SUICIDE PREVENTION
IN
OCCUPATIONAL REHABILITATION
2017 Survey & Report
2019

Your safety is important to us

Interpretation of evidence in this report has inherent demands including reflection on suicide, suicidal behaviour and profound, life changing experiences. We respect that such information can be difficult for people, for a range of reasons and therefore encourage all readers to be mindful that care for others, begins with care for oneself.

If you have experienced suicidality or believe you may enter an acute state of distress by engaging with this material, please wait to speak with your GP, an appropriate treatment provider or Suicide Risk Assessment Australia, to identifying strategies that will allow you to safely engage with these materials.

Australian 24 Hour Crisis Lines

Lifeline – 13 11 14

Suicide Call Back Service – 1300 659 467

Men's Line – 1300 789 978

This document was developed by Suicide Risk Assessment Australia with the important voluntary contributions of Australian Occupational Rehabilitation Consultants. We would like to acknowledge their willingness to share difficult experiences and opportunities to advance the quality of our work. We hope that the development of this framework, training and associated resources allows you to make a difference in the lives of others.

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Contents

Suicide Prevention in Occupational Rehabilitation: 2017 Survey & Report

Message from the Director

Suicide Risk Assessment Australia have a vision to develop and maintain strong collaborative relationships with caring professionals, workplaces and our broader communities with the view of preventing the contexts in which suicide occurs.

Our goals include being responsive to the needs of our partners, delivering services that are evidence based and creating impact. While the focus of suicide prevention can be a challenging topic, we recognise that without purposeful effort, we will not achieve meaningful advances in reducing rates of suicide.

We are committed to continuous improvement and know that together, we can all make a difference in the lives of others.

Carmen Betterridge
Director and Principal Psychologist
Suicide Risk Assessment Australia

Executive Summary

Occupational rehabilitation providers (ORPs) have the capacity to support the delivery of collaborative care, recovery at and return to work, through strategic engagement between treatment providers, employers, insurers and most importantly, workers who may have been injured or have been unwell as a result of their work.

Suicide prevention has received considerable attention in recent years. Despite considerable investment in suicide prevention initiatives across Australia, to date, the role that occupational rehabilitation may play in supporting stakeholders (injured/ill workers, employers, treatment providers and insurers) in identification and intervention has not been advanced.

Suicide Risk Assessment Australia (SRAA) recognised that ORPs are in an exceptional position to identify and respond to individuals evidencing or reporting symptoms of suicidality and self-injury. As such, research was undertaken to understand their experience, capacity and capability to engage and respond to individuals experiencing suicidality.

Key findings detailed challenges associated with the diverse training, skills and experiences of Occupational Rehabilitation Consultants, with 52.5% of respondents stating that they had a brief or no prior training in suicide screening. Rehabilitation Consultants described fear and anxiety relating to working with injured workers who may be suicidal, described feelings including a lack of support from management and not believing that existing systems facilitated suicide prevention activities. It is of little surprise that Rehabilitation Consultants also expressed concern about their ability to remain working in the industry.

This research, synthesised with current evidence-based practice, argues for:

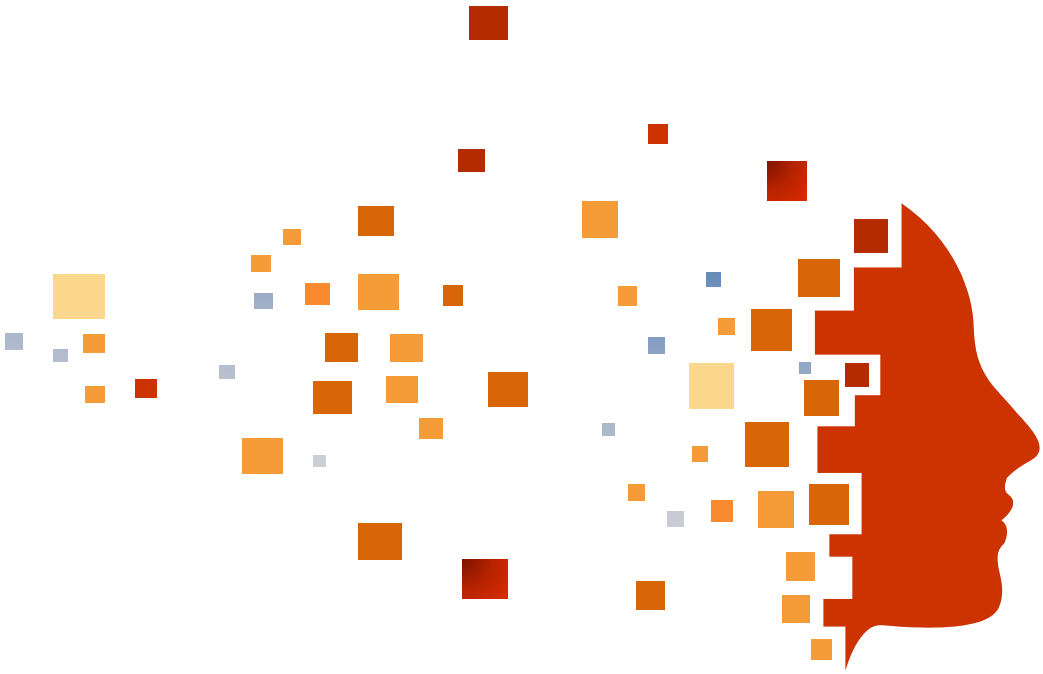
- ✓ Integrated suicide prevention policy
- ✓ Suicide prevention training, specific to the needs of Occupational Rehabilitation Providers and stakeholders
- ✓ Access to suicide specific ('direct') Psychotherapy for clients
- ✓ Supervision, support and capacity to engage self-care for consultants, when needed
- ✓ Data collection, evaluation and suicide surveillance across the industry
- ✓ Holistic intervention framework, with provision to include family and carers in psychoeducation, decision making and Safety Planning

Solutions to these needs have, at least in part, been a focus for SRAA with the development of a range of resources and training, specifically tailored to Occupational Rehabilitation Provider and stakeholder needs, delivered nationally.

The ongoing focus on stakeholder engagement, to support access to evidence-based treatment and collaborative care planning is critical. Similarly, the development of resources such as stakeholder information packs, family and Carers support packs and strategies to assist in transparent and collaborative communication between providers is also ongoing. The development of a Supervision Framework for Rehabilitation Consultants and stakeholders, is underway with the goal of simplifying access to immediate support, via an open access portal.

SRAA continue to research and engage with industry leaders with respect to the need for enhanced data collection and suicide surveillance, across multiple stakeholders and industry. Targeted advocacy for strategic suicide prevention activities within Heads of Workers Compensation Authorities and Safe Work Australia will continue to be a key priority, with the view of working together to build a strong system for collaborative suicide prevention.

It is envisaged that this report will dovetail into existing workplace mental health strategies and suicide prevention activities. Ongoing research and development are an inherent aspect to achieving these goals and associated sustainable improvements for our clients. We can all make a difference!



Occupational Rehabilitation

> ***Workplace rehabilitation is a managed process involving timely intervention with appropriate and adequate services based on assessed need, and which is aimed at maintaining injured or ill employees in, or returning them to, suitable employment***

HWCA, 2015, p.4

In the context of workplace or compensable injury, this process is guided by national and state/territory legislation. Occupational Rehabilitation Providers (ORPs) must adhere to legislation and capability standards, including employing qualified staff to focus on recovery and workplace outcomes (HWCA, 2015). Occupational rehabilitation is a recovery-oriented process, that principally, aligns with the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council, 2017), despite not being explicitly included therein.

ORPs facilitate and coordinate recovery-oriented activities for people experiencing illness, injury and disability. They function as a key link in the communication between stakeholders, namely treatment providers, employers, insurers and the injured worker. The goals of occupational rehabilitation are primarily to expedite recovery for the injured person, returning them to meaningful activity which is often the workplace. The range of activities undertaken by an ORP can be diverse but does not include the provision of treatment, insurance claim management (or determining access to entitlements) or work conditioning activities.

In considering recovery at/ return to work, often the ORP supports determination of whether suitable employment is a return to the pre-injury role or a new role with their pre-injury employer (Same Employer – SE). Alternatively, it may be engaging with a new employer (New Employer – NE). Ultimately, the role must be within the workers' functional capacity, and within their skills education and experience. In circumstances where this is difficult to achieve due to the nature of their injury or capacity, the ORP can assess and facilitate access to available programs or training that may support future employment options. ORPs therefore support workers to contribute to and engage in meaningful activities and promote improved health outcomes.

A comprehensive evaluation of ORPs and services is outside the scope of the current report, however, a principle strategy undertaken by ORPs is case management. These services are delivered by Occupational Rehabilitation Consultants (RC) or Counsellors. The injured worker or client, is supported by the RC to identify recovery goals, ensure they are accessing

necessary treatment and are generally supported in their recovery goals. Some RCs are experienced and qualified to undertake assessments with injured workers' regarding their functional capacity, (physical or psychological), as well as vocational assessments that evaluate and identify the opportunities available to them occupationally.

ORPs also have a critical role in facilitating communication between injured workers, employers, insurers and treatment providers. They draw on research demonstrating that holistic principles of recovery, highlighting early intervention, cohesive and meaningful re-integration, are aligned with improved health and wellbeing outcomes (Andersen, Nielsen & Brinkmann, 2012; Butterworth et al 2011). Evidence demonstrates that the vast majority of injured workers successfully return to work (Social Enterprise Centre, 2016), however, psychological injury is associated with greater complexity, higher claim costs and time off work (Brijnath, et al., 2014; Safe Work Australia, 2015). Further, the longer a person stays off work, the more likely incapacity will persist (Blank, Peters, Pickvance, Wilford & Macdonald, 2008; SWA, 2015; Munoz-Murillo et al, 2018) correlating with increased risk for suicide (Bottomley & Neith, 2010).

Strategies to support recovery at work include liaising with employers about suitable adjustments to the work environment or a workers' duties, whereby there may be reduced functional demands or durations expected of a person to perform certain tasks, or time spent at work.

> *Research has consistently demonstrated that injured workers' who experience the employer as supportive in their recovery process achieve better recovery outcomes*

Wyatt, Cotton & Lane, 2017

Factors influencing the patterns for recovery are many and varied (Collie et al., 2019), with barriers relating to pain and injury severity (Cameron & Gabbe, 2009), the nature of the injury and the workers' self-perception of potential for recovery, as well as the relationships they maintain in the workplace (Comcare, 2016) all relevant. Systemic factors, including poor communication, 'red tape' and processes examining the validity of the injury implicated as barriers to recovery (Brijnath, et al., 2014; Wyatt et al., 2017).

