NORTHERN MALLEE SUICIDE POSTVENTION PROTOCOL

The Healing Tree by Tracy Wise

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CONTENTS

The Northern Mallee Suicide Postvention Protocol is an initiative of the Mildura Place-Based Suicide Prevention Trial (2017-2022) led by Murray PHN and funded by the State Government of Victoria.

Those using the Northern Mallee Suicide Postvention Protocol as part of research, education, publication and/or community development of postvention should acknowledge it as follows:

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Version	Document Title	Date released	Prepared by	Approved
1.6	Northern Mallee Suicide Postvention Protocol	July 2021	Merryl Whyte, Teresa Cavallo	
2	Northern Mallee Suicide Postvention Protocol	May 2022	Ian Johansen	

Acknowledgments

Postvention, as collaborative and multi-organisational coordination of events after suicide deaths, began in 2014 in the Northern Mallee region. Processes in use at that time were informed by the Casey Cardinia Suicide Recovery Project that was initiated in 2013 by the Victorian State Government and delivered by headspace, and the work done by the Victorian Bayside and Macedon Ranges communities. Under the banner of the Northern Mallee Community Partnerships, a range of key agencies across the region built and enacted a coordinated response to suicide within Sunraysia - an area that spans the Victoria and New South Wales border. This work has continued to evolve through application. Postvention developments in the Northern Mallee region have included:

- Publication of the first 'Northern Mallee Suicide Postvention Communication Protocol' (Version 1.0) in 2016.
- Establishment of the Mildura Place-Based Suicide Prevention Trial (2017), led by Murray PHN and funded by the Victorian Government. This trial takes a systems approach to community suicide prevention – and has enabled review and strengthening of postvention and community response planning in the Northern Mallee region.
- Widening of postvention work outside the original demographic brief[1]. From establishment of the trial in 2017, postvention activation has occurred more widely within the Northern Mallee region.
- Relocation of the 'organisational home' of postvention in the Northern Mallee to Mildura Base Public Hospital in 2019 – based on a review of operation.
- Victoria Police revision of their procedures and information collection post suicide death (2019) to support postvention work in the Northern Mallee region.

This document, the Northern Mallee Suicide Postvention Protocol (2021), is the latest development and reflects learning from all prior postvention work in the region. It is an initiative of the Mildura Place-Based Suicide Prevention Trial (2017-2020) and has been informed by practice-based and lived experience, peer-reviewed literature and consultation with suicide prevention experts.

Special acknowledgments

In 2019-2020, the Mildura Place-Based Suicide Prevention Trial supported engagement of Associate Professor Jo Robinson, Orygen Head of Suicide Prevention and PhD student Nicole Hill, to support and review postvention practice in the Mildura local government area and inform the development of the revised Northern Mallee Suicide Postvention Protocol (2021). Their contributions of expertise, experience and evidence provided invaluable support to the Sunraysia community and will strengthen ongoing postvention strategy and leadership capacity in the Northern Mallee region.

The following people and organisations are also acknowledged for their work within this protocol and in development of postvention approaches in the Northern Mallee:

- David Kirby and Chris Hermans (Mildura Base Public Hospital)
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- Teresa Cavallo and Pia Mok (headspace Mildura)
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1 Activation for suicide deaths of young people (12-25 years) and for those from an Aboriginal and Torres Strait Islander background.

1.0 Background

Approximately 135 people are affected by each individual death by suicide (Cerel et al., 2019), and within the Australian population, a large proportion of those exposed to suicide (37%) report lasting impacts where the death has 'a significant or devastating effect on them that was still felt' (Maple, Kwan, Borrowdale, Murray, & Sanford, 2016).

Short to medium term impacts[2] also occur, with the degree of life disruption varying with perceived closeness of relationship with the deceased. Higher levels of distress and disruption are reported by those people identifying as Aboriginal and Torres Strait Islander.

Along with life disruption and distress, growing evidence suggests that people exposed to, or affected by, suicide are themselves at greater risk[3] for subsequent suicidal behaviours (N. T. M. Hill et al., 2020; Pitman, Osborn, King, & Erlangsen, 2014). These risks also occur from exposure to suicide attempts (N. T. M. Hill et al., 2020).

1.1 Defining postvention

The Northern Mallee Suicide Postvention Protocol adopted the definition of postvention as:

The coordination of events after a suicide[4] [or a serious suicide attempt[5]] with a dual focus on bereavement support and the prevention of future suicidal behaviours amongst the bereaved and within the wider impacted community. The term 'postvention' is used to include all those activities developed by, with, and for those bereaved by suicide, in order to facilitate recovery and to prevent adverse outcomes including suicidal behaviour (Palmer, Inder, Shave, & Bushnell, 2018).

The concept of postvention is also therefore ultimately the act of prevention (Andriessen & Krysinska, 2012; Andriessen et al., 2019).

Under this definition, those supported through postvention are not just bereaved family or friends. Support extends to others whose life may be impacted or changed. This can include witnesses, first responders, health care providers, sporting clubs, community groups, employers and work colleagues.

1.2 Postvention support

Evidence as to efficacy of postvention supports is still emerging (Andriessen et al., 2019), however evaluation has found:

- Active versus passive postvention appears to make a substantial difference[6] – where traditional or 'passive' postvention requires the bereaved to find themselves resources or supports available in their communities (and may take weeks after the death) and where 'active' postvention supplements services from first responders and arranges support referrals without the bereaved having to seek services themselves (and results in more timely access and engagement) (Cerel & Campbell, 2008).
- Postvention is an opportunity for activating 'natural or common supports'[7], with programs that increase social support after suicide loss found to reduce depressive symptoms and suicidality in the suicide bereaved (Oexle & Sheehan, 2020).

Practically, postvention support for individuals or impacted groups can be divided into four types (Australian Institute for Suicide Research and Prevention & Postvention Australia, 2017):

1. Information - including leaflets, books, booklets, factsheets, posters and online information (sufficient for most who experience a normal level of distress following a bereavement)
2. Assistance - including support services, support groups, self-help groups, helplines, community support and educational support (moderate grief reactions)
3. Counselling - (severe grief reactions)
4. Psychotherapy - (mental health and complicated grief reactions).

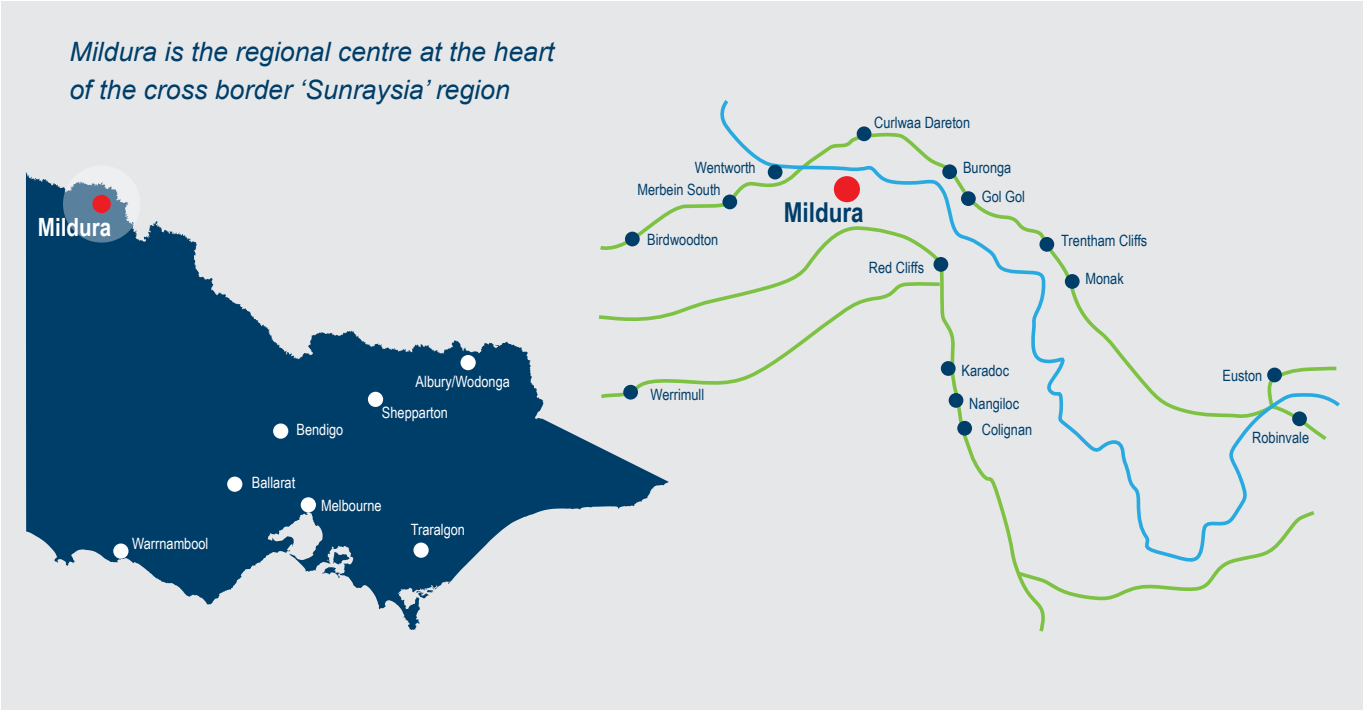
2.0 Northern Mallee Suicide Postvention Protocol purpose

The Northern Mallee Suicide Postvention Protocol documents the ways in which the Sunraysia community coordinates and operationalises postvention activity. It has a dual focus on bereavement support and the prevention of future suicidal behaviours. Specifically, it outlines ways that the responsible organisations[8] in the Northern Mallee region will:

1. Provide a coordinated and effective response to suicides and serious suicide attempts[9]
2. Prevent suicide contagion and other community impacts[10]
3. Identify and map emerging suicide trends
4. Identify and progress areas to strengthen local system responses (both postvention and prevention) to prevent suicide and suicide attempts within the community in an ongoing way.

2.1 Target populations

The Northern Mallee Suicide Postvention Protocol covers communities in the following police jurisdictions and within an area generally referred to as Sunraysia.



Victoria

Western Region Division 6 – Mildura, Irymple, Red Cliffs, Merbein.

Some activities described in the protocol may at times be extended to the following additional locations within Victoria Police Western Region Division 6: Robinvale and Ouyen. This is at the discretion of the Local Response Group Chair in consultation with Victoria Police, and where there are concerns for possible contagion or other lasting community impacts.

NSW

Barrier Police District – Wentworth, Dareton, Buronga, Euston, Gol Gol.

