



Connected & Compassionate

Implementing a national
whole of governments approach
to suicide prevention



Australian Government

December 2020



Foreword

Every death by suicide is a tragedy because it is the loss of a person for whom the reasons for living have been outweighed by a desire to end the pain and isolation they are experiencing. Each suicide attempt and experience of suicidal distress also comes with significant impacts for the individual and those who care about them. Suicide prevention is a priority for all of us.

I am pleased as National Suicide Prevention Adviser to provide this *Final Advice* and Recommendations, building on earlier reports and drawing on the contributions of the National Suicide Prevention Taskforce, the Expert Advisory Group, Commonwealth agencies, State and Territory governments, and the suicide prevention sector. It is also based on and includes the results of research and consultation activities that have engaged with thousands of Australians who have generously shared their experiences.

A key component has been working with Gayaa Dhuwi (Proud Spirit) Australia as they have led the development of an Indigenous Suicide Prevention Strategy that accelerates the approaches to suicide prevention for Aboriginal and Torres Strait Islander individuals and communities.

A change in outlook on suicide prevention is needed. Most importantly, our efforts must be informed by the insights offered by those who best understand the nature of suicidal distress and what will help to reduce its occurrence - those people, families and communities who themselves have lived with, and through, suicidal distress, suicide attempts and suicide deaths have expertise that we need to use. It is the knowledge of those with lived experience that must guide strategy, action and service provision to ensure a response that puts their needs at the forefront.

A shift in orientation on suicide prevention is also required. Those who experience suicidal behaviours can frequently identify things in their lives that influenced the progression in their despair. The opportunity is to go to where people are and respond much earlier to their distress. This means embedding support in the settings where people live, work, learn and interact. It also means using the levers of government and partnerships with other agencies to address the social and economic drivers of distress that are often deeply rooted in the social determinants of mental health and wellbeing.

In making this shift, we must not overlook the importance of health and mental health services.

Many people going through a suicidal crisis have contact with health services, but often report that their experiences do not meet their needs. Work on mental health service improvements for suicide prevention is underway, but there is a need to complement this with a focus on early distress interventions to prevent the escalation into suicidal crisis. Improved linkages to other services will also ensure we are able to support the whole person in the context of their lives.

Accordingly, suicide prevention must become broader and more connected across all functions of government – a whole of governments approach together with contributions from and through workplaces, schools, social networks, families and communities. We need to identify stressors across employment, finances, relationships, social connection, schools and education, and justice systems.

Governments can do much for suicide prevention. There is the potential at every level and across each portfolio to identify aspects of suicide prevention that relate to existing responsibilities. There are improvements that can be made to better equip the workforces involved in the delivery of services. Governments, however, cannot and should not do everything on suicide prevention. We also need those in business and in community spheres of influence to examine how they can make a contribution that complements government action.

It has been a privilege to witness the passionate commitment held by so many in Australia to prevent suicide and suicide attempts. This report and its accompanying documents are submitted to put forward actions for better results that match this passion.



Christine Morgan
National Suicide Prevention Adviser

About this advice

This report presents the *Final Advice* of the National Suicide Prevention Adviser, prepared with the assistance of the National Suicide Prevention Taskforce. It builds on the Initial Findings submitted in November 2019 and the *Interim Advice* submitted in August 2020. It is intended to be read together with two further documents prepared as part of our consultation and engagement over the past 18 months. The *Compassion First*¹ report provides insights from commissioned research and engagement with people who have a lived experience of suicide and sets the foundations for this advice. *Shifting the Focus*² then lays out a proposed approach for operationalising a comprehensive whole of government approach and a decision-making tool. The report is also accompanied by a separate Appendices document, which summarises key Taskforce activities and actions that have been progressed. Together, these documents form the National Suicide Prevention Adviser's complete advice on how to drive the shift towards a new approach to suicide prevention that maximises the reach and effectiveness of government to reduce suicide attempts, reduce suicide deaths and support people earlier in distress.

We gratefully acknowledge the many jurisdictional, sector and lived experience representatives who provided invaluable input to inform this advice. Each person who has attended a forum or meeting, provided a submission, reviewed a draft, participated in research, or taken the time to make contact has helped to strengthen our full understanding of what is needed moving forward. Each State and Territory and all Commonwealth portfolios have provided significant input, along with Primary Health Networks, Local Government Authorities, suicide prevention organisations, lived experience networks and peak medical and allied health organisations.

We also acknowledge the important work of all members on the Expert Advisory Group (listed in full in Appendix 4), under the leadership of Chair Lucy Brogden AM and Deputy Chair Alan Woodward. We thank Suicide Prevention Australia for their invaluable support with research and sector engagement throughout the process.

In developing this advice, we have worked closely with Gayaa Dhuwi (Proud Spirit) Australia who are leading the development of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Implementation of this strategy will be critical to suicide prevention action in Australia.

A special acknowledgement and thank you goes to Dr Jaelea Skehan OAM who has tirelessly led the work of the Taskforce. Her passionate commitment to understanding and reducing suicide through the lens of lived experience, and her extensive knowledge and expertise has informed every aspect of our work and this *Final Advice*. A thank you also to each person who has contributed to the work of the Taskforce and the Commonwealth agencies who supported their secondment to the team.

While many different voices contributed to this conversation, there is a unified desire to work together to ensure that individuals, households and communities get the support they need as early as possible. This shared intent will drive the collective action for change to be achieved.



Contents

Foreword	1
Introduction	4
Summary of recommendations	9
Enabling a shift in approach	13
1. Leadership and governance to drive a whole of government approach	15
2. Lived experience knowledge and leadership	23
3. Data and evidence to drive outcomes	26
4. Workforce and community capability	30
The shifts we need	35
5. Responding earlier to distress	37
6. Connecting people to compassionate services and supports	44
7. Targeting groups that are disproportionately impacted by suicide	49
8. Policy responses to improve security and safety	56
References	60

To cite this document:

National Suicide Prevention Adviser. Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention (Final Advice). Canberra; December 2020.



Introduction

In Australia, we are missing too many opportunities to prevent the onset of suicidal behaviour and to reach people earlier in distress.

Suicidal distress, suicide attempts and suicide will affect most Australians at some point in their lives, often with long lasting and far-reaching impacts for those who experience the intense pain and despair that comes with suicidal distress. It also has wide-reaching impacts on others including families, caregivers, workplaces, services and communities. There is still little understanding of the complexities and diverse individual experiences of suicidal behaviour. This results in shame, stigma, discrimination and crisis-driven service responses. To understand suicidal behaviour, it is necessary to see it through the lens of a person's life experiences – including their experiences of trauma, distress, disadvantage, inequity and adversity.

In 2019, 3,318 Australians died by suicide; seven men and two women each day. Australian research has estimated that a further 65,000 people will find their situation so unbearable that they attempt suicide and many more people experience suicidal thoughts.³ Approximately half of the people who die by suicide are not accessing mental health services at the time of their death, with men and people living in rural and regional areas being particularly unlikely to have been in contact with these services. Those who do reach out often report upsetting or unhelpful service experiences which can leave them feeling even more distressed, further isolated and less hopeful about the future. In focusing on those who are already in crisis, our current approach misses the opportunity to support people early.

The factors influencing a person's suicidal distress can be social, personal, financial or arise from other stressors in their lives. Currently, suicide prevention services and supports are primarily provided through the health system: hospital emergency departments, mental health services and limited community based services.

We need a new approach, one informed by the insights of people with a lived experience of suicide. We must learn from those who have experienced suicidal distress and from the resilience shown by people who are recovering from suicide attempts. This knowledge is critical in designing a more effective and compassionate approach.

These insights tell us that the approach must focus on the whole picture of a person's life, identifying and using the right points to engage with them to prevent escalation into suicidal crisis. This approach takes help to people – where they are, when they are vulnerable, and in a way that relates to their needs, their culture and their circumstances. This approach does not wait for people to seek help. It strengthens the supports available through our community organisations and health systems and builds on them to ensure help is available to people through every agency and service they interact with throughout their lives. It leverages early distress interventions as a critical tool in addition to – but not as a substitute for – clinical and non-clinical interventions and broader prevention initiatives.

The foundational principles of this approach are connection and compassion, putting the needs of people at the centre of how services are designed and delivered. Our shared aim becomes reducing distress, building a sense of connection and strengthening hope. We achieve this by identifying and, where possible, addressing the full range of factors that drive each person's suicidality.

This calls for a change in how we think about suicidal behaviour. We must broaden our understanding to acknowledge the role of life stressors like unemployment, relationship breakdown and insecure housing, recognising how they can contribute to people feeling trapped and overwhelmed. For some people, these stressors interact with mental illness and alcohol or other drug problems to heighten suicidal distress; for others they are the primary driver of distress. We need more integrated and connected approaches that can recognise and respond to people's complete needs.

In broadening our approach, we must also shift away from measuring activities and outputs. Instead, we must focus our attention on the outcomes and impacts of our collective suicide prevention action. We must be clear in our objectives and ensure that our approach has a sharp focus on outcomes that will make a difference to individuals, families and communities.

Growing the reach of suicide prevention beyond our health systems

To achieve this, all agencies and arms of government must take responsibility for identifying and getting the right support to people. From family law courts to financial services and justice settings, government agencies need to play a far more proactive role in responding to the underlying drivers of people's distress. Importantly, they need to do so in close coordination and collaboration with other agencies – building a protective web of support around people and reducing the chances of them falling through service or system gaps. This approach recognises that it takes a breadth of actions delivered in many settings and service contexts to reduce suicides, prevent suicide attempts and respond effectively to people's distress. The health system will play a vital role in this, particularly through primary care and specialist mental health services, but it should do so as one partner among many working together to address each individual's needs.

Delivering a more comprehensive approach to connect with those who are vulnerable

Putting people's needs at the centre of how we design and deliver supports calls for a comprehensive view across the life journey. We must recognise and address the individual and whole-of-community factors that may be shaping someone's trajectory towards suicide.

At the individual level, this means identifying opportunities to intervene early in life and earlier at points of vulnerability to prevent or address distress. People with a lived experience have told us that suicidal distress is usually a product of intersecting and compounding life experiences. Intervening early when distress first arises is critical. It means connecting people with the right supports, together with stronger care coordination, improved aftercare and postvention responses.

Targeted interventions will also be needed to proactively reach people whose life experiences and the impacts of societal factors can make them more vulnerable to suicidal behaviour. This includes Aboriginal and Torres Strait Islander people, the Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer plus (LGBTIQ+) communities and people from culturally and linguistically diverse communities who may experience greater rates of discrimination, isolation and exclusion. It also includes having a more targeted focus on men and people in rural and regional communities who can find it more difficult to ask for, or access, support. There is also an opportunity to support people through key points of transition or disconnection where existing supports may drop away, including a focus on veterans and their families, people leaving prison and young people disconnecting from education. A deeper understanding of the unique needs of priority populations, and the range of intersecting vulnerabilities that have an impact on people, will enable us to improve the design and delivery of supports to better meet their needs.

We must recognise that there are whole of population factors that can help promote security and safety. These are frequently based in the social and economic determinants of wellbeing and include factors like economic security; safety from violence, discrimination and harm; and social connectedness.



Challenges of living as a young person in a remote/regional area: limited access to mental health support; job opportunities; costs of relocation and issues with living at home; drug use; loneliness; perceived misunderstanding; burdensomeness; lack of resources; parental capacity to support emotional and financial needs; (and) lack of sense of belonging.

– Personal story, Private Voices study



Bringing governments and agencies together to achieve a connected and compassionate approach

A whole of government delivery model is essential to enable this shift to a more connected and compassionate approach. Leveraging the many different touchpoints government has with citizens across the lifespan will enable us to offer supports much earlier, and in more accessible places. Seeing the whole picture of someone's life and circumstances – not just their moments of crisis – enables us to deliver supports that genuinely respond to their needs.

Moving to a whole of government delivery model is an ambitious objective. It requires a coordinated and integrated approach involving all agencies within each jurisdiction, and a 'whole of Australian governments' approach at the national level. It also means connecting this approach to the work done by and within communities at the local level.

Portfolio areas which have not traditionally engaged with suicide prevention will need to be enabled and empowered to join health portfolios in this effort, both within and across jurisdictional boundaries. A culture shift is required, so that all portfolios understand their roles and responsibilities in suicide prevention and do not approach their efforts as secondary or merely supporting Health portfolios. Different levels of government will need to cooperate more closely and effectively than ever before. Strategically placing the commitment to suicide prevention at the highest levels within governments will be a key enabler of this shift, providing clear leadership and authorising more effective coordination. Strengthened monitoring and reporting on action across all portfolios, and clear roles and responsibilities between different levels of government, will also be essential to translate shared objectives into practical actions.

A whole of government delivery model does not mean all governments must do all things. Some suicide prevention initiatives are best delivered nationally, while others will be most effective if implemented through State and Territory systems or coordinated and delivered at the regional level, with the involvement of local governments, Primary Health Networks and community services.

Design through lived experience

Lived experience knowledge and insights will be vital to guiding this collective shift towards a more connected and compassionate approach. All levels of government will need to incorporate lived experience in the design, implementation and delivery of policies and services

Genuine inclusion means bringing in the collective voices of people with a lived experience in diverse ways. Direct representation in decision-making is an important channel, but on its own is not sufficient. Governments must be open to engaging and listening much more broadly. This includes through co-production of new services and initiatives, lived experience involvement when implementing and evaluating these, and undertaking research which distils the collective insights to inform policymaking.

The Adviser and Taskforce's work has been guided by lived experience from the start. The *Compassion First* report, which accompanies this advice, draws together key insights, perspectives and priorities identified through research and close engagement with people who have direct experience of suicide. Their generously-shared knowledge has been critical to informing every aspect of the *Final Advice*.

The clearly articulated message from those with lived experience is that existing health services alone do not provide the kinds of support that people want and need. There is a strong desire for options offering compassionate community-based support, for a commitment to addressing the causes of distress, and for an approach that fosters social connection and builds hope.



I think the role of consumers and carers with lived experience of suicide is a historically overlooked and under recognised essential component for effective suicide prevention. Lived experience of suicide can be greatly enhanced by listening to the voices, needs and experiences of those with firsthand experience. I believe without this inclusion, understanding and suicide prevention is starkly incomplete.

– Caregiver story, Private Voices study



Seizing this moment for change

This advice is being provided to the Australian Government at the end of 2020 – a year in which mental health and wellbeing has been in focus like never before. Reform initiatives including the Productivity Commission Inquiry into Mental Health⁴ and the Royal Commission into Victoria's Mental Health System,⁵ the Royal Commission into Aged Care⁶ and *Vision 2030*⁷ have sparked a wide-ranging national conversation about what Australians need when they experience mental ill health and suicidality, and how existing service systems must change to better support them.

Australia's worst-ever bushfire season and the COVID-19 pandemic have brought into urgent focus the importance of supporting people and communities in times of crisis. These events have exposed Australians to situations that have increased vulnerability and exacerbated existing social, physical and mental health concerns. From the physical danger and trauma of loss brought about by the bushfires, to the isolation and extensive social and economic disruptions of COVID-19, the resilience of Australians has been tested in ways that create risks we must closely monitor and act upon. These twin crises have also highlighted the importance of governments working together to support individuals, in parallel with strengthening population safety and wellbeing through policies and services that address key risks and stressors.

The response of all governments to the bushfires, including the development of the *National Disaster Mental Health and Wellbeing Framework*⁸ and the *National Action Plan* to lower suicide rates and improve health outcomes for current and former Emergency Services Workers, has shown effective whole of government action is possible. This has been further underlined through the response to the pandemic. The *National Mental Health and Wellbeing Pandemic Response Plan*⁹ (Pandemic Response Plan) was developed in coordination between the Commonwealth and State and Territory governments, and endorsed by the National Cabinet. It identifies suicide prevention as a shared responsibility across multiple portfolios at all levels of government. It also recognises the need to address it through the lenses of social determinants and vulnerabilities of different priority population groups.

The *Pandemic Response Plan* included a focus on enhanced health system supports plus extending these into other areas – demonstrating a strong understanding of the multiple drivers of suicidal distress and the many possible touchpoints for governments to provide support. It established agreed national priorities and actions, with a flexible approach to recognise different requirements and priorities in jurisdictions. This approach is recommended for a whole of government approach to suicide prevention, combining national priorities to ensure scalability, reach and consistency, with local flexibility in delivery.

Now it is time to draw on everything that has been learned through this most testing year to drive structural and lasting reform in suicide prevention. We know there is an urgent case for change, built on decades of evidence and lived experience advocacy about the gaps in our current approach. This year has shown just how much agencies and all levels of government can achieve by working effectively together. This can and should drive a new approach which sees all governments and agencies join forces to address suicidal distress and its causes.

This report presents advice on how to deliver a more connected and compassionate approach to suicide prevention by leveraging the full range of levers, touchpoints, and resources available to governments nationally and within each jurisdiction. The enablers to achieve this have been placed first in the report, outlining the critical importance of addressing system and systemic issues to enable more effective actions at the national and regional level.

While this report takes a whole of government perspective throughout, the structure of the chapters broadly aligns with the *National Suicide Prevention Strategy for Australia's Health System: 2020-23*, with the enablers presented before the priority actions. This strategy was developed as a key action under the *Fifth National Mental Health and Suicide Prevention Plan* and forms the foundations for current national suicide prevention reform initiatives that are being led within the health system in each jurisdiction. By broadly aligning this advice with that Strategy, we aim to provide a framework that supports strong coordination of actions taking place within health systems and extend that across government.

The *Final Advice* also integrates and connects with the key themes outlined in the *Draft National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* developed by Gayaa Dhuwi (Proud Spirit) Australia that will be a critical element of our national suicide prevention approach beyond 2020.



Summary of recommendations

1. Leadership and governance to drive a whole of government approach

Recommendation 1: All governments work together to deliver a whole of government approach – at the national (cross-jurisdictional), jurisdictional (cross-portfolio) and regional levels; with national outcomes to be developed and adopted by all governments.

