



Australian Government

Interim Advice Report:

Towards a national whole-of-government approach to suicide prevention in Australia

A Report developed by the National Suicide Prevention Taskforce
as part of the Interim Advice to the Prime Minister

August 2020

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Foreword

Each suicide is a tragedy. Each suicide attempt is devastating to everyone involved. Reducing suicidal behaviour is the responsibility of all governments, all portfolios and all communities. We can only realise the benefits of a national whole-of-government approach to suicide prevention, if we outline the necessary actions and all collectively commit to implementing them.

The *Interim Advice* builds on the *Initial Findings* provided to government in November 2019. Those findings focused on current suicide prevention activities in Australia and examined their effectiveness. The *Initial Findings* called for a paradigm shift to a more assertive outreach approach aimed at preventing the onset of suicidal behaviours and responding much earlier to distress. It also called for the approach to be informed by lived experience.

The *Interim Advice* is based on further consultation and research conducted since November, and in the context of the Commonwealth Government's response to the bushfires and the COVID-19 pandemic. It focuses on how we can build a shared understanding of suicidal behaviour, as well as what a national whole-of-government approach should look like and how it can be achieved.

A whole-of-government approach is vital to moving from activities predominantly focused on suicide *intervention* to a more substantive suicide *prevention* approach. We need to ensure that, through the breadth of government and other services, we can address the social and economic drivers of distress and reach out to people as early as possible, building social connection, support and hope. This need for such an enhanced and extended approach is informed by the experiences of those that have a lived experience of suicidal behaviour as well as caregivers and those bereaved by suicide.

When our work commenced in 2019 no one could have anticipated a global pandemic occurring so closely behind the devastating bushfires and long-term drought. The events of this year have affected so many Australians, whether through social isolation, loss of employment, housing or financial instability, domestic violence, physical or mental illness, or the death of a loved one. We have worked with governments to ensure the COVID-19 response packages developed for the Australian people have considered their impact on suicide behaviour and the contribution they make to suicide prevention. The response has required a whole-of-government focus, which has afforded opportunities to further consider the cross-portfolio approach that is required in the longer-term.

This *Interim Advice Report* provides the background to the in-principle recommendations for shifting to a national whole-of-government approach. We look forward to consulting with stakeholders to refine these recommendations for inclusion in the Final Advice Report in December.

Christine Morgan

National Suicide Prevention Adviser

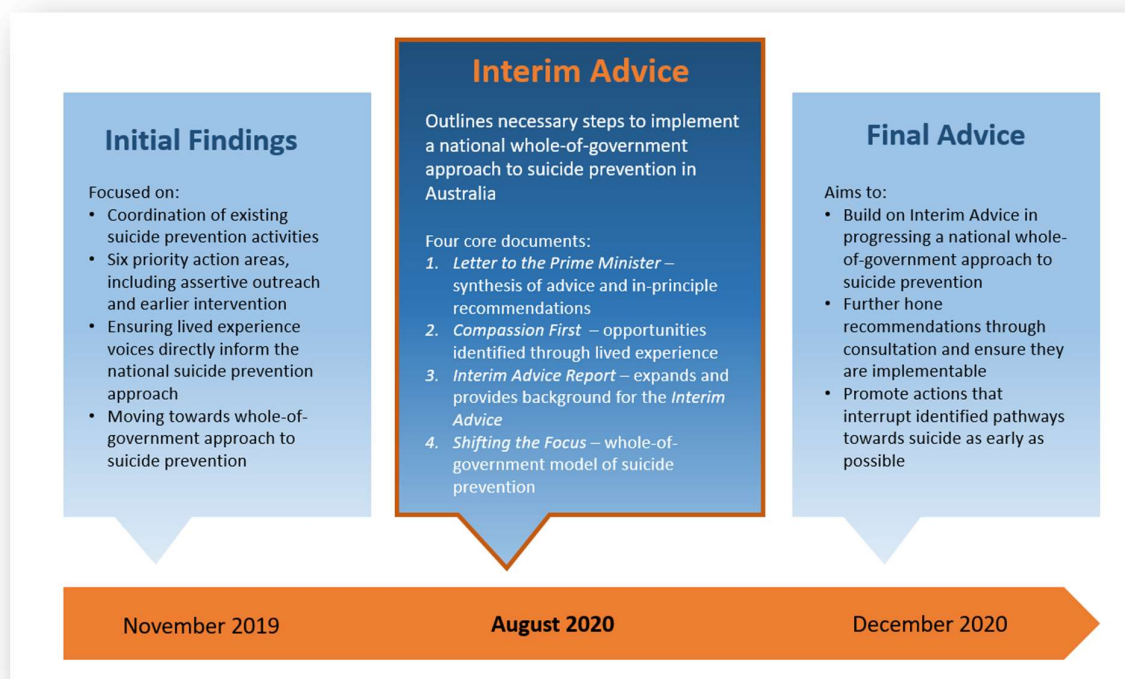
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“Being suicidal is exhausting and all-consuming. Most of the time, those who are suicidal are also trying to keep their and their family’s day-to-day life afloat. Expectations on us to reach out, follow up, navigate siloed services and systems, chase referrals, do extra or self-advocate are completely unrealistic.”

Statement from Lived Experience contributor at the Black Dog Institute

Four core documents that form the interim advice

This report is one of four core documents that together form the *Interim Advice* and outline the necessary actions for government to enable a national whole-of-government approach to suicide prevention. This approach requires an expanded understanding across government and community of suicidal behaviour, vulnerabilities and protective factors. In line with the *Initial Findings*, the *Interim Advice* is informed by work that has been undertaken to map and thematically analyse the journeys of those with lived experience of suicide. The *Interim Advice* has also been formed through consultation with representatives from government and suicide prevention experts, with ongoing input from the Expert Advisory Group.



Purpose of this document

This report expands on and provides background to support the in-principle recommendations. The initial chapter provides the context to the *Interim Advice*, describing the relevant current and pending reforms and the impact of recent events such as bushfires and the COVID-19 pandemic. There is chapter that provides the core principles for a whole-of-government approach and the governance options that would support improved national and regional approaches. A chapter of the report addresses the importance of data and evidence, with later chapters focusing on cross-portfolio and multijurisdictional approaches and actions for unlocking progress on the health-led and the Aboriginal and Torres Strait Islander suicide prevention strategies.

Drawing from Lived Experience

The *Initial Findings* presented to the Prime Minister in November 2019 identified an urgent need to better understand the journeys and experiences of people who have lived experience of suicidal distress and suicide attempt. This is critical to guiding the shift to a whole-of-government approach. Without their knowledge, experience and expertise, the reforms and service improvements will fall short of what people and their caregivers need. In the accompanying document – *Compassion First: Designing our national approach from the lived experience of suicidal behaviour*, some key insights of people with lived experience of suicidal thoughts and behaviours have been documented via research commissioned by the Taskforce. While the findings emphasised that there was no simple or singular pattern of experiences that precedes a suicide attempt, there were some identified commonalities or shared experiences that provide opportunities to interrupt the trajectory towards suicide. These opportunities have been used throughout the crafting of this report to inform the background to the *Interim Advice*.

Links to *Shifting the Focus* – a National Suicide Prevention Model

To support the shift towards a national whole-of-government approach to suicide prevention in Australia, the *Interim Advice* includes *Shifting the Focus: A whole-of-government approach to suicide prevention in Australia*. This document provides a guide to help government departments and agencies to shift suicide prevention to a whole-of-government approach, and includes a practical decision-making tool that they can use to develop and refine their own suicide prevention activities. Throughout this report, you will see breakout boxes that point to how the work of the Taskforce has fed into the development of the model (see *Shifting the Focus* document).

Interim advice recommendations and priority actions

In the body of this *Interim Advice Report* are a series of 13 ‘in-principle’ recommendations to be tested with government agencies and stakeholders. Further priority actions, which support the shift towards a national whole-of-government approach, are also included throughout the chapters for consideration.

Chapter 1: Current context

“What services are people accessing during their most vulnerable time? Services located everywhere and anywhere that might deal with social, emotional, physical, financial, or spiritual problems or needs. From the grocery store to Centrelink, a General Practitioner to Emergency Department, spiritual or religious supports to a sports club.”

Statement from Lived Experience contributor at the Black Dog Institute

Meaningful and sustained change to suicide prevention in Australia cannot happen in a vacuum. To achieve a national whole-of-government approach the change needs to leverage off mental health reforms and drive transformation in other portfolios.

The findings in this report need to be considered within the context of current reform efforts at the national and jurisdictional level. In this section, the key elements of this work are briefly outlined.

1.1 National reforms

The Fifth National Mental Health and Suicide Prevention Plan

The *Fifth National Mental Health and Suicide Prevention Plan 2017-2022* (Fifth Plan), to which all Australian governments have committed, includes suicide prevention as one of its eight priority areas. The Fifth Plan also incorporates the *National Suicide Prevention Strategy for Australia's health system: 2020-2023* (Health Suicide Prevention Strategy) which forms the foundation for current national suicide prevention health-led reform initiatives. This is discussed in more detail in Chapter 6 of this report.

Productivity Commission inquiry into Mental Health

On 23 November 2018, the Commonwealth Government requested the Productivity Commission undertake an inquiry into the role improving mental health to support economic participation and enhancing productivity and economic growth. At the time of writing this report, the Final Report of the Productivity Commission has been handed to the Commonwealth Government and is due to be tabled in Parliament later this year.

Noting that the Final Report may differ slightly from the Productivity Commission's Draft Report, there is nonetheless clear alignment between the Draft Report's recommendations and the *Interim Advice* in-principle recommendations. In particular, there has been a consistent emphasis on the need for assertive outreach to people in their communities, early intervention, recognition of the social determinants and their impact on levels of distress, and developing more coordinated health approaches.

Royal Commission into Victoria's Mental Health System

The Victorian Government established the Royal Commission in 2019 to investigate how the state's mental health system can most effectively prevent mental illness and deliver treatment, care and support to those living with mental illness, and their families and carers. The Royal Commission's final report is due to be delivered in February 2021. Similar to the Productivity Commission, the Royal Commission is looking closely at how to improve coordination within the mental health system, how to identify and implement measures that will increase efficiency and how to meet needs in community-based settings. This aligns with the approaches for enhanced suicide prevention in the *Interim Advice*.

Vision 2030: Blueprint for Mental Health and Suicide Prevention

Vision 2030 is a blueprint for a person-centred, connected, and well-functioning mental health and suicide prevention system that meets the needs of all Australians. It provides long-term national direction for mental health and wellbeing in Australia. This work is being led by the National Mental Health Commission, in consultation with State and Territory governments, and is expected to be completed this year. Vision 2030 calls for two significant system changes: (1) define community-based care including its essential components of care, national standards and outcome measurements; (2) shift from an expenditure view of mental health to an investment view where the focus is on the mental health and wellbeing of Australians. These changes are closely aligned with the paradigm shift called for in the *Interim Advice*.

National Cabinet reforms

The establishment of a National Cabinet was a key initiative in ensuring a coordinated national approach to the COVID-19 pandemic and, in May 2020, the Prime Minister announced the introduction of the National Federation Reform Council. These new approaches afford an opportunity to achieve more effective national whole-of-government responses to enduring issues such as suicide prevention.

Other relevant reforms

Deputy Chief Medical Officer for Mental Health

In May 2020, Dr Ruth Vine was appointed as Australia's first Deputy Chief Medical Officer for Mental Health. As Deputy Chief Medical Officer for Mental Health, Dr Vine will work closely with the National Suicide Prevention Adviser to contribute to the Commonwealth Government's mental health policy reforms.

National Commissioner for Defence and Veteran Suicide Prevention

In February 2020, the Prime Minister announced the creation of the new National Commissioner for Defence and Veteran Suicide Prevention, with legislation introduced to Parliament on 27 August 2020 by the Attorney-General. This will operate as a permanent independent body to examine deaths by suicide among Australian Defence Force personnel and veterans, and aims to support the prevention of future deaths of serving and ex-serving Australian Defence Force people. The National Suicide Prevention Advisor and the National Commissioner will work collaboratively.

National Suicide Prevention Adviser

Following the appointment of a National Suicide Prevention Adviser, suicide prevention has been elevated to a national priority. This has contributed to better alignment and integration of suicide prevention policy development across all governments. To continue to achieve meaningful and sustainable suicide prevention reform, it will be necessary to have ongoing national leadership, with an appropriate transition of responsibility from the Adviser upon end of tenure.

Priority Action: All governments to capitalise on the strategic work already done (for example, Fifth Plan, Health Suicide Prevention Strategy, Pandemic Response Plan) to accelerate the implementation of a whole-of-government approach to suicide prevention across Australia.

1.2: Recent events

This year has brought unprecedented challenges for the mental health and wellbeing of all Australians. From August 2019 to January 2020, Australia's bushfire emergency burned more than 18 million hectares, destroyed thousands of homes and businesses, and left 34 people dead. The scale and devastation of the bushfires reverberated around the country, impacting on people far from the fire fronts. On 30 January, an outbreak of a novel coronavirus, now formally named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) causing coronavirus disease 2019 (COVID-19), was declared a Public Health Emergency of International Concern by the World Health Organisation (WHO). The rapid spread of the COVID-19 pandemic in Australia and globally led to introduction of social distancing and physical isolation measures to reduce transmission rates and save lives. The pandemic and the necessary measures required to contain it continue to affect the mental health and wellbeing of Australians and to reshape the social and emotional environment in this country and beyond.

In these unprecedented times, it is crucial that government support is made available to vulnerable groups to help reduce suicidal behaviours and risks, and build and strengthen protective factors.

The 2019-20 Australian bushfires

On 12 January 2020, the Commonwealth Government announced a bushfire mental health response support package. This included immediate counselling, ongoing psychological support, additional mental health services through Primary Health Networks, measures to address the needs and impact on emergency service workers and their families, specialised support for children and young people through headspace, and grants to help communities recover. It reflected the views of those that had

experienced the fires that their neighbours and local communities were integral to providing mental health support and sustaining mental wellbeing.

The bushfire response aligns strongly with the suicide prevention approach in the *Interim Advice*, in that it emphasised cross-portfolio initiatives, early intervention at points of distress, anticipating and meeting the needs of vulnerable groups, and a coordinated community-led approach.

The Commonwealth Government also announced a suicide prevention package in February 2020. This package was based on the call in the *Initial Findings* for a more assertive outreach and community-led approach. Although funded from the health portfolio, the aim of the package was to equip community services to pivot and reach out to those vulnerable to suicide – through peer mentoring and support, youth focused initiatives, and more comprehensive aftercare.

COVID-19 pandemic

In addition to the health risks of COVID-19, the mental health impact of physical distancing and isolation and the economic consequences of the pandemic are significantly impacting on most, if not all, Australians. Financial stress, job loss, housing instability, physical illness, reduced social connectedness, and sudden bereavement are all factors that can increase distress and vulnerability to suicide. These factors are exacerbating the impacts already being felt from bushfires and, prior to that, the long drought.

An initial mental health pandemic package was announced in late March 2020. This supported the necessary pivot to telehealth services and provided additional targeted mental health support to both known and emerging priority populations. After the initial package, a nationally coordinated response was developed by the Australian Ministers responsible for mental health, and the *National Mental Health and Wellbeing Pandemic Response Plan* (Pandemic Response Plan) was endorsed by National Cabinet in mid-May. The approach taken by the Pandemic Response Plan aligns with the approach to suicide prevention in the *Interim Advice* including providing early intervention in distress, focusing on assertive outreach and community-based services, and addressing the specific needs of priority populations.

National whole-of-government approach

The Pandemic Response Plan reinforced that suicide prevention is a shared responsibility across multiple portfolios at all levels of government. Importantly, the suicide prevention initiatives considered for the plan were predominately from non-health portfolios, demonstrating strong understanding and commitment for a national whole-of-government approach to suicide prevention (see Chapter 2 for more details on the whole-of-government approach). The increased collaboration across governments, sectors and the community has been critical to the accelerated implementation of innovative service models – for example, the use of digital health. The variety of actions taken to date reflects the flexible approach set out in the Pandemic Response Plan, which allows for national priorities to be addressed in a manner that meets unique state and territory conditions.

Initiatives outside of health portfolios aim to address the social and economic factors contributing to distress. They include: financial distress outreach support; connecting government and community touchpoints to respond earlier to distress; compassionate care and distress reduction training for

frontline Australian Public Service employees; a focus on cross-portfolio settings (justice, child protection, housing services, educational settings and workplaces); activities to reduce social isolation and build community cohesion; and population level interventions, such as prevention activities for alcohol and other drug-related harm and violence. See Chapter 4 and Appendix 1 for detailed discussion on the cross-portfolio and multijurisdictional initiatives.

Priority Populations and early distress interventions

The immediate actions for the Pandemic Response Plan were to identify priority populations with specific or emerging vulnerabilities, to develop tailored interventions for early distress, and connect the intervention services together. The collection and sharing of jurisdictional data was critical to the monitoring of population-level suicide behaviours and risk, identification of priority populations, and the development of effective policy responses. This is critical need for national data has been emphasised by the National Cabinet. See Chapter 5 for more details on priority populations.

Aligning priority actions for suicide prevention

The Pandemic Response Plan has fast tracked some of the agreed actions of the Fifth Plan and the Health Suicide Prevention Strategy with a particular focus on regional suicide prevention efforts. Common links to the Fifth Plan include early intervention, community-based actions, whole-of-life care, flexible delivery of care (including by non-healthcare professionals), and a focus on vulnerable groups.

Priority Action: All governments to ensure all responses to national disasters and other declared emergencies include strategies that address risk and protective factors for suicidal behaviours, both in the immediate response and ongoing recovery periods.

Chapter 2: A whole-of-government approach to suicide prevention

“To create a genuinely effective, sustainable approach to suicide prevention, we need to ... look at...how we communicate, and how we treat others, especially those who are vulnerable, and how our various systems—health, social, welfare, economic, education, and others—exacerbate or contribute to suicide.”

Statement from Lived Experience contributor at the Black Dog Institute

A national whole-of-government approach to suicide prevention requires all governments to address the social and economic drivers of distress, to target approaches early in the trajectory towards suicidal behaviour and to provide services that respond more effectively when someone is in distress.

The complex challenge to a national whole-of-government approach is how to make it work effectively across the federated model of government, enabling and empowering other portfolio areas to join the health portfolios, to provide a broader, more effective response. Translating genuine commitment and goodwill into sustainable structural change will shift the focus from crisis-driven and reactive interventions to a comprehensive approach. To accomplish this, suicide prevention must be strategically placed at the highest levels within governments, with strengthened monitoring and reporting on action across all portfolios, and clear roles and responsibilities between the different levels of government.

In-principle recommendations

Recommendation 1: To adopt a national whole-of-government governance structure for suicide prevention, with suicide prevention identified as a portfolio responsibility of all Ministers and ideally led by First Ministers. The final governance architecture should be informed by other governance reviews underway and should be developed in consultation with all jurisdictions. It should consider:

- 1.1 Revised national structures which include the creation of a Ministerial Reform Council or similar and the establishment of a National Office for Suicide Prevention.
- 1.2 A review of the arrangements for regional coordination and delivery of suicide prevention services and programs to ensure they have the authority and resources to implement a whole-of-government and whole of community approach.

Recommendation 2: A stand-alone whole-of-government National Suicide Prevention Strategy should be developed to provide authority and guidance to enable all governments, all portfolios, and stakeholders to align their plans and activities. This strategy should be available by 2021, with immediate action undertaken through:

- 2.1 Implementing the *National suicide prevention strategy for Australia's health system 2020-2023*, including any immediate priorities aligned to the *National Mental Health and Wellbeing Pandemic Response Plan*.
- 2.2 Resourcing the implementation of the *National Aboriginal and Torres Strait Islander Suicide Prevention Plan* from 2021.
- 2.3 Identifying and implementing priority cross-portfolio suicide prevention initiatives across Commonwealth agencies, with agencies to use the *Shifting the Focus* model to develop suicide prevention action plans.
- 2.4 Ensuring all responses to national disasters and other declared emergencies, including the COVID-19 response, include strategies that address risk and protective factors for suicide.

Recommendation 3: All governments and their agencies recognise that lived-experience knowledge is central to planning, priority setting, design and delivery of a national whole-of-government suicide prevention approach. This includes:

- 3.1 Increasing lived experience research, particularly with people who have attempted suicide.
- 3.2 Ensuring that diverse lived experience expertise is core to governance structures at all levels of government and across funded programs.
- 3.3 Ensuring that co-design with lived experience is a demonstrated requirement for funded suicide prevention programs, services and research.
- 3.4 Escalating work to develop the lived experience workforce, with a specific focus on the peer lived experience workforce to support new service models.

Recommendation 4: Develop a long-term whole-of-government workforce strategy for suicide prevention to support the delivery of a National Suicide Prevention Strategy, considering all relevant workforces across government and community settings. Immediate actions to implement workforce priorities should occur:

- 4.1 All governments to prioritise contemporary and evidence-based training for clinical and other health staff, ensuring the training focuses on collaborative and therapeutic approaches (as identified in the *National suicide prevention strategy for Australia's health system 2020-2023*).
- 4.2 Australian Public Service Commission implement compassion-based training for frontline workers across the Australian Public Service; with other jurisdictions to consider similar training for their frontline workers.
- 4.3 All governments to increase suicide prevention training for services providing financial, employment and relationship support to people experiencing distress.
- 4.4 Inclusion of suicide prevention considerations within the *National Mental Health Workforce Strategy* and the *National Peer Workforce Development Guidelines* currently in development.

2.1 The role of government in suicide prevention

No single government, government agency, person, or organisation can reduce suicide attempts and suicide deaths alone, but they can collectively make a big difference. Government plays an important leadership role in suicide prevention, but a range of other sectors, services, individuals and communities are critical in reducing the incidence and impacts of suicidal behaviour as well.

Governments can:

- Set strategic directions and a clear and consistent vision for suicide prevention
- Use policy levers to improve population wellbeing and to reduce the social and economic drivers of distress
- Use legislation to increase community safety
- Provide funding for services especially those relating to health, mental health, social services, employment and income support
- Ensure the service systems it controls work together, provide linkages and respond to people in suicidal distress
- Use levers of government to influence practices of businesses, the private and non-government sectors
- Develop partnerships and support local community based action for suicide prevention.

Good governance in suicide prevention recognises that the governments play a significant role in leadership, accountability, resourcing and coordination, but that top down approaches or creation of government structures alone will not reduce suicidal behaviour. It is the known, trusted, accessible, and locally delivered actions that will best support people experiencing suicidal distress.

Why a whole of government approach is needed

Throughout Australia, there is strong community interest and good will to prevent deaths by suicide, reduce suicide attempts and address the impacts on individuals, households and communities. Within governments, suicide prevention is currently the responsibility of Health Ministers, with significant activity and investment at both the Commonwealth and the State and Territory level. While the health system plays a vital role in suicide prevention, particularly through primary care and specialist mental health services, suicidal behaviour is multi-factorial meaning that no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress.

Attention to the provision of affordable, accessible and effective mental health services is essential for suicide prevention. It is not, however, sufficient if attention is not also given to the non-health related factors that may contribute to suicidal behaviour. The economic and social drivers of distress often sit outside of health and include access to financial security, employment, education, and safe communities. Improvements in health services alone will also miss the fact that agencies working outside the health system also have contact with some of the most vulnerable members of the community. They play an important role in supporting people experiencing financial hardship,

housing insecurity, relationship loss, childhood trauma, community adversity, legal issues, and social isolation.

A true whole-of-government approach, that has effective cross-portfolio and multijurisdictional actions, requires an authorising environment at both the First Minister and Ministerial level. Strengthened monitoring and reporting on action across all portfolios, and clear roles and responsibilities between the different levels of government is required. It is not possible for one Minister or one department alone to influence, and indeed fund, the range of responses required across portfolios and across communities to really make a difference. Planning should also identify the suicide prevention programs that are best delivered nationally to provide core architecture for suicide prevention and those that are best delivered through state and territory systems or coordinated and delivered at the local community level. This approach needs to be guided at all levels by those with lived experience of suicide, as without this knowledge the reforms and service improvements will fall short of what people need and what people deserve.

Principles to guide the approach

It is only through a shared commitment, with combined and aligned actions, that suicidal behaviour can be reduced and lasting change for suicide prevention can be achieved. Good governance is at the heart of achieving a comprehensive national approach to suicide prevention. It is critical to:

- Galvanising commitment across governments, businesses, communities and individuals based on a shared understanding of suicide prevention
- Driving coordinated and effective action across all governments and all portfolios as well as the communities where people live and interact
- Allocating long-term and significant resources to match the need, working in partnership with the philanthropic and business community
- Measuring outcomes for people.

The governance arrangements set by most jurisdictions tend to reflect four core principles: (1) clarity of purpose; (2) the role of government; (3) efficiency and performance; and (4) accountability to Parliament and the public.¹ A series of core principles for suicide prevention have been developed using this framework and will form the basis of ongoing consultations and design with all jurisdictions and key stakeholders, outlined in the table below.