Injured workers require adequate, evidence-based treatment to maximise their potential for recovery to full pre-injury functioning. The absence of adequate, evidence-based treatment may contribute to functional impairment and suicidality (Mishara & Chagnon, 2016). Of note, there is potential for workers to initially present with a physical injury or complaint, with secondary psychological symptoms or disorder emerging thereafter, posing additional layers of complexity (Brijnath et al, 2014).

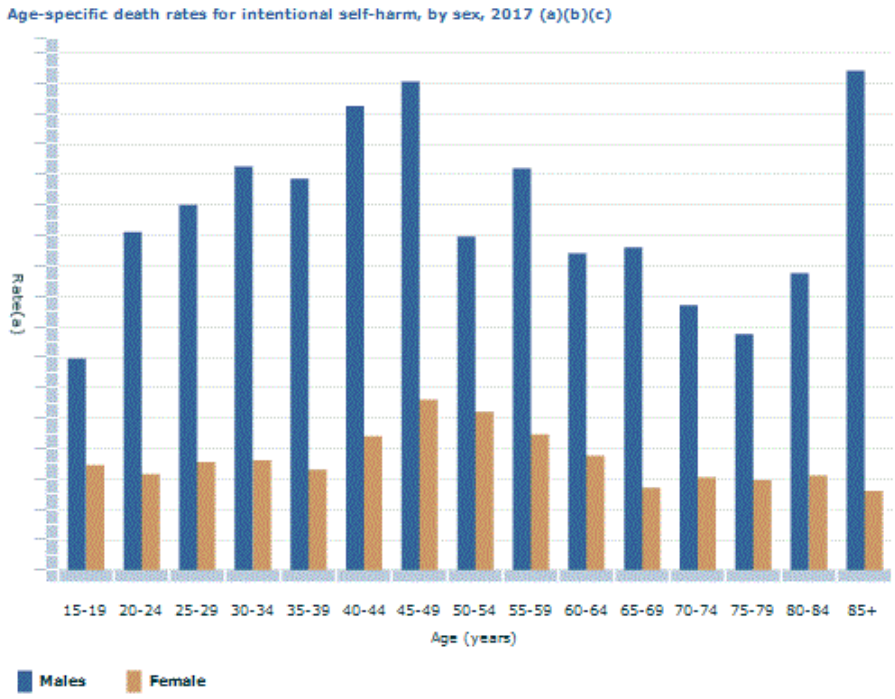
Access to treatment and occupational rehabilitation is often via compensation schemes. This may be further complicated by the adversarial nature of these system, seeking to prove or disprove the causal factors related to the injury or illness (Brijnath, et al., 2014). Oftentimes,

ongoing access to psychological treatment is reliant upon causal evidence of psychological injury. Engagement in the compensation process has been argued to be onerous, stressful and potentially iatrogenic (Brijnath, et al., 2014; Kilgour, Kosny, McKenzie & Collie, 2015) though it is also noted that sampling bias may, at least in part, reflect the poorer health and recovery outcomes in this cohort (Elbers, Hulst, Cuijpers, Akkermans & Bruinvels, 2013).

Suicide in Australia

Suicidality is a complex behaviour. For a long time, suicide has been a taboo subject – both privately and publicly. Suicide prevention has remained in the domain of psychological treatment providers. The role of employment, family and the community has been overlooked. Even people experienced in mental health practice can lack the confidence to talk with clients about suicidality. Despite these factors, all members of the community have the capacity to make a difference to the lives of others, including Occupational Rehabilitation Providers (ORPs), in ensuring that claimants and injured workers (clients) receive collaborative and appropriate care.

In Australia, suicide is the leading cause of death for people under 44 years of age. The graph below reflects suicide deaths, by age and gender. Men account for the highest proportion of deaths by suicide, approximately three men to every woman across the lifespan.



Age specific death rates for suicide by gender

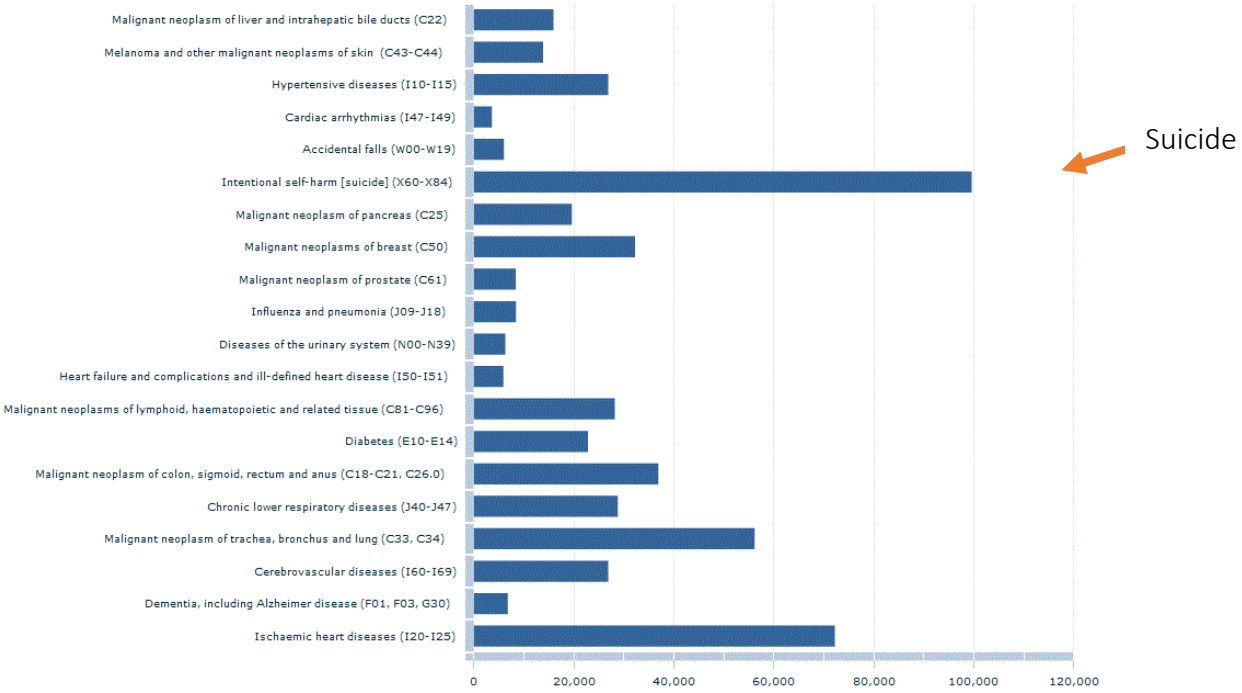
ABS, 2018

Approximately 180 people engage in suicide behaviour daily in Australia, between eight to ten Australians die every day by suicide, and approximately 90 people are hospitalised per day due to suicide behaviours (ConNetia, 2016).

Aboriginal and Torres Strait Islander peoples are seriously over represented in the statistics, accounting for 26.7% of all deaths of children and young people between the ages of 5 and 17 years (ABS, 2017).

In relation to Years of Potential Life Lost (YPLL), the graph below clearly evidences the role suicide (intentional self-harm) has with respect to premature mortality.

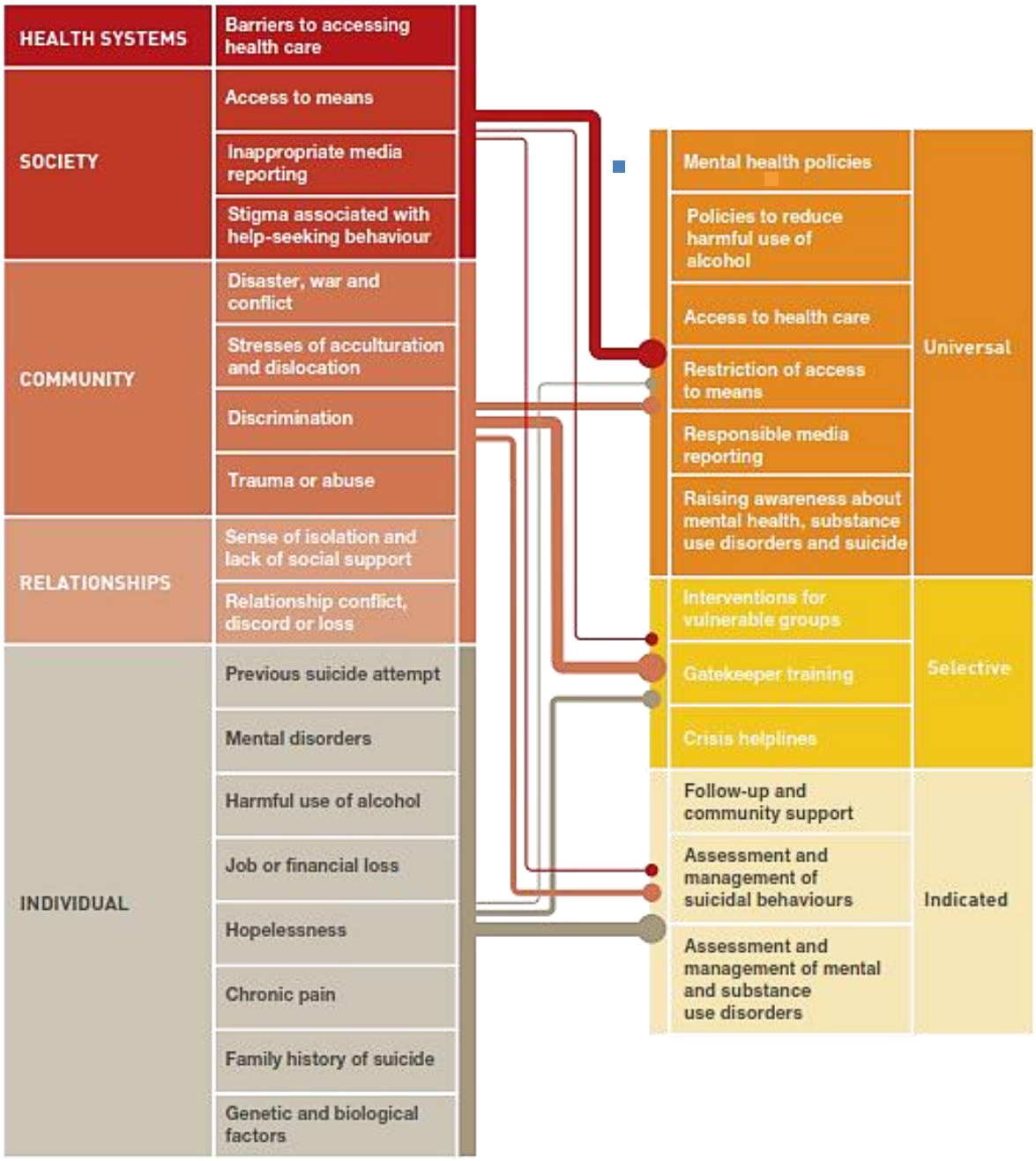
Leading Causes of Death and Years of Potential Life Lost (YPLL) 2016



Leading Causes of Death and YPPL

See (ABS 2017) for explanatory footnotes (a)(b)(c)(d)(e)

Major risk factors for suicide aligned with interventions



Major risk factors for suicide aligned with interventions

WHO, 2014

ORPs acting across various aspects of their roles, have the capacity to deliver services across universal, selective and indicated interventions, from ensuring all employers and stakeholders are aware of factors influencing potential suicidality (such as use of language, stigma in the workplace etc), through to advocating for gatekeeper training within workplaces, availability of Employee Assistance Programs and other selective strategies.