This includes the following **priority actions**:

- 1.1** All governments to continue or shift to a whole of government approach, with suicide prevention authorised by First Ministers and mechanisms to drive cross-portfolio action implemented.
- 1.2** A *National Suicide Prevention Strategy* is developed to align with the National Agreement on Mental Health and Suicide Prevention, identifying initiatives, which require a strategic national approach.
- 1.3** A National Suicide Prevention Office is established in 2021 to set strategic directions, build capabilities, support cross-jurisdictional and cross-portfolio action and report on agreed outcomes.
- 1.4** The National Agreement on Mental Health and Suicide Prevention to include strengthened and resourced regional arrangements for suicide prevention.

2. Lived experience knowledge and leadership

Recommendation 2: All governments commit to integrate lived experience knowledge into national priority setting, planning, design, delivery and evaluation of suicide prevention services and programs.

This includes the following **priority actions**:

- 2.1** All governments integrate lived experience expertise into leadership and governance structures for suicide prevention.
- 2.2** All governments include a requirement for demonstrated engagement and co-design with people who have lived experience of suicide in funded research, services and programs.
- 2.3** All governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce.
- 2.4** All governments increase lived experience research, particularly focused on people who have experienced suicidal distress and/or attempted suicide.

3. Data and evidence to drive outcomes

Recommendation 3: Recognising that measurement of outcomes is essential to monitor impacts of suicide prevention initiatives, all governments commit to work together to identify data needed for such measurement, undertake to improve the quality and timeliness of that data, and enable sharing across agencies.

This includes the following **priority actions**:

- 3.1** All jurisdictions maintain or, where not already in place, establish a suicide register and mechanisms for the routine collection and timely sharing of data on suicide, suicide attempts and self-harm.
- 3.2** Regular national surveys to determine the population prevalence of suicidal ideation, self-harm and suicide attempts and to ensure adequate data capture – including in relation to priority populations.
- 3.3** The National Office for Suicide Prevention to lead: (a) the development of a national outcomes framework for suicide prevention, informed by lived experience, to be applied at the program and service level as well as the national level; and (b) the development of national definitions of, and standards for, self-harm and suicide attempts.
- 3.4** All jurisdictions work with the National Office for Suicide Prevention to set priorities for suicide prevention research and share knowledge for continual improvement.

4. Workforce and community capability

Recommendation 4: All governments to commit to prioritising evidence-based and compassion-focused workforce development to drive cultural change in and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention.

This includes the following **priority actions**:

- 4.1** All jurisdictions resource contemporary and evidence-based training for clinical and other health staff.
- 4.2** All jurisdictions implement contemporary compassion-based training for frontline workers that enable them to respond to distress – especially those providing financial, employment and relationship support to people experiencing distress.
- 4.3** The National Office of Suicide Prevention works with all jurisdictions and relevant stakeholders to lead the development of a national suicide prevention workforce strategy.

5. Responding earlier to distress

Recommendation 5: As a priority action and reform, all governments work together to develop and implement responses that provide outreach and support at the point of distress, to reduce the onset of suicidal behaviour.

This includes the following **priority actions**:

- 5.1** Coordinated cross-jurisdictional and cross-portfolio action to intervene early in life to: (a) mitigate the impacts of adverse childhood experiences; (b) strengthen supports for families; and (c) ensure early access to programs, treatment and support for children and young people.
- 5.2** Developing, implementing and evaluating a scalable early distress intervention for people experiencing: (a) intimate relationship distress; (b) employment or workplace distress; (c) financial distress; and (d) isolation and loneliness.
- 5.3** Implementing and evaluating interventions that support people through transitions, including: (a) entering or being released from justice settings; (b) leaving military service; (c) finishing or disengaging from education or vocational settings; (d) entering retirement; and (e) **engagement with aged or supported care services**.

6. Connecting people to compassionate services and supports

Recommendation 6: All governments work together to progress service reform to achieve integrated, connected and quality services for people experiencing suicidal distress, people who have attempted suicide as well as caregivers and people impacted by suicidal behaviour.

This includes all governments working together to implement **priority actions** from the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* and the *National Mental Health and Wellbeing Pandemic Response Plan*, including:

- 6.1** Integrated digital and face-to-face supports to improve accessibility, service options and appropriate levels of service.
- 6.2** New service models incorporating compassionate community-based support for people experiencing suicidal distress.
- 6.3** Aftercare services for anyone who has attempted suicide or experienced a suicidal crisis.
- 6.4** Timely and compassionate supports for families, friends, caregivers and impacted communities, including bereavement and postvention responses.
- 6.5** Connecting alcohol and other drug prevention and treatment services to our suicide prevention approach.

7. Targeting groups that are disproportionately impacted by suicide

Recommendation 7: All governments to apply an equity approach to suicide prevention planning and funding to prioritise targeted approaches for populations that are disproportionately impacted by suicide.

This includes the following **priority actions**:

- 7.1** National funding of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* from 2021, implementing Indigenous leadership and governance, place-based initiatives and building on workforce and community strengths.
- 7.2** All jurisdictions to commit to identifying priority actions for male suicide prevention to be incorporated into the *National Suicide Prevention Strategy*, including: (a) the Commonwealth government to lead on identifying priority actions that leverage their government services and systems, such as employment services, family law courts, relationship services and aged care; and (b) all jurisdictions to review and report on the accessibility of their funded services and programs for men.
- 7.3** All jurisdictions contribute to identifying national actions for priority populations to be included in a *National Suicide Prevention Strategy*, including: children and young people; LGBTIQ+ communities; culturally and linguistically diverse communities; veterans and their families; and those living in rural and regional communities impacted by adversity.
- 7.4** Drawing from regular data reviews and evidence, all jurisdictions contribute to identifying national actions for occupations and industries with higher rates of suicide.

8. Policy responses to improve security and safety

Recommendation 8: Working towards a 'suicide prevention in all policies' approach, all governments: build capabilities within key policy teams and departments, and review existing policies to enhance opportunities for improved security and enhanced safety through a National Strategy.





Enabling a shift in approach

Governments have made significant investments in suicide prevention in recent years and there is much valuable work already underway to build upon. To enable the shifts that we need to see in Australia, however, it is important to set the groundwork for system reform and create the authorising environment for a new approach.

A truly whole of government and whole of community approach will help us to achieve a more connected and compassionate approach, but we must have the right structures and enablers in place. This includes lived experience knowledge and leadership as central to the approach, growing and developing the workforce to ensure compassionate and contemporary approaches are used across all touchpoints, and a much stronger use of data, agreed outcomes and evidence to set priorities and drive accountability. It also means having the right governance at the national and regional level to drive a truly coordinated approach.

The actions recommended here aim to harness and extend current reform activities and focus them explicitly on delivering a more complete suicide prevention system for Australia.

Addressing these priority enablers will build shared capacity to identify and respond to new suicide prevention priorities as these emerge over time. Getting these enablers in place should therefore be an immediate practical priority for governments, to lay strong foundations for enduring and ongoing reform.

There are four enablers to help governments to deliver the shifts in Australia's approach to suicide prevention that are required:



Leadership and governance to drive a whole of government approach



Lived experience knowledge and insight



Data and evidence to drive outcomes



Workforce and community capability

1. Leadership and governance to drive a whole of government approach

Suicide prevention efforts require coordination and collaboration among [...] both health and non-health sectors such as education, labour, agriculture, business, justice, law, defence, politics and the media. These efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide.

— Lived experience statement

Learning from lived experience

- People with lived experience have called for a national approach that spans all ages, ensures early and connected responses and acknowledges the range of stressors and co-occurring adverse life events that can impact on people and communities.
- People describe our suicide prevention approach as a series of disconnected programs, services and supports that do not address the underlying distress, trauma and pain they experience.

The shift we need

A national whole of government approach to suicide prevention requires all governments to shift from a health-only approach to a whole of government approach that can prevent the onset of suicidal behaviour, respond earlier in distress and connect people to the range of services and supports they need. Suicide prevention must be authorised the highest levels within governments, with clear roles and responsibilities between the different levels of government and across portfolios.

Recommendation 1

All governments work together to deliver a whole of government approach - at the national (cross-jurisdictional), jurisdictional (cross-portfolio) and regional levels; with national outcomes to be developed and adopted by all governments.

This includes the following priority actions:

- 1.1** All governments to continue or shift to a whole of government approach, with suicide prevention authorised by First Ministers and mechanisms to drive cross-portfolio action implemented.
- 1.2** A *National Suicide Prevention Strategy* is developed to align with the National Agreement on Mental Health and Suicide Prevention, identifying initiatives which require a strategic national approach.
- 1.3** A National Suicide Prevention Office is established in 2021 to set strategic directions, build capabilities, support cross-jurisdictional and cross-portfolio action and report on agreed outcomes.
- 1.4** The National Agreement on Mental Health and Suicide Prevention to include strengthened and resourced regional arrangements for suicide prevention.

Why this is important

Suicide prevention has historically been the responsibility of Health or Mental Health Ministers, with significant activity and investment at both the Commonwealth and State and Territory levels, and increasing involvement of local governments.

While the health system plays a vital role in suicide prevention, as it does in mental health, no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress. As outlined in the *Productivity Commission Inquiry into Mental Health*, this also applies more broadly to Mental Health, where prevention and early intervention and recovery efforts would be enabled through a whole of government rather than health-only approach.

Governments have already started the shift towards whole of government considerations and have considered suicide prevention as a separate area of focus. The *Fifth National Mental Health and Suicide Prevention Plan* for the first time included suicide prevention as a discrete area of focus with a suicide prevention strategy delivered under the plan. To further this work, a National Suicide Prevention Adviser role was established to develop options to support a whole of government approach and National Cabinet has committed to the development of a new National Agreement that considers both mental health and suicide prevention.

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



I began selling off some of my belongings to make my mortgage payments, which reinforced my feeling of failure and unworthiness.

– Personal story, male interview participant



Abusive relationship for three years in the mid-2000s, took another three years to get out of. Next relationship also destructive. Work history patchy...workplaces have been chaotic (and) stressful, and short-term contracts have meant ongoing financial stress. This recent incident was preceded by high level of stress rather than suicidal ideation, and wanting pain to stop rather than wanting to die.

– Personal story, Private Voices study



Core principles to guide the approach

Principle	Application to suicide prevention
Clarity of purpose	<ol style="list-style-type: none"> 1. Coordinated whole of government and whole of community action must occur to reduce suicide attempts, reduce suicide deaths and better support people in distress. 2. Individuals and communities must be central to planning and priority setting in suicide prevention to complement scientific and other expertise. This includes: <ul style="list-style-type: none"> • Designing and implementing approaches based on lived experience knowledge. • Enabling coordination and decision-making at the regional level to meet needs identified by and in the community. • Targeted approaches for populations disproportionately impacted by suicide. • Aboriginal and Torres Strait Islander leadership and delivery for Indigenous communities.
Leveraging the role of government	<ol style="list-style-type: none"> 3. Earlier, more connected and more effective responses to distress are required to ensure people get the right supports in a timely way. This includes: <ul style="list-style-type: none"> • Using all available government and community touchpoints to respond early to distress. • Paying particular attention to key points of disconnection, vulnerability and transitions. • Ensuring hospital, mental health, alcohol and other drug, social services and psychosocial supports are available, well coordinated and connected, and delivered to quality standards. 4. Policy and regulatory leadership across government portfolios is required to build a strong platform for suicide prevention action, with a focus on enhancing security, safety and resilience.
Efficiency and Effectiveness	<ol style="list-style-type: none"> 5. Data-informed decision-making is required, with the agility to respond in a timely way to emerging or shifting vulnerabilities. 6. A systematic commitment to measuring outcomes, building the evidence base and translating knowledge into practice must occur to guide ongoing priorities and investments.
Accountability	<ol style="list-style-type: none"> 7. Increased transparency and regular reporting on the outcomes from suicide prevention investments is required, measuring reduction in attempts as well as deaths. 8. All stakeholders and communities are engaged and informed about suicidal behaviour and suicide prevention action; ensuring that communication is safe for all people and reduces stigma.

Governance considerations

- Governments across Australia work together on suicide prevention, with cross-portfolio action authorised at the First Minister and Ministerial level.
- A National Agreement on Mental Health and Suicide Prevention is developed that considers whole of government action on suicide prevention, with clear roles and responsibilities.
- Human and financial resources committed across jurisdictions and portfolios with governance mechanisms to enable joint action, linkages and a comprehensive approach to reduce distress, attempts and deaths.
- A National Strategy to set whole of government priorities, extending the suicide prevention strategy developed under the Fifth Plan, to guide ongoing evaluation, reporting and improvements.
- A suite of programs and services that form nationally available infrastructure for suicide prevention is available as well as effective regional mechanisms for the co-ordination and delivery of services and programs in communities.
- Workforce development across the public sector and in communities to build compassion, skills and capabilities, using contemporary approaches, including peer workers.
- Linked data available with close-in-time monitoring of suicide deaths, suicide attempts, self-harm and key risk factors, to support decision-making and priority setting.
- Quality assurance for suicide prevention programs and services, and use of shared program level outcomes, to ensure consistent and comparable measures of impact.
- Continual review and adjustments to the priorities based on available data, agreed outcomes measures and evidence; including evidence from lived experience and Indigenous informed practice.

What we need to do

A true whole of government approach has effective cross-portfolio and multijurisdictional actions delivered in a consistent and coherent manner. A critical component to this is authorisation and oversight from First Ministers with explicit support from the Ministerial level.

To ensure accountability across all governments, a revised national governance structure is required, building on the work already announced and progressing through the National Cabinet structures. Following consultation with all governments and key stakeholders on the *Interim Advice*, the following mechanisms to achieve a national whole of government delivery model for suicide prevention are recommended.

Jurisdictional structures to drive change

In achieving this significant shift in approach, the first step is to ensure that each Australian jurisdiction implements a whole of government approach. This should engage all Ministers and portfolios, with each jurisdiction retaining the flexibility to design and implement processes that build on their current structures and working arrangements.

The Commonwealth and a number of States and Territories have already started the shift to a cross-portfolio approach to suicide prevention, with some states and territories making significant progress in this area (See *Appendix 1*). While no jurisdiction has suicide prevention as a portfolio responsibility of First Ministers specifically, those that are working well have First Ministers authorising the approach and receiving regular and direct reporting on suicide prevention. This approach of placing suicide prevention leadership at the highest levels of government should be strengthened across jurisdictions, with clear mechanisms to facilitate input and shared accountability across multiple Ministers and portfolios.

Proposed actions:

- Suicide prevention is authorised, or led, by the First Minister with clear mechanisms for involvement of all other Ministers.
- There is regular reporting of data and progress against agreed priorities to the First Minister to build transparency and accountability.
- A senior executive interdepartmental committee or similar is established (or retained) within each of the jurisdictions to support cross-portfolio priorities and reporting of progress against this.
- Agencies undertake staged implementation of the *Shifting the Focus* decision-making tool, to build capability across portfolios, with suicide prevention to be considered in each stage of the policy cycle.

Revised national structures to drive coordinated whole of government action

For suicide prevention to be driven as an issue of national importance that cuts across different levels of government, it must be agreed and endorsed as a whole of government priority for multiple governments simultaneously. At a time when the collective wellbeing and health of Australians is at greatest risk, co-ordinated and clear decision making and funding has never been more essential. Unilateral ad hoc investment and organic priority setting for suicide prevention across portfolios and levels of government will not deliver the coordinated and integrated response that Australia needs.

Suicide prevention action in Australia needs to be strengthened through enhanced national arrangements for suicide prevention, endorsed and overseen by First Ministers. This will help to drive agreed priorities across jurisdictions and portfolios, together with the appropriate focused investment to support implementation.

The following steps are recommended to strengthen the national architecture for coordination across and between levels of government.

Adopting suicide prevention as a priority reform for First Ministers

There has been significant investment in suicide prevention, particularly in the past five years, but governance has not kept pace with decision-making and new funding announcements across jurisdictions. This has resulted in duplication in some areas and continuing gaps in others.

To strengthen national coordination and governance, suicide prevention must be prioritised by First Ministers, connected to, but distinct from mental health.

A National Agreement on Mental Health and Suicide Prevention has been committed for delivery in 2021, which is a strong foundation to build upon. Priority work in 2021 should focus on reaching agreement on:

- Clear, shared and measurable outcomes for suicide prevention actions across jurisdictions;
- Priority areas of investment including national priorities for responding earlier to distress and earlier in the trajectory towards suicidal behaviour;
- Regular monitoring of core data sets to ensure agility and early responses to shifting vulnerabilities.

Establishing a National Office for Suicide Prevention

It is recommended that a National Office for Suicide Prevention be established and resourced in 2021, with responsibility for building capability to deliver a national whole of government approach and reporting regularly on progress. This recommendation is strongly supported by government and community stakeholders, with an Office seen as an essential enabler to drive strategic action and culture change.

Based on consultation outcomes, the National Office would operate as an entirely separate authority to enable transparency and collaboration across jurisdictions and portfolios, with enabling legislation to support its establishment as required. Considering jurisdictional feedback and recommendations from the *Productivity Commission Inquiry into Mental Health*, there would also be support for the National Office to be established as a specialist office with discrete reporting lines within the National Mental Health Commission. Some jurisdictions outlined this approach as their preferred option as it builds on existing working relationships and streamlined reporting and monitoring functions.

It is recommended that the functions of the National Office include to:

1. Lead the development of a whole of government *National Suicide Prevention Strategy* (see details below);
2. Ensure lived experience knowledge is embedded into the national approach;
3. Lead the co-design of a national outcomes Framework for suicide prevention and a national workforce strategy which extends on the National Agreement;
4. Provide ongoing advice to support multijurisdictional and cross-portfolio planning as required;
5. Work closely with the Australian Institute of Health and Welfare (AIHW), centres for research excellence, and other data and research leads to ensure jurisdictions, regions, stakeholders and organisations supporting priority populations have access to the data, knowledge and evidence they require;
6. Build capability and collaborative efforts that ensure cross-portfolio, cross-jurisdictional, sector, Primary Health Network, Indigenous and lived experience engagement, including through agreed arrangements and involvement of all jurisdictions;
7. Work collaboratively with a national leadership group for Aboriginal and Torres Strait Islander suicide prevention and the Commissioner for Defence and Veteran's suicide prevention;
8. Monitor and report on national implementation of suicide prevention priorities.

