Not Now. Not Ever. *Together*

SUICIDE PREVENTION FRAMEWORK

for working with people impacted by domestic and family violence

Queensland Government

CONTENTS

ACKNOWLEDGMENTS

The Queensland Government acknowledges the significant effort of individuals, organisations and government agencies across Queensland who are working to reduce suicide and domestic and family violence.

This Framework has been developed in collaboration and consultation with mental health, suicide prevention, and domestic and family violence experts. The Queensland Government acknowledges and values the contributions of these stakeholders. Refer to Appendix A for a full list of stakeholders consulted.

BACKGROUND

Despite ongoing investment and attention on prevention strategies, over the past decade, suicide rates in Queensland have continued to rise.

No single factor is responsible for suicidal behaviour. Suicide risk is influenced by an interaction of individual, social and other factors. Factors including social isolation, stigma and discrimination, employment, disability, financial hardship, substance abuse, housing (including homelessness) and adverse life events such as the breakdown of a relationship can all influence vulnerability to suicide.[1]

While suicide can affect all people, some people and groups are more vulnerable than others. Research indicates intimate partner violence is a significant risk factor for suicide in female victim/survivors, with some studies suggesting women who have been abused by their intimate partners are almost four times more likely to experience suicidal ideation compared to non-abused women in the general population.[2] While threats of suicide may be used by a perpetrator as a form of domestic and family violence, many suicides that occur in the context of domestic and family violence involve the perpetrator taking their own life.[3]

The Queensland Government is committed to the prevention of suicide and domestic and family violence and, to taking action. This is evident through the state-wide reform programs under *Every life: The Queensland Suicide Prevention Plan 2019–2029* and the *Domestic and Family Violence Strategy 2016-2026* including the *Third Action Plan 2019-20 to 2021-22*.

Service providers also have a role to play in reducing the rates of suicide and ensuring the vulnerable members of our community are able to access the support they need. Effective suicide prevention responses require integration and support across multiple sectors including health, justice, education and social services.[4]

Apparent suicides contribute the largest number of domestic and family violence deaths in Queensland each year, including victim/survivors and perpetrators.[5]

The Domestic and Family Violence Death Review and Advisory Board (the Board) is responsible for the systemic review of domestic and family violence deaths in Queensland. The Board reviewed two deaths (suicides) that occurred within women's shelters due to overdose of prescribed medication during 2016-17.

As a result of this review, the Board recommended that a targeted suicide prevention framework, which accounts for the detection of, and response to, vulnerable individuals be developed and implemented within domestic and family violence shelters.

The development of a Suicide Prevention Framework is also a supporting action under the *Third Action Plan 2019-20 to 2021-22* to Queensland's *Domestic and Family Violence Prevention Strategy 2016-2026* and Action 35 under *Every Life: The Queensland Suicide Prevention plan 2019-2029*.

In responding to this recommendation, the Queensland Government expanded the scope, to be applicable to all specialist practitioners working with people impacted by domestic and family violence. This decision was made in acknowledgement that suicide is a risk factor across the entire spectrum of responses to people impacted by domestic and family violence (including perpetrators), not only a risk for victim/survivors when they are in shelters.

The Queensland Government recognises that domestic and family violence is a gendered issue, with approximately one in six women, and one in 17 men since the age of 15 in Australia experiencing physical violence from a current or former partner.[6] The potential adverse impacts of domestic and family violence can affect everyone involved, including victim/survivors, perpetrators, children/dependants and witnesses to the violence.

AIM

This Suicide Prevention Framework (the Framework) aims to guide practitioners who work with people impacted by domestic and family violence (including both victim/survivors and perpetrators) in Queensland, to effectively support people who may be at risk of suicide.

Domestic and family violence specialist workers are not expected to be experts in suicide prevention. This Framework is intended to be used as a guide to inform best practice suicide prevention responses and referral to mental health experts, to ensure clients and their children/dependants can access the support they need.

In cases where a client's children/dependants are also being supported, their needs should also be considered. This includes the trauma that may result from witnessing violence or suicidal behaviour, as well as their care in emergency situations.

The Framework is not intended to replace or supersede existing policies, processes, resources or programs that are already in place within organisations. This Framework is not intended to create additional burden for organisations. Whilst the implementation of this Framework will not be a requirement under the *Human Services Quality Framework*, it should support organisations to improve their responses to suicide risk.

GUIDING PRINCIPLES OF THE FRAMEWORK

The principles of this Framework are aligned with the principles of the *Domestic and Family Violence Prevention Strategy 2016-2026*, *Every life: The Queensland Suicide Prevention Plan 2019–2029*, and *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*. This includes:

- Safety of the client, their children/ dependants and their extended family is paramount.
- Suicide prevention is everyone's responsibility.
- Co-designed initiatives between practitioners in mental health, suicide prevention, domestic and family violence sectors and people with lived experience are more effective and result in better outcomes.
- Responses to suicide prevention should be cross-sectoral.
- Clients should have access to appropriately skilled support services that are responsive to their needs.
- Staff are supported to provide adequate and considered responses to suicide risk assessment and referrals.
- The safety and wellbeing of workers is a priority.

SELF-CARE FOR PRACTITIONERS WORKING WITH PEOPLE WHO MAY BE AT RISK OF SUICIDE

Practitioners can support clients to avoid harm and make positive choices, ultimately however clients may make their own decisions.

Supporting someone who may be at risk of suicide should never be the sole responsibility of one person. This Framework outlines guidance for referring and seeking further support for clients where suicide risk is present.

Vicarious trauma can occur when practitioners are exposed to trauma from a person they are supporting, and can lead to a practitioner experiencing a range of negative effects. This usually occurs over an extended period of time and exposure.

Practitioners should take steps to support themselves, especially following an interaction where suicide is discussed.

