Suicide Prevention Australia

Pre-Budget Submission

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Introduction

Suicide Prevention Australia is the national peak body for the suicide prevention sector. Counting Australia's largest and smallest suicide prevention and mental health not-for-profits, practitioners, researchers and leaders among our members. Suicide Prevention Australia supports and strengthens the services of our members, is an information channel connecting the sector and government, as well as providing leadership, policy services, training and research support to the suicide prevention sector.

Our National Policy Platform sets out a clear agenda for Government to pursue. We're advocating for systemic change through the three pillars of whole of government approach, workforce strategy and reliable data. This Budget submission is consistent with our Policy Platform.

In the 2020-21 Budget the Federal Government unveiled a suite of measures designed to reverse the COVID-19 related recession, stimulate jobs, support vulnerable individuals and families, and restore business confidence. We were heartened to see the $76 billion JobMaker Plan at the centre of the Budget. And we welcomed key investments in suicide prevention.

However, a notable omission from the previous Budget announcements was any mention of two key reports that were soon to be released. These were the National Suicide Prevention Adviser's Interim Report, and the Final Report of the Productivity Commission Inquiry into the Mental Health System. With the Final Report of the Productivity Commission now released and the Final Report of the National Suicide Prevention Adviser submitted to the Prime Minister, it is critical that reforms stemming from the recommendations of these reports not be delayed. Whilst we recognise that there will be ongoing work to further refine understanding of reforms needed, such as the inquiry of the Select Committee on Mental Health and Suicide Prevention, the key recommendations of the National Suicide Prevention Adviser and the Productivity Commission can and should be progressed.

Our recommendations in this submission align with the recommendations that the National Suicide Prevention Adviser has made so far in their Interim Report. We would urge that funding be allocated for the progression of key reforms such as the creation of a National Office for Suicide Prevention, the development of a National Suicide Prevention Plan and of a Suicide Prevention Workforce strategy.

This submission covers the following priority areas:

1. Whole of government approach
2. Reliable Data
3. Equipping the Suicide Prevention Workforce
4. Quality improvement for the suicide prevention sector
5. Suicide Prevention Research Fund
6. Universal access to aftercare
7. Universal access to postvention
8. Targeted Support for Vulnerable Groups

9. Responding to future disasters
10. Responding to the economic impacts of COVID-19

We're confident the measures we've proposed for the 2021/22 Budget will help the Commonwealth Government make real progress against their commitment to a Toward Zero suicide rate.

Together, we can achieve a world without suicide.

For more information

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Priority Area 1: Whole of government approach

Australia needs a whole-of-government approach to suicide prevention.

Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. As noted in the Interim Report of the National Suicide Prevention Advisor: "no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress".[1] Preventing suicide therefore requires a holistic, cross-governmental approach that effectively coordinates funding and policy attention to address the social, economic, health, occupational, cultural, and environmental factors involved.

The Interim Report recommends the adoption of national whole-of-government governance structure for suicide which would include a National Office for Suicide Prevention and a stand-alone whole-of-government National Suicide Prevention Strategy.[2]

Suicide Prevention Australia strongly supports these recommendations and advocates that they should be implemented, as outlined in our National Policy Platform,[3] by:

- Making the National Suicide Prevention Adviser's role permanent by setting up a National Suicide Prevention Office, preferably housed within the Department of Prime Minister and Cabinet

- Passing a Suicide Prevention Act to provide a legislative framework for a three-yearly National Suicide Prevention Plan, integrating actions with a responsible agency, committed funding, measurable performance indicators and a suicide reduction target

- Tasking the National Suicide Prevention Office with developing, delivering, and monitoring performance against the National Suicide Prevention Plan, including coordinating cross-portfolio policy approaches and supporting Primary Health Networks (PHNs) in their suicide prevention focus.

International case studies supporting a whole of government approach

Our proposals are supported by strong international evidence showing that a whole-of-government approach is essential to driving reform, coordinated action and a reduction in the suicide rate.[4]

In 2006 Japan, recognising the urgent need to drive down the nation's high suicide rate, passed legislation to organise the machinery of government to coordinate suicide prevention strategy and

[1] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention. Canberra; August 2020, p 8. Accessed online at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/3.%20Interim%20Advice%20Report.pdf>.