If agreed, there would also be benefit in the Office leading or partnering on:

- Action to address disproportionate impacts of suicidal behaviour on priority populations.
- Translation and sharing of new scientific knowledge, including knowledge sharing and knowledge transfer across jurisdictions, regions, portfolios and communities.

These arrangements may be strengthened by the development of a *Suicide Prevention Act* if it is required, given their value in driving whole of government action in other countries.

A national whole of government approach should include Aboriginal and Torres Strait Islander cultural governance and leadership.

The *Draft National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, prepared by Gayaa Dhuwi (Proud Spirit) Australia, recommends that all Australian governments support and resource a national leadership body to support national and place-based action, with oversight of an accompanying Implementation Plan.

As part of establishing the Office, and subject to the enabling legislation, a review and appropriate assignment of existing suicide prevention functions in other Departments would need to be undertaken. Mechanisms to enable collaboration with other national and jurisdictional suicide prevention roles would also be required. Advisory and scientific groups supporting the National Office would also be considered upon establishment.

Development of a stand-alone National Suicide Prevention Strategy

The *National Mental Health Strategy* has been used to guide reforms in mental health and suicide prevention for almost 30 years, but it no longer meets individual, community and service provider expectations for suicide prevention. While a *Suicide Prevention Strategy* under the *Fifth National Mental Health and Suicide Prevention Plan* has been developed and agreed to, this focuses primarily on health interventions and selected community based activities. A new *National Suicide Prevention Strategy* would complement the work being done as part of the National Agreement on Mental Health and Suicide Prevention. It would focus on the key national priorities by identifying what is required for scalability, reach and consistency to be adopted at a national level, with a particular focus on cross-portfolio and early distress responses. Over time, this Strategy, together with the Partnership Agreement, would enable all governments to align their individual plans and activities, while still allowing flexible approaches within States and Territories.

There has been strong support for a National Strategy underpinned by annual reporting on progress by First Ministers. Data and evidence should be used to ensure the strategy has flexibility to identify and meet shifting priorities.

The *National Suicide Prevention Strategy* should:

- Shift the focus from health portfolios alone to a national whole of government approach.
- Build on, and connect with, the National Mental Health and Suicide Prevention Agreement being delivered through the Health Reform Council in 2021.
- Create the basis for annual reporting on progress as well as outcomes on agreed targets and the impact of the system overall.
- Integrate priority national elements of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* to be implemented from 2021.
- Enable alignment with State and Territory and regional suicide prevention action plans – creating a more coordinated effort overall for suicide prevention within five years.
- Set the foundations for longer term investments across jurisdictions.

Implementation of existing jurisdictional and national suicide prevention strategies and plans should continue without delay, to ensure a seamless approach. The National Strategy will provide a scaffold to identify and elevate national priorities requiring coordination across all jurisdictions. This should include action to progress the following without delay:

- Implementation of the *National Suicide Prevention Strategy for Australia's Health System 2020-2023*, including any immediate priorities aligned to the *Pandemic Mental Health and Wellbeing Response Plan*.
- Resourcing the recommendations of the *National Aboriginal and Torres Strait Islander Suicide Prevention Plan* from 2021.
- Identifying and implementing priority cross-portfolio suicide prevention initiatives across Commonwealth, State and Territory agencies, using the *Shifting the Focus* model developed to guide cross-portfolio planning.
- Ensuring that responses to bushfires, COVID 19 and other disasters include strategies that address risk and protective factors for suicide.

Co-designing outcomes for suicide prevention

In its review of mental health and suicide prevention in 2014,¹⁰ the National Mental Health Commission recommended strengthening accountabilities across jurisdictions based on outcomes. A clear outcomes framework for suicide prevention has not yet been progressed and has been highlighted by stakeholders as a key barrier to success. Given the number of portfolios and levels of government that need to coordinate to improve outcomes for individuals, households and communities, this should be a priority action undertaken in 2021 to inform the National Agreement on Mental Health and Suicide Prevention and National Strategy.

These outcomes need to be:

- Co-designed with people who have a lived experience of suicide, and focus on outcomes that are valued by individuals experiencing distress, suicidal behaviour and their caregivers.
- Inclusive of service providers, communities and governments.
- Linked with whole of government wellbeing outcomes being progressed in jurisdictions.
- Inclusive of both quantitative and qualitative outcomes – such as the percentage reduction in suicide attempts and suicide deaths of people presenting to services, and whether services were compassionate and met the needs of people accessing them.
- Designed to include key outcome measures for priority populations.
- Inclusive of measures to assess the level of collaboration between agencies and levels of government.
- The basis of ongoing monitoring and reporting at the national, jurisdictional, regional and service level, noting the need for flexibility in how outcomes are achieved.
- Supported by a stronger evaluation and research culture and improvements to data collection and linkages across data sets.



Losing my job in the Army was just a start of my downfall, one damn thing after another. In a span of one year seven people I knew killed themselves, I was noticing things happening around me, which pushed me to the moment of attempt.

– Personal story, male interview participant



I believe that more literacy and keeping communication channels open about suicide would make a difference. People complete suicide when they have no hope. If we can teach people how to have hope-engendering conversations – not wantonly optimistic conversations, but conversations that can have space to hold the real complexity of both the person's distress and the hope to be heard, understood and feel connected to the helper – then I think we have a chance to make a difference.

– Personal story, Private Voices study



Revised regional arrangements and investment

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

Australia has seen significant funding and activity in suicide prevention at all levels of government, but there is ongoing lack of clarity about the types of suicide prevention activities that are best delivered or coordinated by the various tiers of government. This results in duplication in some areas, gaps in others and can create barriers to collaboration and data sharing at the local level.

Primary Health Networks are the mechanism through which regional planning and commissioning of Commonwealth-funded mental health and suicide prevention services currently occurs. Alongside this activity, there are a range of other place-based or community-led initiatives and networks supported through State and Territory governments, local governments and the not-for-profit sector. The *Draft National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* also recommends shifting regional commissioning of Indigenous suicide prevention activities to State and Territory Aboriginal community-controlled health peaks.

Many of the elements for effective and responsive regional suicide prevention exist within the structures of government in Australia. At present, however, they are not operating within agreed arrangements on roles and responsibilities. As a result, they are not forming the necessary linkages across agencies and services. While some regions have worked to connect diverse actions and governance arrangements at the local level, there is no clear and consistent approach across Australia. There is also a major focus on health and community networks, with little integration with other jurisdictional portfolios and services.

Following release of the *Interim Advice*, a discussion paper and targeted consultations occurred with Commonwealth agencies that deliver regional services, all State and Territory governments, Local Government authorities, some Regional Development Australia networks, Primary Health Networks, suicide prevention organisations and services and people with lived experience of suicide. The Draft Final Evaluation report for the National Suicide Prevention Trial and the Interim report of the Summative Evaluation of Suicide Prevention Trial Evaluations were also reviewed for insights on regional coordination of activity.

The consultation revealed mixed feedback about whether regional planning is best delivered through enhanced roles and responsibilities for Primary Health Networks, through States and Territories or through a shift to local collaborative networks connected to local governments. Stakeholders identified various strengths and weaknesses with each of these approaches, but demonstrated consistent support for:

- Resourcing regional coordinators as core infrastructure.
- More flexible funding models to meet the needs of the local communities.
- Improved bilateral agreements between Commonwealth and State and Territory governments on new service models to be rolled out locally.
- An enhanced role for local governments, drawing together all three levels of government for greatest effect.
- A review of current frameworks being provided for regional planning to ensure they are fit-for-purpose in the Australian context and in light of specific challenges identified in rural and remote regions.
- Development of a platform to bring together Commonwealth, state, local and regional stakeholders.
- Improved methods of translating national and local knowledge for continuous improvement.

Drawing together systems and approaches at the local level is complex. A review of regional arrangements should occur in 2021 to inform the National Agreement, ensuring that strengthened and resourced regional arrangements are in place to deliver coordinated whole of government and whole of community action. Particular attention to the needs of rural and remote communities is required, given the impact of suicide in rural Australia, the limited availability of services and supports and feedback suggesting current frameworks and models are less applicable in rural and remote communities.

A decision on further funding of suicide prevention trials should be made based on evaluation outcomes, with a preference for continuation of coordination funding (at a minimum) where trials have enabled local partnerships and planning.

2. Lived experience knowledge and leadership

I think the role of consumers and carers with lived experience of suicide is a historically overlooked and under recognised essential component for effective suicide prevention. Lived experience of suicide can be greatly enhanced by listening to the voices, needs and experiences of those with firsthand experience. I believe without this inclusion, understanding and suicide prevention is starkly incomplete.

— Personal story, Private Voices study

Learning from lived experience

- There is a need for a serious shift in the public representation and narrative around suicide – including who it affects, what kinds of responses people need and the shortcomings of the current approach. This can only be achieved by giving lived experience perspectives and voices more prominence.
- There has been a gradual increase in engagement of lived experience in suicide prevention policy and service planning, but there is variability in how and when people are involved. The diversity of lived experience voices is also somewhat limited and needs to be expanded to ensure diverse perspectives are heard and included.

The shift we need

If systems and services are to truly meet the needs of people experiencing suicidal distress as well as caregivers and those bereaved by suicide, then lived experience must be actively involved at all stages of suicide prevention action.

Recommendation 2

All governments commit to integrate lived experience knowledge into national priority setting, planning, design, delivery and evaluation of suicide prevention services and programs.

This includes the following **priority actions**:

- 2.1** All governments integrate lived experience expertise into leadership and governance structures for suicide prevention.
- 2.2** All governments include a requirement for demonstrated engagement and co-design with people who have lived experience of suicide in funded research, services and programs.
- 2.3** All governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce.
- 2.4** All governments increase lived experience research, particularly focused on people who have experienced suicidal distress and/or attempted suicide.

Why this is important

People must be at the centre of everything we do in suicide prevention. This is the only way to ensure that the reforms and service improvements being implemented do not fall short of what people experiencing suicidal distress really need. Lived experience knowledge and insights are invaluable at all stages, from research that builds the evidence base and government policy and program planning, to service design and delivery, program implementation and evaluation.

The knowledge and insights of caregivers and people who have been bereaved by suicide are also critical in designing new and better supports, services and approaches for families, friends, peers and community members. Governments, communities and stakeholders need to work closely together with those who have lived experience at all levels to prevent suicide and its impacts.

What we need to do

Embed lived experience in leadership and governance

Governments must shift from approaching lived experience knowledge as a finite input, towards engaging with people with lived experience as ongoing partners in delivery. This means people with lived experience taking on more leadership, governance and advisory roles across government bodies and agencies.

As a start, this should include embedding lived experience expertise within the National Office for Suicide Prevention and other national and jurisdictional suicide prevention committees or boards. Lived experience knowledge will also strengthen regional service planning and delivery through inclusion within the governance structures of Australia's 31 Primary Health Networks.

Strengthening lived experience involvement in leadership and governance will require further investments in building the lived experience workforce, equipping people with the skills to leverage their personal experiences safely and effectively. It will also require a focus on mechanisms that enable people with lived experience to participate fully and safely – including appropriate pay and support structures.

The Productivity Commission Inquiry into Mental Health recommended the establishment of separate standalone national peak bodies for mental health consumers and carers. There would be value in considering the representation of people with lived experience of suicide within the establishment of these groups or a national lived experience body with a dedicated suicide prevention focus. This would considerably strengthen the capacity for lived experience participation nationally.

Strengthen lived experience research

Lived experience knowledge and insights are essential for extending what we know about factors that contribute to suicidal behaviour and what really helps when people are in distress.

While individual insights can be illuminating, there is significant value in research which systematically draws on many people's lived experience to identify the common themes and trends.

One particular area where more investment in research is urgently required is lived experience journey mapping. Understanding more about the diversity of stressors and life events that can set someone on a trajectory towards suicide is essential for delivering effective early intervention. Having a clearer view of where and when people seek help and their experiences when they do is also vital to identify opportunities to better support those who are vulnerable to suicide.

Understanding diverse lived experiences is also important. The perspectives and journeys of men, young people, Aboriginal and Torres Strait Islander Australians and other priority populations can differ from other people with lived experience in important ways that need to be captured and reflected in policy or service design.

Strengthening lived experience research will provide the opportunity to draw together knowledge and insights from a wider range of individuals and capture a broader spectrum of views. This will contribute to ensuring service design and delivery is genuinely responsive to people's needs, not just reactive to past failings or experiences.

Maximise co-design for services and interventions

In recent years, health and community services agencies have gradually been growing capability in undertaking co-design with lived experience. Governments should continue to strengthen this capability, with opportunities to expand this approach across agencies by embedding co-design techniques at all levels of government effort.

In particular, lived experience knowledge needs to be central to designing outcome measures for suicide prevention initiatives, evaluating government services and programs, developing new service models and reviewing public messaging about suicide and suicide prevention. Engaging a diversity of lived experience from priority populations is also important, acknowledging that what works for one person or community will not be experienced the same way for all.

To facilitate this, it will be necessary for governments to provide appropriate time and resourcing for collaborative planning and co-design processes. Governments also need to ensure that program and research funding related to suicide prevention includes a requirement to demonstrate engagement with people who have lived experience. This should start immediately with programs funded through health portfolios, including nationally funded programs.

Build and support the lived experience workforce

People with a lived experience of suicide have much to offer in terms of compassionate support grounded in first-hand knowledge. These workers will be essential to deliver service models like 'safe spaces' and other peer-led and peer-to-peer supports. While small at present, this workforce is growing rapidly as State and Territory governments and other partners invest in these new services and ways of working.

To build a lived experience workforce with the skills and capabilities to fulfil these roles, immediate focus is needed on developing consistent training, accreditation, support and professional pathways. This will also mean dedicated work to understand the unique contribution of the lived experience of suicide peer workforce and how this integrates with the existing peer workforce in mental health.

The Commonwealth is currently in the process of developing a new *National Mental Health Workforce Strategy* and the National Mental Health Commission is developing the *Lived Experience (and Peer) Workforce Development Guidelines*. These plans provide an early opportunity to address suicide prevention peer and lived experience workforce development nationally, and map out practical next steps for all jurisdictions to take. This planning should look beyond training and career pathways to also consider the supports and safeguards that will be needed to protect the wellbeing of lived experience workers.

It must be recognised that lived experience work in suicide prevention presents unique challenges to the wellbeing of those who undertake it, including the risks of re-traumatisation, burnout and vicarious trauma. Planning to address these is an essential component of workforce development, to ensure suicide prevention lived experience workers can have positive, productive and sustainable careers.

Leveraging lived experience knowledge and leadership will help ground all government suicide prevention activity in a genuine understanding of people's needs – throughout the life course and in times of crisis. Armed with this understanding, governments will be enabled to identify and act on opportunities for change across portfolios and service systems, wherever these arise. Without this, there is a risk that shared efforts will continue to miss the mark and fail to achieve the wholesale shift in approach we need.

3. Data and evidence to drive outcomes

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

— Lived experience statement

Learning from lived experience

- National data to date has focused on the number of people who die by suicide and the factors associated with these deaths. But it is crucial to strengthen our focus on understanding the prevalence of, and factors associated, with suicide attempt and suicidal distress to ensure a more proactive and agile response.
- People with a lived experience of suicidal distress report poor experiences with current services and programs and a range of missed opportunities for more connected and integrated care. Lived experience knowledge is critical in designing the outcomes that people expect, and need, from funded services and programs.

The shift we need

A collaborative and nationally coordinated approach to data, monitoring, evaluation and research is vital to ensure the shift to a whole of government approach to suicide prevention is meaningful and sustained. We must shift to collecting and using data in close-to-real time to shape more agile and proactive policy and service approaches.

Recommendation 3

Recognising that measurement of outcomes is essential to monitor impacts of suicide prevention initiatives, all governments commit to work together to identify data needed for such measurement, undertake to improve the quality and timeliness of that data, and enable sharing across agencies.

This includes the following **priority actions**:

- 3.1** All jurisdictions maintain or, where not already in place, establish a suicide register and mechanisms for the routine collection and timely sharing of data on suicide, suicide attempts, and self-harm.
- 3.2** Regular national surveys to determine the population prevalence of suicidal ideation, self-harm and suicide attempts and to ensure adequate data capture, including for priority populations.
- 3.3** The National Office for Suicide Prevention to lead: (a) the development of a national outcomes framework for suicide prevention informed by lived experience, to be applied at the program and service level as well as the national level; and (b) the development of national definitions of, and standards for, self-harm and suicide attempts.
- 3.4** All jurisdictions work with the National Office for Suicide Prevention to set priorities for suicide prevention research and share knowledge for continual improvement.

Why this is important

Governments need to be able to make informed decisions, provide evidence-based advice, and demonstrate the effectiveness of shifting to a national whole of government approach to suicide prevention. To achieve this, there needs to be a shift to the use of shared outcomes at strategic and program levels, supported by an equivalent national and joined up approach to collecting, sharing and using suicide data, evaluating funded programs, setting research priorities and undertaking knowledge translation.

This approach needs strong cross-agency coordination, with close-in-time monitoring of suicide deaths, suicide attempts and key risk factors. Through monitoring and evaluation against outcomes, standardising definitions, improving consistency of data collection and analysis, and linking data sets for priority populations, governments will be better armed to make informed decisions about vulnerabilities and needs – at both the population and regional levels.

What we need to do

Collect more consistent and timely data

Better, faster and more reliable information on suicide deaths and attempts is essential to drive government policy and service delivery. We need to know much more about who dies by suicide or attempts it, the factors that contribute to this and the things which can help prevent it. Governments can use this data to create a positive feedback loop that drives continuous improvement in policy, service design and implementation, and become more agile in *preventing* suicide deaths or attempts when risks emerge.

The Australian Institute of Health and Welfare (AIHW) should be tasked with data leadership, with regular reporting of key data sets to First Ministers. Jurisdictions should work together to improve how data is collected, recorded and disseminated to address current gaps and speed up the availability of reliable data for all agencies who need it. Access to these improved data sets also needs to be expanded to include regional agencies and others involved in community-level responses to suicide so that they can drive more proactive activity on the frontline of service delivery.