These steps can include:

- Sharing responsibility for providing the support
  - Where possible, family, friends or clinicians of the client should be involved in the support process
- Talking about the situation
  - Discussions with a trusted colleague, family or friend can help alleviate pressures of the situation
  - Practitioners should ensure to not disclose any confidential information
- Professional support
  - Referrals to mental health care services or counselling services can be provided via General Practitioners
  - Counselling services may also be able to be accessed through employee assistance programs

FRAMEWORK OVERVIEW

SCREENING

Suicide risk screening is used to identify whether there is risk of suicide present and should always be considered as part of routine risk screening processes when working with people impacted by domestic and family violence.

- Ask direct questions
- Observe presentation and behaviours
- Consider warning signs and risk factors such as:
- looking for ways to hurt or kill oneself
  - talking and writing about suicide or death
  - feelings of hopelessness
  - expressing rage, anger or revenge
  - engaging in reckless or risky behaviours
  - previous suicide attempts or self-harming
  - drug and alcohol misuse
  - withdrawing from friends and families
  - quitting activities that were previously important
  - putting affairs in order
  - anxiety or agitation
  - abnormal sleep patterns
  - dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness, or depression
  - writing a suicide note or goodbye letters to people
  - Relocation of children/ dependants to the care of others.
- Consider impact of domestic and family violence on the client's mental health and ability to seek support
- Gather appropriate information
- Consider if further assessment or intervention is required

Suicide risk screening is an ongoing process, and the level of risk may fluctuate. This reflects the ongoing and complex nature of domestic and family violence, as well as other risk factors.

ASSESSMENT

If the risk screening process identifies that there may be risk of suicide, a thorough suicide risk assessment needs to take place by a clinician or relevant professional to inform appropriate safety strategies, referral options and treatment.

Referral pathways should be utilised to support a client at risk to receive a comprehensive mental health risk assessment from a specialist clinician

DIVERSE AND/OR HIGH RISK GROUPS

Some Queenslanders may face additional risks and barriers to seeking support, this includes people who identify from diverse and/or high risk groups.

These groups could include:

- Aboriginal and Torres Strait Islander people
- Culturally and Linguistically Diverse people
- People with disability
- People with an identified mental illness
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer people
- Children and young people
- People living in regional, remote and rural locations

Intersectionality recognises that the characteristics of these groups are not independent, and create complex interactions that may change the way a person experiences domestic and family violence or their risk of suicide.

RESPONSE + REFERRAL

PRIMARY RESPONSE — immediate risk

- If immediate suicide risk is identified and/or the client declines referral, thorough suicide risk assessment and/or safety planning – call 000 for assistance
- Where possible, remove access to lethal means
- Consider the location of the client and their access to support

SECONDARY RESPONSE – referral to a clinician or relevant mental health specialist for further assessment and treatment or development of a safety plan

When discussing referral options:

- Listen to the client's needs, including the needs of their children/dependants
- Consider any cultural or diverse needs of the client
- Ensure that referral will not risk their, or anyone else's safety
- Discuss alone, in private and use non-judgmental language
- Provide a range of options and clearly explain the referral process.

Referral pathways should include hospital emergency departments, mental health practitioners, medical practitioners, specialist mental health services, Mental Health Access Line (1300 642 255), and relevant non-government suicide prevention services.

Where practitioners are continuing to support a client where suicide risk has been identified, the client should be supported to develop a collaborative suicide safety plan. The plan is recommended to include, but not be limited to, safety contacts, lists of relevant support services available in their community, and safety strategies for when the client is experiencing vulnerability to suicidal ideations.

A useful suicide safety plan template that a client could be supported to use can be found at https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

TERTIARY RESPONSE — providing information regarding further support

Where risk is identified, but it is not considered that intervention or referral is required, practitioners should take steps to support the client moving forward. The client at risk should be made aware of the services available for them to seek further support or self-refer at any time. This may include the following services:

- **Lifeline** – 13 11 14
  www.lifeline.org.au/gethelp
- **Suicide Callback Australia** — 1300 659 467
  www.suicidecallbackservice.org.au
- **Mensline** — 1300 789 978
  www.mensline.org.au
- **Beyond Blue** — 1300 224 636
  www.beyondblue.org.au
- **SANE Australia Helpline** — 1800 187 263
  www.sane.org
- **Qlife (LGBTIQ+)** — 1800 184 527
  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

ONGOING CONSIDERATIONS

Risk of suicide is not a static event, and may fluctuate as circumstances change for a person.

Ongoing suicide risk screening is particularly important during periods of increased risk.

Client-driven and client-directed practice should always be considered in determining appropriate support responses for a vulnerable client.

Continue to gather information about suicide risk and use this to inform any further action.

RISK SCREENING AND ASSESSMENT

The delivery of quality, timely, and appropriate suicide risk assessment, management and ongoing care is vital to a comprehensive cross-sectoral approach to suicide prevention. Noting this, risk screening should not be used in isolation to determine treatment decisions and services should use all available options to support clients who may be at risk of suicide.

It is common practice for practitioners that work with people impacted by domestic and family violence to have routine risk screening and risk assessment processes in place however, screening for domestic and family violence risk is different to screening for suicide risk.

Suicidal ideation is where a person has had serious thoughts about taking their own life. People who have suicidal ideation and who have made suicide plans are at increased risk of suicide attempts.[7]

Clinical research supports that talking to someone about suicide and suicidal thoughts, can reduce (not increase) their risk of suicidal ideation.[8] Despite this, it is important for there to be consideration about the language used when discussing suicide with clients. It is recommended that conversations about suicide are direct and take into account cultural considerations.[9]

The experiences of people impacted by domestic and family violence may cause them to be reluctant to discuss their mental health or suicidal ideation and behaviours. It is important when engaging with people who may be at risk of suicide, that the language used by practitioners is trauma-informed and does not attribute any blame to the client. Language should be supportive and inclusive, in a culturally safe and appropriate context.