Impacts of suicide and suicidality

Recent research into the impact of suicidality on families, communities and the workforce evidences severe consequences to those bereaved, also known as 'survivors'. Exposure to suicidality can result in enduring distress and increased risk for suicide in survivors (Maple, et al., 2016), with each suicide potentially impacting up to 135 others (Cerel, 2016), this is a major concern. The Ripple Effect research evidenced that people experienced high levels of distress over long periods of time, and in some instances, decades (Maple, et al., 2016). While grief can be lifelong and follow a non-linear trajectory, people were noted to experience an improvement in the severity of their grief approximately five years following the loss. The Ripple Effect research made recommendations to provide specific post-suicide bereavement support in recognition of the risks to those left behind. The workplace has the capacity to support such efforts.

Suicide Prevention

Research from around the world have identified a number of key areas where we can make a difference in terms of suicide prevention. Below are a few suicide prevention activities highlighted by the World Health Organisation (WHO, 2014) and Suicide Prevention Australia as important to achieving meaningful reduction in suicides.

- Increasing accessibility to healthcare and support. This includes education about available services through broad reaching community education programs.
- Addressing how suicidality is communicated: reducing stigma, increasing help seeking, challenging damaging media reports and inappropriate social media use and ensuring conversations and communications promote available services and interventions.
- Implementation of policies and procedures: not only in relation to suicidality, but those factors known to be risk factors for suicide, such as substance dependence, bullying and harassment, and discrimination. In addition, policies supporting identification and recovery, such as access to Employee Assistance Programs, Wellbeing initiatives and Gatekeeper training.
- Inclusive workplaces where the culture supports disclosure, help seeking and timely provision of support.
- Restricting access to methods/means.
- Recognising the importance of Lived Experience in not only developing and informing strategies implemented, but the importance of timely support.

Underpinning these points (and many other prevention activities) is that suicide prevention is "everyone's business". Indeed, it is argued that universal screening for suicidality has the potential to profoundly reduce the frequency of undetected suicide risk (Horowitz, Roaten, Pao & Bridge, 2019). Universal screening could be readily incorporated into settings where medical care is delivered (Horowitz, et al., 2019), including ORPs.

Treatment for Suicidality

There are a range of interventions that have been investigated with the view of reducing suicidal ideation and behaviours. It should be noted that when examining treatment interventions, evidence-based and evidence informed practice is of the utmost importance. Psychotherapies must be evaluated for efficacy with sound methodological underpinnings for all research. In addition, the treatment efficacy research must be undertaken with populations or cohorts reporting suicidality, where suicide specific symptoms are monitored for change (for example, reductions in frequency of ideation, severity of harming behaviours, self-injury related hospital admissions etc). An understanding of the mechanism for change can then be directly attributed to the intervention, rather than due to another moderating or confounding factor. While a treatment may evidence reductions in psychological symptoms, this is not consistent with reductions in suicidality per se (Meerwijk, et al., 2016). Further, treatment must evidence that it causes no harm. Although these expectations are the foundation of sound scientific principles, they are not consistently demonstrated in the literature and therefore, problematic interpretation has emerged, when translated into practice.

Below is a summary of available evidence and while it is certainly not exhaustive, has been drawn from research evaluated for scientific rigour, including meta-analysis, systematic reviews and randomised control trials. Such research is of the highest quality, validity and value to suicide prevention efforts.

Psychotropic Medication

There have been inconsistent research findings regarding psychopharmacotherapy and the efficacy in preventing suicide. Most research appears to focus on 'indirect' treatment approaches; treating the psychological symptoms that may co-occur with suicidality without addressing the suicidality specifically (Jurdi, Swann & Mathew, 2015). Current evidence notes;

> "It has been clearly demonstrated that psychopharmacological interventions do not assist with reducing reattempts of suicide"

Fishburn & Barker, 2019

As such, psychopharmacology may assist with reducing underlying psychological symptoms or distress, however, there is no evidence for suicide prevention per se. There are some medications that have been trailed for potential 'ant-suicide properties', including Ketamine, however these are not yet readily endorsed specifically in the treatment of suicide behaviours. As such, pharmacotherapy is recommended to coincide with other psychotherapeutic interventions.

Crisis and Brief Interventions

Brief interventions are up to three sessions, delivered proximally to the individual's suicidal crisis and have demonstrated efficacy in reducing suicide deaths and suicide attempt (McCabe, Garside, Backhouse & Xanthopoulou, 2018; O'Connor et al., 2018). While there is limited research in this domain, there is evidence that brief interventions, including Safety Planning, result in fewer suicide attempts and reduced likelihood to die by suicide in the 12 months following the intervention, despite the ongoing presence of suicidal ideation (McCabe, et al., 2018). Of note, psychotherapy should dovetail and compliment brief interventions, as the effects are not sustained independently (without psychotherapy) after 24 months (McCabe, et al., 2018).

Safety Planning (Stanley & Brown, 2008) and Crisis Response Planning (Bryan, et al., 2017) are very similar in design, with only Crisis Response Planning having undergone randomised controlled trials. SRAA conducted an evaluation of these models against a lesser known and inferior intervention, confirming current practice and international consensus that Safety Planning and Crisis Response Planning are appropriate for administration with clients.

Means Restriction Counselling is a process by which a person is encouraged, through collaborative discussion, to remove, reduce or disrupt their access to the method for suicide. There is considerable evidence that if a person is experiencing increased thoughts of suicide that accessibility of means for suicide may result in suicidal behaviour and potentially death (Hawton, 2007).

Brief contacts can involve support offered to clients via postcards, telephone calls and letters. These brief interventions, although simple and nurturing, were not found to have a significant positive reduction in suicide attempt, according to a systematic and meta-analytic review (Milner, Carter, Pirkis & Robinson, 2015). As such, no endorsement for these types of brief interventions can be offered as independent suicide prevention strategies, though they may assist in maintaining client engagement.

Crisis Intervention, whether that is for suicidality or another difficulty, has the goal of stabilising the crisis and fostering an opportunity of learning and growth (Granello, 2010; O'Connor, et al., 2018). Crisis intervention is expected to engage effectively with the client, understand the factors causing distress and support problem solving and action. Granello (2010) makes the observation that crisis intervention is not necessarily linear in approach, but also should move from being directive to more collaborative in nature.

Brief interventions do not require any extensive psychological intervention training, skill or knowledge for delivery (that is, they do not need to be Psychologists, Psychiatrists or Mental Health Practitioners). These interventions offer defined strategies to a support person collaboratively and within a relatively brief interaction. It is essential that people delivering brief interventions possess or are trained in techniques including engagement, communication and rapport building.

Psychotherapy

Psychotherapeutic treatment is undertaken by appropriately trained and qualified clinicians, who may be Psychologists, Psychiatrists or other mental health clinicians with endorsement in counselling therapies.

'Direct' treatment approaches to suicidality describe psychotherapy that focuses directly on a person's desire for death, suicidal ideation and behaviours, working with them to learn strategies to cope with those thoughts and behaviours. 'Indirect' treatment works to target reductions in the distress that may co-exist with suicidality, that is, delivering treatment for depression, anxiety, pain or hopelessness, with the view for example, that reductions in depressive symptoms correlates with reductions in suicidality. Evidence has demonstrated that safety from suicide is only reliably achieved in the immediate term, when suicidality was ***directly*** targeted (Meerwijk, et al., 2016). Indirect therapies were found to offer benefit only in the longer term, with 1.5 times greater potential for death by suicide in the immediate term when compared with those receiving 'direct' treatment methodologies.

> "...clinicians working with patients at risk of suicide should address suicidal thoughts and behaviours with the patient directly"

Meerwijk, et al., 2016

Based on these findings, it is therefore strongly advocated for the direct treatment of suicidality, in the first instance. Of course, for Australian's in areas or contexts where access to clinicians trained in Direct therapies is limited, any evidence-based treatment is better than no treatment at all.

There are three psychotherapies endorsed as evidence-based therapies for the direct treatment of suicidality in adults, having undergone the rigors of randomised controlled trails.

Cognitive Therapy for Suicide Prevention (CT-SP) and **Cognitive Behavioural Therapy for Suicide Prevention (CBT-SP)**, utilises the same principles as general CBT, however, ensures treatment addresses cognitions and behaviours associated with suicidality (Brown, et al., 2005; Bryan, 2015). CBT-SP is also noted to incorporate brief interventions, ensuring minimum standards of care (Bryan, 2019).

Dialectical Behaviour Therapy (DBT) was previously synonymous with treatment for people with Borderline Personality Disorder, however, more recently DBT has demonstrated efficacy across multiple presentations and difficulties (Swales, 2018). DBT is evidenced to stabilise suicidal and self injurious behaviours (Panos, Jackson, Hasan and Panos, 2014).