To strengthen the consistency and timeliness of suicide data, immediate priorities should include:

- Continuing and accelerating the work to establish suicide registers in all jurisdictions with regular reporting to the AIHW.
- Setting consistent definitions, and undertaking routine collection and reporting, of suicide attempt data – sourced from hospitals, first responder agencies, and other government settings.
- Setting consistent definitions, and undertaking routine collection and reporting, of self-harm and suicide attempt data through each of the above settings.
- Improving integration between government and non-government agency data to gain a more complete picture of activity and needs – nationally and within particular regions or communities.
- Consistent and timely collection and sharing of population level data on suicidal thoughts, suicide attempts, self-harm and exposure to suicide through representative national surveys using comparable questions.
- A dedicated focus on improving the collection and sharing of data on priority populations and their unique vulnerabilities and needs – especially for LGBTIQ+ people, culturally and linguistically diverse communities, veterans and their families.
- Any expansion of investment in suicide data, including the collection and sharing of all relevant health and non-health data, will require specific attention to address data gaps in relation to Aboriginal and Torres Strait Islander individuals, families, communities.

Beyond improving the timeliness and consistency of data on suicide deaths, self-harm and suicide attempts, there is a need for data linkages to understand the full range of factors and vulnerabilities that contribute to suicidality as well as the events that precede an individual's point of crisis. To achieve this, it will be important to collect data from *all* relevant portfolios – not just health portfolios. For example, governments would ideally be able to analyse high-quality data on suicide attempts in the context of data provided by community services, housing and justice agencies, and overlay this with granular insights about priority populations. Linking together a wide range of data sets collected across government with more consistent and timely suicide and self-harm data will enable powerful insights that can inform policy and practice.

Shift to measuring outcomes

Having a shared set of agreed outcomes for suicide prevention – nationally and across governments – is a critical tool for channelling collective effort. Without clear direction on what prevention, early distress, intervention and postvention activities and initiatives are meant to achieve, it is not possible to deliver the level of coordination required for effective whole of government delivery. A core focus on outcomes will be the point of difference between the new *National Suicide Prevention Strategy* and previous attempts to improve suicide prevention through policy in Australia.

It is often implicitly assumed that the long-term measure of success for suicide prevention is a reduction in suicide deaths. While this should always be a shared aspiration, suicide is too complex a phenomenon to be reduced to a single, high-level indicator. Through consultation with States and Territories and other stakeholders a strongly expressed need for more granularity in outcomes and objectives has been identified, to focus the diverse efforts of governments while supporting practical evaluation of the effectiveness of different programs and interventions.

The development of a meaningful outcomes map would need to be co-determined with jurisdictions, people with lived experience – including those from the priority populations identified earlier in this advice – and other experts. The National Office for Suicide Prevention should lead the co-design and identification of such a shared outcomes framework for suicide prevention to be used in all future funding agreements and for ongoing evaluations. This would ensure governments and individual agencies are more accountable for driving impact, and provide increased transparency where activities are not achieving intended results. It would also help strengthen the local evidence base by facilitating the evaluation of individual programs and interventions, and their contribution to suicide prevention in Australia.

Evaluation of suicide prevention programs and interventions is currently patchy, inconsistent, and negatively impacted by the operating environment of suicide prevention including having multiple classifications for programs and interventions. When evaluations are conducted, they are often retrospective evaluations of a specific program with a focus on short-term output measures and no attempt to link with other programs and interventions or long-term outcomes. This does not do enough to further understanding of effective interventions for preventing suicide attempts or deaths. We need better evidence on which of the current actions taken by government make the most difference for people who are vulnerable to suicidal distress, under what conditions and for which individuals or communities. Identifying short, medium and long-term outcomes linked from the new *National Suicide Prevention Strategy* to individual programs and interventions, based on a clear logic framework and shared service classifications, will enable better and more consistent evaluation of these important issues.

Prioritise research to address knowledge gaps

Strengthening the evidence base through research is critical to informing collective government efforts towards suicide prevention.

New innovation and improved service responses are likely to come from the combination of lived experience knowledge, research expertise, and practice knowledge. Opportunities to invest in these types of collaborative efforts will be critical.

Research activities need to address the right questions to fill priority information gaps in the current knowledge base, so that research more directly connects with suicide prevention policy and practice. There would be significant value in developing a national strategy for research that aligns with the new *National Suicide Prevention Strategy*. This would identify shared priorities for research in the short and medium term, and support the allocation of funding through the Suicide Prevention Research Fund in line with these priorities.

More targeted research would support improved understanding of interventions that work to reduce the onset, severity and impacts of suicidal behaviour. Targeted research can also assist with refining and improving new service models and shaping ongoing national reforms.

Strengthen knowledge translation

Generating more complete and timely data sets, sharpening the focus of our research building the evidence, is an important step forward. However, the greatest benefit will come from governments and other sector partners using this to drive continual improvement, ongoing priority setting and investment. It is essential to also strengthen the structures and processes for knowledge translation.

There is value in embedding a knowledge brokerage function within the national governance arrangements for suicide prevention. This could be connected to, or directly delivered by, the National Office for Suicide Prevention, providing a channel for government agencies and partners to access the latest available evidence on suicide prevention and advice on how to translate this into practice. All jurisdictions would feed data, evidence and insights into this central repository, with knowledge-exchange activities to occur on a regular basis to share lessons learned and discuss collaborative approaches.

Governments currently face significant challenges with siloed data and information – with limited knowledge sharing or translation sometimes even within jurisdictions. Establishing better knowledge brokerage capability would help ensure that insights gained in one jurisdiction or part of government can be widely shared to drive more effective policy and service responses.

Data, evidence and research are essential enablers of effective suicide prevention, with all agencies and levels of government having a role to play in strengthening these. Improving visibility of needs and vulnerabilities, speeding up the capacity to act and sharpening the focus on what works will equip governments to work together more effectively and make services more connected than ever before.



My daughter was taken from me by the courts and her mother was given full parental custody, her lawyers argument was that I was a jealous ex partner just trying to get back at her... After leaving the court room that late morning, I went to a park which I used to take my daughter to [and attempted suicide]... I was an emotional mess.

– Personal story, Private Voices study



4. Workforce and community capability

Helpful responses are those that see our humanity, offer time and a safe space to be deeply listened to and validated, provide genuine compassion, free of judgement and agendas. This empowers a person to find their own meaning and the answers to the problems in their own life.

— Lived experience statement

BELONGING

Learning from lived experience

- People with a lived experience of suicidality report that the services and workforces that should assist them often leave them feeling “unheard, judged or problematised”.
- Stigma and discrimination is regularly experienced by people with a lived experience of suicide – in our health services, in our frontline services, in our workplaces and in the broader community.
- People who have had negative experiences with health and community services in the past can be reluctant to reach out again.

The shift we need

All formal and informal workforces that engage with people or communities experiencing distress must have the capacity and the capability to provide a compassionate response, relevant to their role. This will require a significant focus on professional development to ensure that frontline providers, government agencies and community partners are all enabled and empowered to put compassion at the centre of how they support people.

Recommendation 4

All governments to commit to prioritising evidence-based and compassion-focused workforce development to drive cultural change in and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention.

This includes the following **priority actions**:

- 4.1** All jurisdictions resource contemporary and evidence-based training for clinical and other health staff.
- 4.2** All jurisdictions implement contemporary compassion-based training for frontline workers that enable them to respond to distress – especially those providing financial, employment and relationship support to people experiencing distress.
- 4.3** The National Office of Suicide Prevention to work with all jurisdictions and relevant stakeholders to lead the development of a national suicide prevention workforce strategy.

Why this is important

People experiencing distress and who are vulnerable to suicide interact with workforces across various sectors, at different times and in different ways. People are also likely to talk to friends and family before seeking any professional help. The first time a person discloses their distress or suicidality is a critical moment. There is an imperative to build capability across workforces and across community settings to ensure a shared understanding and a consistent and compassionate approach.

This means broadening the focus to include government services and community networks that are often directly in touch with people at times of distress, transition or disconnection. This includes people experiencing unemployment, housing insecurity or homelessness, those entering or exiting the justice system, people engaging with family law courts, or attending a GP appointment for a range of concerns. Every contact an individual has with a department, service or worker should be considered an opportunity to have a positive impact, ensuring they get the right supports at the right time. Linking the community into this approach is also critical.

What we need to do

In strengthening workforce capability, the clear priority needs to be ensuring a better experience for each individual and the people who care for them. There are some universal competencies required for all workers, but a whole of government delivery model for suicide prevention involves a broad and diverse workforce, which means specific knowledge and skills will also be required.

To maximise capability in delivering a more compassionate approach, there must be an investment in contemporary and evidence-based training supported by internal policies, leadership training, practical supports and the development of 'warm' referral pathways. Efforts to strengthen workforce capability must be underpinned by a commitment to the safety and support of workers who engage with people in distress. Workers who feel supported are better able to support others.

Strengthening community capacity to respond with compassion and link people in distress with the right supports is also an important priority to amplify efforts within government. We need to empower communities to respond in the right ways by leveraging and refining education campaigns, training, resources and localised pathways to care.

Build capability within government departments

Chapter 8 of this advice emphasises the importance of embedding suicide prevention considerations within all policymaking. Staff within government departments will need to be supported to develop the capabilities to effectively deliver this shift.

The National Office for Suicide Prevention should work with government agencies to identify opportunities for change, drive new practices and build capabilities for the policy context. This would include embedding the capacity for suicide prevention to be considered and addressed in policy agenda-setting, formulation, decision-making, implementation and evaluation. Where relevant, these considerations should further be applied across all three levels of Australian government: Commonwealth, State and Territory, and Local Government.

Shifting the Focus is a guide that supports government agencies to identify, scope and deliver suicide prevention initiatives appropriate to their policy or service context. Agencies should be supported to use this tool. This would include linking in with broader mental health and suicide prevention capability development activities as well as delivering specific internal training on how and when to apply this within policy-making processes as part of broader capacity-building initiatives.

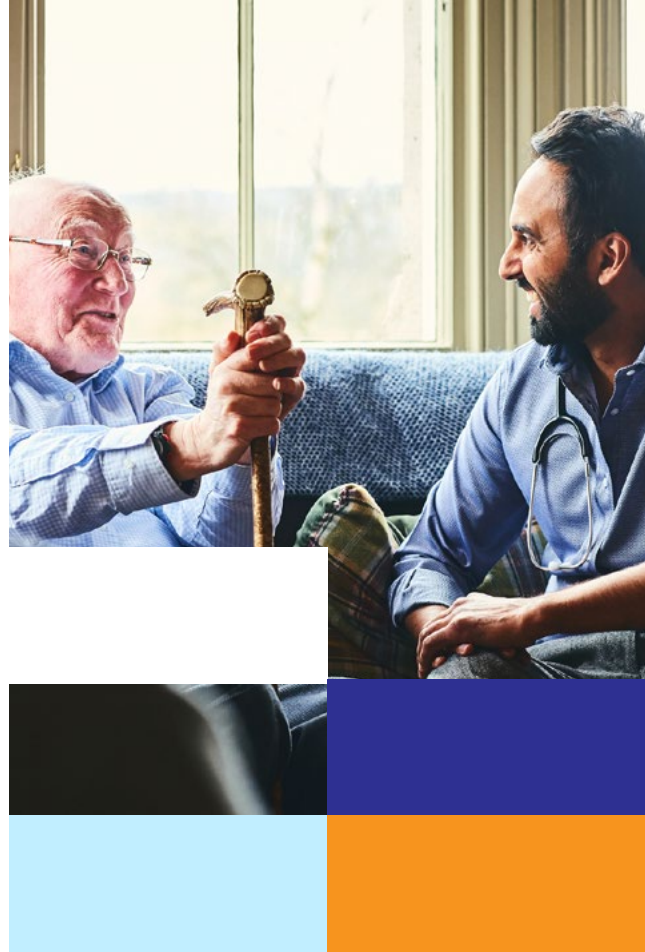
Build capability in all frontline workforces

Frontline staff are key to delivering the early distress intervention approach discussed throughout this advice. A strong focus on training and support for these workers will be needed to ensure people in distress receive a compassionate response and are linked to the right supports, every time.

Different agencies and service providers will have different priorities for workforce development. For example, in frontline agencies like Services Australia and community service providers, staff need to be equipped with the skills to identify people who are experiencing distress or at risk of this, and initiate compassionate and safe conversations that connect them to the right supports. By comparison, strengthening capability among emergency services personnel may call for a focus on techniques which can help people safely manage their distress at home or in other community settings, without the use of restraint or escalated interventions.

While each frontline agency will have its own needs, there is benefit in developing a common training framework for government staff to improve interagency coordination, a shared language, collaboration and the promotion of best practice across a wide range of settings. Consistency across Commonwealth, State and Territory and Local Government staff would also be of benefit. The training used must be contemporary in its approach to suicidal behaviour and be well-suited for a broad government workforce, allowing for scaffolded learning for different roles and capability needs. This training must be well evaluated across each service setting to understand outcomes for individuals (and the staff members) at the point of distress. Critically, it should have a focus on compassion – compassion for the person and compassion for the staff member. Any existing training being provided must be reviewed against these measures. Governments across Australia should consider the feasibility of broader implementation of a consistent program and its alignment with other training that is provided or planned for agency workforces. There is a clear leadership role for public service commissions and agencies across jurisdictions to ensure a consistent approach.

Governments should also seek opportunities to extend this training to funded services and programs delivered by community and other external partners. Particular priorities for this extension would include funded services providing financial counselling and other financial supports, employment services and relationship services.



Build capability within health and clinical workforces

Building the capacity for a more compassionate approach among clinical workers is a clear priority emerging from lived experience consultation; it is also a priority action under the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* developed under the *Fifth National Mental Health and Suicide Prevention Plan*. Many jurisdictions are progressing work in this area, which should be escalated and strengthened as a priority. This should sit alongside work to build the lived experience peer workforce (see Chapter 6).

In doing this, it will be important to tailor initiatives to address the complexity of healthcare environments and challenge unhelpful or outdated ideas about what people experiencing suicidal distress need from clinicians. This means drawing on contemporary approaches to suicide prevention training that emphasise the importance of a collaborative and therapeutic relationship between clinicians and those accessing care. The training delivered to health and other clinical workforces should have compassion as its foundation, be evidence based from the perspective of people accessing services, and focus on risk formulation and safety planning over risk identification and management. Clinicians must also be supported to safely tailor these approaches through extension training addressing the needs of priority populations to ensure services are:

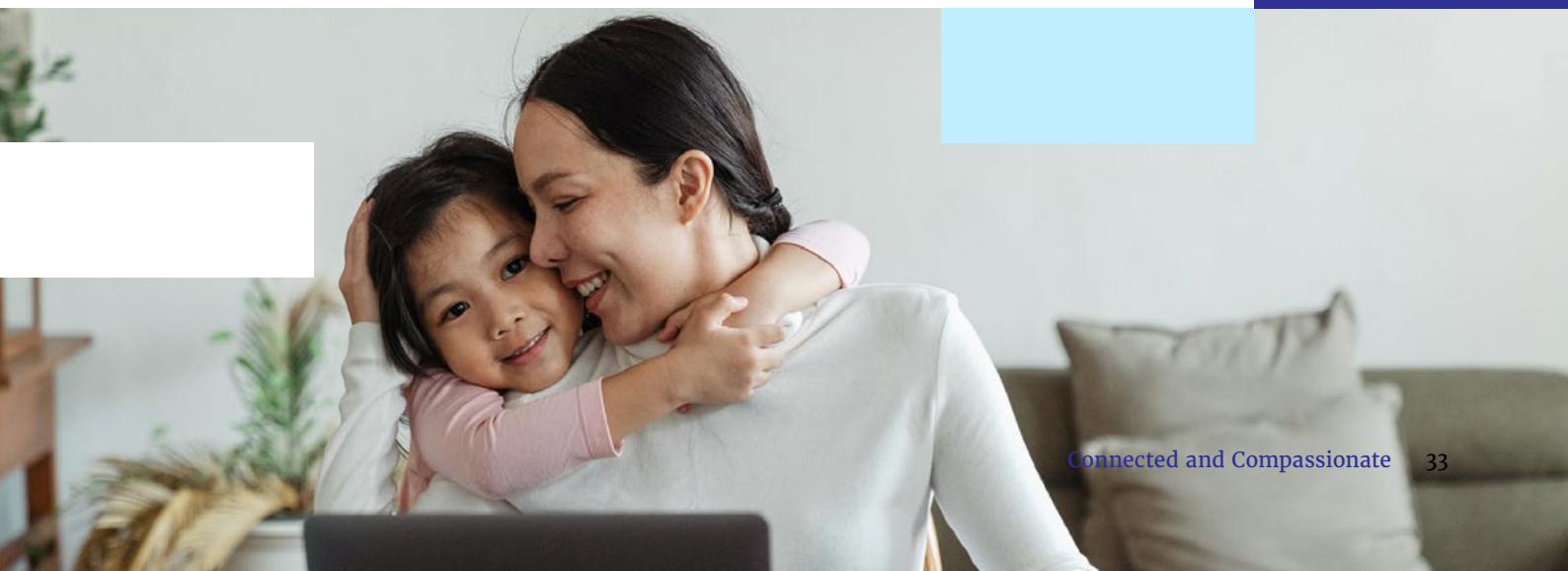
- culturally safe for all,
- can identify if someone is a Veteran and the specific supports needed,
- able to effectively engage and support men in ways that work for them, and
- competent to work in ways that are safe and inclusive for LGBTIQ+ people.

Informed by lived experience insights, particular priorities for strengthening the capability of clinical workers would include and immediate focus on:

- emergency departments,
- alcohol and other drug services,
- Aboriginal Community Controlled Health Services, and
- emergency services.

General Practitioners and other primary care providers are an important clinical touchpoint for people experiencing distress and should be prioritised, noting that many Primary Health Networks and place-based trial sites have had variable success in engaging general practitioners. This needs to be addressed and strengthened through national leadership and local partnerships. There are also opportunities to strengthen clinical training and specific suicide prevention competencies for psychologists, especially those working in the private sector.