Core principles for a whole-of-government approach

| Principle | Application to suicide prevention | Governance considerations |
|--|--|---|
| Clarity of purpose | <ol style="list-style-type: none"> Coordinated national action must occur to reduce suicide attempts, reduce suicide deaths and better support people in distress. Individuals and communities must be central to planning and priority setting in suicide prevention. This includes: <ul style="list-style-type: none"> - Designing and implementing approaches based on lived experience knowledge - Enabling coordination and decision-making at the local level to meet needs identified by and in the community - Targeted approaches for populations disproportionately impacted by suicide - Aboriginal and Torres Strait Islander leadership and delivery for Indigenous communities. | <ul style="list-style-type: none"> ✓ Governments across Australia work together on suicide prevention, with cross-portfolio action owned and authorised at the First Minister and Ministerial level. ✓ A single national strategy and a national agreement with clear roles and responsibilities to support priority setting, resourcing, evaluation and accountability. ✓ Human and financial resources committed by each jurisdiction and portfolio with governance mechanisms to enable joint action, linkages and a comprehensive approach to reduce distress, attempts and deaths. |
| Leveraging the role of government | <ol style="list-style-type: none"> Policy and regulatory leadership across government portfolios is required to address the social and economic drivers of distress and increase safety and wellbeing in the community. Earlier and more effective responses to distress are required to ensure people get the right supports in a timely way. This includes: <ul style="list-style-type: none"> - Using all available government and community touchpoints to respond to distress - Paying particular attention to key points of disconnection, vulnerability and transitions - Ensuring hospital, mental health and social services are available and delivered to quality standards. | <ul style="list-style-type: none"> ✓ A suite of programs and services that form nationally available infrastructure for suicide prevention is available. ✓ Effective regional mechanisms for the co-ordination and delivery of services and programs in communities. ✓ Workforce development across the public sector and in communities to build compassion, skills and capabilities, using contemporary approaches, including peer workers. ✓ Continual review and adjustments to the priorities based on available data, agreed outcomes measures and evidence; including evidence from lived experience and Indigenous informed practice. |
| Efficiency and Effectiveness | <ol style="list-style-type: none"> Data-informed decision-making is required, with the agility to respond in a timely way to emerging or shifting vulnerabilities. A systematic commitment to evidence, measuring outcomes and translating knowledge into practice must occur to guide ongoing priorities and investments. | <ul style="list-style-type: none"> ✓ Linked data available with close-in-time monitoring of suicide deaths, suicide attempts, self-harm and key risk factors, to support decision-making and priority setting. |
| Accountability | <ol style="list-style-type: none"> Increased transparency and regular reporting on the effectiveness of suicide prevention investments and action is required, measuring reduction in attempts as well as deaths. The community should be actively engaged and informed about suicide, ensuring that communication is safe for all people and reduces stigma. | <ul style="list-style-type: none"> ✓ Quality assurance for suicide prevention programs and services, and use of shared program level outcomes, to ensure consistent and comparable measures of impact. |

2.2 Options for whole-of-government architecture

A true whole-of-government approach, that has effective cross-portfolio and multijurisdictional actions that are delivered in a consistent and coherent manner, requires an authorising environment at both the First Minister and Ministerial level. To ensure accountability across all governments, revised national governance structures will be required.

The approach needs to consider the degree to which suicide prevention is driven through:

1. A national approach with aligned actions between the Commonwealth and State and Territories and/or local decision making and resourcing at the community level.
2. A whole-of-government approach that requires all Ministers and First Ministers to be accountable for suicide prevention and the degree to which it remains the responsibility of Health Ministers.

Given the multifactorial nature of suicidal behaviour and the principles outlined in the table above, it is recommended that suicide prevention action in Australia must be delivered through improved national and regional arrangements for suicide prevention. To do only one or the other would miss the opportunity for real change.

The alternatives for strengthening national coordination enabling durable whole of government arrangements and commitments are:

1. National whole-of-government approach led by First Ministers and supported by Ministerial leadership and a National Office of Suicide Prevention reporting to the Prime Minister.
2. Suicide prevention remains the responsibility of Health Ministers with enhanced arrangements for cross-portfolio commitment including a National Office of Suicide Prevention reporting to the Federal Minister for Health.

To facilitate further consultation with all jurisdictions, as well as other stakeholders, the options outlined in the table below, and the considerations for regional approaches, will form the basis of a discussion paper for consultation and further design with all jurisdictions and key stakeholders before final recommendations to the Prime Minister in December 2020. Once final recommendations are made, any authorising legislation required would be considered.

Options for supporting architecture

| Option | Option 1: National whole-of-government approach led by First Ministers and supported by Ministerial leadership and a National Office of Suicide Prevention reporting to the Prime Minister. | Option 2: Suicide prevention remains the responsibility of Health Ministers with enhanced cross-portfolio arrangements and a National Office of Suicide Prevention reporting to the Minister for Health. |
|---------------------------|---|---|
| Authority | <ul style="list-style-type: none"> - Suicide prevention, including wellbeing, is formally endorsed as a national priority and a First Ministers portfolio responsibility. - National Cabinet provides the forum for setting priority areas for investment and for the agreeing to Commonwealth and State and Territory roles. - Reporting of regular data and progress against the National Suicide Prevention Strategy to the National Cabinet. | <ul style="list-style-type: none"> - Suicide prevention is led by Health Ministers, but with strengthened whole of government arrangements, including suicide prevention accepted as a portfolio responsibility other Ministers. - Cross-portfolio actions and responsibilities developed and clearly outlined in the national suicide prevention strategy, with reporting at least yearly to National Cabinet. |
| Leadership | <ul style="list-style-type: none"> - A Ministerial Taskforce, Reform Council or similar (dependent on current reviews) to be established for suicide prevention and endorsed by National Cabinet. - This should include cross-portfolio and multi-jurisdictional representation. Key portfolios would include health, social and community services, employment, education, justice, housing and Treasury. - It will not be practicable to have a structure that simultaneously involves tens of ministers from all jurisdictions who are responsible for the portfolios that are relevant to suicide prevention. Membership could include the chairs of other reform councils and/or a rotation of core membership, aligned to yearly priorities. | <ul style="list-style-type: none"> - The Australian, State and Territory Governments establish a National Working Group on suicide prevention to facilitate the delivery of health and non-health reforms in suicide prevention. - An agreed policy framework to guide consideration of, and decision-making on, cross-portfolio resource allocations over the long term. - A staged approach to policy reform and cross-portfolio action may be necessary to support joint action between health and other policy portfolios, including housing, employment, social and community services, justice and education. |
| Coordination and delivery | <ul style="list-style-type: none"> - A resourced National Office for Suicide Prevention (National Office) to be established reporting directly to the Prime Minister. - The National Office would: (1) lead the development of a whole-of-government National Suicide Prevention Strategy; (2) provide ongoing strategic advice, including advice on multijurisdictional and cross-portfolio policy development; and (3) Monitor and report on implementation. - The National Office would build collaborative efforts and work closely with data and research leads to ensure jurisdictions, regions and stakeholders have access to the data, knowledge and evidence they require. - In reporting to the Prime Minister, the National Office would ideally operate as a separate authority to support enhanced transparency and collaboration, but could be established within the Department of Prime Minister and Cabinet or as a specialist unit within the National Mental Health Commission. | <ul style="list-style-type: none"> - A resourced National Office for Suicide Prevention is established to sit independent of the Department of Health, reporting to the Minister for Health and supporting the National Working Group. - The office would lead on cross-portfolio enhancements and partnerships, support the National Working Groups and monitor and report of suicide prevention action. - The National Office would support collaborative work, including close working relationships with data and research leads. - Under Health leadership, this function could be filled by a dedicated team within the National Mental Health Commission or established as a separate authority. |

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|----------------------|---|---|
| Collaboration | <ul style="list-style-type: none"> - Interagency and inter-jurisdictional arrangements to support collective action on priorities. This would include an Interagency Committee, comprised of senior public service officials from central agencies across jurisdictions. - It is also recommended that Interdepartmental Committees at the Commonwealth, State and Territory levels are continued or established to ensure effective delivery and alignment within jurisdictions. | <ul style="list-style-type: none"> - Interagency and inter-jurisdictional arrangements to support collective action on health and non-health priorities – lead by senior officials in health and central agencies. - It is also recommended that Interdepartmental Committees - jointly led by Health and the Central agency are continued or established in all jurisdictions to ensure jurisdictional alignment and action. |
| Key enablers | <ul style="list-style-type: none"> - A stand-alone suicide prevention plan that shifts responsibility from the health portfolio alone to a national whole-of-government approach, led by First Ministers and reported to National Cabinet at least yearly. - Aligned State and Territory and regional suicide prevention plans, outlining key roles and responsibilities and progress on collective priorities. - Data leadership with regular reporting of key data sets to National Cabinet and all advisory committees to enable agility and timely response to emerging issues. - An Intergovernmental Suicide Prevention Agreement that outlines clear roles and responsibilities and codifies funding arrangement to drive improved outcomes. - A whole-of-government suicide prevention workforce strategy. | <ul style="list-style-type: none"> - Extension of the current health strategy developed under the Fifth Plan occurs to add key cross-portfolio and policy level priorities and actions. - A series of 3 year action plans developed collaboratively between health and identified portfolios. - An Intergovernmental Suicide Prevention Agreement that outlines clear roles and responsibilities across health and other identified portfolios. - A suicide prevention workforce strategy focussed on health and other identified portfolios. |
| Benefits | <ul style="list-style-type: none"> - This option provides the strongest commitment to suicide prevention as a whole-of-government responsibility and creates momentum for reform. - First Ministers can require / mandate actions across all portfolios of government including budget allocations. - Transferring responsibility out of health broadens the approach to align with evidence and enables joint accountability. - Stronger options to use whole-of-government funding levers to address the multifactorial nature of suicidal behaviour and distress intervention. - Facilitates expertise from disciplines and policy areas outside of mental health being applied to suicide prevention strategy and service improvement. - Ministerial arrangements and a National Office provide infrastructure for change and increased transparency. | <ul style="list-style-type: none"> - Builds on the existing arrangements and the existing strategy that has been endorsed by governments. - Structurally aligns to jurisdictions with leadership from Department of Health and/or Mental Health Commissions. - Keeps connections between current mental health reform, wellbeing initiatives and suicide prevention. - Keeps technical expertise within health/mental health to provide consistency. |
| Risks | <ul style="list-style-type: none"> - May not achieve commitment and agreement from all governments. - Disconnection from mental health reform which is still critical to success. | <ul style="list-style-type: none"> - Partnerships and cross-portfolio approaches to drive change rather than an agreed national whole-of-government approach. - Risk that suicide prevention will be deprioritised behind other health and mental health priorities (especially over time). |

Regional arrangements

Regional approaches to suicide prevention have been adopted in Australia, and strengthened through the Fifth Plan, reflecting the evidence that regional-based activity is more responsive to local and community needs in that:

- The specific risk and protective factors that can impact on individuals and whole communities are addressed in planning and priority setting for suicide prevention, recognising the variations in these factors across all regions in Australia.
- The service promotion and use in the context of the local environment is maximised, using services that are known, trusted, accessible, inter-connected, and responsive to people's needs.
- The nature of the impacts of suicidal behaviours on defined populations are understood; especially given that suicide has differential impacts across communities.
- The community capability to contribute to suicide prevention is built and sustained, recognising that 'informal' contacts and support networks play a critical role in earlier responses to need.
- The potential to link more closely with community based action for suicide prevention which may arise through the business sector, charities and local community groups.

Primary Health Networks (PHNs) are the mechanism through which regional planning and commissioning of Commonwealth-funded mental health and suicide prevention services occurs. Presently, however, there are unclear relationships between PHNs and other jurisdictional structures, and little connection with non-health services such as the Commonwealth-funded family and social services, aged-care, and economic/employment programs, which also have a regional presence.

State and Territory governments contribute significantly to suicide prevention through hospital and community mental health services but they do not always have regional linkages formed to include non-health services like education/schooling, family support, housing, community services, youth services, emergency services, justice and corrections. Local Governments operate community development and local support services that are highly relevant to suicide prevention, but are not formally seen as such.

Many of the elements for effective and responsive regional suicide prevention exist within the structures of government in Australia, however they are not operating within an agreed arrangement on roles and responsibilities, and as such are not forming the linkages across agencies and services that are necessary. This contrasts with the multi-layered structures for economic development such as those for the tourism industry, and those for other priorities on national action such as road safety. If this were done effectively for suicide prevention, it would provide vulnerable individuals, households and communities with better, earlier, more responsive action and a broader reach that utilises all available resources.

Enhanced arrangements to ensure whole-of-government action is coordinated at the regional level must be a priority for reform and a key consideration for effective governance. Available evaluation data for current suicide prevention trials (Commonwealth, state and philanthropic), and a focused consultation with governments and other stakeholders should occur before December 2020 to inform final recommendations and advice.

Consideration should be given to:

1. Preferred arrangements for local coordination and commissioning of services that can deliver stronger linkages between Commonwealth, jurisdictional and local government resources and effectively deliver cross-portfolio approaches to support community action. Regardless of the approach, clear agreements between the different levels of government are required and arrangements that facilitate cross-portfolio involvement in planning and delivery of suicide prevention at the local level. This could involve one of the following options:
 - PHNs retaining the role of local planning, coordination and commissioning but with a review of current structures and supports to build in the mechanism and agreements required to achieve a whole-of-government and cross-jurisdictional approach at the local level. Resourcing as well as national support to build capability should be reviewed.
 - New regional structures for coordination and commissioning of suicide prevention programs and services – with responsibility sitting within States and Territories (or local government), and strong links to central agencies to enable a joined up approach.
2. Dedicated regional coordinators for suicide prevention as core infrastructure for communities, potentially co-funded by the Commonwealth and jurisdictions. Mechanisms to support these roles should be a consideration in the workforce strategy.
3. The potential for Local Government support of suicide prevention action to be reflected in increased options for funding and assisting this tier of government to contribute activities and community engagement expertise.
4. Promotion and refinement of innovative models of regional collaboration to foster more consistent approaches throughout Australia, with the evaluation findings from Suicide Prevention Trials examined as a priority for their applicability to inform regional arrangements.
5. Timely regional data must be provided to local authorities to ensure regionally relevant planning and timely responses to emerging risks.

2.3 Enablers to a national whole-of-government approach

In addition to the architecture and governance options described in the previous section, there are other significant enabling mechanisms that will be required to achieve a national whole-of-government approach to suicide prevention.

National Suicide Prevention Strategy

The Commonwealth and a number of States and Territories have started the shift to a cross-portfolio approach to suicide prevention. While there is a Health Suicide Prevention Strategy, there is no current suicide prevention strategy that sets priorities for a national whole-of-government approach. A new National Suicide Prevention Strategy would provide such direction and would be the single, coherent policy document that outlines a comprehensive approach to suicide prevention in Australia that enables all governments to align their plans and activities.

The National Suicide Prevention Strategy should:

- Shift responsibility from the health portfolio alone to a national whole-of-government approach, ideally led by First Ministers and reported to National Cabinet at least yearly.
- Have clear roles and responsibilities outlined for Commonwealth, State and Territory and Local Governments, and outline key priorities, reforms and actions. This this should inform an intergovernmental Suicide Prevention Agreement that codifies funding arrangement to drive improved outcomes.
- Create the basis for annual reporting on progress and impact (on defined Commonwealth, State and Territory and Local Government responsibilities).
- Enable aligned State and Territory suicide prevention plans and detailed action plans for all government agencies – creating a more coordinated effort overall for suicide prevention.
- Enable planning and delivery of tailored suicide prevention activities at the local level.

Lived experience

Any approach must ensure that people are placed at the forefront of all that is done in suicide prevention. Otherwise, reforms and service improvements will fall short of what people need. If systems and services are to truly meet the needs of people experiencing suicidal thoughts, suicidal distress and suicide attempts, they require active involvement of lived experience at all stages, from research that aims to build the evidence base, government policy and program planning, service design and delivery, to program implementation and evaluation. Lived experience as a caregiver and lived experience of people who are bereaved by suicide are also critical in designing better and improved supports, services and approaches for families, chosen families, friends, peers and community members. Governments, communities and stakeholders need to work together to prevent suicide and its impacts. This work cannot and should not occur, however, without lived experience input and leadership at all levels.

The capacity to engage and involve people with lived experience of suicide should continue to be developed within health as well as in cross-portfolio agencies. It is also critical to have a diversity of lived experience represented – with services, programs and priorities designed with consideration to young people, men, Aboriginal and Torres Strait Islander people, LGBTIQ+ people (including Indigenous LGBTIQ+), people from Culturally and Linguistically Diverse (CALD) backgrounds and all other groups that experience suicidal distress or are impacted by suicide in some way. The following should be considered as priorities:

- Lived experience knowledge should be central to designing new service models, reviewing public messaging about suicide and designing outcome measures for suicide prevention programs, ensuring that outcomes are focussed on individuals and their care-givers.
- Further research focussed on lived experience journey mapping should be conducted, with a focus on opportunities to better support those more vulnerable to suicide, including priority populations.
- Lived experience expertise included on the boards, governance arrangements and advisory groups established to support suicide prevention planning and action.

- Further work to develop and support the lived experience of suicide workforce.

Workforce Strategy

People experiencing distress interact with workforces across various sectors, at different times and in different ways. Indeed, government services are often provided at the very points of life transitions that can be distressing, such as becoming unemployed, experiencing housing insecurity or homelessness, entering or exiting the justice system, or resolving child custody arrangements. Every contact that a person has with a department, service or individual worker should be considered an opportunity to have a positive impact, ensuring the person gets the right supports at the right time.

People with a lived experience of suicidality, however, report that a number of services and workforces that could have assisted them, in particular health and community services, left them feeling “unheard, judged and problematised” instead, with the distress and trauma underlying their suicidality rarely acknowledged. Investing in and developing the workforce development is a key enabler for a national whole-of-government approach to suicide prevention. An obvious priority for workforce development is to ensure a better experience for the person accessing a service and those who care for them. While there are some universal competencies that are required for all people who could come into contact with a person experiencing distress, the workforce involved in suicide prevention is not homogenous and therefore the specific knowledge and skills required will be different. Training alone, however, is not enough, with consideration needed for internal policies, practical supports and warm referral pathways.

Workforce development must also be led by a commitment to the safety and support of workers who care for and respond to people in distress. Workers who feel supported are better able to support others. A comprehensive workforce strategy for suicide prevention needs to be developed as component part of the National Suicide Prevention Strategy, but there is an opportunity for immediate action to be taken to strengthen current approaches. The following should be in place and reported on six-monthly:

- Action by Commonwealth and State and Territory governments to increase contemporary training for clinical and other health staff – with a focus on emergency departments, general practitioners, alcohol and other drug services, Aboriginal Community Controlled Health Services (ACCHS) and emergency services. This also includes an assessment of current and future requirements for clinical professionals skilled in contemporary treatments for suicidality. This is an existing priority under the Health Suicide Prevention Strategy and should be progressed as a priority.
- The Australian Public Service Commission to lead the roll-out of compassion-based training for frontline workers across the Australian Public Service and support a review of internal policies, resources and referral pathways to enhance the training, with consideration of similar approaches in other states and territories.
- The Commonwealth Government ensures that the *National Mental Health Workforce Strategy* and the *National Peer Workforce Development Guidelines* include consideration of suicide prevention.

Data, evidence and knowledge translation

Governments need be able to make informed decisions, provide evidence-based advice, and demonstrate the effectiveness of the national whole-of-government approach to suicide prevention. As such, there is a need to have a complementary national approach to suicide data, research priorities and knowledge translation. This approach requires joined up data, rather than data siloed in departments and agencies, with close-in-time monitoring of suicide deaths, suicide attempts and key risk factors. A priority for a national approach is the standardisation of definitions, consistency of data collection and analysis, and being able to link data sets for priority populations, whilst reporting at a population and regional level. It also requires joined up efforts related to research and knowledge translation to support implementation of a National Suicide Prevention Strategy. Central to achieving a national approach are the following:

- Data leadership and provision should be undertaken through the Australian Institute of Health and Welfare (AIHW), with regular reporting of key data sets to National Cabinet.
- A series of data improvement measures (outlined in Chapter 3) should be implemented – including collection of consistent and timely data, with reporting to authorities (including regional agencies) who require data for suicide prevention planning.
- The co-design of outcome measures for suicide prevention activities should be developed, commencing 2021, and used in all future funding agreements and for ongoing evaluations.
- The delivery of a national suicide prevention research strategy and priority-based allocation of research funding through the Suicide Prevention Research Fund would strengthen the alignment between research priorities and suicide prevention reforms.
- A knowledge brokerage function within the machinery of government should be considered for policy and program development.

When to start

The intent of the *Interim Advice* is to present in-principle recommendations that can be refined through further consultation before providing Government with the final advice in December 2020. In terms of governance, it is not *whether* to shift to a national whole-of-government approach but *how* to shift effectively that will be the focus of discussion. Therefore, there are some immediate steps that can and should be taken to progress a national whole-of-government approach:

- Take action to improve the timeliness and quality of national suicide data across jurisdictions and start work towards mapping and evaluating services and programs (see Chapter 3).
- Commonwealth portfolios and jurisdictions can take action to identify and implement priority cross-portfolio and multijurisdictional suicide prevention initiatives and start to consider the development of suicide prevention action plans (see Chapter 4).
- Take action to improve the understanding of suicide vulnerabilities, risks and protective factors in priority populations and start to increase the inclusion of lived experience into suicide prevention reform (see Chapter 5).

- Led by Gayaa Dhuwi the National Aboriginal and Torres Strait Islander Suicide Prevention Plan should be completed by December 2020, which will require resourcing for its implementation and evaluation from 2021 (see Chapter 6).
- The Fifth Plan and Health Suicide Prevention Strategy should be resourced and actioned by all governments, including any immediate priorities aligned to the Pandemic Response Plan (see Chapter 7).

Chapter 3: The role of data, monitoring and evaluation in suicide prevention

“It is extremely challenging to understand the complex phenomenon of suicide...the extensive knowledge base of risk and protective factors have relevance. But we ask that these are used with awareness of their limitations – they do not reflect every individual’s experience of suicidal thoughts and behaviours.”

Statement from Lived Experience contributor at the Black Dog Institute

A collaborative and nationally coordinated approach to data, monitoring, and evaluation is vital to ensure the shift to a whole-of-government approach to suicide prevention is meaningful and sustained.

In-principle recommendations

Recommendation 5: All governments expand their investment in suicide data in a consistent and systematic approach, including collection and sharing of all relevant health and non-health data, to support policy decisions and agility to respond to emerging and shifting vulnerabilities. In particular:

- 5.1 All governments to work with the Australian Institute of Health and Welfare and remove the barriers to the routine sharing of relevant data with the National Suicide and Self-Harm Monitoring System.
- 5.2 All governments to establish consistent definitions for suicide-related data (including agreed distinctions between self-harm and suicide attempts) and increase data capture for priority populations.

Recommendation 6: Develop a long-term research strategy for suicide prevention together with an evaluation framework to measure the impact of funded programs and services. In particular:

- 6.1 The Commonwealth, with other governments, to facilitate the development of an outcomes framework for suicide prevention programs and services.
- 6.2 The Suicide Prevention Research Fund (and other research funding sources) to fund research that aligns with strategic priorities in suicide prevention.

3.1 Improved suicide data

Suicide Registers

The main source of data on deaths by suicide in Australia is the annual Australian Bureau of Statistics (ABS) Causes of Death series of reports. This data includes deaths that are found by coroners to be suicides. In addition, the AIHW is working with States and Territories who have established suicide registers (Queensland, Victoria, Western Australia and Tasmania), or are currently establishing (New South Wales and South Australia) or considering doing so subject to resourcing (Northern Territory and Australian Capital Territory).

Suicide registers contain detailed information that is entered, usually by the coronial team, about the circumstances of people who it is suspected have died by suicide, together with the circumstances surrounding their death. At the time of being entered the information is not validated by a full coronial inquiry, but it is entered by those with experience in suicide. Just under 95% of the deaths initially judged as 'probable suicide' by the coroner are later confirmed as suicides.² Not only does the breadth of information collected in suicide registers allow for a comprehensive analysis of the reasons why someone may have died by suicide, the inclusion of probable suicides provides for a more timely analysis than with the ABS Causes of Death data. This has been of significance to informing the Commonwealth Government's response to the COVID-19 pandemic, where the AIHW has been providing weekly data on probable suicide deaths to National Cabinet. This has been made possible by States and Territories that have established suicide registers sharing their data. Having comparable suicide registers in every State and Territory would improve the consistency of data, enhancing linkages, and providing timely information on suicide deaths in Australia.

National suicide and self-harm monitoring system

Systems-based quality and timely monitoring of suicide, suicide attempts and self-harm is identified by the World Health Organisation as one of the 11 essential elements of a national approach,³ and is included as an action in the Health Suicide Prevention Strategy.

In 2019, the AIHW commenced work on the National Suicide and Self-harm Monitoring System. The aims of this system are to aid governments, researchers and service providers to inform policy and service development and planning, and respond more rapidly to emerging issues. It will continuously bring together accurate and timely information from all jurisdictions on suicidal behaviour and self-harm. The monitoring system will include data from crisis lines, ambulance services, emergency departments and hospitals, suicide registers, and data sets from housing, justice and other areas of government. To ensure this system is successful and provides a national perspective of suicide data, it is critical that the data sources are consistent in their data collection, and there are no barriers to data sharing between Commonwealth and State and Territory governments, as well as relevant data in the private sector. Although the national perspective is important, the data from a national system also needs to be available at a level that can inform regional and local responses, with the system ensuring that linked data sources are reportable at least at a regional level (SA3 and PHN).

National approach to suicide data

To shift towards a national whole-of-government approach to suicide prevention, it is vital that a range of government portfolios and communities have access to comprehensive data about suicidal behaviours. This will inform their understanding of the specific vulnerabilities and protective factors in the populations they serve, support the development and implementation of tailored interventions, and allow evaluation of the interventions for their contributions to suicide prevention. This requires a collaborative and coordinated data approach at a national level where government can develop and strengthen surveillance and provide and disseminate data that can inform action.⁴

A national approach to suicide prevention data will deliver a number of benefits:

- It reduces duplication of analysis by governments.
- It allows everyone to contribute to a shared understanding of suicide behaviours and activities.
- Collecting the same data across jurisdictions allows comparisons and shared learning between governments.
- It provides greater breadth to the collection of data about suicide behaviour and suicide prevention activities in Australia.
- It raises suicide behaviour to be of national significance and supports a national whole-of-government approach to suicide prevention.
- It allows Australia to monitor suicide rates and prevention activities against other comparable countries.
- Having this data available to the public can contribute to stigma reduction, provide transparency of decision making by government, and allow for community engagement and innovation.

As part of the Interim Advice, the *Shifting the Focus* paper outlines a national whole-of-government approach to suicide data.

The model needs to be supported by a national whole-of-government approach to suicide-related data to enable:

- Systematic monitoring, reporting and evaluation of suicide prevention activities.
- Service mapping of suicide prevention activities.
- Simulation modelling of suicidal behaviour.
- Localised responses to emerging trends, suicide attempts and deaths.
- Practical research into suicidal behaviours and prevention activities.

All governments can contribute to the collection and sharing of data about specific risk factors, services and outcomes to monitor and evaluate the impact of suicide prevention activities in Australia.

Priority Action: All governments to identify and remove the barriers to the routine sharing of relevant data with the National Suicide and Self-Harm Monitoring System. This includes establishing suicide registers that enable nationally consistent and timely access to data about suicide deaths and suicide behaviours.

Timeliness, breadth and quality of suicide data

Timely and effective evidence-based interventions are critical in preventing suicides. With current methodology, the majority of suicide data sources have a time lag of months to years before the data is available to be used. There is an intent to continually improve the timeliness data in the National Suicide and Self-harm Monitoring System and through the suicide registers. This should work towards being able to have close to immediate notification, which would enable more timely responses to emerging localised patterns of suicide deaths or attempts in a particular location or within a vulnerable group, and more responsive local postvention and bereavement support services to be provided to impacted families, friends and communities.