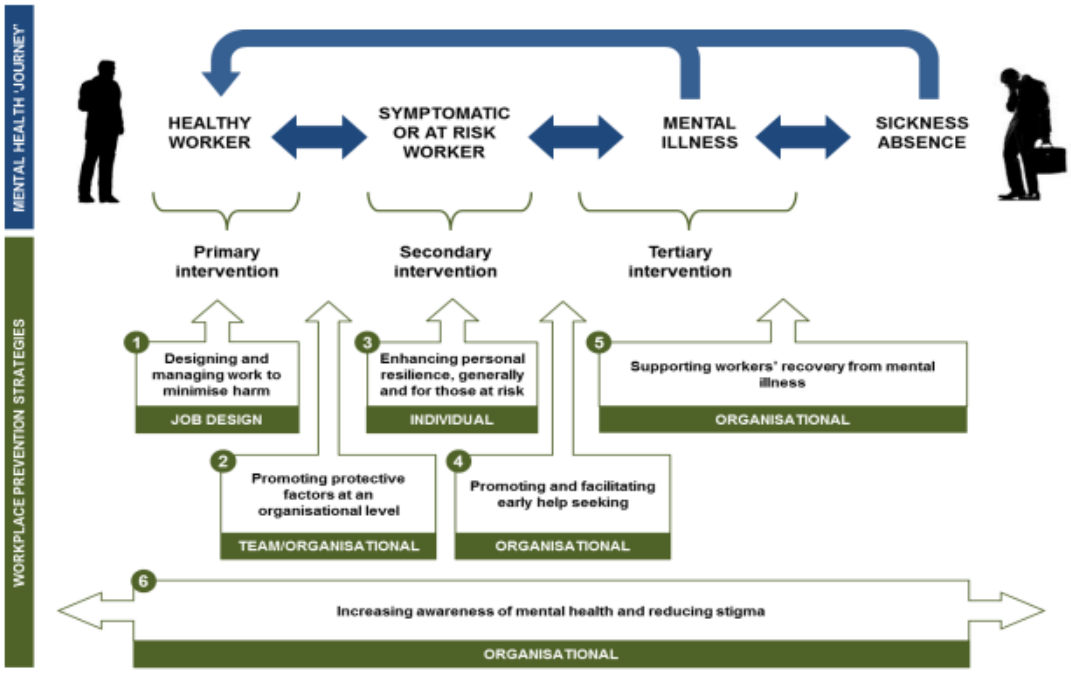
Collaborative Assessment and Management of Suicidality (CAMS) is not widely known within Australia. It is a nondenominational model of psychotherapy, engaging the person to identify factors 'driving' suicidality through "empathy, collaboration and honesty" (Jobes, Piehl & Chalker, 2018).

Although other psychotherapies have been trialled for efficacy in treating suicidality, including Acceptance and Commitment Therapy, research of sufficient methodological rigour is yet to demonstrate whether this is an appropriate treatment approach (Calati & Courtet, 2016).

Some treatment responses have gained approval within the Australian context in the absence of a standard research design, whereby a *Delphi-method* may be undertaken. This involves experts in suicidology developing a consensus with respect to certain areas of practice. The Delphi method may be necessary where conducting research to test a given model is considered unethical or unreasonably impracticable. As an example, the Black Dog Institute developed *Guidelines for integrated suicide-related crisis and follow up care in Emergency Departments and other acute settings* (2017). This guide supports service planning and compassionate responses to people experiencing suicidality when in suicide-related crisis and identifies appropriate assessment and interventions strategies.

Suicide Prevention in the Workplace

There is a necessary call to action to progress workplace strategies beyond mental health promotion and wellbeing initiatives, to include not only extend injury management but include suicide prevention strategies. Despite exceptional information and research supporting the need for early intervention, treatment and recovery at work, suicide specific processes or actions facilitating these goals are often absent, as evidenced in the figure below, taken from *Developing a mentally healthy workplace: A review of the literature* (Harvey, et al., 2014).



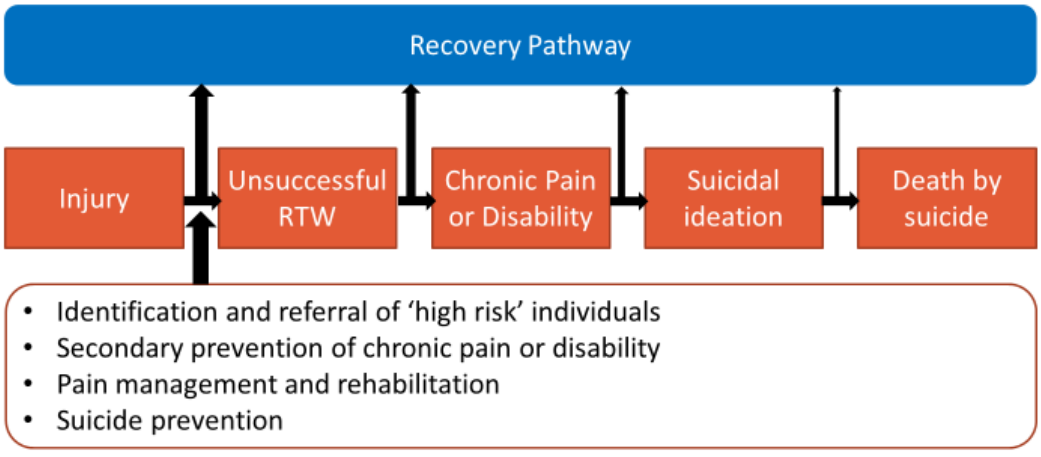
Harvey, et al., 2014

The emergence of excellent resources for the workplace, including Heads-Up (Beyond Blue and the Mentally Healthy Workplace Alliance) and the Black Dog Institute's Workplace Mental Health and Wellbeing program is promising. However, these programs have not included skills-based suicide prevention activities. Suicide prevention has to date, primarily been delivered and implemented through health and education, often after an individual discloses suicidality. More recently, holistic and 'community' based approaches have been developed, including the LifeSpan project (Black Dog, 2017), yet even within that framework, suicide prevention in the workplace has had limited attention.

Suicide is rarely, if ever, attributable to a single causal factor. It is recognised as a complex, multifaceted phenomena that extends beyond the presence or absence of risk and protective factors, to include proximal factors acting to transition suicidal ideation to suicidal behaviour (Joiner, 2005; O'Connor & Kirtley, 2018; Klonsky and May 2015). While a lot is yet to be understood about the development of suicidality, beyond primary prevention in the first instance, there is an urgent need for early intervention and the delivery of support to inhibit the transition from ideation to action, should it emerge.

Research and deductive theorising support the notion that risk factors for suicide may emerge for individuals within certain occupations, for certain demographics and under certain conditions. The workplace offers potential for personalised suicide prevention activities that are measured, monitored and adapted for efficacy. Contextual workplace factors that may predispose or precipitate a worker's development of suicidality should be considered in the first instance. These risk factors include considerations such as low psychological safety, exposure to psychological hazards (such as trauma) and responses to workplace injury (Harvey et al., 2014; LaMontagne & Milner, 2017), with some occupations observed to hold greater risk than others (Milner, Spittal, Pirkis & LaMotagne, 2013).

A model proposed by Davis and colleagues (2013) highlights the potential trajectory from workplace injury to suicide, clearly identifying processes worthy of greater consideration.



Davis, Ibrahim, Ranson, Ozanne-Smith & Routley, 2013

Unfortunately, this model is conceptually limited, with a brief, highly medicalised approach to suicide prevention, failing to incorporate suicide specific intervention principles. Notwithstanding the identified limitations, this model clearly highlights the potential roles for occupational rehabilitation providers, return to work coordinators and treatment providers in suicide prevention initiatives.

With respect to injury, it is noted that the Australian Institute for Suicide Research and Prevention (AISRAP) demonstrated through data gleaned from the Queensland Suicide Registry (QSR) that physical injury plays a significant role in the expression of suicidality, more so than mental disorder (Leske & Kolves, 2018). While this data did not allow for the extrapolation of causal factors in the injury or illness, it remains an important consideration in the context of workplace risk factors for suicide. Further, this data is consistent with findings from Bottomley and Neith (2010) indicating that injured workers that had died by suicide within an 11 year period, had entered the compensation system with physical injuries.

Challenges in introducing mental health initiatives and specifically suicide prevention activities to some workplaces may be due to factors including mental illness and help-seeking stigma (Haugen, McCrillis, Smid & Nijdam, 2017), in addition to difficulties addressing risk factors inherent to the role, as well as lower socio-economic status and education levels of those occupations (Stanley, Hom & Joiner, 2016; Milner, et al., 2013).

It is important to explain that the role of the Coroner does not extend to determining the extent to which a suicide death may be work-related. While work related factors may be explicitly recorded in one case, it may not be recorded in another. Further, not all suicide deaths are even reviewed by a Coroner.

Similarly, workers' compensation schemes are not required to identify, monitor or report on the prevalence of suicidal ideation, behaviour or deaths by suicide for people on claim. There does not appear to be a surveillance system examining the potential relationship between employment, workplace injury, illness or engagement in a compensation or occupational rehabilitation process.

Suicide Prevention in Occupational Rehabilitation

In 2015-16 there were over 100,000 workers' compensation claims lodged to Safe Work Australia, of which 6% were for "mental disorder" (SWA, 2015). Safe Work Australia provide data on workplace fatalities, however, death by suicide is actively excluded from these statistics. There is limited Australian data detailing self-injury and suicide rates associated with or proximal to compensable injury.

Given the above observations, Occupational Rehabilitation Providers (ORPs) and Occupational Physicians may be in contact with people experiencing suicidality, beyond injured workers to include workers who are under-employed, facing demotion, disciplinary proceedings, redundancy and retirement (Baumert, et al 2014; Bottomley, Dalziel, Neith, 2002; Bottomley & Neith, 2010).

In a comprehensive review of the available literature guiding occupational rehabilitation and return to work processes, it was determined that currently, Australia does not have any strategic suicide prevention initiative embedded within these schemes or systems. Despite occasional references to the prevalence of suicide being incorporated into documents for Work Health and Safety, workplace wellbeing initiatives and recovery at work programs, suicide prevention strategies are not appropriately detailed in any publication by Safe Work Australia (SWA), including the *Taking Action: best practice framework for the management of psychological claims in the Australian workers' compensation sector* (SWA, 2018) or the Heads of Workers Compensation Authorities, *Nationally Consistent Approval Framework for Workplace Rehabilitation Providers* (HWCA, 2015). Currently, it is observed that while there may be pockets of activity or consideration for workplace suicide prevention, it remains fragmented at best and absent at worst.

In relation to the management of psychological injury claims, SWA (2018) mentions that claims managers should receive training on identifying and responding to risk of harm and suicide, however, this has not been extrapolated to consider the standards or behaviours expected from such training. There is reference to training available, however, given the concerns expressed by Lund and colleagues (2017) (see over page), these options require review with the provision of extended training components.