2.2 Accessing the protocol

The Northern Mallee Suicide Postvention Protocol is a guide for those directly involved[11] in the collaborative response to suicide deaths or suicidality in the target populations, and for those responsible for strategic suicide prevention and community response planning in the region.

The complete protocol may be shared in instances where it informs or benefits postvention and community suicide prevention work, however a summarised version for broader community use is available on the Murray PHN website: murrayphn.org.au/suicideprevention

2.3 Involving people who have experienced suicide bereavement

Those bereaved by suicide are in a unique position to contribute wisdom to community suicide prevention and postvention response planning. The wisdom and participation of those with lived experience of suicide has been integrated into planning, leadership, design, enactment and evaluation of the protocol. Specific acknowledgment goes to those with lived experience who have acted as advisors to the Mildura Place-Based Suicide Prevention Trial (2017-2022).

3.0 Northern Mallee Suicide Postvention Protocol local response group

Under the Northern Mallee Suicide Postvention Protocol, provision of bereavement support and prevention of future suicidal behaviours is achieved through enactment of the Local Response Group (LRG). Comprising representatives from responsible organisations[12], the LRG convenes in the event of a death by suicide or a serious attempt in the target populations.

Mildura Base Public Hospital has been the organisational home of the LRG since 2019 and provides the Chair. This ensures continuity, coordination and secure record keeping. Within Mildura Base Public Hospital, the Director of Mental Health Services is the nominated LRG Chair, deputised by the Centre Manager of headspace Mildura. (See Appendix A for 2021 contacts).

3.1 Enactment of the Local Response Group

Enactment of the LRG is triggered when Victoria or NSW Police notify the Northern Mallee LRG Chair (or their deputy) of a suicide death or serious attempt within the target populations. The Chair invites representatives to meet, develop and activate a collaborative postvention response aligned to the protocol. Each LRG enactment may involve different organisations, as determined by the Chair to reflect circumstances and/or demographics.

Ideally, a meeting of the LRG takes place within 1-5 days of the suicide death or serious suicide attempt, but the urgency for LRG enactment depends on perceived community impacts[13] and is determined by the Chair in consultation with the notifying police member.

It is the responsibility of the Chair or their nominated representative to address any media enquiries that may eventuate after a suicide in the Northern Mallee region. Australian guidelines for safely speaking about suicide in public or to the media are outlined in Sections 4.2.1 and 4.2.2.

3.1.1 Parties involved in LRG enactment

Contemporary guidelines recommend that communities establish multi-organisational groups who are responsible for local planning and activation of responses to support those affected by suicide and to prevent further deaths (Hawton, Lascelles, Husband, John, & Percy, 2019). Leadership of Northern Mallee LRG enactment is the responsibility of Mildura Base Public Hospital, headspace Mildura, Victoria and NSW Police and Murray PHN. See Appendix A.

The full list of organisations that may be involved in a collaborative response or LRG enactment is included in Appendix A.

3.1.1.1 Guests

Individuals or organisations may be invited to attend an enactment of the LRG to achieve optimum information sharing and activation of community postvention. Guests will be identified on a case-by-case basis dependent on the circumstances of the deceased. The Chair holds responsibility for inviting guests and briefing them on their role and obligations.

The Chair may choose to invite guests to be present for the whole or part enactment during the appropriate times to ensure privacy and confidentiality of sensitive information, which will be achieved by in-camera sessions or allocated time-slots for sharing of their information. Guests may also be invited to consult to the LRG, such as academics with expertise in youth suicide prevention or Aboriginal and Torres Strait Islander. All guests will be required to adhere to the requirements of the protocol and maintain confidentiality.

3.1.1.2 Enactment for suicide deaths of Aboriginal and Torres Strait Islander people

Where the passing by suicide or serious attempt involves a person who identifies as Aboriginal or Torres Strait Islander, the LRG Chair will ensure that the following occurs:

- representatives from the relevant Aboriginal Controlled Community Health Organisation attend the LRG enactment and provide leadership and guidance
- An invitation to participate is also extended to the Koori Engagement Unit within the Coroner's Court of Victoria (03 86851157) via which regional involvement with the National Indigenous Critical Response Service (NICRS) may be facilitated if required
- The enactment begins with an acknowledgement of country
- The enactment begins with a consideration of the preferred use of names of the deceased, and appropriate warnings about use of those names, including in LRG discussions convened via technological means. LRG enactment for Aboriginal or Torres Strait Islander people should avoid using the first name of the deceased, and instead the titles "Miss ….Surname' (for all females) or 'Mr…Surname' (for all males) should be used.
- Enactment discussions should avoid using the word 'death' and instead refer to a 'passing by suicide' or a person who has 'passed'.

3.1.1.3 Enactment for suicide deaths of Culturally and Linguistically Diverse (CALD) people

The Northern Mallee region has a large multicultural population with linguistic diversity. Pertinent to postvention approaches, CALD populations have unique identities and experiences of mental health and suicide, with multicultural differences, trauma and experiences of discrimination and stigma, influence of social networks and family and acculturation difficulties (Bowden, McCoy, & Reavley, 2019). Where the suicide death or serious attempt involves a person, who is from a CALD background, the Chair will ensure a representative from the Sunraysia Mallee Ethnic Communities Council provides input and assistance.

3.1.1.4 Enactment for suicide deaths of children or adolescents

Where the suicide death or serious attempt involves a child or adolescent, the Chair will ensure appropriate representation from the following list of organisations attends the enactment:

1. headspace schools (provide support to schools who are responding to or recovering from a suicide or attempted suicide. In Victoria, this can be accessed by calling 0458 559 736 and in NSW 0475 838 049. Support is provided via 'Be You' consultants (Be You & Beyond Blue), who are available to schools during the hours of 9am–5pm, Monday to Friday[14])
2. Mildura Base Public Hospital Child and Youth Mental Health Service
3. Department of Education and Training Victoria, or Department of Education and Communities NSW
4. Catholic Education Office
5. Independent schools.

3.1.2 Criteria for LRG enactment

After receiving advice from police of a suicide death or serious attempt, the Chair will decide whether to enact the LRG.

Criteria for LRG enactment[15] includes:

- The deceased was part of a community group/ sub-group or minority that is over-represented in the suicide statistics[16]
- The deceased was aged 10-25 years[17]
- The deceased was well-known or well-connected in the community
- The death occurred in a public space
- The suicide death is receiving a lot of attention in the community including via the media, social media, and if it was broadcasted live through social media
- There is a reasonable suspicion or concern that the suicide was linked to a previous suicide or unexpected, traumatic event in the community
- The death occurred in the same context/closed environment as a previous suicide e.g. individuals from the same school, or place of employment
- Enactment of the LRG could inform future prevention of suicide e.g. sentinel event[18]
- A serious attempt where any of the above criteria may apply.

3.1.3 Requirements of LRG enactment

Participating individuals, as representatives of their organisation, share information within the LRG to achieve the purposes of the Northern Mallee Suicide Postvention Protocol. The nature and manner of information shared within enactment is detailed in this section.

3.1.3.1 Information collected and used within an enactment

To achieve the purposes of the protocol, the following types of information may be collected and shared within an enactment:

Information	Examples of how this information can be used to inform postvention
Personal information, including identifying the individual's known next of kin, family, colleagues, friends, groups or clubs[19].	To determine whether direct family members, dependents within the household, workplace colleagues or community group members require referral for specific supports e.g. financial assistance, bereavement support.
Recent or past health service interactions, including general practice	To determine whether the person was engaged in services and why/why not e.g. did the person experience barriers accessing mental health services? Has their regular GP been informed/involved? Any known behaviours or characteristics or situational risk factors or vulnerabilities that may inform postvention or prevention in the community, determine reporting/action requirements and to identify opportunities to strengthen local system responses.
Aboriginal and Torres Strait Islander background	Ensure culturally appropriate postvention and community supports.
Members of culturally or linguistically diverse groups	To identify culturally specific support services.
Method and location of the suicide or serious suicide attempt	To identify trends in methods and the provision of means restriction in the community, identification of witnesses and first responders who may require debrief and support.
How the next of kin wish to refer to the death	This information is to be shared with support services when relevant, as it is has the potential to facilitate and promote engagement with next of kin who are bereaved. This information should also be provided to media professionals should there be any media coverage of the death.

3.1.3.2 Requirements of privacy, confidentiality and respect

During an LRG enactment, and during any activities undertaken in relation to it, the personal information of individuals must be protected and dealt with in accordance with all applicable privacy legislation and statutory obligations.[20]

In addition to requirements of the legislation, and to ensure respectful use of personal, health and sensitive information of deceased persons, the following principles operate within the protocol:

- Distributed LRG postvention action summaries will identify the deceased via use of their initials only.
- LRG enactment for Aboriginal or Torres Strait Islander people should avoid using the first name of the deceased.
- Guests to the LRG will be required to complete an agreement to ensure they understand their responsibilities under the relevant Acts and Legislation.

Further detail and guidance for collection, sharing and storage of information relating to an LRG enactment is included in Appendix B: Relevant Acts and Legislation.

3.1.3.3 Duty of care for LRG participants

Both burnout and fatigue may be experienced in postvention teams and can impact the sustainability of prevention activities following a suicide in the community. As such, care for LRG participants is an important component of postvention. Towards prevention and mitigation of adverse impacts, the Chair will ensure the following occurs:

- Possible impacts from participation are acknowledged and explicit in relevant processes and communications.
- Participants are encouraged to use support functions within their individual organisations, including Employee Assistance Programs (EAP) and professional supervision mechanisms to mitigate impacts and to ensure sustainability of participation.
- For the purposes of preventing and addressing burnout and fatigue, participants are encouraged to 'opt-out' or 'sub-in' to LRG meetings should they require a break.
- External supervision and group debriefing are arranged for the LRG as required.

3.1.4 Activities relating to LRG enactment

To achieve the purposes of the protocol, the following activities generally relate to LRG enactment.

3.1.4.1 Police activity prior to an enactment

NSW or Victoria Police complete the following prior to the LRG enactment:

- Attend the scene, determine a suicide death, suspected suicide death or serious attempt has occurred, and interview close contacts.
- Collect personal, sensitive and health information[21] as required (see Appendix C: Information Record in use by interviewing officers within Victoria Police Western Region Division 6).
- With consent, make support referrals for the deceased's immediate family and significant others and for any civilians who located the deceased. In Victoria, referrals for victim support[22] can be made through the Victoria Police e-Referral Program (VPeR) to help with financial counselling or alcohol and other drug support. In NSW, it occurs through the Victims Access Line (1800 633 063).
- Arrange for follow-up contact with impacted parties to pursue support referral consent if declined at first contact, which is recommended 3-4 days later.
- Distribute Northern Mallee Postvention Support brochure.
- Notify Northern Mallee LRG Chair of death or suspected death by suicide or serious suicide attempt.

