and remote areas. Impact on communities, schools, workplaces and professionals**.**

Communities also suffer the negative effects of suicide. A death through suicide, especially that of a young person, can cause a feeling of collective grief, particularly in small, close-knit communities, such as those located in rural/remote areas or those communities with strong cultural identities (e.g. Indigenous or ethnic communities).

Evidence suggests that in communities where there have been a number of suicides, this collective grief can become entrenched and may lead to other social and economic problems and even a total loss of cohesion or a breakdown of the community.

Colin Tatz (1999) in his seminal work "Aboriginal Suicide is Different" notes the over exposure to suicide amongst Aboriginal communities and that combined with historic experiences of dispossession and cultural loss means that many Aboriginal people and communities find themselves "in the constant cycle or procession of grief", thus disabling community functionality. Evidence about similar group exposure and the associated negative impacts has also recently been correlated for the GBLTI community and amongst refugee and other cultural groups.

In many areas of Australia, there is limited awareness and understanding of the risk factors and warning signs for suicide and appropriate responses or actions to take to prevent suicide or following a suicide event. These limitations can lead to feelings of stigma and shame for people bereaved by suicide and reduce their capacity or willingness to seek help and support. Limited capacity to respond appropriately to suicide incidents, especially those related to young people, can also create a sense of disempowerment within a community, with local emergency and community services' personnel feeling powerless to prevent suicide from occurring and helpless through not knowing how to support the bereaved.

Some communities may also experience cluster or contagion suicide effects, where the occurrence of one suicide leads to more suicides or suicide attempts. Schools, correctional centres, mental health facilities, Indigenous communities and communities with previous experience of suicide or suicide clusters are indicated to be at higher risk of experiencing a

suicide cluster (Pirkis 2010). The occurrence of contagion and/or cluster suicides can be extremely traumatic and disabling for a community and bears considerable emotional, social and economic costs for families, schools, workplaces and community groups.

Schools and workplaces often have difficulty dealing with the suicide death of a student, teacher or employee, often unaware of how to discuss the issue or provide appropriate support for others within the community. This can result in lost productivity, the occurrence of complicated grief and/or other mental health conditions amongst other students, teachers or employees and may increase the risk of further suicidal behaviours.

The increased risk where adverse publicity about suicide clusters or 'copy cat' behaviour has occurred has also been identified (Etzersdorfer, et al 2004) and impacts of media reporting for those bereaved by suicide have also recently been studied (Skehan et al 2013). The need for rapid response capacity where cluster and contagion effects occur was tragically highlighted recently by the suicide events at Bridgend, Wales where 25 young people died by suicide in a two year period.There are various other people and organisations that may be impacted by a death through suicide of children or young people. For example, health professionals, such as general practitioners, psychologists, psychiatrists and other mental health and health professionals, are known to experience considerable feelings of grief, guilt and professional failure following the suicide of a patient. However, many are unable to express their grief, often having to provide objective support to family and friends of the deceased and, in some cases, face claims of negligence or incompetence and/or feelings of blame from the deceased's loved ones. In small regions these professionals also know the deceased and have several social impacts from the loss in addition to the clinical impact that occurs.

Increased understanding of suicide bereavement as a public health issue has been a key driver in change as population statistics become more significant with growing knowledge of the long term impact of suicide loss on productivity and service demand and the sheer number of those exposed to suicide loss. A recent as research study in the USA has indicated that 60% of the population surveyed had been exposed to suicide loss in a meaningful and impactful way (Cerel, et al 2013).

ABOUT UNITED SYNERGIES LTD

United Synergies Ltd. is a human services organisation committed to making a difference to the lives of others. The service supports young people, families and communities around Australia, with particular emphasis on those experiencing some form of disadvantage or vulnerable to assist them in achieving their full potential.

A company limited by guarantee, United Synergies Ltd. evolved from the former Noosa Youth Service (NYS). NYS was incorporated in 1989 with the aim of providing support to young people who were homeless, or at risk of becoming homeless. During its 15-year history, NYS developed into a wider range of services for youth and families. In 2005, NYS became United Synergies Ltd., largely representing its growth beyond Noosa, which now provides its core services largely across the Sunshine and Fraser Coast regions of southeast Queensland, but has also expanded its scope to offer specialist suicide bereavement services through a consultancy and partnership basis in 17 regions and through 13 partner organisations across every State and Territory around Australia. Whilst being proud of the organization's capacity to respond to emerging needs in new locations, the service remains grounded and guided by its values and vision for clients.