HWCA (2015) clearly describes standards expected of Occupational Rehabilitation Providers (ORPs) and their consultants, with respect to their qualifications and holding registration with the Australian Health Practitioner Regulation Agency (AHPRA) or their relevant associations. HWCA (2015) details that consultants should evidence "appropriate skills, knowledge, and experience to deliver workplace rehabilitation services" (HWCA, 2015, p.11) in addition to a range of points pertaining to learning and development, policy and procedures and the availability of appropriate supervision and support. Practice Standards (Appendix 5 of HWCA, 2015) offer additional guidance, for functional, workplace and

vocational assessment. Despite clearly outlining expectations of ORPs in the provision of rehabilitation services, the absence of suicide prevention specific expectations from HWCA and SWA documents, evidences likely gaps in the delivery of strategic suicide prevention services.

Based on these findings, it would appear that the training, experience and skills of Occupational Rehabilitation Consultants (RCs) are varied, inconsistent, and may not meet the needs identified with respect to suicide prevention, nor indeed align with current evidence. This challenge is not unique to Australia. Research was conducted by Lund and colleagues (2017; 2018) in the USA, with respect to the Vocational Rehabilitation Counsellors working with clients experiencing suicidality. It is noted that this research is relevant, yet not directly translatable to Australian contexts for a number of reasons. Firstly, the Vocational Rehabilitation Counsellors (VRCs) sampled, delivered 'treatment' as well as case management services. Further, their clients are more diverse, delivering services to people who are disabled or otherwise impaired (physical, psychological and learning disabilities included). The client's injury, disability or impairment impacts their capacity to secure sustainable employment whereby VRCs support occupational recovery. Despite the differences identified, there are also commonalities, namely with respect to maintaining an occupational recovery focus in the face of functional impairment.

In exploring suicide prevention in vocational rehabilitation, it was found that VRCs engaged with clients reporting suicidality on a weekly basis, on average, yet only half of VRCs described having received suicide specific training or feeling competent and capable of working with clients reporting suicidality (Lund, et al., 2017). Results were similar with respect to clients reporting non-suicidal self-injury (Lund, et al., 2018). Given the frequency of engagement with clients reporting suicidality, Lund and colleagues (2017) concluded that suicide risk assessment and crisis management is "…a critical clinical skillset among rehabilitation counsellors" (Lund, et al., 2017, p.60). In evaluating training needs for VRCs in the USA, skills based, practical and applied suicide prevention training was deemed necessary. Lund and colleagues (2017) reported that 'gatekeeper' training, such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills Training (ASIST) and SafeTALK, although excellent starting points, did not recognise the role of VRCs in their client's recovery, or their greater clinical skills. Specifically, it suggested that more advanced and tailored training was necessary.

Further, this research highlighted the critical role of Supervisors in establishing and maintaining competency in suicide risk identification, assessment and management practice with VRCs, including supporting staff in understanding and responding to the emotional consequences of working with clients experiencing suicidality (Lund, et al., 2017).

The SRAA Suicide Prevention in Occupational Rehabilitation Survey

The Survey and Sample Characteristics

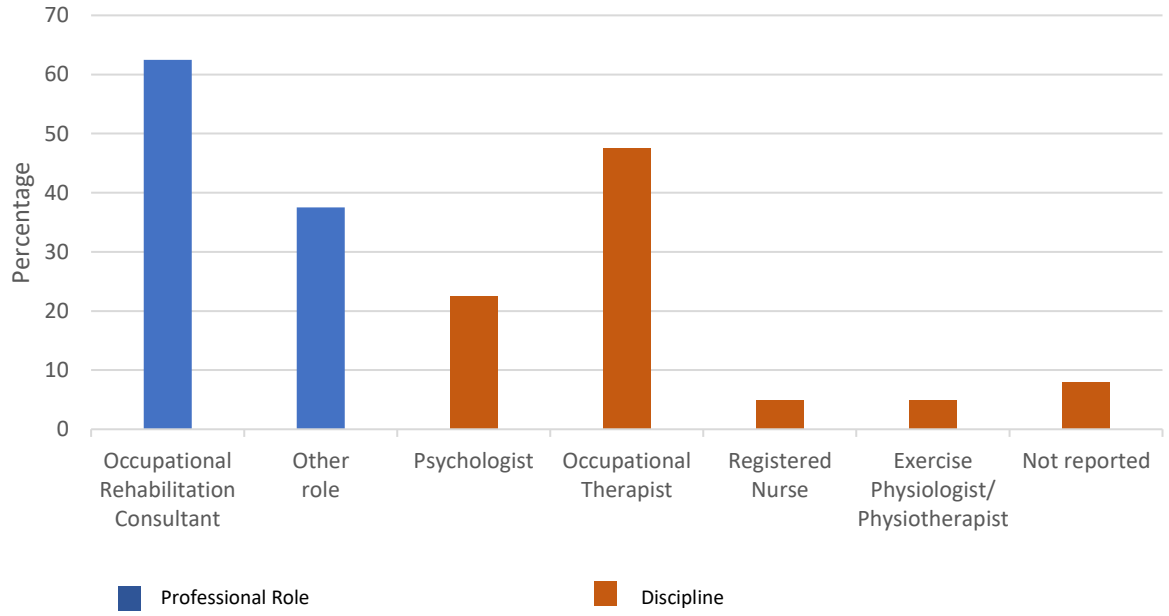
Synthesising the findings from Lund and colleagues (2017) with the aforementioned Australian context, suggests potential limitations in the provision of occupational rehabilitation services to Australian injured workers. As such, SRAA sought to understand the existing skills and experiences of workers within the Occupational Rehabilitation sector with respect to working with injured workers, who may have or are currently, experiencing suicidality. This was undertaken through survey responses and interview, described below.

The survey explored Occupational Rehabilitation Consultants' (RCs) experience in working with clients (injured workers) reporting suicidality. The survey was promoted directly to RCs through LinkedIn, concurrently with invitations to Approved Occupational Rehabilitation Providers[1] across Australia, as identified under each federal, state and territory scheme.

All responses were voluntary, and the average time taken to complete the survey was 5 minutes. Forty responses were received with interviews conducted thereafter. The professional representation of respondents is detailed in figure 1. The majority of respondents identified their role as Occupational Rehabilitation Consultants, with 'other' role represented including Manager, New Employer Services Consultant, Injury Management Consultant, Emergency Welfare Officer and Educator. For the ease of reporting, all respondents will be referred to as RCs, although we acknowledge that there is variability in the roles captured herein.

Occupational Therapists were the primary discipline represented, followed by Psychologists. Registered Nurses, Exercise Physiologists and Physiotherapists were also identified. Several respondents did not disclose their discipline.

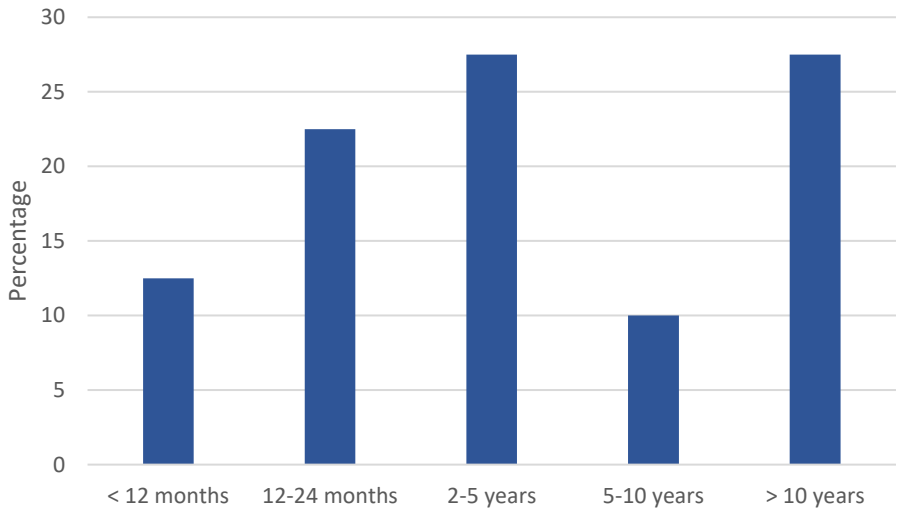
Figure 1: Respondents by Role and Discipline



[1] As defined by HWCA, 2015

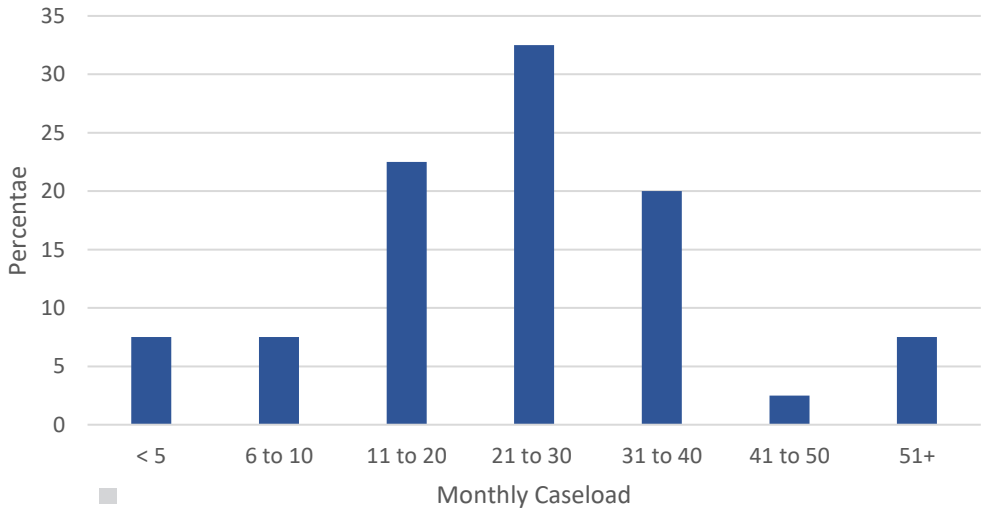
In relation to the extent of professional experience of respondents, figure 2 outlines that over 37.5% of people reported in excess of five years' experience in occupational rehabilitation, and of those 27.5% held in excess of 10 years' experience. 12.5% of respondents reported less than 12 months experience in occupational rehabilitation.

Figure 2: Length of professional experience



Individuals engaged in occupational rehabilitation or reporting to be 'on claim' are often described as 'cases'. To carry a 'case load' reflects the number of individuals supported by the RC in the workplace rehabilitation activity. Figure 3 shows the average monthly caseload for respondents, indicating that most commonly RCs carry between 11 and 40 cases per month. Alarmingly, over 5% of respondents reported managing in excess of 50 cases per month.