The introduction of suicide registers and the national suicide and self-harm monitoring system are significant steps towards better quality suicide data. However, there is a priority need for improved data on suicide attempts and suicidal ideation. To facilitate deeper insights into the vulnerabilities that lead to suicidality, greater breadth of data collection is also needed. This includes collecting: (1) relevant data from all portfolios; (2) data that covers all priority populations; and (3) increased population level collection through the inclusion of relevant questions in national surveys.⁵

Suicide attempt data

People with lived experience have been emphatic in identifying that standardising the assessment, recording, collection and analysis of suicide attempts is a priority. This is a group of people that can be actively engaged to better understand their journeys, the points of crisis and, most importantly, what was effective or not for them in terms of interventions. Currently, the approach to suicide attempt data is not standardised across all governments and there is no consistent method for determining a suicide attempt from a self-harm presentation, with presentations simply coded as being mental health related or not.

The Mental Health Information Strategy Standing Committee (MHISSC) and the AIHW are leading work to improve the data collected in emergency departments and have established the National Ambulance Surveillance System (NASS), which can now distinguish between suicide attempts and deliberate self-harm. This will also become possible within emergency departments when the next iteration of the International Classification of Diseases (ICD-11) is available.

As a priority, the new coding that distinguishes between suicide attempts and deliberate self-harm using the ICD-11 should be adopted. This will provide the foundation for a standardised approach to data recording in hospitals, emergency departments and frontline services, as well as help improve the clinical interventions themselves. Additionally, there needs to be agreement on what information on suicide attempts and deliberate self-harm should be recorded, and how this can be done across the breadth of services in primary, tertiary, cross-portfolio and community settings.

Data on priority populations

Other data gaps include the lack of consistent data for priority populations. This includes Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and CALD people. Any data improvement actions will need to ensure such information is considered for inclusion in routine or specific data collections as much as practicable. Not to do so would hamper the ability to understand the unique vulnerabilities

of these groups, the development of tailored suicide prevention activities, and the ability to evaluate their effectiveness.

Cross-portfolio data

Any data improvement action also needs to support the shift towards a national whole-of-government suicide prevention approach by including data from other relevant government services. This will allow the monitoring of suicide behaviour through the specific services that government agencies provide, such as unemployment support. From an evaluation perspective, having this data will allow a better understanding of how an initiative from any portfolio, not just health, can contribute to enhanced suicide prevention outcomes.

Priority Action: All governments to prioritise and appropriately resource their approach to suicide data to enable the AIHW to:

1. Establish consistent definitions of suicide-related data across jurisdictions, including agreed methods for distinguishing between suicide attempts and deliberate self-harm.
2. Increase the breadth of suicide-related data collected so that it includes all relevant cross-portfolio data and data on priority populations, including Indigenous, LGBTIQ+ and CALD.
3. Increase the amount of population level data through national surveys that include self-reported psychological distress, suicidal ideation and suicide attempts, as well as the impact of suicide bereavement.
4. Improve the timeliness of the recording, collection, and routine analysis of suicide-related data to support systematic event notification to relevant service providers.

3.2 Monitoring

Monitoring describes the regular collection and analysis of information to track the implementation of suicide prevention policies and activities, and to detect emerging trends and risks. It is important the information from monitoring is translated into knowledge that can be used to inform policy and service delivery decisions. There are three priorities for enhancing the suicide monitoring function: (1) conduct data quality improvements to strengthen the ability to monitor suicide behaviour and activities; (2) provide for the translation of knowledge into the continuous improvement of policy and programs; and (3) ensure there are timely and appropriate responses to the translation of emerging trends and risks. Knowledge translation is required to ensure data monitoring leads to continuous improvement and timely advice. It will also be important to build capability in the system so that timely responses to emerging trends and vulnerabilities can be delivered at a local level while also being integrated into the national suicide prevention approach.

Priority Action: All governments to work with the AIHW to ensure the national whole-of-government approach to suicide data includes the capacity and governance required for the data to be used for research into strategically prioritised areas that can practically inform policy and practice change.

Service mapping

Service mapping is a useful tool in the monitoring of suicide prevention activities. It allows the activities to be described by type and location, which can then demonstrate whether the right type of activities are being provided to the right people in the right locations. In Australia, there are several models of suicide prevention in operation, which also have different funders. As such, there is no nationally standardised 'service taxonomy' or centralised approach to the collection of data on the delivery of suicide prevention activities. To be able to model the activities being provided in Australia there is a need to: (1) adopt a standardised description of suicide prevention activities; (2) collect output data on the programs and services that are being delivered; and (3) be able to map this against population needs at a local level.

Simulation modelling

A recognised benefit of COVID-19 has been the introduction of health-based simulation modelling to the general public, including the acceptance of such modelling as the evidence to implement physical distancing and other restrictions to 'flatten the curve'. This acceptance of simulation modelling has transferred into the mental health and suicide prevention space, with subsequent calls to use predictions in suicide prevention as well.⁶ Simulation modelling is a useful tool for monitoring but also uses the monitoring information and other evidence sources to predict future outcomes.

Simulation modelling should never be expected to be 100% accurate in its predictions. Instead, the value of simulation modelling is in its usefulness to provide a simplified description of how a complex system behaves to deliver the desired outcomes, and how these outcomes can be effected when things change. There are a number of simulation modelling methods and each have strengths and weaknesses, but importantly they have different data and computational requirements. The best approach to simulation modelling is to use a combination of modelling methods to understand how the system behaves from various perspectives. All methods of simulation modelling require quality, timely and relevant data to make predictions.

Priority Action: All governments to enable the AIHW to collect data that supports service mapping and simulation modelling of suicidal behaviours and suicide prevention activities. This information to be used for the routine monitoring of: (1) whether communities have access to the right service mix to meet their needs; and (2) the implementation, outcomes and impact of suicide prevention activities in Australia.

3.3 Evaluation and research

The approach to the evaluation of suicide prevention programs and services in Australia requires significant improvement. When evaluations are conducted, they are usually retrospective evaluations of a specific program, with a focus on short-term output measures. While this may demonstrate whether a program has been implemented appropriately and as funded, it does little to further the understanding of what is effective or not at preventing suicide attempts or suicide deaths.

Outcomes

Common-sense would suggest that the long-term measure of success for suicide prevention would be a reduction in suicide deaths. While this should always be the aspiration for any intervention, using the suicide rate or number as the only outcome does not allow the fidelity to understand what is working and what is not. The rate or number of suicide deaths also needs a significant period of time to demonstrate any change as a result of an intervention and is subject to fluctuations that may be misleading if not considered. In addition to the statistical issues, people with lived experience also caution about the use of suicide deaths as the measure of success. The use of the rate or number of deaths does not support the shift to earlier intervention for distress. As such, there is a strong need to identify lead and lag indicators that can be used to evaluate a full range of suicide prevention activities.

To support the shift to a national whole-of-government approach a collective approach to the evaluation of suicide prevention in Australia needs to be implemented through an evaluation framework. The framework would allow outcomes for suicide prevention activities to be mapped and applied across all suicide prevention activities as well as supporting individual programs to be evaluated for their contribution to the suicide prevention system in Australia. The development and implementation of an evaluation framework needs to be phased so that it: (1) incorporates the current suicide prevention activities with limited impact and does not delay the implementation of planned activities; and (2) supports the initial application of process or implementation evaluations.

To be meaningful, outcomes and indicators for the evaluation of suicide prevention activities in Australia would need to be co-determined with people with lived experience and be shared by everyone who delivers activities. This includes ensuring meaningful outcomes for priority populations, such as Aboriginal and Torres Strait Islander people⁷, LGBTIQ+ and CALD populations, as well as commonly shared outcomes for everyone. An evaluation approach such as this would need to be coordinated nationally with suicide prevention programs evaluated for their outputs and outcomes as well as how they contribute to the long-term impact of suicide prevention in Australia. A key component of this approach is ensuring there is effective governance within the national system to support the translation of evaluation and research into continuous improvement actions.

Summative analysis of national suicide prevention trials

There are currently a number of distinctive suicide prevention trial sites funded across the country, including the National Suicide Prevention Trial sites, place-based suicide prevention trials funded by the Victorian Government, and LifeSpan research trials overseen by the Black Dog Institute. The Commonwealth Government is undertaking the coordination of suicide prevention trial evaluation findings which will synthesise and analyse the outcomes of these suicide prevention trial activities across Australia. Given the importance of identifying effective regional delivery of suicide prevention, this work aims to identify common themes and triangulate data across evaluations to improve the evidence-base at a national level. This work is expected to be completed in 2021.

Priority Action: All governments to facilitate the development of an outcome framework that maps key outcomes for suicide prevention activities. This outcome framework to enable evaluation of the impact of suicide prevention activities nationally.

Research

Funding for suicide prevention research

The Government has increased its investment in suicide prevention research, including:

- Funding the Centre for Mental Health at the University of Melbourne to play a national leadership role in suicide prevention research.
- Funds of \$12 million to support the establishment of a Suicide Prevention Research Fund managed by Suicide Prevention Australia, and a further \$4.2 million announced in May 2020.
- \$8 million allocated to suicide prevention research under the Million Minds Mission.
- Support for the development of a National Research Plan for Mental Health and Suicide Prevention, led by the National Mental Health Commission.

The Suicide Prevention Research Fund is managed by Suicide Prevention Australia and was established to support world-class Australian research into suicide prevention and facilitate the rapid translation of knowledge into more effective services for individuals, families and communities. The fund prioritises intervention research, with particular emphasis being given to indicated interventions and protective factors for suicide. The *Initial Findings* suggested there was scope to refocus some of the fund to enable rapid translation of evidence into practice and to test effectiveness of newly funded or emerging approaches identified through reform processes.

Research priorities

Strengthening the evidence base through research is critical to informing the national whole-of-government approach to suicide prevention. The key to achieving this is to ensure the research activities address the right questions and the research priorities are connected to policy and practice. Targeted research funding and priorities would support improved understanding of interventions that work to reduce the onset, severity and impacts of suicidal behaviour. Targeted research can also assist with refining and improving new service models and national reforms.

There are a range of reform priorities identified through the Health Suicide Prevention Strategy that should be considered as a priority for targeted research funding. This includes a commitment to progressing 'safe spaces' and increasing the reach of aftercare programs. Building the evidence for these service models is an immediate priority to ensure current investments have strong foundations for broader rollout. It is also important to evaluate whether current models are effective for priority populations, including Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and LGBTIQ+ people. Other areas that could benefit from targeted research funding includes further research with people who have lived experience of suicide attempts and research connected to current services and programs – especially programs targeting alcohol and other drugs, justice settings, children's services, homelessness, family violence, or within broader community settings.

Priority Action: The Research Advisory Committee for the Suicide Prevention Research Fund to fund research that aligns with strategic priorities to enable a rapid translation of evidence into practice and to test the effectiveness of new and emerging approaches. Priority options for 2020-2021 have been provided for consideration.

Chapter 4: Cross-portfolio and multijurisdictional initiatives

"I have lived with suicide ideation and many attempts. However, the most recent was back in 2013. Just prior to this attempt, I was in severe financial stress. I was about to become homeless for the second time in a short period of time. I was isolated and estranged from my family and friends."

Personal Story, Private Voices study, UNE

A national whole-of-government approach to suicide prevention requires a cross-portfolio and multijurisdictional effort to mitigate risk factors for suicide, to target approaches early in the trajectory towards suicidal behaviour and to respond earlier to distress.

Historically, the responsibility for suicide prevention has been given to health departments, with a range of suicide prevention plans, frameworks and policies currently in place. Effective suicide prevention not only requires health intervention and support for individuals, but for efforts to be aligned and responsibilities shared across multiple sectors to respond to broader contributing factors.⁸

In-principle recommendations

Recommendation 7: To support further implementation efforts, all Commonwealth portfolios (with consideration for States and Territories to do the same) to apply the decision making tool in *Shifting the Focus* to identify key initiatives for implementation and evaluation in each portfolio. In addition:

- 7.1 Agency Heads develop and report on agency-specific suicide prevention actions plans.
- 7.2 Develop a Commonwealth process for reviewing new policies or initiatives to ensure they assess any impacts (positively or negatively) on suicide risk or behaviour.

Recommendation 8: Population-level interventions which address key social, economic, and health stressors should be prioritised and implemented including:

- 8.1 An immediate and ongoing focus on individuals, industries, and communities most affected by economic downturn associated with COVID-19 and the implementation of policies and programs that mitigate distress.
- 8.2 Coordinated cross-jurisdictional action to intervene early in life to mitigate the impacts of childhood adversity and trauma, with a focus on children and young people in out of home care.
- 8.3 Cross-jurisdictional action to enhance suicide prevention interventions targeted at people in touch with the justice system and those who are homeless or with insecure housing.

Recommendation 9: The Commonwealth with States and Territories work together to ensure government systems or services that interact with people experiencing distress provide earlier and more effective responses. This includes an increased capacity to provide outreach and support at the point of distress. Actions should include:

- 9.1 Reviewing and enhancing the outreach and support provided to people who are involved in family disputes, legal action, child custody arrangements and workplace disputes.
- 9.2 Providing interventions delivered at critical points of transition – ensuring there are evidence based approaches for people released from justice settings and those transitioning from certain workplaces such as the Australian Defence Force.

The need for a comprehensive approach: Learning from lived experience

For many, suicidal thoughts and behaviours could be traced back to childhood and adolescent experiences of abuse, violence, trauma, family conflict or bereavement. People also reported experiences with discrimination and cultural taboos as well as the role of co-occurring and complex life stressors closer in time to a suicide attempt.

A number of opportunities were identified, including:

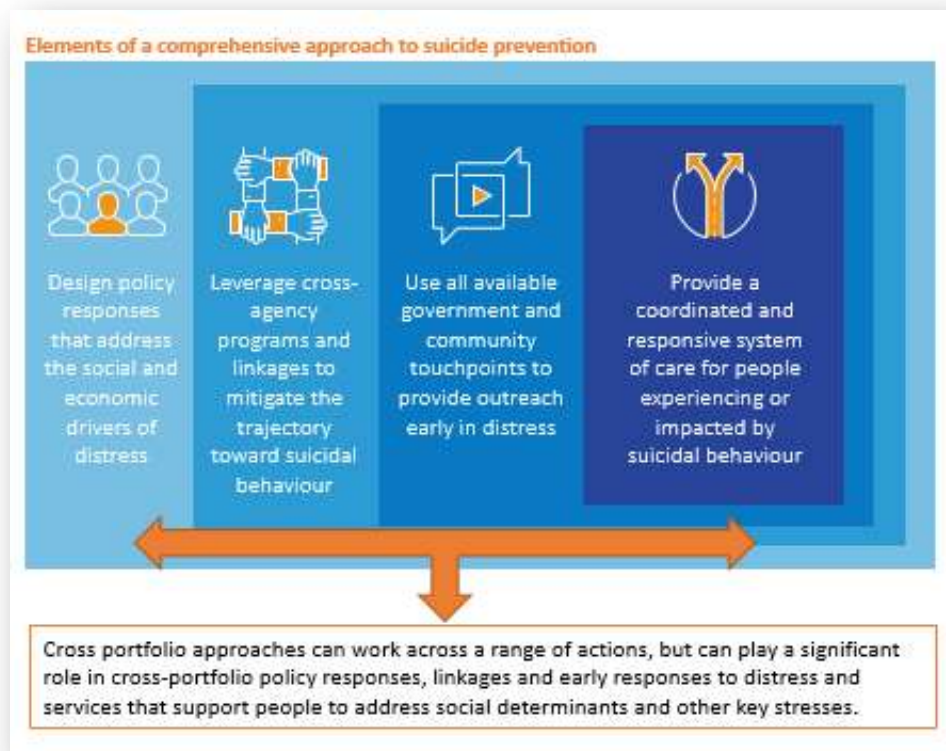
- Implementing population level interventions that address key social and economic stressors
- Intervening early in life to mitigate the impacts of abuse and adversity in childhood
- Increased capacity to provide outreach and support at the point of distress to ensure people get the right supports in a timely way – especially at critical points of transition.

A range of potential supports and services were identified by those with a lived experience of suicidal distress as being important – including housing and homelessness service, legal centres and the family law court, family and community services, including services that support people through domestic and family violence, as well as a range of financial and other community services.

Shifting the focus to a whole-of-government approach

A range of government portfolios at the Commonwealth and jurisdictional level can support collective action on suicide prevention. As outlined in *Shifting the Focus*, this can include:

- Policy responses that address the social and economic drivers of distress and by enhancing population and community-level protective factors.
- Linking across agencies and programs to intervene early across various settings – targeting underlying vulnerabilities or key moments of disconnection or transition to interrupt the trajectory towards suicide.
- Using all available governments and community touchpoints to respond early to distress, enabling frontline workers to respond with compassion and link people to supports.
- Ensuring a coordinated and responsive system of care across the lifespan with multiple opportunities to link people to the right support at the right time.
- Ensure responses and programs are informed by data and evidence through their continuous monitoring and evaluation supported by timely data collection and analysis.



The value of a national whole-of-government approach has been demonstrated through the response to COVID-19. The creation of National Cabinet has afforded opportunities to strengthen multi-jurisdictional and cross-portfolio approaches, including a response to suicide prevention. The government has responded to potential risks on multiple levels through economic policies to reduce financial distress; social policies and investments; innovation to unlock the health and crisis response services; and sharing of data across jurisdictions.

This chapter provides a summary of key actions and work in progress to advance cross-portfolio approaches to suicide prevention, at the Commonwealth and multijurisdictional level. This work complements the significant work that some Commonwealth departments, such as the Department of Defence and the Department of Veterans' Affairs, and the work of many States and Territories have begun to shift to a cross-portfolio approach to suicide prevention.

4.1 Cross-portfolio initiatives

Suicide prevention in all government policy development

A broad range of factors and experiences can contribute to population-level distress, as well as exacerbate suicidal behaviour specifically. There is an opportunity to ensure a suicide prevention lens is applied across all new policies and initiatives, whereby suicide prevention outcomes are considered as a routine undertaking by all government departments and agencies.

In early 2020, the Commonwealth Interdepartmental Committee agreed to explore ways in which new policies identify and take into account possible impacts on psychological distress and suicide risk. Where potential risks are identified, the policy is amended, or strategies are put in place to lessen the impacts or provide additional supports to those affected. If no mitigations are possible, this should be noted in the advice accompanying the policy. There are four options that could be considered, with more details provided in Appendix 1.

Priority Action: The Commonwealth Government to adopt and implement *Shifting the Focus* to support action at the Commonwealth level to develop agency-specific suicide prevention actions plans, and that, whenever new policies or initiatives are being developed, there is consideration given to the potential impacts with regards to suicide behaviour and opportunities to enhance suicide prevention.

Enhanced opportunities to support people through government systems

There are opportunities to use government touchpoints across different portfolios and services to identify and assist Australians who are experiencing distress and who may be vulnerable to suicidal behaviour, particularly during periods of transition, sudden change or crisis. These touchpoints can be used to identify and respond to people experiencing distress and/or suicidal behaviour, engage in compassionate outreach, and link people to supports. People experiencing distress or impacted by mental ill-health can disengage from government services. This is especially relevant for groups that may be experiencing a level of vulnerability such as veterans and people living with a disability.

Commonwealth departments represented on the Interdepartmental Committee have commenced scoping an initiative that seeks to progress this area of work (with a brief update provided in Appendix 1). This work may also be enhanced by mapping the journeys of people with lived experience of suicidal distress through a range of government service systems. For example, given the significance of relationship breakdown and child custody issues for men experiencing suicidal distress, there would be benefits in mapping the range of government services and systems that interact with men to understand their current experiences and to identify opportunities to integrate supports that better suit their needs.

Priority Action: All governments to monitor government systems or services that are likely to interact with people experiencing distress. Governments to identify how frontline workers can make the most of these opportunities to provide support and connect people with appropriate services.

Priority Action: All governments to encourage their agencies to share relevant data with other agencies to enable timely identification of cohorts or individual clients that may be vulnerable to suicide.

Workforce training for frontline staff in Commonwealth agencies

Every contact that a person has with a department, service or individual worker is an opportunity to have a positive impact, ensuring they get a compassionate response and then linked to the right supports. Developing a medium to long-term training framework would improve interagency coordination, collaboration and cooperation across a wider range of settings and with the shared goal of providing a compassionate and effective response to people in distress. Targeted training and supports for frontline staff is expected to have multiple benefits – for people engaging with frontline government agencies, and also for government workers and services. With over 144,000 staff employed across the APS, it also builds on and supports approaches targeted at community gatekeepers with many frontline workers also involved in community networks and organisations.

The APS will be rolling out workforce training in 2020/2021, based on a compassion-led approach, feasibility of immediate and longer-term roll-out, and the opportunity to align with training being delivered, or to be delivered, across a number of States and Territories. People with lived experience of suicidal behaviour have expressed a strong need for compassionate approaches within government and community services. The training will use a contemporary approach to suicidal behavior, community distress and staff wellbeing, is well aligned with a move towards early distress responses in Australia and demonstrates leadership through the APS. It will be suited for a broad government workforce, allowing for scaffolded learning for different roles and capability needs.

The initial roll-out of training is being led by the Australian Public Service Commission, with input from a range of Commonwealth departments (more detail is provided in Appendix 1). It is acknowledged, however, that training alone will not be enough, with workers across the APS requiring the support of healthy and safe workplaces, practical policies and support, and clear commitment from their leaders.

Priority Action: The Australian Public Service Commission to lead the roll-out of compassion-based training for front-line workers across the Australian Public Service and support a review of internal policies, resources and referral pathways to enhance the training, with consideration of similar approaches in other states and territories.

Priority Action: Expand and build on current Australian Public Service workforce training across all portfolios to build workforce capacity to respond to distress and prevent suicide.

Distress brief intervention

Current and previous reviews and inquiries highlight that in a whole-of-government approach to suicide prevention, one of the most significant opportunities is to respond early and effectively to those experiencing distress, using all available community and government touchpoints. The *Initial Findings* recommended responding earlier to people's distress through community and government touchpoints, highlighting the need for a whole-of-government portfolio approach.

Elevated levels of distress and possible increases in suicidal behaviour is an ongoing concern for people impacted by sudden changes and adverse events, including those impacted by COVID-19, as well as recent droughts and natural disasters. Immediate distress responses are vital to addressing these suicide risks and supporting communities to recover.

A Distress Brief Intervention (DBI) model of care involves developing regionally based government and community level referral pathways and service providers to deliver a brief and proactive intervention to ensure all people presenting in distress are able to access immediate support and care-coordination that links them to ongoing supports that fit their need. A DBI model of care has been in place in Scotland since 2016 and has received support here in Australia.⁹

The DBI typically involves two stages: an immediate compassionate response with the offer of a referral if required; and a guarantee of support within 24 hours, with the goal to provide immediate low-intensity support and to link people to other practical, psychological, counselling, community-based problem-solving support. By intervening early in distress, the intervention seeks to divert care away from emergency services and clinical service involvement where it is not required. It is also more likely to support groups less likely to present to mental health services, including rural communities and men.

Interim findings from the DBI pilot program in Scotland have shown the programme to be effective in increasing collaborative, cross-sector networks both within and across the pilot, as well being positively received by people who have received the DBI and successful in reducing their distress and helping them to plan for the future.

Whilst there are various suicide prevention initiatives and pilots underway across Australia all working 'towards zero' suicides, there is no DBI model being trialled currently. A number of agencies consulted with on the initial advice and/or making submissions to other enquiries such as the Productivity Commission Review and the Victoria Royal Commission have supported consideration of a DBI approach for Australia. This would also align with immediate priorities under the Pandemic Response Plan to increase outreach, coordination and linkages between services.

Priority Action: The Taskforce to work with stakeholders to further scope options for a Distress Brief Intervention in Australia to enable the Commonwealth to work with States and Territories to implement to approach. This needs to be implemented in a way that enables earlier intervention, interrupting people's pathway towards suicidality and improve outcomes.

Improving social connection and reducing loneliness

Agencies providing submissions to the Taskforce recommended a national approach to increasing social connection and reducing loneliness. This builds on the workshop conducted at the Towards Zero Suicides National Forum held in November 2019. Quality social interactions have the potential to improve people's wellbeing and increase their social and economic participation. In the context of COVID-19 this was particularly important, with identification of cross-portfolio action occurring through the interdepartmental committee, and government resources and messaging to support 'physical distancing with social connection'. Further work is required, but options for a whole of government approach should be considered to address the distress people experience when their social relationships are felt to be inadequate.

Loneliness is highly prevalent in Australia, with research by the Australian Psychological Society suggesting that a quarter of Australians experience loneliness.¹⁰ Loneliness affects people of all ages, but especially young people. Men may also be particularly vulnerable to loneliness, with research indicating that men's social support diminishes in their middle years (30-65), with one in four having no one outside their family they can rely on, and one in three dissatisfied with the quality of their relationships.¹¹ By investing in the quality of people's relationships, resilient and thriving communities can be built. National leadership is critical, with the UK's loneliness strategy - '*A connected society: A strategy for tackling loneliness*' – providing a useful blueprint for coordinating government, employers, local authorities, and volunteer agencies to improve social connectedness.

Priority Action: The Taskforce to work with stakeholders and the IDC to further scope options for a national approach to improving social connections and addressing loneliness. This needs to consider priority populations and regional implementation.

4.2 Multijurisdictional initiatives

The Taskforce met with State and Territory governments at the Deputy Senior Officials Meeting (DSOM) about potential opportunities for multijurisdictional suicide prevention. Through the Suicide Prevention Research Fund (managed through Suicide Prevention Australia), the Taskforce commissioned a series of rapid reviews and evidence checks to guide future considerations for initiatives focussed on:

- a. *The justice system* – do interactions with the justice system have an impact on suicidal behaviour and what interventions are effective in reducing suicide thoughts and behaviours among people in contact with the justice system?¹²
- b. *Children in out-of-home care* - does childhood trauma and interactions with the child protection system play a role in suicidal behaviour and what interventions have been effective in reducing suicidal thoughts and behaviours?¹³
- c. *Housing stress and homelessness* – what role does housing insecurity and homelessness play in cultivating suicidal behaviour, and what interventions are effective in reducing suicidal thoughts and behaviours?¹⁴

These reviews were used in the development of this report and accompanying documents, including the summary sections below. They will be available upon release of this report and used in further engagement with jurisdictions and stakeholders.

