PARTNERS IN PREVENTION:

UNDERSTANDING AND ENHANCING FIRST RESPONSES TO SUICIDE CRISIS SITUATIONS

SUMMARY REPORT

Queensland Government

ACKNOWLEDGEMENTS

We would like to acknowledge the Traditional Custodians of the land on which our services are located. We pay our respects to the Elders both past and present and acknowledge Aboriginal and Torres Strait Islander peoples across the State. We continue to recognise that to Close the Gap we need to work together with Aboriginal and Torres Strait Islander people, communities, staff and stakeholders to ensure that we are meeting the needs of the community.

We acknowledge those who experience suicidality and those lost to suicide, and their families, friends, loved ones, and others who are affected by suicide.

Disclaimers

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Queensland Police Service

The authors wish to acknowledge the support and assistance from the Queensland Police Service in undertaking this research. The views expressed in this publication are not necessarily those of the Queensland Police Service and any errors of omission or commission are the responsibility of the authors.

Roses in the Ocean

The views expressed by people with a lived experience of suicide engaged in consultation throughout this project and publication are their own specific perspectives and do not endeavour to represent all lived experience perspectives. We acknowledge that all lived experience insights are valuable and important.

Queensland Alliance for Mental Health (QAMH)

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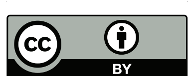

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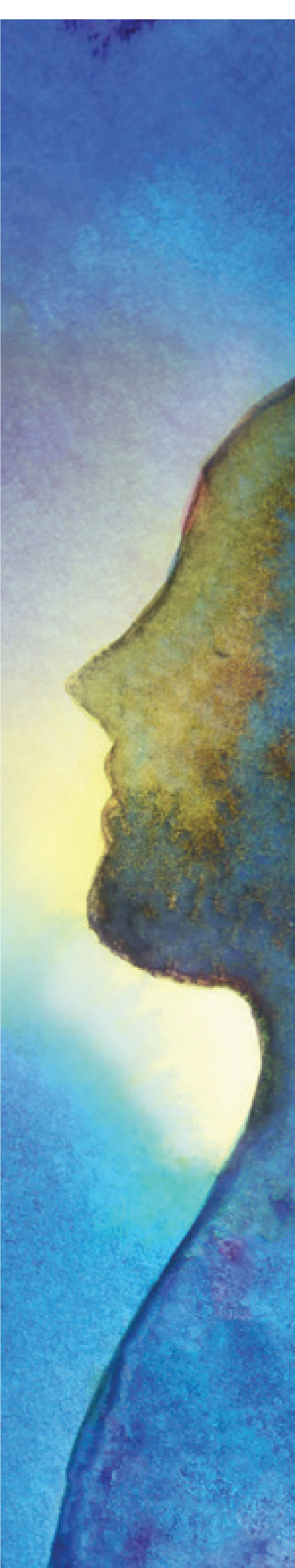

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KEY MESSAGES

Between 2014 and 2017 there were, on average, **209** suicide related calls to Queensland Police Service or the Queensland Ambulance Service every day.

Almost all **(96%)** individuals who had a suicide related contact with police or paramedics had contact with an emergency department over the period 2013-2018.

84% had contact with a public mental health service.

46% of individuals had at least one contact with an emergency department or public mental health service where suicidal or self-harming thoughts or behaviours were identified.

19% of individuals had a confirmed mental health diagnosis.

36% of individuals who died due to intentional self-harm and came into contact with police or paramedics had been alive in the month following an index contact with police or paramedics.

We found that several formal and informal collaborative suicide crisis responses, between Queensland Police, Ambulance and health services, are operating. However, there is a need to improve the specification of models of service and ensure that evaluations measure benefits to service users.

Individuals with lived experience of suicide identified a need to develop alternative pathways for individuals in crisis. Several promising models of care are being implemented within Queensland.

Enhancing respectful and empathetic information sharing and communication between individuals in crisis, first responders, other health stakeholders and families, is critical to improving the first response.

Surveys and interviews with Queensland Police Service staff identified overall high levels of knowledge, skills and confidence in responding to suicide crisis situations.

There are opportunities to support police in making best use of Emergency Examination Authorities and in facilitating the use of emerging alternative care pathways.

The mental health needs of first responders are important, and continued efforts to destigmatise mental illness among this group are required.

SUMMARY

Why we did this

Individuals who experience a suicide crisis or self-harm often come into contact with police or paramedics. Those who have experienced a suicide crisis report deficiencies with the existing system, and police and paramedics report that responding to these events is one of the most challenging aspects of their role. However, little is known about the nature, extent, precipitating factors, pathways and outcomes of a suicide related call-out, and what responses will most effectively and compassionately meet the needs of those in crisis. Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations, funded by the Queensland Health Suicide Prevention Health Taskforce, was established in 2017 to address these knowledge gaps and inform systems enhancements.

What we did

In partnership with Roses in the Ocean, Queensland Ambulance Service, Queensland Health, Queensland Police Service, Brisbane North PHN, Queensland Centre for Mental Health Research, Queensland Alliance for Mental Health, and the Queensland Mental Health Commission, the Partners in Prevention team undertook the following five initiatives:

- Establishment of the Partners in Prevention linked dataset;
- Service mapping of collaborative services involving police, ambulance and mental health services;
- Consultation with individuals with lived experience of suicide;
- Literature reviews; and
- A study of knowledge, skills, attitudes and confidence of police in responding to suicide crisis situations.

This summary report presents the key findings from each component of work. Further details are provided in a series of individual reports that accompany this report.

What we found

Data linkage study

We estimated that there were 228,550 suicide related calls to Queensland Police Service or Queensland Ambulance Service over the three-year period 1 February, 2014 – 31 January, 2017, or, an average of 209 calls per day. We identified and linked data for 69,451 individuals to over seven million health services records. There was an increase in suicide related calls to Queensland Police Service and Queensland Ambulance Service of approximately 25% over the three-year period. Almost all individuals (96%) who had a suicide related contact with police or paramedics had at least one emergency department record for the period 1 February, 2013 – 31 January, 2018, a time frame that included the twelve months prior to, and after, the index police or paramedic contact recorded for an individual. The majority (84%) had at least one public mental health record (Consumer Integrated Mental Health Application record) for this period. Nineteen percent had a confirmed mental health diagnosis.

Of those who were identified in our cohort, 5% died in the four-year period from 1 February, 2014 – 31 January, 2018, and 2% (40% of those who died) had the primary cause of death identified as intentional self-harm. These deaths due to intentional self-harm accounted for at least 56% of deaths due to intentional self-harm in Queensland over the same time period. Among those who died due to intentional self-harm, 36% were alive in the month after their index contact with police or paramedics.

Service mapping

We identified several different types of mental health and first responder collaborations in Queensland. These include state-wide approaches such as the Mental Health Intervention Program, Mental Health Liaison Services – co-located within Queensland Ambulance Service and Queensland Police Service call centres – and local Hospital and Health Service approaches, such as co-responder models.

Perspectives from lived experience

Individuals with lived experience of suicide identified a need to develop alternative pathways for individuals in crisis. Enhancing respectful and empathetic information sharing and communication, between individuals in crisis, first responders, other health stakeholders and families, is also critical. Reflections, supplied by first responders following small group consultations, highlighted the powerful benefit of facilitating conversations between first responders and individuals with lived experience of suicide.

Optimal care pathways

Several models of care that may meet the needs of individuals who experience suicide crisis were identified through a literature review. The review examined care models, including collaborative responses, safe haven cafés, and aftercare services. Gaps that were identified in the literature include limited tailoring to vulnerable subgroups and those under the age of 18.

Knowledge, skills, attitudes and confidence of police

Surveys and interviews with police staff on their knowledge, skills, attitudes and confidence in responding to suicide crises, identified overall high levels of knowledge, skills and confidence. However, it was identified that police lack knowledge and confidence with regards to the use of legislative powers and in facilitating the use of alternative care pathways to emergency departments.

What it means

On average, Queensland Police Service and Queensland Ambulance Service will respond to over 200 suicide related calls every day, a number that appears to climb each year. They will respond to people who are overwhelmed by psychosocial crisis, who have acute mental illness, or who have lost hope. They will respond to people who are attempting to take their own life and people who are deceased. They will be responding to families and loved ones who may be facing one of the most challenging days of their lives: confronting the fact that their loved one has just died by suicide. They will respond to a diverse group of people across gender, age, health and cultural background. To respond effectively, they will need a diverse skill set and effective collaborative relationships with other agencies.

Police staff who were surveyed, including sworn officers, police recruits and civilian call-takers, see it as their duty to respond to people in suicide crisis, but the majority do not find this a rewarding part of their role. In some cases, the experiences may be traumatic. Police and paramedics need to be supported in responding to suicide crisis situations, and they need appropriate services to which they can refer individuals in crisis whom they encounter. Responders also need services and supports in place to meet their own mental health needs.

Individuals in crisis and first responders both need a services context that supports them. Existing and emerging collaborations, identified through service mapping and literature reviews, were encouraging in this regard. However, responses must be expanded to include peer-led services, family support services, and non-government services, including caring non-health or non-clinical responses. State-wide coordination coupled with strong local collaborations, supported by rigorous evaluation, is needed to realise their full potential. Clarity and transparency in specifying these models of service is needed, as is continued collection and use of high quality data to support evaluations.

Partners in Prevention has demonstrated what can be achieved by combining the voices of lived experience, excellent interagency collaboration, and insights from data linkage. It has articulated the extent of suicide crises that first responders will encounter. It has provided, for the first time, unique data from multiple perspectives that can be translated into practical service efficiencies, enhancements, and developments. A comprehensive service mapping and evaluation framework for crisis care – one that incorporates government, non-government, health and non-health based services – is needed. All facets of work should be informed by the voices of lived experience.

INTRODUCTION

Recent figures highlight the tragedy of suicide in Australia, with suicide deaths in 2017 sitting at a ten-year maximum of 12.6 deaths per 100,000 persons (Australian Bureau of Statistics, 2018). Suicide is often preceded by a suicide crisis or crises. Approximately three out of every 100 Australian adults will attempt suicide during their lifetime and more than four out of every 1000 Australian adults will make an attempt in any one year (Johnston et al., 2009).

Individuals who experience a suicide crisis or self-harm may come into contact with police or paramedics. Those who have experienced a suicide crisis report deficiencies with the existing system, and police and paramedics report that responding to these events is one of the most challenging aspects of their role. Little is known about the nature and full extent of suicide-related call-outs, and what responses will most effectively and compassionately meet the needs of those in crisis. Partners in Prevention: Understanding and Enhancing First Responses to Suicide Crisis Situations, funded by the Queensland Health Suicide Prevention Health Taskforce, was established in 2017 to address knowledge gaps and inform systems enhancements in this area.

Revitalising and enhancing service delivery to improve collaborative responses

For almost fifteen years, Queensland Police Service, Queensland Health, and Queensland Ambulance Service have been working together, through the Mental Health Intervention Program (MHIP), to safely resolve mental health crisis situations for both individuals in crisis and responders, and to facilitate health care for individuals in crisis (Queensland Health, 2010; Queensland Police Service, 2017). However, there is a need to revitalise and improve these collaborations, and improve and extend linkages across the government and non-government sector to ensure consistent and optimal responses to those who experience crisis throughout the state.