Figure 3: Average case load per month



Responding to suicidality in the workplace

Occupational Rehabilitation Consultant Role

The majority of respondents considered that RCs have an important role in suicide prevention (77.5% yes, 5% don't know, 17.5% no response). In examining the responses about why RCs consider they have an important role to play, four main themes were evident:

- Being the front-line communicator – developing rapport and relationships
- Being a coordinator and facilitator for services
- Being able to identify risks and signs of suicidality
- Being an important source of ongoing support

"We are a trusted health professional and have the opportunity to identify risk factors and facilitate access to appropriate interventions

"I am the person who communicates between employer, CM and health professionals. I am probably going to be privy to more information and see the worker in different contexts which will enable me to pick up on warning signs then provide immediate support, followed by referrals to appropriate agencies..."

"We remain in regular contact with the client; facilitate communication between all parties; monitor workers progress; are in the position to identify any potential flags or signs indicative of suicidal

"...We are often dealing with people at the lowest point in their lives... identifying risk and linking to support networks early is something RCs can help to benefit injured workers"

"...I'm in touch with all parties and therefore potential to influence level of support/treatment for the worker"

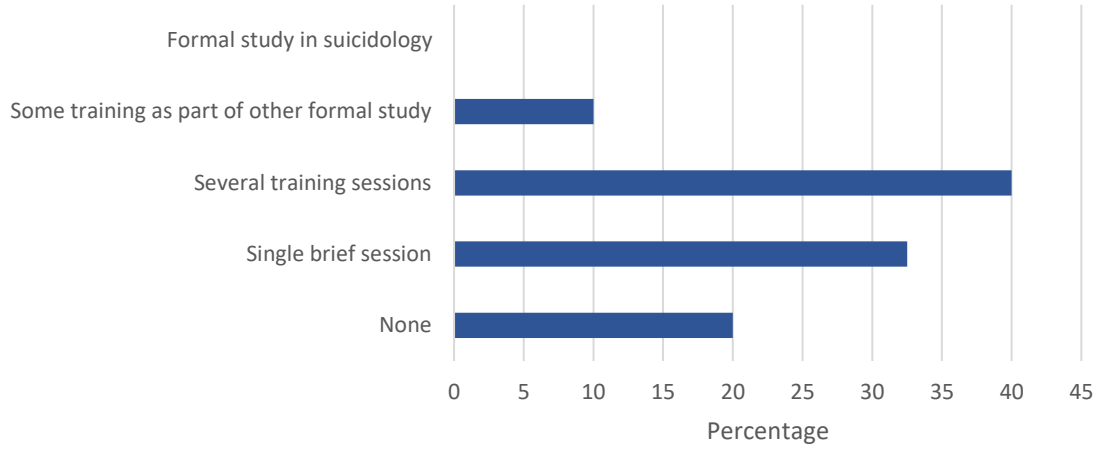
"...Facilitating referral to services such as encouraging worker to attend GP for referral, even if via Medicare and not supported by insurer. Show empathy and gain consent from worker to discuss with relevant parties about how we can support the worker..."

"Occ Rehab providers are often front line contact. They develop relationships and rapport and are able to create change..."

Training

While it is positive that 40 % of respondents had received several training sessions, there is significant inconsistency in training for RCs evidenced from the results shown in figure 4. Of concern, 52.5% of the respondents identified that they had never received any, or had only 'brief' training in identifying and responding to suicidality.

Figure 4: Training experiences



"I've had 20 years nursing and 20 plus years in occupational rehab... I've done a few courses.. plus a husband who is a Psych Nurse..."

"... I make a phone call to my colleagues who's a psych, to ask for advice..."

"Personally, I have not been invited to or had an opportunity to participate in any training related to this, making me feel less confident and relying solely on my personal experience with it and/or colleagues with psychology backgrounds..."

"I worked for several years in a mental health setting, community, acute and rehabilitation wards..."

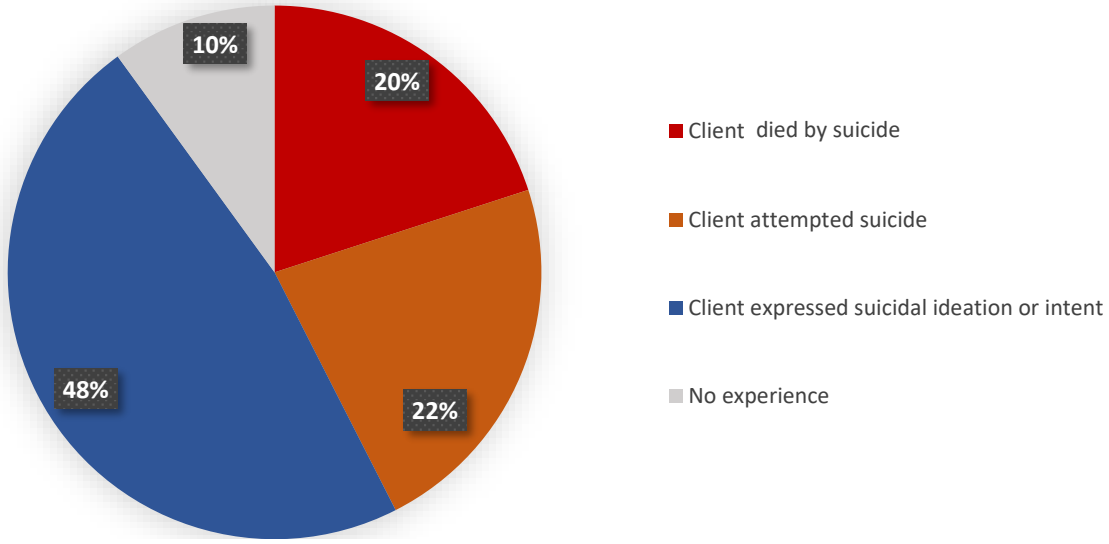
"I recognise the signs well but I had an incident recently and I did not see the signs.... I want to learn about what I missed"

Experience in working with clients reporting suicidality

Figure 5 details the level of experience or exposure RCs have had to clients reporting suicidality, while working in occupational rehabilitation. Sadly, 20% of RCs indicated having lost a client to suicide and a further 22% reported clients attempting suicide. The majority of respondents, almost 50%, described having worked with clients expressing suicidal ideation or intent. Only 10% of RCs reported having ***never*** experienced any suicidality in clients.

There are several considerations when interpreting this data. Firstly, there is insufficient information to determine whether the 10% who reported no experience in working with clients reporting suicidality is due to a lack of training in how to identify warning signs and screen for risk, or whether this is a genuine absence of suicidality in their client group. What is also evident is that there is a significant need within the RC cohort for training and support in dealing with this client group, given that at least 90% of respondents had described clients presenting with a range of suicide related behaviour, from ideation to death by suicide.

Figure 5: Experience of suicidal clients



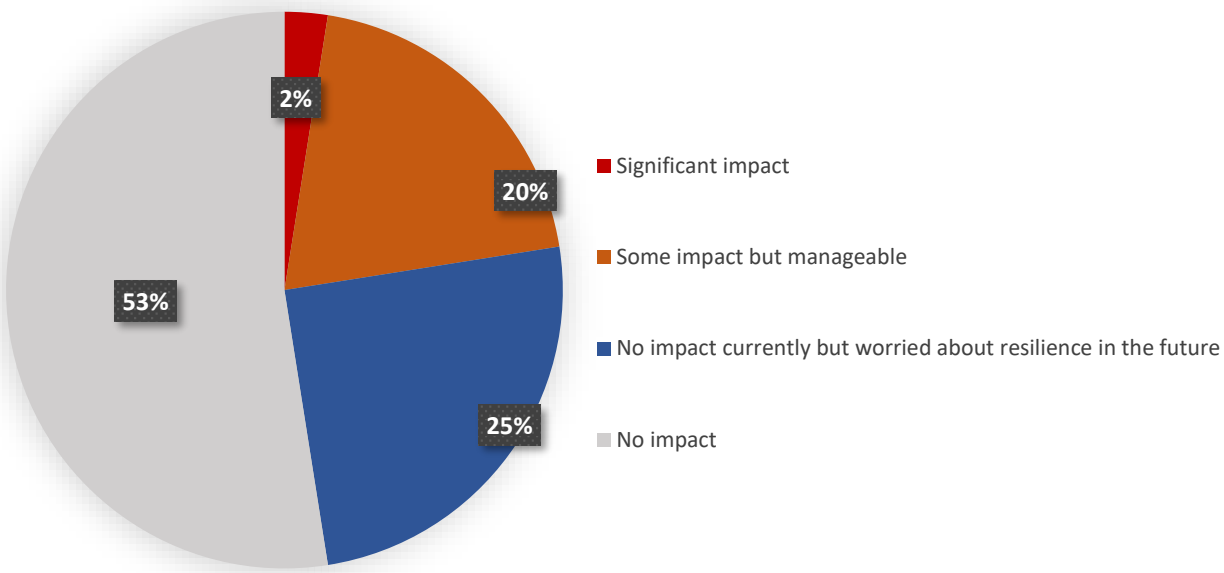
"I'm inexperienced. I'm unsure how to handle a suicidal situation. I worry that I may say something to escalate the situation"

"I have only experienced suicide from personal family/friends and have been fortunate to have an awareness and a passion to assist… All consultants should have training to deal with suicidal issues from an OR point of view especially with increase of drug dependence"

Psychological Impact on RCs

This survey examined how the experience of engaging and responding to suicidal clients had impacted on RCs, particularly with respect to potential suicidality clients. Figure 6 indicates that just over half of the respondents had not found their work with suicidal clients to have resulted in negative impacts. However, a significant number of respondents had either experienced some impact or were concerned about their ability to cope in the future without significant supports. 2% of respondents described the loss of a client to suicide had significantly impacted them.