While training for those in the workforce is an immediate priority, the development of core competencies to be embedded into the pre-service training of all relevant professions would lead to more lasting change. There is a clear role for the Commonwealth to lead on work with universities and professional bodies to deliver this.



Build community capability

Many people who experience suicidal distress are likely to talk to a family member or friend before they ever reach out to a service. It is important to continue to build community capability to support suicide prevention action, linking to regional and local community planning. As part of this, there is an opportunity for a more coordinated and consistent approach to community education and skill building and linking communities into localised support pathways.

The *National Suicide Prevention Strategy for Australia's Health System 2020-2023* has three key areas of focus to increase individual and community capacity to seek help and to offer help, being: population-wide and localised public education campaigns, workplace initiatives and community connector training. Based on lived experience research outlined in *Compassion First* and engagement with regional and national stakeholders, the following should be considered:

- Ensuring that public education campaigns and other public awareness approaches have a clear theory of change, are well evaluated in terms of knowledge and actions taken following the campaign, and better targeted local communities and priority populations.
- Community-focused activities, including public campaigns, should be guided by and include those with lived experience, with a focus on increasing the voice of those who can speak to recovery from suicidal distress.
- Campaigns, programs and training should focus on building community strengths and protective factors – especially those that build social connections and social cohesion.
- Preference must be given to contemporary and evidence-based community training, with ongoing quality assurance built in, including possible accreditation for effective programs. Programs that meet the needs and preferences of particular communities and priority populations need to be considered.

Further work is required to clarify responsibilities for funding between jurisdictions, local governments and Primary Health Networks, especially related to community (or 'gatekeeper') training to reduced duplication and gaps, and to ensure training is not delivered in isolation to other local work to build pathways to care.

The interactions that government workers have with people every day collectively add up to millions of opportunities for a conversation or a referral that makes a difference for someone in distress. Building and supporting compassionate workforces focused on providing connected care will enable governments to seize many more of these opportunities. Increasing individual and community capacity to seek and offer help when it is needed will also enable much earlier intervention, helping to change the trajectory for people who are at risk of suicide or self-harm.

Develop a suicide prevention workforce strategy

The actions outlined in this section will help strengthen capability across existing workforces, ensuring that no matter where people work across government or community settings, they have the skills and knowledge to provide a compassionate response to people in distress.

There is also a need for longer-term workforce planning and development as Australia's suicide prevention system continues to evolve. Jurisdictions must come together to develop a long-term workforce strategy for suicide prevention to support the delivery of the *National Suicide Prevention Strategy*. This should consider all relevant workforces across government and community settings, ensuring a whole of government and whole of community approach to building future suicide prevention capability. It needs to focus on methods to grow and diversify the workforce to ensure it can adequately cater for the age, gender, and cultural diversity of those accessing services. Focus is also needed on workforce models that support rural communities, where workforce supply issues are significant. Immediate steps to consider suicide prevention workforce needs as part of the *National Mental Health Workforce Strategy* is a priority.



The shifts we need

To prevent deaths by suicide and suicide attempts, we need to shift how governments at all levels engage with and support Australians. This means stepping back from the point of crisis to look at all the ways we can reach and engage people to *prevent* distress and divert them from a suicidal trajectory.

It also means governments working together to provide coordinated care across the life journey – addressing people’s needs holistically rather than just providing support in a crisis.

This section summarises the key shifts that will underpin a more connected and compassionate approach to suicide prevention, and outlines specific recommendations on where to focus priority effort.

In driving these shifts, governments need to consider initiatives capable of reaching individuals in distress and at risk of suicide; groups which are disproportionately impacted by suicide; and population-level interventions that increase security and safety. This multi-layered approach will identify and maximise opportunities for early intervention. This approach aims to ensure that early responses to distress through government and community touchpoints are as strong a consideration as crisis responses and clinical interventions delivered primarily through health services. This will create a stronger, more holistic and coordinated suicide prevention approach for Australians.

To achieve a more connected and compassionate approach to suicide prevention, efforts by governments at the national and jurisdictional levels should prioritise four key shifts:



Responding earlier to distress



Connecting people to compassionate services and supports



Targeting groups that are disproportionately affected by suicide



Delivering policy responses that improve security and safety

5. Responding earlier to distress

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

— Lived experience statement

Learning from lived experience

- For many people, suicidal thoughts and behaviours emerge because of intersecting and compounding harms across a lifetime, often commencing in childhood and adolescence.
- People often experience acute situational stressors at the time that they attempt or die by suicide, and may become disconnected from their networks and supports.
- The service system in Australia is primarily focused on responding to a suicidal crisis or responding after a suicide attempt rather than addressing distress early.

The shift we need

We need to shift from only responding once a suicidal crisis emerges to a more prevention-focused approach that responds early to distress and early in the trajectory towards suicidal behaviour.

Recommendation 5

As a priority action and reform, all governments work together to develop and implement responses that provide outreach and support at the point of distress, to reduce the onset of suicidal behaviour.

This includes the following **priority actions**:

- 5.1** Coordinated cross-jurisdictional and cross-portfolio action to intervene early in life to: (a) mitigate the impacts of adverse childhood experiences; (b) strengthen supports for families; and (c) ensure early access to programs, treatment and support for children and young people.
- 5.2** Developing, implementing and evaluating a scalable early distress intervention for people experiencing: (a) intimate relationship distress; (b) employment or workplace distress; (c) financial distress; and (d) isolation and loneliness.
- 5.3** Implementing and evaluating interventions that support people through transitions, including: (a) entering or being released from justice settings; (b) leaving military service; (c) finishing or disengaging from education or vocational settings; (d) entering retirement; and (e) engagement with aged or supported care services.

Why this is important

As people move through different stages in life, they will encounter a range of stressors, transition points and times of disconnection. These can contribute to distress, which can develop into suicidal behaviour in the context of other risk factors. There is an opportunity to respond early in the trajectory towards suicide by identifying these points of vulnerability and meeting people 'where they are' to provide effective supports and alleviate the distress. By taking a more proactive prevention approach, we can reduce the distress that can lead to suicide, connect people with support and the means to address the cause of the distress, and help build or restore hope.

Governments provide, or fund, a range of services that support people through difficult times – including family crisis, intimate relationship breakdown, financial distress, and job loss or business failure. Each point of contact a person has with a government agency or funded service is an opportunity to provide more proactive outreach and support to prevent distress escalating into suicidal behaviours. We must not wait until people reach a point of crisis – intervening much earlier is key to achieving genuine prevention.

Achieving this effective early intervention requires improved coordination across portfolios and between jurisdictions, assisting governments to reach and support people in a holistic way. It requires clear alignment between service responses and policy approaches (further discussed in Chapter 8). It will also be strengthened by clear definitions of distress and measures to support ongoing evaluation of the approach.

What we need to do

Intervene earlier in life

One of the most effective opportunities for early intervention is with children. Proactive and coordinated support for children and young people whose early life experiences can make them vulnerable to distress are clear priorities. Key opportunities for intervention early in life include the following.

Addressing childhood trauma and strengthening support for children at-risk

Adverse childhood experiences are a risk factor for suicidal behaviour in children and young people, as well as in later life.¹¹ Coordination across agencies and between jurisdictions will provide opportunities to mitigate the impacts of childhood adversity and trauma, with particular focus on high risk factors such as when children and young people are placed in out of home care or kinship care, are transitioning from out of home care, or are otherwise in contact with the child protection system. Reducing the abuse of children in the home and in out of home care settings is a priority, as well as ensuring effective trauma-informed care and wrap around services for young people in distress.

Welfare and family services agencies, first responders, early childhood services, schools and healthcare providers can improve processes for identifying and engaging with children and young people who are exposed to violence and abuse, and can strengthen proactive provision of coordinated supports that are trauma-informed. There is also a need to review online protections for children to reduce exploitation and harms.

The Draft *Aboriginal and Torres Strait Islander Suicide Prevention Strategy* includes a focus on children and young people including: expanding culturally informed services addressing social and emotional wellbeing; strengthening training to identify distress among Indigenous children and young people; and improving the accessibility of service options.

Identifying parents and families needing additional support

Children and young people's wellbeing is closely linked to that of their parents and the safety of their home environments. Governments can strengthen supports provided to all parents, especially new parents, and leverage more of their touchpoints to identify families needing additional supports with parental mental illness, alcohol and other drug problems, and family and domestic violence.

Relevant services and touchpoints are available at multiple levels of government. Frontline Commonwealth agencies like Services Australia and national services like 1800RESPECT, as well as primary care providers in communities provide clear opportunities for early identification of families and parents needing additional support. At the State and Territory level, child health centres, early childhood services and schools, housing and community services agencies are among those that are in touch with families in ways that can support more proactive outreach and early intervention.

A focus on children and young people, including early intervention, treatment and support

Suicidal ideation, self-harming behaviours and suicide attempts often first emerge in adolescence, but can also occur in younger children. There is an imperative to prioritise prevention and early intervention approaches for children and young people, linking with the environments where they live, learn and interact. There are a number of programs that have shown effectiveness in reducing suicidal ideation and suicide attempts, targeted at schools and other universal settings. These initiatives should be considered for scale. There is also a key opportunity to link with other programs targeted at the prevention of mental ill-health and alcohol and other drug harms in this age group.

Effective early treatment for mental illness or mental health challenges, including any alcohol or other drug problems, needs to be available for young people. This should have strong links to schools, youth services and other settings that support identification and warm referrals of young people into services. These services should be co-designed with a diverse range of young people to ensure they are readily accessible, and should be resourced in such a way as to be available when young people need them.

National services like headspace together with State and Territory-based mental health and alcohol and other drug services have a role in the delivery of these supports.

A stronger focus on outreach and embedding services in community, including community controlled services that can engage with Indigenous young people and services that support LGBTIQ+ young people, will help promote access and broaden their reach. Better connections with the range of other government services and agencies discussed in this section will also ensure these are provided as part of a holistic approach to addressing young people's needs, particularly to proactively intervene when there is a risk of suicidal distress. This also includes proactive approaches to support young people who are impacted by suicide attempts and suicide deaths occurring at their school or among their broader community networks.

Many children and young people are using and engaging with digital platforms, including social media platforms. There is an opportunity to use these platforms as a way of engaging with and empowering young people. Increased access to evidence-based digital programs can be integrated into environments where young people seek support. In parallel, continued work is required to ensure safety and protection for all children and young people engaging online (further explored in Chapter 8).

The processes and mechanisms underpinning this shift to early intervention for children and young people may look different in each Australian jurisdiction and within individual regions or communities. However, the shared goal should be to build protective networks of support around people early in life and strengthen their resilience so that early adverse life events do not become a driver of long-term distress or suicide risk.



I live a life where suicide will always be a risk factor – for myself and for my loved ones. Neglect, incest, sexual abuse...gave all my family a life sentence of severe trauma and life-long mental health challenges. Suicide has never been far from any of our minds. I have attempted suicide and I've sat beside siblings and called ambulances...

– Personal story, Private Voices study



Respond earlier to distress

Government agencies help millions of Australians every day. Some of the services that governments deliver support people through difficult times including relationship breakdown, job loss, business failure or bereavement. Each one of these service touchpoints is an opportunity to identify and proactively engage with people experiencing, or at risk of, significant distress. There is an opportunity to address both the capacity and the capability of these services to reach more people.

Developing an early distress response system for Australia

To support effective and comprehensive early intervention, there is value in developing an early distress service model for Australia. Informed by international evidence, this would include:

- Increased capacity across government and community services to provide outreach and support for those experiencing situational stressors likely to contribute to distress.
- Developing workforce capability across services to respond with compassion to people who are experiencing distress.
- Improving data systems to identify people accessing multiple services and systems that may need a proactive approach.
- Developing, testing and scaling up a service system that can provide immediate follow-up and support to connect people to the right services at the regional level.

Responding early to distress has its origins in crisis theory, which recognises the importance of addressing non-clinical stress and trauma to avert the onset or exacerbation of mental ill-health or suicidal thoughts. It also aligns with research focused on natural disaster responses, which have reinforced the value of non-clinical, emotional and practical support for people as a way to prevent escalation of distress and to enable recovery.

One promising option for embedding early distress intervention across government services and agencies is the Distress Brief Intervention model.¹² Developed and piloted in Scotland, this approach aims to provide people with access to immediate support at times of acute distress, followed up with care coordination that links them to ongoing supports

that meet their needs. Services are available to anyone experiencing distress where emergency care is not required. Importantly, services are not explicitly presented as 'mental health' or 'suicide prevention' supports – this helps to make them more accessible for people who do not define their needs in these terms.

The Distress Brief Intervention service combines two kinds of support: an immediate compassionate response paired with the offer of a referral for further support, and follow-up contact within 24 hours by a trained support worker who can help an individual work through the underlying drivers of their distress. In this model, support is offered where and when people are experiencing distress, without them having to present to a dedicated mental health service. In the Australian context, an early distress response using principles of this approach could be implemented with the service touchpoints highlighted throughout this section.

Proactive early intervention for distress – taking help to where people are when they are in distress – is of particular value for those cohorts of people who are not likely to proactively seek help from existing health services, including men who are vulnerable to suicide. Early distress intervention approaches focus on linking people with a range of services and supports to address their diverse needs, including supports for alcohol and other drug issues, which people with a lived experience have told us often co-occur with distress.

A focus on particular stressors

In addition to this general early distress response approach, data linkage work and engagement through lived experience will help to identify the specific government and community touchpoints that are most critical for action. Based on evidence, immediate priorities could include a focus on providing outreach and support for people experiencing the following life stressors:

Intimate relationship distress

Relationship breakdowns are frequently a source of significant distress, especially when coupled with interactions with the family law courts. Exposure to all forms of family, domestic and sexual violence may cause people to feel trapped and helpless within their intimate relationships and can be another serious cause of distress.

Our intimate relationships are an important source of social and emotional connection, particularly for men. When they break down or are under strain, the distress this causes can be compounded by feelings of disconnection and social isolation.

Australia's family law courts and funded family relationship services – including mediation services, family and domestic violence services and child protection – are key service touchpoints for people who are experiencing intimate relationship distress. There is an important opportunity to embed proactive outreach within these services to identify people who may be on a trajectory towards suicide, and help disrupt this through connecting them with the right supports.

Employment or workplace distress

A job is fundamental to the economic security and wellbeing of most Australians. Some people also derive an important part of their sense of self from their work. When employment is disrupted through job loss, a workplace injury or a dispute, this can cause distressing feelings of loss, powerlessness, anger and reduced self-esteem.

Government services are often among the first points of contact for people who are experiencing employment and workplace distress. For example, newly unemployed people may engage with Services Australia for support payments and employment services to seek assistance in finding a new job. Workers' compensation agencies can be closely involved in supporting the recovery of those who have been injured at work, and agencies like the Fair Work Ombudsman and State and Territory equivalents provide advice in relation to disputes. Each of these agencies could play an important and transformative role in early distress intervention.

Financial distress

Financial stressors can take many forms, including mortgage or housing stress, the financial impacts of owning a small business, or financial stress due to gambling harms. Sometimes one can cascade into others, leaving people feeling like they cannot see a way out of their financial situation. Financial stress can also be triggered by, or occur in parallel with, other stressors like relationship breakdown or unemployment, all of which compound the distress.

Financial institutions are a critical service touchpoint for people experiencing financial distress, but there are a range of other government agencies that may also be contact points, including the Australian Taxation Office, the Financial Ombudsman Service and the National Gambling Helpline, as well as State/Territory revenue authorities and financial counselling services. In embedding the capacity for early distress intervention within these services, it will be important to consider opportunities for linkages with programs or initiatives delivered by private sector financial institutions.

Loneliness and disconnection

People can become disconnected from social networks and community supports for a wide range of reasons. These can include the life events discussed above; mental illness or alcohol and other drug abuse; social relocation – including through migration; and bereavement. Unlike other forms of distress, people experiencing loneliness and disconnection may not be engaging with a particular set of government services. This can make it more difficult to identify them and undertake early distress intervention.

The constituency offices of Members of Parliament, national helplines such as Lifeline and elder care agencies are potential touchpoints for reaching and engaging with some people who are feeling socially isolated. However, all government agencies and services could be alert to behaviours which may signify this kind of distress, such as frequent contact outside of any apparent service need, and extended engagement with staff. Further consideration of relevant touchpoints for priority populations will also be required.



Childhood depression led to divorce at 27, and mid-life crisis with lack of financial stability. Over time, multiple situations created a sense of despair and incompleteness leaving with a sense of total failure in life. This caused dependency and extreme loneliness.

– Personal story, male interview participant



Provide earlier support during work and life transitions

Life transitions can be positive, but in some cases they can also bring disconnection from familiar environments, relationships and structures that have supported people's wellbeing. There are opportunities for agencies across jurisdictions to work together to provide proactive support for people undergoing significant life transitions which increase vulnerability to suicidal behaviour.

Delivering early intervention at key points of transition requires an important shift in thinking across government agencies and services. The risk is that agencies are structured in such a way that they perceive their obligation to citizens ending when they cease to access a particular service or have a particular role. To address people's vulnerability at points of transition, we need to strengthen the capacity for warm and effective handover across agencies and service streams. Strengthening systems for data and information sharing and co-case management is an important enabler but the most important shift will be governments taking shared responsibility for people's wellbeing as they move within and between service systems – seeking opportunities to keep people connected.

Evidence suggests that an immediate focus is needed on the following transition points, with opportunities for further priorities to be identified as data and evidence are improved.

People in contact with the justice system, with a specific focus on the transition from custodial settings to the community

The risk of suicide among those who are released from prison is more than six times as high as within the general population.¹³ While State and Territory governments have put in place initiatives to reduce suicide attempts and deaths within custodial settings, those in non-custodial settings (e.g. community orders, bail) and people exiting prison, have an elevated risk of suicide. People leaving prison frequently lack the fundamental supports that foster wellbeing, like employment, housing and social connections. They can also experience stigma and other challenges associated with an adjustment to community life as well as ongoing challenges with mental ill-health, substance use or past trauma.

