

FOR DISCUSSION

**A report detailing key themes and early findings
to support initial advice of the
National Suicide Prevention Adviser**

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About this report

To support initial advice to the Prime Minister, enclosed in this report is a summary of contextual information on the impact of suicide in Australia and suicide prevention approaches as well as a summary of work undertaken by the National Suicide Prevention Adviser (the Adviser) and Taskforce.

This has led to the development of initial findings and recommendations, part of which will inform the 2020 work plan of the Adviser.

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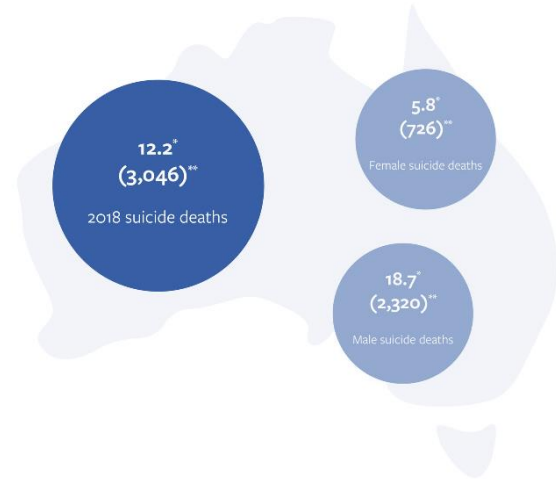
Background to the Advice

The impact of suicide in Australia

Each day in Australia, more than eight people will die by suicide and it is estimated that a further 200 people will attempt suicide.

In Australia, 3,046 people died by suicide in 2018 and it is estimated that a further 78,000 people made a suicide attempt. The highest rates of suicide in Australia occurred among men over 85 years and men aged 40-49 years, but suicide is also the leading cause of death for all Australians aged between 15 and 44 years.ⁱ

Suicide rates in Australia peaked in the early 1960s, with 17.5 deaths per 100,000 recorded in 1963 and declined to 11.3 per 100,000 in 1984 before rising again in the 1990s when they reached 14.6 per 100,000 in 1997. Rates of suicide have since remained lower than 1997; however, they have steadily increased in recent years, with suicide rates recorded at 12.1 per 100,000 in 2018 compared to a recorded rate of 10.9 per 100,000 a decade earlier in 2008. Trends in Australia tend to mirror the experiences of other Western democracies such as New Zealand, the United States of America, United Kingdom and Canada.



The impacts of suicide are not only measured in loss of life, but the impacts of suicidal thoughts and behaviours can be felt across the community. Research suggests that about 135 people are exposed to each suicide death, and that these people experience varying impacts in terms of their own mental healthⁱⁱ. Recent research from Australia revealed that on average, each person surveyed knew six people who had attempted suicide and four people who had died by suicide, with many reporting high levels of impact following that exposure.ⁱⁱⁱ

It is not possible to reliably predict individual suicidal behaviour. While some people and groups are more vulnerable to suicide than others, suicide occurs across all demographics. This is complicated by the reluctance of many suicidal persons to disclose their feelings of distress, or to access services. Suicide prevention therefore should be considered from a whole of population perspective.

Working ‘towards zero’ suicides means that suicide prevention approaches must consider the whole population as well as opportunities to target groups at greater risk of suicide.

More timely data, mapped to the local area and linked to other data sources, will assist in identifying those at greatest risk and possible intervention points.

Three quarters of those who die by suicide in Australia are male

Men aged 25–54 years account for the largest percentage of suicides in Australia, while men over 85 years have the highest age-specific suicide rate. Some of the factors that particularly contribute to suicide by men include mental ill-health and personal and social factors such as family relationship breakdown, alcohol and substance use problems, contact with the justice system, unemployment, financial struggles and housing stress. These may be combined with a prior history of trauma, violence or self-harm. Notably, the male suicide rate in rural and remote areas is double the rate recorded in metropolitan areas. The following Case Study, drawn from the detailed data available through the Victorian Suicide Register, illustrates the way in which personal and social factors for rural males relate to suicidal behaviour.

Case study: Men in rural and regional Victoria

Research by Lifeline South West Victoria (2015) based on data from the Victorian Suicide Register, demonstrated the range of stressors impacting men in the 12 months prior to their death:

- **Family and relationships:** 71 per cent of men were not in a relationship; 37 per cent were recently separated and 25 per cent had a history of being perpetrators of intimate partner violence
- **Employment status:** 56 per cent were unemployed, unable to work or retired
- **Substance misuse:** 51 per cent had substance misuse as a significant stressor
- **Mental ill-health:** 37 per cent of men had a diagnosed mental illness
- **Financial and housing stress:** 41 per cent had contact with welfare and housing services.

In the six weeks prior to their deaths, these men were likely to be in contact with a range of government services (e.g. justice, housing and support payments).

Aboriginal and Torres Strait Islander communities are disproportionately impacted by suicide

The Aboriginal and Torres Strait Islander suicide rate is twice that of the non-Indigenous population. Suicide accounted for 5.3 per cent of all Aboriginal and Torres Strait Islander deaths in 2018 compared with 1.9 per cent of all non-Indigenous deaths for the same year.^{iv} Suicide also occurs at much younger ages, with Aboriginal and Torres Strait Islander children aged under 17 years having a suicide rate four times higher than non-Indigenous children.^v There are a range of factors contributing to the higher rates of suicide, with the personal and social experiences for Indigenous Australians including intergenerational trauma, lack of self-determination, ongoing racism and discrimination, and lack of available, affordable and culturally-appropriate health and community services.

Suicide is the leading cause of death for young people

Nationally, suicide accounts for more than 40 per cent of all deaths among people aged 15–24 years. Children who experience traumatic childhood events such as abuse, neglect or household dysfunction can have an increased risk of poor lifelong outcomes, with children known to the child protection system at greater risk of suicide than other children.

Over 40 per cent of suicides occur outside of metropolitan centres

People who live in rural and remote areas of Australia encounter increased challenges to wellbeing that may increase their vulnerability to suicide. Personal and social factors, including stigma, isolation and the impacts of natural disasters affect rural and remote people, their families and communities. They are also more likely to face barriers when trying to find appropriate services and interventions, thus exacerbating their isolation and difficulty seeking support in times of high personal distress.

People with a history of self-harm are at increased risk of dying by suicide

A person's previous suicidality and/or self-harming behaviour is the leading psychosocial factor identified in those who have died by suicide, across all age groups. The Australian Bureau of Statistics (ABS) reported that almost one in three people who died by suicide in 2017 had a personal history of self-harm. This highlights the importance of a recovery-based response when a person is in contact with services following an experience of suicide attempt, or suicidal crisis.

Mental ill-health is reported in many people who die by suicide

Mental ill-health is a critical factor surrounding suicidal behaviour – often combined with personal and social factors or contributing to personal difficulties and social isolation. The ABS reported that in 64.9 per cent of suicides, coroners found that the person had a prior experience of a mental or behavioural disorder.^{vi} Suicide is a prominent cause of death for people with borderline personality disorder (risk is 45 times greater than the general population), anorexia nervosa (31 times greater), major depression (20 times greater), bipolar disorder (17 times greater) and schizophrenia (13 times greater).^{vii}

Alcohol and other drugs can increase vulnerability to suicide

Suicide is the leading cause of death among people who misuse alcohol and other drugs.^{viii} Recent research also suggests that excessive alcohol consumption may play a significant role in the transition from thoughts about suicide to acting on those thoughts.^{ix} In 2018, 29.4 per cent 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 per cent of people who died.^x

Available data suggests that the LGBTIQ+ community experiences higher rates of suicidal distress

Suicide data for lesbian, gay, bisexual, transgender, intersex, queer and gender diverse (LGBTIQ+) communities is limited in Australia. However, survey data indicates that members of the LGBTIQ+ community are more likely to attempt suicide or live with suicidal thoughts than the broader community. Research suggests this is likely due to experiences of discrimination and exclusion experienced by people identifying as LGBTIQ+.^{xi}

Refugees and asylum seekers in Australia have an elevated risk of suicide

The suicide rate for male asylum seekers has been reported as 33 per 100,000 which is significantly higher than for other males.^{xii}

People with disability and chronic health issues may be more vulnerable to suicide

Research indicates that nearly 10 per cent of men aged 18-55 who have a disability have experienced suicidal thoughts in the past year,^{xiii} compared to four per cent in men without disability. This finding is supported by ABS data which found that experiencing limitation in daily activities, due to disability or chronic health conditions, was a top 10 psychosocial factor in suicides in 2017 and that 47 per cent of people who died by suicide had a physical disease.^{xiv}

Transition out of the Australian Defence Force can increase vulnerability

Serving Australian Defence Force personnel have significantly lower rates of suicide than the general population (51 per cent lower for current serving and 47 per cent lower for reserve personnel). However, once transitioned from service, veterans have a suicide rate 18 per cent higher than the Australian population.^{xv} For male veterans under 30, the rate is double that of Australian men of the same age.^{xvi} Female veterans may have rates of suicide that are more than double that of other women.^{xvii}

Some occupational groups have higher rates of suicide

There is evidence to suggest that people employed in certain occupations may be at increased risk of suicide or suicidal behaviour, including construction and mining, the transport industry, agricultural and fisheries workers, doctors and nurses, veterinarians and emergency services personnel.

Suicide rates are higher in communities with lower social and economic advantage

Data demonstrates that there is a correlation between suicide rates and levels of socioeconomic disadvantage, with high incomes and advantage generally associated with lower rates of suicide. Financial stress, housing insecurity and homelessness, unemployment and a lower level of education have all been associated with vulnerability to suicide.

Those who die by suicide often have multiple points of contact with government services

There is emerging Australian evidence indicating that many people who die by suicide have had no contact with the mental health system in the 12 months prior to their deaths, but may have contact with other health, government and community organisations.^{xviii}

Case study: Youth suicide and government interaction

A 2014 report by the Ombudsman of Western Australia (WA) into 36 suicide deaths by a young person (aged between 13—17 years) illustrates that many people who die by suicide have significant contact with government agencies.

Of the 36 young people:

- 20 were known to the Department for Child Protection and Family Support, had experienced one or more forms of child maltreatment and had contact with WA Health.
- Many had significant contact with the justice system and the majority also had contact with the Department of Housing (22 per cent had experienced homelessness).
- While only 12 had a diagnosed mental illness, 56 per cent had communicated suicidal intent.
- During the last year of their lives, 14 of the 19 young people enrolled at school attended less than 60 per cent of the time.