It is expected that practitioners provide respectful and appropriate service delivery responses. While personal attitudes towards suicide may vary, this should not impact the support provided to vulnerable clients who may be at risk of suicide.

Where a parent has a mental health or suicide concern, including drug and alcohol misuse issues, the risk impact on children and planning for their needs is also necessary. Children of Parents with a Mental Illness (COPMI) is an identified population with increased risk of mental health concerns. Further information to support COPMI can be accessed through Emerging Minds https://emergingminds.com.au/

Risk Screening

Suicide risk should always be considered as part of routine domestic and family violence risk screening processes when working with people impacted by domestic and family violence (including victim/survivors and perpetrators). Where there are multiple risk screening processes, such as domestic and family violence risk screening and suicide risk screening, practitioners should ensure these processes work in collaboration and consider one another to increase safety for clients. This includes considerations such as the risk of re-traumatising a victim/survivor, contradicting advice, and continued involvement with the client.

Suicide risk screening is used to identify whether there is risk of suicide present, it is not intended to replace the need for a more comprehensive suicide risk assessment by health practitioners.

Routine suicide risk screening should occur from first contact with a client, and as part of ongoing service delivery. Risk of suicide is not a static event, and may fluctuate as circumstances change for a person. Ongoing suicide risk screening is particularly important during periods of elevated risk, such as separation from a partner. For victim/survivors, this may also include contact with a violent perpetrator, or further exposure to domestic and family violence, and for perpetrators, it may include risk of the victim/survivor leaving the relationship or loss of control. It is important to consider that elevations in risk may be different in different circumstances and should be considered on a case-by-case basis.

The interaction between suicide risk and domestic and family violence risk is complex. The mental health of a victim/survivor of domestic and family violence may be compromised for a variety of reasons, including due to the experience of trauma or abuse, or as a result of targeted abuse from a perpetrator.

Some forms of abuse used by a perpetrator may specifically aim to compromise a victim/survivor's mental health. This includes denial of access to support or medical needs and requirements (such as disability equipment, communication devices, wheelchairs), including through financial control, or by a perpetrator threatening suicide.

Emotional manipulation (sometimes referred to as gaslighting), threats of suicide and other forms of psychological abuse may directly or indirectly prevent a victim/survivor from seeking support. People who are unable to receive support or access medication, may also turn to illicit drugs or alcohol as a form of self-medication in response to physical or emotional abuse.[10]

Research suggests that direct questions about suicidal thoughts or behaviours are appropriate and do not increase the risk of suicide.[8] These questions should gauge the presence of suicide intent, as well as if the client has a plan for suicide. These are key factors to determining the level of risk. The context and environment in which discussions of suicide take place should be considered to ensure a safe place. If a client is displaying suicidal behaviours or thoughts in a group setting, a private conversation should be initiated immediately following the end of the session to further explore the risk.

When screening for risk of suicide, direct questions should be asked about previous history of suicidal thoughts or behaviours, the presence of risk factors, any current suicidal thoughts, if a suicide plan has been made, and the existence of protective factors.

Suicidal ideations may arise in people impacted by domestic and family violence where their experience has been ongoing and they feel there are no other options.

Warning Signs and Risk Factors

A person at risk of suicide may display various behaviours and experience various emotions and may verbally deny suicidal ideation or previous attempts.

Therefore, the following warning signs and risk factors may indicate a person has elevated suicide risk and requires a thorough assessment:

- looking for ways to hurt or kill oneself
- talking and writing about suicide or death
- feelings of hopelessness
- expressing rage, anger or revenge
- engaging in reckless or risky behaviours
- previous suicide attempts or self-harming
- drug and alcohol misuse
- withdrawing from friends and families
- quitting activities that were previously important
- putting affairs in order, e.g. giving away possessions, especially those that have special significance for the person, or relocating children/dependants to the care of others
- anxiety or agitation
- abnormal sleep patterns
- dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness, or depression
- writing a suicide note or goodbye letters to people.[11]

Suicide risk factors most commonly experienced by people impacted by domestic and family violence may include (but would not be limited to):

- Loss of accommodation and risk of homelessness (e.g. where a victim/survivor or perpetrator may have left a relationship by choice or as a result of a court order, and is in temporary accommodation or a shelter)
- Contact with the criminal justice system
- Separation from partner and/or family
- Experience of trauma and abuse
- Experience of non-fatal strangulation including injuries (e.g. acquired brain injury)
- Removal of children
- Experience of sexual abuse
- Control from perpetrator during pregnancy and early parenthood
- Experience of reproductive coercion (e.g. where contraception is deliberately thrown away or tampered with, threats and use of physical violence if contraception or other safe sex methods are used, emotional blackmail, forcing sex, termination of pregnancy or to continue an unwanted pregnancy)
- Loss of family relationship due to cultural 'shame' of domestic and family violence
- Experience of coercive control
- Symptoms of depression stemming from experience of domestic and family violence
- Knowing someone who has died by suicide.

Additional warning signs and risk factors can be found at https://www.beyondblue.org.au/the-facts/suicide-prevention/feeling-suicidal/suicidal-warning-signs

People impacted by domestic and family violence often face barriers to seeking support, both for their experience of domestic and family violence and for their mental health. These barriers can include fear of additional abuse, shame or humiliation, threats from perpetrators, cultural stigma, and not knowing what support is available. Some groups may face additional unique barriers. Considerations for working with these groups have been included in the 'Working with Diverse and/or High Risk Groups' section later in this Framework.

Perpetrators of domestic and family violence may use threats of self-harm and suicide as a form of control and abuse over the victim/survivor. There are further lethality factors to be considered when a perpetrator threatens to kill themselves, as in some cases, perpetrators may endanger not only themselves, but also victim/survivors and/or children.