Figure 6: Impact of working with suicidal clients



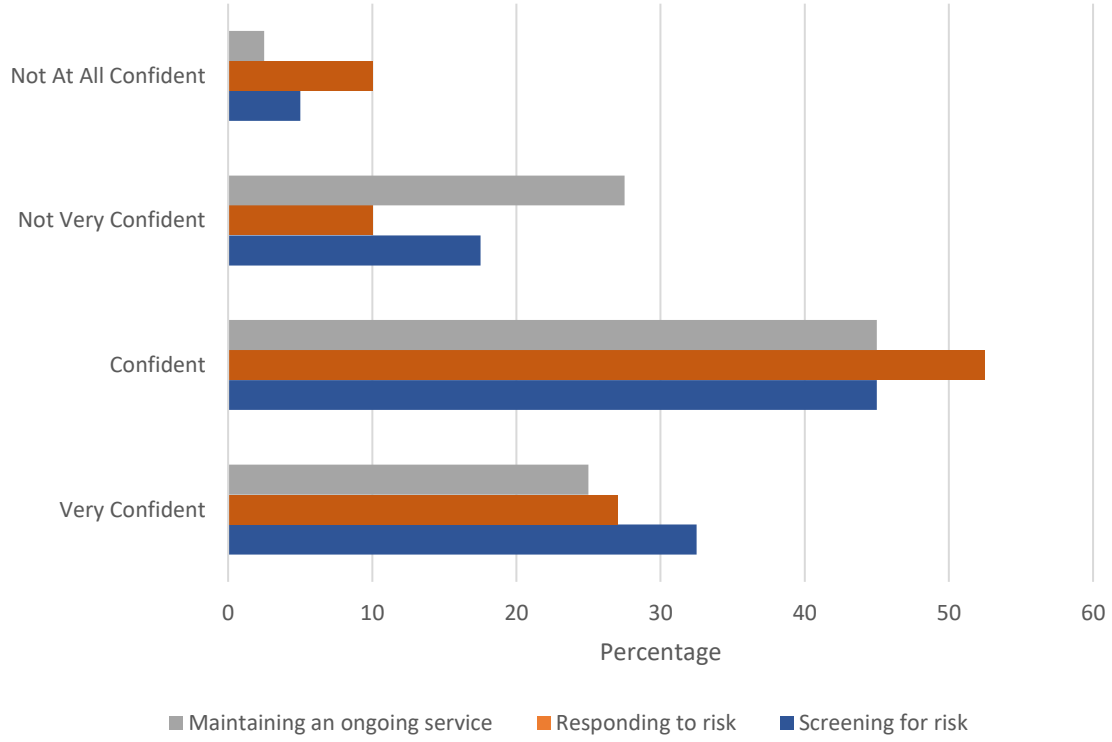
"I have been exposed to people with suicidal intent but I am concerned about dealing with the aftermath should someone suicide and how I would deal with the next situations."

"…the follow up is concerning sometimes… I recently had a suicidal worker who was acute… I contacted his GP who said he couldn't assist. Insurer also stated they couldn't assist. I was left to manage him myself which led to exhaustion and an exceptionally long day"

Confidence

A large percentage of respondents indicated a high degree of confidence in their ability to screen and respond to suicide risk, as well as confidence in their ability to provide an ongoing service for a suicidal client (figure 7). However, this level of confidence was not consistent across survey participants and 27.5% of respondents identified that they were 'not very confident' in maintaining an ongoing service to a suicidal client. This lack of confidence has the potential to significantly impact the resilience of RCs over time. This data suggests RCs require greater levels of support in responding to clients who may be suicidal, including when this service is ongoing. Training may also address lower levels of confidence across all domains.

Figure 7: Confidence in responding to a suicidal client



"I feel out of my depth"

"I feel uncomfortable calling emergency services and impacting a person's privacy e.g. Sending ambulance/police to knock on a person's door in the night. I have said don't turn on siren/lights etc

"It is important that people working in Occupational Rehab are comfortable in addressing suicidal ideation or thoughts rather than trying to avoid dealing with these issues."

Concerns and Challenges for RCs in Suicide Prevention

This survey provided the opportunity for respondents to identify what they perceive as the largest concerns and challenges they have, or face, in dealing with clients who present with suicidality. The concerns and challenges identified at times overlapped. Thematic analysis of responses was undertaken, with the most common concern reported being how to manage suicidal clients. In particular, it was reported that RCs were concerned that about 'saying the wrong thing', while the most common challenge was a lack of confidence and appropriate training.

Common Concerns

- How to manage a suicidal client
- Dealing with a lack of information
- Becoming emotionally involved
- Dealing with poor health networks or support services
- Lack of support from employer & insurer and limitations of service provision
- Lack of support for RCs
- Lack of training
- Challenges of returning clients who experience suicidality to work

"Within the company, all allied health professionals are perceived to have the skills required but with a lot of colleagues, they don't have the confidence or lack the experience."

"I'm concerned that I could trigger things or exacerbate feelings as I have not been trained in appropriate language/response. Also afraid of risking my own mental health due to lack of training and zero support from management"

"Lack of information to provide clients with being able to report this to case manager and THP in a timely manner. Being emotionally involved if client is not seeking support. Lack of drug awareness/information has been a factor in potential suicidal issues

"The health network for referring for support is poor, particularly if the treating doctor doesn't take concerns seriously"

"Concern for the client and team members exposed to their behaviour and the situation"

"chronicity and access [to means] is a concern I have"

"Finding the right referrals. Referring on to an appropriate support service in a regional area"

"The workers comp system does not support this well. Often perceived by other parties other than the injured worker (ie employer, to a lesser extent the insurer) as not part of the "compensable injury"; mental health is often attempted to be separated from the compensable injury. Mental health claims often take longer to be accepted delaying treatment and I feel this is a significant impact on the health of the injured worker and the RTW outcome. Fear of not doing enough, ie. can follow process of contacting GP, Psychologist, putting in place management plan with worker. However, this is often not perceived as my role (Injury Management Consultant)"

"I worry about managing any parties who are of the opinion they should be pushed into doing things they're not ready for"

"saying the "wrong thing" which may lead to increased suicide ideation"

Common Challenges

- Not receiving training
- Not feeling confident
- Dealing with limited resources or funding
- Lack of holistic model
- Poor communications with providers
- Monitoring or maintaining contact with the client
- Maintaining client motivation
- Understanding support networks
- Lack of information

"Communication with the treating providers as they can be difficult to contact"

"Lack of a holistic stakeholder engagement model – people making one file note or one phone call and thinking they can 'pass the buck'… "

"I need more training in identifying suicidal risk and managing suicidal clients"

"Being able to understand and have the support information available. Not being advised of any drug/suicidal issues from case manager during initial referral

"As an OT, I am only assigned physical files and the suicidal training is mainly delivered to psychologists who do the psych files. Often there are cross overs and I don't feel confident when working with suicidal ideation"

"... hospital cannot accommodate them even if high risk so they are discharged to a less supervised environment..."

"As an OT we have mental health training and often are working on the frontline with people who are suicidal either from the circumstances surrounding their injury or exacerbation of a pre-existing condition. GP's often don't see the person frequently enough to detect issues."

"The intractable insurance system – the clients have the feeling of being trapped, unable to move forward due to chronic pain and injury and being pushed by the system to move forward in the systems time frame. Poverty and unemployment add to the downward spiral..."

"Maintaining the most appropriate level of monitoring/contact/knowing of how much to share with other treatment providers or parties"

"We work under service level agreements with insurers which only allow us a certain amount of funding to complete a service. If our clients are suicidal and require extensive levels of contact outside of the available funds, it makes it difficult."

"We need more resources..."

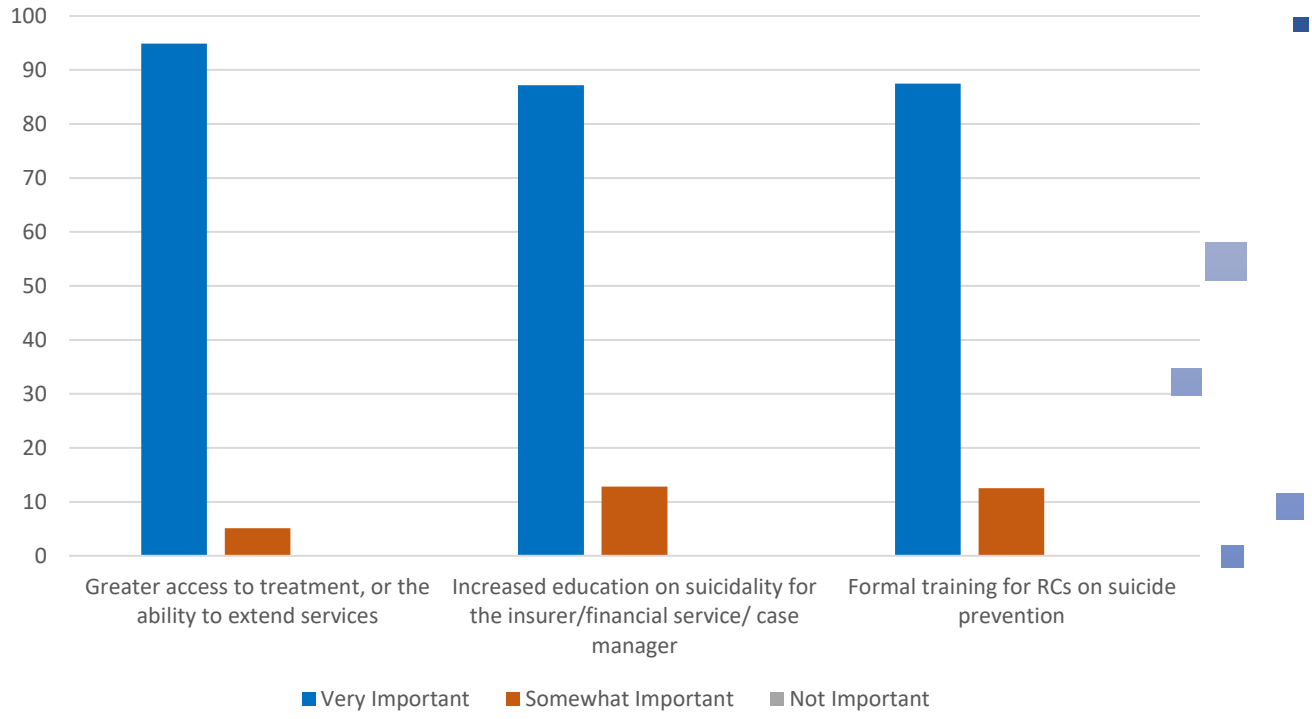
Requests for Action

Respondents were asked to provide feedback on what they consider to be the most important elements supporting more effective suicide prevention activity with injured workers. Three potential starting points for a resource kit or guide were offered;

- Greater access to treatment, or the ability to extend services
- Increased education on suicidality for the insurer/financial service/case manager
- Formal training for RCs on suicide prevention

Respondents did not differentiate between the three focus points, as each were highlighted as very important (figure 7).

Figure 7: Factors for effective suicide prevention



What support would make the greatest difference in your role as a RC when working with suicidal injured workers?