In 2012-13, United Synergies provided services to over 4,000 people through the Sunshine and Fraser Coast services and those of StandBy Response Service partners, across Australia.

The organisation's underpinning values were formed through the dedication and determination of a local community committed to providing better support to young people who were homeless. Today United Synergies' programs are part of a larger integrated suite of services, within a 'strengths based' paradigm covering all ages in a joined up model that includes child protection, emergency relief, education, employment and training support, early intervention mental health support, carer wellbeing services as well as specialist services such as the StandBy Response Service suicide bereavement response service. Through StandBy Response Service United Synergies has earned a national reputation for quality of service delivery, innovation, networking and partnerships, and program evaluation.

Building on United Synergies' experience as the lead agency for the consortium of partner organisations for *headspace Maroochydore* (12-25 year olds), United Synergies has recently also launched a framework for the *Centre for Healthy Minds* (5-12 year olds and their families) and is currently in the process of establishing *headspace Toowoomba.*

The Mission of United Synergies Ltd.

To be recognised leaders in building local networks, partnerships and the capacity for self-reliance, wellbeing and the achievement of human potential.

- The Values of United Synergies Ltd.
  Wisdom and foresight
- Meaningful partnerships
- Continuously listening and learning
- Exemplary service
- Sharing knowledge and experience
- Resourcefulness
- Responsibility

Sense of self, Sense of place, Sense of purpose, Sense of belonging

REPONSE TO ISSUES OF INTEREST TO THE NATIONAL CHILDRENS' COMMISSIONER

1. Why children and young people engage in intentional self-harm and suicidal behaviour?

Suicide is a major cause of mortality in Australia, with more than 2,500 deaths occurring on average across the country each year (ABS Catalogue 3309.0 Suicide, 2012). Every death through suicide significantly affects multiple people, including immediate and extended family members, close friends, colleagues and communities. While this amounts to at least tens of thousands of people bereaved by suicide each year, the impact of suicide can be far greater than these figures suggest. Research also demonstrates that people bereaved by suicide are regarded as a high risk group for completing suicide and can also be vulnerable to self-harming behaviours and the risks associated with suicide contagion.

Understanding the ways in which young people can become vulnerable to engaging in intentional self-harm and suicidal behaviour requires both a clinical perspective of risk and vulnerability as well as an understanding of those areas that can enable young people to increase their individual protective factors against suicide and self harming behaviours. The following non-identifying case study provided by the Maroochydore headspace service, gives some insight into the issue of children and young people engaging in intentional self harm and suicidal behaviour and the benefits of accessible youth centred care.

Case Study

is the youngest of two siblings to her parents and her brother is 5 years older than her. She grew up knowing she was her 'parents' mistake' and experienced emotional abuse from her mother who used as a scapegoat whenever anything went wrong. believes her father left the family (when she was aged 1 year) 'because she was born'. Her mother raised her in a small Country town; a Christian who believed 'non-Christians' were 'evil'. As a result was not permitted to play with friends outside of school, watch television or attend birthday parties. She was and bullied throughout her academic years as a result of her 'differentness' and described a very isolating and lonely childhood. At age 15 years she met on-line who was 3 years older than her and he enticed her to run away from home and live with him. After three years of physical, emotional and sexual abuse, ended

the relationship with . At age 18 years, was alone, vulnerable and ingested three months of 'stock piled' medication, which put her on life support for 24 hours.

At age 19 years presented to headspace. She reported first intentionally harming herself at age 9. She would pull at her hair until chunks came out, push thumb tacks into her thighs and bite at her nails until they bled. reported that at age 11 years she commenced cutting her arms, legs and torso with razor blades and knives. It was around this time that first "fantasized" about ending her life. Her first suicide attempt was at age 12 where she took 24 panadol and 12 of her mothers' anxiety tablets. From 13 through to 15 years of age continued to engage in 'cutting' with increased severity and intensity, often requiting sutures. She recalls at least 4 overdoses and an attempt to hang herself, her risky and dangerous behaviors escalated to her walking in front of cars. She reported that her deliberate self harm assisted her to "feel"; when she cut, she was able to regulate her emotions and return to a state of equilibrium from a highly dysregulated state in a short period of time. When dysregulated, felt "numb".