Policy and services context

The idea for Partners in Prevention grew out of a set of needs for knowledge that were identified by *Mental Health Liaison Service – Police Communications Centre (MHLS-PCC)* clinicians and corroborated by the initial evaluation of that service. Both clinical experience and evaluation highlighted the substantial needs of individuals experiencing suicide crisis. The Partners in Prevention project has subsequently unfolded during a time of fairly rapid policy and services change (Figure 2).

The MHLS-PCC was established in early 2015 and is an embedded mental health consultation-liaison service located within the Brisbane Police Communications Centre (BPCC), Queensland's largest police call centre. The service operates through the co-location of mental health clinicians from the Queensland Forensic Mental Health Service within the BPCC after hours seven days per week, and on public holidays, with on-call psychiatrists available outside of these hours. BPCC call-takers and their supervisory team assess caller needs, prioritise call urgency, and organise dispatch of Queensland Police Service resources. Mental health clinicians can be consulted by referral via the QPS State Duty Officer, enabled under a *Memorandum of Understanding: Mental Health Collaboration* between Queensland Health and Queensland Police Service.

An evaluation of the first year of service corroborated clinicians' observations regarding the high volume of suicide related calls for service. Specifically, it identified that out of 1,621 referrals made to MHLS-PCC from January to December 2015, 59% were in relation to a person attempting or threatening suicide (Queensland Forensic Mental Health Service, 2016).

Partners in Prevention has been further shaped by ongoing state as well as national policy and service developments. The *Queensland Suicide Prevention Action Plan 2015-17*, in effect during the inception of this project, acknowledged the need for the Partners in Prevention initiative. Its fundamental underlying principle was that contact with any government services by those at risk of suicide, including those who have attempted suicide or are experiencing suicidal ideation, is an opportunity to intervene and provide support (Queensland Mental Health Commission, 2015). These sentiments are echoed in *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, which advocates for a whole-of-government response to suicide prevention, including monitoring and surveillance, enhancing acute and crisis interventions, particularly those that do not rely on emergency departments, and reducing unnecessary justice system contacts for people who experience mental health problems (Queensland Mental Health Commission, 2018).

Consistent with the vision of the Shifting Minds strategy, several service reform initiatives have recently been established or announced. These include: a suite of Queensland Ambulance Service initiatives, including: a mental health liaison service, similar to the Mental Health Liaison service that is operating within the Brisbane Police Communications Centre, and co-responder models involving a paramedic and mental health clinician; and a $62 Million Queensland Government commitment to expand aftercare services, safe haven cafés, community-based support and crisis services, and undergo further strategic service reforms.

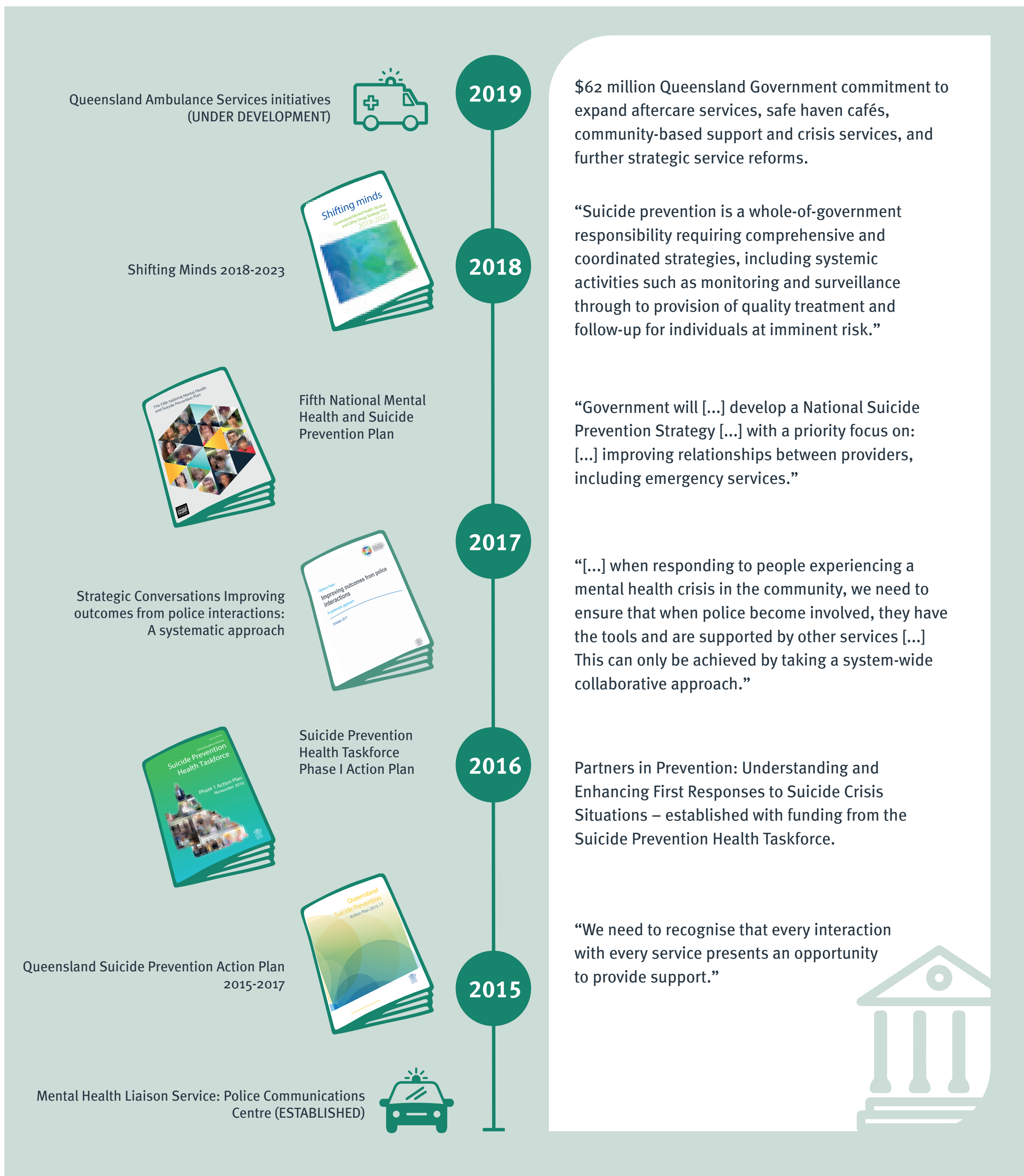

Figure 2 The policy and services context for Partners in Prevention

Providing optimal care to those in need

First responders play a crucial role in helping people through suicide crises and facilitating appropriate intervention and follow up. The World Health Organization acknowledges that: “first responders are in a unique position to determine the course and outcome of suicidal crises” (World Health Organization, 2009). Tailored, effective interventions that can be delivered during or immediately following the first response are vital in order to support a person out of a crisis and prevent future suicide attempts.

The predominant pathway that is used by first responders for persons who are in, or at high risk of, a suicide crisis is transportation to a hospital emergency department (McPhedran & De Leo, 2013). The World Health Organization recommends this approach when a person is considered a high or imminent risk to themselves or others (World Health Organization, 2009). However, when safety can be met in other ways, it is recommended first responders ensure fast access to mental health treatment (World Health Organization, 2009). There is limited, if any, peer-reviewed evidence that transportation to hospital is always an optimal response.

Recent reports published by the Australian Government Productivity Commission (2019) and Australasian College for Emergency Medicine (2018) have highlighted significant barriers to care that await those presenting to Australian emergency departments with mental health problems, including suicide crises. People with mental health problems are less likely to be seen in the emergency department within clinically recommended waiting time, than those presenting with other types of problems (Productivity Commission, 2019); they are also disproportionately more likely to experience access block (defined as waiting eight hours or more for admission following assessment and treatment) (Australasian College for Emergency Medicine, 2018).

Yet, there is no guidance for first responders on minimal or non-interventionist approaches that would empower and allow individuals in crisis to remain safely *in situ*. While the harms of over medicalising, institutionalising or depriving the liberty (through exercise of legislative powers) of those who experience mental illness or suicide crisis are well known, the use of legislative powers to involuntarily transport individuals in crisis to an emergency department is often viewed as the only available solution. At present, there are no national guidelines on clinical care pathways to facilitate the diversion of people in a suicide crisis from presenting at the emergency department (Wilhelm et al., 2007), and non-clinical or psychosocial crisis support services, while expanding, are few and far between.

Improving the knowledge, skills, attitudes and confidence of first responders

Given the extent of interactions between police, and paramedics, and individuals who are at risk of suicide, it is critical that responders are able to accurately, compassionately and confidently identify suicide risk, initiate field-based interventions, and facilitate onwards referrals to appropriate services (Marzano, Smith, Long, Kisby, & Hawton, 2016). Secondary benefits to improving the knowledge, skills, attitudes and confidence of first responders include benefits to responders themselves, in terms of awareness, destigmatisation of mental illness and suicide, and supporting help-seeking behaviours within their organisations (Marzano et al., 2016).

Putting lived experience at the heart of what we do

Improving the lives and welfare of individuals who experience or are affected by suicide crises is what drives the Partners in Prevention team, and the work that we have set out to do. In order to realise real benefits for the community, it is vital that individuals with lived experience are consulted in relation to all facets of research, system re-design, and ongoing monitoring, evaluation and quality improvement activities. The voices of individuals who have experienced suicide crises that have brought them into contact with police or ambulance services, and the voices of their families and loved ones, need to be listened to, reflected on, and acted upon by all who have a role to play in suicide prevention: from field to boardroom.

Data-informed redesign

It is well established that interactions between first responders and individuals in mental health and suicide crisis account for a substantial proportion of police and paramedic time. Yet, little is known about the precise extent of demand that suicide related call-outs place on first responders and whether existing responses effectively meet the needs of persons experiencing suicide crises. There is a pressing need to collect, link, and analyse data to better understand service demand, the characteristics of individuals who are the subject of a suicide related call to police or paramedics, their care pathways before and after a suicide crisis, the types of responses that could best serve their needs, and the capacity of the services to deliver responses in order to improve continuity of care following a suicide crisis. Harnessing the power of linked data can answer these questions, but it also presents opportunities to consider the prospect of tools that can provide real-time support to improve responses to individuals or communities.

Conceptual framework

Partners in Prevention is a translation focussed research project, supported by consultation; every component of research has been designed with an implementation feed-forward in mind. The team aimed to undertake a comprehensive and holistic examination of police and paramedic responses to suicide crisis situations, one that focussed on understanding and improving consumer journeys and pathways, before, during and after a suicide crisis that brings them into contact with first responders, and also that examined the individual, institutional and economic resources that police and ambulance services bring to these encounters. To achieve its aim, Partners in Prevention undertook five initiatives, listed in Table 1.