Approaches to suicide prevention

Suicide is a highly complex behaviour that occurs because of the interplay between biological, clinical, psychological, cultural and social risk factors.

More modern theories and frameworks for understanding suicide have attempted to provide different explanations for the emergence of suicidal ideation, or thoughts about suicide, as well as the transition from thinking about suicide to acting on those thoughts.^{xix} For example, a current and widely adopted theory, the Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour describes:

- (1) The biopsychosocial context in which suicidal thoughts and behaviours may emerge;
- (2) Factors that contribute to suicidal thinking, especially a feeling of entrapment;
- (3) Factors that aid the transition from thinking about suicide to acting on those thoughts.

Another current theory, such as the USA-based Interpersonal Theory of Suicide, directly addresses the upstream factors that generate suicidal thinking as well as the creation of a ‘capability for suicide’ and the mechanisms through which this transition can occur.

Given the complexity of factors that can contribute to suicidal behaviour, the most common approach to suicide prevention planning globally is to ensure a range of initiatives are implemented, which target the whole community, and those at-risk of suicide and those impacted by suicidal behaviour. While there are a number of ways to conceptualise interventions in suicide prevention, a common method used in policy and research globally, is an adapted version of the Institute of Medicine’s framework. Where the design and development of public health strategies and services^{xx} are categorised as ‘universal’, ‘selective’ and ‘indicated’.^{xxi} This has been the backbone of national approaches in Australia for the past two decades described in the *Living is For Everyone (LIFE) Framework*.^{xxii}

Using this broad framework, initiatives focus on:

1. **The whole population** with common examples including efforts to reduce access to means of suicide, school-based interventions to increase resilience and media guidelines to promote safe reporting of suicide (‘universal’ interventions).
2. **Individuals who may be at heightened risk** of suicide, for example those living with mental illness, substance use disorders, exposed to abuse or recently released from prison (‘selective’ interventions).
3. **Individuals showing more immediate risk** of suicide, for example crisis support lines, psychological interventions and follow-up for those who have attempted suicide (‘indicated’ interventions).

In recent years, adaptations to the model have been added with a focus on:

- **Increasing wellbeing** and addressing social determinants that contribute to suicidal distress (‘wellbeing’ interventions); and
- **Individuals and communities affected by suicide** to reduce distress and further risk of suicide (‘postvention’ interventions).

The following table provides a basic summary of a suicide prevention approach that takes a comprehensive approach, including the enablers required.

Diagram 1: Summary of a comprehensive suicide prevention approach, including the enablers required.

Wellbeing interventions	Universal interventions	Selective interventions	Indicated interventions	Postvention interventions
<ul style="list-style-type: none"> - Addressing key social determinants like housing security, financial security, education and employment - Addressing trauma - Building resilience in early childhood and building health families - Building community cohesion and reducing isolation - Having mentally healthy schools, workplaces and sporting clubs - Reducing stigma and discrimination 	<ul style="list-style-type: none"> - Reducing known risk factors across the population (e.g. alcohol misuse) - Providing universal brief distress interventions - Community education about suicide - Reducing access to means - Safe media coverage and online communication about suicide 	<ul style="list-style-type: none"> - Programs to empower, support and build skills in groups at higher risk of suicide, including those experiencing trauma - Targeted interventions at points of vulnerability (e.g. relationship breakdown, job loss, release from prison, transition from the defence force) - Targeted interventions for communities facing adversity (e.g. drought affected communities) - Targeted interventions for workforces at risk 	<ul style="list-style-type: none"> - Crisis services for suicidal persons and their carers when a suicidal crisis requires immediate and effective response - Building community connectors to identify those who may be at risk of suicide - Improved care-coordination for those accessing multiple agencies and services for support - Improved access to safe spaces and alternatives to emergency departments (ED) - Routine aftercare with non-clinical and clinical supports - Improved access to evidence-based treatment, including routine safety planning - Improved supports for families and carers 	<ul style="list-style-type: none"> - Universal and proactive response to those impacted and bereaved by suicide - Critical postvention response plans and services for schools, workplaces and vulnerable communities. - Improved data to identify and respond to potential clusters.
<p>Enabled by:</p> <ul style="list-style-type: none"> - Coordination and leadership to guide a whole-of-government approach - Connected and supported communities with localised planning and delivery with local architecture to support - A compassionate and skilled workforce across all services and agencies that might interact with people vulnerable to suicide <ul style="list-style-type: none"> - Connected data and evidence to inform planning and delivery of suicide prevention actions. 				

A multi-component approach

In 2014, the World Health Organisation released a seminal report on suicide, *Preventing suicide: A global imperative*. This highlighted suggested components of an effective national strategy, which has been adopted under the Fifth National Mental Health and Suicide Prevention Plan. The eleven elements include:

- (1) **Surveillance**—increase the quality and timeliness of data on suicide and suicide attempts.
- (2) **Means restriction**—reduce the availability, accessibility and attractiveness of the means to suicide.
- (3) **Media**—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
- (4) **Access to services**—promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
- (5) **Training and education**—maintain comprehensive training programs for identified gatekeepers.
- (6) **Treatment**—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
- (7) **Crisis intervention**—ensure that communities have the capacity to respond to crises with appropriate interventions.
- (8) **Postvention**—improve response to and caring for those affected by suicide and suicide attempts.
- (9) **Awareness**—establish public information campaigns to support the understanding that suicides are preventable.
- (10) **Stigma reduction**—promote the use of mental health (and other) services.
- (11) **Oversight and coordination**—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

In recent years, there has been increasing international interest in evidence-based interventions and the trial of multi-component or systems approaches that include a range of interventions being implemented simultaneously in a region^{xxiii}. Governments have committed to the trial of system-based approaches at the regional level.

<p>Example 1: European Alliance Against Depression.^{xxiv}</p> <p>This is a five-component intervention model implemented across Europe, where, local agencies and advisory groups deliver five interventions simultaneously. These include: - (1) safe and responsible media reporting of suicide; (2) training for frontline workers and gatekeepers; (3) enhancing screening and treatment in primary and mental health care; (4) support for high-risk groups and their families; and, (5) increasing community awareness and knowledge about depression.</p>	<p>Example 2: Lifespan.</p> <p>LifeSpan uses localised governance and data to support the implementation of nine interventions: (1) improving safety and reducing access to means; (2) encouraging safe media reporting of suicide; (3) equipping primary care to identify and support people in distress; (4) improving the confidence and competency of frontline workers; (5) training the community to recognise and respond; (6) promoting help-seeking and resilience in schools; (7) applying evidence-based treatments to suicidality; (8) improving emergency and follow-up care; (9) engaging the community.</p>
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The Australian Suicide Prevention Context

Australia has had a national approach to suicide prevention for almost 25 years, but the approach has changed over time

History of national strategies

1995: A first National strategy focussed on young people (Commonwealth)

Australia's first National Mental Health Plan (1993-98) did not include suicide prevention as a priority area. The National Youth Suicide Prevention Strategy developed in 1995, was the first attempt to provide a nationally-coordinated approach to suicide prevention in Australia. It was also one of the first national suicide prevention strategies in the world.

2000 onwards: A shift in focus to all ages (Commonwealth)

The National Youth Suicide Prevention Strategy was replaced in 2000 by the National Suicide Prevention Strategy, which expanded the focus on suicide prevention to all age cohorts and considered the needs of specific at-risk groups. The *Fourth National Mental Health Plan* (2009-2014) included prevention as a priority area, which referenced the need for a "nationally agreed suicide prevention framework". In 2011, all Australian jurisdictions adopted the *LIFE Framework* as the common suicide prevention approach.

In 2014, the National Mental Health Commission recommended that the Commonwealth Government develop, agree and implement a National Mental Health and Suicide Prevention Plan with States and Territories in collaboration with people with lived experience, their families and support people. In 2017, the Council of Australian Governments (COAG) Health Council agreed to an integrated mental health and suicide prevention plan: *Fifth National Mental Health and Suicide Prevention Plan* (2017-22) (the Fifth Plan).

Fifth National Mental Health and Suicide Prevention Plan (Commonwealth, States and Territories)

Under the Fifth Plan, responsibility (and funding) for suicide prevention is shared by all jurisdictions. The Fifth Plan has eight priority areas, including suicide prevention (priority 2) and Aboriginal and Torres Strait Islander mental health and suicide prevention (priority 4). The Fifth Plan is underpinned by an Implementation Plan and performance indicators, both of which are still to be fully operationalised.

State and Territory plans

In addition to past Commonwealth Plans and the current Fifth Plan, all States and Territories have a jurisdictional suicide prevention plan, strategy or framework (referred to below as plans). A review of State and Territory plans has provided the following information.

While different approaches are taken, there are common themes across the jurisdictions including building resilience, empowering communities, focusing efforts on vulnerable groups, and designing suicide prevention, intervention and postvention programs and services that are person-centred. Some jurisdictional plans include a whole-of-government focus, including the Northern Territory, New South Wales and Queensland, though there are opportunities even within these jurisdictions to further strengthen a full cross-portfolio approach to drive suicide prevention.

Jurisdictions have a diversity of suicide prevention leadership, governance and funding structures. For example, Queensland's Mental Health Commission is responsible for a whole-of-government approach to suicide prevention with the Department of Health tasked with health services leadership. In Tasmania, the Department of Health and Human Services leads the development of suicide prevention policy and is supported by a Tasmanian Suicide Prevention Committee and the Tasmanian Suicide Prevention Community Network.

States and Territories have generally applied the *LIFE Framework*, have sought to tailor their plans to circumstances in their jurisdictions, but have struggled in the absence of a more detailed model for suicide prevention in Australia to formulate more refined strategies. Accordingly, broad and general directions are most commonly outlined, rather than prioritised action that can be monitored for implementation and results.

Funding of suicide prevention activities

Australia has seen significant funding and activity in suicide prevention at all levels of government. There is a lack of clarity, however, about the types of suicide prevention activities which should be undertaken by various tiers of government, as outlined in the draft report of the Productivity Commission.^{xxv} As a result, both the Commonwealth and the States and Territories fund most types of suicide prevention activities without clear differentiation of roles or how the national, state and regional (Primary Health Network) funded initiatives will be coordinated. For example, place-based trials have been funded by the Commonwealth, the States and by philanthropic organisations. Similarly, post-discharge aftercare, suicide awareness, gatekeeper training and the set up and management of community suicide prevention networks are funded across jurisdictions, with local government also playing an increasing role in suicide prevention.