When working with perpetrators, the real risk of suicide must always still be considered and appropriately responded to, to safeguard both the perpetrator and others who may also be at risk. This risk is especially heightened during a relationship breakdown and separation.[12] The Death Review and Advisory Board 2018-19 Annual Report found that approximately 50% of intimate partner and collateral homicides between 2006-07 and 2018-19 occurred where actual or pending separation was present.[3] The safety of the perpetrator's partner or children must therefore be considered as well. In some cases, there is a risk that domestic and family homicide may occur at the same time as suicide.

People impacted by domestic and family violence may have past and ongoing trauma that increases their risk of suicide, and suicidal thoughts and behaviours. This can include personal and cultural trauma. Trauma should be identified and recognised, through respectful and culturally appropriate language and discussion.

As people impacted by domestic and family violence may be in contact with a wide variety of professionals, not all are expected to be able to provide a thorough risk assessment. Implementing preliminary risk screening enables practitioners working with people impacted by domestic and family violence to make informed decisions about the best way to further support a person at risk of suicide.

Societal and environmental factors may also influence risk of suicide. For example, pandemics or natural disasters, and advice or government directives taken in response, may increase isolation and limit access to family, community and support services and place a vulnerable person at increased risk of experiencing domestic and family violence and of suicide. Where relevant, external influences such as pandemics and natural disasters should be considered with respect to any additional risks they may present.

Children/dependants in families impacted by violence can be both directly and indirectly impacted. Their exposure to risks, harm and safety must also be assessed to inform safety planning including notification to Child Safety (where relevant).

Privacy and Confidentiality

Information gathering during this process is essential and must always have consideration to the added complexity of domestic and family violence risks. Information gathered should be recorded and used to identify any changes in behaviours or risks.

Care must be taken to ensure a client's privacy and confidentiality with respect to any sensitive information collected while supporting them. Any personal information shared with another organisation should be done so with regard to relevant organisational privacy and information sharing protocols. If sharing information with another service for referral, consent must be obtained from the client in the first instance.

Sharing information without consent should be considered on a case-by-case basis, and must adhere to any relevant legislation.

Relevant information sharing legislation may include (but would not be limited to):

- *Information Privacy Act 2009*
- *Domestic and Family Violence Prevention Act 2012*
- *Child Protection Act 1999*
- *Guardianship and Administration Act 2000*
- *Powers of Attorney Act 1998*

Information sharing guidelines for domestic and family violence risk purposes are available at https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/our-progress/strengthening-justice-system-responses/domestic-family-violence-information-sharing-guidelines

Each case should be considered on an individual basis to determine the most appropriate legislation to support information sharing.

Risk Assessment

If the risk screening process identifies that the client is displaying warning signs or several risk factors have been identified, and there may be risk of suicide, a more thorough suicide risk assessment needs to take place by a clinician or relevant professional to inform appropriate treatment or referral options.

Following screening, a more thorough, evidence-based, risk assessment is completed by a clinician or relevant professional to inform appropriate safety strategies, referral options and treatment.

It is not expected that all practitioners working with people impacted by domestic and family are trained to undertake suicide risk assessments. In this case, referral pathways should be utilised to support a client at risk of suicide to receive a comprehensive mental health risk assessment from a specialist clinician.

The Queensland Government recognises the importance of an integrated service response for people experiencing domestic and family violence. An integrated service response ensures coordination of services and supports across government, non-government services and other community organisations from crisis to recovery. Improving the integration of services is essential for effective risk assessment and response for people at risk of domestic and violence and suicide.

RESPONSE AND REFERRAL PATHWAYS

People who receive emotional support, and have access to mental health services, are less likely to act on their suicidal impulses than those who are socially isolated. Where practitioners identify that someone is exhibiting warning signs, they should:

- ask the client if they are depressed or thinking about suicide
- check if they are seeing a mental health practitioner or taking medication
- assure them they are not alone and there is hope of things getting better
- tell them that they care and encourage them to seek professional help, preferably through a warm referral.

Please note that primary, secondary, and tertiary responses as referred to in this Framework, may have a different meaning in the health context. Please refer to the Terminology for further information.

Primary Response — Immediate Risk

If immediate suicide risk is identified, the client should not be left alone and Triple Zero (000) should be contacted for emergency services. This is also critical for persons at immediate risk of suicide who decline referral, thorough assessment and/or safety planning.

Safety strategies should be considered in the context of the physical location of the vulnerable person, including whether they are in the physical presence of practitioners, or in another location (for example, in contact with the practitioner on the phone).

Additional considerations that practitioners should consider when responding to risk of suicide include, but are not limited to:

- working with the client to ensure them and their children/dependants are in a place of safety immediately
- establish if the client and their child/dependants have recently been exposed to harm/violence. If they have been, a harm impact assessment may need to be undertaken
- making contact, as appropriate and in partnership with the client, with an informal support such as family, a friend or community support person to be with the client until formal interventions are arranged and are present
- ensuring the client is included in and informs decision-making regarding appropriate responses to their current situation and keeping them active and consenting in the management of their situation, including from a mental health and a domestic and family violence perspective.

Consideration to the location of the client should be embedded in organisational policies, especially where support is not being provided in person. People in regional, rural and remote regions of Queensland may face additional geographical barriers to accessing effective support. People seeking support outside of standard business hours for support services may also face additional barriers.

Children/dependants of people at risk of suicide

In emergency situations, practitioners may not have the authority or capacity to care for children in the event that their parent/guardian is at risk of suicide. When a client first presents to a service with a child/dependant, requesting emergency contact details for the child/dependant should be prioritised.

In situations that require emergency services to be involved to respond to a client's risk of suicide, emergency services may also be able to provide short-term care and support for any children/dependants of the client, should the client provide permission for this to occur.