3.1.4.2 Activity during the LRG enactment

Upon receiving police notification of a death by suicide within a target population and where criteria for enactment is met, the Chair will coordinate and convene enactment as soon as practicable, ensuring that those invited to participate reflect the circumstances or demographics of the deceased.

To inform postvention responses, activity within LRG enactment includes:

- Sharing of personal, sensitive and health information (generally led by police) about the deceased individual (see Section 3.1.3.1).
- Identification of witnesses and first responders to facilitate their support.
- Consideration of the individual's online presence, to determine vulnerable groups and towards preventing contagion.

- Identification of support mechanisms for identified individuals and groups (see Section 1.2).
- Consideration of community and media responses and messaging about the death, towards preventing contagion and identifying emerging trends (see Sections 4.2.1, 4.2.2, 4.2.3).
- Consider need for local communication of help-seeking pathways and supports e.g. via media, social media, or events that support bereaved community.
- Clarification of next steps, including the need for a follow-up meeting and allocation of tasks to facilitate support and to progress other actions as identified within the enactment.

Example prevention strategies considered in LRG enactment:

- Discuss and identify an appropriate person in the community (e.g. the clergy member who may be conducting the service or the first responder who may have built rapport with the family) to reach out to the family to discuss the funeral or memorial service in a way that minimises glamorising the suicide or death, particularly following the suicide of a well-known person in the community.
- Discuss and identify an appropriate person to reach out to sporting clubs or workplace and discuss support options.
- Identify impacted community groups and encourage them to monitor social media.
- Consider social media posts to encourage help seeking or arrange geotagged advertising.

Activity within an enactment is guided by the Northern Mallee Suicide Postvention Protocol – LRG Activation Template (Appendix D).

3.1.4.3 Activity after an LRG enactment

After an enactment of the Northern Mallee LRG, the Chair or nominated representative will coordinate and complete the following activity:

- Distribute a summary of postvention tasks to those participating in the LRG enactment and ensure that the response is coordinated in an effective way.
- Follow up two weeks from the enactment to ensure postvention supports have been provided to those identified and consider need for debriefing of LRG enactment participants.
- Follow up any required communication or media liaison.
- Consider how data and information from the enactment contributes to broader understanding of:
  1. Emerging suicide trends within the community.[23]
  2. Opportunities to strengthen local system responses for postvention and prevention, and prevent suicide in an ongoing way.
- Engage with those who are responsible[24] for acting trend data or system strengthening and communicate learnings.
- Store data, information and records related to the enactment in a manner which is compliant with the Health Records Act 2001 (Vic).

3.1.5 Resources available to assist the LRG enactment

The following resources support Northern Mallee LRG enactment:

Information	Examples of how this information can be used to inform postvention
Postvention Australia Guidelines	Australian Institute for Suicide Research and Prevention & Postvention Australia resource for organisations and individuals providing services to people bereaved by suicide (accessed 27 May 2020).
Resources for CALD Communities in discussing suicide	Conversations Matter resource for discussing suicide with CALD communities and has a section on postvention focused discussions (accessed 27 May 2020).
Thirrili Trauma, Grief and Postvention	Defines and addresses Aboriginal and Torres Strait Islander trauma, grief and postvention (accessed 27 May 2020).
Be You/Beyond Blue Suicide Postvention Tool Kit	Offers practical guidance on responding to a suicide and managing the impact on a school community (accessed 27 May 2020).
StandBy resources • Support for children and teens after suicide • Workplace postvention toolkit • Medical workplace postvention toolkit	Free downloadable books for teens and children impacted by suicide (accessed 27 May 2020). Workplace toolkit and accompanying training worksheets are designed to assist employers, managers and others in leadership roles to develop a confident and best practice response through understanding and planning for potential impacts of suicide on: • Workplace response and support following the suicide of an employee • Support for an employee bereaved by suicide.
Murray PHN postvention resources	'Supporting you through traumatic bereavement' (distributed by NSW and Victoria Police). 'What to do if a club member dies by suspected suicide? A guide for sporting clubs'. The guide includes fact sheets on how to safely talk about suicide, sample communication messages, monitoring your club's social media, how club members may feel following the suspected suicide of a team member, friend or family member, supports for clubs in dealing with a suicide, and mental health and suicide prevention training options.

4.0 Preventing suicide and suicide attempts in the Northern Mallee community

Information from LRG enactments are used to identify and map emerging suicide trends in the community and identify and progress areas to strengthen local system responses to prevent suicide and suicide attempts in an ongoing way. This is done by sharing learnings from LRG enactments with those who hold responsibility for strategic suicide prevention and community response planning in the region, such as the Victorian Department of Health and Human Services, Murray PHN, the Northern Mallee Mental Health Alliance – Suicide Prevention Working Group and Mildura Rural City Council.

4.1 Identifying and acting on emerging suicide clusters

Though uncommon, and although early detection methods remain challenging (Cheung, Spittal, Williamson, Tung, & Pirkis, 2013; Niedzwiedz, Haw, Hawton, & Platt, 2014), prompt identification of suicide clusters may aid postvention strategies that seek to minimise contagion (Cheung et al., 2013). Rapid response to possible suicide clusters can prevent further deaths, and therefore identification of deaths in which suicide is the likely cause must take place at the earliest possible stage, without awaiting coroners' verdicts (Hawton, Lascelles, Husband, John, & Percy, 2019).

Suicide clusters involve multiple suicides that occur closer in time or place than would normally be expected using statistical inference or community expectation (Hawton et al., 2020). They are generally of two types:

- Mass clusters - media-related phenomena where suicides occur during a restricted time period following, and linked to, the broadcasting or publishing of actual or fictional suicides
- Point clusters (or space-time clusters) - where an unusually high number of suicides occur in a small geographical area or institution and over a relatively brief period of time (Haw et al., 2013).

Distinguishing between suicide clusters that involve exposure to suicide or links between cluster members, can improve a community's postvention response. This involves determining whether a cluster is primarily driven by the social transmission of suicidal behaviour versus population or community-driven factors, as differing interventions and preventative approaches are warranted (N. Hill et al., 2020).

Risk factors for the development of suicide clusters include:

- Being an isolated or sparsely populated remote or very remote community (N. Hill et al., 2020).
- Communities with a high-proportion of Indigenous Australians – who have more dense social networks and interpersonal relationships with family and community than non-Indigenous people and therefore more rapid reach of news regarding a suicide death (Cheung et al., 2013; Cheung et al., 2014; N. Hill et al., 2020).
- Direct or indirect prior exposure to suicide, including having heard about it through word of mouth or via media (Haw et al., 2013; N. Hill et al., 2020).
- Exposure to a sudden, multiple and unexpected and accidental deaths in the community e.g. multi-fatal car accident.
- Exposure to particularly violent methods of suicide e.g. via railway.
- Youth suicides more commonly occur as part of a cluster than adult suicides.

Recent research indicates that not all clusters involve social links between cluster members (N. Hill et al., 2020) and in the absence of social links, community or population risk factors, such as a sudden increase in unemployment or significant barriers to accessing health care services may be important drivers. Areas which have suffered a suicide cluster may be at increased risk of it happening again (echo clusters) – due to the characteristics of the area/population (Hawton, Lascelles, Husband, John, & Percy, 2019).

While global work on the detection and response to suicide clusters continues to emerge, the Northern Mallee Suicide Postvention Protocol adopts and integrates the practices outlined within 'Identifying and responding to suicide clusters - A practice resource' (Hawton, Lascelles, Husband, John, & Percy, 2019).

Key component*	Purpose
Surveillance	Establish mechanisms for local real time suicide surveillance.
Information sharing	Between relevant agencies to ensure consistency of response.
Media and communication	Ensure responsible reporting and understanding of how safe communication contributes to prevention and establish whole population wellbeing and suicide prevention awareness.
Bereavement support	To help those bereaved and affected by suicide.
Prevention	Identify opportunities to reduce risk of further suicides.
Monitoring and review	To assess the impact of the response, what has been learned and to inform future planning and activity.

*Resource: Identifying and responding to suicide clusters a practical resource UK (Date accessed 29 May 2020)

4.1.1 Actions if a suicide cluster is suspected in the region

If enactments of the LRG indicate the possible emergence of a suicide cluster in the Northern Mallee region, the LRG Chair will take the following actions:

- Notify the Victorian Department of Health and Human Services.
- Convene a Suicide Cluster Response Group comprising a small core group of organisations who hold responsibility for strategic suicide prevention and community response planning in the region. At a minimum, representation should include police, the Victorian Department of Health and Human Services, Murray PHN, StandBy Murray and Mildura Rural City Council.
- Consider need for engagement of external expertise to assist with planning and responses (this may include headspace schools if youth-related).
- Actions within and resulting from the Suicide Cluster Response Group should reflect best practice guidelines (Hawton, Lascelles, Husband, John, & Percy, 2019), integrate local knowledge, ensure that organisations who may be affected or may be responsible for provision of support (e.g. GPs, support after suicide services) are informed about concerns for a possible cluster – striking a balance between information sharing levels and containing the risk of spreading anxiety and fear.
- Key influencers[25] in the region should be contacted and encouraged to monitor their communities for any concerning behaviours, communication or social media posts and to actively encourage self-care and help-seeking. Guidance for communication and safe messaging will be shared[26].
- Engage and consult with the Northern Mallee Mental Health Alliance – Suicide Prevention Working Group and where appropriate, the Sunraysia Mallee Suicide Prevention Network to design, lead and enact prevention responses.

4.2 Mitigating population health impacts

Postvention reduces the impacts of suicide or a serious suicide attempt for individuals and groups, but it also has benefits at a population level. Postvention at a population health level includes activities such as: development of support and resources for suicide bereaved (e.g. support groups, online resources, national suicide survivor days), awareness raising activities, activities which reduce stigma and encourage help seeking, implementation of professional standards and implementation of media guidelines for reporting of suicide (Andriessen & Krysinska, 2012).

4.2.1 Suicide and self-harm: Australian guidelines for discussion, reporting and publication

The Australian Mindframe Guidelines are recognised as world-leading and cover discussion, reporting and publication of content which references suicide and self-harm. Media and communication professionals have an important role to play in influencing social attitudes to suicide, and potentially the actions of vulnerable people. Research has demonstrated that the way suicide is reported is significant, with some styles of reporting linked to increased rates of actual suicide.