Justice System

The risk of suicide among those who are released from prison is more than six times as high as the general population, highlighting the importance of providing support to individuals when transitioning out of prison, at identified stages of vulnerability.¹⁵ Being in contact with the prison system results in specific groups being vulnerable to suicide, including Aboriginal and Torres Strait Islander people, those in youth detention, prisoners with a mental illness, people who have had a previous suicide attempt, and those with multiple prior imprisonments (which is almost 3 in every 4 prisoners).¹³

Across governments, there are strategies in place to identify, manage and respond to incidents of self-harm and suicide, such as screening and assessment at the beginning of a stay as well as periodically throughout incarceration; mandatory notification across governments when 'at risk' prisoners are transferred across jurisdictions; alterations of physical environments in cells to increase safety; and individualised management of offenders based on assessment of suicide risk.¹⁶

Although there has been a considerable amount of suicide prevention strategies and initiatives undertaken nationally, the majority of them have not been formally evaluated, reviewed and/or have various limitations. Suicide prevention initiatives for the justice system should be informed by evidence, and by the lived experience of people who have had contact with the system. There is a need for more high-quality, longitudinal research examining the effectiveness of interventions designed to prevent suicidal ideation, self-harm, and suicide attempts in people who come into contact with the criminal justice system.

A comprehensive review of studies relevant to suicide prevention for people who come into contact with the criminal justice system by the University of Melbourne identified that the national and international evidence base is currently inadequate. The same review identified a paucity of research into suicide prevention in Indigenous people who come into contact with the justice system. In light of the marked over-representation of Indigenous people in the criminal justice system, and the higher rates of self-harm observed among Indigenous people than non-Indigenous people¹⁷, this is an urgent priority area for governments. There is a clear need for high-quality, targeted, culturally competent research leading to culturally sensitive suicide prevention initiatives.¹³

More research is needed in criminal justice settings other than prisons and youth detention centres. Such settings include police watch houses and other settings where the police interact with vulnerable members of the community, courts, and community-based correctional and youth justice settings, diversionary program settings, and secure forensic mental health settings.

Interventions and priorities that could further assist and address suicide prevention across jurisdictions in the justice system include:

- The Commonwealth government to invest in the development of national guidelines for preventing suicide after release from custodial settings.

- Criminal justice settings to be routinely included in population-level suicide prevention and related (mental health and drug and alcohol) policies.
- Implement a compassionate and coordinated care model of support for individuals entering into and leaving the justice system.
- Invest in improving data collection and sharing across jurisdictions, including health-related information and data between community healthcare settings.
- Commonwealth and State and Territory governments to consider increased investments in the recruitment and training of health and custodial staff in prison, youth detention, and police watch-house settings.
- Commission longitudinal research examining the effectiveness of interventions implemented that are designed to prevent suicidal ideation, self-harm, and suicide attempts in people who come into contact with the criminal justice system.

Priority Action: In consultation with jurisdictions, relevant experts and stakeholders, priorities should be set for suicide prevention approaches in justice settings, including considering a flexible community-based care model that aligns with the principles of aftercare to support people transitioning from custodial settings back into the community.

Priority Action: The data sharing between governments and jurisdictions, including community and custodial healthcare settings, to be improved so as to reduce suicidal behaviour for people transitioning between treatment settings.

Children in the out-of-home care system

The number of children who die by suicide is small, but child suicide rates (defined as those aged between 5 and 17 years) have risen in the past decade, resulting in further investigation from all governments.¹⁸ A significant number of these children were in contact with child protection and the out-of-home care system.¹⁴ The rates of Aboriginal and Torres Strait Islander children in out-of-home care and as a proportion of suicides occurring among children are significantly higher than for non-Indigenous children.¹⁹

The Victorian Government conducted a study into the death of 35 children from suicide between April 2017 and April 2019 and found that there were multiple, and often chronic, risk indicators. These children were frequently in contact with a range of services and each recorded contact presented an opportunity for intervention and support. Ineffective early intervention was recognised for each case, including system delays, fragmentation and inconsistent response from child protection where key warning signs were being sidestepped. These issues led to the exacerbation of risk factors for children in their daily lives, including family violence and parental substance use problems.²⁰

Research from both Australia and the United States of America demonstrate that children in out-of-home care display almost all risk factors associated with suicide.¹⁴ These include an increased risk of psychological factors such as harm or maltreatment, family problems, peer conflicts, bullying, abuse

or attempted suicide of peer or family member, as well as personality traits featuring low self-esteem, low resilience and low emotional intelligence.

One of the most significant consequences of early childhood trauma is disruption to emotional regulation that can lead to an inability to regulate internal states, which may result in self-harming behaviour and thoughts of suicide in later life.²¹ Research suggests a link between child sexual abuse across all settings and suicidal behaviours.²² Reducing child abuse in the home and in out-of-home care settings needs to be a priority if we are to reduce suicidal behaviours among children and later as adults. As much of the harm has already occurred before children enter into out-of-home care, interventions should also focus on complementary services that involve a joint effort from family and community services to develop a child-focused approach to improve outcomes.

To address the gaps in the system, recognise the risk factors and provide effective intervention strategies, a number of future actions and priorities have been identified for further consideration.

- *Trauma Informed Care.* With trauma as a contributing factor in almost all child suicide, both generally and for out-of-home care, trauma informed interventions and compassionate care is required. Trauma informed care should include culturally appropriate interventions for Aboriginal and Torres Strait Islander children and young people.
- *Wraparound services.* A child-focused approach where complex needs are addressed through a process which joins the efforts of community members from the child's formal and informal networks to improve outcomes for the child. Wraparound service provision will need to take into account Aboriginal and Torres Strait Islander kinship and family structures.
- *Early childhood education and care, school and community programs.* Educating students and communities on suicide prevention and trauma informed responses to build resilience within communities from a young age.

Priority Action: Improve data collection and sharing between services and government agencies in relation to children in out-of-home care. Use this data to inform an evidence-based approach to identifying and addressing risk factors associated with suicidal behaviour in these children. In consultation with jurisdictions, relevant experts and stakeholders, set priorities for suicide prevention approaches in relation to children in out-of-home care.

Homelessness

The causes of homelessness are complex and varied and can include domestic violence, unemployment, relationship breakdown, drug and alcohol use, and mental illness. In addition to being causes of homelessness, they can also be the consequence of it, reiterating the complex, bi-directional relationship between homelessness and suicidality. Evidence shows that for those who experience moderate to severe mental health issues, having a home and being in a secure housing environment, is a protective factor to suicidality. Living in unaffordable housing is detrimental to mental health.²²

The Australian Housing and Urban Research Institute (AHURI) categorised people who are homeless into the following:

- *Unengaged homelessness* – People who are homeless and do not receive any services to support their mental health issues.
- *Discharged homelessness* – People who have seen and have been hospitalised by medical practitioners but have not received adequate support when transitioning back into the community, demonstrating the importance of targeting certain transition points in life for better suicide prevention.
- *Admitted homelessness* – People who are treated in a psychiatric facility in hospital and remain hospitalised without proper transition strategies back into the community.
- *Unstable housing* – People who experience homelessness in substandard and insecure tenures and who struggle to manage. This cohort have reoccurring issues with mental ill-health and housing instability exacerbates it.¹⁵

Each State and Territory government is responsible for services that are provided in their jurisdiction. In addition, the governments fund various agencies nationwide to provide Specialist Homelessness Services (SHS), which include accommodation and other non-accommodation services such as counselling.²³ Current approaches and the availability of services in each jurisdiction varies widely and would benefit from national consistency. Each of the States and Territories have individual strategies and action plans that detail commitment to tackling homelessness. Better defining roles, responsibilities, funding, governance and accountability will contribute to a more effective, co-designed service delivery.

Priority Action: Strategies addressing housing and homelessness reform, under the National Housing and Homelessness Agreement, to align with the whole-of-government approach to suicide prevention and have cross-portfolio and multijurisdictional contributions.

Priority Action: All governments to consider further investments in low-cost, secure and good-quality public housing, linked where necessary with suitable support services. In consultation with jurisdictions, relevant experts and stakeholders, priorities should be set for suicide prevention approaches focused on people experiencing or at risk of homelessness.

Chapter 5: Priority Populations

“In my community mental health issues are problematic. There is stigma, branding and spiritual abuse. Suicide attempts are frowned on and are used to question religious observance and faith”

Culturally and Linguistically Diverse interview participant

A comprehensive approach to suicide prevention must focus on the whole population, as well as address the unique needs of specific groups through tailoring interventions and approaches that are most likely to proactively reach them.

While suicidal behaviour can be experienced by everyone, some populations and groups can be disproportionately affected and targeted responses are required. These groups are not intrinsically more vulnerable to suicidal behaviour, but rather they may experience greater rates of discrimination, isolation and exclusion, or find it more difficult to ask for or access support.

In-principle recommendations

Recommendation 10: Adopting an equity approach to suicide prevention planning, acknowledging the disproportionate impact experienced by some population groups making them vulnerable to suicidal behaviour and requiring targeted approaches. This includes:

- 10.1 All governments prioritise action plans and funding to support approaches that work for men, young people, Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, culturally and linguistically diverse communities, rural and remote communities, and older Australians.
- 10.2 Improved data capture and accountability for funded programs and services to demonstrate outcomes for identified priority populations.

This chapter provides some general considerations for priority populations and some specific concerns in the current environment in Australia.

COVID-19 context

Evidence suggests people who are already disproportionately impacted by suicidal behaviour are far more likely to experience distress during periods of instability and community adversity. Groups that have been identified through emerging research to be more vulnerable to suicide as a result of COVID-19 measures include: people who have experienced unemployment and/or financial distress (especially men), young people, older Australians, the health and frontline workforces and communities that have experienced multiple traumas. Known groups that have a generalised higher risk for suicidal behaviour include men (especially older men), Aboriginal and Torres Strait Islander people, those in rural and remote areas, people from culturally and linguistically diverse backgrounds, people who identify as LGBTIQ+, veterans and carers. Recent studies report uncertainties caused by the COVID-19 pandemic, including lockdowns, have exacerbated a wide range of risk factors including anxiety, isolation, loneliness, financial concerns, anger, irritability, relationship conflicts, post-traumatic stress, fears, and increased use of alcohol and tobacco.²⁴ As part of the Commonwealth Government's \$48.1 million Pandemic Response Plan, additional funding was provided to address gaps in services for priority populations most affected by the pandemic.

Men

Shifting the Focus identifies men as a priority population requiring a cross-portfolio approach.



75% of people who die by suicide are male.¹¹ Men can experience a range of co-occurring life stressors, including relationship breakdown, unemployment and injury. They may change their use of alcohol and other drugs as a coping mechanism, or delay seeking help. Men may not readily access support through mental health services and sometimes these services are not well suited to meet men's needs. The unique needs and experiences of men must be considered in providing support and responses, with a focus on local, immediate supports being provided 'where men are'.

Men are more than three times more likely to die by suicide than women,²⁵ and the impact of male suicide is felt across the whole population, including family members, loved ones, workplaces and communities. Key risk factors for male suicide include stressful life events, experiences of trauma (including exposure to trauma via certain occupations), poor living conditions, and work insecurity.²⁶ Lived experience research indicated that changes in alcohol and other drug use can co-occur with relationship, financial and workplace stressors prior to a suicide attempt – with opportunities for early intervention if a broader cross-portfolio approach is taken. When men are experiencing suicidality they are less likely to seek help through traditional health and mental health services. Stigma and gender stereotypes, such as the stoic male that never complains and 'gets on with it'²⁷ may contribute to this, as can poor service experiences in the past or preferences for peer-based supports.

Pandemic-related unemployment is a critical concern as employment is strongly associated with men's socially perceived role as primary providers. Men who are middle-aged, experiencing financial distress and/or unemployment, and who have been separated from their families and/or children are at particular risk. The Australian Men's Health Forum (AMHF) has argued that social isolation needs to be carefully managed during the wake of COVID-19 to avoid an increase in male suicide. Some men's support services (for example, Men's Sheds) are struggling to continue to operate

through the pandemic. Although some have been successful in moving to an online approach, limited access to usual supports has created further isolation. These forms of social connection are vital for men's emotional and mental wellbeing.

Priority Action: Men should be identified as a priority population within national suicide prevention plans, ensuring a focus on meeting men where they are and providing targeted approaches and supports.

Priority Action: Immediate action to be taken to increase capacity to provide targeted outreach and support at the point of distress, especially for services engaging with men, including training for frontline workers in family, legal and workplace settings as well as at critical points of disconnection and transition life points.

Young People

Shifting the Focus identifies young people as a priority population requiring a cross-portfolio approach.



While young people have a lower rate of suicide compared to other age groups, suicide is a leading cause of death for **people aged 15-29**.¹² Adolescence and early adulthood is also the period where 75% of mental illnesses emerge, and when alcohol and other drug problems may arise; meaning early and effective treatments are imperative. Strategies to prevent suicide in young people need to reach and engage with young people.

Rates of psychological distress among young people has increased during COVID-19.²⁸ The sharp rise in youth unemployment and projected unemployment trends resulting from COVID-19 are creating significant future uncertainties for young people, which is having a profound effect on their mental health and wellbeing.³¹ Young people make up a large portion of Australia's casual workforce and in many cases are the first to lose employment when businesses close or fail.³¹ Many students and younger people working in pandemic impacted sectors, such as retail, tourism, and hospitality services, have lost income and found it difficult to continue their studies, leaving them particularly vulnerable to experiencing psychological, financial, and housing stress in the immediate and longer term.

Since the outbreak of the pandemic, one in two young Australians feel that their mental health (51%) or their mood (47%) has been negatively impacted. Beyond Blue has had an exponential increase in calls compared to similar periods in previous years. The concerns expressed by youth callers included the impacts that COVID-19 is having on their everyday lives including university closures, going through periods where team sports and gyms were closed, as well being unable to travel and see friends and/or partners. These events are occurring for young people in critical life-transition periods already identified as high risk periods, such as the transition into and out of high school, into the workforce, or further study or training. In contrast to recent historical natural disasters where impacts have been confined to a specific geographical region, these stressors are being experienced across the entire Australian youth population. Subsequently, there is expected to be profound and cascading long-term social and economic impacts on young peoples' lives.

Early intervention and outreach for young people, especially young men, will be critical. Research has found that young men often reach a severely distressed state before eventually seeking help, if they seek help at all. Work settings are a recognised resource for engaging young men when distress emerges. However, the recent rise in youth unemployment rates to over 16% in Australia as a result of COVID-19 highlights the complexity of accessible protective factors.

Young people and their families are identified as a vulnerable population in the Pandemic Response Plan, which has resulted in focused activity for this group to minimise the impacts of both the bushfires and the COVID-19 pandemic. Government funding directly to PHNs across Australia is supporting fast track access to mental health services for young people aged 12-25 seeking headspace appointments.

Priority Action: Young people should be identified as a priority population within national suicide prevention strategies and plans, ensuring a focus on co-design with young people and addressing specific stressors.

Priority Action: All governments to outline mechanisms that facilitate effective prevention approaches and mental health services for young people, with opportunities to enhance the role of schools, training colleges and universities as well as employment services and health services.

Older Australians

Health authorities and governments across the world have been preparing older people for the heightened risk of physical complications as result of COVID-19. However, far less attention is given to the psychological challenges for older people. Australian men over 85 years old have the highest rate of suicide in Australia,²⁹ often experienced in conjunction with health deterioration, isolation and loneliness and feelings of not being valued or being a burden on society.

Due to the serious risk of COVID-19 for people over 70 years, it has been recommended that older people stay at home and isolate, avoiding contact with other people. For Indigenous people, it is anyone over the age of 50.³⁰ The COVID-19 pandemic is likely to result in an escalation of risk factors for suicidal behaviours. Social isolation and loneliness are known risk factors for suicide in later life, with older people in senior housing communities (designed to limit isolation) experiencing medium levels of isolation prior to the pandemic.³¹ Pandemics such as COVID-19 also compound past traumatic experiences of older people, which could contribute to suicidal behaviour and mental illness.³²

For older Australians, feelings of worthlessness and being a burden have been exacerbated through a rise in ageism internationally during the pandemic, including media coverage and online discussions suggesting that death of older people is not as important as losing the lives of young people.³³ This has been reported as potentially contributing to suicidal behaviours in older adults 'by reinforcing negative internalised view of ageing'.³² In Australia, residential aged care homes are facing increased difficulties in finding a balance between managing health procedures to reduce the risks to residents, and balance the social needs and wellbeing of people in aged care homes. This has said to also cause a great deal of stress for staff and families of those in aged care facilities.³³ Innovative protective and prevention strategies are required to ensure that isolation and feelings of worthlessness are avoided.

This may include having access to appropriate information and resources, reducing isolation through technology, and providing support programs and assistance for older people at risk.³²

In August 2020, the Commonwealth Government announced the creation of fifteen mental health clinics in Victoria through PHNs to provide mental health support. Support is planned for older Victorians, those in the aged care system and support for residents, carers and families experiencing isolation, loneliness and the stress brought on by the effects of COVID-19. These supports will include access to mental health workers, psychologists as well as telephone and digital mental health services. The Commonwealth Government has also previously commissioned \$82.5 million to PHNs for in-reach psychological services in aged care facilities and \$19 million for nursing services or equivalent support required to address social isolation and loneliness.³⁴

Aboriginal and Torres Strait Islander Peoples

Shifting the Focus identifies Aboriginal and Torres Strait Islander people as a priority population requiring a cross-portfolio approach.



Aboriginal and Torres Strait Islander people are twice as likely to die by suicide than non-Indigenous Australians, with young Aboriginal and Torres Strait Islander four times more likely to die by suicide.¹³ Systemic factors such as discrimination, intergenerational trauma, disadvantage and cultural factors, such as experiences of shame, act as barriers to support being provided. Bereavement, including other suicides in the extended family or community, can increase feelings of being overwhelmed in the lead up to a suicide attempt. Culturally safe responses are needed which consider social, emotional and cultural wellbeing.

Suicide rates among Aboriginal and Torres Strait Islander people remain high, at close to twice the rate for non-Indigenous Australians, but historically only half as likely as other Australians to have received professional help for mental health and other related concerns. Within Indigenous communities, suicide clusters can occur and have significant impacts, as outlined by commissioned lived experience research.

In response to the COVID-19 pandemic, a national Aboriginal and Torres Strait Islander COVID-19 working party was convened through the *Transforming Indigenous Mental Health and Wellbeing Project* at the University of Western Australia to produce an independent report that addressed the specific mental health and social and emotional wellbeing needs of Aboriginal and Torres Strait Islander people in Australia.

Over 30 Indigenous leaders in mental health and wellbeing contributed to *A National COVID-19 Pandemic Issues Paper on Mental Health and Wellbeing for Aboriginal & Torres Strait Islander Peoples*. This Report called for a coordinated response based on best practice research in Indigenous mental health and wellbeing. Indigenous governance was highlighted as a priority to manage the COVID-19 recovery in communities through equitable, needs-based funding to support strengths-based, place-based, Indigenous-led, and community-led initiatives that address the social and cultural determinants of health and wellbeing.

The response by Indigenous communities and leadership groups in response to the COVID-19 pandemic has been widely lauded. While additional investments were made, Aboriginal and Torres

Strait Islander communities kept safe through highly successful united responses including health, education, land councils, government agencies, and communities. Effective communication strategies were quickly developed, and communities were well prepared and protected for lockdown, particularly in remote areas.

While there are still heightened risks during COVID-19 for Aboriginal and Torres Strait Islander people, working with local active community networks has provided effective responses that can address the specific mental health, and social and emotional wellbeing needs of Indigenous people. Continued attention needs to be given to Aboriginal and Torres Strait Islander communities that are already disproportionately affected by suicide and its impacts.

Priority Action: All governments to commit to implementing a revised National Aboriginal and Torres Strait Islander Suicide Prevention Plan once it is completed and agreed to (see the following chapter for further details).

Priority Action: Improved data linkage and inclusion of Aboriginal and Torres Strait Islander people in national surveys and research is required as well as Indigenous-led practices to increase research and evaluation of programs and services.

People who identify as LGBTIQ+

Shifting the Focus identifies LGBTIQ+ people and communities as a priority population requiring a cross-portfolio approach.



LGBTIQ+ young people aged 16 to 27 are five times more likely to attempt suicide; with particularly high rates in transgender people¹⁴. LGBTIQ+ people often report feeling judged, stigmatised and discriminated against by broader society and may experience a lack of acceptance from people around them. They may also be unable to access supports and services due to fear of being misidentified or mistreated. Responses should be tailored to address the unique needs and safety of LGBTIQ+ people.

LGBTIQ+ Australians experienced disproportionate impacts of suicidal behaviour before the pandemic. LGBTIQ+ young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime than their heterosexual age peers, and LGBTIQ+ young people are nearly twice as likely to engage in self-injury. Transgender people aged 18 and over are eleven times more likely to die by suicide, and people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over are almost six times as likely.³⁵

An ongoing issue for identifying risk factors within the LGBTIQ+ community is a lack of real data to illustrate the social and health impacts for LGBTIQ+ people. LGBTIQ+ status is not included in the ABS Census, limiting the availability of population data and linkage studies to focus on LGBTIQ+ people. This can result in this community being excluded from health planning, cross-portfolio approaches and policy.³⁶

The importance of an inclusive environment that supports the mental health and well-being of LGBTIQ+ young people is a major implication of research conducted in Australia and internationally.

This research demonstrates protective factors, such as school, community and family acceptance, and promotion of discrimination awareness, has important implications for the wellbeing of LGBTIQ+ young people.

Connection to community and peer support have an important protective effect for LGBTIQ+ people, and this has been largely disrupted with face-to-face interaction severely limited due to COVID-19. Many people across LGBTIQ+ communities rely on services and programs provided by community-controlled organisations, with access to peer support being disrupted with community venues closed and face-to-face interaction severely limited.

Given the size and significance of the mental health burden for LGBTIQ+ Australians, there is a need to invest in primary prevention and early intervention activities at all levels of Government. In Australia, the current focus appears to address many of the social determinants of suicidal behaviours and poor mental health in LGBTIQ+ people. However, targeted, ongoing, sustained and coordinated Government support is required to ensure measurable results.

Priority Action: LGBTIQ+ communities should be identified as a priority population within national suicide prevention strategies and plans, ensuring a focus on co-design with LGBTIQ+ communities and community controlled service responses. Broader government policies and programs should be assessed for their impact on LGBTIQ+ communities.

Priority Action: Improved population data for LGBTIQ+ people and inclusion of LGBTIQ+ status in research and evaluation should occur as routine practice. Additional research with LGBTIQ+ people with a lived experience of suicidal distress should be progressed as a priority.

People living in rural and remote communities

Shifting the Focus identifies people living in rural and remote communities as a priority population requiring a cross-portfolio approach.



The suicide rate in **rural and regional areas** is 40% higher than in major cities. Rural and regional communities can experience sudden and ongoing adversity through extreme weather events which may result in widespread financial hardship.¹⁵ Also, there can be fewer formal supports and professional services available compared with metropolitan areas. Strategies for rural and regional areas must consider available infrastructure, community supports and resourcing, including services having an understanding of the unique stressors that impact on rural and regional communities.

Lived experience research has highlighted that people in rural areas may feel less comfortable seeking help through health services, while in other areas access to services may be limited.³⁷ Community understanding of suicidal behaviour is paramount to identify risk factors, and to link people with the services and community networks of support to meet their needs.

The pandemic may create or exacerbate vulnerabilities for people in rural and regional areas. These communities are already more exposed to natural disasters, homelessness and housing stress, and

often work in an environment that can be hazardous to their mental health.³⁸ Where farmers feel unable to manage and deal with the impacts of external economic and environmental factors on their businesses and livelihoods, it can cause feelings of powerlessness.

Priority Action: People living in rural and remote areas should be identified as a priority population within national suicide prevention strategies and plans, ensuring a focus on building community capacity, delivering cross-portfolio approaches that address the drivers of distress and facilitating access to health and social services that meet local needs.

Culturally and Linguistically Diverse people

Culturally and Linguistically Diverse (CALD) people also need to be acknowledged and supported. Particular cultures may be less likely to seek help for suicidal distress due to pre-existing cultural stigma and taboos, in addition to language barriers that can render population-wide communications less effective.³⁹

The Pandemic Response Plan sought to provide specific information for CALD people and a number of CALD-related initiatives have been included, including reviewing suicide prevention approaches to ensure they meet the needs of CALD people. The unique vulnerabilities of CALD populations was recognised as part of the Commonwealth's \$48.1 million contribution towards implementation of the Pandemic Response Plan.

Veterans

Military service exposes veterans to both protective factors and risk factors. Although not all veterans are at risk of suicide, they are a particularly vulnerable group, with research showing that particular personnel transitioning from serving in the Australian Defence Force (ADF) have a higher rate of suicide than the general Australian population. As a result of consultation with the veteran community, ADF personnel and the families of those who have died by suicide, the Department of Veterans' Affairs (DVA) is continuing to implement customised measures that target mental health and suicide prevention in the veteran community.

Veterans can access free mental health care without the need to for conditions to be caused by service through non-liability health care. Veterans can also access free, confidential, nationwide counselling and support for current and former members of the ADF and their families through Open Arms – Veterans & Families Counselling. Some of the initiatives DVA have implemented to target suicide prevention in the veteran community include the two suicide prevention pilots, the Mental Health Clinical Management Pilot (MHCMP) and the Coordinated Veterans' Care Mental Health Pilot (CVC). In addition, the Operation Compass suicide prevention trial is one of the National Suicide Prevention Trial Sites.

DVA and the Department of Defence are working together to improve the support for those transitioning from the ADF to civilian life. This includes improving service delivery and streamlining the claims processing through an Early Engagement Model that allows DVA to establish a relationship with members from the time they join the ADF. The data allows DVA to connect with ADF members at appropriate times to ensure they are aware of the care, support and services available to them now and into the future. Through this model, DVA automatically provides personnel transitioning

from the permanent ADF with a Veteran Card (White Card) to access free mental health care. The Early Engagement Model data has also facilitated an Annual Veteran Health Check, with the veteran accessing a health assessment with a general practitioner each year for the first five years following their transition.

Veterans who medically separate from the ADF are a particularly vulnerable group of people and through the sharing of information between Defence and DVA, these veterans and veterans leaving the ADF due to drug or alcohol abuse are contacted by DVA's Veteran Support Officers to ensure a warm handover of their cases from Defence to DVA.