Table 1 Overview of Partners in Prevention initiatives

	Initiative
	DATA LINKAGE A linked data study about individuals who came into contact with Queensland Police Service or Queensland Ambulance Service between 2014 and 2017, and their health services use and outcomes between 2013 and 2018.
	SERVICE MAPPING An integrated service mapping of collaborative services involving police, ambulance and mental health services up to January, 2018.
	PERSPECTIVES FROM LIVED EXPERIENCE A workshop to gather lived experience perspectives on optimal first responses to suicide crisis situations, and situations involving a recent bereavement due to suicide.
	LITERATURE REVIEWS Reviews of literature on: optimal care pathways following a suicide-related call to emergency services; evaluation frameworks for collaborative suicide crisis interventions; and data linkage studies in suicidology.
	KNOWLEDGE, SKILLS, ATTITUDES AND CONFIDENCE OF POLICE A mixed methods study of knowledge, skills, attitudes and confidence of police in responding to suicide crisis situations.

Analysis and recommendations were informed by three rounds of consultation: the first was a workshop to gather perspectives from lived experience; the second was a small consultation with lived experience consultants, and a small number of Queensland Police Service, Queensland Ambulance Service and Queensland Health representatives; and the third was a larger workshop, involving approximately 75 stakeholders from Queensland Ambulance Service, Queensland Health, Queensland Police Service, Roses in the Ocean, Queensland Mental Health Commission, PHNs, and Queensland Alliance for Mental Health, as well as lived experience consultants. A summary of workshop findings is given in Appendix A.

Our partners

Partners in Prevention is a collaborative suicide prevention initiative based within the Queensland Forensic Mental Health Service, involving stakeholders from multiple government and non-government sectors (Figure 3).

Figure 3 Partners in Prevention collaborators

DATA LINKAGE

The centrepiece of this research program has been the establishment of the Partners in Prevention linked dataset (Figure 4), which is built around a cohort of individuals who were the subject of a suicide related call[1] to Queensland Ambulance Service and/or Queensland Police Service between 2014 and 2017.

Data for this cohort were linked to a range of state-wide health datasets over the five-year period 2013-2018. Linkage to Commonwealth health datasets is underway.

The linked dataset provides an unparalleled repository of information on suicide related calls to police and ambulance services, and allows for an examination of service demand, demographics, health characteristics, health services utilisation, health pathways and outcomes. This unique resource provides new opportunities to inform the planning, resourcing, and evaluation of service systems enhancements.

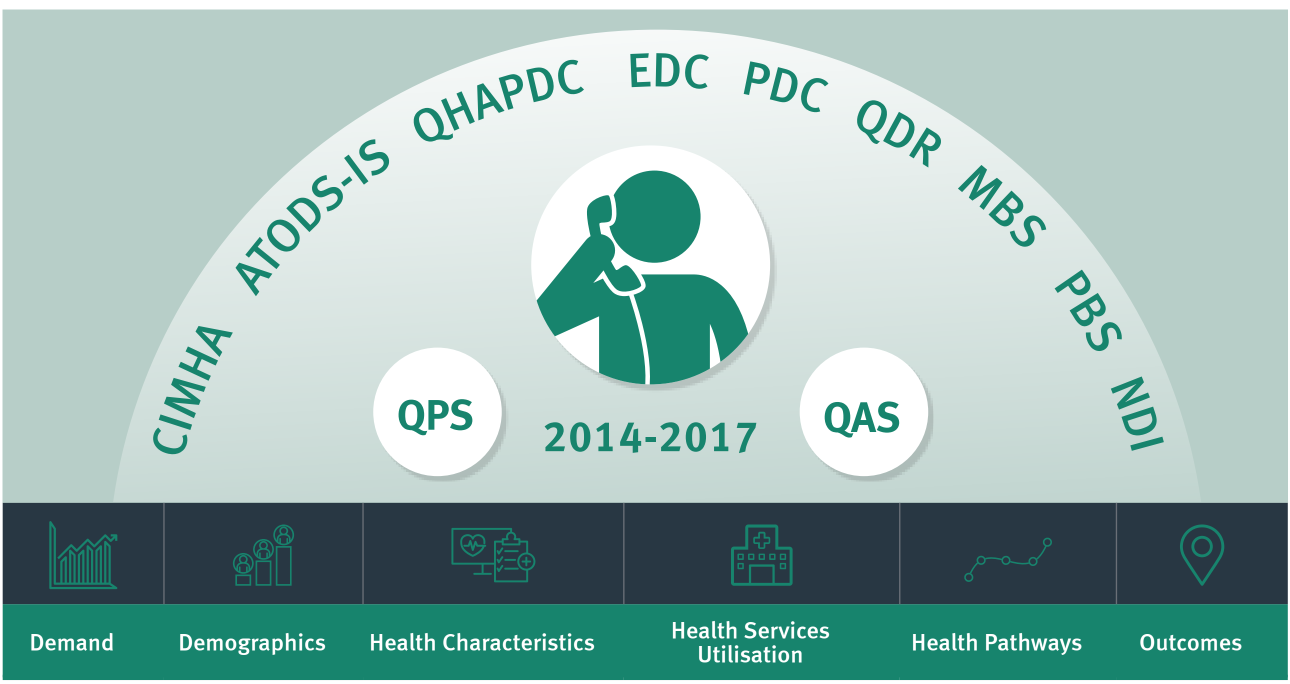

Figure 4 Schematic of the Partners in Prevention data linkage study. CIMHA: Consumer Integrated Mental Health Application; ATODS-IS: Alcohol, Tobacco and Other Drugs Service – Information System; QHAPDC: Queensland Hospital Admitted Patient Data Collection; EDC: Emergency Data Collection; PDC: Perinatal Data Collection; QDR: Queensland Death Register; MBS: Medicare Benefits Schedule; PBS: Pharmaceutical Benefits Scheme; NDI: National Death Index.

The Partners in Prevention linked dataset contains approximately

[1] A suicide related call to emergency services is defined as a documented instance or account in Queensland Police Service or Queensland Ambulance Service records of suicidal ideation, threatened suicide, threatened intentional self-harm, intentional self-harm, suicide attempts, suicidal behaviours, or suicide deaths. A suicide related call encompasses calls where there is a discussion or concern about suicide, or history of suicide (police records), through to calls relating to suicide attempts that are or have been made during the time of the call.

Key findings

Demand

The study team examined suicide related calls to Queensland Ambulance Service and Queensland Police Service over the three-year period 1 February, 2014 – 31 January, 2017. The team estimated that there were 228,550 suicide related calls over the study period, or an average of 209 calls per day. This was made up of 111 calls per day to Queensland Ambulance Service and 98 calls per day to Queensland Police Service (Figure 5). From this set of calls, we were able to link data for 69,451 individuals.

111 calls per day to QAS + 98 calls per day to QPS = 209 calls per day

Figure 5 Average number of calls per day, over three-year period, 1 February, 2014 – 31 January, 2017

Suicide related calls to both Queensland Ambulance Service and Queensland Police Service rose by between 23% and 28% over this three-year period, exceeding the rate of growth in Queensland's population (Figure 6).

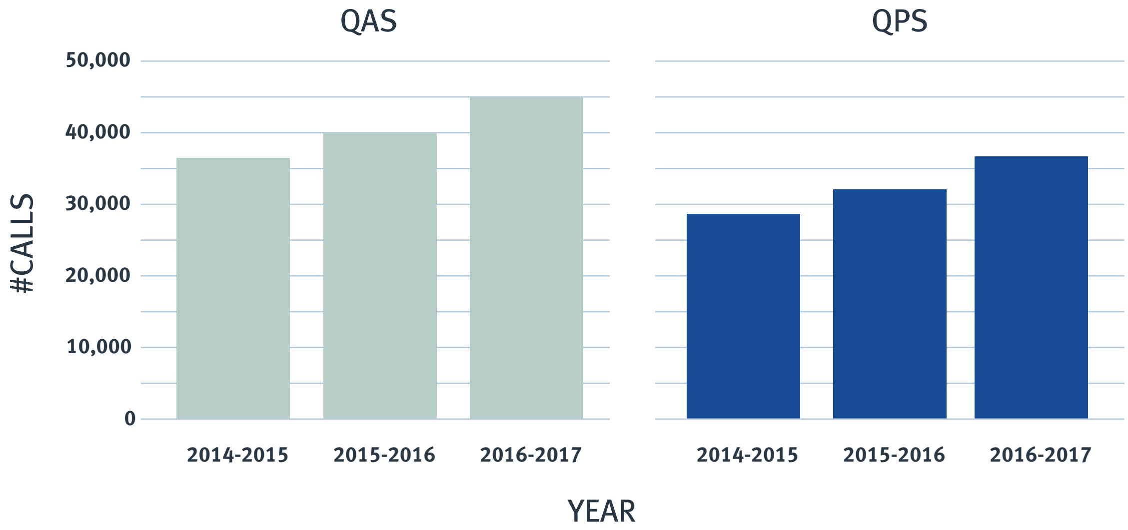

Figure 6 Change in calls per year to QAS and QPS over a three-year period

Demographic characteristics

Figure 7 shows the demographic characteristics of the Partners in Prevention cohort.

Figure 7 Demographic characteristics of the Partners in Prevention cohort

Deaths

Of those who were identified in the cohort, 5% had died in the four-year period from 1 February, 2014 – 31 January, 2018, 2% had the primary cause of death identified as intentional self-harm. Taking only a period of twelve months following the index police or paramedic contact into consideration, 3.5% of the cohort died, and 1.5% of the cohort died due to intentional self-harm. These deaths due to intentional self-harm accounted for at least 56% of deaths due to intentional self-harm in Queensland over the same four-year period. Importantly, among those who died due to intentional self-harm, 36% were identified as being alive in the month after their first contact with police or paramedics.

Health services contacts and activity

The Partners in Prevention cohort includes individuals for whom a link could be found to at least one health services dataset over the five-year period 2013-2018 (Figure 8). Almost all (96%) individuals were identified as having at least one emergency department health record and 84% were identified as having at least one public mental health services record.

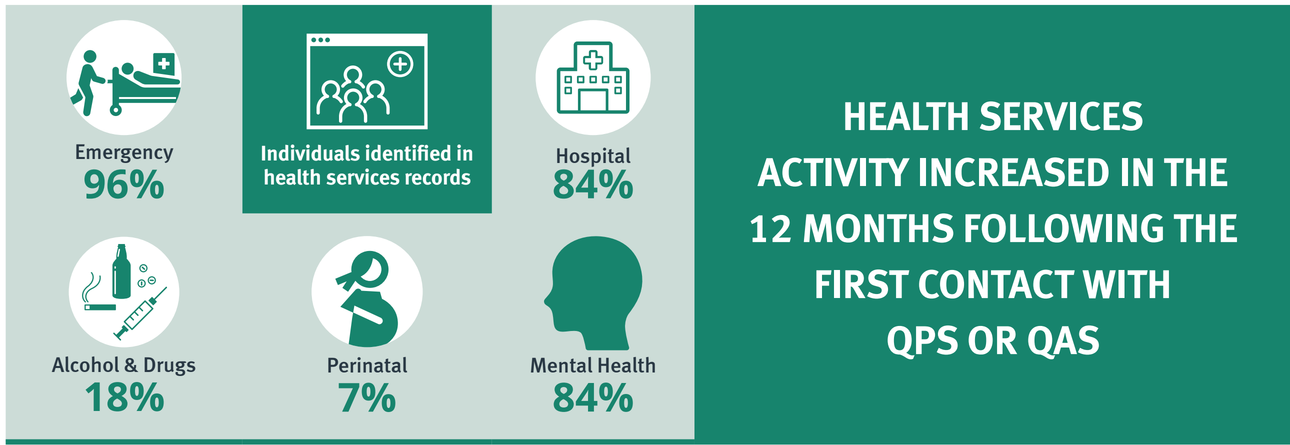

Figure 8 Health services activity among the Partners in Prevention cohort

Health services activity increased in the 12 months following the index contact with police or paramedics, compared with health services activity 12 months prior to the index contact with police or paramedics. This increase was consistent across all health datasets examined.