In the same way that aftercare approaches provide proactive follow-up and care coordination for people following a suicide attempt, people released from prison (or on community orders) could benefit from proactive outreach and dedicated care-coordination to ensure they are linked to supports. This would include partnerships between Commonwealth and State and Territory governments to ensure prisoners have the supports they need to transition well, strengthening the sharing of information between government agencies and service providers to promote continuity of care, and ensuring that basic needs like housing and access to treatments are met. It would also involve rebuilding positive, protective networks of support through models that emphasise human connection and reintegration into community.

People transitioning from military service, including supports for their families

Veterans are defined as those who have served, or are serving as, a member of the Australian Defence Force (ADF), including reservists. While military service has inherent protective factors, it also exposes veterans to risk factors. Although not all veterans are at higher risk of suicide, research indicates that personnel transitioning from the ADF to civilian life do have a higher rate of suicide than the general Australian population. There are also commonalities within the veteran population that intersect with already identified priority populations for increased suicide risk, such as men and young people aged between 20 and 24 years. Veterans leaving service due to physical or psychological injury or issues with alcohol and other drugs are particularly vulnerable.

In recent years, the Departments of Defence and Veterans' Affairs have strengthened the coordination of care and support for veterans and their families, addressing the unique impacts military service can have on health and wellbeing. There has been a particular focus on improving access to mental health care as well as increasing supports and case management through lived experience peers.

The Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023 has a strong emphasis on recognising that transition can begin well before a veteran leaves the Australian Defence Force. Close collaboration with governments, communities, business, peers, and Ex-Service Organisations will better support veterans and their families.

There are opportunities to further enhance support to veterans and their families through stronger coordination with services within the civilian service system, including employment, housing and relationship services, digital services and supports for veterans and their families in trying to navigate these different service systems. The needs of veterans' families have also been recognised, as transitioning from military service can bring with it major life changes for families and disconnection from social networks and supports. Proactive outreach by civilian services that provide support for carers, family and domestic violence and alcohol and other drug services are a priority in helping ensure families get the right help.

Young people who have disengaged from their education or vocation

Study and training provide an important scaffold for young people's wellbeing. Disengagement often happens in parallel with other stressors like family trauma, housing insecurity, issues related to sexuality and gender, mental health challenges, or alcohol and other drug issues. Young people who disengage with education, or are excluded from education, are significantly more vulnerable to suicide as well as other negative life events like unemployment, exploitation and social isolation.

Schools, universities and training institutions are primary touchpoints for young people who have disengaged from education or are at risk of doing so. Supporting young people through this transition will often require a coordinated approach to address the complex drivers of their disengagement. This means other agencies like headspace, family services and housing providers also need to come together to provide integrated outreach and early intervention. There would also be a role for community controlled organisations engaging with particular population groups such as LGBTIQ+ young people. Helping young people to re-engage with study and training is not only important for addressing their vulnerability at this point of transition; it can also be a form of early intervention to help prevent future life stressors like unemployment and economic insecurity.

Older people experiencing major life transitions

Ageing brings with it a range of transitions which can make people vulnerable to loss, disconnection and distress, including the transition from work into retirement, the transition from independent living into aged or supported care, and the grief associated with the death of a partner. Men can experience the distress of these transitions particularly acutely, making them more vulnerable to suicide in older age.

As with people who are experiencing loneliness and social disconnection more generally, older people undergoing some of these transitions may not be well connected to government services and supports. However, touchpoints like Services Australia for pensions and State and Territory government authorities which are involved following a death are two opportunities for proactive outreach. Strengthening mental health and wellbeing supports within aged care settings should also be a priority.

Intervening earlier – in life, in distress and at key points of transition – is crucial to preventing the kinds of distress that can escalate into suicidal crisis. It is not inevitable that traumatic or disruptive life experiences should lead to lasting and cumulative distress. A coordinated approach that leverages all levels and agencies of government to achieve more proactive outreach and coordinated support will help address distress and vulnerability to suicide, enabling people to take a different path towards hope and belonging.



My university really helped me. I was able to receive counselling at a community health centre...as well a scholarship from uni – all of which were life changing. Prior to receiving counselling I would think about suicide every day; it was habitual.

– Personal story, Private Voices study



6. Connecting people to compassionate services and supports

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

— Personal story, Private Voices study

Learning from lived experience

- People experiencing suicidal distress need an accessible and compassionate service response, but describe the current system as disconnected, crisis-driven and ill-equipped to support their complete needs.
- Australia's service system is characterised by multiple drop off points, a lack of integration and a lack of dedicated supports for caregivers and families.

The shift we need

We need to move from providing isolated and one-off interventions to an integrated system of care that has a focus on providing accessible, coordinated and compassionate services – linking people to the right supports at the right time.

Recommendation 6

All governments work together to progress service reform to achieve integrated, connected and quality services for people experiencing suicidal distress, people who have attempted suicide as well as caregivers and people impacted by suicidal behaviour.

This includes all governments working together to implement priority actions from the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* and the *National Mental Health and Wellbeing Pandemic Response Plan*, including:

- 6.1** Integrated digital and face-to-face supports to improve accessibility, service options and appropriate levels of service.
- 6.2** New service models incorporating compassionate community-based support for people experiencing suicidal distress.
- 6.3** Aftercare services for anyone who has attempted suicide or experienced a suicidal crisis.
- 6.4** Timely and compassionate supports for families, friends, caregivers and impacted communities, including bereavement and postvention responses.
- 6.5** Connecting alcohol and other drug prevention and treatment services to our suicide prevention approach.

Why this is important

People with a lived experience of suicide consistently emphasise the importance of coordinated care in effectively supporting people through crisis, as well as the value of ongoing therapeutic approaches and peer support. Services which engage with people at times of acute distress need to be better linked with ongoing supports that help people to develop coping skills, build protective networks and address the underlying drivers of their distress.

People who are experiencing distress often struggle to navigate between different kinds of services, resulting in missed opportunities for coordinated care before and after a suicide attempt or episode of crisis. People with a lived experience have voiced how difficult and emotionally draining it can be to have to 'ask for help' from multiple service systems and emphasised the importance of a compassionate approach at all times.

Health and mental health services are an important component of Australia's suicide prevention system, and they will continue to be so. It is important that therapeutic and contemporary treatment for suicidal thoughts and behaviours and self-harm is available and delivered to quality standards. Reform to the mental health system should deliver better outcomes for people, particularly those who experience suicidal distress alongside, or because of, mental ill-health. But these responses need to be complemented by actions and inputs from other parts of health and other agencies so that people experiencing suicidal distress, their caregivers and those bereaved by suicide have access to compassionate and coordinated service responses. There must be more focus on outreach to people and follow-up to ensure people get the supports they need.

This *Final Advice* has broad alignment with the priority domains and foundations set out in the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* developed under the *Fifth National Mental Health and Suicide Prevention Plan*, the *National Mental Health and Wellbeing Pandemic Response Plan* (the Pandemic Response Plan) and the *Productivity Commission Inquiry into Mental Health* (see Appendix 2 for further details). In particular, these reports and strategies highlight the need for more proactive outreach of services into community settings, and better connectivity to ensure clear and connected pathways to care. This alignment accentuates the opportunity for all governments to work together to begin implementing reforms that are focused on the health and mental health systems, including the shift to community-based care.

Implementation of existing jurisdictional and national suicide prevention strategies and plans should continue without delay, to ensure a seamless approach. This includes implementation of the *National Suicide Prevention Strategy for Australia's Health System 2020-2023*, with a particular focus on immediate priorities aligned to the Pandemic Response Plan. This will maximise opportunities to implement the substantive work to date with broad agreement and action from jurisdictions.

Deliver new and better services that prioritise connected and compassionate support

All elements of the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* should be implemented and monitored, including the development of comprehensive models of care that are being introduced across health services and within emergency departments. This must also be extended to ensure that health and mental health services are using evidence-based interventions and therapies for suicidal thoughts and behaviours. There is good evidence for certain therapeutic approaches that are not routinely delivered or monitored within health and mental health setting. This must be a priority.

In considering a whole of government approach, the following elements have been highlighted as critical to building a connected community-based and whole of government response, including cross-portfolio enhancements to enable a more complete and connected approach.

What we need to do

Implement the Health System Suicide Prevention Strategy

Meaningful and sustained change to suicide prevention in Australia cannot happen in a vacuum. To achieve a national whole of government approach, we must leverage mental health reforms to help drive transformation in other portfolios.

Better integrated digital and face to face services and supports

Crisis helplines and online services form an important part of the suicide prevention system in Australia, with volunteers and trained professionals providing support 24 hours a day. These include Lifeline, MensLine Australia, Kids Helpline and the Beyond Blue Support Service, which collectively respond to well over one million contacts each year. The Commonwealth also funds the Suicide Call Back Service, which combines crisis support with counselling sessions provided by a psychologist, and a series of specialist helplines including QLife which provides vital supports for LGBTIQ+ people, and Open Arms – Veterans and Veterans Families Counselling Service. A digital support service for Aboriginal and Torres Strait Islander people has also been proposed. These services have been particularly important in supporting Australians through the COVID-19 response, with increases in calls and contacts across all services. However, the referral pathways between these services, and with face-to-face ones, are unclear and not well coordinated. This results in people receiving ‘one-off’ or ‘disconnected’ responses. There is an immediate opportunity for these services to be an entry point to coordinated ongoing care and support, noting the confidentiality of some services.

In the context of COVID-19, the Commonwealth Government has commenced work on scoping how to improve referral systems between national telephone and online support services and face to face services available in communities. This is an important step forward, both in the immediate term and in strengthening system connectivity beyond the crisis response. In doing so, it will be important to consider both the range of services offered and how these address the needs of target groups, and the practical infrastructure that supports effective referrals between different kinds of services delivered by different partners. Exploring opportunities for these services to act as an alternative entry point for ongoing and connected care beyond the primary care system could also make this kind of care more accessible and reduce barriers to people reaching out for help.

This work could also connect with other national helplines, including those funded outside the health portfolio such as 1800 RESPECT, the National Alcohol and Other Drug hotline, Gambling Helpline, National Debt Helpline, Health Direct and Open Arms – Veterans and Veterans Families Counselling Service. Many people accessing these services could benefit from an integrated approach where a warm transfer to a suicide prevention service can occur directly and/or where people are offered a ‘call back’ if they are experiencing suicidal distress.

Given that many people experiencing suicidal distress are not in contact with health services, there are opportunities to connect and engage them when seeking informal help through websites, peer to peer forums and other digital interventions. These platforms offer a conduit to engaging people and require further testing for their role in suicide prevention, including the opportunity they provide to connect people directly to other types of supports. Digital tools also show promise in supporting improved care coordination and follow-up for people accessing support through a range of online and primary care settings that could be further tested in the context of suicide prevention.

New service models that align with a compassionate community-based response

People need more options for seeking help when they are experiencing suicidal distress, including options available for people who experience ongoing suicidality. People with a lived experience have emphasised that clinical help is not always wanted or needed, nor is it the only support they need. Many people have communicated a preference to be supported by a peer who has themselves experienced suicidality, from the same community groups that they identify with, in community settings that promote warm and non-judgemental support.

This is the service model underpinning the concept of Safe Spaces and other peer-led, community-based suicide prevention initiatives. Safe Spaces are conceived as places where people experiencing suicidal distress can seek support from peers with lived experience in a non-clinical environment. There is no single model for what constitutes a Safe Space; the ability for communities to develop spaces tailored to meet their local circumstances and needs is an important feature of the approach. A common factor of all Safe Spaces is person-centred support that aims to respond to the individual needs of each person who seeks help. For some guests, this may mean having the opportunity to talk about what they are experiencing with others who have walked the same path. For others, it may simply mean being able to sit in a safe and soothing environment until their feeling of crisis passes.

Several State and Territory governments are piloting these kinds of interventions. For example, NSW is rolling out 20 new Safe Haven services, offering peer-led support in community settings.

Governments could collectively learn from these pilots and build on them to diversify the range of supports available to people experiencing suicidal crisis. Although there are some instances when an Emergency Department will be the right place for a person in crisis to seek help, when it is not, and when the clinical model of care does not respond to someone's individual needs, it is critical that real alternatives exist and can be readily accessed in a way that is inclusive and safe. Given the emergence of these models, ensuring shared and consistent outcomes measures and prioritising multi-site research will be important in informing future scalability and implementation.

There is an opportunity to develop linkages between health portfolios and other portfolios as well as local governments in the design and delivery of these services. For example, government and community infrastructure like public libraries, universities, youth services and other service hubs could play an important role in hosting or linking to Safe Spaces.

Extend access to evidence-based aftercare

A prior suicide attempt is a significant risk factor for further suicide attempts and death by suicide. This risk is greatest in the days and weeks following discharge from hospital or other specialist care. An Australian data linkage study conducted in the past five years found less than half of people who had been admitted to hospital following a suicide attempt at that time had any contact with a public health service after their discharge.¹⁴ This is a crucial time when people should not be left to navigate complex and difficult service systems on their own.

Aftercare models which integrate non-clinical assertive outreach and community-based services are a crucial way to close this gap and make sure people receive coordinated support when they are highly vulnerable to suicide. The Commonwealth currently supports The Way Back Program delivered by Beyond Blue and other models such as the Victorian HOPE initiative are in place, with all jurisdictions committed to providing aftercare services. In this aftercare model, a support worker will usually make contact with a person within 24 hours of their discharge from hospital and offer continued support for up to three months – helping them stay safe and ensuring they are linked to supports. Evaluations of aftercare-type approaches have shown positive results in strengthening people's sense of social connectedness, as well as improving coordination and integration of care. There is an ongoing discussion about the effectiveness of different clinical and non-clinical models of care and whether support for three months is appropriate in all cases.

The Productivity Commission Inquiry into Mental Health includes recommendations that these services should be more widely available and connected with routine care over time. The approach should also be extended to include people who survived a suicide attempt as well as those who have experienced a suicidal crisis without an attempt. In both instances, this would mean exploring broader entry points outside of the hospital system to make sure these supports are not just available to people who present to hospital, as we know many never do. This might include direct referral from emergency services, schools, universities, general practitioners, and other government services, especially considering a lack of hospital services in many rural communities and the tendency for men to present to hospital less frequently than women. Models of care and referral pathways should continue to be co-designed and tested to ensure they meet the needs of men, women, trans and gender diverse people, can support young people and are considered culturally safe.

Review the use of medication in suicide prevention

Australians are among the highest consumers of antidepressants in the world.⁶⁹ There have been conflicting findings in recent years regarding the efficacy and safety of antidepressant use in Australians, specifically among children and young people. Lived experience submissions to the National Suicide Prevention Taskforce and the Productivity Commission Inquiry into Mental Health called for a review of medication use as a treatment for suicidal distress, especially when used in isolation. A comprehensive review and analysis of the rate at which antidepressant medications are being dispensed to young adults is needed to inform future actions. Available data suggest a 66 per cent increase in the rate of antidepressants being dispensed to young people and young adults in the past 10 years, with 90 per cent of antidepressants prescribed by a General Practitioner.¹⁵

Coordinated supports for caregivers and those impacted by suicide

Families, friends and caregivers are the unpaid workforce in suicide prevention, but can often feel over looked and unsupported. With an estimated 65,000 people attempting suicide each year and a further 300,000 having thoughts of suicide, service navigation, psychosocial and emotional support often falls to caregivers. Caregivers are required to provide care coordination, despite frequently lacking the expertise, resources and support to do so. Evidence also suggests that caregivers themselves can be at risk of suicide if timely and appropriate supports are not provided to ensure they have the practical and emotional support they need.

Australian research indicates that for each person who dies by suicide, an average of 135 others will be exposed or affected in some way.¹⁶ This can span those who are directly bereaved like family and friends, as well as first-responders, care providers and a range of others across local communities. Evidence tells us that being bereaved by suicide can increase an individual's own risk of suicide or self-harm, while in some communities suicide can become a source of collective trauma.

In Australia's current service system there is a gap in services and supports available to families, children, caregivers and broader community networks. In designing effective service responses there must be a stronger consideration given to supports for family and caregivers supporting someone through suicidal distress or following a suicide attempt. More universal access to, and local coordination of, postvention and bereavement supports are also needed. Currently, the major providers of postvention services are national organisations that have a limited regional or local footprint in some areas. Broadening the range of partners providing postvention for families and communities, or better connecting national providers into local systems, will be important for strengthening local delivery of these services.

Evidence suggests that priority opportunities to deliver postvention supports would include schools, Indigenous communities and regions where there is an emerging cluster of deaths by suicide. This links to the point discussed in Chapter 3 of this Report about the importance of strengthening data collection and coordination to guide real-time decisions about where service interventions are needed and roll these out in communities quickly.

Connecting the prevention and treatment of alcohol and other drug problems to our national suicide prevention approach

Many Australians drink and enjoy alcohol in moderation, without adverse effects on their health and wellbeing. However, evidence also highlights a range of complex interactions between alcohol and suicide that need to be addressed as part of an integrated approach to the prevention of suicidal behaviour. Can be co-occurring.¹⁷ Through the research undertaken for Compassion First, we have also heard that increased use of alcohol and other drugs can be a co-occurring stressor with life events like job loss or relationship breakdown in people's pathways towards self-harm and suicide. Evidence shows that alcohol and other drug use can particularly amplify the risks faced by some groups including men, Aboriginal and Torres Strait Islander people, and young people.¹⁸

Despite the close links between suicide risk and alcohol and other drug use, current suicide prevention plans and strategies do not directly address this. Support for alcohol and other drug problems must be more closely integrated with the other services and types of support and connected to our prevention approaches in schools, in workplaces and in other community settings. As flagged in Chapter 5, there are particular opportunities to strengthen integration of alcohol and other drug supports with early distress interventions aimed at people experiencing relationship, employment and financial distress. There are also opportunities to screen for and provide brief interventions for alcohol and other drug use across community settings.

Given the chronic and re-occurring nature of problematic alcohol and other drug use and suicidality, proactive follow-up care should be provided for people who have presented with or problematic substance use, independent of a history of suicide attempts. Frontline clinicians in alcohol and other drug treatment services and aftercare services should also receive contemporary training in the contributing role of alcohol and other drug use in suicidal thoughts and behaviours, as well as how to recognise and respond to the early signs of suicidality in their clients. Broader roll-out of national comorbidity guidelines would also be beneficial.