After years of childhood abuse, isolation, abandonment and a violent relationship, wanted change. She wanted to be able to think about the future. for the first time since she could recall, ***wanted to live****. did not know how to do this. As a result of early experiences, she had learnt to rely on maladaptive coping strategies as a means to regulate her overwhelming emotions in the absence of a parent, protective figure or emotional co-regulator. had to learn to cope in ways that were foreign to her. She was supported by headspace for 14 months, at times having twice weekly appointments. treatment and intervention was challenging and she had Hospital Emergency presentations for mental health assessment a number of times as she fought hard to learn healthy ways to cope with her stress and regulate her emotions. Her suicide ideation now remains in the background but not entirely in her past. She remains motivated to move forward, can plan ahead and can think about the future. She enrolled in nursing at University brought a cat called Comet. story is similar to that of many young people who access support from headspace who present with deliberate self-harm and suicide ideation.*

What is known?

- *About one third of individuals who engage in deliberate self harm (DSH) will have symptoms of a diagnosable mental health disorder, such as depression,* McGaughney, Long & Harrisson, 1995
- *Depression is a key factor associated with risk of repetition of adolescent self harm,* Hawton, et al, 1999
- *Depression is an important factor in the presentation of a range of psychological characteristics of adolescent self harm*, Kingsburry et al, 1999
- C*hronic major depressive disorder can be central to deliberate self harm repetition,* Aglan, 2008
- A history of physical and or sexual abuse in childhood increases vulnerability. Yeo et al, 1993, Favazza, 1997
- Gender can be of significance especially females in an adolescent age group, Patton et al, 1997 and males in older age groups (particularly in prison settings and people in detention), Alderman, 1997
- Family dysfunction, conduct disorder, adolescent hopelessness heighten vulnerability, Aglan, 2008
- Drug and alcohol use and eating disorders can have influence ,Alderman, 1997

2. *The incidence and factors contributing to contagion and clustering involving children and young people*

Depression and anxiety are significant and common mental health problems affecting adolescents in Australian and across the globe, "self-harm among adolescents is a major health issue affecting at least 1 in 15 young people". (Truth Hurts, Report of the National Inquiry into self-harming young people, UK, 2007).

<u>Prevalence:</u>
An Australian study of adolescents aged 15-17 years (N=1699) by Patten et al (1997) highlighted that over a 12 month period 5.1% of adolescents deliberately harmed themselves – 1.7% through self-mutilation and 1.5% through self poisoning and 1.8% through deliberate recklessness. More locally a Queensland school survey conducted in 2004 found that of

3757 Year 10 and 11 students from 14 schools, 6.2% reported harming themselves in the previous 12 months. Of these 59.2% had deliberately self harmed (DSH) using an implement to cut themselves and 29.6% had overdosed with medication (de Leo and Haller, 2004, MJA, 181:140-144). A meta-analysis of 53 studies published between 2005 and 2011 illustrated a mean lifetime prevalence of 18% (Muehlenkamp et al, 2012).

This can be understood in terms of 1 in 5 young people engaging in DSH at some time in adolescents. Females are twice as likely to engage in DSH as males with 32% reporting at least 2 previous incidents of self-harm. Sadly only 36% of young people ever report their DSH behaviours to others. Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., & Träskman-Bendz, L. (1998). Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *Bmj*, *317*(7156), 441-447

Suicidal Intent:

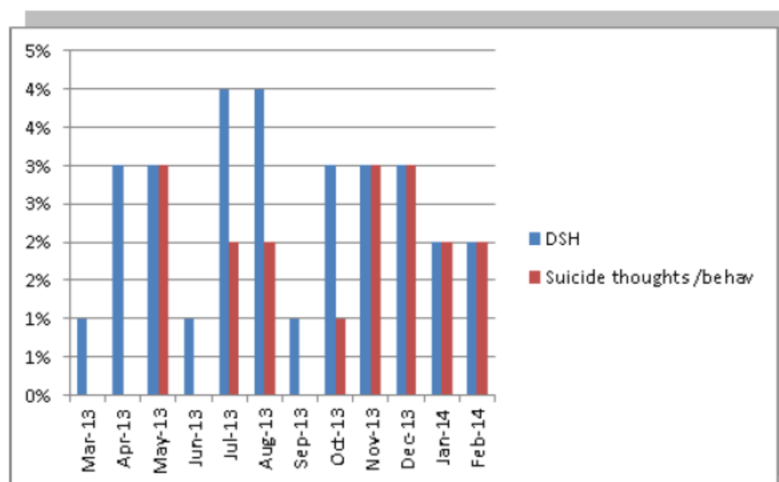
Of the group that harmed themselves, 6% indicated a serious attempt to end their lives, 6% thought that death was probable and Patton et al (1997) found that these figures held across all sub-types of self harming behaviours. The adult literature on self harming as risk factors for suicide indicate that 1% of the people who self harm die by suicide within 1 year. Three to five precent die by suicide within 5 years and a staggering 50% of people who successfully suicide have a history of self harm – of which 20-25% within a year of death. *For adolescents*: DSH was a risk factor for suicide rates estimated at 10% per 100,000 per year (Hawton, 2002).