The Commonwealth funds suicide prevention activities through several channels, including Primary Health Networks (PHNs), national level grants programs, suicide data and evidence, Aboriginal and Torres Strait Islander social and emotional wellbeing grants, and project agreements.

State and Territory Governments fund suicide prevention activities through their hospital systems, investments into sub-acute care, community-based mental health services and partnerships with Non-Government Organisations (NGOs). States and Territories also have primary responsibility for the planning and delivery of other services that are key in a whole-of-government and whole-of-community approach to suicide prevention. Including, housing, drug and alcohol services, police, justice and corrections, disability services, education and early childhood.

The diverse and complex network of plans and funding channels is resulting in duplications, gaps and fragmentation of effort in the suicide prevention space. Multiple reviews, inquiries and reports, including the 2019 Draft Productivity Commission Report on the mental health system, have identified this as a foundational issue requiring remedy. Clear roles, responsibilities, funding, governance and accountability will provide a platform for more effective, co-designed service delivery, integrated governance and reduction in duplication and gaps.

Current and previous reviews

There are several concurrent reviews happening alongside the work of the Adviser. These reviews and their findings will inform future advice to the Prime Minister:

- Productivity Commission report on compensation and rehabilitation for veterans, final report released 4 July 2019.
- Productivity Commission report on mental health, draft report released October 2019 and final report due May 2020.
- Victorian Royal Commission into mental health, draft report released November 2019.
- WA Government response to Coroner's Inquest into the deaths of thirteen children and young persons in the Kimberley Region. The whole-of-government response to the recommendations is scheduled for December 2019.
- National Mental Health Commission Vision 2030 roadmap, available mid-2020.
- The National Children's Mental Health and Wellbeing Strategy, led by the National Mental Health Commission.
- The Royal Commission into Aged Care Quality and Safety, final report due 12 November 2020.

There are also a range of other strategic documents under development that are of relevance to improving suicide prevention. These include (but are not limited to):

- National Mental Health Workforce Strategy, final strategy to be released by December 2020.
- Youth Taskforce (located in Department of Health), plans to develop a National Youth Policy Framework in 2020.
- National Injury Prevention Strategy, a draft strategy is due in 2020.
- National Preventive Health Strategy, a draft strategy due in 2020.
- Veteran Mental Health and Wellbeing Strategy and National Action Plan 2019-2023.

Suicide prevention has been the focus of a number of key inquiries and reviews in recent years. Some of these reviews have resulted in significant changes to suicide prevention in Australia. An analysis detailing the successful implementation of review recommendations, partial implementation and recommendations that have yet to be implemented with related or similar recommendations arising again in subsequent reports will be provided in the Adviser's interim advice in 2020.

Informing the Advice

On 8 July 2019, the Prime Minister, the Hon Scott Morrison MP, announced the appointment of Ms Christine Morgan as his National Suicide Prevention Adviser (the Adviser). Since the appointment, a range of work has been conducted to inform this initial advice.

National Suicide Prevention Taskforce

To support the work of the Adviser a National Suicide Prevention Taskforce (the Taskforce) was established in August 2019 within the Mental Health Division of the Commonwealth Department of Health, with joint governance provided by the Department of the Prime Minister and Cabinet. The Taskforce is headed by Special Adviser, Ms Jaelea Skehan, who brings extensive experience in suicide prevention implementation and research, with staffing comprised of secondees from a range of Commonwealth Government agencies including: Department of the Prime Minister and Cabinet, Department of Defence; Department of Education; Department of Employment, Skills, Small and Family Business; Department of Health; Department of Home Affairs; Department of Human Services; Department of Social Services; and the National Indigenous Australians Agency.

Ministerial engagement

Beyond continued engagement with the Office of the Prime Minister, the Hon Scott Morrison MP, the Adviser has engaged extensively with Commonwealth Ministers and Members of Parliament, both face-to-face and in writing. In October 2019, the Adviser and the Head of the Taskforce met in-person with the following Ministers to discuss ways for various portfolios to contribute to suicide prevention efforts:

- Senator the Hon Matthew Canavan, Minister for Resources and Northern Australia
- The Hon Darren Chester MP, Minister for Veterans and Defence Personnel
- Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians and Minister for Youth and Sport
- The Hon Peter Dutton MP, Minister for Home Affairs
- The Hon Josh Frydenberg MP, The Treasurer
- The Hon Greg Hunt MP, Minister for Health
- The Hon David Littleproud, Minister for Water Resources, Drought, Rural Finance, Natural Disaster and Emergency Management
- The Hon Christian Porter MP, Attorney-General
- The Hon Stuart Robert MP, Minister for the National Disability Insurance Scheme
- Senator the Hon Anne Ruston, Minister for Families and Social Services
- The Hon Dan Tehan MP, Minister for Education
- The Hon Ken Wyatt AM MP, Minister for Indigenous Australians

Suicide Prevention Interdepartmental Committee

A Senior Executive Band 2 Commonwealth Suicide Prevention Interdepartmental Committee (IDC) was established in August 2019 to facilitate input and advice into the development of suicide prevention initiatives across the Government. The membership is extensive in recognition of the range of touchpoints that the Australian Public Service (APS) has with vulnerable Australians and the capacity to use its levers to enhance whole-of-government coordination through policy and service delivery. The IDC has met three times since August 2019 and has considered cross-portfolio suicide prevention contributions, better connecting data and evidence, workforce training and presentations from the Productivity Commission and APS Mental Health Capability Project.

Expert Advisory Group

An Expert Advisory Group (EAG) was established to provide advice to the Adviser. The EAG's membership includes people with expertise through lived experience of suicide, experts in suicide prevention research, experts in Aboriginal and Torres Strait Islander suicide prevention, and experts from social and community policy associated with suicide prevention. The EAG Chair, Ms Lucinda Brogden AM and EAG Deputy Chair, Mr Alan Woodward, are members of the Board of the National Mental Health Commission.

Towards Zero Suicide Prevention Forum

On 13 November 2019, the *Towards Zero Suicide Prevention Forum* (the Forum) was held in Canberra with over 100 people in attendance. Through a series of workshops, participants considered better responses to the needs of specific target groups, ways to address social determinants through policy and program levers and enhanced coordination across multiple agencies at all levels of government. Both the Prime Minister and Minister for Health attended and presented at the Forum and affirmed the importance of this work. They encouraged participants to find common ground and a unified voice that would speak to the solutions could have the greatest impact. An outcomes report is available on the Department of Health website.

Stakeholder engagement

The Adviser and Taskforce have met with a wide range of stakeholders including: each State and Territory government; peak bodies; Primary Health Networks; a range of Aboriginal and Torres Strait Islander organisations, advisory groups, networks and communities; those working in rural and remote areas; individual researchers, mental health practitioners and people with a lived experience of suicide.

Ms Morgan, in her dual role as Chief Executive Officer of the National Mental Health Commission, has also undertaken a national tour as part of the *Connections* project. The Commission visited 26 communities across Australia to hold Town Hall and stakeholder meetings to start a national conversation about the future of mental health and suicide prevention in Australia.

Principles underpinning the advice

The views expressed by those with lived experience and other views expressed by stakeholders, and a review of the evidence and other frameworks has informed the following core principles that directly align with the Adviser's Terms of Reference. The principles provide an interim framework for a comprehensive whole-of-government approach, with a recommendation to develop a new model of suicide prevention for Australia included with the advice.

A coordinated approach

- The shift towards a fully coordinated, whole-of-government approach is essential.

Designed with those with lived experience of suicide

- Co-design and delivery of programs and services in suicide prevention must be done with people who have insight arising from their lived and living experience of suicide, suicidal ideation and suicide attempts.

Builds and supports connected families and communities:

- Effective suicide prevention action must include wellbeing interventions and a focus on social determinants, especially those connected to suicidal behaviour.
- Targeted approaches to suicide prevention are required for groups who are at increased risk of suicide.
- Tailored community-driven approaches to suicide prevention planning and implementation are essential, considering the diversity of Australian communities.

Enables better connected journeys for those vulnerable to and impacted by suicide

- A compassionate and proactive response to those experiencing distress is essential and includes harnessing the range of government and community touchpoints.
- Earlier intervention, care-coordination and follow-up care is required to ensure that individuals and their families get the response they need, when they need it.
- Universal postvention responses and bereavement support for families and others are a critical component of suicide prevention action.

Delivered by a compassionate and skilled workforce

- Suicide prevention action must be built on a comprehensive workforce development strategy, targeting priority front-line services across government and within community.

Enhanced by connected data and evidence

- Suicide prevention planning and implementation must be informed by data and evidence, with national and regional data used to inform policy and practice.

A holistic approach will need to be adopted to focus policy and interventions at all levels in the social ecosystem – the person, their networks, their community and society as a whole.

Initial findings and recommendations

A shift in focus is required

There is a need to “shift the focus” in all areas of suicide prevention to take a broader more proactive and balanced approach.