If this is not possible, a practitioner should be guided by the emergency contact details the client has provided for the child/dependent, to identify an appropriate guardian. If an appropriate guardian is unable to be identified or there are child protection concerns present and the client is unable to identify another appropriate guardian, practitioners should contact Child Safety or the Queensland Police Service for further advice.

Reduction and Removal of Access to Lethal Means

Suicide risk can be reduced by reducing access to lethal means. Where immediate suicide risk has been identified, organisations should aim to prioritise lethal means removal and reduction by identifying any potential means of suicide, and where appropriate, developing a means reduction plan.

For services or practitioners who are responsible for the ongoing support or accommodation of clients, and have the appropriately qualified staff, storage and access to medication should also be considered in all safety planning. Where services are storing medication in any capacity, there must be processes in place to ensure that they are stored safely, alongside considered appropriate protocols concerning access restrictions.

While most people accessing support services are able to self-regulate their medication, where applicable, policies and processes should consider the following:

- Storage and dispensation of medications
- Safety of the client and others
- Providing access to information about medications

Policies and processes should consider the level of storage and security required. In circumstances where a person has received a comprehensive risk assessment, and a risk of suicide has been identified, stricter guidelines may be required.

When developing these policies and procedures, services should also ensure that all relevant legal instruments are adhered to.

Services should ensure that the quality of their broader service provision in supporting clients meets the benchmark set out by the *Human Services Quality Framework* https://www.communities.qld.gov.au/industry-partners/funding-grants/human-services-quality-framework. Standard 4 outlines the expectations for organisations when supporting the safety, wellbeing and rights of clients.

Secondary Response — referral for further assessment and treatment or development of a safety plan

Access to appropriate clinical services and care or community organisations who offer inclusive supports around suicidality is essential for people at risk of suicide. Culturally appropriate and sensitive pathways should be maximised when working with clients who identify as culturally, linguistically, sexually or gender diverse to support more positive outcomes.

While practitioners working with people impacted by domestic and family violence may have some suicide prevention and intervention experience and training, they are still not expected to be experts and relevant referral pathways should be in place to effectively support clients.

When discussing referral options with a person affected by domestic and family violence, the person's individual needs, as well as the needs of their children/dependants, should be explored, considered and steps should be taken to engage appropriate services for support. Discussions regarding referral options should be in private, and use non-judgmental language. Clients should be provided information and service options, as well as supported to make connections as part of the referral process as needed.

Warm or supported referrals are recommended in this instance to improve the uptake of support services and ensure the client receives the support they need.[13]

Supporting people who are at risk of suicide through care is extremely important. Where practitioners are the first point of contact in the support system for a person at risk of suicide, additional considerations are needed to ensure that steps taken to mitigate the risk of suicide and risk of further exposure to domestic and family violence do not counteract each other.

Practitioners should have policies in place that outline their referral pathways. When making referral decisions, considerations should include geographical location, level of risk and the client's exposure to domestic and family violence.

Domestic and family violence High Risk Teams are operating in eight locations throughout Queensland including Logan-Beenleigh, Brisbane, Ipswich, Cairns, Mount Isa, Mackay, Caboolture and Cherbourg, and consist of a range of agencies including police, health, corrections, housing, courts, victims assist, youth justice, child safety and domestic and family violence services. These agencies collaborate to provide integrated, culturally appropriate safety response to victim/survivors and their children who are at high risk of serious harm or lethality from domestic and family violence. The teams utilise Queensland's first Common Risk and Safety Framework.

Referral options may include:

- Hospital Emergency Departments
- Mental health practitioners (e.g. psychologists)
- Medical practitioners (e.g. General Practitioners)
- Specialist Mental Health Services (e.g. Public, private and non-government community services) — can be found at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/services
- Mental Health Access Line 1300 MH CALL (1300 642 255) — confidential mental health telephone triage service for Queenslanders that provides the first point of contact to public mental health services
- DFV Integrated Service Response/High Risk Teams (if in relevant location, and the domestic and family violence risk also meets the requirements for referral https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/our-progress/enhancing-service-responses/integrated-service-responses
- The Queensland Mental Health Intervention Project — a joint program between Queensland Police Service, Queensland Ambulance Services, and Queensland Health to prevent and safely manage mental health crisis incidents, while minimising the risk of injury to the general community and agency staff
- Homeless Health Outreach Team — comprehensive assessment, care coordination and clinical intervention for homeless persons in the community who are experiencing mental illness
- National Disability Insurance Agency — the national statutory agency responsible for implementing the National Disability Insurance Scheme, provide support for people with disability. Local offices and contacts can be found at https://www.ndis.gov.au/contact/locations

- Child safety service centres — Where children/dependants require support, regional centres can be contacted. Information for child safety service centres can be found at https://www.csyw.qld.gov.au/contact-us/department-contacts/child-family-contacts/child-safety-service-centres

If practitioners are continuing to support a client where suicide risk has been identified, the client should be supported to develop a collaborative suicide safety plan. The plan is recommended to include, but not be limited to, safety contacts, lists of relevant support services available in their community, and safety strategies for when the client is experiencing vulnerability to suicidal ideations. The plan should support the client's active role in their recovery. Where practitioners are already developing a safety plan for domestic and family violence, the development of a suicide safety plan can be completed simultaneously. Where children/dependants are involved, safety planning should include considerations for their safety, with support from other services or agencies, such as Child Safety or Queensland Health, as needed.

Clients can be supported to develop a safety plan, using these resources and templates:

- https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning
- https://au.reachout.com/articles/how-to-make-a-safety-plan
- https://mensline.org.au/mens-mental-health/making-safety-plan/
- https://sprc.org/resources-programs/patient-safety-plan-template

In some situations and for a variety of reasons, clients may refuse support or referrals. This is ultimately the choice of the client, however the appropriate people or services should be made aware of the situation. Practitioners should attempt to support the person to get in contact with the most appropriate support person or organisation, including family members or friends.