Suicide clusters have also been viewed as the end result of a contagious disease in which vulnerable individuals connect to superinfect each other (Johansson, Lindqvist and Eriksson 2006). Ensuring support and safe clinical practices are vital to reduce the risk of contagion amongst vulnerable populations. High risk groups such as Aboriginal and Torres Strait Islander and young people from diverse cultural background including refugees require support matched to need as well as concurrent community support and strengthening of existing community infrastructure.

affected communities.

This table features a snapshot of Maroochydore headspace clients who presented to headspace in the last 12 months with DSH and suicide thoughts and behaviours as their primary or secondary presentations. This data demonstrates

- 75% of Young people presenting with a MH issue under the age of 25 years.
- Of these only 50% will access support and/or intervention. Of this 50% who seek support, if they have engaged in DSH or suicide thoughts and behaviours only 1:4 of these will report these to another person.



3. The barriers which prevention children and young people from seeking help include accessibility, practical issues such as transport, emotional barriers such as shame, cultural beliefs, language and literacy challenges. There are many assumptions about a functional level of literacy and numeracy in Australia and literacy issues combined with other factors can be distal factors for suicide risk and vulnerability to self harm. In addition the way in which in which children and young people as well as their immediate communities are supported by professional responders, and others, has a significant and lasting impact on them (Choose Life, The National Strategy and Action Plan to Prevent Suicide in Scotland 2013). This also includes whether children and young people have genuine access to support at vulnerable times in their development and life journey, whether service are culturally relevant and accessible and whether there is capacity for a service to be matched to the individual need as per 'client centred practice' or whether those seeking help are required to meet service criteria based on the need of the organisation not the young person seeking help.

4. Accurate identification and recording of intentional self harm and suicide share many of the impediments that have historically seen under-reporting of suicide internationally and the current challenges for establishing reliable knowledge about the prevalence of suicide and self harm in Australia. Assessment tools are varied and emerging knowledge from high quality research often is not translated to practice. Limitations in what is genuine evidenced based practice as well as hesitancy to recognise the benefits of 'practice based evidence' especially in sociological and cultural settings further impacts the translation of emerging knowledge to good practice.

6. A national child death and injury database is long overdue. The National Standby Response Service has worked closely with the Queensland Commission for Children and Young People and Child Guardian for several years to ensure rapid information sharing, especially where a child suicide death has occurred or where the National StandBy Critical Postvention Response program identifies emerging clusters or suicide contagion risks and provides a response. This collaboration can assist to ensure targeted and informed support as well as reduce unnecessary replication of service provision. In addition these types of collaborations and linkages ensure frontline staff and all involved are sensitive to emerging trends, challenges and potential knowledge gains which can further contribute to practice and program development. The reporting functions of such a database would greatly assist in building reliable evidence as well as targeting services to need. As well as, in the universal setting, allow for population health trends and analysis to best utilise existing knowledge, workforces and the scant resources that exist in a large geographical country with a relatively small population such as Australia

7. The types of programs and practices that effectively target and support children and young people who are engaging in the range of intentional self-harm and suicidal behaviours.

To improve management of DSH it is important to know what 'works' and what is the evidence, if at all available. The literature agrees that there is currently insufficient evidence on which to make firm recommendations about the most effective forms of treatment for young people who engage in DSH however, "there are a number of promising treatments for non-suicidal self harming youth. In general, "psychotherapies that emphasise emotional regulation, functional assessment, and problem solving appear to be most effective in treating self injury" (Klonsky et al, 2011).

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This is a further area for research and exploration and would be built into a programme aimed at reducing self harming behaviours in children and adolescents.

Manually assisted cognitive behavioural therapies (MACT) was developed in the UK by (DBT theorist) Lindeham & et al and covers problem solving, cognitive techniques to manage emotions and negative thinking and relapse prevention strategies. This program, whilst early is showing promising results for the adolescent and young adult population.