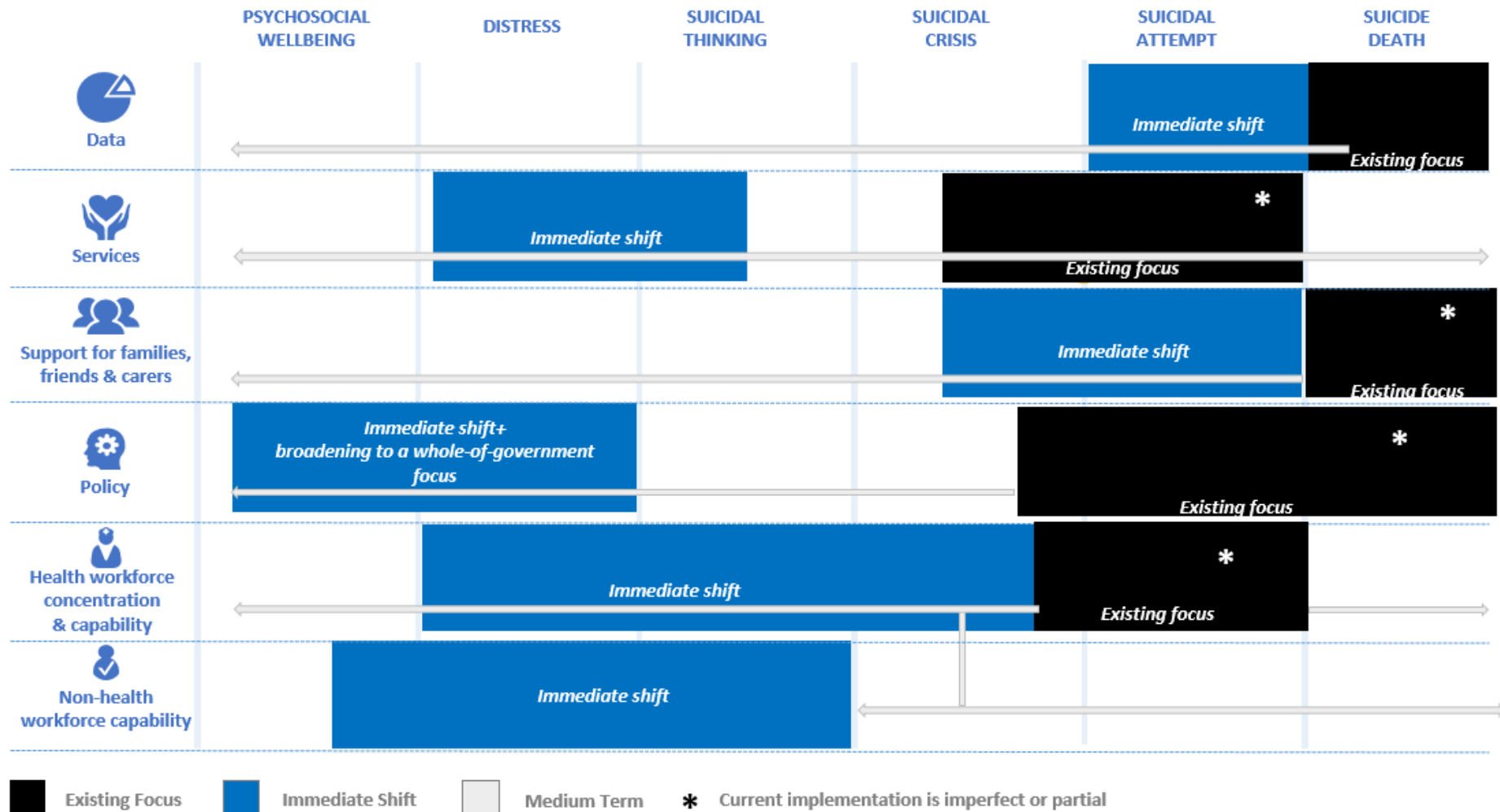
Australia has invested significantly in suicide prevention, but the current approach is best described as reactive and program based, rather than comprehensive and systematic. This is evident when we consider Australia’s current suite of services, supports, workforce and data, all of which tend towards responding to the ‘crisis’ end of the spectrum. For example (and as outlined in Diagram 3):

- **Data and Evidence:** Australia has (and is improving) robust suicide death data but has no continuous national-level data on suicide attempts, suicidal thoughts and associated risk factors. This narrow focus on deaths undermines our ability to plan and implement effective services for people at risk of suicide. Without robust mechanisms for evaluation and research, we are also unable to determine the effectiveness of current programs.
- **Services:** While there are no national expenditure data to allow us to set a dollar figure, it is apparent that current effort and investment is heavily concentrated on services for people in crisis or who have attempted suicide (i.e. crisis lines, health system responses, including emergency departments and aftercare services). It is critical to continue the investment in crisis response, but given there is less infrastructure and investment in responding earlier at the point of distress, or even further back in wellbeing approaches, effort should be applied to establishing services.
- **Families, friends and carers:** While bereavement support and postvention services need enhancement, current approaches to supporting family and friends only occurs after a suicide death. Family and friends play a critical role in supporting those who are in suicidal crisis or who have attempted suicide with almost no service and support offerings.
- **Policy:** While Commonwealth and State policies have suggested that a range of approaches are funded and delivered, the policy has generally been focussed on responding to suicidal behaviour and developed through a health focus. There is a need to broaden the approach and harness opportunities across portfolios to address the factors contributing to distress.
- **Workforce:** Workforce approaches (where they exist) are generally focussed more on the crisis response rather than the full range of knowledge and skills that health and other frontline workforces require.

The present approach does not respond optimally to those in crisis; current efforts are often fragmented and patchy, with access to services often dependent on personal financial resources, support networks, geography, or sheer luck.

Governments at all levels are demonstrating their earnest desire to address this imbalance, through both their strategic documents and the initiatives they are funding. To move to a more effective suicide prevention model, Australia needs to significantly enhance its capacity to deliver compassionate and evidence-based care to those in crisis while also moving towards earlier responses and a focus on wellbeing. This will also require broadening and deepening our data (with an urgent need to collect and report attempts and self-harm data), workforce and community capacity to appropriately identify and respond to people at risk of suicide.

Diagram 3: Current emphasis of suicide prevention effort, with immediate priorities and medium term objectives proposed



Summary of initial findings and recommendations

This section provides a summary of initial themes and key findings of the Adviser and Taskforce from August to November 2019. It is not a comprehensive summary of all suicide prevention efforts in Australia. Initial findings are grouped under six key themes (priority areas) with recommendations to address the complex issues contributing to Australia's suicide rate and find community-led, person-centred solutions.

Priority area 1: Take immediate steps to implement the shift to a whole-of-government suicide prevention approach

- **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.
- **Recommendation 1.2:** The Commonwealth ensure that Gaaya Dhuwi (Proud Spirit) Australia is contractually engaged to deliver an Aboriginal and Torres Strait Islander Suicide Prevention Plan by the end of 2020.
- **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.
- **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.

Priority area 2: Early distress responses using community and government touchpoints

- **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.
- **Recommendation 2.2:** Use government and community systems and services that interact with people at points of vulnerability for policy and service responses.
- **Recommendation 2.3:** Develop a whole-of-government workforce with the required skills to respond to distress and prevent suicide.
- **Recommendation 2.4:** Continue to invest in community-based interventions identified in the Fifth Plan.

Priority area 3: Respond to the specific needs of communities and groups at very high risk

- **Recommendation 3.1:** Provide immediate support to communities impacted by drought and other disasters to respond to distress.
- **Recommendation 3.2:** Consider the value in implementing a multi-component suicide prevention trial focused on Australian Defence Force personnel transitioning from service.
- **Recommendation 3.3:** Hold a policy roundtable to investigate options to address the risk of suicide for children in Out-of-Home Care.

Priority area 4: Enhance the 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.
- **Recommendation 4.2:** Improve, extend and evaluate aftercare approaches.
- **Recommendation 4.3:** Improved care coordination for those accessing multiple services.
- **Recommendation 4.4:** Enhance primary care for people experiencing suicidal distress, including a review of current practice and approaches.
- **Recommendation 4.5:** Work with States and Territory Governments and Primary Health Networks to enhance the capability of those working in alcohol and other drugs to support people at risk of suicide.
- **Recommendation 4.6:** Improved care and support for people with mental illnesses at greater risk of suicide.
- **Recommendation 4.7:** Augment the role of Aboriginal Community Controlled Health Organisations in suicide prevention.

Priority area 5: Support family and friends along the continuum of suicidal behaviour

- **Recommendation 5.1:** Provide psychosocial supports to families and friends supporting a loved one at risk of suicide and following a suicide attempt.
- **Recommendation 5.2:** Extend the reach of postvention and bereavement support and ensure local coordination.
- **Recommendation 5.3:** Build and develop the capacity of the lived experience and peer workforce to help break down stigma and provide person-centred supports.

Priority area 6: Improve data and evidence

- **Recommendation 6.1:** Commonwealth leadership to improve national data sets for suicide, suicide attempts and self-harm.
- **Recommendation 6.2:** Require new Commonwealth contracts to measure outcomes related to suicidal behaviour and redirect research investment towards national suicide prevention priorities.

1. Immediate action is required to shift towards whole-of-government suicide prevention approach.

Summary of recommended actions:

- **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.
- **Recommendation 1.2:** The Commonwealth ensure that Gaaya Dhuwi (Proud Spirit) Australia is contractually engaged to deliver an Aboriginal and Torres Strait Islander Suicide Prevention Plan by the end of 2020.
- **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.
- **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.

In a whole-of-government approach, accountability for working 'towards zero' suicides is shared across multiple portfolios at all levels of government. This means:

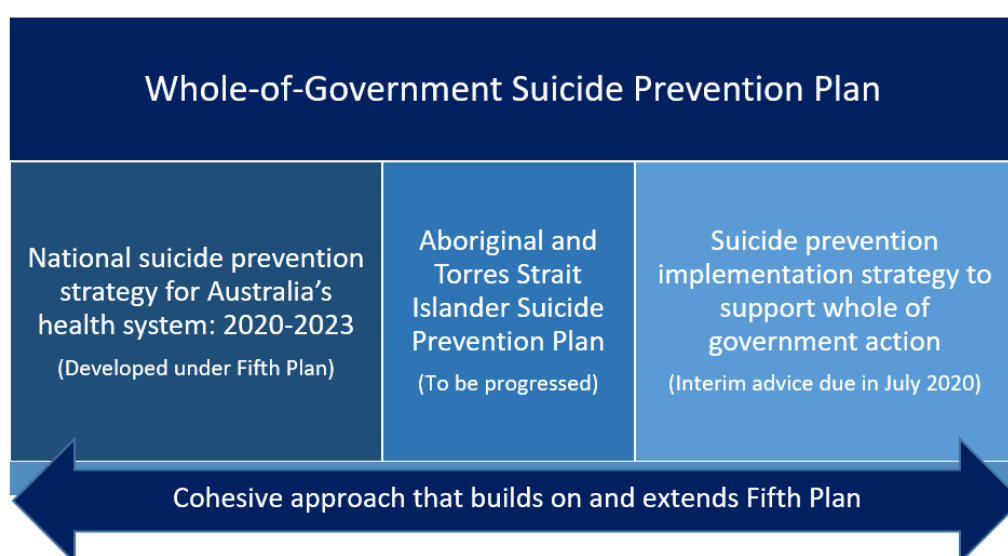
- Driving progress on the agreed actions under the Fifth Plan while a whole-of-government approach is matured.
- Taking a comprehensive approach to ensure that Australia is working towards reducing the onset of suicidal behaviour as well as responding once it emerges.
- Ensuring the right governance and funding architecture is in place to drive the level of coordination and integration required to reduce suicides.

The key objectives of suicide prevention architecture should be to harmonise efforts across portfolios, governments, service delivery organisations and the community to:

- Address social determinants and risk factors that shape wellbeing and suicide risk at both the individual and population level.
- Build the capability of communities, schools, workplaces and other parts of civil society to play a role in suicide prevention.
- Ensure suicide prevention approaches for Aboriginal and Torres Strait Islander people are culturally appropriate and driven through community.
- Provide a proactive response to those experiencing suicidal distress, going to where people are rather than waiting for them to ask for help.
- Improve care coordination, aftercare and postvention responses.
- Empower local decision-making based on improved data and evidence.