Health characteristics

Out of the 84% of individuals in the Partners in Prevention cohort who were identified as having a public mental health services record (Consumer Integrated Mental Health Application record), 23% were identified as having a confirmed mental health diagnosis. This equates to 19% of individuals in the total cohort. While this is likely an undercount of the prevalence of mental disorder among this group, it nevertheless highlights the fact that suicide crises are not manifestations of mental disorder in many, if not the majority, of cases.

Conclusions

Through the Partners in Prevention data linkage project, we have identified the substantial and increasing number of suicide related calls that Queensland Police Service or Queensland Ambulance Service respond to. We identified that individuals who are the subject of a suicide related call constitute a heterogeneous group, and will require heterogeneous strategies for care. The findings highlight the need to develop responses tailored for individuals across the age spectrum and for those from different cultural backgrounds.

The proportion of individuals that were identified as having a recorded confirmed mental health diagnosis is likely an undercount of the true prevalence of mental disorder among these individuals. Nevertheless, the finding highlights the important fact that suicide crises are not necessarily a manifestation of mental disorder.

Police and paramedics encounter a substantial proportion of the Queenslanders who will subsequently die by suicide. Additionally, the number of those who die within twelve months of their first suicide-related contact with Queensland Police Service or Queensland Ambulance Service is more than the number of those who are identified as dying by suicide. Our data show that, in at least some of these cases, enough time elapsed between an individual's first suicide-related contact with police or paramedics and their time of death for a life-saving intervention to be delivered.

Future directions

Future analysis should examine health characteristics and health pathways in more detail, as well as the specific characteristics, needs and pathways of different identified subgroups (e.g., children and young people, Aboriginal and/or Torres Strait Islander peoples, new or expectant mothers). Linkage to Medical Benefits Schedule and Pharmaceutical Benefits Scheme data will help provide a picture of primary care utilisation and a more fulsome understanding of health and diagnostic profile.

Future expansion of the Partners in Prevention dataset should include updating it, and expanding its scope through linkage to other datasets, to incorporate information on the social determinants of suicide crisis (e.g., child safety records, defence records, construction industry data).

SERVICE MAPPING

The Partners in Prevention team completed a service mapping of collaborative mental health, police and ambulance suicide crisis response services in 2018, to gain an understanding of the current service system. An overview of service types in operation, including Queensland Ambulance Service initiatives under development at the time of writing, are provided in Table 2.

Table 2 Overview of service types operating in Queensland

	MENTAL HEALTH INTERVENTION PROGRAM A tri-agency partnership between Queensland Police Service, Queensland Ambulance Service, and Queensland Health implemented in 2005. This program is designed to enhance collaboration, training delivery, and foster information sharing between agencies to improve outcomes. The program is currently under review.
	POLICE-MENTAL HEALTH CO-RESPONDER MODEL A paired police and mental health service that is co-deployed to identified crisis events, to better assess and respond to individual health needs and community safety during a crisis situation.
	MENTAL HEALTH SUPPORT TO POLICE NEGOTIATORS Police negotiators are supported by a mental health model of service. Police negotiators provide expertise in the de-escalation and resolution of critical incidents, including suicide situations where loss of life is imminent, with 24/7 access to mental health clinicians, if required.
	MENTAL HEALTH LIAISON SERVICE – POLICE COMMUNICATIONS CENTRE Mental health clinicians are co-located within the Brisbane Police Communications Centre outside of working hours, to provide advice to police responding to mental health crisis and facilitate referrals as needed.
	QUEENSLAND AMBULANCE SERVICE INITIATIVES (UNDER DEVELOPMENT AT TIME OF WRITING) Initiatives established in 2019 include co-responder services, mental health liaison service, and a state-wide coordination role.

Mental Health Intervention Program

The Mental Health Intervention Program (MHIP) originated as a tri-agency partnership between Queensland Police Service, Queensland Ambulance Service, and Queensland Health in 2005. The Mental Health Intervention Program comprises four elements: 1) delivery of specialised mental health training; 2) Mental Health Intervention Coordinator positions established within three agencies; 3) information sharing between Queensland Health and Queensland Police Service to assist with the safe resolution and care of people with mental illness who come in contact with police; and 4) localised tri-agency collaboration.

A multi-agency internal review into the Mental Health Intervention Program was underway at the time of writing. The review included membership from Queensland Health (Mental Health Alcohol and Other Drug Branch and Queensland Forensic Mental Health Service), Queensland Ambulance Service, and Queensland Police Service.

Police-Mental Health Co-responder models

The co-responder model combines policing and health services capability to respond to mental health and suicide crises. The concept is co-response to mental health crisis situations, meaning that police and health services are paired and co-deployed to identified crisis events in order to better assess and respond to community safety and health needs within the situation. The co-responder model has been implemented in Queensland as a multi-disciplinary secondary response to mental health crisis situations, in which health services and police officers work together as a response unit. The model has been the subject of local adaptation and is also referred to as mobile emergency response, ride-along, or embedded response (Boscarato et al., 2014; Parker et al., 2018; Steadman, Deane, Borum, & Morrissey, 2000).

Mental Health Support to Police Negotiators

Police negotiators are highly-trained police officers who provide specialised leadership and expertise in the de-escalation and resolution of critical incidents. They are available 24/7 and respond to incidents such as suicide crisis situations, barricade sieges, high risk warrants and other situations where loss of life is imminent.

The police negotiator model is supported by a mental health model of service. The *Mental Health Support of Police Negotiator Program – Model of Service* sets out overarching principles including scope of practice and respect for organisational expertise, and outlines a model of service for the provision of support by mental health services during an incident requiring police negotiation.

Specifically, a dedicated phone line is utilised to make contact with mental health clinicians within the Queensland Forensic Mental Health Service, who provide initial and additional responses toward resolution of the incident. These include:

- Provision of general advice regarding mental illness and drugs and alcohol issues;
- Obtaining and sharing relevant collateral and historical information under a Memorandum of Understanding;
- Liaising with the Office of the Chief Psychiatrist regarding any incidents that may result in significant systemic and/or media issues;
- Facilitating linkage with other Queensland Forensic Mental Health Service programs such as Queensland Fixated Threat Assessment Centre (where other Queensland Forensic Mental Health Service programs provide additional input when indicated);
- Facilitating linkage with the local Authorised Mental Health Service (where local Authorised Mental Health Service may undertake assessment and provide follow-up treatment and care when indicated); and
- Liaison with relevant Clinical Directors.

Following incident resolution, ongoing responsibility for follow-up care lies with the relevant Authorised Mental Health Service in consultation with Queensland Forensic Mental Health Service, as required.

Mental Health Liaison Service – Police Communications Centre

The *Mental Health Liaison Service – Police Communications Centre* (MHLS-PCC) model is an embedded mental health consultation-liaison role. The MHLS-PCC service co-locates experienced mental health clinicians from the Queensland Forensic Mental Health Service within the Brisbane Police Communication Centre (BPCC) from 3.30 pm daily Monday-Friday and 8 am to midnight on weekends and public holidays, with on-call psychiatrists available outside of these hours. The BPCC receives emergency triple zero calls that are directed to police. BPCC call-takers and their supervisory team assess caller needs, prioritise call urgency, and organise dispatch of Queensland Police Service resources. The embedded MHLS-PCC clinicians can be consulted by referral via the Queensland Police Service State Duty Officer. MHLS-PCC clinicians liaise with police and mental health services, enabled under a *Memorandum of Understanding: Mental Health Collaboration* (State of Queensland, 2016) between Queensland Health and Queensland Police Service. The level of information supplied to Queensland Police Service by the MHLS-PCC clinician is based on whether the clinician considers the situation to properly constitute a 'mental health crisis'. MHLS-PCC clinicians do not provide case management, primary care, or have direct contact with the consumer, with the caller, or with any person who is the subject of a call to emergency services.

Queensland Ambulance Service initiatives

Under establishment at the time of reporting, the Queensland Ambulance Service Mental Health Liaison Service (QAS MHLS) aims to provide relevant clinical information and state-wide support to Operation Centre staff and paramedics. Clinicians have access to Queensland Health clinical databases, including mental health databases, and can provide timely information about a person's mental health history, treatment plans, Police and Ambulance Intervention Plans, and other pertinent information which will help and support the clinical decision making of Queensland Ambulance Service officers. QAS MHLS clinicians can also assist paramedics to navigate mental health and hospital systems. The service is being piloted, and currently operates from 8 am to midnight 7 days per week.

Also under establishment are the Queensland Ambulance Service-mental health co-responders that will provide specialist mental health responses to people experiencing mental health crisis by providing immediate mental health assessment, short term management and interventions within the community. Co-responders will be based in ambulance stations.

Other supporting mechanisms, structures and instruments, including informal local relationships

A range of technologies create additional 'touch points' between Queensland Police Service, Queensland Ambulance Service and Queensland Health. These include the aforementioned Memorandum of Understanding between Queensland Police Service and Queensland Health to support appropriate information sharing in the context of mental health crises; major software infrastructure to support cross-agency emergency communications via the Inter-CAD Electronic Messaging System (ICEMS); and multi-agency liaison structures such as the Operational Liaison Committees. Additionally, some districts noted that PHNs had provided input and other support for training (e.g., Crisis Intervention Training). Informal relationships that were identified indicated good connectivity between Queensland Police Service, Queensland Health, Queensland Ambulance Service and other governmental and non-government agencies.

Gaps

Gaps were noted in documentation and evaluation of services that were mapped. In particular, it was sometimes difficult to ascertain precise details on hours of operation, activity and resourcing. Evaluations have been conducted for some, but not all, services in operation. Evaluations that have been conducted, while favourable, tend to focus on process and not outcome measures (i.e., they predominantly measure activity relating to Queensland Police Service, Queensland Ambulance Service, or emergency department services resources and time).

Conclusions

The services mapping provided an opportunity to obtain a state-wide overview of collaborative services initiatives in operation, up until 2018. It is notable that the service mapping that was initially undertaken quickly dated, due to a relatively rapid flourishing of services. This is encouraging. There is a need to improve specification of models of service and evaluate outcomes. There is benefit to updating and expanding the service mapping that was undertaken in order to facilitate coordination of services, and support evaluation and quality improvement activities.

Future directions

Regular updates of the service mapping should be undertaken in order to maintain oversight over the collaborative initiatives occurring throughout the state. Service providers should be encouraged and incentivised to improve the specification of models of service, to support coordination, resourcing, and quality improvement activities.