The National StandBy program is also an example of a proven and economically efficient (Comans et al 2013) program that reaches young people and children by providing a broad based integrated response to communities affected by suicide loss and serious suicide attempts. Extending the reach of StandBy across all Australian communities, as has already been submitted to the National Mental Health Commission, in a similar way to the recent further expansion of the headspace program would have a genuine impact on the incidence of suicide, the effects of suicidal behaviours on individuals and communities and the infrastructure of communities overall as well as the potential to reduce the incidence of intentional self ham and suicidal behaviours occurring within Australia's child and youth population. Utilisation of existing community infrastructure and building capacity within communities to respond immediately to suicide/self harm and its aftermath is already occurring with demonstrated outcomes. Reducing further risk of clusters and contagions as well as bringing improvement in the integrated service pathways already established in many areas is cost effective, efficient and a way to ensure the safety and support for children and young people as they become our future leaders and custodians of communities across Australia.

8. The feasibility and effectiveness of public education campaigns require both pre-developed capacity for response to any increased demand and caution regarding messaging, especially where the potential risk for normalisation of concerning behaviours exists. The recent development within the national suicide prevention field of collaborative action groups including a National Media & Communications Mangers group under the leadership of Suicide Prevention Australia, the peak body in this area, has seen great advances in a united and informed approach to public education campaigns.

A focus on programs that build resilience as espoused by Professor Graham Martin, Advisor to the National Suicide Prevention Strategy as well as a concerted effort for strategic use of all media and communication platforms and emerging technologies have shown promise. The benefit of the internationally acclaimed Mindframe Media initiative have placed Australia in a leading role across several areas related to health messaging and public campaigns whilst also reducing the proven risks associated with public discussions as guided by the knowledge that now exists in Australia and internationally about successful and safe communication approaches and national campaigns.

Conclusion

As one of Australia's leading family and youth providers United Synergies and its 'whole of population' national suicide postvention program, the National StandBy Response Service is well placed to address the needs and risks associated with suicide bereavement through its model of proactive support of those left behind (Arensman et al 2012). StandBy is a community based program that provides 24 hour coordinated response to assist families, friends and associates who have been bereaved by through suicide. The StandBy service has been established in several regions around Australia and has significant experience in the provision of postvention support in a range of different communities and contexts. The goals of postvention include supporting the bereaved, preventing imitative suicides by identifying other individuals who are at risk for self-destructive behaviour and connecting them to intervention services, reducing bereaved identification with the deceased, and providing long-term surveillance and support (Gould & Kramer, 2001). By providing an active, integrated and comprehensive response (Campbell et al 2004), working in partnership with existing emergency and community support organisations as well as individuals and networks, the StandBy model addresses these goals in its efforts to reduce potential adverse health outcomes associated with suicide, and to assist in addressing further suicidal behaviour.

The focus of the StandBy Response Service is the establishment and operation of a long term program of support for people bereaved by suicide. However, in response to emergent community needs StandBy developed the short term Critical Postvention Response otherwise referred to as the StandBy CPR program. The CPR is a community based approach which seeks to acknowledge and address the short term needs of a community after a high number of suicides, to embed some additional capacity to respond to suicide and

to assess ongoing need. This short term model is intended for use in communities where concerns exist about high incidence of suicide and its effects on the community. Built on a consultative community driven process, the StandBy CPR program has been delivered in several communities in response following local concerns about increased suicidal behaviours. Supported by the Australian Government and in partnership with a local community organization, this short term program provides direct support to people bereaved by suicide, community training and the development of a coordinated community response plan for the provision of ongoing postvention support. The literature underpinning this program suggests that postvention support requires coordination and continues over a time period involving crisis responses, therapeutic recovery and positive adjustment strategies (Saarinen, Hintikka, et al 2000; Deranieri et al., 2002). There is also a need to address the healing process and understand the bereavement experience and its context to ensure better and more coordinated culturally appropriate services (Degrov 2011). This program applies these principles and works intensively with the community using a variety of activities, training workshops and community engagement approaches to establish an effective response to suicide and build capacity to reduce further incidence of suicide and self harming behaviours in a comprehensive and life affirming way.