The Veteran Mental Health and Wellbeing Strategy and National Action Plan (Strategy and Action Plan) was released in May 2020 and provides information on the priorities and actions of DVA as well as the context and the evolution of veteran mental health and suicide prevention policy. The Strategy and Action Plan also reflects point-in-time components of the Government's response to the COVID-19 pandemic to mitigate the likely adverse impacts on veteran mental health and wellbeing.

Other populations to be considered

People who have experienced multiple traumas

The impacts of COVID-19 and an increase in distress and anxiety may be felt more acutely by those who have previously experienced trauma. This could include healthcare workers, people in aged-care facilities, people that are experiencing or have experienced homelessness, ex-military personnel, as well as individuals and communities impacted by the recent bushfires which devastated many communities who are still in the early stages of recovery. Trauma informed care should be implemented at all times, but has particular relevance for people that are exposed to multiple traumatic event, such as COVID-19 and the bushfires. The WHO Guidelines for essential trauma care states that after experiencing multiple traumatic events simultaneously, many people may feel great dread, loneliness, and frustration from losing their family, or as a result of injuries, fatalities, and broader financial burdens".⁴⁰ Therefore, essential trauma informed care must be implemented.

Women

Although men represent more than 75% of suicide deaths, women are more likely than men to engage in self-harm and attempt suicide,⁴¹ with hospitalisation due to intentional self-harm at 361 per 100, 000 persons for females. A range of risk factors have been identified for women, including mental illness, family and relationship issues, domestic violence, cultural expectations, eating disorders and body image issues, drug and alcohol misuse, postnatal depression and regional location.^{42,43} In the context of the COVID-19 pandemic, there has been an increase in family and domestic violence reported - Australian Google searches related to domestic violence have almost doubled and there have been increasing calls from potential perpetrators of domestic violence.⁴⁴ This is particularly pertinent to suicide prevention because female victims of domestic violence are four-and-a-half times more likely to die by suicide.⁴⁵ Much like men's suicide prevention strategies, more needs to be done to cater to gender specific policies and programs for women. This could include further family support programs, domestic violence intervention strategies to address body image issues.

Caregivers and families

Providing care for those who have attempted suicide or are experiencing suicidal thoughts has been shown to have a detrimental impact on the lives of caregivers and families.⁴⁶ Research shows that the suicide attempt of a spouse or family member has enduring effects on the caregiver years after the suicidal event. Caregivers in general have much greater risk of suicide than the general population⁴⁷ and caregiving has been associated with higher prevalence and incidence of depression.⁴⁸ Described as the 'caregiver's burden', caregivers are significantly more distressed than the general population, with negative impacts including psychological stress, poor physical health, and limits on their own activities due to caring responsibilities. With COVID-19 causing an increase in poor mental health, the risk of suicide has risen, increasing the demands and pressures felt by families and carers. There are numerous programs and support networks in place to support the mental health of carers and family members of someone with suicidal thoughts or who has attempted suicide. This includes support lines, resources, counselling and networks. Recently, a new evidence-based resource (*You are not alone*) has been created by SANE Australia alongside university partners and is being piloted in South Australia.⁴⁹

As part of the Interim Advice, the *Shifting the Focus* paper outlines the how a national whole-of-government suicide prevention model would better support priority populations.

The model allows for governments to understand the suicide-related vulnerabilities, risk and protective factors of the priority populations their service engages with. This helps government agencies design tailored suicide prevention initiatives and ensure that policies do no harm to those groups, and possibly help them.

It is clear that vulnerable groups require a national whole-of-government commitment to providing culturally appropriate cross-portfolio suicide prevention initiatives and support services. This requires a community commitment and understanding of suicidal behaviour so that communities can identify the early risk factors and can provide timely support at earlier intervention points.

Priority Action: All governments ensure that supports are tailored to the specific needs of priority populations. These supports to be provided in a way that prevents the onset of major distress, whenever possible, to prevent people reaching a point of crisis.

Priority Action: Consistent with the principles of co-design, suicide prevention supports and services to be designed, delivered and evaluated with genuine involvement from the targeted priority populations.

Chapter 6: Indigenous suicide prevention

“A culturally safe service environment and access to Indigenous or culturally competent staff for Indigenous people will be important”

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)

Aboriginal and Torres Strait Islander people require a culturally appropriate, whole-of-community and whole-of-government approach to suicide prevention. It must consider how colonisation, intergenerational trauma and contemporary social determinants can impact on suicidal behaviour within Indigenous contexts.

In-principle recommendations

Recommendation 11: Strengthen the role and capability of Aboriginal and Torres Strait Islander organisations in suicide prevention and improve cultural safety within mainstream service providers, to better respond to the needs of Indigenous Australians. This could include:

- 11.1 Implementing key actions within the *National Aboriginal and Torres Strait Islander Suicide Prevention Plan* once completed and approved (from 2021).
- 11.2 Collective action to build the capacity of Indigenous services and organisations as preferred providers, including an enhanced role for Aboriginal Community Controlled Health Services.

Learning from Aboriginal and Torres Strait Islander lived experience

Aboriginal and Torres Strait Islander Lived Experience is a relatively new area of research, but evidence suggests that Indigenous peoples' experience of suicide is inherently different to mainstream experiences of suicide. The effects of colonisation and associated trauma contribute to this lived experience. The Aboriginal and Torres Strait Islander Lived Experience Centre in partnership with the Seedling Group and Black Dog Institute conducted virtual yarning circles with Aboriginal and Torres Strait Islander people with a lived experience of suicide to explore factors contributing to suicidal behaviour and inform the *Interim Advice*.

Racism and discrimination was reported as isolating and disempowering by Aboriginal and Torres Strait Islander people, contributing to intergenerational trauma and reducing equitable access to resources and services. A number of other ongoing and recent stressors were identified, including (but not limited to) disruptions to family life because of child removal, incarceration, trauma and bereavement, with increases in disconnection, alcohol and substance use and other risky behaviours

close in time to a suicide attempt. Many considered asking for help to be “impossible”. They reported that non-Indigenous services were generally not trusted nor culturally safe and that Indigenous services were sometimes avoided because of the “grapevine”. Many people reported a lack of trust in services due to poor experiences in the past as well as the sense of shame that can come from having to tell others about what has been happening in their lives.

Establishing Indigenous governance

National governance, coordination and oversight of national level activity

Evidence indicates that suicide prevention interventions for Aboriginal and Torres Strait Islander people are most effective when the relevant Aboriginal and Torres Strait Islander community is involved and has control over the intervention. The establishment of *Gayaa Dhuwi (Proud Spirit) Australia* (Gayaa Dhuwi) in early 2020 secured a strong national representative voice that aims to lead and advocate for system-wide changes to suicide prevention approaches for Aboriginal and Torres Strait Islander people. Gayaa Dhuwi is currently developing a revised *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, using the 2013 strategy as a starting point for consultation and development. Initial work from Gayaa Dhuwi suggest that an overarching Indigenous-led strategic response to heal trauma in Aboriginal and Torres Strait Islander communities, families and individuals is needed to halt the intergenerational transmission of trauma.

The need for oversight and coordination of Indigenous suicide prevention was acknowledged in the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* developed in 2013 (2013 NATSISPS). This need is also reflected in the Council of Australian Governments COAG/National Cabinet committees’ commitment to implement the Fifth Plan, and the role of the *Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention* (CBPATSIISP). A touchstone of the renewed *Closing the Gap Agreement* highlights the importance of Aboriginal and Torres Strait Islander leadership and self-governance in our efforts to close the gap. Significantly, the renewed *Closing the Gap Framework* includes a suicide prevention target.

Regional governance

Since 2015, PHNs have been responsible for developing and implementing regional and community mental health and suicide prevention plans with Aboriginal and Torres Strait Islander communities. The 2013 NATSISPS identified the need to investigate the feasibility of approaches to regional coordination of suicide prevention including, but not limited to, roles of key government agencies and partners. This work needs to be reviewed as the new plan is developed and take into account learnings from current funding and service arrangements with PHNs. The work of *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project* (ATSISPEP) and CBPATSIISP highlight that a critical factor to PHN-channelled suicide prevention activity in Indigenous communities will be that PHNs ensure community members partner with community level implementation, from needs assessment to implementation and evaluation.

Community level governance

A new NATSISPS will likely support promoting community level governance for suicide prevention activities as well as integrated approaches that build on the learnings from the Commonwealth-funded Indigenous suicide prevention trial sites that have been under Indigenous community

governance (such as, the Kimberley Aboriginal Medical Service in the Kimberley region, and the Danilla Dilba Aboriginal Medical Service in Darwin). Community-specific integrated approaches to suicide prevention provide opportunities to respond more flexibly and incorporate community-specific cultural elements that can better address their particular challenges.

Priority Action: All governments to agree as a matter of urgency to support Gayaa Dhuwi and the *Centre for Best Practice for Aboriginal and Torres Strait Islander Suicide Prevention* to implement the revised *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

Priority Action: Suicide prevention activity to be Indigenous-led, at the national, regional and community level, with collaborative and integrated approaches developed, involving Primary Health Networks, Aboriginal Community Controlled Organisations, and Indigenous communities.

Establishing elements for consideration in integrated approaches to Indigenous suicide prevention

Promoting Social and Emotional Wellbeing (SEWB) and cultural strengths

Promoting SEWB and cultural strengths, particularly at the community level, is a foundational suicide prevention activity in Indigenous communities and should be included in any overall response to Indigenous suicide. In particular, the *National Empowerment Project* (NEP) was an Aboriginal-led community empowerment project that worked with Indigenous communities to develop, deliver and evaluate a program to promote SEWB, address negatively operating social determinants of health and reduce suicide. A 2017 evaluation reported that the program resulted in a strengthened sense of identity, including cultural identity specifically, and a renewed focus in communities on the importance of reconnecting with country and culture.

Unique elements - Upstream activity to address challenges that can contribute to suicide

Included in the 2013 NATSISPS are programs and activities that aim to reduce the impact of factors that can weaken SEWB at the individual, family and community level, as well as cause mental illness and mental health issues in their own right. ATSISEPP in particular has stressed the need for upstream approaches to Indigenous suicide prevention within a community context, including families and early childhood, family violence, self-harm, alcohol and drug use, and contact with the criminal justice system. These will be considered again in the new NATSISPS.

At-risk groups within the Indigenous population

The 2013 NATSISPS was concerned for the wellbeing of males and Indigenous children in out-of-home care and noted that addressing these at-risk cohorts should focus on upstream suicide prevention measures. Given males comprise almost three quarters of Indigenous suicide deaths there will likely be a continued focus in a renewed NATSISPS on preventing male suicide, with an acknowledgement of social and emotional wellbeing-related effects.

AIHW data in 2020 noted that Aboriginal and Torres Strait Islander children are significantly overrepresented in out-of-home care, with eight times as many Aboriginal and Torres Strait Islander

children to have received child protection services compared to non-Indigenous children.⁵⁰ As noted in the section of this report on children in the out-of-home care system, any interventions will need to be culturally appropriate. Other at-risk groups in Indigenous populations include Indigenous youth and LGBTIQ+ people, both groups requiring strong leadership and support from those with lived experience.

Service models to complement integrated approaches to suicide prevention

Integrated services within Aboriginal Community Controlled Health Services and relevant community services

A continuing focus through the new NATSISPS will be the development of integrated Indigenous social and emotional wellbeing, mental health, suicide prevention, and alcohol and other drug service models. This could be supported by the establishment of social and emotional wellbeing teams in Indigenous primary health care services, including Aboriginal Community Controlled Health Services (ACCHSs), linked to Indigenous specialist mental health services. Such teams might include SEWB workers, mental health workers, psychologists, Aboriginal and Torres Strait Islander mental health workers and occupational therapists. There are elements of mainstream system or integrated approaches that should also be implemented within Aboriginal and Torres Strait Islander communities. These include gatekeeper training and means reduction. Both activities are widely supported within the sector and link to key elements identified in the Fifth Plan. Another critical aspect is cultural competency training for mainstream services in health, human services, and related fields of activity, as well as for training institutions.

Partnerships with Aboriginal Community Controlled Health Services (ACCHS)

In line with Gayaa Dhuwi's promotion of Indigenous leadership and control across relevant parts of the Australian mental health system, Gayaa Dhuwi recommends that, wherever possible, ACCHSs should deliver mental health services to Indigenous communities.

Partnership models that may be considered in a renewed NATSISPS include:

- *Statewide Specialist Mental Health Services (SSMHS)*. There is an example in Western Australia that is designed for Indigenous people with severe and persistent mental illness.
- *Headspace*. Headspace as an ACCHSs partner in the delivery of mental health services to young people in communities. For example headspace centres in the Kimberly region and in others areas are already working from ACCHS.
- *Residential mental health/custodial settings*. Partnership programs can build links between residential/custodial settings and community support (such as transition from prison to community or from alcohol rehabilitation to community reintegration), including to provide specific suicide prevention and assessment training for staff in high risk settings who work with Indigenous clients. Examples of this are the Winnunga Nimityah prison health care model⁵¹ and the assessment of fit for purpose Indigenous mental health assessment tools by CBPATISIP within its MMRF research program.

Ensuring the cultural safety of mainstream services

It is critical to ensure Indigenous presence and leadership is in place across all parts of the mainstream Australian mental health and suicide prevention system as the best guarantee of cultural safety. Gaaya Dhuwi have suggested that further consideration should be given to:

- Identified leadership positions across relevant parts of the mental health and suicide prevention system to help ensure it is culturally safe.
- Training and employment of an Indigenous suicide prevention workforce for working in the mainstream system in addition to ACCHSs and place-based services.

Chapter 7: Health-led responses to suicide prevention

“My experience at the mental health service was completely horrible. During the course of a year, I had seen a total of five different psychologists and two different psychiatrists. There was a complete lack of consistency and it made treatment difficult. I felt patronised...”

Personal stories, Private Voices study, UNE

Consolidating and accelerating the work already underway across Commonwealth, State and Territory health portfolios is a vital part of a national whole-of-government approach to suicide prevention.

In-principle recommendations

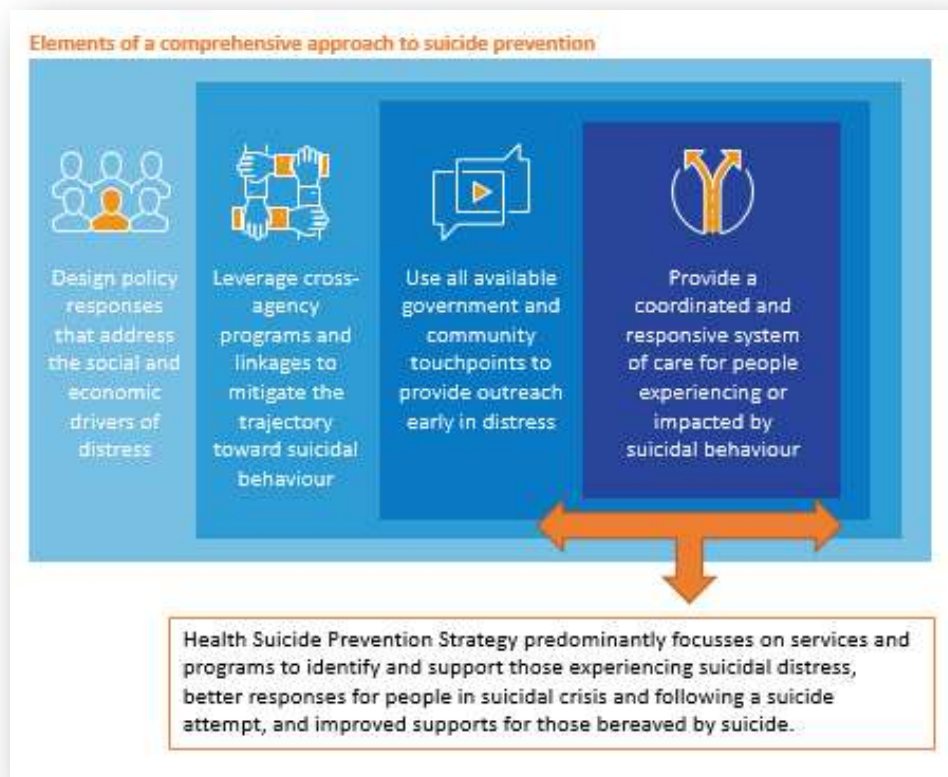
Recommendation 12: All government health portfolios to implement and report on actions within the *National Suicide Prevention Strategy for Australia’s health system: 2020-2023* and the *Pandemic Mental Health and Wellbeing Response Plan*. Based on evidence from lived experience for a more compassionate approach, particular priorities include:

- 12.1 Improved emergency responses for people in suicidal crisis – including increased training for emergency departments and frontline emergency services personnel.
- 12.2 New service models that align with a compassionate response – delivered in community, with a focus on providing supports at home or in ‘safe spaces’, and integrating peer workers.
- 12.3 Better linkages and integration of services, including: blended models of care (for example, digital and face-to-face) to increase service access and responsiveness; and better integration between national crisis lines and community-based supports.
- 12.4 Service models that support psychosocial needs and ongoing follow up, including broad access to aftercare approaches for people who have attempted suicide.
- 12.5 Better supports for family and caregivers – including those supporting someone through a suicidal crisis as well as those bereaved by suicide.
- 12.6 Targeted responses for communities impacted by suicide, through more coordinated and timely postvention responses.

Recommendation 13: All government health portfolios, in partnership with other portfolios, to take a more comprehensive approach to suicide prevention by including policies and programs that mitigate the impact of alcohol and other drug use. In particular:

- 13.1 Governments to increase the availability of brief or ongoing alcohol and other drug interventions delivered across settings where people may present in the context of relationship, financial and workplace stresses.
- 13.2 All government health portfolios to increase training and support for alcohol and other drug services to support people who are experiencing suicidal distress, including provision of contemporary training and supervision.

The fundamental premise of a national whole-of-government approach for suicide prevention is that it needs to be more than just a health portfolio responsibility. However, that does not negate the importance of and need for a robust nationally coordinated health approach in response to suicide.



The need for a compassionate system: learning from lived experience

People with a lived experience of suicidal behaviour reported disrupted and disconnected care with multiple 'drop-off' points along the way. They described a common scenario where, precisely when people are highly distressed and in need of a compassionate response, our health systems provide disjointed and crisis-focused care that is lacking in compassion. Individuals described feeling rejected, disempowered and invalidated – often discouraging people to seek help again. A number of opportunities for action were identified through the lived experience research:

- Improved health service responses – especially through emergency departments
- Developing and supporting health workforces to respond with compassion
- New 'entry' points and service models that align with a compassionate response – including 'safe spaces' and peer-led services
- Service models that support psychosocial needs, care-coordination and ongoing follow up – including broad access to aftercare
- Safe and culturally appropriate services for all people
- Better supports for family and caregivers
- Increased supports for those exposed to the suicidal behaviour of others.

7.1 National Suicide Prevention Strategy for Australia's health system: 2020-2023

The Fifth Plan builds on the foundations of previous reform efforts and establishes a national approach for collaborative government action to improve the provision of integrated mental health and suicide prevention services across Australia. The Fifth Plan is the first of the national mental health plans to specifically include suicide prevention in its title. This is in recognition of its importance and that, while it aligns with mental health, suicide prevention warrants a particular focus. The *National Suicide Prevention Strategy for Australia's Health System* (Health Suicide Prevention Strategy) is a deliverable of the Fifth Plan.

A review of the national and State and Territory strategies and plans provides an overview of the level and diversity of suicide prevention activity in Australia. While all strategies and plans are based on evidence and identify priority areas for activity, there is a lack of coordination, particularly across jurisdictional lines. This can result in unnecessary duplication, gaps in a comprehensive service delivery approach, and a lack of consistent evaluation. These challenges are impeding what can be achieved across the health portfolios nationally. The Health Suicide Prevention Strategy is regarded as an opportunity to address existing challenges and the substantive work on this strategy has already been done, with broad agreement from jurisdictions.

There are four priority domains and three priority foundations within the strategy, with actions outlined under each.

- Priority Domain 1:** Supporting individuals and communities to seek help and support others.
- Priority Domain 2:** Building a system of care to change the trajectory of people in suicidal distress.
- Priority Domain 3:** Enabling recovery through post-crisis aftercare and postvention.
- Priority Domain 4:** Community-driven Aboriginal and Torres Strait Islander suicide prevention.
- Priority Foundation 1:** Building and supporting a competent compassionate workforce.
- Priority Foundation 2:** Better use of data, information and evidence.
- Priority Foundation 3:** Government leadership that drives structures and partnerships to deliver better outcomes.

This report aims to identify ways in which the Health Suicide Prevention Strategy can be ‘unlocked’ so that implementation can begin, given that many of the priority areas identified would support a stronger service system for people experiencing or impacted by suicidal behaviour.

Alignment to the Pandemic Response Plan

The priority domains and foundations of the Health Suicide Prevention Strategy broadly align with the actions called for under the Pandemic Response Plan, particularly in relation to the collation, coordination and modelling of data; assertive outreach of services into community settings’ and connectivity to ensure clear pathways to care (see Appendix 2 for more details). This alignment accentuates the opportunity for all governments to work together to begin implementing the Health Suicide Prevention Strategy as soon as possible.

While actions under the Health Suicide Prevention Strategy can, and should, be accelerated and aligned to actions under the Pandemic Response Plan, the impact of any improvements into tangible changes experienced by people with lived experience and their caregivers will take time. To ensure accountability and transparency there should be regular monitoring and reporting from all jurisdictions about the activities implemented and the reported impacts. This could include the development of routinely collected data on suicide prevention expenditure, workforce, and program and service activity across all jurisdictions, as well as regular surveys of people with lived experience who have accesses services or programs.

Priority Action: All governments to adopt and align the priority domains, foundations, and actions of the Health Suicide Prevention Strategy and the Pandemic Response Plan with their suicide prevention plans and initiatives. Governments to also implement and monitor this progress as a matter of urgency.

Priorities: Enhanced health responses to suicidal distress

All elements of the Health Suicide Prevention Strategy should be implemented and monitored, including comprehensive models of care that are being implemented across the health services and within emergency departments. The following elements have been highlighted in this report as critical to building a connected community-based and whole-of-government response informed by lived experience. Options for cross-portfolio extensions have also been highlighted for further consideration.

Accelerate and evaluate new models of care as alternatives to Emergency Departments

Many people in suicidal distress present to emergency departments across Australia. Although there will always be a need for emergency departments to provide timely and compassionate assessment and care, evidence demonstrates that emergency departments are not best placed to support people in suicidal distress. In a recent study⁵² of people presenting to the emergency department for suicidal crisis, only one-quarter reported being willing to return to the emergency department for a future crisis. Their satisfaction with the care they received while in the emergency department was the strongest predictor of their willingness to return, and of their attendance at follow-up appointments. In an online survey of people who had made a suicide attempt, only one-third of participants who had presented to an emergency department had contact with another health service.⁵³

The Health Suicide Prevention Strategy identifies the need for alternatives to emergency departments for people who are experiencing suicidal crisis and do not need medical care, evaluation for these types of services seen as an immediate priority for funding. While there has been a number of localised pilots of alternative to emergency department services, overall progress has been slow in adopting a more coordinated effort. The Commonwealth Department of Health has engaged a consultant to scope the feasibility of developing a national network of 'safe spaces' to offer a consistent quality of care across jurisdictions while still being able to meet diverse individual and local needs.

Priority Action: All governments to support further development of compassionate community-based models and 'safe spaces' as alternatives to emergency departments and ensure new models have a sound evidence base through targeted research funding.

Cross-portfolio extension: Consideration could be given for using other government and community infrastructure and services to host these 'safe spaces' (e.g. public libraries managed by local governments, universities, and other government services).

Improve, extend and evaluate aftercare approaches

A prior suicide attempt is a significant risk factor for further suicide attempts and suicide deaths, with the risk greatest in the days and weeks following discharge from hospital. In an Australian data linkage study, however, only 41% of people who had been admitted to hospital following a suicide attempt had any contact with a public health service after hospital discharge. People who experience a suicidal crisis often require a range of services, and yet this is a time when many people are left to navigate several complex and difficult systems on their own. Various models of aftercare are being implemented across Australia, which usually include an integrated mix of non-clinical assertive

outreach and community-based services. Most models, such as *The Way Back Program*, will usually make contact with a person within 24 hours after discharge and continued supports for up to three months to help the person stay safe and ensure they are linked to supports. While aftercare programs are designed for delivery following a suicide attempt, extension of the service to people who have experienced a suicidal crisis without an attempt should be considered. Broader entry points outside of the hospital system should also be explored.

Australian research undertaken in 2019 with 758 people providing care to a family member or friend post a suicide attempt, found that 65% did not receive any information about how to care for their loved one from the treating health professional and only 18% felt supported to provide care.⁵⁴ Many sought information online, from support groups and/or their own psychological supports.

Priority Action: All governments to support expanding the reach and quality of aftercare and follow-up support for individuals and their caregivers following a suicide attempt. Aftercare should be prioritised for national research funding to progress the evidence-base in Australian settings.

Priority Action: All governments to work together to increase education and support options for caregivers who are involved in supporting a loved one recover following a suicide attempt.

Cross-portfolio extension: Extending referral pathways from other government and community settings (e.g. from schools and universities, emergency services, other government departments where suicide attempt may be disclosed) would be of benefit. Aftercare-type services should also be considered to support people transitioning to the community from other settings, especially those released from prison.

Integrated crisis response and support through helplines

Crisis helplines form an important part of the suicide prevention system in Australia, with volunteers and trained professionals providing crisis support and early intervention 24 hours a day. These include Lifeline, MensLine Australia, Kids Helpline and the Beyond Blue Support Service, which help thousands of Australians each year. The Commonwealth also funds the Suicide Call Back Service, which provides crisis support as well as offering six counselling sessions with a psychologist, a specific helpline for people who identify as LGBTIQ+ through QLife and for Veterans and their families through Open Arms.

These services have been particularly important in supporting Australians through the COVID-19 response with increases in calls and contacts across all services. There are, however, challenges in coordinating referral pathways across the various digital and online services, and between digital services and face-to-face services, meaning that people are often receiving ‘one-off’ and ‘disconnected’ responses rather than a coordinated pathway to ongoing care and support. It is also critical to ensure that services are provided in a range of formats to meet the preferences and needs of those accessing the services – including web-chat and text messaging services.

Many benefits would come from redesigning relevant helplines and integrating service responses. This redesign should consider:

- Clear and visible services that meet the needs of the whole population, including target services that meet the needs of priority populations
- Identified services being extended to provide ‘follow-up’ calls and/or short periods of counselling to callers who would benefit from it
- Improved referrals, including direct call transfer or ‘hot referrals’ between services
- Options for referrals into local services, including aftercare services.