Resource	Use
Mindframe Guidelines for Communicating and Reporting about Suicide	National guidelines for the discussion, reporting and publication of content which references suicide and self-harm.

4.2.2 Guidelines for safely discussing suicide in communities and online

What is said and done matters when it comes to suicide. It is important to consider both the explicit messages (stated, exact, external) and tacit messages (understood without being expressed directly) being sent, particularly in public forums.

Posts on social media are not the ideal form of communication about death. When the death is discussed by people who are not closely connected, speculation and misinformation can spread quickly, and people who are vulnerable or thinking about death can be adversely affected by hearing about the details of another person's death. Sharing memories posts (automated posts using historic pictures) and/or finding out about the suicide death of a friend or loved one on social media can be very distressing or triggering for some people. News of a suicide may lead others to share their own experiences of suicidality online.

Conversely, social media can be an important tool in postvention responses to a suicide and can help prevent suicide clusters. Examples of positive social media use include rapid sharing help and support information with large numbers of people and in defined geographic areas.

Resource	Use
Conversations Matter conversationsmatter.com.au	Provides a basic summary of issues to consider when talking broadly about suicide and suicide prevention in group and community settings and online communications. Provides basic tips for talking to someone who may have lost a family member, friend or colleague to suicide, including telling a child about suicide. Core principles for discussing suicide with Aboriginal and Torres Strait Islander people and CALD individuals, families and communities.
ChatSafe Guide for Communities using social media following the suicide of a young person and to help prevent suicide clusters[27] orygen.org.au	Helps communities who have experienced the suicide of a young person to provide information and support via social media. Includes tips for using social media as a postvention tool.
ChatSafe Guide for Young People communicating safely online about suicide[28] orygen.org.au	Helps young people communicate safely about suicide on social media. Also provides practical assistance to parents, educators, and those who provide support to young people engaging in online activities.

4.2.3 Guidelines for memorials or events after a suicide death

After a suicide, many people feel that they need to construct meaning or 'do something' to make sense of the death – or to commemorate their loved one. This is a very natural and understandable response. Memorials can include community events or pages on social media to remember the person who has died. Memorials can be a chance for people to mourn as a group and seek support. Annual events or activities have been described by some as helpful and a valid way of coming together to express grief, however people who are vulnerable may also participate in these events.

When holding events or memorials after a suicide death, it is important to think about possible unintended impacts. This includes thinking carefully about the use of images, stories and ceremonies, and the ways in which they may influence those who may participate. It is particularly important to ensure messaging does not inadvertently glamourise the death, as it can be expected that if the person who has died by suicide is praised or glorified, then there will be an increased tendency for others to identify with them and to judge suicide as an appropriate solution to their own problems (Haw et al., 2013).

In some settings, such as schools, public memorials may be discouraged, and feedback from those with lived experience suggests that care needs to be taken around linking fundraising to the suicide death of a young person.

Where possible, those organising events or memorials should work with a professional to discuss location, how information is managed and how people who are upset will be supported.

Resource	Use
'In Memoriam' beyondblue.org.au	This is a space for family and friends to honour a loved one who has died. beyondblue monitors the pages to ensure concerning content is addressed.
headspace Memorials and important events after suicide - headspace.org.au	Advice on safe and respectful memorials.
Chatsafe Guide for Online Memorials - orygen.org.au	Advice for setting up a page or group to remember someone who has died.

4.2.4 Guidance for reaching high priority populations in postvention communications

Communicating public health messages on topics such as suicide prevention, help-seeking and postvention supports can be difficult for a community to approach. The following resources can assist in achieving effective postvention communication with high priority groups in the Northern Mallee region.

4.2.4.1 Young people

Orygen, through their #ChatSafe project, found that Instagram and Snapchat were the most effective social media platforms for reaching young people 16-24 years. Information on how to best construct messaging for this age group is found in: ChatSafe Guide for Communities using social media following the suicide of a young person and to help prevent suicide clusters (Date accessed: 3 August 2020)

4.2.4.2 Aboriginal and Torres Strait Islander people

The Australian Government Department of Prime Minister and Cabinet produces guidelines for effectively communicating with Aboriginal and Torres Strait Islander audiences. Key to this guideline is the reminder that every community has their own local protocols which should dictate the communications approach taken. Aboriginal controlled organisations and Elders should lead where possible.

4.2.4.3 Culturally and Linguistically Diverse (CALD) communities

An Australian case study (Macnamara & Camit, 2017) found the three key parts of effective health communication targeting CALD communities are: in-depth qualitative formative research, a collaborative community-based approach and cultural competency. This means working with the impacted community via an intermediary such as Sunraysia Mallee Ethnic Communities Council, and communicating in a way that is culturally appropriate (e.g. informed by prevalent social and cultural norms), uses the information pathways familiar and already in use (which may include via Elders or church leaders), translated or rewritten and always developed with members of the impacted community. Other advice for clear communication with CALD communities includes using pictograms or other visual cues, increasing the use of audio visual resources rather than those that are text heavy, ensuring that images and voices represent the cultural group and content is sensitive to the 'norms' and values.

4.2.4.4 Men

The University of Western Sydney has produced a Guide to Effective Men's Health Messaging. Key points in the guide include:

- Males tend to go to friends and family as their primary source of health advice.
- Males are more likely to have a functional view of health, not seeking help until the problem is shown to clearly impact on physical function, does not resolve of its own accord or is not amenable to self-diagnosis or treatment.
- Men seem disposed to self-monitoring whereby they seek information from different sources before coming to an informed decision about whether to seek help and are more likely to express their emotions in terms of action.

This guide includes useful advice for communicating such as:

- Avoiding messages that 'blame and shame' or attempt to 'frighten'.
- Using respectful, non-judgemental, non-deficit language and graphics, including thoughtful and appropriate humour.
- Graphics should portray positive male images.
- Legitimise male health-seeking by emphasising the relationship between good health and other aspects of life that are meaningful to men, such as partners, family, work, recreation and retirement.
- Target male attendance by appealing to partners and family, or through education or occupational structures, or groups or clubs, which legitimise illness prevention and health-seeking among a peer group.

Appendix A: Parties involved in Northern Mallee LRG enactment

ORGANISATION	PROTOCOL FUNCTION	PRIMARY CONTACT (2021)
Mildura Base Public Hospital Area Mental Health Service, includes psychological therapy services, primary mental health clinical care coordination, mental health acute community intervention service. T: 03 5022 3500 or 1300 366 375	Lead	
headspace Mildura For people aged 12-25 years and their families	Lead	
Victoria or NSW Police	Core	
Murray PHN	Core	
GUESTS FOR INCLUSION IN NORTHERN MALLEE SUICIDE POSTVENTION ACTIVITY (AS APPROPRIATE)		
VICTORIAN SERVICES		
StandBy Murray - Support After Suicide Murray region T: 1300 727 247	Guest (see 3.1.1.1)	Check updated contact details at time of activation
General practitioners (various)	Guest (see 3.1.1.1)	
Sunraysia Community Health Services Provider of Psychological Therapy Services and HeadtoHelp (MentalHealthHub@schs.com.au) Mental health issues including: anxiety, depression, grief and loss, trauma, torture, abuse and counselling for refugees and new arrivals. Managing emotions including: self-esteem, interpersonal communication issues. Day rehabilitation, addiction and relapse prevention counselling. Home and hospital based detox and opioid replacement therapy (ORT). Healthy Mothers Healthy Babies Pregnancy and Parent Support Service, pain rehabilitation service, GP service, primary mental health clinical care coordination. 137 Thirteenth St, Mildura. T: 03 5022 5444 E: schs@schs.com.au	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Mallee District Aboriginal Services Social and Emotional Wellbeing Hub: referrals to psychologist and psychiatrist services. Psychological counselling available for people aged from 16 years and for children by referral in Mildura. Counselling is available for couples and family groups who are experiencing depression, anxiety or stress. Having trouble coping with life challenges. Wanting to improve their overall emotional wellbeing. Drug and alcohol issues. Need someone to talk to who isn't family. T: 03 5018 4100 (Mildura) T: 03 4013 2000 (Robinvale) mdas.org.au	Guest (see 3.1.1.2)	Check updated contact details for organisational representative at time of activation

ORGANISATION	PROTOCOL FUNCTION	PRIMARY CONTACT (2021)
Department of Education & Training Victoria Student Support Services Branch - Mallee North Western Region, 91 Pine Ave Mildura T: 1300 338 691	Guest (see 3.1.1.4)	Check updated contact details for organisational representative at time of activation
Wellways Australia, incorporating Australian HealthCall Group Mildura Way Back Support Service Mildura Prevention and Recovery Care (PARC) Mildura T: 1300 111 400	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Tristar Medical Group Treatments available include: psychotherapy, counselling, pharmacological interventions, specialist perinatal and suicide prevention psychological therapy services. Level 1, 87-89 Langtree Avenue Mildura. T: 03 5022 5800 tristarmedicalgroup.com.au	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Centacare Mildura Counselling, family and relationship services, Family Dispute Resolution Regional Parenting Program and Family Mental Health Support Service. 136 Lime Avenue, Mildura T: 03 5051 0050	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Mallee Family Care Children's mental health services providing therapy for children up to 12 years of age with an emerging mental health disorder. Specialist psychosocial support to manage mental health issues and improve wellbeing and quality of life. T: 03 5023 5966 (Mildura) T: 03 5027 7600 (Dareton) T: 03 5027 3578 (Wentworth) T: 03 5026 1401 (Robinvale) malleefamilycare.com.au	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Sunraysia Mallee Ethnic Communities Council 107-111 Twelfth Street, Mildura. T: 03 5022 1006 mecc.org.au	Guest (see 3.1.1.3)	Check updated contact details for organisational representative at time of activation

ORGANISATION	PROTOCOL FUNCTION	PRIMARY CONTACT (2021)
ROBINVALE SERVICES		
Murray Valley Aboriginal Corporation Multidisciplinary health service offering a range of primary care services, including general practice, social and emotional wellbeing, drug and alcohol counselling to the Aboriginal and Torres Strait Islander community. 87 Latje Road Robinvale T: 03 5026 3353 mvac.org.au	Guest (see 3.1.1.2)	Check updated contact details for organisational representative at time of activation
Robinvale District Health Services Health and wellbeing centre and access to counselling and social work services. 128-132 Latje Road, Robinvale T: 03 5051 8168 rdhs.com.au	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
OUYEN, MURRAYVILLE, UNDERBOOL, PATCHEWOLLOCK, SEA LAKE AND SURROUNDING DISTRICTS		
Mallee Track Community & Health Services T: 03 5092 1111	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
NSW SERVICES		
Far West Health Services, including Mental Health Drug and Alcohol Service Provides a range of services and programs for people living in Wentworth, and surrounding areas (Dareton, Buronga, Gol Gol, Euston) from a hub based in Broken Hill. T: 03 5021 7200 (Dareton Primary Health Centre) fwlhd.health.nsw.gov.au	Guest (see 3.1.1.1)	Check updated contact details for organisational representative at time of activation
Coomealla Health Aboriginal Corporation Free service with GPs, Aboriginal health practitioners and allied health workers. Delivering primary health care services to the NSW communities of Wentworth, Ellerslie, Pooncarie, Dareton, Buronga, Gol Gol, Euston and Balranald. Social emotional wellbeing support and suicide prevention education and support (Kumpa Kiira Suicide Prevention Project). 51 Sturt Place, Dareton, NSW T: 03 5027 4824 chacams.org	Guest (see 3.1.1.2)	Check updated contact details for organisational representative at time of activation
Department of Education & Communities NSW Student wellbeing E: wellbeing@det.nsw.edu.au	Guest (see 3.1.1.4)	Check updated contact details for organisational representative at time of activation

Appendix B: Relevant Acts and Legislation

B1. Guidance for collection, sharing and storage of information relating to an LRG enactment

The Health Records Act 2001 (Vic), which covers a wide range of organisations including local governments and police, provides guidance for the collection, sharing and storage of personal health information.