While the current architecture espouses these objectives, it cannot deliver upon them for several key reasons:

- Unclear roles and responsibilities between Commonwealth, State and Territory and local governments with respect to suicide.
- Current approach to suicide prevention through a reactionary health systems lens focussed on intervening late, with most non-health portfolios and service providers unclear or unaware of their role in suicide prevention.
- Suicide prevention policy siloed from policies and services acting on the risk and protective factors for suicide.
- Lack of strategic coordination of funding for suicide prevention programs and services (both within and across Governments) and a lack of key enablers (including funding and governance levers) to drive actions aimed at improving coordination.



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.

Under the Fifth Plan, all governments committed to drafting a *National Suicide Prevention Implementation Strategy for Australia's health system: 2020-2023*. The Strategy will be presented to COAG for endorsement in early 2020.

The strategy will provide an anchor point for Commonwealth, State and Territory suicide prevention strategies, and regional and local suicide prevention efforts. The strategy is likely to focus on setting priorities and improving coordination within the current architecture for suicide prevention and is unlikely to propose new options in the design and delivery of suicide prevention.

Appropriate funding must be committed to implementing the Strategy. Key elements that the Commonwealth should consider immediately are included throughout this advice and specifically in Recommendation 4.

Recommendation 1.2: The Commonwealth ensure that Gaaya Dhuwi (Proud Spirit) Australia is contractually engaged to deliver an Aboriginal and Torres Strait Islander Suicide Prevention Plan by the end of 2020.

Given the impact of suicide on Aboriginal and Torres Strait Islander communities, it is important to ensure that approaches to Aboriginal and Torres Strait Islander suicide prevention are fit-for-purpose, culturally safe and self-determined.

In 2013, the Commonwealth Government developed a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in consultation with Aboriginal and Torres Strait Islander people. The Strategy, which complemented the then National Suicide Prevention Strategy, was designed to run for 10 years (to 2023) and was to be supported by targets, guidelines and reportable outcomes. The Strategy was not implemented at the time. Since 2013, the suicide prevention landscape has changed significantly, with the establishment of a devolved commissioning model via Primary Health Networks, current reforms to the primary care funding model for Aboriginal Community-Controlled Health Services, and the development and implementation of the Fifth Plan. The evidence base for Aboriginal and Torres Strait Islander suicide prevention has also been greatly enriched by the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (2016).

Current actions to progress this

The National Suicide Prevention Implementation Strategy developed under the Fifth Plan is likely to recommend that a new *Aboriginal and Torres Strait Islander Suicide Prevention Strategy* be developed. The Adviser supports this recommendation and notes that an Indigenous-specific strategy would complement the Fifth Plan and also support transition towards a whole-of-government approach.

In the 2019-20 Budget, the Government allocated \$4.5 million to support the establishment of a national independent and inclusive Indigenous social and emotional wellbeing, mental health and suicide prevention leadership body: Gayaa Dhuwi (Proud Spirit) Australia. Supported by National Aboriginal and Torres Strait Islander Leadership in Mental Health, Australian Indigenous Psychologists' Association and Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Gayaa Dhuwi (Proud Spirit) Australia would have the expertise and capacity to lead an inclusive development process for an updated Indigenous suicide prevention plan. This plan should build on and update the strategy developed in 2013 to align with the timing of the Fifth Plan and be closely aligned with developing options for a whole-of-government approach.

It is recommended that:

- Gayaa Dhuwi (Proud Spirit) Australia is tasked with updating and finalising a suicide prevention plan for Aboriginal and Torres Strait Islander people by the end of 2020 from within its core \$4.5 million funding from the Commonwealth Government.
- The Commonwealth and States and Territories endorse this plan and jointly arrange funding to support immediate implementation of key components.

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.

More consultation and work is required before recommendations can be made about an overarching funding and governance model for suicide prevention in Australia. This will be a core focus of work for the Adviser and Taskforce in 2020, with options presented in the interim report due in July 2020. The Productivity Commission's recommendations for a broader mental health governance architecture will be considered, as well as the views of other stakeholders.

Development of a Framework to guide whole-of-government planning

While the *LIFE Framework* has been used to guide suicide prevention policy and planning to date, an updated model is now required. During the consultations conducted to date, stakeholders have identified the importance of a fit-for-purpose model for suicide prevention being widely adopted in Australia as the basis for future strategic planning, coordination of effort, program development and priority setting and for the ongoing evaluation and monitoring of performance.

To develop a sound evidence-based Model of Suicide Prevention and the necessary consensus across a range of stakeholders for its adoption, the Adviser will task the Expert Advisory Group with developing a draft model of suicide prevention in consultation with State and Territory Governments, experts, people with lived experience of suicide, clinicians, professionals, social service and community.

Considerations for a whole-of-government architecture for suicide prevention

The Productivity Commission's Draft Report recommends that a new multilateral agreement between the Commonwealth and the State and Territory Governments be progressed (recommendation 22.1); Health Ministers recently agreed to progress this recommendation (COAG Health Council October 2019). Negotiation of a new funding agreement presents an opportunity to clarify roles and responsibilities for suicide prevention and settle national priorities in a coordinated and funded way.

When negotiating a new multilateral agreement with State and Territory governments, there are two possible approaches the Commonwealth could consider (with option 2 as the preferred option, if found feasible).

1. Develop a National Mental Health and Suicide Prevention Agreement between the Commonwealth and States and Territory governments that specifies the roles and responsibilities of each tier of government with respect to particular mental health and suicide prevention services, and agrees the funding arrangements required to support the agreement.
 - This agreement should include the role of alcohol and other drug services and aged care services within its scope (rather than focussing solely on mental health) and should duly consider the role of other portfolios in addressing justice, housing and child protection as priority social and cultural determinants to underpin a whole-of-government response to suicide prevention.

2. Develop a National Suicide Prevention Agreement (separate to a mental health agreement) between the Commonwealth and State and Territory governments which specifies clarifies roles and responsibilities and funding arrangements for suicide prevention and creates a whole-of-government architecture under COAG to drive progress. That would allow for engagement of all relevant portfolios at the COAG level rather than positioning suicide prevention within health.

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.

During the consultations conducted to date, stakeholders have communicated that more needs to be done to enhance the quality of the advice that the Government receives from the Australian Public Service about the impacts that new policy proposals may have on groups vulnerable to suicide. This includes drawing attention to policies or programs which may exacerbate suicide risk and proposing practical mitigations, where possible, to address these risks.

There are two options under consideration for a further recommendation in 2020 to enhance the advice Government receives about the likely impacts of proposed policies on suicide. The first is the addition of a “Suicide Impact Assessment” or “Suicide Risk Statement” to the Cabinet submission template. Consultation with the Department of the Prime Minister and Cabinet indicates that this option may not lead to high-quality outcomes given that policy staff from across the APS are unlikely to have the expertise or data resources required to be able to appropriately identify and assess such risk. The alternative under consideration is to upskill central agency staff with policy responsibility for suicide prevention to recognise policies which may increase suicide risk in vulnerable people and then direct them to harness existing Cabinet briefing processes to provide the Government with advice on the risk and any mitigation strategies. Additional resourcing may be required to cover staff training and data monitoring.

There are a range of current policies, plans, and strategies which touch on suicide or important risk factors for suicide. These do not appear to have been developed with sufficient consultation with those with suicide prevention knowledge, including the Department of Health’s suicide prevention lead area. Relevant current frameworks identified by the Taskforce include: the Youth Strategy; National Drug Strategy and the National Alcohol Strategy; Injury Prevention Strategy; the National Preventive Health Strategy; the Government Response to the Aged Care and Disability Royal Commissions; the next iteration of the National Plan to Reduce Violence Against Women and their Children; and Government responses to a number of recent or current parliamentary inquiries.

As an immediate next step, the Adviser and Taskforce will:

1. Consult with central agencies and the IDC before the interim report is due in July 2020 to investigate feasible options to review new policies for impacts on suicide prevention to support a whole-of-government approach.
2. Work with the Department of the Prime Minister and Cabinet (with input from the Department of Health) to conduct an audit of relevant policies, frameworks, strategies, plans, and government responses currently under development (or likely to be forthcoming) to review immediate and ongoing options to ensure suicide prevention has been appropriately addressed.

2. Early distress responses using community and government touchpoints.

Summary of recommended actions:

- **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.
- **Recommendation 2.2:** Use government and community systems and services that interact with people at points of vulnerability for policy and service responses.
- **Recommendation 2.3:** Develop a whole-of-government workforce with the required skills to respond to distress and prevent suicide.
- **Recommendation 2.4:** Continue to invest in community-based interventions identified in the Fifth Plan.

Community-driven approaches to suicide prevention are at the heart of current government-funded suicide prevention trials as well as long standing work across regional and rural communities. Communities can provide protective factors such as belonging and sense of purpose, can rally around and support people when they experience circumstances that may place them at increased risk of suicide and can be at the frontline of identifying and supporting people experiencing suicidality. Communities can be geographical, but they can also be cultural, interests-based (sports clubs, arts organisations, advocacy groups), virtual (online), or based around formal institutions like schools, universities and workplaces. It is probable that community-driven approaches will look different in rural and remote regions as compared to urban regions.

There are periods in life that may be inherently stressful due to the disruption they create to a person's identity or support networks. These transitions may include progressing from primary to secondary to post-school education or the workforce, changing employment or employment status (including retirement), becoming a parent, experiencing a family breakdown, loss and grief. Government services often engage with people at these life-cycle transition points and research has indicated that applying a 'transitions' frame may be a useful mechanism to guide policy approaches to target people at points of vulnerability. There are many touchpoints across all government portfolios, including services and support as well as regulatory or funding levers. Service touchpoints may be large systems that many Australians would be familiar with (e.g. the income support and payment systems or the taxation system) or discrete services targeted at smaller cohorts (e.g. members of the business community; serving, reserve or ex-serving defence personnel; rural communities etc.). All have a role to play in supporting a comprehensive whole-of-government approach to suicide prevention in Australia.

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.

Evidence indicates that multi-component approaches may be the most effective way of reducing the rate of suicide and suicide attempts given the many factors that contribute to suicide. These approaches generally combine preventive interventions ranging from those that target individuals (e.g. people who are at risk of suicide) or personnel (e.g. workers who support those in suicidal crisis) to those that apply to the wider community (e.g. increasing awareness and knowledge of suicide and reducing access to means of suicide). There has been significant investment from the Commonwealth and other funders in implementing a community-driven systems based approach.