Priority Action: All governments, as the funders of helplines, to work together to consider the role and design of helplines to support a connected service system – including options to include direct referrals to other services and call back functions.

Cross-portfolio extension: People accessing a range of other national helplines such as 1800 RESPECT, National Alcohol and Other Drug hotline, Gambling Helpline, National Debt Helpline, and Health Direct would benefit from an integrated helpline approach where they could either be directly referred or offered a ‘call back’ if experiencing suicidal distress.

Timely and effective postvention services

The effects of suicide are far reaching and can vary across communities and between different groups. Australian research indicates that for each person who dies by suicide, an average of 135 others will be exposed or affected in some way. Those bereaved by suicide include family, friends, and community members and well as first-responders including police, paramedics, firefighters and a range of other professions. Postvention and bereavement support in Australia is significant but still patchy and not always well coordinated. The Commonwealth Government is the major funder of postvention and bereavement support services. There are also a range of other providers and services and local community networks that provide bereavement support groups, with the Department of Education and some coroner’s taking a lead role in some states.

Coordination of services is a challenge at the local level, especially when national providers are relying on state systems to provide an alert. Improved and timely data collection, should enable a more timely response to suicide deaths and emerging clusters, but joint planning across jurisdictions to increase coverage will be required. Systems for more robust notification to relevant providers will also be required. The South Australian Government has recently signed a Memorandum of Understanding with Commonwealth and State-funded postvention services to address the integration gap between postvention services and its suicide notification systems. This is intended to ensure a more consistent universal postvention response.⁵⁵ The New South Wales (NSW) Government has similar intentions, with the development of a Suicide Data Register designed to enable sharing of information on confirmed suicides with key stakeholders.

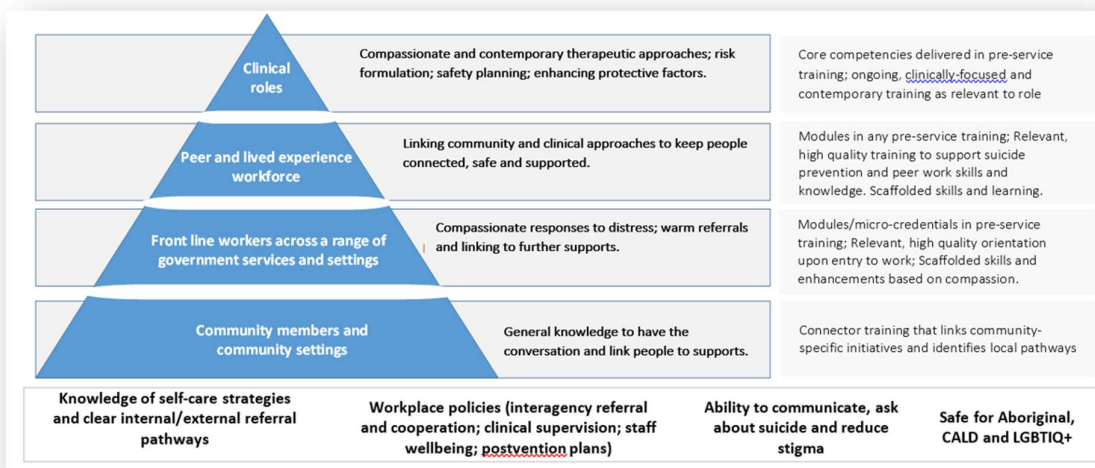
Priority Action: The AIHW to support jurisdictions to establish suicide registers that enable event notification. These event notifications should prompt a coordinated postvention response. The Department of Health to work with jurisdictions to develop funding models to increase postvention services and bereavement supports.

Cross-portfolio extension: Schools, workplaces, universities, prisons and other defined settings can be impacted by suicide. Options for cross-portfolio guidelines and partnerships to deliver effective postvention responses would be beneficial.

Given the impacts of suicide-attempts and well as suicide deaths, expanded supports should be considered. Self-harm surveillance programs, which have been implemented in other countries, may also be a model that can provide benefits. A current trial in Victoria aims to provide Australian evidence on the benefits of a self-harm surveillance system, particularly whether it will assist in supporting assertive aftercare, better education and training for staff, improvements in quality of assessment, and real time data for suicide and self-harm surveillance.

Investing in the workforce to deliver compassionate responses

Developing and supporting the broad range of workforces involved in suicide prevention is needed to respond with compassion to underlying distress. Currently, health and other related professionals are required to complete separate training in overlapping areas (such as, suicidality, domestic violence, substance use), that require the same capacity for active listening, empathy, and compassionate care. Newer models of suicide prevention training emphasise the importance of a collaborative and therapeutic relationship. Training packages selected for delivery to health and other workforces should have compassionate responses as a stated foundation, be evidence based from the perspective of people accessing services, and have a focus on risk formulation and safety planning over risk identification and risk management. Extension training to support engagement and safety for priority populations should also be included. This work would be better supported by a review of policies, procedures and internal supports for staff and work with universities and professional bodies to integrate core competencies into the pre-service training environments.



Community capacity building

The Health Suicide Prevention Strategy outlines three key areas of focus to increase individual and community capacity to seek help. These include population-wide and localised public education

campaigns, community connector training and support for mentally healthy workplaces in Australia. While led through health, each of these provides an opportunity for cross-portfolio engagement, in addition to the policy and program responses referred to in Chapter 4 of this report. Based on lived experience research outlined in *Compassion First*, the following should be considered:

- Public education campaigns and other public awareness approaches should be guided by and include those with lived experience, with an increase in those who can speak to recovery from suicidal distress.
- Campaigns, programs and training that target key protective factors within communities should be considered – especially those that build social connections and social cohesion.
- Preferences should be given to contemporary and evidence-based connector training and further work to clarify responsibilities for funding between jurisdictions, local governments and PHNs should be progressed to reduced duplication and gaps in training provision.
- Workplaces provide an important setting for suicide prevention. Targeted approaches should occur, particularly where occupational risks may increase vulnerabilities (e.g. male-dominated industries, emergency services, veterinarians, health professionals, small businesses).
- Educational settings such as schools, universities and TAFEs should be considered for comprehensive and targeted approaches in partnership with the relevant portfolios.

How to Align Activity?

Align the Health Suicide Prevention Strategy with concurrent priority work

The work that has gone into the Health Suicide Prevention Strategy is a strong foundation for enhancing the health-led responses to suicide prevention. Aligning the Health Suicide Prevention Strategy with the actions being taken by the health portfolios across all jurisdictions under the Pandemic Response Plan would provide an immediate benefit.

Taking a national whole-of-government approach to wellbeing is critical to tackling the social determinants of mental illness and support prevention activities that affect multiple outcomes. The interface between the health system and other systems, for example the National Disability Insurance Scheme and aged care, is a threshold issue for all governments.

In a national whole-of-government approach, accountability for suicide prevention is shared across multiple portfolios at all levels of government. An approach that could be taken by other portfolios is to adopt the same priority domains and foundations but with portfolio specific actions.

The figure below, provides a summary of the suggested response and recovery actions for suicide prevention from the Pandemic Response Plan. Appendix 2 to this report outlines ways in which the Health Suicide Prevention Strategy priority domains, foundations, and actions can be aligned to the Pandemic Response Plan.

RESPONSE PHASE ACTIONS

- Establish warm referral pathways between helplines and other service sectors
- Assertive outreach models to better support people at risk of suicide
- Build capacity of suicide prevention services to use digital and telehealth tools
- Review current approaches to ensure they meet the needs of vulnerable groups including men, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people and LGBTIQ people
- Improve immediate supports for families and carers, including those bereaved
- Enhance workforce training for frontline staff in health and non-health settings
- Outreach to older people and those isolated during the pandemic
- Use financial touchpoints to increase supports for those in distress.

KEY RECOVERY CONSIDERATIONS

- Build on existing work to further develop safe spaces and other alternative options to emergency departments to build capacity to meet long-term demand.
- Ensure aftercare services are available and have appropriate reach
- Integrating digital, telehealth and face to face interventions and supports
- Enhanced regional planning and delivery of community-based interventions
- Ensure health services are themselves mentally healthy
- Improve data collection to monitor impacts and prepare intensive support, including postvention for communities impacted by suicide.
- Integration of suicide prevention interventions into key cross-portfolio settings, including – justice, child protection, housing and homelessness services, alcohol and other drugs services, financial services.

Priority Action: Consistent with their commitment to implementing the key actions of the Fifth Plan, governments to provide compassionate supports for people who seek help in suicidal distress, including new 'safe spaces' service entry points, broader aftercare approaches, and better supports for family and caregivers.

7.2 Alcohol and other drugs

Addressing alcohol and other drug use: Learning from Lived experience

People with lived experience revealed that alcohol and other drugs had an impact across multiple points in their journeys. Many adverse experiences in childhood were described in the context of parental challenges with alcohol or substance misuse and many people reported their own alcohol and other drug issues commencing in adolescence (often before or in combination with the onset of mental illness). A recent change in alcohol use (particularly among men), was reported in the context of co-occurring life stressors such as relationship breakdown or job loss. There are opportunities for population level interventions to reduce access to alcohol and other drugs across the life course, to

intervene early with young people to change attitudes to alcohol and to ensure effective and early treatment with opportunities to screen for alcohol use at key points of distress to provide pathways to brief or longer-term support.

Understanding the role of alcohol and other drugs in suicidal behaviour

Australia has a cultural relationship with alcohol that is multifaceted and diverse and includes the use of alcohol at times of celebration, as routine in our diet and meals, and sometimes as a coping mechanism. Harms from alcohol use undermine personal wellbeing and coping capabilities. It has detrimental impacts on physical, emotional and mental health, including neurological impacts.⁵⁶ It increases impulsivity and aggression and can promote feelings of helplessness.^{57,58} Australian data shows that in 2018, 29.4% of those who died by suicide had an alcohol or substance use disorder, and alcohol or other substances were found in the blood of 21.5% of people who died by suicide.

Addressing problematic alcohol and other drug (AOD) use requires an approach that considers the complex interplay it has with other risk factors identified in this report, including those associated with the groups vulnerable to suicide. Addressing alcohol and drug use in isolation downplays the bidirectional relationship it has on the wellbeing of many groups in the community.⁵⁹ Evidence suggests that adverse life events, such as job loss and economic downturn impact on patterns of alcohol and other drug use. Increases in harmful alcohol use is also indicated in priority populations, in particular men, Aboriginal and Torres Strait Islander people, and adolescents and young adults. Evidence also suggests that AOD use can contribute to the transition from suicidal thoughts to suicidal acts, and acute intoxication has been implicated in suicide attempts which were more likely to result in death. As such, AOD use remains one of the leading risk factors, across all groups and cohorts, for suicide.⁶⁰ Yet, it rarely features in suicide prevention plans, policies and programs in Australia.

Alcohol and other drug interventions as suicide prevention activities

The National Drug Strategy⁶¹ and National Alcohol Strategy⁶² aim to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms. The strategies focus on demand, supply and harm reduction activities. However, there is no defined implementation or action plan that measures the success of the strategies in changing behaviour and these strategies have not been connected to national suicide prevention approaches. There is a range of programs currently available, both online and face-to-face, that provide information and resources on alcohol and other drug use, but they are not as widely promoted as mental health related programs.

The WHO highlights that policies seeking to reduce access to alcohol are effective strategies for suicide prevention. This suggests implementing strategies to restrict access to alcohol, campaigns to change attitudes towards alcohol, and improvement of treatment practices for problematic alcohol use should also be viewed as contributing to suicide prevention in Australia.⁶³

In 2020, the Taskforce commissioned The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use to undertake a Rapid Review and Evidence Check. The overall objective of this Rapid Review and Evidence Check was to outline the role of alcohol/other drugs as a risk factor for suicidal behaviour, and to review interventions focussed on alcohol/ other drugs for

their effectiveness in reducing suicide attempts and suicide deaths. The review revealed a variety of individual and population-level interventions focussing on AOD use which targeted different levels of risk for suicide.⁶⁴

Interventions included Government policies (e.g., alcohol legislation, outlet density), community-based and primary care initiatives (e.g., awareness-building and gatekeeper training, alcohol restrictions in at-risk communities), school-based interventions, interventions targeting high priority groups (e.g., psychoeducation), and psychosocial and other clinical interventions for adults and adolescents in treatment (e.g., Cognitive Behaviour Therapy, brief interventions). Research in this area was limited by the fact that most suicide prevent interventions do not include AOD use as a focus and there was a scarcity of evaluation data for implemented interventions, reliance on self-report measures of suicidality, and insufficient sample sizes to detect meaningful reductions in suicidal behaviours. Furthermore, the research is mainly investigator-led and is not clearly aligned to national policy.

Reducing access to alcohol

Reducing access to alcohol has received limited traction in Australia as a public health measure. However, research indicates that reducing access to alcohol at a population level can reduce suicide rates. This is a 'means restriction' strategy for in suicide prevention. Evidence-supported policies include those which centre on alcohol pricing and taxes, reducing on-premise and off-premise outlet density, and zero-tolerance drink driving laws for learner and provisional drivers. At the population level, these alcohol-related policies are potentially impactful in light of Australia's popular drinking culture, high prevalence of harms attributable to alcohol, including self-injury, hospitalisations and death, and high suicide risk among male youth who use alcohol/other drugs.

School based programs

A large proportion of the recent literature on AOD-focussed suicide prevention interventions examines the effectiveness of school-based interventions. Multicomponent school-based interventions which address multiple risk factors for suicide, including AOD use, are likely to be appropriate and feasible for the Australian context. Schools provide an optimal setting for delivering suicide prevention interventions, as they are a setting in which adolescents are already engaged. Interventions may be both universal and delivered to the whole school population, such as within their Personal Development, Health and Physical Education (PDHPE) curriculum. Alternatively, interventions may be targeted to groups of students who are already accessing school counselling services and/or are identified as having a number overlapping risk factors between problematic AOD use and suicidality (e.g., minority sexual orientation, gender identity, low academic attainment, social isolation and bullying, early sexual initiation, trauma history, depression).

Health service responses: workforce training and aftercare

Given the chronic and remitting nature of both problematic AOD use and suicidality, the provision of aftercare is needed not only for people who have attempted suicide but also for people who have presented with and/or been treated for problematic AOD use and are therefore at increased risk of suicide, independent of a history of suicide attempts. It is also recommended that frontline clinicians in AOD treatment and aftercare services receive contemporary training in understanding the contributing role of AOD use in suicidal thoughts and behaviours, as well as recognising and

responding to the early signs of suicidality in their clients. Broader roll-out of national comorbidity guidelines and other supports would also be beneficial.

Community-based initiatives

Community-based initiatives drawn from the recent empirical literature, which may be appropriate and feasible in the Australian context, include awareness-building campaigns, the promotion of telephone and web-based support services, and the implementation of routine screening and brief interventions for depression and problematic AOD use within primary care/GP services. It is recommended that these initiatives have an integrated focus on suicide prevention and AOD use, as well as other risk factors for suicide which often interact with problematic AOD use (e.g., financial stress, unemployment, relationship breakdown). There may also be benefit in the creation of online communities and peer support programs that provide online community spaces, enabling connection and assistance in guiding people to information and support.

Priority populations

There are additional considerations when developing community-based AOD/suicide prevention initiatives within priority populations (e.g., Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse, LGBTIQ+). It is important that initiatives are community led and leverage the community's unique strengths. To do this involves ongoing engagement and collaboration with community members, utilising existing suicide prevention/AOD support networks and resources within the community, and drawing on the expertise of community members with lived experience of AOD use issues and suicidality.

Priority Action: The Commonwealth Government to consult with jurisdictions, relevant experts and stakeholders, to identify feasible opportunities in the Australian context reduced access to alcohol, especially at times of community stress or for particular cohorts.

Priority Action: Department of Health to increase the screening for alcohol and other drug-related issues at earlier distress points in primary and general medical care settings.

Priority Action: Governments to prioritise expanding alcohol and other drug workforce capacity and capabilities to respond to suicidal distress, which aligns with identified actions in the Health Suicide Prevention Strategy.

Cross portfolio extension: Many people with lived experience, especially men, reported a change in alcohol use in combination with life stressors (especially relationship breakdown). Cross-portfolio approaches to screening, intervention and peer-support for alcohol problems should occur across government systems and services.

7.3 Antidepressant use and youth suicide

Australians are among the highest consumers of antidepressants in the world.⁶⁵ There have been conflicting findings in recent years regarding the efficacy and safety of antidepressant use in young Australians, specifically children and young adults.

The debate between clinical researchers over the use of antidepressants, specifically new products such as Selective Serotonin Reuptake Inhibitors (SSRIs) is largely due to a 2004 warning issued by the US Food and Drug Administration (FDA). The FDA warned that antidepressant use in people under 18 years of age was associated with an increased risk of suicidal thoughts and behaviours.⁶⁶ Following this warning, there was a slowed dispensing rate of antidepressants to young Australians. However, from 2008-2018 there has been a marked increase in both the rate of antidepressants being dispensed to young adults (66%) as well as suicide rates (49%). While this does not represent a causal relationship between antidepressant use and suicide rates, the increase in both warrants exploration of any potential relationship.

To address the gaps in the system, recognise the risk factors and provide effective intervention strategies, a number of future actions and priorities have been identified.

- Focus on engaging and educating the friends and family of young Australians about the importance of maintaining good health and wellbeing from early in life.
- A comprehensive review and analysis of the rate at which antidepressant drugs are being dispensed to young adults by using available data. Recent evidence suggests that over 90% of antidepressants dispensed to young adults, is from a General Practitioner and only 5-10% of antidepressants are prescribed by a psychiatrist.⁶⁶
- Collation and synthesis of suicide prevention approaches from other countries that are youth specific in their intervention approaches to suicide in both clinical and community settings, to develop a coordinated, connected, whole-of-government approach to addressing suicide prevention in this priority population.

Priority Action: The AIHW to lead a coordinated, national push to improve data recording and collection of suicide and self-harm rates in Australia, linked to antidepressant use, and report on this data annually.

Priority Action: The Department of Health to commission a review into the prescribing and dispensing of antidepressants to young Australians.

Next steps

The development of the *Interim Advice* has been built on the key themes and early findings provided to the Commonwealth Government in November 2019, emphasising the importance of undertaking appropriate engagement and consultation in any proposed reform. The National Suicide Prevention Advisor has met with a wide range of stakeholders in forming this *Interim Advice*, including: Mental Health Ministers, State and Territory governments; peak bodies; PHNs; a range of Aboriginal and Torres Strait Islander organisations, community networks; priority populations; those working in rural and remote areas; individual researchers, and mental health practitioners in addition to people with a lived experience of suicide.

Future consultation

The release of the *Interim Advice* will act as a stepping stone to a comprehensive consultation period that will further inform and shape recommendations and priority actions ahead of the *Final Advice Report* being provided to the Commonwealth Government in December 2020. Further consultation throughout September to December 2020 will be informed by a consultation strategy and will include:

- Nationally held feedback sessions across sectors and jurisdictions to:
 - Test the practical application of the recommendations and the proposed suicide prevention model in real world settings.
 - Gather feedback and guidance on local issues to ensure rural and remote communities, priority populations, and stakeholders remain engaged and can provide input into any final recommendations.
- Continued work with Commonwealth and State and Territory governments in the refinement of the governance required to implement a national whole-of-government approach.
- Continued work with Aboriginal and Torres Strait Islander organisations such as Gayaa Dhuwi.
- Further engagement with people who have a lived experience of suicide to harness their expertise and shape recommendations that target priority populations as well as points of vulnerability and failure in the current service system.

Pending reforms

The refinement of the *Interim Advice* will ensure that the final advice appropriately aligns with and complements the key government reforms that are expected to be released prior to December 2020. These include (but are not limited to):

- The Productivity Commission Final Report on Mental Health

- The Royal Commission into Victoria's Mental Health System
- National Mental Health Workforce Strategy
- The Royal Commission into Aged Care Quality and Safety
- National Mental Health Commission Vision 2030 roadmap
- The National Children's Mental Health and Wellbeing Strategy.

Pandemic Response Plan

The National Suicide Prevention Taskforce will continue to work closely across governments, sectors and the community to ensure that recent events, such as the COVID-19 pandemic and the bushfire crisis, are considered in any whole-of-government approach to suicide prevention. The mapping document located in Appendix 2 demonstrates the interconnectedness between what is currently happening across Australia and its potential impacts on suicide rates and how it aligns with the advice the National Suicide Prevention Advisor will be providing to the Commonwealth Government.

How to contact the Taskforce

Any public feedback on the *Interim Advice* and proposed consultation approach can be sent to the National Suicide Prevention Taskforce by emailing SP.Taskforce@health.gov.au.

Appendix 1: National Suicide Prevention Taskforce and progress of activity and recommendations from *Initial Findings*

About the National Suicide Prevention Taskforce

To support the work of the National Suicide Prevention Adviser, a National Suicide Prevention Taskforce was established in August 2019 within the Commonwealth Department of Health, and with joint governance provided by the Department of the Prime Minister and Cabinet. The Taskforce is headed by Special Adviser, Dr Jaelea Skehan OAM, who brings extensive experience in suicide prevention implementation and research. The Taskforce has been staffed by secondees from a range of Commonwealth Government agencies over the past 12 months. These secondees bring to the Taskforce their knowledge and expertise of their home agency, as well as their experience of working within government.

The Taskforce's work is supported by an Expert Advisory Group. The group's membership is listed below and includes people with a lived experience of suicide, suicide prevention researchers, and experts in Aboriginal and Torres Strait Islander suicide prevention. This group has been instrumental in the forming the *Interim Advice*, as well as supporting the National Suicide Prevention Adviser in the role of advising on government policies such as the Pandemic Response Plan.

Members of the Expert Advisory Group to the National Suicide Prevention Taskforce

| | |
|--------------------------------|----------------------------|
| Lucy Brogden AM – Chair | Parker Forbes |
| Alan Woodward – Deputy Chair | Graeme Holdsworth |
| Nicky Bath | Professor Myf Maple |
| Stefani Caminiti | Pino Migliorino AM |
| Professor Helen Christensen AO | Nieves Murray |
| Leilani Darwin | Christine Morgan |
| Professor Pat Dudgeon | Ingrid Ozols AM |
| Professor Jane Pirkis | Glen Poole |
| Professor Nicholas Procter | A/Professor Jo Robinson |
| Dr Jaelea Skehan OAM | Professor Maree Teesson AC |

The Taskforce's work is also informed by a Commonwealth Suicide Prevention Interdepartmental Committee (Suicide Prevention IDC). The committee comprises senior leaders in the Australian Public Service and provides the capacity to enhance the national whole-of-government coordination of suicide prevention through policy and service delivery.

The Taskforce has also been able to engage with the Australian Government Deputy Senior Officials Meeting (DSOM) to discuss key priorities for suicide prevention across jurisdictions and to identify cross-portfolio and cross-jurisdictional priorities for further investigation in 2020. This engagement informed the decisions to prioritise four evidence-checks to inform future approaches, focussed on alcohol and other drugs, justice settings, children in out-of-home care and housing and homelessness (further described in Chapter 4).

Taskforce activity through the Commonwealth Interdepartmental Committee and Deputy Senior Officials Meeting

Workforce training for frontline staff in Commonwealth agencies

In April 2020, the Commonwealth Interdepartmental Committee identified that frontline staff across Commonwealth agencies were providing support to an increased number of Australians in distress. The current environment with the COVID-19 pandemic and ongoing impacts from the bushfires and drought have highlighted the need and urgency for additional training. While there are already a range of training modules being provided across services, it was identified through the APS Mental Health Capability Taskforce that there was no consistent approach to frontline training. The Interdepartmental Committee supported the identification of training that was feasible for delivery across frontline agencies and that would:

- a. Increase the knowledge, skills and confidence of frontline staff to support customers and clients in distress
- b. Increase their capacity to care for themselves and their colleagues
- c. Provide a platform for further work across the APS to build capabilities and internal supports for staff.

This training would align with and support workforce development priorities identified under the Fifth Plan and seek, where possible, to support a coherent training approach across jurisdictions so that frontline workers in Commonwealth and State and Territory services share a common language. Providing this training across portfolios also provides a consistent platform to shift towards early distress responses in Australia.

Distress Brief Intervention program (DBI)

As a result of early consultation with governments and non-government stakeholders during 2020, there is increasing support for a DBI program to be implemented in Australia. A DBI program aims to build connected compassionate support, through a large and far-reaching national and regional distress collaboration between health and social care, emergency services and the not-for-profit sector, with applicability to a cross-portfolio and whole-of-government approach.

A DBI is a time limited and supportive problem solving contact with an individual in distress that puts community members at the centre of care. Interim findings from a DBI program pilot in Scotland have shown the program to be effective in increasing collaborative, cross-sector networks and has been positively received by people who have received the intervention; reducing their distress and helping them to plan for the future.

The Scottish DBI program was developed to address a significant gap in support for those who present in distress or with multiple contributing factors, but do not fit into or meet the criteria for the traditional clinical model of support.⁶⁶ All of which was leading to frustration in front-line staff and poor outcomes for people in distress and their families. These same issues have been reported by Australian services as well as people with lived experience of suicidal behaviour and their families.

Ideally an Australian DBI program would require the Scottish model of DBI to be adapted to suit the Australian federated model of providing health, social care, financial, employment and other services. This adaptation is the subject of further consultation, however a range of Commonwealth agencies and services, as well as state and regional services, are uniquely placed to identify and provide an immediate response to people who present in distress and who may or may not be in touch with mental health services. The intervention would involve:

1. An immediate compassionate response with the offer of a referral as required (with workforce training across frontline services and roles required).
2. A guarantee of support within 24 hours, with most people only requiring support for up to three weeks. The goal of this support is to provide immediate low-intensity support and to link people to other practical, psychological and community-based support.

The DBI would include cross-portfolio touchpoints as entry points into the second level service, as well as to GPs, emergency departments, hospitals and emergency services where required.

Suicide Prevention in all government policy development

In early 2020, the Commonwealth Interdepartmental Committee agreed to explore ways in which new policies identify and take into account possible impacts on psychological distress and suicide risk. Where potential risks are identified, the policy is amended, or strategies are put in place to lessen the impacts or provide additional supports to those affected. If no mitigations are possible, this should be noted in the advice accompanying the policy. There are four options that could be considered further to enhance the advice Government receives about the impacts of proposed policies on suicide:

1. The addition of a mandatory 'Suicide Impact Assessment' or 'Suicide Risk Statement' to all Cabinet submission templates, which includes a breakdown of the comprehensive risk assessment/statement that was completed and assessed prior to the submission template being developed.
2. Upskill central agency staff with policy responsibility for suicide prevention to recognise policies which have the potential to increase suicide risk and then direct them to harness existing Cabinet briefing processes to provide the Government with advice on the risk and any mitigation strategies.