The information collected must be necessary for one or more functions of the organisation collecting it, and necessary to provide a health service or, for research or compilation or statistics in the public interest or required, authorised or permitted under law.

To achieve the purposes of the Northern Mallee Suicide Postvention Protocol, collection and sharing of health information to activate postvention and inform future community suicide prevention cannot feasibly be done with information that does not identify the individual, or from which the individual's identity cannot reasonably be ascertained.

Sections 1.1 (e), (f), (g) and Sections 2.2 (f), (g) of the Act allow for this if the collection and use is necessary for research, or the compilation or analysis of statistics in the public interest, to plan, monitor, improve or evaluate health services to prevent or lessen a serious threat to the life, health, safety or welfare of an individual or the public, where collection is by or on behalf of a law enforcement agency and where the information is not published in a generally available publication. Use of the information as part of an investigation or in reporting concerns to relevant persons or authorities is also covered in these sections of the Act – and in these circumstances Section 2.3 prescribes that the organisation must make a written note of the disclosure.

Section 2.5 of the Act qualifies disclosure and use restrictions by allowing an organisation to use or disclose health information about an individual when it is known or suspected that they are dead or have been involved in an accident or other misadventure and incapable of consenting. In these circumstances, identification of the individual and their immediate family members is allowed for the purposes of enabling a police officer, coroner or other prescribed organisation to make contact with the immediate family for compassionate reasons.

Specific to personal or health information shared by police within an LRG enactment, the Health Records Act 2001 (Vic) states that when personal information is given in confidence to a health service provider with a request that it not be communicated to the individual to whom it relates, the health service must record the information only if it is relevant to the provision of health services to, or care of, the individual, and take reasonable steps to record that the information was given in confidence and is to remain confidential.

The Health Records Act 2001 (Vic) speaks specifically to transborder data flows, stating that an organisation may transfer health information outside of Victoria if the recipient organisation is subject to similar requirements for the handling of information.

Under the Health Records Act 2001 (Vic) information collected and used in the LRG enactment must be held by Mildura Base Public Hospital, as organisational home for the Northern Mallee Suicide Postvention Protocol, in a manner that protects it from loss, unauthorised access, modification or disclosure.

B 1.1 Privacy for deceased persons

The Commonwealth and State of Victoria privacy legislation puts no limit on protection of personal information after death. In NSW, personal information protections exclude information about an individual who has been dead for more than 30 years.

The Health Records Act 2001 (Vic) applies to deceased individuals who have been dead for 30 years or less.

Section 346 of the Mental Health Act 2014 (Vic) allows disclosure where the person to whom the health information relates is deceased and the senior available next of kin of the person consents to its disclosure.

B 1.2 Privacy for living persons who have made a serious suicide attempt

The Mental Health Act 2014 (Vic) allows disclosure of health information where the disclosure is:

- reasonably necessary for the mental health service provider to perform functions
- required by another mental health service provider or a health service provider to provide health services
- made in general terms to a friend, family member or carer of the person to whom the health information relates and the disclosure is not contrary to the views and preferences expressed by the person
- is reasonably required by a carer of the patient to determine the nature and scope of the care to be provided to the patient and to make the necessary arrangements in preparation for that role or to provide care to the patient
- is made to a parent (where the person is under the age of 16 years) or guardian of the person to whom the health information relates
- reasonably required in connection with the performance of a duty or the exercise of a power by a support person.

B2. Key excerpts of Acts as relevant to the Northern Mallee Suicide Postvention Protocol

B 2.1 Privacy Acts – Commonwealth, NSW and Victoria

B2.1.1 Privacy Act 1988 (Cth) (Date accessed: 26 May 2020)

For the purposes of the Privacy Act 1988 (Cth), "personal information" includes information or an opinion that can be used to identify an individual, and can include a name and address, date of birth, as well as sensitive information. "Sensitive information" includes information relating to health, religion, race or ethnic origin.

Part 3 - Dealing with personal information

Australian Privacy Principle 6 - use or disclosure of personal information

Use or disclosure

6.1 If an APP entity holds personal information about an individual that was collected for a particular purpose (the primary purpose), the entity must not use or disclose the information for another purpose (the secondary purpose) unless:

(a) the individual has consented to the use or disclosure of the information or

(b) subclause 6.2 or 6.3 applies in relation to the use or disclosure of the information.

6.2 This subclause applies in relation to the use or disclosure of personal information about an individual if:

(a) the individual would reasonably expect the APP entity to use or disclose the information for the secondary purpose and the secondary purpose is:

(i) if the information is sensitive information directly related to the primary purpose or

(ii) if the information is not sensitive information - related to the primary purpose or

(b) the use or disclosure of the information is required or authorised by or under an Australian law or a court/tribunal order or

(c) a permitted general situation exists in relation to the use or disclosure of the information by the APP entity or

(d) the APP entity is an organisation and a permitted health situation exists in relation to the use or disclosure of the information by the entity or

(e) the APP entity reasonably believes that the use or disclosure of the information is reasonably necessary for one or more enforcement related activities conducted by, or on behalf of, an enforcement body.

Note: For *permitted general situation*, see section 16A. For permitted health situation, see section 16B.

6.3 This subclause applies in relation to the disclosure of personal information about an individual by an APP entity that is an agency if:

(a) the agency is not an enforcement body and

(b) the information is biometric information or biometric templates and

(c) the recipient of the information is an enforcement body and

(d) the disclosure is conducted in accordance with the guidelines made by the Commissioner for the purposes of this paragraph.

6.4 If:

(a) the APP entity is an organisation and

(b) subsection 16B(2) applied in relation to the collection of the personal information by the entity, the entity must take such steps as are reasonable in the circumstances to ensure that the information is de identified before the entity discloses it in accordance with subclause 6.1 or 6.2.

16A Permitted general situations in relation to the collection, use or disclosure of personal information

(1) A *permitted general situation* exists in relation to the collection, use or disclosure by an APP entity of personal information about an individual, or of a government related identifier of an individual if:

(a) the entity is an entity of a kind specified\in an item in column 1 of the table and

(b) the item in column 2 of the table applies to the information or identifier and

(c) such conditions as are specified in the item in column 3 of the table are satisfied.

Permitted general situations			
Item	**Kind of entity**	**Item applies to**	**Condition(s)**
1	APP entity	(a) personal information or (b) a government related identifier.	(a) it is unreasonable or impracticable to obtain the individual's consent to the collection, use or disclosure and (b) the entity reasonably believes that the collection, use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety.
2	APP entity	(a) personal information or (b) a government related identifier.	(a) the entity has reason to suspect that unlawful activity, or misconduct of a serious nature, that relates to the entity's functions or activities has been, is being or may be engaged in and (b) the entity reasonably believes that the collection, use or disclosure is necessary in order for the entity to take appropriate action in relation to the matter.
3	APP entity	Personal information	(a) the entity reasonably believes that the collection, use or disclosure is reasonably necessary to assist any APP entity, body or person to locate a person who has been reported as missing and (b) the collection, use or disclosure complies with the rules made under subsection (2).
4	APP entity	Personal information	The collection, use or disclosure is reasonably necessary for the establishment, exercise or defence of a legal or equitable claim.
5	APP entity	Personal information	The collection, use or disclosure is reasonably necessary for the purposes of a confidential alternative dispute resolution process.
6	Agency	Personal information	The entity reasonably believes that the collection, use or disclosure is necessary for the entity's diplomatic or consular functions or activities.
7	Defence Force	Personal information	The entity reasonably believes that the collection, use or disclosure is necessary for any of the following occurring outside Australia and the external Territories: (a) war or warlike operations (b) peacekeeping or peace enforcement (c) civil aid, humanitarian assistance, medical or civil emergency or disaster relief.

2) The Commissioner may, by legislative instrument, make rules relating to the collection, use or disclosure of personal information that apply for the purposes of item 3 of the table in subsection (1).

16B Permitted health situations in relation to the collection, use or disclosure of health information

Collection—provision of a health service

(1) A permitted health situation exists in relation to the collection by an organisation of health information about an individual if:

(a) the information is necessary to provide a health service to the individual and

(b) either:

(i) the collection is required or authorised by or under an Australian law (other than this Act) or

(ii) the information is collected in accordance with rules established by competent health or medical bodies that deal with obligations of professional confidentiality which bind the organisation.

(1A) A permitted health situation exists in relation to the collection by an organisation of health information about an individual (the third party) if:

(a) it is necessary for the organisation to collect the family, social or medical history of an individual (the patient) to provide a health service to the patient and

(b) the health information about the third party is part of the family, social or medical history necessary for the organisation to provide the health service to the patient and

(c) the health information is collected by the organisation from the patient or, if the patient is physically or legally incapable of giving the information, a responsible person for the patient.

Collection—research etc.

(2) A permitted health situation exists in relation to the collection by an organisation of health information about an individual if:

(a) the collection is necessary for any of the following purposes:

(i) research relevant to public health or public safety

(ii) the compilation or analysis of statistics relevant to public health or public safety

(iii) the management, funding or monitoring of a health service and

(b) that purpose cannot be served by the collection of information about the individual that is de identified information and

(c) it is impracticable for the organisation to obtain the individual's consent to the collection and

(d) any of the following apply:

(i) the collection is required by or under an Australian law (other than this Act)

(ii) the information is collected in accordance with rules established by competent health or medical bodies that deal with obligations of professional confidentiality which bind the organisation

(iii) the information is collected in accordance with guidelines approved under section 95A for the purposes of this subparagraph.