Where efforts to voluntarily engage persons at immediate suicide risk have been exhausted, the at-risk person should not be left alone and Triple Zero (000) should be contacted for emergency services.

Tertiary Responses – providing information regarding further support

Where any risk is identified, but it is not considered that intervention or referral is required, practitioners should take steps to support the client moving forward. When determining appropriate responses, this process should be client-driven and client-directed.A person at risk of suicide should be made aware of the services available for them to seek further support or self-refer at any time. This may include the following services:

- Lifeline — 13 11 14 www.lifeline.org.au/gethelp
- Suicide Callback Australia — 1300 659 467 www.suicidecallbackservice.org.au
- Mensline — 1300 789 978 www.mensline.org.au
- Beyond Blue — 1300 224 636 www.beyondblue.org.au
- SANE Australia Helpline — 1800 187 263 www.sane.org
- Qlife (LGBTIQ+) — 1800 184 527 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

ONGOING MONITORING AND SUPPORT

If a client has received a comprehensive suicide risk assessment and is receiving ongoing support from a domestic and family violence practitioner, ongoing screening of suicide risk is required. Where appropriate, practitioners should incorporate any considerations from the suicide risk assessment, into new and updated domestic and family violence safety plans.

WORKING WITH DIVERSE AND/OR HIGH RISK GROUPS

There may be additional factors to consider regarding suicide risk when working with specific groups. While every individual is different, some may share common risk and protective factors. The considerations below are not comprehensive. Practitioners working with these specific groups should utilise a range of suicide prevention resources to inform how they respond to risk of suicide for these cohorts.

The *Domestic and Family Violence Prevention Strategy 2016-2026* identifies groups who, for various reasons, face either a higher risk of being subjected to domestic and family violence or face greater challenges in accessing support services to help them escape, or recover from, the violence.

Many of these groups also face similar challenges in regard to experiencing and receiving support for suicide risk. Historically, some of these groups may have faced systemic barriers to seeking support including exclusion from policy and support, gaps in data, research and knowledge regarding their experiences with domestic and family violence and risk of suicide and a lack of inclusive and peer-led supports and services.

These groups include:

- Aboriginal and Torres Strait Islander people
- Culturally and Linguistically Diverse people
- People with disability
- People with an identified mental illness
- Lesbian, Gay, Bisexual, Transgender, Intersex and Queer people
- Children and young people
- People living in regional, remote and rural locations

Some Queenslanders may identify with more than one cohort which intersects and increases their risk of experiencing domestic and family violence and suicide. Intersectionality recognises that these characteristics are not independent, and create complex interactions that may change the way a person experiences domestic and family violence or risk of suicide.[14] When supporting clients, intersectionality should always be considered.

When supporting people from diverse and/or high risk groups, nuanced practices may be required to meet their needs. Practitioners should adhere to appropriate cultural practices and language when referencing suicide and mental health.

Practitioners should recognise that there may be a stigma around suicide and mental health in some communities. Individual client and community protocols should be sought and adhered to, to provide effective support.

Training and education provided to practitioners and staff regarding risk screening and assessment, referral pathways and suicide risk, should be culturally appropriate, trauma-informed and supportive of diversity.

This includes utilising language support, cultural practices, and traditional ceremonies as required.

A focus should be given to protective factors, community-led solutions, supports and resources, and improving holistic social and emotional wellbeing.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are significantly over-represented as deceased in domestic and family suicide homicide cases between 2006-07 and 2018-19. In one-fifth (20%) of all domestic and family homicides, the deceased identified as Aboriginal and Torres Strait Islander, which is significantly higher than the proportion (4%) of the Queensland population that identifies as Aboriginal and Torres Strait Islander. In 2015-16 to 2018-19, 15.9% of apparent suicides where domestic and family violence was present, involved a deceased person who identified as Aboriginal and Torres Strait Islander.

The use of appropriate language and cultural protocols is extremely important when engaging Aboriginal and Torres Strait Islander community members, and is unique to each community. For example, some communities refer to mental health as "healthy minds" to remove the negative connotations around mental health issues. Where practitioners are working with these communities, policies and practices should recognise these cultural considerations.

A culturally appropriate approach should emphasise opportunities for self-determination, involvement with community and Aboriginal and Torres Strait Islander leadership. Approaches should be strength-based, locally led and culturally informed.

Aboriginal and Torres Strait Islander people may face cultural trauma as a result of historical discriminatory systems and policies. This may cause mistrust in government and mainstream services. Identifying and recognising this trauma is important for providing effective support.

Intersectionality with other diverse and/or high risk groups is important to be aware of when supporting Aboriginal and Torres Strait islander people. Aboriginal and Torres Strait Islander people have higher rates of disability than non-indigenous people across all age groups.[15] Further, Aboriginal and Torres Strait Islander youth are a particularly vulnerable group to suicide.

Protective factors for this group may include:

- Social connectedness and sense of belonging
- Connection to land, culture, spirituality and ancestry
- Living on or near traditional lands
- Self-determination
- Strong community governance
- Passing on of cultural practices
- Access to Aboriginal and Torres Strait Islander cultural healers and healing methods
- Trauma-informed engagement
- Understanding of suicide
- Conversations about suicide
- Effective early intervention
- Access to Aboriginal and Torres Strait Islander Hospital Liaison Officers.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Widespread grief and loss
- Intergenerational trauma
- Unresolved trauma
- Separation from culture and identity issues
- Discrimination based on race or culture
- Economic and social disadvantage
- Physical health problems
- Incarceration
- Systemic racism

- Interpersonal conflict with community or family
- Grief from deaths of family and/or community members
- Knowing someone who has died from suicide
- Overrepresentation of community in issues such as incarceration and experience with child protective services
- Violence
- Substance misuse.[16]

Culturally and Linguistically Diverse people

People from culturally and linguistically diverse communities may face additional barriers to seeking and accessing support for both domestic and family violence, and for mental health. This is an extremely diverse group, and there are varying risk and protective factors depending on a person's cultural background, however some factors may be shared.