3. Upskill line agency staff through the training of appropriate teams such as Cabinet areas and embedding a specific suicide prevention function in an appropriate team in the line agency.
4. Explore the feasibility of adding a suicide prevention analysis to the Regulation Impact Statements (RIS) where relevant, administered by the Office of Best Practice Regulation (OBPR).

Enhanced opportunities to support people through government systems

Commonwealth departments represented on the Interdepartmental Committee have commenced scoping an initiative that seeks to identify people at risk of disengaging from government services and to provide assertive outreach and plan for the support required if they do disengage. This would help to minimise the number of people who have attempted suicide or died by suicide after a lack of engagement from Commonwealth agencies.^{67,68}

The draft process for review would use a flag system to identify and reach out to Australians who have connected with government services and who are at risk of increased distress, suicidal behaviour and disconnection from services include:

- Building self-rating surveys into government systems, similar to those used by the eSafety Commissioner, that will flag a user's distress levels and trigger a process to refer the user to the most appropriate support services.
- Funded outreach to support people engaging with Government systems or active referral of people to appropriate support services.
- Increased funding to already operating social workers at Services Australia to make outbound welfare checks and ensure availability of supports and services at key points of the Services Australia customer or National Disability Insurance Scheme (NDIS) participant cycle.
- An increase in data sharing between government agencies would enable quicker and more accurate identification of vulnerable clients. The identification of vulnerable individuals would require data from other agencies and consider privacy and other implications if progressed.
- Investigate the possibility of using shared data to perform a cohort analysis based on common vulnerabilities, such as geographic location, income or housing pressures to raise a system flag for an entire cohort that may require additional support.

Progress of the Recommendations from the *Initial Findings*

| 1. Immediate action is required to shift towards whole-of-government suicide prevention approach. | |
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| <p>Recommendation 1.1: The Commonwealth works with the States and Territories to fund key elements of the National Suicide Prevention Implementation Strategy developed under the Fifth Plan, while whole-of-government options are further developed.</p> | <p>The <i>National Suicide Prevention Implementation Strategy for the Health System: 2020-2023</i> (Health Suicide Prevention Strategy) has been completed and provides high-level strategic directions for suicide prevention activities for the Commonwealth and State and Territory governments.</p> |
| <p>Recommendation 1.2: The Commonwealth ensure that Gayaa Dhuwi (Proud Spirit) Australia is contractually engaged to deliver an Aboriginal and Torres Strait Islander Suicide Prevention Plan by the end of 2020.</p> | <p><i>Gayaa Dhuwi (Proud Spirit) Australia</i> (Gayaa Dhuwi) was established in early 2020 and aims to lead and advocate for system-wide changes to approaches to Indigenous suicide prevention. Gayaa Dhuwi is leading the co-design of a strengths-based Indigenous suicide prevention strategy and implementation plan by December 2020, including an extensive consultation process. Gayaa Dhuwi will also be leading in the implementation of the <i>National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' mental Health and Social and Emotional Wellbeing 2017-2023</i>.</p> |
| <p>Recommendation 1.3: The Commonwealth to provide national leadership on a whole-of-government approach to suicide prevention via negotiation of a new funding and governance architecture that appropriately involves and resources non-health sectors and clarifies roles and responsibilities and ensures services are appropriately resourced.</p> | <p>The National Suicide Prevention Adviser is developing advice to government on the architecture for a national whole-of-government suicide prevention approach, which form part of the <i>Interim Advice</i> and will be part of the <i>Final Advice</i> provided to government during 2020.</p> |

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| <p>Recommendation 1.4: Take action at the Commonwealth level to progress a ‘suicide prevention in all policies approach’ by connecting suicide prevention with other policy areas and reviewing the impact of any new policies.</p> | <p>During 2020, the Suicide Prevention Inter-Departmental Committee (Suicide Prevention IDC) explored how to ensure all new policies consider and clearly identify possible or perceived impacts on psychological distress and suicide risk. This work is referenced in the cross-portfolio and multijurisdictional chapter of this <i>Interim Advice Report</i>.</p> |
| <p>2. Early distress responses using community and government touchpoints.</p> | |
| <p>Recommendation 2.1: Extend the National Suicide Prevention Trial and enhance coordination of all suicide prevention trial site evaluations to enhance understanding of effective interventions and inform future decisions.</p> | <p>In January 2020, the Government announced \$13.4 million to extend the National Suicide Prevention Trial for a further year to 30 June 2021.</p> <p>In response to a recommendation provided to government in November 2019, funding of \$1 million has been allocated to enhance coordination of suicide prevention trial site evaluations to better understand effective interventions and inform future decisions.</p> |
| <p>Recommendation 2.2: Use government and community systems and services that interact with people at points of vulnerability for policy and service responses.</p> | <p>There has been a commitment from Commonwealth and State and Territories governments for new initiatives to support suicide prevention for specific groups more vulnerable to suicide.</p> <p>On 5 February 2020, the Prime Minister announced the creation of the new National Commissioner for Defence and Veteran Suicide Prevention. The announcement was made in recognition that too many ADF members and veterans take their own lives, and that concerted action is needed to ensure that everything possible is done to prevent these deaths. The National Commissioner for Defence and Veteran Suicide Prevention is being established as an independent body to inquire into, and support the prevention of, deaths by suicide among Australia’s Defence, reservist and veteran service men and women. While a Commissioner has not yet been appointed, legislation was introduced to Parliament on 27 August 2020 by the Attorney-General.</p> <p>The Council of Australian Governments (COAG) asked senior officials, through the Deputy Senior Officials Meeting (DSOM) to focus on developing targeted and discrete projects to build on existing suicide prevention work. Based on feedback from State and Territory governments through the DSOM, the National Suicide Prevention Taskforce partnered with the Suicide Prevention Research Fund to commission a series of evidence checks to guide any future considerations for initiatives related to: the</p> |

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| | <p>justice system; children in out-of-home care; and housing stress and homelessness. Further detail is provided in the cross-portfolio and multijurisdictional chapter of this report.</p> <p>A Senior Executive Commonwealth Suicide Prevention Interdepartmental Committee (Suicide Prevention IDC) was established in August 2019 to facilitate input and advice into the development of suicide prevention initiatives across the Government. In February 2020, the Suicide Prevention IDC agreed on a targeted work plan to progress action on a range of initiatives, including to use Government touchpoints across different portfolios and services to identify and assist Australians who are experiencing distress and who may be vulnerable to suicidal behaviour, particularly during periods of transition, sudden change or crisis.</p> |
| <p>Recommendation 2.3: Develop a whole-of-government workforce with the required skills to respond to distress and prevent suicide.</p> | <p>On recommendation of the Suicide Prevention IDC and in response to COVID-19 requirements of frontline workers, a project has commenced to build capability across the Australian Public Service (APS) frontline workforce to support members of the Australian community who may be vulnerable to suicide. The project, led by the Australian Public Service Commission, aims to improve compassion and resilience and create the capacity for ongoing delivery of training in a consistent and sustainable way.</p> <p>The Suicide Prevention IDC agreed in April 2020 that all frontline APS staff, including and especially those recently deployed to frontline roles, should be appropriately trained and supported to respond to community members in distress. With the support of the National Suicide Prevention Taskforce (Taskforce), appropriate training was identified and funding of up to \$5 million has been allocated to support the rollout.</p> |
| <p>Recommendation 2.4: Continue to invest in community-based interventions identified in the Fifth Plan.</p> | <p>A key action under the Fifth Plan was the development of the Health Suicide Prevention Strategy to be contributed to and adopted by all States and Territories. Actions under the Health Suicide Prevention Strategy encompassing community-based interventions required commitments from all governments to progress.</p> |
| <p>3. Respond to the specific needs of communities and groups at very high risk.</p> | |
| <p>Recommendation 3.1: Provide immediate support to communities impacted by drought and other disasters to respond to distress.</p> | <p>Since January 2020, the Commonwealth Government has announced a number of emergency response measures to support the mental health and wellbeing of Australians through the 2019-20 bushfires and the COVID-19 pandemic, including:</p> |

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| | <ul style="list-style-type: none"> • \$76 million in mental health support for Australians affected by the 2019-20 bushfires • \$64 million for suicide prevention and mental health initiatives such as Australia's journey towards zero suicides • \$74 million to support the mental health and wellbeing of all Australians during the COVID-19 pandemic • an additional \$13.4 million in bushfire funding as part of the Community Wellbeing and Participation through Primary Health Networks (PHNs) • \$48.1 million investment to support the three immediate priorities in the Pandemic Response Plan: Data and Modelling, Outreach and Connectivity • more than \$20 million in funding from the Medical Research Future Fund for research to improve mental health care and suicide rates in Australia • \$7.3 million for additional Medicare-subsidised psychological therapy sessions for those subject to public health orders restricting their movement within the state or territory, and to people who are required to isolate or quarantine under public health orders. <p>Under these packages, a number of services were introduced or scaled up to provide immediate support for individuals and communities, including:</p> <ul style="list-style-type: none"> • Additional support for older Australians, young Australians, Indigenous Australians, new and expecting parents, Culturally and Linguistically Diverse (CALD) Australians and carers, through existing service providers and PHNs • Funding for PHNs in bushfire affected communities to commission initial trauma and grief counselling, extend existing services, employ bushfire mental health response coordinators, extend headspace services and provide community grants • new temporary Medicare Benefits Schedule telehealth items for bushfire-affected communities and in response to the COVID-19 pandemic to support improved access to services for all Australians. <p>The investments in response to these national emergencies are in addition to existing funding of other initiatives to provide more permanent mechanisms to deliver services to Australians, such as:</p> <ul style="list-style-type: none"> • \$64 million investment in mental health and suicide prevention activities, in response to initial advice from the National Suicide Prevention Adviser. The funding supports services that are |
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| | <p>working to build resilience in youth; ensure that crisis line services are available for those in need; expand the reach of aftercare services; and ensure that supports are available for those who may have lost someone to suicide.</p> <ul style="list-style-type: none"> Expansion of the Beyond Blue Way Back Support Service which provides non-clinical, assertive outreach, follow up care and practical support to individuals after a suicide attempt or suicidal crisis. The Government has reached agreement with the majority of jurisdictions to provide this service in partnership with states and territories. |
| Recommendation 3.2: Consider the value in implementing a multi-component suicide prevention trial focused on Australian Defence Force personnel transitioning from service. | Improving the mental health and wellbeing and reducing the risk of suicide among veterans and their families is at the forefront of a four-year Department of Veteran's Affairs (DVA) Veteran Mental Health and Wellbeing Strategy and National Action Plan launched in May 2020. Over the course of this four-year strategy, DVA will drive a series of changes to enable a shift from an illness focus to a wellness focus. This move will better ensure the appropriate services are available to support transitioning Australian Defence Force (ADF) members, veterans and their families to live healthy and productive lives. |
| Recommendation 3.3: Hold a policy roundtable to investigate options to address the risk of suicide for children in Out-of-Home Care. | The National Suicide Prevention Taskforce engaged the Australian Catholic University to undertake research on the suicide risk factors for children in out-of-home care, and this will inform consultations to further investigate the options for suicide prevention. This evidence is reflected in the National Suicide Prevention Adviser's <i>Interim Advice</i> and will inform the <i>Final Advice</i> provided to government in 2020. |
| 4. Enhanced health response to suicidal distress. | |
| Recommendation 4.1: Accelerate alternatives to emergency departments to ensure people are not required to go through the "wrong door" to access services. | <p>The Fifth Plan acknowledges the need for alternatives to emergency departments and some efforts have been made at the National, State and Local level to invest in new models.</p> <p>The Department of Health has engaged a consultant to examine the feasibility of strengthening services and supports for people at risk of suicide through a national network of 'safe spaces'. 'Safe Spaces' are intended to provide a place for people to seek help in a more therapeutic environment than current service options, such as emergency departments.</p> <p>A national 'safe spaces' network is proposed to draw together 'safe spaces' operating across five different tiers providing a range of services and supports depending on people's needs. 'Safe spaces' are currently operating or in planning for delivery in a range of jurisdictions around Australia. A focus of this scoping study is to explore how diverse activity undertaken by state governments, community groups, NGOs and</p> |

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| | <p>other partners can be integrated into a national network that offers a consistent quality of care and support, and provides services aligned with the different tiers to meet diverse individual needs.</p> <p>Building the evidence for the effectiveness of these new service models is an immediate priority to ensure that the current investments have strong foundations for broader rollout. It is also important to ensure that outcomes for the person and their family; outcomes for the system (including cost-effectiveness); and key issues related to workforce development, safety and quality are progressed in a coordinated way. These new models of care have been identified as a priority for the Suicide Prevention Research Fund in 2020-2021 as outlined in Chapter 3 of this report.</p> <p>The Pandemic Response Plan prioritised a move away from hospital services and further develop safe spaces and other alternative options. Similar priorities were also identified in the draft Productivity Commission's Final Report for the Inquiry into Mental Health.</p> |
| Recommendation 4.2: Improve, extend and evaluate aftercare approaches. | <p>Various models of aftercare are being implemented across Australia, including non-clinical and community-based services. Programs such as The Way Back Program are providing supports that recognise the aftercare service gap.</p> <p>On 30 January 2020, the Commonwealth Government announced an additional \$7 million over two years (2020-21 to 2021-22) to expand Beyond Blue's the Way Back Support Service across Australia. This is in addition to \$37.6 million (2018-19 to 2021-22) announced in the 2018-19 budget. Given the joint responsibility for suicide prevention, the Commonwealth Government has sought and secured co-contributions from the majority of State and Territory governments for the service delivery component. Bilateral Agreements are currently executed with the ACT, NT, NSW, QLD, SA and Victorian Governments.</p> <p>The Way Back Support Service is a Beyond Blue initiative which provides non-clinical, assertive outreach, follow up care and practical support to individuals after a suicide attempt or suicidal crisis.</p> |
| Recommendation 4.3: Improved care coordination for those accessing multiple services. | <p>Governments continue to implement suicide prevention initiatives according to priorities identified as part of the Health Suicide Prevention Strategy under the Fifth Plan, and the Pandemic Response Plan.</p> <p>As part of the Commonwealth Government's response to the Pandemic Response Plan, a Connecting Mental Health Services to Outreach Services initiative will enable a direct warm transfer of consumers with ongoing or more complex mental illness to more appropriate intensive in-home outreach services, ensuring they continue to receive the level of care they need.</p> |

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| | <p>In addition, the Productivity Commission is testing firm recommendations regarding Australian suicide prevention efforts, and the National Suicide Prevention Adviser continues to focus on targeted projects to build on existing suicide prevention work. This work will continue with jurisdictions and portfolios to develop reform initiatives.</p> |
| <p>Recommendation 4.4: Enhance primary care for people experiencing suicidal distress, including a review of current practice and approaches.</p> | <p>Governments continue to implement suicide prevention initiatives according to priorities identified as part of the Health Suicide Prevention Strategy under the Fifth Plan, and the Pandemic Response Plan.</p> <p>The Commonwealth Government has allocated additional funding to support the mental health of Australians during 2020, including: \$74 million supporting the mental health of Australians through the Coronavirus pandemic; \$48.1 million to support the Pandemic Response Plan; \$20 million for Mental Health and Suicide Prevention Research; and \$76.1 million for community support through the Bushfire emergency.</p> <p>As part of the \$48.1 million provided in response to the Pandemic Response Plan, funding was provided to PHNs to address gaps in services for vulnerable populations. Specific funding included: \$3.5 million (plus \$15.5 million from existing services) for Older Australians to expand PHN services in residential aged care services; \$1.1 million for PHNs to deliver culturally appropriate services; and \$3.5 million for Indigenous Australians where PHNs will work with local communities to expand existing programs.</p> <p>\$28.4 million was provided to PHNs, as part of the \$74 million mental health package, to support transition of psychosocial support clients to the NDIS by providing an additional year of transition.</p> <p>As part of the Bushfire Mental Health Package, funding to PHN's included:</p> <ul style="list-style-type: none"> • \$10.5 million for immediate frontline emergency distress and trauma counselling, with up to 10 free mental health support sessions for individuals, families and emergency services personnel. • \$4.2 million was provided to PHNs to expand their services in bushfire affected regions, and \$3.2 million was provided to establish Mental Health Bushfire Coordinators positions in Bushfire affected regions. These coordinators will ensure that all government services are working together effectively so that any individuals and families in crisis will receive rapid and quality care. • \$2.7 million was allocated to a small community grants round to fund activities at grass-roots level to help mental health and healing activities post bushfires. |

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| | <ul style="list-style-type: none"> • A total of \$7.4 million was allocated for Headspace services, including up to \$300,000 for each headspace centre in bushfire affected regions, and to expedite and expand the planned Bateman's Bay headspace site. • \$0.5 million was also allocated to the National Mental Health Commission to work with PHNs, and State and Territory governments to develop a cross-jurisdictional mental health framework for national disasters and emergencies. <p>The Department of Health has been monitoring mental health service activity during the COVID-19 pandemic, including Medicare funded mental health services, national crisis and phone support lines, other online digital services and headspace.</p> <p>Across the country, the demand for national crisis and phone support lines and digital mental health services, including the Australian Government's digital mental health gateway Head to Health (www.headtohealth.gov.au), is significantly greater than the same time last year. In recognition of this, the Government's mental health response to COVID-19 provided additional funding to a number of phone and online mental health services (such as Lifeline and Kids Helpline), to increase their capacity to respond.</p> <p>The total number of Medicare funded mental health services from late March to early April 2020 was lower compared to the same time in 2019, and by July 2020 had gradually increased to higher than the same time last year. There was significant uptake of telehealth following its introduction with around half of Medicare funded mental health services delivered by telehealth in April 2020. The proportion of Medicare funded mental health services delivered by telehealth gradually decreased in June and July 2020, as lifting of physical restrictions enabled greater face to face consultations.</p> <p>For COVID-19 specific national mental health services – the Beyond Blue Coronavirus Mental Wellbeing Support Service has received 15,068 contacts since launch on 7 April to 15 July 2020 and the Healthcare Worker Program by Smiling Mind has 16,037 subscribers since launch on 7 May to 15 July 2020.</p> <p>On 6 August 2020, the Prime Minister announced a further \$12 million to support mental health services in Victoria to manage the increase in demand associated with a tightening of pandemic related restrictions. The funding will be provided to headspace, Beyond Blue, Lifeline, and Kids Helpline to support service responsiveness, and connecting to ongoing and more intensive support when needed.</p> |
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| <p>Recommendation 4.5: Work with States and Territories and Primary Health Networks to enhance the capability of those working in alcohol and other drugs to support people at risk of suicide.</p> | <p>Governments continue to implement suicide prevention initiatives according to priorities identified as part of the Health Suicide Prevention Strategy under the Fifth Plan, which includes workforce recommendations for the alcohol and other drug services.</p> <p>In 2020, the National Suicide Prevention Taskforce partnered with the Suicide Prevention Research Fund to commission an evidence check on the role of alcohol and other drugs in suicidal behaviour and the effectiveness of interventions. Chapter 7 includes a summary from the evidence check and priority actions.</p> |
| <p>Recommendation 4.6: Improved care and support for people with mental illnesses at greater risk of suicide.</p> | <p>Governments continue to implement suicide prevention initiatives according to priorities identified as part of the Health Suicide Prevention Strategy under the Fifth Plan. In addition, the Productivity Commission is testing firm recommendations regarding Australian suicide prevention efforts.</p> |
| <p>5. Support family and friends along the continuum of suicidal behaviour.</p> | |
| <p>Recommendation 5.1: Provide psychosocial supports to families and friends supporting a loved one at risk of suicide and following a suicide attempt.</p> | <p>Lived experience research commissioned by the Taskforce and summarised in <i>Compassion First</i> identified a lack of supports for caregivers, even when their loved one was in contact with a health service. While there are carer support groups in most jurisdictions, support people are unaware of these resources. Governments continue to implement suicide prevention initiatives according to priorities identified as part of the Health Suicide Prevention Strategy under the Fifth Plan, but progress on better supports for caregivers is unknown.</p> |
| <p>Recommendation 5.2: Extend the reach of postvention and bereavement support and ensure local coordination.</p> | <p>On 30 January 2020, the Commonwealth Government announced funding of \$10 million over two years (2020-21 to 2021-22) to support the expansion of the StandBy Support After Suicide (StandBy) service. StandBy provides coordinated on-the-ground support to individuals, families, workplaces and communities impacted by suicide, including frontline workers. The additional \$10 million will support StandBy to operate in more locations across the country.</p> |
| <p>Recommendation 5.3: Build the lived experience and peer workforce to help break down stigma and provide person-centred supports.</p> | <p>The National Suicide Prevention Adviser is developing advice to government on a national whole-of-government suicide policy approaches, including the integration of lived experience knowledge and expertise, and peer support models, which formed part of the <i>Interim Advice</i> and will be part of the <i>Final Advice</i> provided to government in 2020.</p> |

6. Improve data and evidence.

Recommendation 6.1: Commonwealth leadership to improve national data sets for suicide, suicide attempts and self-harm.

In the 2019-20 Federal Budget, the Commonwealth Government established the National Suicide and Self-Harm Monitoring System. The Department of Health is funding the Australian Institute of Health and Welfare (AIHW) to lead the development of this work. The AIHW is working in collaboration with the National Mental Health Commission.

The system will improve the coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm and will inform the development of suicide and self-harm policy, as well as identify trends, emerging areas of concern and at risk groups.

The system has already started quality improvement and linkage work on suicide data. Suicide registers are being established in States and Territories that do not have any in place. The monitoring system will include data from crisis-lines, ambulance services, emergency departments and hospitals, State and Territory suicide registers, and data sets from housing, justice and other areas of government.

During COVID-19, the AIHW has been working with other Commonwealth agencies and jurisdictions to collate available data to inform decision making.

Recommendation 6.2: Require new Commonwealth contracts to measure outcomes related to suicidal behaviour and redirect research investment towards national suicide prevention priorities.

The Commonwealth Government has increased its investment in suicide prevention research specifically, in addition to existing health and medical research funding, including:

- As part of the Commonwealth Government's response to the Pandemic Response Plan, \$4.2million was committed to Suicide Prevention Australia for the Suicide Prevention Research Fund.
- A targeted round of funding under the Million Minds Mission, with \$8 million allocated to suicide prevention research.
- Support for the development of a National Research Plan for Mental Health and Suicide Prevention, to be led by the National Mental Health Commission.

During 2020, the Suicide Prevention IDC explored how to ensure all new policies consider and clearly identify possible or perceived impacts on suicide behaviour and risk. This work is continuing, and has

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| | assisted the National Suicide Prevention Adviser develop advice to government on suicide policy approaches. |
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Appendix 2: Alignment of priority areas and actions

The table in this appendix demonstrates the alignment of the priority areas in the *National Mental Health and Wellbeing Pandemic Response Plan* (Pandemic Response Plan) mapped against the priority domains and foundations in the *National Suicide Prevention Implementation Strategy for the Health System: 2020-2023* (Health Suicide Prevention Strategy). The recommendations that have been made in the *Interim Advice* are also included. The alignment mapping across the Pandemic Response Plan and the Health Suicide Prevention Strategy highlights common actions that all jurisdictions have agreed to take and summarised below.

Meet immediate mental health and wellbeing needs of the community

Particularly relevant during COVID-19, the use of existing services such as helplines across portfolios, the need for continued warm referral and linkages to regional services and supports – with opportunities to expand ‘call back’ options and increasing offering of diverse services such as crisis text services. Utilising services already in existence to link people in distress to support earlier, aligns with the priority areas of focus for better suicide prevention in both the Pandemic Response Plan and the Health Suicide Prevention Strategy.

Implement new models of care

Across public, private and non-government service delivery models. The expansion of Telehealth services as a result COVID-19 warrants further consideration for expanded service offerings. There is also a need to accelerate the implementation of community-based alternatives to emergency departments for mental health and suicidal crisis presentations. A whole-of-government shift to better suicide prevention models, includes expanding alternatives to the current service system. At present, it struggles to meet demand and provide optimal support for people presenting in distress, particularly to emergency departments.

Facilitate and improve quality mental health services

An emphasis on timely and appropriate care and better planning and coordination across sectors for people presenting in distress.

Address the social determinants of health and wellbeing relevant to suicide prevention

This includes social connectedness, violence and abuse, economic security and participation.

Strengthen workforce capacity and capability

Sector training to enable a more suicide aware workforce that can identify, act and work with people experiencing distress and suicidal crisis. There is a need to highlight key areas of focus in building capacity across those workforces with a focus on key competencies. Evidence as well as feedback

from those with lived experience tells us there is a need to upskill the workforce in more contemporary and compassionate approaches to support. This assist in targeting educating distress earlier in an individual's journey through the service system to reduce the impact of risk factors that lead to suicidal behaviours.

Better meet the needs of vulnerable populations such as Aboriginal and Torres Strait Islander People, LGTBQ+ people, and Culturally and Linguistically Diverse (CALD) cohorts

Strategies and services for vulnerable people that are developed and implemented in a culturally sensitive way and are championed by members of the relevant community.