Use or disclosure - research etc.

(3) A permitted health situation exists in relation to the use or disclosure by an organisation of health information about an individual if:

(a) the use or disclosure is necessary for research, or the compilation or analysis of statistics, relevant to public health or public safety and

(b) it is impracticable for the organisation to obtain the individual's consent to the use or disclosure and

(c) the use or disclosure is conducted in accordance with guidelines approved under section 95A for the purposes of this paragraph and

(d) in the case of disclosure - the organisation reasonably believes that the recipient of the information will not disclose the information, or personal information derived from that information.

Use or disclosure - genetic information

(4) A permitted health situation exists in relation to the use or disclosure by an organisation of genetic information about an individual (the first individual) if:

(a) the organisation has obtained the information in the course of providing a health service to the first individual and

(b) the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of another individual who is a genetic relative of the first individual and

(c) the use or disclosure is conducted in accordance with guidelines approved under section 95AA and

(d) in the case of disclosure - the recipient of the information is a genetic relative of the first individual.

Disclosure - responsible person for an individual

(5) A permitted health situation exists in relation to the disclosure by an organisation of health information about an individual if:

(a) the organisation provides a health service to the individual and

(b) the recipient of the information is a responsible person for the individual and

(c) the individual:

(i) is physically or legally incapable of giving consent to the disclosure or

(ii) physically cannot communicate consent to the disclosure and

(d) another individual (the carer) providing the health service for the organisation is satisfied that either:

(i) the disclosure is necessary to provide appropriate care or treatment of the individual or

(ii) the disclosure is made for compassionate reasons and

(e) the disclosure is not contrary to any wish:

(i) expressed by the individual before the individual became unable to give or communicate consent and

(ii) of which the carer is aware, or of which the carer could reasonably be expected to be aware and

(f) the disclosure is limited to the extent reasonable and necessary for a purpose mentioned in paragraph (d).

Australian Privacy Principle 11 - security of personal information

11.1 If an APP entity holds personal information, the entity must take such steps as are reasonable in the circumstances to protect the information:

(a) from misuse, interference and loss and

(b) from unauthorised access, modification or disclosure.

11.2 If:

(a) an APP entity holds personal information about an individual and

(b) the entity no longer needs the information for any purpose for which the information may be used or disclosed by the entity under this Schedule and

(c) the information is not contained in a Commonwealth record and

(d) the entity is not required by or under an Australian law, or a court/tribunal order, to retain the information

(e) the entity must take such steps as are reasonable in the circumstances to destroy the information or to ensure that the information is de identified.

B.2.1.2 Privacy and Personal Information Protection Act 1998 (NSW) *(Date accessed 26 May 2020)*

The definition of 'personal information' within the Privacy and Personal Information Protection Act 1998 (NSW) excludes information about an individual who has been dead for more than 30 years.

18.0 Limits on use of personal information

A public sector agency that holds personal information must not use the information for a purpose other than that for which it was collected unless:

(a) the individual to whom the information relates has consented to the use of the information for that other purpose or

(b) the other purpose for which the information is used is directly related to the purpose for which the information was collected or

(c) the use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual to whom the information relates or of another person.

B 2.1.3 Privacy and Data Protection Act 2014 (Vic) *(Date accessed 26 May 2020)*

Part 3 – Information Privacy

Division 6 – Information Use Arrangements

6.45 Meaning of information usage arrangement

(1) In this Division, an information usage arrangement is an arrangement that:

(a) sets out acts or practices for handling personal information to be undertaken in relation to one or more public purposes and

(b) for any of those acts or practices, does any one or more of the following:

(i) modifies the application of a specified Information Privacy Principle (other than IPP 4 or 6) or an approved code of practice

(ii) provides that the practice does not need to comply with a specified Information Privacy Principle (other than IPP 4 or 6) or an approved code of practice

(iii) permits handling personal information for the purposes of an information handling provision.

(2) An information usage arrangement must:

(a) specify the parties to the arrangement; and Note See section 46 as to who can be a party to an information usage arrangement

(b) specify the personal information or type of personal information to be handled under the arrangement and

(c) describe how the arrangement would facilitate one or more public purposes and

(d) if handling personal information under the arrangement modifies or provides for noncompliance with an Information Privacy Principle or an approved code of practice:

(i) identify the Information Privacy Principle or approved code of practice and

(ii) state how the Information Privacy Principle or approved code of practice would be modified or not complied with and

(e) if the arrangement would be for the purposes of an information handling provision:

(i) identify the provision and

(ii) describe the effect of the provision and

(f) for every party to the arrangement:

(i) describe the personal information or type of personal information that the party could disclose or transfer to other parties to the arrangement and

(ii) state the manner in which a party could use personal information, including whether a party could disclose that information to another person or body and in what circumstances and

(g) for every organisation that is a party to the arrangement:

(i) state adverse actions that an organisation could reasonably be expected to take as a result of handling personal information under the arrangement and

(ii) specify the procedure that an organisation must follow before taking adverse action as a result of handling of personal information under the arrangement.

(3) An information usage arrangement may include an expiry date. However, if an information usage arrangement does not do so, it must include the reason why it does not do so.

6.46 Parties to an information usage arrangement

The parties specified in an information usage arrangement may only be:

(a) in the case of a single party, an organisation (other than a contracted service provider) and

(b) otherwise, an organisation (other than a contracted service provider) and one or more of the following:

(i) another organisation

(ii) a person or body that is an agency of the Commonwealth, another State or a Territory

(iii) any other person or body (including a private sector body) that is not an organisation, whether or not located within Victoria.

6.47 Information Commissioner to consider information usage arrangement

(1) A lead party may apply for approval of an information usage arrangement by submitting to the Information Commissioner an information usage arrangement.

(2) The Information Commissioner may:

(a) direct each organisation that is a party to the information usage arrangement to consult with any person that the Information Commissioner considers appropriate and

(b) consult any person that the Information Commissioner considers appropriate.

(3) If the arrangement would modify the application of, or provide for noncompliance with, a specified Information Privacy Principle or an approved code of practice, the Information Commissioner must consider whether the public interest in handling personal information under the information usage arrangement in the way specified under section 45(2)(d) would substantially outweigh the public interest in complying with the specified Information Privacy Principle or approved code of practice.

(4) If the arrangement is for the purposes of an information handling provision, the Information Commissioner must consider whether the public interest in treating the handling of personal information as being permitted for the purpose of the information handling provision would substantially outweigh the public interest in treating that handling of information as not being permitted for the purpose of the information handling provision.

B 2.2 Health records

B 2.2.1 Health Records Act 2001 (Vic) (Date accessed 26 May 2020)

The Act applies to the health, disability and aged care information handled by a wide range of public and private sector organisations. This includes health service providers, and also other organisations that handle such information. For example:

- bodies such as companies, incorporated associations, unincorporated associations, local government, Victorian government agencies and departments, public hospitals and other public bodies such as Victoria Police and
- sole practitioners, partnerships, members of parliament and trustees.

Relevant excerpts:

95 Deceased individuals (1)

This Act applies in relation to a deceased individual who has been dead for 30 years or less, so far as it is reasonably capable of doing so, in the same way as it applies in relation to an individual who is not deceased.

Principle 1 - Collection: when health information may be collected

1.1 An organisation must not collect health information about an individual unless the information is necessary for one or more of its functions or activities and at least one of the following applies:

(a) the individual has consented

(b) the collection is required, authorised or permitted, whether expressly or impliedly, by or under law (other than a prescribed law)

(c) the information is necessary to provide a health service to the individual and the individual is incapable of giving consent within the meaning of section 85(3) and:

(i) it is not reasonably practicable to obtain the consent of an authorised representative of the individual within the meaning of section 85 or

(ii) the individual does not have such an authorised representative

(d) if the collection is necessary for research, or the compilation or analysis of statistics, in the public interest:

(i) that purpose cannot be served by the collection of information that does not identify the individual or from which the individual's identity cannot reasonably be ascertained and

(ii) it is impracticable for the organisation to seek the individual's consent to the collection and

(iii) the information is collected in accordance with guidelines issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this subparagraph:
Section 22 (5) the Health Complaints Commissioner may only issue, approve or vary guidelines that would have the effect of lessening the level of privacy protection afforded by the relevant Health Privacy Principle if he or she is satisfied that the public interest to be protected by the guidelines, or the guidelines as varied, substantially outweighs the public interest in maintaining that level of privacy protection.

(e) the collection is necessary to prevent or lessen:

(i) a serious threat to the life, health, safety or welfare of any individual or

(ii) a serious threat to public health, public safety or public welfare - and the information is collected in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this paragraph

(f) the collection is by or on behalf of a law enforcement agency and the organisation reasonably believes that the collection is necessary for a law enforcement function

Information given in confidence

1.7 If personal information is given in confidence to a health service provider about an individual by a person other than:

(a) the individual or

(b) a health service provider in the course of, or otherwise in relation to, the provision of health services to the individual - with a request that the information not be communicated to the individual to whom it relates, the provider must:

(c) confirm with the person that the information is to remain confidential and

(d) if the information remains confidential:

(i) record the information only if it is relevant to the provision of health services to, or the care of, the individual and

(ii) take reasonable steps to ensure that the information is accurate and not misleading and

(e) take reasonable steps to record that the information is given in confidence and is to remain confidential.

Principle 2 - use and disclosure

2.1 An organisation may use or disclose health information about an individual for the primary purpose for which the information was collected in accordance with HPP 1.1.