Improving cultural competence through staff training can improve outcomes for both practitioners and clients. Where relevant, practitioners should collaborate with or refer to culturally specific organisations for support.

People from culturally and linguistically diverse backgrounds may face trauma stemming from their experiences in other countries, or their cultural experiences in Australia. Trauma should be identified and recognised when providing support.

Protective factors for this group may include:

- Strong family and social relationships
- Supportive environments and communities
- A qualified interpreter that supports understanding — it is recommended that family members and friends are not utilised in this role.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Difficult migration process and trauma (e.g. persecution or war)
- Resettlement issues including lack of suitable employment, accommodation and social and community support
- Barriers to accessing to public or mental health services
- Language barriers
- Cultural factors that may impact disclosure of violence, including shame, gender roles, fear of retribution and loss of visa status.
- People on temporary visas may have increased barriers to access support or gain financial independence.[17]

People with disability

People with disability experiencing domestic and family violence face a number of unique factors when seeking support for domestic and family violence or suicide. An intimate partner can also be a carer and a perpetrator. People who have an acquired brain injury, (a brain injury that occurred after birth), may also face additional risks.

When communicating with a person with an intellectual/cognitive disability or acquired brain injury, it is recommended to explain suicidal ideations using easy English language.

Protective factors for this group may include:

- A supportive carer
- Strong social and community support
- Access to support through disability system, including support workers (where applicable)
- Access to mainstream domestic and family violence services
- Access to allied health services such as occupational therapists and social workers
- Access to employment services
- Appropriate language for people with disability, including the use of easy English.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Social isolation and loneliness
- Lack of employment opportunities

- Domestic and violence perpetrated by a carer
- Financial hardship
- Discrimination due to disability
- Coming to terms with a disability due to accident or illness in later life
- People with an intellectual/cognitive disability or acquired brain injury who may experience additional challenges in the legal and justice contexts
- Issues with accessibility or inclusiveness of support system
- Experiencing an acquired brain injury
- Low levels of social support.[18]

People with an identified mental illness

People with mental illness may be further impacted by their exposure to domestic and family violence. Some mental illnesses may also be associated with an increased risk of suicide.

Protective factors for this group may include:

- Access to a mental health support system
- Strong social support network
- Access to appropriate medication.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Alcohol and drug use, especially as a coping mechanism for mental illness
- Specific mental illnesses including depression, anxiety, bipolar or PTSD
- Re-traumatising events
- Previous suicide attempts.

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) people

Members of LGBTIQ+ communities are disproportionately impacted by experiences of poor mental health and suicidality. A person's sexuality, sex characteristic and/or gender identity does not lead to suicidal ideation and suicide,[19] but can be attributed to pervasive experiences of social stigma, discrimination, marginalisation, exclusion and violence across multiple clinical, social and institutional settings. This could include homophobia, biphobia, transphobia and interphobia. This trauma, coupled with an individual's life experiences, may lead people within the LGBTIQ+ community to experience suicidality.

Protective factors for this group may include:

- Strong social and community support
- Social connectedness and sense of belonging
- Family acceptance
- Self-acceptance
- Self-determination and bodily integrity
- Access to affirming health care
- Access to ongoing affirmative psychological support, including peer support.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Increased prejudice and discrimination
- Rejection from family and peers
- Victim/survivor of violence related to sexual orientation and/or sex characteristics
- Gaps in research and knowledge regarding the experience of domestic and family violence of people who identify with a non-binary sexuality and identity
- Gaps in research and knowledge about the experiences and needs of intersex people with regards to domestic and family violence
- Lack of understanding in support system of peoples' sexuality, relationships, gender identity and bodies resulting in barriers to accessing medical and mental health services
- Lack of inclusive and peer-led supports and services
- Lack of resources and upskilling for workers, and peer-led intersex organisations
- Lack of cultural safety risk management in services
- Exclusion of non-binary people in historical support and frameworks.

Children and young people

Suicide is the leading cause of death for Australians aged 15-24. Children and young people exposed to domestic and family violence are at increased risk of mental health concerns. This risk is further heightened when they are affected by people in their lives who have suicidal thoughts or have completed suicide.

Children and young people that also identify as LGBTIQ+ or Aboriginal and Torres Strait Islander young people face a much higher risk of suicide. Aboriginal and Torres Strait Islander young people have a suicide rate up to 2.6 times the rate of non-indigenous Australians.[20]

Children/dependants of people impacted by domestic and family violence may experience trauma as a result of witnessing, or being involved in the violence. This can lead to psychological and behavioural impacts, health and socioeconomic impacts, and lead to intergenerational transmission of violence and re-victimisation. This may lead to an elevated risk of suicide.

Protective factors for this group may include:

- Strong positive connection with parents/ guardians or trusted adults
- Positive connection to friend/s or network of supportive peers
- Safety in school
- Awareness of and access to local health/ support services
- Safety in neighbourhood and living area
- Academic achievement.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups, Aboriginal and Torres Strait Islander young people are especially vulnerable to suicide
- Experiencing domestic or family violence
- Experiencing bullying
- Exposure to the Youth Justice system
- Loss of a family member, particularly parents or significant care provider/family member or close friend

Regional, Rural and Remote locations

Queensland's rural and remote population can experience unique challenges. These include social and geographical isolation, limited access to support services, economic uncertainty and hardship, environmental challenges such as extended drought and other natural disasters and reduced employment opportunities.[21]

Protective factors for this group may include:

- Sense of community through community participation and social inclusion
- Community ownership of any initiatives designed to enhance wellbeing
- Positive relationships.