Service delivery enhancements could be usefully informed by data arising from the Partners in Prevention data linkage study. This includes informing hours of operation and resourcing requirements.

Rigorous evaluation frameworks should be established to build the evidence-base and support ongoing quality improvement activities, utilising the Partners in Prevention linked dataset where appropriate.

LIVED EXPERIENCE PERSPECTIVES

The Partners in Prevention team were invited to present their preliminary findings to a workshop at the Roses in The Ocean – Lived Experience Summit, held in Brisbane in August, 2018. At this event, delegates were invited to workshop answers to two questions on optimal first responses to suicide crisis situations, based on their lived experience:

QUESTION 1	When Police / Ambulance arrive to assist someone experiencing suicidal crisis or imminent attempt – how would you like them to respond?
A) What is going to be most helpful, supportive?	B) Who needs to be there?

QUESTION 2	When Police / Ambulance knock on your door to advise you that a loved one has taken their own life, how can they best deliver this life changing message?
A) What can they do, say? (Understanding that nothing they do will change the news, but how it is delivered and what happens next can make an enormous difference to those receiving it.)	

Individuals with lived experience of suicide identified a range of do's and don'ts, in relation to how first responders approached, interacted and related to a person in crisis or who was recently bereaved, as well as systems factors that were important in improving first responses. These are summarised in Table 3.

Table 3 Summary of the views of individuals with lived experience of suicide on what constitutes an optimal first response

DO'S

- Put into practice a proportional and discreet response
- Communicate empathetically
- Be mindful of context (e.g., family and visibility)
- Consider, and facilitate, connections
- Utilise resources of lived experience
- Provide information and follow-up

DON'TS

- Don't threaten or use excessive force
- Don't search rooms unless absolutely necessary

SYSTEMS FACTORS

- Create a specialist suicide response division
- Create support options that do not rely on emergency departments
- Establish routine trauma-informed suicide crisis intervention training

Do's

Put into practice a proportional and discreet response

Individuals with lived experience of suicide emphasised that first responders should focus on providing a discreet and proportional response when attending to an individual who was experiencing a suicide crisis. Several suggestions were made about ways this could be achieved, including:

- Having a plain clothes response;
- Parking or moving vehicles away from driveways;

- Minimising the number of vehicles dispatched; and
- Avoiding the use of lights and sirens.

In the context of bereavement, individuals pointed to the need for discretion and respect for autonomy and privacy when attending a residence to deliver news of a suicide death. By minimising visibility, first responders give those who are grieving the power to decide if, when, and how they share information about a suicide death.

Communicate empathetically

Individuals with lived experience of suicide highlighted the importance of communication that was warm, empathetic and compassionate. Specifically, individuals identified that first responders should use non-judgmental language, convey calmness and empathy, and utilise active listening skills when engaging with a person in crisis. In the context of a bereavement, those with lived experience of suicide noted that a bereavement needed to be understood as a life changing event. In addition to the general need for warmth, empathy and compassion, individuals noted the value of responders sitting and waiting with a person until supports could be identified and established.

Be mindful of context

In the context of suicide crisis, individuals highlighted the importance of first responders being informed about, and sensitive to, the context of the person in crisis. This included being able to access relevant information about any history of domestic violence or refusing care. Cross-cultural awareness, particularly being sensitive to the impacts of responding within Indigenous communities, was also highlighted. Sensitivity to social context, including the needs of others – both people and pets – who may need care or support during or after a suicide crisis, was also highlighted.

Consider, and facilitate, connections

Individuals identified that first responders had an important role to play in facilitating connections with 'natural supports' i.e., to people's own, existing, support persons and networks, as well as helping to facilitate connections with the health system. Facilitating connections with the health system included facilitating information sharing between providers, and facilitating contact with an individual's regular care provider. Individuals with lived experience of suicide said that they would value first responders asking them if there was anything that responders should know when facilitating a transfer (handover) to another health service.

Individuals were clear that health and caring professionals (including the lived experience workforce) also had a role to play in the context of bereavement, both in terms of being involved at the time that this life changing news was being delivered and also in the immediate aftermath.

Utilise resources of lived experience

Individuals advocated that first responders utilise resources of lived experience, including engaging and involving third party organisations who could provide peer support services.

Provide information and follow-up

Providing information, in both the context of a suicide crisis or bereavement, was considered an important part of optimal first response. One suggestion was for a family support pack that included numbers for service providers, including non-clinical and peer support groups. However, it was highlighted that in the context of a crisis event (including bereavement), information might not 'sink in'. Thus, it was important for first responders to follow-up with individuals. Some individuals expressed a preference that they receive follow-up from the officers who attended them in the first place.

Don'ts

Some don'ts that were identified were the obverse of the above mentioned do's. Additionally, two unique don'ts were identified.

Don't threaten or use excessive force

Individuals highlighted the importance of police not using excessive force, for example, breaking down doors, banging on doors, or shouting. Individuals highlighted the importance of not treating those in suicide crisis as though they were criminals.

Don't search rooms unless absolutely necessary

The second don't that was identified related to room searches. Individuals wanted police to consider whether it was absolutely necessary to search rooms or accommodation of persons who had died by suicide. Some individuals felt that room searches portrayed a false and stigmatising idea that suicide was subversive or criminal.

Systems factors

In addition to the do's and don'ts identified, individuals had a number of systems level suggestions.

Create a specialist suicide response division

Workshop delegates identified the need for specialist response undertaken by specially trained police or paramedics. Some delegates were in favour of co-responder models, in which a mental health clinician attended an emergency alongside police or paramedics.

Create support options that do not rely on emergency departments

Individuals with lived experience of suicide identified the benefit of having mental health clinicians attend crises, alongside first responders, in order to assess the need for further care. Workshop delegates also highlighted the need to create alternative care options to emergency departments, for people in crisis. One example that was given was that of a safe haven café.

Establish routine trauma-informed suicide intervention training, particularly focussed on communication

Individuals identified the importance of suicide prevention intervention training being provided to all first responders, as well as triple zero operators. In particular, and consistent with the identified do's, training in communication was considered to be especially important.

In the context of bereavement, the question was posed as to whether police should be responsible for delivering news of a suicide death. Alternatives that were suggested were co-responders or non-aligned third parties, including lived experience organisations. The question as to whether police should be responsible for delivering this life changing news was posed, but not resolved.

Conclusions

In terms of systems change, individuals with lived experience of suicide identified the need to consider alternatives to emergency departments for those who experience suicide crises.

Individuals with lived experience of suicide also highlighted the paramount importance of respectful, and empathetic communication. The written reflections on practice provided by one paramedic following one of the lived experience consultations that was held, highlighted the value of this workshop in bringing together a small group of first responders and lived experience representatives to participate in respectful conversation.

Information exchange and facilitating connections was highly valued, both during and in the aftermath of a crisis. Individuals with lived experience of suicide, who were part of the lived experience consultation, endorsed the value of the role of the Mental Health Liaison Service in Police Communications, in facilitating inter-agency information sharing. However, they identified that information sharing should extend to the resources and needs of families, who not only engage with first responders, but in many senses are first responders themselves.

Needs and responses in relation to a recent bereavement by suicide were identified as an important gap. While services for those who are bereaved by suicide, such as StandBy, operate in some areas, first responders also need to be equipped with resources to support those who have been bereaved by suicide.

Future directions

Continued enhancement to the service system is paramount. The benefit of facilitating conversations between police and paramedics, and individuals who experience suicide crisis, was clearly demonstrated to all who participated in the Partners in Prevention lived experience consultation. Facilitating ongoing conversations between first responders and individuals with lived experience, and encouraging first responders to reflect on these conversations, will very likely improve the quality of interactions in the community.

OPTIMAL CARE PATHWAYS

Service models that may meet the needs of individuals who experience suicide crisis were identified through a literature review completed in early 2019. Relevant models identified are summarised in Table 4.

Table 4 Summary of service models reviewed

	CO-RESPONDER MODELS Mental health clinicians assist first responders by providing advice, conducting mobile assessments, or taking over the care of a person in suicide crisis. Co-responder models operate in parts of Queensland.
	SHORT STAY SAFE HAVENS Safe, comfortable spaces for people in suicide or mental health crisis to go, as an alternative to presenting to an emergency department.
	BRIEF CONTACT INTERVENTIONS Time limited, structured interventions focussed on problem solving, crisis planning, and linking to other services; these interventions aim to deliver a compassionate and proportionate first response to individuals in crisis.
	BLENDED MODELS A holistic, multi-factorial model of service, beginning at the point of call and that combines multiple service elements.
	CULTURALLY APPROPRIATE CRISIS RESPONSES Crisis services that focus on the needs of specific cultural groups.
	AFTERCARE SERVICES Services that link people in need to appropriate services to prevent suicidality in the future. Referral pathways have traditionally been via an emergency department, however, the possibility exists to create direct pathways from police and paramedics.

Co-responder models

Co-responder programs assist first responders by providing advice, conducting mobile assessments, and taking over the care of a person in suicide crisis. This enables the first responders to return to duties, avoiding extended engagement with the person in crisis, and thus increasing first responder capacity.

Puntis et al., (2018) conducted a systematic review of police-mental health co-responder models. They found significant variability among services described as 'co-responder' services. Some models involved mental health professionals providing remote telephone contact only, and others involved mobile teams attending the site in person (Puntis et al., 2018). There were also differences regarding whether the co-responder was deployed as a first or secondary response, following a risk or safety assessment by the first responders to a scene. Of the 26 papers utilised in the review, 19 different co-responder models were found:

- Twelve were ride-along, whereby the police officer and mental health clinician attended in the vehicle together;
- Five encompassed both a ride-along model and communication support, whereby the clinician can advise police via telephone or police radio remotely. Four of the five predominantly utilised communication support remotely, with only serious incidents activating the ride-along unit; and
- Two services utilised communication support remotely as the only method.

In addition to police-mental health co-responder models, ambulance-mental health co-responder models have recently appeared. For example, the Psychiatric Emergency Response Team (Psykiatrisk akut Mobilitet - PAM) operates in Stockholm, Sweden, and attends emergency calls involving members of the community with severe mental illness or acute suicide risk (Bouveng, Bengtsson, & Carlborg, 2017). PAM is described as representing a unique approach to pre-hospital care, that provides the consumer with specialist assessment and intervention, is time efficient (average waiting time 15-20 minutes, and average assessment time 1 hour 15 minutes), and reduces work load for first responders (Bouveng et al., 2017). PAM is staffed by two specialist psychiatric nurses and a paramedic, who liaise with police, ambulance, rescue services and the psychiatrist on call at the psychiatric emergency department (PED), who can provide advice and assistance, as required (Bouveng et al., 2017).

Short stay safe havens

Safe havens are safe, comfortable spaces for people in a suicide or mental health crisis to go to, as an alternative to presenting to an emergency department.

An example of a safe haven is the Aldershot Safe Haven Service in England, a mental health crisis service providing an alternative to emergency department presentation for adults (Griffiths & Gale, 2017). It is a walk-in centre, staffed by two peer support workers and a mental health clinician (Griffiths & Gale, 2017). Entry to the Safe Haven is restricted via a locked entry door; this ensures that every individual is greeted on arrival by a staff member, who can then assess the level of service required (Griffiths & Gale, 2017).