"Peer supervision, having a pro-active employer and training"

"We are in a unique position where we can assist workers to adapt their role (if able to return to their pre-injury employment) and negotiate on their behalf, while providing them support. Alternatively, if a new career is required because they can't return to their pre-injury role in any capacity, we can provide the guidance and support to assist them in completing retraining, job seeking, and placing them into new employment, to find their "new normal" and reduce some of the stresses associated unemployment."

"We are often dealing with people at the lowest point in their lives. I think identifying risk and linking to support networks early is something Occupational Rehab consultants can help to benefit injured workers."

Synthesis of the evidence – What are the industry needs?

There appears to be some key areas of need identified by respondents in relation to service delivery. When synthesising this information with the available research, a range of opportunities become apparent that are likely to support Occupational Rehabilitation Providers integrate suicide prevention activity into their practice.

1. Integrated suicide prevention policy

First and foremost, it is recommended to embed suicide prevention strategies into policy and frameworks guiding the delivery of occupational rehabilitation services. Universal screening has the capacity to identify otherwise unidentified risk. Whilst there is an absence of data to evidence the extent of suicide (and self-harm) impacting injured workers engaged in occupational rehabilitation services nationally, what is apparent is that the workforce supporting occupational recovery and return to work, require specific evidence-based strategies to identify risk and respond appropriately.

There are six overarching benefits identified:

- Policy that integrates suicide prevention activities ensures that each and every ORP has the capacity to consistently respond to suicidal individuals, according to evidence-based practice.
- Those providers that are not only ineffective but potentially perpetuating harmful or inaccurate attitudes and practices, can identify and correct their approach. This includes use of standardised appropriate language and interventions.
- Further, stakeholders engaged with ORPs (whether they are clients and their families, employers, insurers or otherwise) can be assured that the ultimate consideration for psychological safety is delivered.
- Policies deliver a framework supporting escalation, accountability and decision making and this is particularly critical when considering life threatening contexts.
- Should there be a complaint or perceived failure with respect to suicide prevention initiatives, policy and procedures allow evaluation and consideration more readily.
- Formalising provisions for consultant wellbeing, supervision and training, acknowledges what is known of the emotional demands of working with suicidality

2. Suicide Prevention Training specific to ORPs

The research clearly articulates that currently, Australian Occupational Rehabilitation Consultants (RCs) need training in evidence-based suicide prevention. The delivery of training is of fundamental importance, supporting RCs to build confidence in responding appropriately to their client's needs. In addition, training is noted to benefit emotional resilience against the demands of working with clients that may be demonstrating suicidality.

Of note, RCs described training need to extend beyond ORPs, to include all stakeholders engaged with an injured workers recovery, with Claims/Case Managers specifically mentioned. In reflecting on the research of Lund and colleagues (2017; 2018) training must acknowledge existing RCs practice strengths; knowledge, skills and experience in working with injured workers in addition to the context of occupational rehabilitation. While there are programs such as ASIST, QPR and SafeTALK that may be helpful to ORPs, these were not identified as sufficient for the needs described (Lund, et al., 2017).

Suicide Risk Assessment Australia propose training that includes, but is not limited to;

- Examination of attitudes and beliefs and their role in perpetuating stigma
- Suicide specific information on risk and protective factors, warning signs and relevance to people engaged in occupational rehabilitation
- Skills based practice in assessment and brief interventions (such as Safety Planning and Means Restriction Counselling)
- Skills, strategies and principles in collaborative engagement with clients' family and trusted others
- Administration and use of templates and resources, specifically designed for ORPs to expedite communication with stakeholders, efficiently formulate client information for treatment/ intervention/ return to work planning and case management, and escalation protocols
- A framework to support RCs (and stakeholders) who are impacted by working with clients experiencing suicidality
- Extensive and longer-term evaluation of not only the benefit perceived by ORPs of training, but also those of clients and other stakeholders.

To maximise training outcomes, it is also recommended that a training protocol is initiated upon induction and at regular intervals during a person's career (for example, every 12 to 24 months).

Further, supervisors, managers and those in executive positions should actively participate in suicide prevention training, to recognise the importance and support adoption of all aspects of the strategy.

3. Access to suicide specific 'direct' Psychotherapy for clients

A key concern raised by RCs related to the ability for clients to access treatment. What is unclear from their comments is whether they were aware of all available provisions for treatment, or whether treatment options had been exhausted.

Based on the feedback received through this research, it is suggested that treatment provisions available to clients reporting suicidality should be more clearly articulated for RCs. This may in part be addressed through the development of specific suicide prevention policy and protocols. However, if treatment options have been exhausted and alternate sources of support are not available for clients reporting suicidality, then an evaluation of how to address RCs concerns should be undertaken.

Further, research has demonstrated that suicide specific psychotherapeutic treatment is necessary to adequately respond to people reporting suicidality. While cognitive behavioural therapy has been widely accepted as an effective approach to many psychological difficulties, this may not be a 'direct' intervention for suicidality, whereby 'direct' treatment approaches must be emphasised.

As such, dissemination of information relating to suicide specific treatments appears indicated, with only three interventions identified as appropriate currently;

- Cognitive Therapy – SP/ Cognitive Behavioural Therapy – Suicide Prevention (CBT-SP)
- Dialectical Behaviour Therapy (DBT)
- Collaborative Assessment and Management of Suicidality (CAMS)

Policies and procedures that detail evidence-based treatments can facilitate greater engagement and collaborative treatment planning with providers delivering these services. Identifying, developing and engaging support services and health networks for suicidal clients is necessary in the context of holistic health care, and relies heavily on collaborative stakeholder engagement and consideration of factors outside of compensable injury. In addition, the necessity to understand suicidality, and for stakeholders to understand the role of ORPs within a recovery at work context, is necessary. Such provisions could better reflect a holistic model to client care and wellbeing. Finally, greater emphasis on clinicians that are trained in direct therapies is necessary, particularly when they are becoming an accredited treatment provider within the workers' compensation industry.

4. Supervision, Support and Self-Care

It became evident through the research, that RCs can experience a lack of support and perceive systemic barriers as contributing to their difficulties in service provision. While ORPs are expected to deliver supervision and support to their workforce as part of the *Nationally Consistent Approval Framework for Workplace Rehabilitation Providers* (HWCA, 2015), this may not be sufficient for the demands in working with suicidality.

Supervisors should be able to support RCs in their work, advocate for their recommendations and continue to build and develop meaningful relationships with all stakeholders. It is for this reason supervisors are expected to have more advanced understanding of not only the clinical implications of suicidality, but also the available support systems and structures. ORPs should be actively encouraged to highlight gaps in systems or service availability, with the view of working with providers to creatively explore opportunities to meet all stakeholder needs.

ORPs should be evaluated on their strategies to highlight support mechanisms available to their staff as well as promoting mentoring, coaching and training to enhance skills development with respect to suicide prevention activities.

5. Data collection, evaluation and suicide surveillance

This is a simple recommendation with complex implications for existing Australian data systems. The inclusion of suicide and self-injury specific data within the existing data systems is recommended to allow greater in-depth understanding of the factors impacting people to experience suicidality as well as the capability of the workforce to respond appropriately.

Capturing and reporting surveillance data may allow;

- The prevalence of suicidal ideation, behaviour and death by suicide for people on claim or otherwise engaged with compensation systems
- Real-time tracking of the efficacy of suicide prevention interventions
- Greater understanding of risk factors for suicide, for clients reporting workplace injuries, in addition to their responsivity to interventions and prevention strategies
- Greater responsivity to stakeholders needs, as well as accountability for suicide prevention efforts delivered by stakeholders
- Evaluation of longer-term sustainability of programs and interventions supporting recovery after suicidality while engaged in occupational rehabilitation, across the industry

Other data that is considered relevant and important, yet may not align with a surveillance system per se, includes;

- ORPs preparedness, likelihood and capacity to sustain suicide risk assessment/screening and intervention case management

- Frequency at which brief interventions are undertaken by RCs
- The availability of treatment providers delivering direct (suicide prevention) psychotherapy (SP-CBT, DBT or CAMS) from a Federal, State and Territory perspective

The above suggestions are by no means exhaustive, with further information on the importance of data collection and surveillance systems in suicide prevention activities. What is clear is that without knowing the extent of the challenges, it is hard to understand the industries needs or priorities in achieving positive suicide prevention outcomes.

See Proposed Suicide Prevention Framework for NSW (2015) for additional information on Adopting a common evaluation framework. WHO (2016) have developed a Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm, that may be of further interest.

6. Working with the family & trusted others

While the research did not explicitly highlight ORPs considerations in collaboratively working with family and trusted others, it is an essential aspect to the delivery of holistic care, that can be incorporated into service delivery, with the client's consent. There is significant evidence that engaging and empowering the support network around people experiencing suicidality, assists in recovery.

Often, providing psychoeducation to family /carers for the client, supports the development of collaborative systems facilitating recovery.

Resources supporting clinician's working with families and carers specific to the occupational rehabilitation context are currently in development, however, the following links are noted to be helpful;

- ✓ Mind – help hope and purpose – Mind's approach to working with families and carers
- ✓ Mind Australia and Helping Minds – A practical guide for working with carers of people with a mental illness

There are multiple resources detailing approaches in supporting people who have experienced suicidality, including;

- ✓ SANE - Suicide prevention and recovery guide; A resource for mental health professionals
- ✓ Black Dog Institute – multiple resources
- ✓ Beyond Blue – information for family and friends on safety planning, support and recovery strategies, and supporting others
- ✓ Mind for better health – how to support someone who feels suicidal

- ✓ Lifeline – Tool kit – Carers of people with mental illness
- ✓ AHMAC – Consumer and carer guide to recovery principles that support recovery-oriented mental health practice

Knowledge of strategies facilitating transparent communication, in the face of challenging contexts is a skill that often requires practice. It is for this reason that some clinicians may avoid engaging with family and trusted others. However, family can also support the client's engagement with services, motivation for recovery and disclosure of relevant information. They are likely to want to support their loved one, and this is one strategy where, with the client's consent, meaningful improvements can be made.

Summary

In summary, the available evidence and research demonstrates that ORPs are in an exceptional position to identify and respond to individuals evidencing or reporting symptoms of suicidality and self-injury.

In addressing the key recommendations, namely the development of integrated policy, delivery of training, provision of suicide specific psychotherapy, surveillance of suicide data and support for RCs, it is envisaged that suicide prevention in the sector is achievable.

Resources supporting ORPs continue to be developed by SRAA as identified through this work and in consultation with providers. Those resources include templates and guides to support ORPs engagement with the injured workers' family and support networks, complementing the existing training and resources for stakeholder engagement.

If you would like to contribute the work of SRAA, please get in contact.

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