Improve data collection, monitoring and sharing across governments

There is a need for better data and evidence to support the identification of vulnerable groups, improve service responses and the evaluation of mental health and suicide prevention activities

| PANDEMIC RESPONSE PLAN | NATIONAL SUICIDE PREVENTION STRATEGY FOR AUSTRALIA'S HEALTH SYSTEM: 2020-2023 | INTERIM ADVICE RECOMMENDATIONS |
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| <p>Priority Area 1: Meeting immediate mental health and wellbeing needs</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Identify mental health services as essential services. Provide appropriate personal protective equipment for those providing crisis services that cannot be provided virtually. Provide telehealth services where face-to-face services are not optimal. Ensure community mental health services are able to adjust to the needs and circumstances of the pandemic, based on an assessment of circumstances. Consider the role of all health sectors in improving service delivery for people affected by the pandemic. <p>RECOVERY</p> <ul style="list-style-type: none"> Integrate innovations and improvements identified into ongoing business practice. Consider mechanisms to improve access to services available to support those in distress due to the pandemic and its impacts. Ensure program governance and accountability reforms to enable ongoing flexibility in activity with agreed outcomes. | <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> <p>Health and Mental Health Ministers to:</p> <ul style="list-style-type: none"> Strengthen the design and integration of Commonwealth and State and Territory funded crisis helplines by commissioning a rapid project to understand their usage, effectiveness and efficiency, and how their role could be strengthened and better integrated with other care pathways for people in distress | <p>Recommendation 12: All government health portfolios to implement and report on actions within the <i>National Suicide Prevention Strategy for Australia's health system: 2020-2023</i> and the <i>Pandemic Mental Health and Wellbeing Response Plan</i>. Based on evidence from lived experience for a more compassionate approach, particular priorities include:</p> <ul style="list-style-type: none"> 12.1: Improved emergency responses for people in suicidal crisis – including increased training for emergency departments and frontline emergency services personnel. 12.2: New service models that align with a compassionate response – delivered in community, with a focus on providing supports at home or in 'safe spaces', and integrating peer workers. 12.3: Better linkages and integration of services, including: blended models of care (for example, digital and face-to-face) to increase service access and responsiveness; and better integration between national crisis lines and community-based supports. 12.4: Service models that support psychosocial needs and ongoing follow up, including broad access to aftercare approaches for people who have attempted suicide. 12.5: Better supports for family and caregivers – including those supporting someone through a suicidal crisis as well as those bereaved by suicide. 12.6: Targeted responses for communities impacted by suicide, through more coordinated and timely postvention responses. <p>Recommendation 13. All government health portfolios, in partnership with other portfolios, to take a more comprehensive approach to suicide prevention by including policies and programs that mitigate the impact of alcohol and other drug use. In particular:</p> <ul style="list-style-type: none"> 13.1: Governments to increase the availability of brief or ongoing alcohol and other drug interventions delivered across settings where people may present in the context of relationship, financial and workplace stresses. 13.2: All government health portfolios to increase training and support for alcohol and other drug services to support people who are experiencing suicidal distress, including provision of contemporary training and supervision. <p><i>Shifting the Focus</i> - National Suicide Prevention Model</p> <p>The model supports the application of targeted approaches to specific settings, industries and workplaces.</p> |
| <p>Priority Area 2: Implementing new models of care</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Support strategies to address mental health issues in the broader community. | <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> | <p><i>Compassion First</i> - Lived Experience report</p> <p>Lived experience knowledge and expertise needs to be prioritised and integrated into the planning and delivery of whole-of-government suicide prevention action.</p> |

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| <ul style="list-style-type: none"> Identify and respond to the likely demand for mental health services Develop targeted mental health programs that support individuals and families in quarantine and connect them to supports as required. <p>RECOVERY</p> <ul style="list-style-type: none"> Identify and prioritise new evidence-based mental health service models for people most impacted by the pandemic informed by the reform activities to date including the NMHC Vision 2030, Productivity Commission, Victorian Royal Commission, the advice of the National Suicide Prevention Adviser, and other relevant inquiries or reports at Federal, and State and Territory levels. Build on existing activities by all jurisdictions to further develop community-based services that decrease inappropriate reliance on primary or tertiary care by people impacted by the pandemic. Funding opportunities to support the development of blended digital health services. | <p>Health and Mental Health Ministers to commission a national project that explores the following key questions in relation to using digital technology to enable suicide prevention:</p> <ul style="list-style-type: none"> How is digital technology currently being used in Australia and overseas to prevent suicide? What benefits does it offer, including cost-effectiveness? How could digital technology be better harnessed to strengthen current suicide prevention efforts? | <p><i>Shifting the Focus</i> - National Suicide Prevention Model</p> <ul style="list-style-type: none"> Ensures earlier and proactive supports are provided to improve responsiveness to early signs of distress. Helps to identify and provide earlier support during points of critical life stressors. Helps to identify and provide earlier support during life transitions regardless of suicidality Ensures a suicide prevention lens is used across all new policies and initiatives. |
| <p>Priority Area 3: Facilitating access to appropriate and timely care</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Enhance cooperative administrative arrangements to provide a ‘warm referral’ system between jurisdictions and services across the spectrum of need. Strengthen coordination between primary and acute care and alcohol/mental health services. Headspace services should focus on young people re-engaging to access services, including eheadspace. Mental health and wellbeing services and policies within schools and workplaces and in other community sites such as aged care facilities to be made more accessible as required. <p>RECOVERY</p> <ul style="list-style-type: none"> Improve care planning and coordination for those with complex mental health concerns. Scope universal screening measures for key touchpoints with public services. Adult mental health centres to be designed in the context of the recovery period in the pandemic. | <p>Priority Domain 1: Supporting individuals and communities to seek help and support others</p> <p>Health and Mental Health Ministers to:</p> <ul style="list-style-type: none"> Make their health departments mentally healthy workplaces Support workplaces across Australia to be mentally healthy workplaces, in collaboration with their Ministerial colleagues responsible for occupational, health and safety. <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> <ul style="list-style-type: none"> Health and Mental Health Ministers re-affirm commitments to continue to invest in improving access to quality mental health services. | <p><i>Compassion First</i> - Lived Experience report</p> <ul style="list-style-type: none"> Progress an interagency and cross-portfolio approach to connect with and support people across a range of settings. Ensuring there are a range of compassionate services and supports for people who do seek help in suicidal distress <p><i>Shifting the Focus</i> - National Suicide Prevention Model</p> <ul style="list-style-type: none"> The model can facilitate timely and coordinated access to services across the entire service system. The model ensures a diverse range of services are delivered in ways that are appropriate and preferred by different population groups. |
| <p>Priority Area 4: Complex mental health presentations</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Proactive outreach processes embedded into primary and allied health care, community mental health services and the work of specialist clinicians to ensure continued treatment and medication provision to those with mental health concerns. Maintenance of staffing and resources for high-level needs care. <p>RECOVERY</p> <ul style="list-style-type: none"> Scale-up capacities of high intensity and crisis support services in both community and hospital settings to manage potential surges in service access from those with complex mental health concerns. | <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> <ul style="list-style-type: none"> State and Territory Health and Mental Health Ministers to implement models of care in Emergency Departments that improve the experience for people with suicidal behaviour. | <p><i>Compassion First</i> - Lived Experience report</p> <p>Effective interventions and available support options are needed to mitigate the impacts of co-occurring psychological and relational stressors for young people</p> <p><i>Shifting the Focus</i> - National Suicide Prevention Model</p> <ul style="list-style-type: none"> The model provides for outreach services across all service and community settings for people impacted by suicide attempts or deaths. The model provides for a range of clinical and non-clinical options across prevention, intervention and postvention. |

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| <ul style="list-style-type: none"> Investigate new models of assertive community-based treatment using evidence-based models or consider continuing with new models of care developed during the pandemic. | | |
| <p>Priority Area 5: Focussing on mental health and suicide risk factors in their social context</p> <p>RESPONSE</p> <ul style="list-style-type: none"> All elements of the pandemic response should consider the mental health, suicide risk and economic and social impacts on Australians. Provide ongoing mental health screening and follow up for people treated for COVID-19 in hospital, including appropriate data collection. <p>RECOVERY</p> <ul style="list-style-type: none"> Psychological and mental health first aid and training in distress identification and response for all frontline workers and those working in consumer-facing roles that are likely to encounter individuals at risk for mental health issues and suicide. Build on existing psychological support programs embedded within education systems to ensure they respond to the challenges faced during and after the pandemic. Facilitate employment services (especially disability employment services) having a substantial role in supporting people with established and emergent mental health conditions to access work. Enhance coordination between health care providers offering mental health and drug and alcohol services. Domestic violence services to take into account the restrictions people face in accessing help if 'trapped' in the household by perpetrators and any surge in violence as a consequence of the pandemic. Implementation of mentally healthy workplace initiatives. | <p>Priority Foundation 1: Building and supporting a competent, compassionate workforce</p> <ul style="list-style-type: none"> The Commonwealth to undertaking a stocktake of suicide prevention activity by PHNs, to better understand suicide prevention activities of PHNs and to support them to share best practice and innovation. The Commonwealth to establishing a digital PHN community of practice for suicide prevention, complemented with an annual face-to-face forum for PHNs. Governments to consider the Peer Workforce Development Guidelines, once completed, and implications for the peer workforce in relation to suicide prevention. | <p>Compassion First - Lived Experience report</p> <p>Population-level interventions that address key social and economic stressors should be prioritised and implemented</p> <p>Shifting the Focus - National Suicide Prevention Model</p> <ul style="list-style-type: none"> The model provides for a more comprehensive approach to mitigating the impact of alcohol and other drug use on suicidal behaviour is needed. The model focus on delivering evidence-based programs in a range of government, workplace and community settings. The model can be used to apply targeted approaches to specific settings, industries and workplaces. |
| <p>Priority Area 6: Meeting the needs of vulnerable populations</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Foster re-establishment of community activities and support community institutions to maintain protective factors such as organised sport as restrictions are eased. Ensure residential aged care facility staff are able to identify and compassionately respond to mental health needs of residents. Early mental health support and robust, proactive referral processes for both victims and perpetrators of domestic, family and sexual violence. Monitor service delivery to bushfire affected communities and enable digital delivery and community connection during physical and social isolation. All elements of the pandemic response should consider the specific mental health needs and suicide risk of identified vulnerable populations. <p>RECOVERY</p> | <p>Priority Domain 1: Supporting individuals and communities to seek help and support others</p> <ul style="list-style-type: none"> Health and Mental Health Ministers to work together to coordinate funding for evidence-informed suicide prevention community connector training including training that is culturally safe <p>Priority Domain 4: Community-driven Aboriginal and Torres Strait Islander suicide prevention</p> <ul style="list-style-type: none"> To facilitate a dedicated focus on suicide prevention in Aboriginal and Torres Strait Islander communities, Health and Mental Health Ministers to developing a new National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan. To support Aboriginal and Torres Strait Islander people receiving care that is culturally safe and responsive, Health and Mental Health Ministers to developing culturally safe post-suicide attempt aftercare models in each State and Territory. Health and Mental Health Ministers to develop clinically and culturally appropriate risk assessment tools and resources for assessing risk of suicide in Aboriginal and Torres Strait Islander people. | <p>Recommendation 2: A stand-alone whole-of-government National Suicide Prevention Strategy should be developed to provide authority and guidance to enable all governments, all portfolios, and stakeholders to align their plans and activities. This strategy should be available by 2021, with immediate action undertaken through:</p> <ul style="list-style-type: none"> 2.1: Implementing the <i>National suicide prevention strategy for Australia's health system 2020-2023</i>, including any immediate priorities aligned to the <i>Pandemic Mental Health and Wellbeing Response Plan</i>. 2.2: Resourcing the implementation of the <i>National Aboriginal and Torres Strait Islander Suicide Prevention Plan</i> from 2021. 2.3: Identifying and implementing priority cross-portfolio suicide prevention initiatives across Commonwealth agencies, with agencies to use the <i>Shifting the Focus</i> model to develop suicide prevention action plans. 2.4: Ensuring all responses to national disasters and other declared emergencies, including the COVID-19 response, include strategies that address risk and protective factors for suicide. |

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| <ul style="list-style-type: none">• Provide accessible entry points to mental health services, which are culturally appropriate.• Ensure that children in mental distress have early access to programs that meet their needs, including their families port.• Empower Aboriginal and Torres Strait Islander organisations to lead the development of trauma informed responses specific to Aboriginal and communities.• Integrate learnings from the COVID-19 family, domestic and sexual violence response to proactively address the known driver of violence against women – systemic sexism and gender inequality – which will likely be amplified in recovery and ensure this experience informs the next National Plan to Reduce Violence Against Women and their Children and other related policy initiatives.• Ensure specialist crisis accommodation, case management and perpetrator intervention services can provide timely services to women and children experiencing family, domestic and sexual violence. | <p>Recommendation 3: All governments and their agencies recognise that lived-experience knowledge is central to planning, priority setting, design and delivery of a national whole-of-government suicide prevention approach. This includes:</p> <ul style="list-style-type: none">• 3.1: Increasing lived experience research, particularly with people who have attempted suicide.• 3.2: Ensuring that diverse lived experience expertise is core to governance structures at all levels of government and across funded programs.• 3.3: Ensuring that co-design with lived experience is a demonstrated requirement for funded suicide prevention programs, services and research.• 3.4: Escalating work to develop the lived experience workforce, with a specific focus on the peer lived experience workforce to support new service models. <p>Recommendation 4: Develop a long-term whole-of-government workforce strategy for suicide prevention to support the delivery of a National Suicide Prevention Strategy, considering all relevant workforces across government and community settings. Immediate actions to implement workforce priorities should occur:</p> <ul style="list-style-type: none">• 4.1: All governments to prioritise contemporary and evidence-based training for clinical and other health staff, ensuring the training focuses on collaborative and therapeutic approaches (as identified in the <i>National suicide prevention strategy for Australia’s health system 2020-2023</i>).• 4.2: Australian Public Service Commission implement compassion-based training for frontline workers across the Australian Public Service; with other jurisdictions to consider similar training for their frontline workers.• 4.3: All governments to increase suicide prevention training for services providing financial, employment and relationship support to people experiencing distress.• 4.4: Inclusion of suicide prevention considerations within the <i>National Mental Health Workforce Strategy</i> and the <i>National Peer Workforce Development Guidelines</i> in development. <p>Recommendation 10: Adopting an equity approach to suicide prevention planning, acknowledging the disproportionate impact experience by some populations making them vulnerable to suicide behaviour and requiring targeted approaches. This includes:</p> <ul style="list-style-type: none">• 10.1: All governments prioritise action plans and funding to support approaches that work for men, young people, Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, culturally and linguistically diverse communities, rural and remote communities, and older Australians.• 10.2: Improved data capture and accountability for funded programs and services to demonstrate outcomes for identified priority populations. <p>Recommendation 11: Strengthen the role and capability of Aboriginal and Torres Strait Islander organisations in suicide prevention and improve</p> |
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| | | <p>cultural safety within mainstream service providers, to better respond to the needs of Indigenous Australians. This could include:</p> <ul style="list-style-type: none"> 11.1: Implementing key actions within the <i>National Aboriginal and Torres Strait Islander Suicide Prevention Plan</i> once completed and approved (from 2021). 11.2: Collective action to build the capacity of Indigenous services and organisations as preferred providers, including an enhanced role for Aboriginal Community Controlled Health Services. <p>Compassion First - Lived Experience report</p> <p>Intervene early in life to mitigate the impacts of childhood adversity.</p> <p>Shifting the Focus - National Suicide Prevention Model</p> <p>The model allows to tailor initiatives to target people and communities who are disproportionately impacted by suicidal behaviour.</p> |
| <p>Priority Area 7: Clear communication strategies</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Facilitate communications within families, schools, workplaces and other community institutions, focused on normalising experiences, encouraging resilience and promoting help seeking. Promote national services that provide both crisis support and targeted intervention. Promote services available outside health care settings, including through education, welfare, employment and home sites. Ensure clear and consistent communications by governments that family, domestic and sexual violence help remains available for those that need it. Provide consistent messages nationally that clarify the need for physical distancing with social connection during periods of isolation and quarantine. <p>RECOVERY</p> <ul style="list-style-type: none"> Enhance national coordination and communication efforts to reduce stigma (including self-stigma) and discrimination, recognising that the pandemic presents a unique opportunity for a whole-of-population discussion on mental health and wellbeing. Ensure communications specifically address issues such as financial stress, domestic, family and sexual violence, alcohol and drug misuse, and re-engaging in education and employment. Sustain mental health campaigns throughout the recovery phase and beyond to inform the “new normal” and enhance broader mental health literacy. | <p>Priority Domain 1: Supporting individuals and communities to seek help and support others</p> <ul style="list-style-type: none"> Health and Mental Health Ministers to continue to fund and coordinate well evaluated population-wide and localised context-specific suicide prevention public education campaigns | <p>Shifting the Focus - National Suicide Prevention Model</p> <ul style="list-style-type: none"> The model focuses on promoting protective factors and increasing general wellbeing. The model promotes safe media reporting. Language and reporting that reduces the risk of further suicidal behaviour and decreases stigma. |
| <p>Priority Area 8: Supporting a multidisciplinary mental health workforce</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Develop, consolidate and communicate resources and guidance for mental health practitioners who are using telehealth. | <p>Priority Foundation 1: Building and supporting a competent, compassionate workforce</p> <ul style="list-style-type: none"> The Commonwealth to continue to fund evidence-informed training for general practice. The Commonwealth to: | <p>Compassion First - Lived Experience report</p> <p>Increasing capacity to provide outreach and support at the point of distress to ensure people get the right supports in a timely way.</p> <p>Shifting the Focus - National Suicide Prevention Model</p> |

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| <ul style="list-style-type: none"> Strengthen partnerships between community managed organisations, and State, Territory and Federal services to enable agile mobilisation of trained workforce to meet gaps and surges. Improve the capability of non-health workers in customer-facing roles to identify distress and connect individuals to mental health and other health and community services as appropriate. Clarify the role of peer workforce and connection with consumer and carer lived experience in the pandemic context. <p>RECOVERY</p> <ul style="list-style-type: none"> Review actions taken in response to COVID-19 to identify ongoing workforce opportunities and needs. Identify ways to attract, train and retain key professionals within the mental health workforce. | <ul style="list-style-type: none"> Work with PHNs to update the Health Pathways suicide prevention related content State and Territory Health and Mental Health Ministers to support every emergency department clinician in their jurisdiction to complete contemporary risk mitigation and safety planning training for people presenting with suicidal behaviour. Health and Mental Health Ministers to support a national project to work with universities across Australia to ensure there is high-quality suicide prevention content in undergraduate and postgraduate education Health and Mental Health Ministers to support working with colleges and associations, and State and Territory Ambulance Services, to strengthen suicide-related continuing professional development programs Health and Mental Health Ministers to support reviewing the suicide prevention content on MHPOD and promoting MHPOD more widely Health and Mental Health Ministers to support funding an annual suicide prevention webinar series through the MHPN <p>Priority Foundation 2: Better use of data, information and evidence</p> <ul style="list-style-type: none"> Health and Mental Health Ministers to establish a central online repository to facilitate knowledge sharing on in-progress research, emerging evidence and research outcomes. | <p>The model provides for a broader understanding of the workforce involved in early outreach to ensure universal, compassionate and competent responses across settings.</p> |
| <p>Priority Area 9: A specific focus on suicide prevention action</p> <p>RESPONSE</p> <ul style="list-style-type: none"> Establish warm referral pathways between helplines and other service sectors. Assertive outreach models to better support people at risk of suicide. Build capacity of suicide prevention services to use digital and telehealth tools. Review current approaches to ensure they meet the needs of vulnerable groups including men, Aboriginal and Torres Strait Islander peoples, CALD people and LGBTIQ+ people. Improve immediate supports for families and carers, including those bereaved. Enhance workforce training for frontline staff in health and non-health settings. Outreach to older people and those isolated during the pandemic. Use financial touchpoints to increase supports for those in distress. <p>RECOVERY</p> <ul style="list-style-type: none"> Build on existing work to further develop safe spaces and other alternative options to emergency departments to build capacity to meet long-term demand. Ensure aftercare services are available and have appropriate reach. Integrating digital, telehealth and face to face interventions and supports. Enhanced regional planning and delivery of community-based interventions. Ensure health services are themselves mentally healthy. | <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> <p>Health and Mental Health Ministers to:</p> <ul style="list-style-type: none"> Assess funding levels to ensure calls don't go unanswered. Work together to expand the referral criteria so that existing aftercare services for people who have attempted suicide are equipped to include anyone in suicidal distress. Work together to establish evidence-informed non-clinical alternatives to the Emergency Department in each State and Territory where Australians in suicidal distress who do not need urgent medical care can receive compassionate peer led care tailored to their needs. Fund and share robust evaluations so that what works best within a range of contexts can be understood. <p>Priority Domain 3: Enabling recovery through post-crisis aftercare and postvention</p> <p>Health and Mental Health Ministers to ensure that every person who attempts to take their own life and presents to an emergency department is offered evidence-informed, person-centred aftercare at the intensity they require.</p> <ul style="list-style-type: none"> Health and Mental Health Ministers to widen referral pathways to include community mental health, mental health triage, crisis helplines, ambulance services, alcohol and other drug services, GPs and postvention bereavement support providers, so that more people are supported to recover Health and Mental Health Ministers to develop a co-designed online support package to build the capability and confidence of families and friends to help a loved one recover. Health and Mental Health Ministers to work together to ensure there is adequate coverage of postvention bereavement services in each jurisdiction according to population distribution and need. | <p>Recommendation 7: To support further implementation efforts, all Commonwealth portfolios (with consideration for States and Territories to do the same) to apply the decision making tool in <i>Shifting the Focus</i> to identify key initiatives for implementation and evaluation in each portfolio. In addition:</p> <ul style="list-style-type: none"> 7.1: Agency Heads develop and report on agency-specific suicide prevention actions plans. 7.2: Develop a Commonwealth process for reviewing new policies or initiatives to ensure they assess any impacts (positively or negatively) on suicide risk or behaviour. <p>Recommendation 8: Population-level interventions which address key social, economic, and health stressors should be prioritised and implemented including:</p> <ul style="list-style-type: none"> 8.1: An immediate and ongoing focus on individuals, industries, and communities most affected by economic downturn associated with COVID-19 and the implementation of policies and programs that mitigate distress. 8.2: Coordinated cross-portfolio action to intervene early in life to mitigate the impacts of childhood adversity and trauma, with a focus on children and young people in out-of-home care. 8.3: Cross-jurisdictional action to enhance suicide prevention interventions targeted at people in touch with the justice system and those who are homeless or with insecure housing. <p>Recommendation 9: The Commonwealth with States and Territories work together to ensure government systems or services that interact with people experiencing distress provide earlier and more effective responses. This includes an increased capacity to provide outreach and support at the point of distress. Actions should include:</p> |

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| <ul style="list-style-type: none"> • Improve data collection to monitor impacts and prepare intensive support, including postvention for communities impacted by suicide. • Integration of suicide prevention interventions into key cross-portfolio settings, including – justice, child protection, housing and homelessness services, alcohol and other drugs services, financial services. | <ul style="list-style-type: none"> • Health and Mental Health Ministers to work with Ministerial colleagues to explore establishing automatic notifications from police to postvention bereavement service providers. <p>Priority Foundation 1: Building and supporting a competent, compassionate workforce</p> <ul style="list-style-type: none"> • State and Territory Health Ministers to support the alcohol and other drugs workforce to undertake effective suicidal risk assessment and management. | <ul style="list-style-type: none"> • Reviewing and enhancing the outreach and support to people who are involved in family disputes, legal action, child custody arrangements and workplace disputes. • Providing interventions delivered at critical points of transition – ensuring there are evidence-based approaches for people released from justice settings and those transitioning from certain workplaces such as Australian Defence Force. |
| <p>Priority Area 10: Strong governance and integrated coordination</p> <p>RESPONSE</p> <ul style="list-style-type: none"> • Identify the roles and responsibilities of government and non-government agencies and establish appropriate partnerships to manage the delivery of mental health and suicide prevention services and supports during and after the pandemic. • Improve collaboration and cooperation between health departments and other departments including social services, justice and corrections. • National Cabinet to oversee the plan during the response phase. • Empower the Mental Health Principal Committee to be the implementation governance committee. <p>RECOVERY</p> <ul style="list-style-type: none"> • Continue to consider the roles and responsibilities of Australian Government and State and Territory governments in the delivery of mental health care during recovery and ongoing. | <p>Priority Domain 2: Building a system of care to change the trajectory of people in suicidal distress</p> <p>State and Territory Health and Mental Health Ministers to:</p> <ul style="list-style-type: none"> • Put in place evidence-informed systems in their State or Territory to prevent the suicides of people receiving treatment in a public health service (encompassing inpatient and community care settings). • Work together to improve the public reporting of patient suicides. <p>Priority Foundation 2: Better use of data, information and evidence</p> <ul style="list-style-type: none"> • The Commonwealth to develop a new national system for the collection and coordination of information on suicide and self-harm, working with State and Territory governments and data custodians to operationalise the system. • Governments to work with registry data custodians to establish a suicide register in each jurisdiction, a national minimum dataset and increased access to data by researchers. • Governments to utilise data on people that have taken their own life in the community who have been receiving clinical mental health services to learn from their deaths. • Governments to improve data on suicide attempt presentations to emergency departments. • Governments to work with data custodians to regularly make localised data available to those involved in suicide prevention efforts to better target investments and improve outcomes. • The Commonwealth to analyse and share primary care data to better understand suicidal behaviours seen in a range of primary care settings. <p>Priority Foundation 3: Government leadership that drives structures and partnerships to deliver better outcomes</p> <p>Health and Mental Health Ministers to develop national best practice guidelines.</p> <ul style="list-style-type: none"> • Health Ministers to have a dedicated strategic discussion on suicide prevention annually at a COAG Health Council meeting. • Governments to strengthen structures and approaches to whole-of-government suicide prevention in their jurisdiction. • Utilising existing infrastructure, Governments to developing a single suicide prevention digital gateway. | <p>Recommendation 1: To adopt a national whole-of-government governance structure for suicide prevention, with suicide prevention identified as a portfolio responsibility of all Ministers and ideally led by First Ministers. The final governance architecture should be informed by other governance reviews underway and should be developed in consultation with all jurisdictions. It should consider:</p> <ul style="list-style-type: none"> • 1.1: Revised national structures which include the creation of a Ministerial Reform Council or similar and the establishment of a National Office for Suicide Prevention. • 1.2: A review of the arrangements for regional coordination and delivery of suicide prevention services and programs to ensure they have the authority and resources to implement a whole-of-government and whole of community approach. <p>Recommendation 5: All governments expand their investment in a consistent and systematic approach to suicide data, including collection of all relevant health and non-health data, to support policy decisions and agile responses to emerging and shifting vulnerabilities. In particular:</p> <ul style="list-style-type: none"> • 5.1: All governments to work with the AIHW and remove the barriers to the routine sharing of relevant data with the National Suicide and Self-Harm Monitoring System. • 5.2: All governments to establish consistent definitions for suicide-related data (including agreed distinctions between self-harm and suicide attempts) and increase data capture for priority populations. <p>Recommendation 6: Develop a long-term research strategy for suicide prevention together with an evaluation framework to measure the impact of funded programs and services. In particular:</p> <ul style="list-style-type: none"> • 6.1: The Commonwealth, with other governments, to facilitate the development of an outcomes framework for suicide prevention programs and services. • 6.2: The Suicide Prevention Research Fund (and other research funding sources) to fund research that aligns with strategic priorities in suicide prevention. |

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