Thirty suicide prevention trial sites are being funded across the country, by Commonwealth, States and Territories, NGOs and philanthropic means. Each trial site uses, and is therefore seeking to evaluate, a multi-component approach. Twelve of these trials are funded until June 2020 by the Commonwealth government through 11 PHNs, with evaluation due by the end of 2020 or later. These community-driven approaches vary in design, leadership, service commissioning, the degree to which they follow a prescribed 'framework' and the degree to which they are community led.

There is no consistent or coordinated approach to the evaluation of all current trials. As a consequence, the evaluations are unlikely to determine the mandatory components of a multi-modal system or inform the development of indicators that will underpin effective community engagements and responses.

It is recommended that the Commonwealth:

1. Ensure resources are provided to extend the National Suicide Prevention Trials, until the outcomes of the evaluation are complete, to manage community expectations and ensure continuity of action.
2. Coordinate and enhance the evaluation of the 30 suicide prevention trials operating across the country. This review would seek to translate evaluation findings to extract the greatest amount of information from across all trial sites to identify effective suicide prevention strategies. The review would:
 - identify opportunities for enhanced outcomes and address any omissions;
 - assess what data can be extrapolated across sites and which components are mandatory for success;
 - assess what level of systems integration is needed to support multi-modal interventions; and
 - identify what indicators can be used to predict which interventions may be successful.

Recommendation 2.2: Use government and community systems and services that interact with people at points of vulnerability for policy and service responses.

Background research and consultations, including workshops at the *Towards Zero Suicide Prevention Forum: Opportunities for a coordinated response*, identified a range of ways to identify and meet people at points of vulnerability. A two-pronged approach is required: firstly to facilitate a proactive response to distress; and secondly, to identify policy levers that may reduce distress in the future. Further exploring cross-portfolio opportunities will be a key focus of work in 2020. Some of the opportunities include (but are not limited to):

- Mapping the journey of men through government agencies at points of vulnerability. This includes identifying levers within the family law court, mediation providers and financial counsellors to implement proactive brief distress interventions and possibly peer-based support within the system/s for men experiencing a relationship breakdown and/or child custody matters. This work would be enhanced through engaging with men about their lived experience of suicidality and their interaction with government agencies, with options to host a forum or roundtable in 2020.
- Identifying and harnessing the policy levers and service systems that interact with people who are transitioning out of employment (redundancy; dismissal; retirement), or experiencing business stress including bankruptcy (for business owners).
- Identifying opportunities to proactively support those transitioning into and out of the justice system, including youth detention. Opportunities for scalable delivery of treatment for comorbid alcohol, substance use and mental ill-health should be explored and other evidence-based options to reduce suicidal behaviour in this cohort.
- Investigating the experiences of LGBTIQ+ people interacting with a range of government and health and community services at points of vulnerability, especially where discrimination is experienced.
- Investigating the scalability of evidence-based school programs that target children and young people, or other places where young people connect (sporting clubs, drama groups). International models have been explored that could be considered.
- Investigating peer-led models of suicide prevention integrated into workplaces, communities, or government service systems, especially focussed on young people, LGBTIQ+ people and men (including older men).

Recommendation 2.3: Develop a whole-of-government workforce with the required skills to respond to distress and prevent suicide.

Creating better connected journeys will not just depend on identifying and addressing services gaps and duplications or enhanced service integration. The cornerstone of integration will be ensuring we have workforces that recognise suicide prevention as a key component of their work. The workforce will require the necessary skills and resources to identify and support people at risk of suicide and support people in distress. These workforces are not limited to the mental health, or even the broader health sector; rather, they are the frontline staff that interact with Australians across a variety of Government and non-Government services.

The Productivity Commission's draft report offers findings on Australia's mental health workforce, particularly the need for more mental health nurses, peer workers and psychologists. The Productivity Commission also touched on the need to improve the confidence and capability of general practitioners with respect to mental health more broadly.

Work has commenced at a whole-of-government level through the Suicide Prevention Interdepartmental Committee to identify priority Commonwealth Government suicide prevention touchpoints and the current suicide prevention capability of their staff. The Commonwealth Government services that people who are vulnerable to suicide are likely to be in contact with include:

- Centrelink / Income Support (including mutual obligation compliance and contracted income management and debt recovery service providers);
- Indigenous Services including Night Patrol and the Remote School Attendance Strategy;
- Unemployment Services (JobActive, Disability Employment Services, and the Community Development Program);
- Employment dispute services (Fair Work Commission and Fair Work Ombudsman)
- Australian Taxation Office;
- Business-oriented programs and services, including business.gov.au, the Small and Family Business Ombudsman and support to rural industries;
- NDIA and non-NDIS disability services;
- Family Court of Australia;
- Commonwealth funded aged care and alcohol and drug services; and
- Tertiary education institutions.

This work will also include relevant policy and regulatory touchpoints, including the role of improved transport, building and urban planning in reducing access to means of suicide. It will be complemented by a suicide prevention training audit conducted by the Taskforce, which will inform recommendations about which training which workforces should undertake.

While this work is progressed, it is recommended that:

- The Commonwealth consider funding and leading the development of pre-service training options for relevant workforces. Training in suicide prevention for relevant professions is highlighted in the Fifth Plan but unlikely to progress without Commonwealth leadership. It needs to take a curriculum approach, rather than optional gatekeeper training options which have become more common.

Recommendation 2.4: Continue to invest in community-based interventions identified in the Fifth Plan.

Within the Fifth Plan, continued investment and implementation of well-evaluated public health campaigns, safe communication programs, community connector training and workplace initiatives have been prioritised in addition to investments in other community based networks and programs. These interventions are an important part of a system-based or multi-modal approach to suicide prevention and should continue to form part of the national approach. Some key points raised through investigations to date for further consideration include:

- Ensuring ongoing mechanisms to train and support those with lived experience to be part of community suicide prevention approaches, including public speaking, media, campaigns and training.
- Ensuring any funded campaigns or communication programs are guided by lived experience, are built from and build on the evidence base, have the capacity to empower people to take actions (with options for local implementation) and are well connected to service responses for those in need.
- Community connector training (gatekeeper training) has the capacity to build knowledge and skills, with a range of programs available in Australia. Consideration should be given to funding mechanisms for this work as connector training is funded nationally by the Commonwealth, by States and Territories, by PHNs and by local governments, sometimes simultaneously in the same region.
- Workplaces provide an important setting for suicide prevention, especially in male dominated and disconnected industries. Consideration could be given to higher risk workforces (such as doctors, veterinarians, transport, construction and mining, and agriculture and fisheries) and the emerging evidence suggesting an increase in distress among small business owners.
 - It is recommended that the National Mental Health Commission include in the National Workplace Initiative guidance for Australian workplaces on appropriate suicide prevention strategies.

3. Respond to the specific needs of communities and groups at very high risk.

Summary of recommended actions:

- **Recommendation 3.1:** Provide immediate support to communities impacted by drought and other disasters to respond to distress.
- **Recommendation 3.2:** Consider the value in implementing a multi-component suicide prevention trial focused on Australian Defence Force personnel transitioning from service.
- **Recommendation 3.3:** Hold a policy roundtable to investigate options to address the risk of suicide for children in Out-of-Home Care.

Recommendation 3.1: Provide immediate support to communities impacted by drought and other disasters to respond to distress.

Suicide risk is an ongoing concern for people impacted by adverse events, such as droughts and natural disaster, with elevated attempted suicides and suicide deaths being recorded in both the short and longer term. Immediate distress responses and activities that build the medium to longer-term resilience and capacity of families and communities is vital to addressing these suicide risks and supporting communities to recover.

It is recommended that:

- the Commonwealth commit immediate investment to support localised responses that assist all people in distress early following adverse community-wide events and support community-led activities that build resilience for people in drought and fire affected communities. Activities should:
 - be easily accessible (i.e. be mindful of cost, transport, telecommunication challenges, and burden as barriers to entry);
 - respond proactively and quickly to people impacted by adverse events and have a workforce that can identify people who may be suicidal;
 - assertively engage and follow-up individuals and families;
 - address a wide range of social needs from a problem-solving approach, including but not limited to brief mental health interventions; support for families and communities; and
 - be integrated into the Commonwealth's disaster response and community resilience programs and leverage the role of existing services.

Recommendation 3.2: Consider the value in implementing a multi-component suicide prevention trial focused on Australian Defence Force personnel transitioning from service

There is a growing body of evidence pointing to the effectiveness of multi-sectoral and whole-of-community approaches to suicide prevention, with 12 national trial sites (and 18 additional sites) currently funded in Australia to test different approaches with diverse communities.²⁶ One of the Commonwealth trial sites (Townsville) is targeting veterans in a community context. The Department of Veterans' Affairs is also running the Veterans' Suicide Prevention Pilot, which is evaluating the benefits of an aftercare service to support veterans following a suicide attempt. This pilot is due for evaluation by June 2021.

To better understand how a multi-component approach can be applied to this cohort, the Commonwealth Department of Defence should lead the establishment of a new trial focussed on Australian Defence Force (ADF) cohorts transitioning to civilian life. Such a trial may provide additional information about how the protective nature of the defence force service can be maintained through the transition process and beyond.

It is recommended that:

- the Commonwealth consider making resources available in 2020 to plan and commence implementation of a suicide prevention trial focused on ADF personnel transitioning from service to civilian life.
- The Commonwealth considers resources for a complementary piece of work to engage with serving and former ADF personnel who have expressed suicide ideation, experienced suicidal distress and / or engaged in suicide attempts (both during and after ADF service) and families and carers (including those who have lost people to suicide).

Recommendation 3.3: Hold a policy roundtable to investigate options to address the risk of suicide for children in Out-of-Home Care.

Early adverse childhood experiences, such as physical and sexual abuse and parental neglect, are risk factors for suicidal behaviour in childhood and adolescence.²⁷ Research has also found that adolescents who are sexually or physically abused in childhood are two to five times more likely to attempt suicide than those who do not have such experiences.²⁸ Children who have had contact with the child protection system are also at an increased risk of dying by suicide because, as a population, they are more likely to present with the risk factors associated with suicide.²⁹ Recent reviews have identified that a significant number of young people in the Out of Home Care system have died by suicide, and those transitioning to independent living may also experience points of vulnerability during the transition. The disproportionate number of Indigenous children in out of home care is of particular concern, given the high rates of suicide in Indigenous communities. The factors contributing to suicide in these children and young people is likely to be complex, but immediate steps should be taken to better understand the opportunities to turn these startling figures around.