7. Targeting groups that are disproportionately affected by suicide

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

— Personal story, culturally and linguistically diverse participant

Learning from lived experience

- A person's age, gender identity, cultural background, where they live and how they are treated by broader society can have an impact on the factors contributing to suicidal distress and their experiences with services. Experiences of discrimination and exclusion were critical in some people's journeys.
- Aboriginal and Torres Strait Islander peoples' experience of suicide is described as different from mainstream experiences of suicide. The effects of colonisation and associated trauma contribute to this lived experience.

The shift we need

Governments must shift from a one-size-fits all approach for suicide prevention to targeted approaches that will reduce suicide attempts and deaths within populations that are disproportionately impacted by suicide.

Recommendation 7

All governments to apply an equity approach to suicide prevention planning and funding to prioritise targeted approaches for populations that are disproportionately impacted by suicide.

This includes the following **priority actions**:

- 7.1** National funding of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* from 2021, implementing Indigenous leadership and governance, place-based initiatives and building on workforce and community strengths.
- 7.2** All jurisdictions to commit to identifying priority actions for male suicide prevention to be incorporated into the *National Suicide Prevention Strategy*, including: (a) the Commonwealth government to lead on identifying priority actions that leverage their government services and systems, such as employment services, family law courts, relationship services and aged care; and (b) all jurisdictions to review and report on the accessibility of their funded services and programs for men.
- 7.3** All jurisdictions contribute to identifying national actions for priority populations to be included in a *National Suicide Prevention Strategy*, including: children and young people; LGBTIQ+ communities; culturally and linguistically diverse communities; veterans and their families; and those living in rural and regional communities impacted by adversity.
- 7.4** Drawing from regular data reviews and evidence, all jurisdictions contribute to identifying national actions for occupations and industries with higher rates of suicide.

Why this is important

Suicidal behaviour can be experienced by anyone, but some populations and groups are disproportionately affected. These groups are not intrinsically more vulnerable to suicidal behaviour, but may experience greater rates of discrimination, isolation and exclusion, minority stress, or find it more difficult to ask for, and access, support.

In our national response, it is imperative that we consider all of the factors that may increase distress and ensure our approach works for all vulnerable groups. This is particularly the case for men, including older men who have the highest rate of suicide, as we know the impacts and the places they seek support can be very different.

We need to ensure we have a focus on younger people who experience significant levels of distress, and keep a sharp focus on the increasing rates of self-harm, attempts and suicide deaths among women.

Our approach must work in urban centres as well as rural and remote communities and it must include a focus on the groups that we know to experience disproportionate impacts. This includes Aboriginal and Torres Strait Islander people, the LGBTIQ+ community, those from culturally and linguistically diverse backgrounds, and people living with mental illness and alcohol and other drug problems. It also includes groups such as veterans, emergency services workers, veterinarians, those bereaved by suicide and communities impacted by multiple adversities

What we need to do

Fund and implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The *Draft National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (the Draft Strategy) has been progressed in 2020 under Indigenous leadership and is due to be finalised in early 2021 following a final consultation period.

The Draft Strategy has been developed in recognition of the fact that Indigenous conceptions of wellbeing and the contextual underpinnings of suicide in Indigenous communities are different from non-Indigenous Australians. This also aligns with the 2020 *National Closing the Gap Agreement* that states: ‘strong Aboriginal and Torres Strait Islander cultures are fundamental to improved life outcomes for Aboriginal and Torres Strait Islander people’.¹⁹

Closing the Gap acknowledges the ongoing strength and resilience of Aboriginal and Torres Strait Islander people in sustaining the world’s oldest living cultures. For the first time, the National Agreement on Closing the Gap has been developed in genuine partnership between Australian Governments and Aboriginal and Torres Strait Islander peak organisations. The National Agreement sets out ambitious targets and new Priority Reforms that will change the way governments work to improve life outcomes experienced by Indigenous Australians. Working towards all targets will support suicide prevention in Australia, with Target 14 now outlining the importance of “Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero”.

While all suicide prevention programs and initiatives need to be culturally safe, Aboriginal and Torres Strait Islander peoples must lead and develop their own tailored approaches to suicide prevention, which are culturally appropriate, community connected, relevant, and safe. Aboriginal and Torres Strait Islander communities have a unique emphasis on ‘social and emotional wellbeing underpinned by cultural values and perspectives that support connection and belonging to family, community, culture, country, spirituality and ancestry within a collective context’.²⁰ This conceptualisation of what health and wellbeing means and what sustains it is fundamentally different from the individually-oriented model upon which Australia’s health and mental health systems are built.

Suicide within Aboriginal and Torres Strait Islander communities occurs within a broader context which includes intergenerational trauma and disadvantage, together with ongoing experiences of racism and discrimination. Recognising these broader factors and how they shape both Indigenous wellbeing and engagement with mainstream services is essential to developing responses that meet the needs of Aboriginal and Torres Strait Islander peoples.

This advice deliberately connects the recommendations for action on Indigenous suicide to the Draft Strategy, in recognition that Aboriginal and Torres Strait Islander people must lead and govern efforts to design, implement and evaluate their own responses to suicide. This is an important expression of Indigenous peoples' right to self-determination. It will also help ensure that solutions genuinely work for Aboriginal and Torres Strait Islander people.

Governments must allow for a shift to occur to a more holistic view in terms of what is prioritised, actioned and funded within the scope of Indigenous suicide prevention.

The Draft Strategy maps out actions under four key domains that should be prioritised and resourced to support targeted responses to Indigenous suicide (see *Appendix 3* for a summary).

1. **System architecture** – including establishing new national, regional, and community level leadership arrangements for planning, commissioning, monitoring, and evaluating Indigenous suicide prevention activity.
2. **Children and families** – including expanding culturally-informed and appropriate services addressing social and emotional wellbeing; strengthening channels for, and training in relation to, early identification of distress among Indigenous children and young people; family wellbeing; and improving the accessibility of digital and virtual service options as part of a broader service mix.
3. **Priority groups** – including working through the new Indigenous-led system architecture to deliver tailored initiatives that recognise and address the specific needs and different experiences of Indigenous young people; men; women; LGBTIQ+SB¹ people; Stolen Generations Survivors; and those in contact with the criminal justice system.
4. **Workforces and services** – including expanding the health workforce as directed by the *National Aboriginal and Torres Strait Islander Health Workforce Strategy*, with a particular focus on Indigenous peer and lived experience workers; partnerships with Aboriginal Community Controlled Health Services in the provision of suicide prevention and broader social and emotional wellbeing services, resourcing them for this expanded role; and co-designing transformational change to mainstream services to address their appropriateness and accessibility for Indigenous peoples.

Governments at all levels will need to resource and facilitate implementation of the actions outlined in the Draft Strategy. Equally importantly, governments must embrace the fundamental shifts in approach called out and addressed through it.

Primary among these is the shift to genuine community control, design, and empowerment to ensure that Indigenous-led implementation of future suicide prevention activity occurs. This shift must be pursued at all levels, from national policy and service planning through to program design, delivery and evaluation on the ground. It must include a much expanded role for Indigenous people with lived experience.

Expanding the current scope of suicide prevention to encompass culture and social and emotional wellbeing is another important shift that is required. The Draft Strategy has been designed to be implemented in tandem with the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017 – 2023*. This recognises that Indigenous suicide cannot be addressed in isolation from its broader context. Governments must shift to a more holistic view in terms of what is prioritised, actioned and funded within the scope of Indigenous suicide prevention.

Finally, governments must shift from an individually oriented approach to suicide to one that also encompasses families and communities. The Draft Strategy makes clear that suicide and preventative approaches within Indigenous communities are an inherently social phenomenon. Responses must address the complex vulnerabilities and needs of all community members. This shift also acknowledges the vital role that Indigenous communities can play in protecting each other and building shared resilience – distinct from any services or interventions that governments can offer.

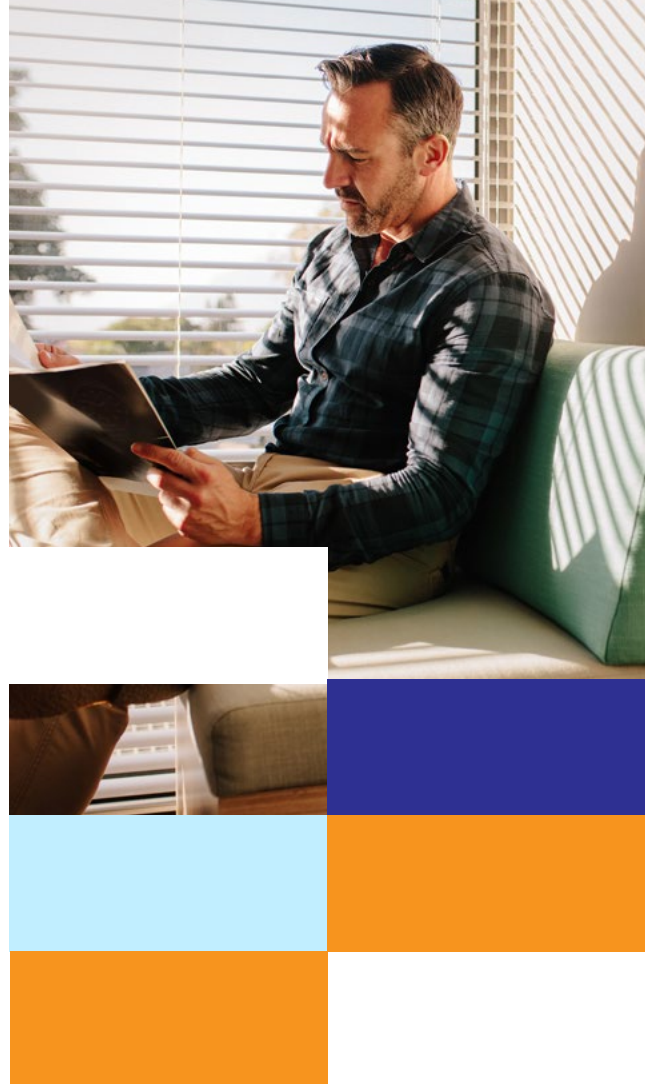
1. Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Sistergirl and Brotherboy. This acronym incorporates terms used to describe trans and gender diverse people in some Aboriginal and Torres Strait Islander communities.

A co-ordinated focus on male suicide prevention

In considering an equity approach to suicide prevention, the disproportionate impacts of suicide on males, and those who care for them, must be called out as a priority for whole of government attention. While the increasing rates of suicide among women, especially younger women, is of concern and should also be considered and prioritised, data shows that 75 per cent of those who die by suicide each year in Australia are males. That equates to seven men dying by suicide each and every day, with particularly high rates in older men, men in middle age, and men living in rural and remote areas. A fully inclusive gendered lens to suicide prevention action in Australia is required, with particular emphasis on ensuring accessibility of appropriate services in places and formats that suit the needs of men, including men from other priority population groups.

While men are more likely to die by suicide than women, they are also less likely to access mental health services, especially in rural areas. Risk factors for male suicide can look different to the risk factors for women, and the opportunities for intervention may also differ. Key factors affecting men include relationship breakdown, separation and post-separating parenting issues, unemployment, financial distress, alcohol or substance use, mental health issues, legal issues and experiences of childhood abuse. There is an imperative to ensure that programs and services go to where men are – embedding supports in the environments where they live, learn and work.

A shift to earlier responses to distress (outlined in earlier chapters) that focuses on intimate relationship distress, financial and workplace distress, justice settings and key transitions and isolation for older men should lead to earlier opportunities and identify men requiring additional support. There is also an opportunity to ensure that current services and programs funded in suicide prevention are evaluated to identify whether, and how, they engage with men. Where necessary, service models must be redesigned to be more accessible to and better meet the needs of men. A greater focus on involving men with lived experience of suicide, and mapping their journeys through government systems, is critical. There is an opportunity for Commonwealth leadership on male suicide prevention, leveraging its portfolios, systems and services – for example, employment services, family law courts, relationship services, Primary Health Networks, drug and alcohol programs, and the aged care sector. There is also an opportunity for all jurisdictions to review for accessibility, and report on the effectiveness of, their services and programs for meeting the needs of men.



Working in a café and bar after losing my job felt like I had lost my status and identity, which were the major reasons for recurring suicidal ideation.

– Personal story, male interview participant



Report on actions to address the specific needs of all priority populations

People's experiences of distress can be driven by a wide range of factors, and different people will experience this in diverse ways. It is crucial that government efforts to prevent and respond to distress include targeted initiatives addressing the needs of people who are known to be more vulnerable to suicide, accounting for the impacts of social determinants and societal attitudes.

The data presented overleaf highlights the importance of understanding and addressing the needs of LGBTIQ+ people; culturally and linguistically diverse communities, people living in rural and remote communities, and veterans and their families. This also underscores the importance of developing targeted approaches for Aboriginal and Torres Strait Islander peoples, young people, adult and older men, and women, as discussed in previous sections.

All jurisdictions need to work together to develop and report on priority actions that focus on engagement and support for these priority populations, while also considering other priority groups outlined throughout this Advice.

As part of these plans, governments need to invest in improved and more consistent data collection relating to priority populations, with a particular focus on improved data for LGBTIQ+ populations. Research and co-design efforts should be expanded to include these priority populations, considering diversity and intersectionality within this groups.

A better understanding of the unique factors that impact help-seeking and uptake of services within these groups is needed, along with investment in locally delivered and/or community controlled services that best suit their needs. Further engagement with people with lived experience within these groups will shed more light on their unique service needs and preferences.

More transparent monitoring and reporting is needed on service access and outcomes for priority populations within mainstream funded services and programs. Government agencies need to be more accountable for the cultural safety and accessibility of their services and take action where it is clear that they are not reaching all people.

Where mainstream services cannot reach priority populations or are not considered safe or relevant and accessible by them, specialised service responses will be needed. Government action plans should identify where and how specialist approaches will be implemented, and clearly articulate the measures that will be used to assess their effectiveness.

Finding appropriate, relevant and accessible ways to support people from these groups must be a priority going forward. A whole of government delivery model will support this by providing more opportunities for proactive outreach and early intervention wherever people are interacting with government. But this must be coupled with a focused effort to understand the experiences and needs of priority populations so that services and interventions genuinely connect with them. This must include investing in approaches that work in rural areas, and addressing workforce shortages across rural and remote Australia.



In rural communities, there is a strong culture of pulling themselves up by their bootstraps and denying the need for help and being distrustful of mental health professionals. Doctors and psychologists – who are educated, unlike my family – do not really get it when it comes to the struggles of rural living and low socio-economic status.

– Personal story, Private Voices study



The experiences of priority populations intersect with points of vulnerability, and social and economic determinants of wellbeing discussed throughout this report. This means governments need to think and plan with the whole picture of someone's life experiences in mind. This is where a whole of government approach can add significant value, by strengthening our capacity to see and understand the diverse factors that may be shaping a person's life.

Implement targeted workplace and industry approaches

While suicide rates are higher among people who are not in the labour force, the majority of suicides in Australia still occur among those of working age, with many employed at the time of death. Research has shown that individuals in certain occupations may have a higher risk of suicide, due to both personal and occupational factors.^{22, 23} Targeting these occupations and workplaces provides an opportunity to reach people who may not otherwise seek supports or services.

While there is significant work being undertaken to advance mentally healthy workplaces, and some specific approaches for workplace suicide prevention, there are further opportunities to tailor, evaluate and scale approaches for:

- male-dominated industries such as construction, mining and transport,
- workforces exposed to danger, death and trauma – including emergency services workers, health professionals and veterinarians,
- rural and isolated workforces such as farming and fly-in-fly-out workers, and
- small businesses and sole-traders, including people in the entertainment industries.

There are opportunities for governments to invest in their own workforces, for example through initiatives addressing the needs of emergency services workers. Governments can also invest in 'fit-for-purpose' approaches for other identified industries and workforces and consider how procurement practices may preference businesses that can demonstrate commitment to their people and their safety – such as through infrastructure contracts.



A focus on the following priority populations and areas of focus for targeted interventions would be of benefit, noting the intersectionality between groups:

Adult and older men	Men are more than three times more likely to die by suicide than women are. They are also less likely to access health services before their death. Risk factors for male suicide include relationship breakdown, separation and post-separation parenting arrangements, unemployment, financial distress, alcohol or substance use, mental health issues, legal issues, experiences of childhood abuse and social isolation and loneliness in older age. ²⁴
Aboriginal and Torres Strait Islander Peoples	Aboriginal and Torres Strait Islander Australians are twice as likely to die by suicide as non-Indigenous Australians, with young Aboriginal and Torres Strait Islander people being four times more likely to die by suicide. ²⁵ Systemic factors such as discrimination, intergenerational trauma, disadvantage and cultural factors like the experience of shame can all act as barriers to people receiving appropriate support.
Children and Young people	Suicide is a leading cause of death for children and young people. Adverse experiences in childhood and adolescence can increase vulnerability to suicide, with 75 per cent of mental illnesses and alcohol and other drug problems occurring by early adulthood – two key underlying risk factors for suicidality. Young people also present with self-harming behaviours at higher rates than other age groups which requires dedicated attention. ²⁶
People who identify as LGBTIQ+	Compared to the Australian population, LGBTIQ+ people are nearly twenty times more likely to have considered suicide and ten times more likely to have attempted suicide, with particularly high rates for transgender and gender diverse people. ²⁷ LGBTIQ+ people often report feeling judged, stigmatised and discriminated against by broader society and can experience a lack of acceptance from those around them. The importance of an inclusive environment that supports the mental health and well-being of LGBTIQ+ people must be recognised and promoted.
People living in rural and remote communities	The suicide rate in Australia's rural and regional areas is 40 per cent higher than in major cities. ^{28,29} Rural and regional communities can experience sudden and ongoing adversity, which can lead to widespread financial hardship. There are also generally fewer supports and professional services available in rural and remote communities. Lived experience research has highlighted that people in rural areas may feel less comfortable seeking help through health services, while in other areas access to services may be limited.
Culturally and linguistically diverse communities	While there is limited data available on rates of suicide and suicide attempts within culturally and linguistically diverse communities, these communities can face distinct risks because of cultural stigma and taboos, combined with language barriers that can prevent help seeking and effective public health communications.
Veterans	Particular cohorts of veterans transitioning from the Australian Defence Force (ADF) have higher rates of suicide than the general Australian population, with those who medically separate from the ADF being particularly vulnerable. ³⁰ Continued improvement to service delivery and enhanced support for families and carers is required.
People living with mental illness	Many people who die by suicide in Australia have a prior experience of a mental illness. Suicide is a prominent cause of death for people with complex mental illness, with the risk increased for people with borderline personality disorder (45 times greater), anorexia nervosa (31 times greater), major depression (20 times greater), bipolar disorder (17 times greater) and schizophrenia (13 times greater). ³¹
Women	Women, especially young women, are more likely to engage in self-harm and attempt suicide. ³² A range of risk factors have been identified for women that require attention, especially given increasing rates of suicide among women in recent years. These include mental illness, family and relationship issues, domestic violence, cultural expectations, and eating disorders.