The services offered include: peer to peer contact with persons in similar situations (other service users); a place of safety for individual time alone; or direct contact and communication with a staff member (Griffiths & Gale, 2017). Peer support staff provide social contact, and can reduce feelings of social isolation (Griffiths & Gale, 2017). Support workers assist in crisis plan development and can make contact with a person's GP or mental health team if needed (Griffiths & Gale, 2017). If a formal assessment of the person's mental health is required, the support worker will identify this and engage the onsite clinician (Griffiths & Gale, 2017). If appropriate, the clinician can refer the consumer onto other mental health services. Support is also provided to carers of people with mental illness.

Brief contact interventions

Brief contact interventions are time limited, structured, interventions that aim to deliver a compassionate and proportionate first response to individuals in crisis (The Scottish Government, 2015). These interventions are designed so as not to be reliant on mental health or allied health professionals, but open to delivery by suitably concerned and interested individuals who receive appropriate training. These models of contact are time limited, but involve ongoing contact, employing multiple forms of communication (e.g., telephone or written contact).

An example of a brief contact intervention is the Distress Brief Intervention (DBI), currently being trialled in Scotland. The purpose of DBI is to coordinate care across multiple service providers in order to increase engagement and maintain support for people in a suicide crisis, as well as those with mental illness (O'Neill, 2018). DBI is a time limited (14 days) problem-solving intervention available in addition to services as usual. DBI has been designed as a potential care pathway for individuals in crisis who come in contact with police or paramedics, present to a hospital emergency department, or present to a primary care professional (O'Neill, 2018). However, it could be a relevant referral pathway from a wide range of services.

DBI adopts an "ask once get help fast" motto, and comprises two levels of support. Level 1 is implemented by the frontline staff where the person presents (i.e., police, ambulance, emergency department or primary care) and includes a compassion focused response, education regarding relevant services, and referral to level 2 DBI, if the person in crisis accepts the offer (O'Neill, 2018). Trained staff from numerous organisations provide DBI level 2, which includes contacting the person within 24 hours, delivering community-based and compassionate problem solving, planning around wellness and distress management, and support in connecting with follow up services (O'Neill, 2018). DBI is staffed by trained practitioners, including peer workers and other interested individuals.

Blended models

Blended models provide a holistic, multi-factorial model of service, beginning at the point of call. An example of this is Crisis Now, a comprehensive model of care initially introduced in Arizona, and now replicated across the United States of America and New Zealand. The model centres around the essential principles and practices of recovery focussed, trauma-informed treatments, use of peer workers, commitment to safety, commitment to zero suicide, and collaboration with law enforcement (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016). Crisis Now aims to link together several service elements similar to those mentioned elsewhere in this review, namely: High-Tech Crisis Call Centres; 24/7 Mobile Crisis Teams; and Crisis Stabilisation Retreats/Programs (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016).

Culturally appropriate crisis responses

Culturally appropriate crisis responses are those that are focused on meeting the needs of specific cultural groups, for example, Aboriginal and/or Torres Strait Islander peoples. This review included discussion of two crisis response models developed by, and for, Aboriginal and/or Torres Strait Islander peoples.

An example of a crisis response service for Aboriginal and/or Torres Strait Islander peoples is the National Indigenous Critical Response Service (NICRS) delivered by Thirrili Ltd, a non-profit organisation focused on the wellbeing of Aboriginal and/or Torres Strait Islander peoples (Thirrili Ltd., 2017). The aims of NICRS are to:

1. "provide a critical response to support individuals, families and communities affected by suicide-related or other trauma that is culturally responsive to their needs"; and
2. "strengthen community capacity and resilience in communities where there have been high levels of suicide to better recognise and respond to critical incidents and strengthen service system coordination (Thirrili Ltd., 2017)."

Advocates can be contacted on a free phone number 24/7. If not able to be answered, an advocate will respond as soon as practicable. The service is staffed by advocates who identify as Aboriginal and/or Torres Strait Islanders. Staff are not counsellors and do not provide counselling or clinical support. The aim of the service is to provide a culturally responsive service, support local services and strengthen community resilience through response to critical incidents. Service provision includes an informal needs assessment, practical social support, linkages with local social, health and community services, and cultural supports. Ongoing support can be provided to individuals and families (Thirrili Ltd., 2017).

The advocates ensure that culturally appropriate engagement with service providers occurs, monitor how the services fulfil the psychosocial needs of the person and encourage services to adopt a collaborative approach to care and through-care (Thirrili Ltd., 2017).

NICRS also encompasses a community capacity building program that assists communities to support families and respond to community needs following a suicide or traumatic event, help the family access co-ordinated care, and focus on local risk factors that contributed to the suicide such as mental illness, homelessness, violence, alcohol or drug abuse, unemployment, and forensic issues (Thirrili Ltd., 2017).

Aftercare services

Strictly speaking, post-ED suicide prevention services ("aftercare services") were deemed out of scope of this review. However, several aftercare services, including those that are operating within Queensland, were considered to offer the potential to connect directly to the police or paramedic response, rather than being mediated via an emergency department presentation.

While primary care and community based mental health services all have an important role to play in providing support to those who are at risk of suicide, for the purposes of this review, aftercare community suicide prevention services were defined as services that engage with an individual for a limited time, linking them in with appropriate services to prevent suicidality in the future. There is diversity in the types of services available, including non-clinical and clinical services.

One example of an aftercare service is the PAUSE peer support program recently implemented by Brook RED (https://www.brookred.org.au/) in Brisbane. The program works directly with the Logan Hospital emergency department, which is the only referral pathway into the program, after a person has presented in a suicide crisis or with deliberate self-harm. Following triage, and if judged suitable, the person may be referred to PAUSE during or after discharge from the emergency department. PAUSE endeavour to follow up with the individual within 24 hours. The PAUSE team comprises four peer support workers with lived experience of mental illness or suicidality.

Common interventions include peer support focused on recovery, advocating for the person to link in with services (including private psychologists, psychiatrists, and GPs), assisting with linkages to public services (such as Department of Housing) or non-government organisations (for services such as financial counselling), and providing education to carers and family members of the person.

Conclusions

The implementation or expansion of many of the service models described in this literature review is being supported by current government investment. However, several gaps in service models are evident, including limited tailoring of services to vulnerable subgroups and limited services for younger people in a suicide crisis; nearly all pathways focussed on adults 18 years or over.

While evaluations that were available indicated a high degree of consumer satisfaction, there was an overwhelming lack of evidence regarding efficacy or cost-effectiveness. Limitations in evaluations, included: limitations in specifications of model of service; limitations to study design; and limitations in measurement of clinical and other outcomes.

Future directions

Given overall evidence gaps it would be wise to undertake staged implementation of these models, supported by careful evaluation, in order to ensure that these services result in benefits to consumers. Critical gaps in services for vulnerable groups, particularly young people under the age of 18, need to be addressed.

Undertaking regular mappings of these service models will be of benefit in the governance and evaluation of these services, and ultimately will support development of guidelines to inform optimal care pathways for individuals in suicide crisis who come into contact with police or paramedics.

KNOWLEDGE, SKILLS, ATTITUDES AND CONFIDENCE OF POLICE

A mixed methods study, including a short (quantitative) paper-based survey and (qualitative) semi-structured interview was undertaken with police, in order to understand perspectives and experiences in responding to suicide crisis situations. The study also examined perceptions of self-stigma, self-care and coping practices of police. Data were collected in 2018 and 2019. Data were gathered purposively, with the aim of recruiting a diverse mix of general duties frontline officers, communication centre call-takers, trainees and instructors, and individuals who undertake a specialist negotiator role directly involved in suicide crisis. These are referred to throughout as police staff (all Queensland Police Service employees surveyed or interviewed, including recruits, sworn and civilian members), police officers (all sworn members, including uniformed and plain clothed roles), or police recruits (individuals undergoing police training). Data collection focused on obtaining views from staff across a range of ranks and districts, including metropolitan, regional and remote areas. Key findings are summarised in Table 5.

Table 5 Summary of key findings from surveys and interviews with police responders

	Culture and training in relation to mental health and suicide have improved overtime
	Police are generally confident and knowledgeable when handling suicide crisis situations
	Police are not always confident in facilitating care pathways other than to an emergency department
	Communication is paramount to effectively handling suicide crisis situations
	While police do not hold stigmatising beliefs of others with mental illness, there remains stigma that may hamper self-disclosure of one's own mental illness
	Supporting self-care and providing support for first responders who experience traumatic situations, and their families, is important

Changes in culture and training

Many police staff who were interviewed highlighted that they had witnessed a process of positive cultural change within the Queensland Police Service. Changes included positive changes to the culture of the service over time, improved training for officers and recruits, and promotion of communication-based resolution to crisis situations.

A range of opportunities for organisational improvement were also highlighted by interviewees, including a need for more access to high quality training, further exploration of models of service with health and Queensland Police Service partnership (e.g., co-responder programs), and continued culture change.

Knowledge and confidence

The average score for knowledge of suicide prevention among police staff to a 10-item questionnaire was seven out of ten, indicating an overall high level of knowledge. Confidence levels were high overall. In particular, the majority of police officers (82%) agreed that they felt that they could accurately identify situations where a person is at risk of suicide.

However, police knowledge on use of powers to involuntarily transport, examine or treat individuals at risk of suicide, indicated that the majority believe that the use of police powers to involuntarily detain and transport persons at high risk of suicide is warranted. Police officers were less likely to believe that the use of police powers was warranted than police recruits.

Areas where police lack confidence

Confidence was lowest among police with respect to knowing how to refer people in need to appropriate services. Fifty-five per cent of those surveyed agreed that they knew how to refer people at risk of suicide to the services most appropriate to their needs and level of risk. Confidence was higher among police officers than police recruits.

Communication

In interviews, police officers identified that communication was paramount in effectively handling suicide crisis situations. Key approaches that were advocated for were:

- Conveying empathy and caring;
- Listening;
- Developing rapport;
- Showing one's human side;
- Not 'fixing their problem';
- Being authentic and genuine;
- Being patient and taking time;
- Creating a calm environment; and
- Acting respectfully.

Stigma

Some issues of stigma associated with mental illness within the Queensland Police Service were identified. While staff generally described that they felt comfortable in assessing individuals for suicide risk, and also that they would feel comfortable working with a colleague with mental illness (94% agreed), over one-half of officers (53%) stated that they would not disclose experiencing a mental illness to their colleagues for fear of being treated differently. Overall, officers indicated less willingness to disclose a mental illness to colleagues for fear of being treated differently (58%) than did new recruits (45%).

Experiences and self-care practices

The experience of responding to suicide crisis situations, or those involving a suicide death, can be traumatic for first responders. Both survey and interview responses indicated that police saw responding to suicide crises as a legitimate part of their role as police, specifically related to the oath to preserve life and community safety. However, fewer than half of those surveyed (42%) considered that responding to those in suicide crisis was a rewarding aspect of their job.