The Adviser intends to consult with the National Children's Commissioner, Aboriginal and Torres Strait Island Social Justice Commissioner, State Commissioner, Guardians and Ombudsmen in 2020 to lead a policy discussion focussed on prevention of suicide.

4. Enhanced health response to suicidal distress.

Summary of recommended actions:

- **Recommendation 4.1:** Accelerate alternatives to emergency departments to ensure people are not required to go through the “wrong door” to access services.
- **Recommendation 4.2:** Improve, extend and evaluate aftercare approaches.
- **Recommendation 4.3:** Improved care coordination for those accessing multiple services.
- **Recommendation 4.4:** Enhance primary care for people experiencing suicidal distress, including a review of current practice and approaches.
- **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.
- **Recommendation 4.6:** Improved care and support for people with mental illnesses at greater risk of suicide.
- **Recommendation 4.7:** Enhance the role of Aboriginal Community Controlled Health Organisations in suicide prevention.

Accessible, evidence-informed and coordinated care options for people in suicidal distress are limited or missing from Australia’s suicide prevention system.

Australians do not know where to go when they need support. Even when they find an entry point, they may still experience significant difficulties in patching together a connected and logical care plan from multiple services that are often unable to coordinate.

The current system does not adequately incentivise or facilitate care coordination or seamless transitions, leaving vulnerable people and their loved ones to advocate and navigate complex, disjointed care systems.

Moving to a distress-focused, early-intervention approach with appropriate care coordination and follow-up care would better meet the needs of individuals and their families. Services need to be available earlier through assertive outreach, engaging a mix of clinical, non-clinical and peer-based workforces, be culturally safe, and appropriate for the age, gender and broader diversity of the Australian population.

More work is required to determine practical steps that can be taken to implement such an approach to care and will be a focus for the advice in 2020. There are, however, some more immediate actions that could be taken to enhance cultural safety and integration with alcohol and drug services and build a foundation for future enhancements.

Recommendation 4.1: Accelerate to emergency departments to ensure people are not required to go through the “wrong door” to access services.

Many people in suicidal distress present to emergency departments across Australia. Evidence demonstrates that emergency departments are improper sites for supporting people in suicidal distress. The sensory environment exacerbates psychological distress and the workforce and pace of service delivery are often ill-equipped to provide clients with compassionate responses and critical

interventions such as safety planning, counselling, and care coordination. Lived experience stakeholders concur, expressing that emergency departments are the “wrong door” for caring and compassionate responses.

The Fifth Plan acknowledges the need for alternatives to emergency departments but there has been slow progress in systematically implementing Australian models with sufficient resourcing and evidence to support broad rollout. Some efforts have been made at the national, State and local level to develop alternatives to emergency departments. Some examples include the adult mental health hubs being funded by the Commonwealth government, safe spaces staffed by mental health clinicians and lived experience peer support workers, a residential recovery centres project trialling 24-7 peer-led support, and care for people experiencing a suicide-related crisis in a homelike environment, and the ACT’s Acute Response and Intensive Home Treatment service which is focused on providing brief interventions in a person’s home or other community environment

Such initiatives are promising, but also need to be evaluated using shared measures to compare models for client outcomes, cost-effectiveness as well as monitor and appropriate standards of safety and quality.

It is recommended that:

- Evidence to guide the development and evaluation of these models be developed as an immediate priority to ensure the current investments have strong foundations for a broader rollout.
- Alternatives to emergency departments be considered as a research priority for investment under the Suicide Prevention Research Fund (see Recommendation 5.2).

Recommendation 4.2: Improve, extend and evaluate aftercare approaches.

The Productivity Commission is testing firm recommendations about aftercare, including that aftercare be mandatory for all people presenting to hospitals, emergency services and General Practitioners (GPs) in suicidal distress and/or with injuries resulting from suicide attempts. This is in line with views of people with lived experience and other stakeholders.

Aftercare is an important investment; however, our current understanding of the efficacy of aftercare models is undermined by a lack of consistency and implementation fidelity in the initiatives being funded, the varying levels of support provided, and a lack of coordination across evaluation activities. It is also unclear whether current models are effective for some target cohorts, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people with complex vulnerabilities (including family relationship difficulties and homelessness).

It is clear that for aftercare to work properly, emergency departments, emergency services, outpatient and community mental health services, and general practitioners need to recognise the importance of intensive aftercare support and embed this into discharge practices and care approaches. There is also a role for allied health and non-health services.

The Adviser supports the Productivity Commission’s recommendation that aftercare be universally provided, including when people present to emergency services and GP settings, noting that any universal aftercare approach should ensure that people receive the intensity and types of services they require to recover.

It is recommended that:

- Aftercare is listed as a national research priority (see section 6 below) with options to have independent researchers conduct a multi-program evaluation to compare all current model and trials for client outcomes.
 - The evaluation should focus on forming recommendations for best-practice, including baseline operational service and system integration requirements, standardised indicators and performance benchmarks, and approaches to determining the level of support required. Non-Emergency Department presentations should be included in scope. This should be done irrespective of any evaluations being conducted on individual models.

Recommendation 4.3: Improved care coordination for those accessing multiple services.

The difficulty of navigating existing supports and systems for people experiencing suicidal behaviours is an issue which the community, experts and previous reports have repeatedly raised, requiring remedy. The capacity of people to navigate the various health and non-health system supports they require can be improved through various means, but given the vulnerability of the people in suicidal distress there is also a need for care coordination to be available to people in distress, particularly where they are experiencing multiple complex issues in their lives or healthcare.

There are many models of care coordination and sites in which such services could be embedded, but for suicide prevention these will need to work across settings and systems. The Adviser and Taskforce will further explore models to provide recommendations with due consideration of the outcomes emerging from the National Suicide Prevention Trial, Link-me, and other services and pilots that have tested how to best offer care coordination for people experiencing suicidal distress, as well as building on the work of the care coordination working group under the Mental Health Principal Committee.

Recommendation 4.4: Enhance primary care for people experiencing suicidal distress, including a review of current practice and approaches.

Suicide is not only a mental health issue; many people in suicidal distress may not fit the criteria for mental illness and may be better understood as reacting with intense distress to life events. In these cases, treatment by a mental health specialist may not be needed or appropriate.

Many people in suicidal distress do not use mental health services. A systematic review of international studies (including some Australian data), found that in the three months prior to suicide, about 41 per cent of people accessed primary healthcare, and 35 per cent accessed mental healthcare.³⁰ In Australia, just 10 per cent of Aboriginal and Torres Strait Islander people and 26 per cent of non-Indigenous people were in contact with mental health services in the three months prior to suicide.³¹

However, some of these people may be in contact with the primary care practitioners either for assistance in managing these issues, or for unrelated physical health care. In these cases, GPs and other primary care practitioners may be well placed to identify and provide early assistance to people in suicidal distress, either through their own care or through coordinating care with other clinical and non-clinical suicide prevention and intervention measures.

To ensure that more people in suicidal distress receive appropriate, person-centred and timely care, we need to harness the trusted relationships that many Australians have with GPs, pharmacists and other primary health care professionals.

Feedback from stakeholders (in particular those with lived experience) demonstrates that many people are receiving a purely medical (or even narrowly pharmacological, antidepressants for example) intervention without psychosocial or care responses.

Improving the capacity of primary care practitioners to undertake or coordinate appropriate and compassionate responses to suicidal distress that make use of clinical, non-clinical and peer workforces requires more time. The following initial actions can be progressed by the Commonwealth Government within current resources:

- Analyse prescribing and Medical Benefits Schedule (MBS) service use data to ascertain whether people in suicidal distress are being treated according to a best-practice model of care. If appropriate following the analysis, call for a utilisation review of antidepressants.
- Work with primary care practitioners, including pharmacists, on opportunities to better identify people in suicidal distress and enhance care coordination.

Recommendation 4.5: Work with States, Territories and PHNs to enhance the capability of those working in alcohol and other drugs to support people at risk of suicide.

The connection between alcohol and substance misuse and suicide is complex. Alcohol and substance misuse are leading risk factors for suicide, with suicide ranking as the leading cause of death among people who misuse drugs and alcohol. Alcohol use was responsible for 5.1 per cent of the total burden of disease and injury in Australia in 2011, with 23 per cent of this burden due to suicide and self-inflicted injuries.

There are opportunities to identify and support people at risk of, or experiencing, suicidal behaviours and alcohol and drug misuse by referral to alcohol and drug services where appropriate, and by supporting this workforce to undertake contemporary risk mitigation and safety planning training. State and Territory governments have primary responsibility for alcohol and other drug (AOD) treatment services, however the Commonwealth has a national leadership role, which needs to be used to progress immediate action on this issue which has been prioritised under the Fifth Plan. The Commonwealth also directly funds alcohol and other drug treatment services with a national and state-wide intake, and provides funding to PHNs to commission drug and alcohol treatment services to meet local need. This position needs to be leveraged.

The Taskforce will review current AOD programs and services, including national helplines, for their inclusion of suicide prevention content, and provide recommendations on what is needed to enhance, augment or consolidate these programs and services in the Adviser's July 2020 report.

In the meantime, it is recommended that:

- The Commonwealth and the States and Territories prioritise the relevant actions likely to be included in the National Suicide Prevention Implementation Strategy due for release in 2020.

Recommendation 4.6: Improved care and support for people with mental illnesses at greater risk of suicide.

Mental health and primary care services interact frequently with people who are at greater risk of suicide. Those living with mental illness are at increased risk of suicide, and many are in contact with primary care or mental health services. In addition, people who present with self-harming behaviour (regardless of suicidal intent at the time) are at increased risk of suicide. For mental illnesses where self-harming behaviour is a feature of the illness (Borderline Personality Disorder) the risk of suicide is 45 times greater than the general population.

It is recommended that hospitals, health services, AOD services and primary care providers should take self-harm seriously and ensure that every person presenting with self-harm undergoes a thorough, collaborative, psychosocial assessment, and include motivations for the behaviour and any current or past diagnosis of mental illness. Evidence based interventions (that are culturally and age appropriate) should be provided with inclusion of families and carers where possible.

Recommendation 4.7: Augment the role of Aboriginal Community Controlled Health Organisations in suicide prevention.