ABOUT THE NATIONAL STANDBY RESPONSE SERVICE

In the past decade, successive Australian governments have supported some prevention and 'active' postvention services targeting known 'at risk' individuals in the community. Postvention describes activities and services that aim to assist people who have experienced the loss of a loved one through suicide. These programs aim to reduce the incidence of adverse health outcomes amongst the bereaved, including reducing the risk of further suicides especially amongst youth populations where the risk of contagion is. Postvention also refers to activities that aim to build the capacity of communities to respond appropriately to suicide incidents and better deliver support those who are grieving. One of the postvention programs showing most demonstrated effect is the National StandBy Response Service, internationally recognized as the largest evidence-based program of its kind globally and currently responding to more than half of Australia's land mass. The StandBy Response Service and the StandBy Critical Postvention Response program have considerable experience and knowledge in the area of responding after suicide and especially responding to suicide clusters and contagion, particularly those related to 'copy cat' or subsequent suicidal behaviours amongst children and young people exposed to suicide loss.

The StandBy Response Service is a community-based, active postvention program that provides a 24-hour coordinated crisis response to assist families, friends and associates who have been bereaved by suicide. The service is founded and operates on the principle of community respect, understanding and support for the health and wellbeing of people bereaved by suicide providing people bereaved by suicide with access to timely support and clear pathways to care.

StandBy sites external to the Sunshine Coast & Wide Bay Burnett regions are auspiced by a number of other organisations across Australia, delivering the StandBy Response Service model to their communities. United Synergies developed and has been operating the StandBy Response Service on the Sunshine Coast in Queensland since 2002.

In 2006, with the assistance of the Australian Government Department of Health and Ageing, a trial project was commenced to replicate the program in three additional communities – Cairns, Canberra and North Brisbane n 2009, further expansion of the program occurred, with the establishment of services in Western Australia and Tasmania. Most recently in 2012

the service was expanded to the Northern Territory, regional South Australia, Mt Isa, Wide Bay Burnett (partially), North Coast NSW and North Western Victoria.

The service currently operates in seventeen (17) regions across Australia including:

- Brisbane, QLD
- Sunshine & Cooloola Coasts,QLD
- Wide Bay Burnett, QLD
- North West Central, QLD
- Far North, QLD
- North Coast, NSW
- Canberra, ACT
- Loddon Mallee, VIC
- Southern Tasmania
- North/North West Tasmania
- Top End, NT
- Central Australia, NT
- Country North, SA
- Country South, SA
- Pilbara region, WA
- East and West Kimberley, WA

Regular contact and ongoing
discussions have been held with multiple communities and community groups across Australia regarding the possible introduction of the service into their local area.

In 2011 the StandBy Response Service conducted a ground-breaking economic evaluation of its delivery of suicide bereavement support which demonstrated the cost effectiveness of this approach with cost savings of $800 per person annually, but more importantly provided evidence that StandBy Response Service significantly lowers the risk of suicidality and improves quality of life for those accessing StandBy's integrated model of support (Comans et al 2013). These improvements include potential reductions in the risk for complications of grief and prolonged grief disorder and some minimization of the impact of suicide loss on existing mental health disorders. The study also found that the program increases community capacity to respond to suicide loss. StandBy also works closely with the University of New England, the University of Kentucky, the University of Manchester and other national and international research institutions towards further increasing knowledge and building the evidence base in the area of suicide postvention.

Despite previous constraints related to social taboos and stigma, the issue of suicide bereavement and postvention support are rapidly emerging as a significant health concern. Whilst there are still issues of social ambiguity related to suicide loss, i.e. where society does not know how to respond and thus withdraws (Jordon 2011) the increase in awareness of the serious effects of suicide loss has been matched by increasing evidence of positive health outcomes for those in receipt of good quality postvention support. Investment in this area has produced demonstrated improvements in health, economic and social wellbeing amongst a significant population group and a proven successful health intervention.

DEFINITIONS

Suicide is a conscious act to end one's life. By conscious act, it is meant that the act undertaken was done in order to end the person's life

Suicidal Behaviour includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts

Suicide Ideation: Thinking about suicide (*MindFrame* 2012)

Cluster: A group of suicides or acts of deliberate self harm (or both) that occur closer together in time and space than would normally be expected on the basis or statistical predication and/ or community expectations. (Pirkis 2011).Suicide clusters have been viewed as the end result of a contagious disease in which vulnerable individuals connect to superinfect each other (Johansson, Lindqvist and Eriksson 2006)

Contagion: The process where one person's suicide influences another person to engage in suicide behaviour (Pirkis 2011)

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