8. Delivering policy responses to improve security and safety



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

— Personal story, Private Voices study



Learning from lived experience

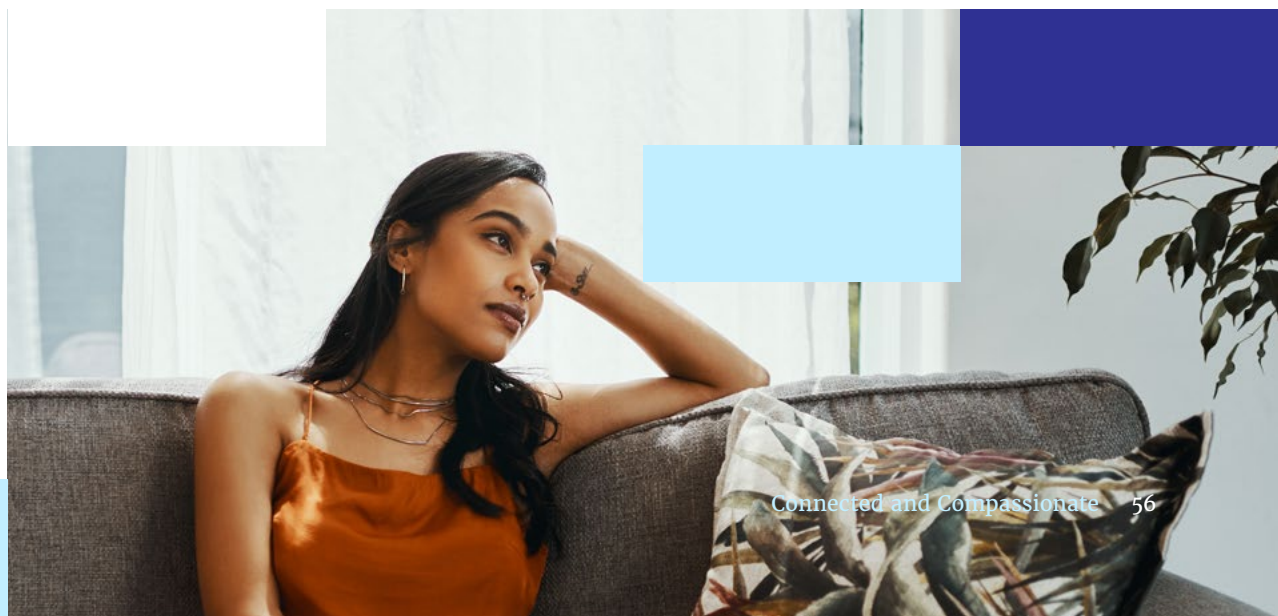
- For many, suicidal thoughts and behaviours occurred in the context of discrimination, life experiences, hardship and withdrawal or ongoing disconnection from people and supports.
- Implementing population level interventions that address key social and economic stressors and community safety can have an impact on all people and further support individual interventions.

The shift we need

Governments can enhance the work done to support individuals and targeted groups through policy and regulatory leadership to increase safety, reduce the drivers of distress and mitigate risks across new policies.

Recommendation 8

Working towards a 'suicide prevention in all policies' approach, all governments: build capabilities within key policy teams and departments and review existing policies to enhance opportunities for improved security and enhanced safety through a National Strategy.



Why this is important

While each person's experience of suicidal distress is unique, evidence suggests that suicidal behaviours can be shaped by the social, economic and physical environments in which we live. These factors are often deeply rooted in the social determinants of health and wellbeing and include: economic, employment and housing security; safety from violence, abuse and discrimination; social connection and participation in community.

An important part of suicide prevention is therefore ensuring that governments deliver well on their core business. This means providing people with access to basic supports, services and resources they need to live well, and ensuring policies and services not only enable interventions when people are in distress but also provide support for the development of social and emotional wellbeing and resilience. This is not to suggest that suicide is because of lack of resilience. Rather, there is a need to ensure that the places where people live, work and learn enable them to address life's challenges.

Governments, through their agencies and activities, may not be able to prevent the onset of distress in a person's life. However, they can and should ensure that they do not – through their actions or the administrative systems that they operate – add to a person's distress without providing ways through which those mounting distress levels can be addressed.

What we need to do

Implement policies to enhance security and safety

Australia has funded a number of population level approaches in suicide prevention. These have primarily focused on public education campaigns, educating and working with the media around safe and appropriate communication and messaging, and means restrictions. There is an opportunity to extend this work through whole of government policy initiatives that address some of the drivers of distress and vulnerability.

Policies to address economic security

A range of economic risk factors have been associated with vulnerability to suicide, including poverty, unemployment, homelessness and the financial impacts of gambling.

In the wake of COVID-19, economic wellbeing has come into sharp focus as a particular priority for national action as Australia looks towards the post 2020 recovery. This has included, and should continue to include, a focus on economic security for people recently unemployed, those experiencing business failure or housing distress as a result of COVID-19, or those impacted by other disasters such as the Black Summer bushfires. There are clear roles for government agencies responsible for employment, skills, social services, industry, housing and others tasked with supporting economic recovery. It also involves leveraging partnerships with financial institutions and the business sector to ensure supports for those who experience economic insecurity.

Policies to address safety and inclusion

Evidence suggests that being exposed to violence, including family, domestic and sexual violence and inequalities experienced by subgroups of the population, including the LGBTIQ+ community, have also been linked to suicide rates.³³ Population level policies that enhance social cohesion and reduce discrimination and violence are a critical component to building stronger communities. This, in turn, will assist in reducing the distress that can contribute to suicide.

There is an opportunity to enhance the significant work progressing across jurisdictions to reduce violence against women and children, and intimate partner violence, and ensure linkages between policies, programs and workforces for maximum benefit. This includes continued efforts to reduce the onset of violence and to intervene at the earliest possible point. Supports for all people involved in family, domestic and sexual violence is critical for suicide prevention in the short and longer term. This includes the victims, the perpetrators and children exposed to the violence and its impacts as data clearly indicates an elevated risk of suicide for all who are exposed. This highlights a need for better partnerships between policy makers, emergency services, the justice system and service providers working across family, domestic and sexual violence and suicide prevention.

Discrimination, exclusion and minority stress has a significant impact on the health and wellbeing of LGBTIQ+ people. National debates, media reporting and legislative processes can all exacerbate these impacts. A coordinated approach, supported through government policy, is needed to address experiences of discrimination, social exclusion, harassment and physical violence that people are exposed to. This will require effort across multiple sectors beyond health, including education, employment, social services, housing and justice.

Policies to address suicide safety

Access to means of suicide, availability of alcohol and media reporting of suicide have all been associated with increases in suicidal behaviours.³⁴

Reducing access to means of suicide has shown strong effectiveness in reducing suicide deaths. While there has been significant action in Australia to date, there is ongoing concern about the number of deaths occurring in public places that comprise approximately 23 per cent of all suicide deaths. Approximately 3 per cent of all suicide deaths take place at identifiable 'hotspots'.³⁵ There is good evidence for the effectiveness of several suicide prevention strategies to reduce suicide deaths at hotspots. An improvement in the timeliness and accuracy of data is needed to support identification of these sites. While there has been some government and philanthropic funding to support action at known hotspots, and action through local governments, emergency services and suicide prevention networks, this approach could and should be enhanced through government and stakeholder partnerships to take action at these sites. Reducing access to means of suicide at hotspots does not reduce the underlying distress associated with suicide, but it is effective in reducing suicide deaths. This in turn, reduces the follow-on impacts on emergency services workers and those in the broader community. Governments have an ongoing and strategic role in reducing access to means of suicide through building codes and regulations, and the embedding of safety considerations into infrastructure investments. They also have a role to ensure telecommunications access at known hotspots.

Reducing access to alcohol has received limited traction in Australia as a public health measure. Research indicates that reducing access to alcohol at a population level can reduce suicide rates,³⁶ meaning consideration should be given to evidence-supported policies. These could include measures that centre on alcohol pricing and taxes, reducing on-premise and off-premise outlet density, and zero-tolerance drink driving laws for learner and provisional drivers. At the population level, these alcohol-related policies could be beneficial in light of Australia's popular drinking culture, and the high prevalence of harms attributable to alcohol including self-injury, hospitalisations and death.

Australia has taken a leading role internationally in supporting media, organisations and communities to communicate about suicide in a way that is safe, builds connection and breaks down stigma, including online safety and communication. This work can be further enhanced through active involvement of agencies outside of health and stronger regulation, guidelines and programs to increase safety for all people online, particularly children and young people. Further education about safe use of social media is needed to accompany regulatory approaches, including partnerships with education, the eSafety Commissioner, health agencies and young people themselves.

There is also a need to increase the availability of accurate information about suicide and suicide prevention, including a focus on lived experience stories to break down stigma. All government departments have a responsibility to ensure their communications, public information and resources use accurate information and safe language associated with suicide.

Strengthening individual and community capacity to manage life's challenges

It is simplistic and stigmatising to view a person's journey into suicide as being a reflection of their ability to cope with life. As is crystal clear from all the lived experience that has informed the work for this Advice and otherwise, each person's journey is complex, individual and multi-dimensional. However, in delivering a comprehensive response to suicide prevention, it is important to ensure that individuals and communities are provided with the appropriate tools and supports to build overall wellbeing and manage the challenges of life.

Australia has funded a number of population level approaches. These have primarily focused on public education campaigns, as well as work to build mentally healthy schools and workplaces for all. There is an opportunity to enhance and extend this work through whole of government initiatives focused on strengthening connection and wellbeing.

This includes building on school and workplace approaches to enhance social and emotional skills, and ensure people are supported well through transitions and change. Taking an integrated approach to promoting mental health and wellbeing, reducing alcohol and other drug harms, and building knowledge and skills to respond early to distress will have benefits in these universal environments. This will avoid initiatives being delivered as disconnected and one-off approaches that compete for attention and time. This will require different levels of government and multiple agencies to work together and coordinate activity.

There is also an imperative to build on the strengths of communities and ensure that proactive policies and supports are provided immediately and in the longer-term for regions and populations affected by particular adversity, including natural disasters. Providing seamless supports that cut through red tape at times of great need, and investing in community building and connection, can make a big difference to communities impacted by adversity.

Connection to family, place, culture and land is integral to healing for Aboriginal and Torres Strait Islander people. Effective suicide prevention must include policies and investments that support social, emotional and cultural wellbeing, as outlined in the *Draft National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

Embed suicide prevention considerations in policymaking

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

It is recommended that governments commit to ensuring that all policies are assessed over time for their impact on suicide risk, and any identified risks are addressed. This should be done in parallel with leveraging the knowledge and reach of their portfolios to connect with Australians in distress. This process should commence immediately, with the shift towards a 'suicide prevention in all policies' approach being supported by building capacity across key policy teams and applying the *Shifting the Focus* guide and support tool.

***Shifting the Focus* is a guide outlining the key components required for a whole of government delivery model in suicide prevention. It will assist in building suicide prevention knowledge and policy capability across portfolios. It includes a decision making tool for agencies to identify targeted initiatives relevant to their areas of work which will address specific vulnerabilities.**



I believe that more literacy and keeping communication channels open about suicide would make a difference. People complete suicide when they have no hope. If we can teach people how to have hope-engendering conversations – not wantonly optimistic conversations, but conversations that can have space to hold the real complexity of both the person's distress and the hope to be heard, understood and feel connected to the helper – then I think we have a chance to make a difference.

– Personal story, Private Voices study



This Final Report is supported by a separate report of Appendices:

- Appendix 1: Jurisdictional suicide prevention governance
- Appendix 2: Reform themes and recommendation mapping of major reports and inquiries
- Appendix 3: Summary National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Plan
- Appendix 4: National Suicide Prevention Taskforce – Summary
- Appendix 5: National Suicide Prevention Taskforce – Consultation summary

References

1. National Suicide Prevention Taskforce. Compassion First: Designing our national approach from the lived experience of suicidal behaviour. Canberra; August 2020.
2. National Suicide Prevention Taskforce. Shifting the Focus: A national whole-of-government approach to guide suicide prevention in Australia Canberra; August 2020.
3. Slade T, et al. The mental health of Australians. Report on the 2007 National Survey of Mental Health and Wellbeing, Department of Health and Ageing. ACT; 2009
4. Australian Government Productivity Commission. Productivity Commission Inquiry into Mental Health Draft Report. DPC; October 2019. Available at: <https://mhaustralia.org/our-work/productivity-commission-inquiry>
5. Royal Commission into Victoria's Mental Health System. Interim Report. VIC; November 2019. Available at: https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic.rcvmhs.files/4215/8104/8017/Interim_Report__FINAL_.pdf
6. Royal Commission into Aged Care Quality and Safety. Interim Report: Neglect. Volume 1. Commonwealth of Australia; 2019. Available at: <https://agedcare.royalcommission.gov.au/publications/interim-report-volume-1>
7. National Mental Health Commission. Vision 2030 for Mental Health and Suicide Prevention. NMHC; 2020. Available at: <https://www.mentalhealthcommission.gov.au/mental-health-reform/vision-2030>
8. National Mental Health Commission. National Natural Disaster Mental Health Framework. About the Framework. NMHC; 2020. Available at: <https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Natural-Disaster-Mental-Health-Framework>
9. Australian Government. National Mental Health and Wellbeing Pandemic Response Plan. NMHC; 16 May 2019. Available at: <https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan>
10. National Mental Health Commission. Report of the National Review of Mental Health Programme and Services: Summary. NMHC; 30 November 2014. Available from: <https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF>
11. Trew S, et al. A review of effective interventions to reduce suicidal thoughts and behaviours among children in contact with child protection and out-of-home care systems. Canberra: Institute of Child Protection Studies. Australian Catholic University; 2020.
12. Distress Brief Intervention. Distress Brief Intervention. DBI Scotland; n.d. Available at: <https://www.dbi.scot/>
13. Borschmann R. Interventions to reduce suicidal thoughts and behaviours in people who have had contact with the criminal justice system: A rapid review. University of Melbourne. Melbourne; 2020.
14. Spittal M, et al. Community mental health care after self-harm: A retrospective cohort study. Australian & New Zealand Journal of Psychiatry; 2016; doi: 10.1177/0004867416676366
15. Lees B, et al. Neurobiological and Cognitive Profile of Young Binge Drinkers: a Systematic Review and Meta-Analysis. Neuropsychology Review. 2019; doi: 10.1007/s11065-019-09411-w
16. Maple M, et al. Is exposure to suicide beyond kin associated with risk for suicidal behaviour? A systematic review of the evidence. Suicide and Life-Threatening Behaviour. Pubmed.gov. 2017; doi:10.1111/sltb.12308.
17. Fisher A, et al. The role of alcohol and other drugs in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours. The Matilda Centre for Research in Mental Health and Substance Use; 2020.
18. Fisher A, et al. The role of alcohol and other drugs in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours. The Matilda Centre for Research in Mental Health and Substance Use; 2020.
19. Department of Prime Minister and Cabinet. Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian Governments. National Agreement on Closing the Gap. DPMC; 2020. Available at: <https://www.closingthegap.gov.au/>.

20. National Department of Health. National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan. DOH; 2020. Available at: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy>.
21. Australian Government. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2020. Australian Health Ministers' Advisory Council; February 2017. Available at: https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf
22. Case R, et al. High-risk occupations—Suicide: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health. Sax Institute; 2020. Available at: <https://www.saxinstitute.org.au/publications/evidence-check-library/suicide-prevention-in-high-risk-occupations/>
23. Milner A, et al. Suicide by occupation: Systematic review and meta-analysis. *British Journal of Psychiatry*. 2013; doi: 10.1192/bjp.bp.113.128405
24. King K, et al. Suicide prevention for men: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health. Sax Institute; 2020. Available at: <https://www.saxinstitute.org.au/publications/evidence-check-library/suicide-prevention-for-men/>
25. Australian Bureau of Statistics. Causes of Death. ABS. ACT; 2019.
26. Australian Institute of Health and Welfare. Suicide & self-harm monitoring data. AIHW; 2020 Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data>
27. Hill AO, et al. Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. La Trobe University, Melbourne; 2020. Available at: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf
28. Australian Institute of Health and Welfare. Suicide & self-harm monitoring data. AIHW; 2020. Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data>
29. Australian Bureau of Statistics. Causes of Death. ABS. ACT; 2019.
30. Australian Institute of Health and Welfare. National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2020 update. AIHW; 2020. Available at: <https://www.aihw.gov.au/getmedia/64a2cab8-19ff-49aa-9390-197a1ec0b81c/aihw-phe-277.pdf.aspx?inline=true>
31. Chesney E, et al. Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*. 2014; doi.org/10.1002/wps.20128
32. Australian Institute of Health and Welfare. Suicide and intentional self-harm. AIHW. ACT; 23 July 2020. Available at: <https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm>
33. Devries K, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLOS Med*. 2013; doi: 10(5):e1001439.
34. Black Dog Institute. What can be done to decrease suicidal behaviour in Australia? A call to action. Director, Black Dog Institute White Paper. October 2020; Sydney.
35. Too EL, et al. Identifying and prioritising suicide hotspots in Australia. Final Report. The University of Melbourne for Lifeline Australia; May 2019.
36. Kölves k, et al. Impact of Alcohol Policies on Suicidal Behaviour: A Systematic Literature Review. *International Journal of Environmental Research and Public Health*. 2020.