Aboriginal and Torres Strait Islander people, as well as the Productivity Commission, have been consistent in expressing the importance of engaging Indigenous controlled and operated organisations to deliver services to Aboriginal and Torres Strait Islander people. This may require resources and funding arrangements that will support organisational and workforce capacity-building. The Adviser will consult with the National Aboriginal Community-Controlled Health Organisation in early 2020 to understand, and therefore advise on, the role of the Aboriginal Community Controlled Health Organisations (ACCHOs) in suicide prevention and immediate next steps to build capability.

While work is undertaken on a new suicide prevention plan for Aboriginal and Torres Strait Islander people (Recommendation 1.2), it is recommended that the following initial actions be progressed within current resourcing:

- The Department of Health to ensure all Primary Health Networks are commissioning services in accordance with *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for Primary Health Networks*.
- The Department of Health demonstrates a commitment to cultural safety and transparency by working with PHNs and ACCHOs to better understand and record current commissioning of Aboriginal and Torres Strait Islander suicide prevention services.
- PHN boards be required to have Aboriginal and Torres Strait Islander representation.
- The proposed evaluation of all suicide prevention trials (see Recommendation 2.2) includes an evaluation of ACCHO-led planning and service delivery.

5. Support family and friends along the continuum of suicidal behaviour.

Summary of recommended actions:

- **Recommendation 5.1:** Provide psychosocial supports to families and friends supporting a loved one at risk of suicide and following a suicide attempt.
- **Recommendation 5.2:** Extend the reach of postvention and bereavement support and ensure local coordination.
- **Recommendation 5.3:** Build the lived experience and peer workforce to help break down stigma and provide person-centred supports.

Recommendation 5.1: Provide psychosocial supports to families and friends supporting a loved one at risk of suicide and following a suicide attempt.

Families, friends and carers are the unpaid workforce of the suicide prevention sector in Australia. With 78,000 people attempting suicide each year and a further 300,000 having thoughts of suicide, service navigation, psychosocial and emotional support often falls to families and friends. While there are some current investments in aftercare services, these are only available in limited locations. This limitation means that families and friends are required to provide care coordination, despite frequently lacking the expertise, resources and support to do so.

Australian research undertaken in 2019 with 758 people providing care to a family member or friend post a suicide attempt, found that 65 per cent did not receive any information about how to care for their loved one from the treating health professional and only 18 per cent felt supported to provide care.³² Many sought information online, from support groups and/or their own psychological supports. As outlined in the Fifth Plan, there is an opportunity for governments to work together to develop a co-designed online support package to build the capability and confidence of families and friends to help a loved one recover following a suicide attempt.

Given the current gap in service supports, the Commonwealth should provide funding to accelerate the timeframe, and consider family support integration with existing programs like the Way Back Support Service and more broadly. This work would include a range of small-scale projects and research trials which could inform the approach:

- Everymind has written and conducted a small-scale pilot of a psychoeducation and support for families and carers to complement the Way Back Service. A grant under the Suicide Prevention Research Fund will allow this work to be translated for online delivery and trial in 2020.
- SANE Australia is conducting research to develop a booklet for families and friends following a suicide attempt, in addition to the resource booklet Beyond Blue has developed.
- Roses in the Ocean and Beyond Blue are collaborating to trial a peer-led family trial connected to the way Back Service in Queensland;
- Some carer services and NGOs provide counselling and other supports to carers.

As suggested in the Productivity Commission Draft Report, an MBS item number for families and carers should also be considered, as well as assertive outreach options using teleweb providers.

Recommendation 5.2: Extend the reach of postvention and bereavement support and ensure local coordination.

The statistics show that for each person lost to suicide, 135 may be exposed with research showing that losing a friend or family member to suicide increases a person's own suicide risk, as well as their risk of anxiety and depression. Postvention and bereavement support in Australia is significant but still patchy and not always well coordinated.

The Commonwealth is the major funder of postvention bereavement support services. There are also a range of smaller providers and services and local community networks that provide bereavement support groups, and education plays a lead role in some State school responses. In NSW and ACT there are also social workers connected to the Coroner's Courts providing outreach to all families.

Coordination of services is a challenge at the local level, especially when national providers are relying on State systems to provide an alert. Postvention services tend to operate in regional and rural areas, leaving many urban centres without the option of a service. The South Australian (SA) Government has recently taken action to address the integration gap between postvention services and its suicide notification systems, with the SA Coroner's Office signing a Memorandum of Understanding with Commonwealth and State funded postvention services to ensure universal response in SA.

The following recommendations, aligned with suggestions under the Fifth Plan, should be adopted:

- Review funding arrangements and undertake joint planning to increase coverage across Australia.
- Examine and advise on the pros and cons of the SA model of notification from the Coroner's Court for wider application.
- Work with States and Territories to monitor data to enable a response to an emerging cluster.
- Developing protocols and models for postvention bereavement which can be incorporated into other workplace programs and assertively promote such inclusion.

Recommendation 5.3: Build and develop the capacity of the lived experience and peer workforce to help break down stigma and provide person-centred supports.

People with lived experience of suicidal behaviour who are trained and supported have an important role in suicide prevention. This includes reducing stigma and discrimination by sharing their experiences, program design and delivery and delivering peer-supported or peer-led programs. The evidence for peer delivered programs is strengthening, although it is more limited in suicide prevention. As reported by Roses in the Ocean, what is required is best practice guidance on supporting people with a lived experience of suicidal behaviour, integration with other workforces and research to build the evidence.

It is recommended that the suicide peer workforce be included as an integral part of the National Mental Health Workforce Strategy currently being developed. The Taskforce will review other relevant workforce development strategies across Government and include recommendations on enhancing the competency of the non-mental health workforce in responding to suicide and suicidal behaviours.

6. Improve data and evidence.

Summary of recommended actions:

- **Recommendation 6.1:** Commonwealth leadership to improve national data sets for suicide, suicide attempts and self-harm.
- **Recommendation 6.2:** Require new Commonwealth contracts to measure outcomes related to suicidal behaviour and redirect research investment towards national suicide prevention priorities.

Data and evidence are the bedrock enablers of a whole-of-government approach to suicide prevention. They improve our understanding about the prevalence of risks factors for suicidal thinking, suicide attempts and suicide deaths and inform policy and service design and delivery.

Recent years have seen improvements to data quality, promising investments into investigator-led research, and funding committed for a nationally integrated suicide and self-harm information system. However, challenges remain to achieving a comprehensive and timely operational data system that can be used to inform national and regional responses. Similarly, there are continuing gaps in connecting evaluation and research expertise to current investments in suicide prevention.

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

All States and Territories collect suicide data through their coronial processes; this data forms the basis of national data sources like the National Coronial Information System and suicide data and reports prepared by the Australian Institute of Health and Welfare (AIHW) and the ABS. To improve data quality and allow monitoring of probable suicide deaths, several States have established suicide registries (e.g. Queensland, Victoria, Tasmania) with others progressing towards a registry (e.g. NSW and NT).

This is a promising development; however, what is needed is a nationally-integrated suicide, suicide attempt and self-harm information system, as per the 2019-20 Budget measure: *National Suicide Information Initiative*. For the Initiative to achieve its vision, State and Territory cooperation is required to resolve significant issues with the quality, availability, consistency and timeliness of data.

Establishing a National Minimum Dataset (NMD) for suicide registers would ensure data from the various registers are comparable and reflect best practice. In conjunction with other national data projects, an NMD would also provide an opportunity to address existing data limitations such as Aboriginal and Torres Strait Islander identification and sexuality and gender identification.

We must prioritise data sets relating to suicide attempts, self-harm and associated risk factors. With an estimated 78,000 people making a suicide attempt each year, but with no national standard on the way emergency departments collect data on suicide attempts and self-injury there is a critical gap in the data. The coding of ambulance data, currently completed by Turning Point, is a critical data piece but it is not yet universally available.

Collecting data on attempts could facilitate (or enhance existing) alerts for cross-portfolio action (e.g. Department of Social Services or Veterans) and will enable more significant engagement with and learnings from those with a lived experience.

The AIHW is working with data custodians to address these issues, including consistent and improved data coding practices for self-harm across hospitals and emergency services and enhanced data richness. However, it may take several years to get national agreement and for the new coding practices to be implemented.

To ensure timely progression on data improvements, it is recommended that:

- The Commonwealth seek commitment from State and Territory government, at a First Minister level, to establishing a jurisdictional suicide register (based on the Victorian Suicide Register) by 2022, and earlier where feasible to ensure the objectives of National Suicide Information Initiative can be realised.
 - States and Territories work with the AIHW to agree on a minimum data set, including suicide attempt data, to complement the data collected by State registries which can be aggregated into the National Suicide Information Initiative, hosted by the AIHW.
 - That Commonwealth funding be made available to support States and Territories to establish these registries within this timeframe. Funding should be conditional on States matching the Commonwealth's investment and an enduring commitment that the data will be available to participant jurisdictions.

The Adviser and Taskforce will continue to have immediate input into suicide-attempt and self-harm questions to be added to the Intergenerational Survey on Mental Health and Wellbeing (in progress). The Adviser and Taskforce will continue to work with Commonwealth agencies to enhance our understanding of suicide risk at a regional level through data linkage projects and mapping exercises.

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

There have been investments in suicide prevention research, with \$12 million allocated for a National Suicide Prevention Research Fund and \$8 million allocated to suicide prevention research under the Million Minds Mission, but there is scope to refocus some of this research to expand the evidence base for current programs and priorities.

Targeting and coordination of suicide prevention research and program evaluation is required to enable rapid translation of evidence into practice and to test effectiveness of current approaches. Programs and services are often funded without robust outcomes evaluation built into design and contracts. Where evaluations exist, they tend to focus on implementation milestones and outputs rather than outcome measures. This limits the capacity to determine the efficacy of approaches or whether the investment represents value-for-money.

The Commonwealth should take action to better harness research and evaluation expertise through developing an outcomes framework for key suicide prevention programs. The Suicide Prevention Research Fund could be utilised to support funded organisations.

The Adviser will work with stakeholders to develop a set of immediate research priorities for Australia for the next three years.

It is recommended that:

1. The Commonwealth, with the States and Territories action the development of an outcomes framework for suicide prevention programs, to be completed in 2020 to inform funding contracts from 2021.
2. The Commonwealth Government provide a further three years of funding to the Suicide Prevention Research Fund (managed by Suicide Prevention Australia), but recommend that the fund shift focus to prioritise:
 - Commissioned research for identified priority areas and large multi-site evaluations.
 - Embedding career researchers within funded programs and services. This will simultaneously support research careers in suicide prevention and support the goal of improving the evidence base for suicide prevention investments.

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