2.2 An organisation must not use or disclose health information about an individual for a purpose (the secondary following paragraphs applies:

(a) both of the following apply:

(i) the secondary purpose is directly related to the primary purpose and

(ii) the individual would reasonably expect the organisation to use or disclose the information for the secondary purpose or

(b) the individual has consented to the use or disclosure or

(c) the use or disclosure is required, authorised or permitted, whether expressly or impliedly, by or under law (other than a prescribed law) or

(d) all of the following apply:

(i) the organisation is a health service provider providing a health service to the individual and

(ii) the use or disclosure for the secondary purpose is reasonably necessary for the provision of the health service and

(iii) the individual is incapable of giving consent within the meaning of section 85(3) and:

(A) it is not reasonably practicable to obtain the consent of an authorised representative of the individual within the meaning of section 85 or

(B) the individual does not have such an authorised representative or

(e) all of the following apply:

(i) the organisation is a health service provider providing a health service to the individual and

(ii) the use is for the purpose of the provision of further health services to the individual by the organisation and

(iii) the organisation reasonably believes that the use is necessary to ensure that the further health services are provided safely and effectively and

(iv) the information is used in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this paragraph or

(f) the use or disclosure is for the purpose of:

(i) funding, management, planning, monitoring, improvement or evaluation of health services or

(ii) training provided by a health service provider to employees or persons working with the organisation and

(iii) that purpose cannot be served by the use or disclosure of information that does not identify the individual or from which the individual's identity cannot reasonably be ascertained and it is impracticable for the organisation to seek the individual's consent to the use or disclosure or

(iv) reasonable steps are taken to de-identify the information and

(v) if the information is in a form that could reasonably be expected to identify individuals, the information is not published in a generally available publication and

(vi) the information is used or disclosed in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this subparagraph or

(g) if the use or disclosure is necessary for research, or the compilation or analysis of statistics, in the public interest:

(i) it is impracticable for the organisation to seek the individual's consent before the use or disclosure and

(ii) that purpose cannot be served by the use or disclosure of information that does not identify the individual or from which the individual's identity cannot reasonably be ascertained and

(iii) the use or disclosure is in accordance with guidelines issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this subparagraph and

(iv) in the case of disclosure

(A) the organisation reasonably believes that the recipient of the health information will not disclose the health information and

(B) the disclosure will not be published in a form that identifies particular individuals or from which an individual's identity can reasonably be ascertained or

(h) the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent:

(i) a serious threat to an individual's life, health, safety or welfare or

(ii) a serious threat to public health, public safety or public welfare - and the information is used or disclosed in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this paragraph or

(iii) the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the health information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities and, if the organisation is a registered health practitioner, the use or disclosure would not be a breach of confidence or

(j) the organisation reasonably believes that the use or disclosure is reasonably necessary for a law enforcement function by or on behalf of a law enforcement agency and, if the organisation is a registered health practitioner, the use or disclosure would not be a breach of confidence or

(k) the use or disclosure is necessary for the establishment, exercise or defence of a legal or equitable claim or

(l) the use or disclosure is in the prescribed circumstances. Note nothing in HPP 2 requires an organisation to disclose health information about an individual. An organisation is always entitled not to disclose health information in the absence of a legal obligation to disclose it.

2.3 If an organisation discloses health information under paragraph (i) or (j) of HPP 2.2, it must make a written note of the disclosure.

2.4 Despite HPP 2.2, a health service provider may disclose health information about an individual to an immediate family member of the individual if:

(a) either:

(i) the disclosure is necessary to provide appropriate health services to or care of the individual or

(ii) the disclosure is made for compassionate reasons and

(b) the disclosure is limited to the extent reasonable and necessary for the purposes mentioned in paragraph and

(c) the individual is incapable of giving consent to the disclosure within the meaning of section 85(3) and

(d) the disclosure is not contrary to any wish:

(i) expressed by the individual before the individual became incapable of giving consent and not changed or withdrawn by the individual before then and

(ii) of which the organisation is aware or could be made aware by taking reasonable steps and

(e) in the case of an immediate family member who is under the age of 18 years, considering the circumstances of the disclosure, the immediate family member has sufficient maturity to receive the information.

2.5 Despite HPP 2.2, an organisation may use or disclose health information about an individual where:

(a) it is known or suspected that the individual is dead or

(b) it is known or suspected that the individual is missing or

(c) the individual has been involved in an accident or other misadventure and is incapable of consenting to the use or disclosure - and the use or disclosure is to the extent reasonably necessary

(d) to identify the individual or

(e) to ascertain the identity and location of an immediate family member or other relative of the individual for the purpose of:

(i) enabling a police officer, a coroner or other prescribed organisation to contact the immediate family member or other relative for compassionate reasons or

(ii) to assist in the identification of the individual - and, in the circumstances referred to in paragraph (b) or (c)

(f) the use or disclosure is not contrary to any wish:

(i) expressed by the individual before he or she went missing or became incapable of consenting and not withdrawn by the individual and

(ii) of which the organisation is aware or could have become aware by taking reasonable steps and

(g) the information is used or disclosed in accordance with guidelines, if any, issued or approved by the Health Complaints Commissioner under section 22 for the purposes of this paragraph.

Principle 4 - Data Security and Data Retention

4.1 An organisation must take reasonable steps to protect the health information it holds from misuse and loss and from unauthorised access, modification or disclosure.

Principle 9 - Transborder Data Flows

9.1 An organisation may transfer health information about an individual to someone (other than the organisation or the individual) who is outside Victoria only if:

(a) the organisation reasonably believes that the recipient of the information is subject to a law, binding scheme or contract which effectively upholds principles for fair handling of the information that are substantially similar to the Health Privacy Principles or

(b) the individual consents to the transfer or

(c) the transfer is necessary for the performance of a contract between the individual and the organisation, or for the implementation of pre-contractual measures taken in response to the individual's request or

(d) the transfer is necessary for the conclusion or performance of a contract concluded in the interest of the individual between the organisation and a third party or

(e) all of the following apply:

(i) the transfer is for the benefit of the individual

(ii) it is impracticable to obtain the consent of the individual to that transfer

(iii) if it were practicable to obtain that consent, the individual would be likely to give it or

(f) the organisation has taken reasonable steps to ensure that the information which it has transferred will not be held, used or disclosed by the recipient of the information inconsistently with the Health Privacy Principles or

(g) the transfer is authorised or required by any other law.

B 2.2.2 Mental Health Act 2014 (Vic) (Date accessed 26 May 2020)

Provisions under this act cover disclosure of health information about individuals (whether deceased or not) by mental health service providers, as well as their employees, officers, contractors and volunteers (whether current or former).

Circumstances under which disclosure of health information is allowed:

(2) Subsection (1) does not apply in the following circumstances:

(a) the person to whom the health information relates consents to its disclosure

(b) the person to whom the health information relates is deceased and the senior available next of kin of the person consents to its disclosure

(c) the disclosure is reasonably necessary for the mental health service provider to perform functions or exercise powers under this or any other Act

(d) the disclosure is permitted by an Act other than the Health Records Act 2001

(e) the disclosure is permitted by Health Privacy Principle 2.1, 2.2 (a), (f), (g), (h) or (k) or 2.5

(f) the disclosure is required by another mental health service provider or a health service provider (within the meaning of section 3 of the Health Records Act 2001) to provide health services (within the meaning of section 3 of the Health Records Act 2001) to the person to whom the health information relates

(g) the disclosure is made in general terms to a friend, family member or carer of the person to whom the health information relates and the disclosure is not contrary to the views and preferences expressed by the person that the health information must not be disclosed to that friend, family member or carer

(h) the person to whom the health information relates is a patient and:

(i) the disclosure is reasonably required by a carer of the patient to determine the nature and scope of the care to be provided to the patient and to make the necessary arrangements in preparation for that role or to provide care to the patient and

(ii) regard has been had to the patient's views and preferences, including those expressed in any advance statement that the patient may have prepared

(i) the disclosure is made to a psychiatrist giving a second psychiatric opinion for the purposes of Division 4 of Part 5 of this Act and the disclosure includes:

(i) providing access to the clinical records of a patient or

(ii) discussing the treatment of a patient with the psychiatrist giving a second psychiatric opinion

(j) the disclosure is made to a parent of the person to whom the health information relates and the person is under the age of 16 years

(k) the disclosure is made to the Secretary and the person to whom the health information relates is the subject of a family reunification order or a care by Secretary order

(l) the disclosure is reasonably required in connection with the performance of a duty or the exercise of a power by the Minister, the Secretary, the Commissioner, the chief psychiatrist or an authorised officer under this Act or the regulations

(m) the disclosure is required in connection with a proceeding before the Tribunal, VCAT or the Panel

(n) the disclosure is required by a court in connection with a proceeding under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997

(o) the disclosure is made to a guardian of the person to whom the health information relates and the disclosure is reasonably required in connection with the performance of a duty or the exercise of a power by the guardian

(p) the disclosure is:

(i) made to the medical treatment decision maker of the person to whom the health information relates and

(ii) reasonably required in connection with the performance of a duty or the exercise of a power by the medical treatment decision maker

(pa) the disclosure is:

(i) made to a support person of the person to whom the health information relates and

(ii) reasonably required in connection with the performance of a duty or the exercise of a power by the support person

(q) the disclosure is required in connection with a notification, claim or possible claim to a person or body providing insurance or indemnity (including discretionary indemnity) for any possible liability of the mental health service provider arising out of the provision of mental health services.

Appendix C: Information record in use in Victoria Police Western Region Division 6

Interviewing officers in Victoria Police Western Region Division 6 use the table below to assist in their interactions with those people bereaved by suicide and to inform their coronial investigations.

Interviewing officers are asked to acquire information against each of the headings, recording 'unknown' if they are unable to find information after diligent enquiry.

The interviewing officers in this division are also asked to make Victoria Police e-Referral Program (VPeR) referrals for the deceased's immediate family and significant others by consent, and for any civilians who located the deceased. The division's leadership has directed interviewing officers to conduct follow-up for those who may not consent to a VPeR referral on first contact. This is described as:

"Although consent for a VPeR may not be given in the first instance, please contact the affected parties 3-4 days following the incident to see whether they have changed their mind. Suicide is a traumatic event and support networks for affected parties is important."

Information gathered by interviewing officers in Victoria Police Western Region Division 6 is shared in Northern Mallee LRG enactments to achieve the purposes of the Northern Mallee Suicide Postvention Protocol.

Table 1. Personal, sensitive and health information collected by interviewing officers in Victoria Police Western Region Division 6 post-suicide death (from July 2019)

Age	
Gender	
Suburb of residence	
Occupation	
Suburb of death	
Suicide method	
Sexual identity	
Aboriginal or Torres Strait Islander	
Culturally and linguistically diverse	
Schools/universities attended	
Personal relationship status (if recently separated, include details)	
Children	
Disability	
Physical disorders e.g. chronic pain/illness/disability	
Mental illness - list mental health issues	
Engagement with mental health services - list organisations	

Mental health presentations (police initiated)	
Recent police contact (within previous 12 months)	
Outstanding criminal charges	
Current respondent in IVO or PSIVO	
Current AFM/complainant in IVO or PSIVO	
Previous attempt at suicide	
History of financial hardship	
History of self-harm	
History of substance abuse (alcohol or drugs)	
History of problematic gambling (define type)	
History of bullying (victim)	
History of sexual assault (victim)	
History of physical abuse (victim)	
History of neglect (victim)	
History of major life crisis	
Family history of suicide	
Family history of mental illness	
Exposure to someone who has died - particularly by suicide	
Predilection for violent video games	
Engagement with sporting/social clubs	
Engagement with religion	
VPeR referrals made (names and relationship with deceased)	

Appendix D: Northern Mallee Suicide Postvention Protocol – LRG activation template

LRG Activation Report

Following a (suspected) suicide/serious attempt, representatives from mental health, Victoria Police and Murray PHN come together to share factual information with the intent to reduce community impact by ensuring appropriate supports are identified and activated. On a broader level, the group also monitors trends and risk factors to assist with suicide prevention activities.