In interviews, police identified several self-care and coping strategies that they used to keep themselves well. These were:

- Talking with peers and debriefing;
- Spending time with friends and family;
- Utilising professional support;
- Exercising;
- Distraction;
- Humour;
- Relaxation and meditation; and
- No specific strategies.

Conclusions

Police staff who were surveyed and interviewed showed overall high levels of knowledge, skills, and confidence in responding to suicide crisis situations. However, it was also identified that there was a need to expand the availability of relevant training to all police staff who engage with people in suicide crisis or who have recently been bereaved. It is important to prioritise suicide prevention training for new recruits, who are likely to interact with individuals in mental health or suicide crises very early on in their careers.

Interviews highlighted the paramount importance of communication skills when responding to individuals in suicide crisis. In this way, many of the comments made by police staff aligned with the values and needs expressed by individuals with lived experience of suicide.

Participants' answers to questions regarding the use of legislative powers, as well as their relatively low confidence in relation to referring individuals in need to appropriate services, need to be understood within the context of the broader health system. Not only do appropriate services need to be available for police to refer to, but processes need to be in place to help police confidently manage risk when assessing and facilitating health pathways for individuals in need.

Responding to suicide crises and instances of suicide death are potentially traumatic experiences. Continued efforts are needed to support police staff and their families to disclose experiences of distress or trauma, and facilitate effective and compassionate care.

Future directions

Ongoing initiatives that foster collaboration, knowledge exchange, and mutual support between police, health services and paramedics, are important to improving knowledge and confidence among police staff, and ensuring effective management of risk while minimising use of legislative powers. Maintaining oversight of Queensland's evolving crisis care system will assist police in confidently facilitating appropriate care pathways for individuals in crisis.

CONCLUSIONS AND FUTURE DIRECTIONS

Partners in Prevention aimed to undertake a comprehensive and holistic examination of police and paramedic responses to suicide crisis situations.

Police and paramedics respond to a substantial number of people who experience suicide crisis

Through the Partners in Prevention data linkage project, we identified the substantial and increasing number of suicide related calls that police or paramedics in Queensland respond to. Individuals in crisis are a heterogeneous group with heterogeneous needs for care. Police and paramedics will encounter a substantial proportion of the Queenslanders who will die by suicide. The data show that, in at least some of these cases, there may be enough time available between an individual's first suicide-related contact with police or paramedics and time of death for a life-saving intervention to be delivered.

Systems change is needed to reduce demand on emergency departments

In terms of systems change, the need to implement alternatives to emergency departments that police and paramedics can utilise, is paramount. The services mapping and literature review identified a flourishing of new models of collaborative care, however, there is a need to improve the specification of models of service, and to undertake high quality evaluations.

First responders may be overly reliant on Emergency Examination Authorities and emergency departments. Developing training resources may be useful in encouraging the use of alternative approaches. However, it is also recognised that reliance on these pathways is partly health system dependent. Not only do appropriate alternative services need to be available for police and paramedics to refer to, particularly outside business hours, but processes need to be in place to help responders confidently manage risk when assessing and facilitating health pathways for individuals in need.

Recent investments into crisis care will almost certainly be beneficial in providing new care pathways that are more tailored to individual needs. However, a review of evidence regarding these models indicated the need for further, rigorous evaluation. Furthermore, despite this investment, several gaps in service models remain, including limited tailoring of services to vulnerable subgroups and limited services for younger people in a suicide crisis; nearly all pathways focussed on adults 18 years or over.

The Partners in Prevention methodology could be expanded to include non-clinical and non-health support pathways

The finding from Partners in Prevention, that only 19% of individuals had a confirmed mental health diagnosis, highlights the fact that suicide crises are multifaceted phenomena; mental illness may play a small role or no role at all. Consequently, there is a need to consider the interface between health and non-health support pathways. Opportunities to expand the Partners in Prevention methodology to examine non-clinical or non-health support options that can help reduce risk of suicide (e.g., relating to financial hardship or relationship problems) should be considered.

Information, communication and resources are critical

There was a high degree of alignment between those with lived experience and police who were surveyed, regarding the importance of information sharing, use of appropriate communication techniques, and the availability and provisions of appropriate resources during, and after a suicide crisis or death. There is support for both Queensland Police Service and Queensland Ambulance Service Mental Health Liaison services that facilitate information sharing and service access between health, police and paramedics. The role of families and carers in this regard needs to be given further consideration, given that families both have and need information and, in many respects, should be considered first responders in their own right.

The mental health needs of first responders and their families are important

While the focus of this research was on individuals who experience suicide crisis, and the police and paramedics who attend to them, the impacts on police and paramedics and their support needs was raised and is important to continue to attend to.

Future directions

Continuing to monitor, improve and evaluate burgeoning services, both collaborative suicide crisis response services and crisis care services, is warranted given rapid changes to the crisis care landscape in Queensland. Regular updates of the service mapping should occur in order to maintain oversight over the collaborative initiatives occurring throughout the state. Service providers should be encouraged and incentivised to improve the specification of models of service in order to support coordination, resourcing and quality improvement activities.

The Partners in Prevention linked dataset is a globally unique resource with the potential to be a highly practical tool for use in identifying needs, evaluating responses, and informing planning and resources. With further investment, there is the potential that this dataset could evolve into a real-time surveillance and risk prediction system. While filling several major evidence gaps regarding suicide crises in the community, the dataset is currently being expanded to link to additional datasets in order to include data on potential social determinants of suicide crisis.

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APPENDIX A– SUMMARY OF PARTNERS IN PREVENTION WORKSHOP, HELD 4 JUNE, 2019

Background

The following supplementary material provides a summary of the findings of the Partners in Prevention final workshop. Workshop participants were provided with an overview of four out of five of the project components. Data on knowledge, skills, attitudes and confidence of police was not presented, as it had not been subject to consultation with Queensland Police Service at that stage.

Methods

The Partners in Prevention workshop was a half-day workshop hosted at Victoria Park Golf Course in Brisbane, Queensland, on 4 June, 2019.

The workshop began by providing context to the Partners in Prevention project, and a summation of key findings from the data linkage study, service mapping, lived experience consultation, and literature review. An accompanying summary document was circulated to workshop participants prior to the event.

Following a presentation of findings, workshop participants were split into six groups and invited to participate in discussion of the following six questions:

1. What would an ideal system look like (components and pathways) for those experiencing suicide crisis who come into contact with police or ambulance responders?
2. If there was one component that would most value add to the existing system, what would it be and why?
3. What are the barriers and opportunities for implementing effective and coordinated care for individuals following a first response to suicide crisis?
4. Partners in Prevention examines suicide crisis where ambulance and police are the first responders. What are the alternative responses to suicide crisis?
5. What do families need to better support loved ones and themselves?
6. What do we want from the PiP data and what should be collected in the future?

Participants were given approximately 15 minutes to discuss responses to each question. Responses were scribed by facilitators on butcher's paper. Results are summarised in terms of prominent cross-cutting themes that were discussed.

Results

Several cross-cutting themes emerged across discussions.

Services

- Preventing suicide crises is a whole-of-government issue. People in need require access to a range of support services beyond health, including domestic violence, housing, financial, child care/child safety and employment.
- Services need to be consumer focussed.
- Deficiencies in the current health service ecosystem are fuelling suicide crises.
- Promising existing initiatives for responding to individuals in crisis, include:

- Police and ambulance communications centre mental health liaison services
  - Aftercare services
- Numerous service system gaps exist and need to be filled, including:
  - Preventative services
  - Alternatives to emergency departments
  - Out of hours options
  - 24/7 mental health services
  - Non-government organisation responses
  - Co-responder models
  - Service responses that foster and support family connections
  - Mental Health First Aid
  - Applied Suicide Intervention Skills Training (ASIST)
- Better sign-posting is needed. This could be achieved via a:
  - Single point of contact
  - Navigator roles
- Services need to be better linked and coordinated.
- Services need to be tailored to need groups, for example:
  - Under 18's
  - Aboriginal and Torres Strait Islander people
  - Frequent presenters
- There is inconsistency and variation across current services, particularly with respect to risk assessment.
- Processes need to be in place to facilitate follow-up after a crisis, and ensure that those in need are connected with appropriate services.
- There are opportunities to trial, evaluate and upscale promising services, utilising the Partners in Prevention linked dataset.
- There are geographic barriers to accessing services.
- Funding models for services are ad hoc and need to be more strategic.
- The health system should facilitate and enhance specialty care with respect to different service types.
- There is a need to build workforce capacity across all sectors, with respect to responding to suicide crises.

Consumers

- In an ideal model person-centred care is necessary and is one that is empathetic and acknowledges an individual's concerns, and makes a person feel safe, validated, and respected.
- Priority needs to be given to keeping the consumer safe.
- Increasing the sense of care and worth of the consumer will increase the ability of services to respond effectively.
- All service provision should be trauma informed.
- Health care professionals should explain and empower the consumer to better understand their pathway, any relevant timeframes, and why it has been chosen. This will help consumers feel more prepared and know what to expect.
- Alternative pathways/options need to be accessible to the consumer at all steps along their journey.
- Responders should de-escalate and not exacerbate stressful situations.
- Red tape and overly bureaucratic processes can take the focus away from the consumer.
- There is a lack of consumer representation during and after a first response.
- Conversations by first responders or health professionals, that are overheard by consumers, can be insensitive and stigmatising.
- There is lack of understanding and consent regarding sharing information with family and next-of-kin.

Emergency Department

Preventing unnecessary emergency department presentations

- Mental health support, including assertive outreach or co-responder models, could help de-escalate or reduce unnecessary ED presentations.
- First responders need better processes around who holds risk if a person is not taken to an ED. Mental health support for first responders would reduce risks of not transporting an individual to the ED.
- First responders do not have an appropriate level of training or skillset to know what options are suitable outside of ED/ Emergency Examination Authority versus not doing anything.
- Ambulance presently operate within a dichotomous system where the options are to transport a person to an emergency department or not transport a person to an emergency department.
- If it is appropriate for an individual to be managed safely at home and followed up with an appointment the following day (e.g., at a more specialised or existing MHS), then they should be.
- There is a lack of (community) alternatives to EDs or admissions – could an app be developed with community based appropriate supports and options for QPS/QAS when dealing with the crisis?

Before arrival

- In an ideal model some form of therapy or intervention would have commenced before a person arrives at the ED by treating that person with respect, and validating, engaging, and caring for that person.
- An IT system that first responders can use to link and triage consumers to setup an appointment for a face-to-face meeting within triage time scales, rather than jumping straight to ED presentation and EEAs, could facilitate appropriate care pathways tailored to individual need and risk.

On arrival

- There is a very wide presentation spectrum in the ED.
- Acting with discretion, when individuals in mental health or suicide crisis arrive at the ED, can reduce stigma associated with their presentation. Transfer of information from QAS/QPS personnel to ED staff can be problematic in that it can often be overheard by consumers, and can be clinical, cold, stigmatising and insensitive.