Risk factors for this group may include:

- Intersectionality with other diverse and/or high risk groups
- Economic hardship
- Poor educational outcomes
- Risky behaviours such as alcohol and drug use
- Environmental factors such as prolonged natural disasters
- Limited access to support services
- Low help-seeking behaviours
- Poor/low self-esteem
- Limited access to services.

REFLECTION AND CONTINUOUS IMPROVEMENT

Working with people who are impacted by domestic and family violence who may be at risk of suicide requires continuous growth, learning and improvement. Training and education opportunities for practitioners should focus on protective factors, community led solutions, supports and resources, and the concept of holistic social and emotional wellbeing as a priority.

Best practice continues to evolve as the research base and experience grows. Practitioners should utilise systems such as the *Human Services Quality Framework* (https://www.csyw.qld.gov.au/about-us/funding-grants/human-services-quality-framework) to assess and improve the quality of their support. Cases should be reviewed to identify learnings and strengthen future responses. It is important that all Queenslanders are able to receive the highest quality support for their needs.

The following websites provide additional resources and training for suicide prevention:

- https://www.health.qld.gov.au/public-health/topics/mental-health
- https://www.beyondblue.org.au/
- https://www.lifeline.org.au
- https://www.headspace.org.au/
- https://www.blackdoginstitute.org.au/
- https://www.everymind.org.au/suicide-prevention
- https://suicideprevention.onlinecourses.suicideassessment.com

GUIDANCE FOR EMBEDDING THIS FRAMEWORK

This Framework is designed to support the strengthening of policies and procedures that focus on supporting clients who may be at risk of suicide.

The *Human Services Quality Framework* outlines how to effectively embed standards in an organisation. While the Human Services Quality Framework is only compulsory for specific organisations and the implementation of this Framework will not be monitored via the Human Services Quality Framework, useful tools and resources have been developed for all organisations delivering social services to assist with the development of policies and procedures and quality responses https://www.communities.qld.gov.au/industry-partners/funding-grants/human-services-quality-framework/tools-resources.

TERMINOLOGY

Child/dependent
A person who is the biological child, adopted child, stepchild, or child of a de facto spouse of a parent, guardian or carer.

Client
A person impacted by domestic and family violence who is being supported by a practitioner or service.

Clinician/specialist
An appropriately qualified professional who directly supports patients

Diverse and/or high risk groups
Groups of people who, for various reasons, face either a higher risk of being subjected to domestic and family violence or suicide, or face greater challenges in accessing support services.

Domestic and family violence
When a person in an intimate personal, family or informal carer relationship uses violence or abuse to maintain power and control over the other person.

Human Services Quality Framework
The quality assurance framework for assessing and promoting improvement in the quality of human services in Queensland.

Intersectionality
The interconnected nature of social categorisations such as race, class, and gender as they apply to a given individual or group, creating overlapping and interdependent systems of discrimination or disadvantage.

Lethal means
Access to a method that may facilitate suicide. This may include weapons, medication, and sharp objects and some lethal means may be more dangerous than others.

Perpetrator
A person who has carried out domestic and family violence actions.

Practitioner
A professional working with a person impacted by domestic and family violence.

Primary response
The immediate response a practitioner should undertake when the presence of suicide risk has been identified, and the risk is seen as imminent. It is noted this does not have the same meaning as a ‘primary response’ in the health system.

Protective factor
Something that may decrease a person’s risk of experiencing suicidal thoughts, ideations or behaviours.

Risk Factor
Something that may increase a person's risk of experiencing suicidal thoughts, ideations or behaviours.

Safety Plan
A guide to minimise risk or impacts of an adverse event. This can include domestic and family violence, or suicide.

Secondary response
The second level of response a practitioner should undertake where the presence of suicide risk has been identified, but it is not deemed imminent. It is noted this does not have the same meaning as a 'secondary response' in the health system.

Suicidal behaviour
A range of behaviours related to suicide, including thinking about or considering suicide (thoughts), planning for suicide, intending suicide, attempting suicide and suicide itself.

Suicidal ideation
Thinking about, considering or planning for suicide. This can range from fleeting thoughts to detailed planning.

Suicide
The act of intentionally taking one's own life.

Suicide risk assessment
A comprehensive assessment undertaken by an appropriate clinician or relevant professional to identify the level of risk of suicide.

Suicide risk screening
A method to identify the presence of suicide risk.

Supported referral
Where a practitioner accompanies a client to an initial interview with another service to provide support.

Tertiary response
The third level of response to the presence of suicide risk, where it has been identified that direct intervention is not required. It is noted this does not have the same meaning as a 'tertiary response' in the health system.

Trauma
An emotional response to an adverse event, or events, that impacts a person's mental and physical wellbeing.

Vicarious trauma
The negative impacts experienced by practitioners who are exposed, on an ongoing basis, to trauma from a person they are supporting.

Victim/survivor
A person who has been affected directly or indirectly by domestic and family violence.

Warm referral
Where a practitioner or service makes first contact with another service on behalf of a client, to facilitate the referral and explain to the referral service, the client's circumstances and the reason they believe the client would benefit from the referral.

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APPENDIX A

The following stakeholders have supported the development of the Framework through input and consultation:

Queensland Government Agencies:

- Department of Children, Youth Justice and Multicultural Affairs
- Department of Communities, Housing and Digital Economy
- Department of Education
- Department of Justice and Attorney-General
- Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
- Queensland Corrective Services
- Queensland Health
- Queensland Mental Health Commission
- Queensland Police Service

Non-Government Partners:

- Children by Choice
- Combined Women's Refuge Group South East Queensland
- Domestic Violence Prevention Centre
- Dr Samara McPhedran, Director, Griffith University
- LGBTI Health
- National Multicultural Mental Health Project

Not Now. Not Ever. *Together*

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