This report is confidential. Under the Health Records Act 2001 (Vic), information collected and used in the LRG enactment must be held by Mildura Base Public Hospital as the organisational home for the Northern Mallee Suicide Postvention Protocol, in a manner that protects it from loss, unauthorised access, modification or disclosure. During an LRG enactment, and in the course of any activities undertaken in relation to it, the personal information of individuals must be protected and dealt with in accordance with all applicable privacy legislation and statutory obligations[29].

Date of meeting	
Present	
Apologies	
Guests	

Name of deceased	
Age of deceased	
Date of incident	
Location and suburb of incident	
Incident code	

Incident register

Service involvement	Vulnerabilities	Communitiy affiliation e.g. school, workplace, sporting clubs etc	Family details	Incident details/ circumstances

Vulnerable persons register

	Individual/Group	Relationship	Supports to be offered
Population at risk: increased vulnerability to suicide e.g. mental illness trauma, prior suicidal behaviour, alcohol and other drugs, familial conflict, history of family or peer suicide			
Social proximity: relationships with the deceased e.g. family, friends, romantic partner or ex-partner, professionals with working relationship			
Psychological proximity: identification with the deceased e.g. shared similar characteristics or life problems or experiences			
Geographical proximity: the physical distance a person is from the event location e.g. eyewitnesses, people exposed, first responders, distance to location			

Summary

Perception of risk	Comments
Potential for community distress	
Risk of social transmission of suicidal behaviours	
Potential for media interest	
Other possible or emerging issues	
LRG debrief/ evaluation recommended	

Activity register

Actions arising		
Date	Whom	Action
Actioned		
Date	Whom	Action
Action outcomes post LRG meeting		
Date	Whom	Action

References

1 Activation for suicide deaths of young people (12-25 years) and for those from an Aboriginal and Torres Strait Islander background.

2 A notable shift is reported to take place at the five-year mark after the suicide - with a decrease in the severity of distress levels reported after that time. Those identifying as Aboriginal and Torres Strait Islander were found to experience higher rates of suicide exposure (and distress) compared to the non-indigenous respondents (reporting on average 7 people known to them who had died by suicide) (Maple et al., 2016).

3 Prior exposure to suicide was associated with 3.23-fold increased odds of suicide and 2.91-fold increased odds of suicide attempt (N. T. M. Hill et al., 2020).

4 Death or suspected death by suicide - cause of death is determined by each state's Coroner's Court and ruling about cause of death can take some time. To achieve timely postvention activity all police notified suicide deaths (whether suspected or confirmed) will be treated as 'Death by Suicide'. Therefore, the term 'suicide' also encompasses 'suspected suicide' within this protocol.

5 Serious attempt at suicide/near miss - Within the Northern Mallee Suicide Postvention Protocol, a 'serious suicide attempt' is defined as 'an incident that had the potential to cause harm but didn't, due to timely intervention and/or luck and/or chance' (Department of Health, 2011) where this intervention was not anticipated.

6 Evaluation of an 'active' postvention service for the suicide bereaved (Australian StandBy Response Service) showed that it appeared to reduce negative impacts on physical and mental health, including lower levels of suicidality (particularly within the first two years after the loss) as compared to bereaved who did access the service (United Synergies, 2011). This evaluation also showed that StandBy clients reported higher levels of productivity (work attendance) and less frequent use of health care services after service access.

7 Opportunities for activating 'natural or common supports' via postvention are highlighted in an Australian study (Aoun et al., 2015) which identified three sources of support accessed by bereaved people: 'informal', 'community' and 'professional'.

8 See 4.1.1 Parties involved in Northern Mallee LRG Enactment

9 Exposure to suicide and suicide attempt do not incur uniform risk across the range of suicide-related outcomes. Recent findings propose that exposure to suicide is associated with increased odds

of suicide and suicide attempt—in contrast to exposure to suicide attempt, which is associated with increased odds of suicide attempt only. This distinction is considered important for postvention and public health approaches, and for the prevention of behavioural contagion of both suicide and suicide attempt within a community (N. T. M. Hill et al., 2020);

10 Contagion is a concept from the study of infectious diseases where the underlying assumption is that suicidal behaviour may incite subsequent suicidal behaviour, either directly (via contact or friendship) or indirectly (via word of mouth or via media), behaving like an epidemic. Those who are at greatest risk of contagion are those who have geographical proximity to a suicide (those who witness the suicide or who were exposed to the immediate aftermath), have psychosocial proximity (a high level of identification with the deceased), and who are part of an at risk population (possess pre-existing vulnerabilities; e.g., mental illness, substance misuse, or family conflict) (Haw, Hawton, Niedzwiedz, & Platt, 2013). NB: In public facing documents or forums, individuals with lived experience recommend use of the phrase 'social transmission of suicidal behaviour' rather than 'contagion' (Hawton et al., 2020).

11 See Section 4.1.1 Parties involved in Northern Mallee LRG Enactment

12 See Section 3.1.1 Parties involved in Northern Mallee LRG Enactment

13 See Section 3.1.2 Criteria for LRG Enactment

14 Prior to making contact schools should: undertake immediate risk management processes, follow emergency management protocols, and contact their relevant department or school authority.

15 Under this criteria, the LRG may not need to be activated for all suicide deaths or serious attempts within the Northern Mallee. Likewise, enactment may occur at the discretion of the chair in the event the criteria is not met.

16 Past activity in the Northern Mallee has generated learning on high risk and vulnerable groups for suicide as being: males; young women; Aboriginal and Torres Strait Islanders; perpetrators of family violence; those with alcohol or other substance abuse issues; those with recent interaction with police or the justice system; those experiencing situational distress (financial, relationship breakdown etc). Groups that are overrepresented

in the national suicide statistics also include: LGBTQI+; ex-military personnel; and those living in rural and remote Australia.

17 Young people may be particularly vulnerable following the suicide of another young person in the community and may require access to specific youth appropriate support services.

18 Safer Care Victoria defines a 'sentinel event' as an adverse safety event that results in serious harm or death of a patient while in the care of a health service.

19 Those bereaved by suicide are themselves at higher risk of a range of ongoing detrimental impacts - including (but not limited to) depression, anxiety, alcohol or substance abuse, disruption of family relations and routines, functional impairments in daily activities, difficulties with relationships (Andriessen & Krysinska, 2012). They are also at risk of suicidal ideation and associated at risk behaviours, and at higher risk of being part of a suicide cluster (Hawton, Lascelles, Husband, John, & Percy, 2019).

20 Privacy Act 1988 (Cth), Privacy and Personal Information Protection Act 1998 (NSW), Privacy and Data Protection Act 2014 (Vic), Health Records Act 2001 (Vic), and Mental Health Act 2014 (Vic). These Acts mean that all participants in Northern Mallee LRG enactment are required to comply, regardless if they are from a federal or state government agency, an independent organisation or participating as an individual. Within these Acts extra privacy allowances and exemptions generally apply for law enforcement agencies and health services, however situations contravening the principles described in section 3.1.3.2 should be pursued and examined individually prior to contravention. The Commonwealth and State of Victoria privacy legislation puts no limit on protection of personal information after death. In NSW, personal information protections exclude information about an individual who has been dead for more than 30 years. Collection, use or disclosure of personal information is generally permitted in situations where 'the entity reasonably believes that the collection, use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety.' Collection, use and disclosure of personal information is generally permitted in health situations where: the information is necessary to provide a health service to the individual; the collection is necessary for research, compilation or analysis of statistics relevant to public health or safety; is necessary to lessen or prevent a serious threat to the life, health or safety of another individual who is a genetic relative of the first individual; the collection is for management or monitoring of a health service and that purpose can't be served by information that is de-identified or it is impracticable to obtain the individual's consent. In law enforcement it is permitted for the purposes of community policing or in relation to any other law enforcement agency's functions or activities.

21 Routine collection of exposure to suicide as part of the police and coroner investigation, as well as the inclusion of exposure to suicide in the core-data set of suicide cluster surveillance systems, has the potential to improve postvention responses where there are social links between cluster members (Hill, Too, Spittal, & Robinson, 2020).

22 Within Victoria, VPeR referrals for support after suicide are directed to StandBy Murray – who hold the contract for postvention support across the Northern Mallee Region. At their discretion, StandBy Murray can also provide support after suicide services to NSW border locations where those within the community may identify as being part of their close Victorian community (e.g where they are separated by just a bridge or a river). In the Northern Mallee this means that StandBy Murray can provide support after suicide services in NSW Barrier Police District locations such as Wentworth, Dareton, Buronga and Euston.

23 Trends should also consider 12-month anniversaries or other significant events that may need to be planned for.

24 Data and information collected from Northern Mallee LRG enactments may be shared with the following organisations who hold responsibility for strategic suicide prevention and community response planning in the region: the Victorian Department of Health and Human Services; the Victorian Coroner's Prevention Unit; Murray PHN; Mildura Rural City Council; and state or federal agencies who may be deemed responsible. The LRG Chair must ensure that such sharing complies with provisions in the Health Records Act 2001 (Vic).

25 'Key influencers' are considered to be those organisations and/or individuals who have influence within the demographic of concern. Examples of past influencers targeted by Northern Mallee Postvention activity include: Department of Education and Training; Mallee Sports Assembly; local media.

26 See Section 4.2 Mitigating Population Health Impacts

27 Orygen, 2020, A guide for communities: Using social media following the suicide of a young person and to help prevent suicide clusters, Melbourne, Australia

28 Robinson, J., Hill, N., Thorn, P., Teh, Z., Battersby, R., & Reavley, N., #chatsafe: A young person's guide for communicating safely online about suicide. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2018.

29 Privacy Act 1988 (Cth), Privacy and Personal Information Protection Act 1998 (NSW), Privacy and Data Protection Act 2014 (Vic), Health Records Act 2001 (Vic), and Mental Health Act 2014 (Vic). These Acts mean that all participants in an Northern Mallee LRG enactment are required to comply, regardless if they are from a federal or state government agency, an independent organisation or participating as an individual.

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