During

- Providing an immediate mental health response to those in crisis in ED would reduce distress and feelings of disempowerment (i.e., not feeling as important as someone with a different medical condition).
- The Public Health Act may reduce quality of ED responses, e.g., consumers in crisis may be seen by a social worker and then discharged without a full mental health assessment.
- Child and Youth Mental Health Services have been trialling a model of safety planning in the ED, prior to discharge after an EEA, that involves key supports.

General

- Flexible responses in the system are required to meet the client’s level of risk and need.
- ED should not be the only options available for individuals who experience a suicide crisis.
  - Suitable alternatives would be 24/7, include specialised clinicians and peer support, and facilitate information sharing.
  - When considering safe alternatives to emergency departments, there is a need to consider regions and availability of resources (particularly in remote communities).
  - Safe spaces, including safe haven cafés adjacent to EDs should be established.
  - Acute Care Teams have a role to play.
  - Opportunities for models being trialled should progress once evidence base is built to back up innovative services to address barriers and lead to individualised and tailored follow-up in the community without the need for ED.
  - Peer Respites and supported accommodation are other initiatives that should be considered.
- There is often a poor cultural fit between first responders and ED clinicians, and those who they attend to. For example, first responders and ED clinicians often do not consider cultural supports or liaisons for Indigenous people.
- Educating first responders and ED staff about the legal responsibilities and obligations of each service is required. This will ensure that ED have a better understanding of why QAS or QPS bring someone to hospital, and help QAS and QPS better understand how someone came to be discharged from hospital.

Family-Community

- Families and communities are first responders too. Consequently, there is a need for capacity building to increase skills and confidence among families and next of kin, as well as among first responders and emergency services.
- Holistic approaches to suicide prevention include community-based post-crisis responses. These models could help tackle broader issues, and respect diversity of experience.
- Police and paramedics should consider the needs of families and communities when responding to an individual in crisis.
  - Responders need to be mindful of family dynamics.
  - Families need support.
  - Families need to feel empowered to navigate the system.
  - Children of parents in crisis need support.
  - Family connections – a US model group family program to facilitate vulnerable families to help children (under the age of 18) – maybe worthwhile.
- Families, carers and call makers are crucial sources of information to include in making decisions that will best meet consumers' needs and provide an individualised or tailored response. This is applicable to both the first response, and pre-crisis planning.
  - Call takers should make use of call makers knowledge in terms of what works or triggers to avoid.
  - Opportunities for open disclosure that is respectful of confidentiality should be identified.
  - First responders and health service staff should work to enable communication exchange at hospital and health services while respecting issues of consent.
  - Confidentiality challenges exist post-incident.
- There is a lack of understanding regarding consent and information sharing between families or next of kin, and individuals who experience crisis. This issue may be particularly relevant to young people who experience suicide crisis.
- Families present challenges for police in the first instance, because police are process and job focussed, in relation to the individual in crisis. Current due process does not adequately consider the needs of families.
- Families have specific needs when they interact with first responders in the context of a bereavement.
  - Police require specific training in delivering death messages
  - Police should facilitate referrals to Standby service, where it is available.
- Families would like first responders to understand their experiences
  - No two situations will ever be the same
  - Individuals need to be ready for information
  - Families can experience fatigue
  - Families will go through a grief process, and stages of grief, related to suicide
  - Responders should be mindful of family dynamics
  - Children need support in times of crisis
  - Families need to be prepared, including having some indication of what they might expect will happen
  - Families may need their own referrals to supports, and follow-up
  - First responders should listen and attempt to engage families. If nothing else, families need to have their concerns acknowledged and validated.
- Families would like first responders to take time, and not rush, engagements with family members in relation to suicide crisis situations, including a recent death by suicide.
- First responders would benefit from greater cultural awareness, and being aware of, and facilitating, cultural supports.
- First responders and their families need support as well. Support could include:
  - Checking in
  - Making available resources and information
  - Debriefing mechanisms, including debriefing at scene and soon after
- Families need a range of practical information, potentially supplied by first responders in information packs. Information of value could include:
  - A clear understanding of relevant processes, potential service providers, and the services that they may be able to provide.

- A conceptual map. For example, helping families to understand what happens next, where to get help, or what are the next three steps.
- General information for families about mental health and illness, suicide and stigma.
- General information on supporting a family member in crisis.
- Resources on a range of health and non-health community-based resources – including mental health services, legal services, Centrelink, domestic violence, suicide prevention services etc.
- Information with numbers for support services (e.g., on a 'credit card') would be helpful.
- Specific information for those who are bereaved by suicide, including practical information on coronial processes.

- Support for communities through sports clubs etc., can be beneficial but needs to occur across the board (rather than just in pockets)
- Communities are heterogeneous but there is also a need for state-wide consistency.
    - One size fits all models do not work for remote communities or factor in cultural considerations in the Torres or Cape.
    - However, consistency is needed.

Information

Information sharing

- There is a need to consider open disclosure that is respectful of confidentiality.
- There is a need to consider options to enable communication exchange at Hospital and Health Services while respecting issues of consent.
- Information sharing should be accessible for the duration of the crisis. There is a need to consider whether the current Memorandum of Understanding should be broadened to include sharing of relevant information back to QAS/QPS post-incident, in order to improve care.
- In relation to information sharing, there is a need to increase QAS confidence in QPS advice, to make QAS responders feel confident arriving without a police presence.
- There can be difficulties in inter-organisational translation and interpretation of information between police and paramedics. High acuity/critical situations are communicated well, but less urgent situations can get lost in translation or result in no response.
- Deficiencies exist in feedback of information to (and from) family, next of kin, and General Practitioners. Better co-ordination and information sharing is required between the regular service provider and first responders, and others who are actively involved in the individual's care.

Informational resources

- Families, consumers and responders all have specific informational needs.

Risk and safety

Risk

- Risk is difficult to gauge, but all expressions of suicidality need to be taken seriously.
- There needs to be detailed consideration of risks, and risk management, in order to reduce unnecessary transportation by police or paramedics to EDs.
    - Better coordination between mental health clinicians and first responders could reduce the risk associated with not transporting a person in crisis to an ED.
    - Better processes are needed in relation to who 'holds' the risk if an individual is not taken to an ED.
    - Better education is required on risk.
- Emergency services and health agencies need to work in a way that reduces the risk of compounding an individuals' distress or trauma, through an inappropriate response. Inappropriate service provision may re-traumatise individuals, particularly if it includes involuntary treatment or is overly medicalised.
- Different perceptions and conceptualisations of risk exist, both across and within agencies. There is a need for evidence-informed, flexible responses to meet clients' levels of need and risk.
    - Some sectors, for example emergency departments, have developed models which heavily focus on risk assessment rather than safety planning.
- Risk is not always conveyed to families.
- Risk is not always communicated between first responders and GPs to inform decision-making.

Safety

- An ideal model is one where the person in crisis is safe and feels safe.
- Agencies should be coordinated to do what they do best. QPS manage safety, QAS manage immediate medical and health needs, mental health assess and facilitate referral pathways, including alternatives to EDs.
- If a person can be managed safely at home and be followed up with an appointment the following day, then they should be.
- 1300 clinician support to QAS could help support brief interventions, safety planning and follow-up appointment making.
- A mental health nurse practitioner role could help facilitate patient safety.

Resources

- Responses depend on resources.
- More resources are required. However, existing resources could also be better allocated.
- Suicide related presentations are increasing dramatically, however, resourcing is not.
- There are opportunities to use data to better target resources based on need.

Training

- First responders have several training needs. These include:
  - Training in communication
  - Indigenous Suicide Interaction Skills Training (INSIST) for engaging with Indigenous individuals or communities.
  - Education on response options available, and when, why and what may be most appropriate in a given circumstance.
  - Training in delivering death messages, in the context of suicide.

Access

- Issues of access encompass:
  - Geographic access
  - Accessibility to the right services, e.g., community services, and health and non-health services
  - Accessibility of knowledge and information

Key actions required

Workshop participants identified several priorities for future action. There are deficits in the existing **service** landscape, and a range of health and non-health sector responses are required. The Partners in Prevention **linked dataset** provides opportunities to evaluate new services and facilitate evidence-informed practice.

Consumer-centred care is paramount and should focus on empowerment, respect, safety, representation, and communication.

Broader systems improvements are necessary to enhancing first responses that result in **reduced reliance on emergency departments**. Additionally, agency and inter-agency **policies and procedures regarding risk assessment and management** are required to better assess and prevent unnecessary transportation of individuals in crisis to emergency departments.

Families and communities are first responders, but also have their own care needs. There is a need to build capacity among families whose loved ones may experience suicidal crisis, both to help them provide support to loved ones, and to facilitate self-care. **First responders should focus on empathetic and culturally aware communication with families**, recognising that families are an important source of information that can assist first responders, but also have a need for information to help their loved one.

Information and information sharing is a critical lever to coordinated and joined up care. All agencies should seek to improve information sharing and use, in a way that promotes transparency and availability.

First responders require training in when Emergency Examination Authorities should and should not be used, as well as in how to facilitate community management of crisis, when this is appropriate.

More resources, and better allocation of resources, are required.

Project leads

Assoc. Prof Ed Heffernan
Project Director – Partners in Prevention
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service, and Queensland Centre for Mental Health Research

Dr Carla Meurk
Project Manager – Partners in Prevention
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service, and Queensland Centre for Mental Health Research

Research team

Ms Fiona Davidson
Research and Evaluation Coordinator
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service

Dr Laura Ferris
Project Manager – Partners in Prevention
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service

Dr Megan Steele
Research Scientist
Queensland Centre for Mental Health Research

Dr Lisa Wittenhagen
Research and Evaluation Officer
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service

Collaborators

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Dr Neil Grant
Ms Nancy Grevis-James
Senior Sergeant Peter Heck
Mr Paul Hogan
Ms Nikki Jamieson
Dr Katelyn Kerr
Mr Louis Lee
Ms Karen Liversidge
Ms Susanne Logan
Ms Janet Martin
Inspector Paul McQuaid
Senior Sergeant Michael Mitchell
Inspector Tony Montgomery-Clarke
Mr Glen Morrison
Ms Yasmin Muller
Dr Darren Neillie
Inspector David Nevin
Ms Susanne Oliver-Armstrong
Senior Sergeant Jay Pickard
Mr Stefan Preissler
Ms Tanya Raineri
Ms Jess Smith
Ms Vicki Smith
Dr Rebecca Soole
Sergeant Chris Stafford
Dr Stephen Stathis
Superintendent Mark Stiles
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NEED HELP?

Suicide can be a difficult topic for many people. If you would like to talk with someone, find support, or locate more information, you can contact:

Lifeline 13 11 14
www.lifeline.org.au/gethelp

Suicide Call Back Service
1300 659 467
www.suicidecallbackservice.org.au

MensLine Australia
1300 789 978
www.mensline.org.au

Beyond Blue Support Service
1300 224 636
www.beyondblue.org.au

SANE Australia Helpline
1800 187 263
www.sane.org

QLife (LGBTI)
1800 184 5270
www.qlife.org.au

Kids Helpline
1800 551 800
www.kidshelpline.com.au

Defence Family Helpline
1800 624 608
www.defence.gov.au/dco/defence-helpline.asp

For further information, please contact Associate Professor Ed Heffernan, Ed.Heffernan@health.qld.gov.au