[2] Ibid, p 6.

[3] Suicide Prevention Australia. (2019). National Policy Platform, available online at https://www.suicidepreventionaust.org/wp-content/uploads/bsk-pdf-manager/2019/05/Suicide-Prevention-Australia-National-Policy-Platform-April-2019-high-res.pdf

[4] World Health Organisation. (2018). *National suicide prevention strategies Progress, examples and indicators*, Geneva, accessed online at <https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf>. See World Health Organisation recommendations 18 and 19.

activities.[5] Responsibility for suicide prevention shifted from the Ministry of Health, Labour and Welfare to the central department of the Cabinet Office. The issue of suicide prevention received national prominence and, crucially, became a responsibility shared by all Ministers.

The new government arrangements were followed by progressively released, regularly reviewed strategies to address key issues such as means restriction, youth suicide, and aftercare for suicide attempt survivors. Japan has since seen a significant, progressive decline in its suicide rate.[6]

The Republic of Ireland has a similarly whole of government approach to suicide prevention and has also seen a progressive decline in its suicide rate.[7] Ireland formed a National Office for Suicide Prevention in 2005 to collect and report on suicide related data, as well as oversee the implementation of ReachOut, the nation's first suicide prevention strategy.

In 2015, ReachOut was replaced by Connecting for Life, a five-year strategy that takes a whole of society approach to suicide prevention. Connecting for Life sets out a suite of population level, community based and indicated interventions, as well as policy initiatives to support them. A government agency or funded service provider is assigned lead responsibility to implement each initiative, and is accountable for the outcomes achieved.

Recommendation: Fund a permanent National Suicide Prevention Office, led by the National Suicide Prevention Adviser and responsible for a whole-of-government approach to suicide prevention.

Recommendation: Fund the National Suicide Prevention Office to develop a National Suicide Prevention Plan.

Budgetary impact: Not costed.

Priority Area 2: Reliable Data

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. This includes accurately recording suicide and suicidal behaviour; and linking data on agreed risk factors for suicidal behaviour.[8]

Access to consistent and accurate data enables Government and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions. That is why the Commonwealth Government should continue the important work undertaken by the National

[5] Ibid.
[6] National Office for Suicide Prevention. (2018). National Office for Suicide Prevention Annual Report 2018, accessed online at <https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/about/annualreports/nosp-annual-report-2018.pdf>.
[7] National Office for Suicide Prevention. (2018). *Annual Report:* Dublin. (The Republic of Ireland's National Office for Suicide Prevention reports the rate of suicide in 2016 was 9.2 per 100,000, compared with 11.8 per 100,000 in 2008.)
[8] Productivity Commission. (2019). Draft Report of the Productivity Commission Inquiry into the Mental Health System, available at <https://www.pc.gov.au/inquiries/completed/mental-health#report>.

Suicide Prevention Adviser, by making the role permanent within a National Office for Suicide Prevention.

A National Office for Suicide Prevention would be responsible for leading an initiative on improving the integrity, collation and distribution of suicide data to assist service delivery and research, working in partnership with state suicide registers and relevant organisations to achieve these improvements, and exploring the expansion of data collection and reporting (e.g. data on suicide attempts, self-harm presentations and people accessing help outside of emergency departments, and non-government/community-based mental health services).

The link between suicidality and the social determinants of health will be critical if we are to work towards a zero suicide goal. In recent years Australia has seen emerging trends in housing affordability and the casualization of the workforce.[9] Research is required into how these structural changes are affecting the mental health and wellbeing of Australians. To this end, Suicide Prevention Australia supports the Productivity Commission's recommendation to conduct 'routine national surveys of mental health' and to increase the frequency of which the ABS National Survey of Mental Health and Wellbeing is conducted to be no less than every 10 years.[10]

As outlined in our National Policy Platform,[11] the next iteration of the ABS National Mental Health and Wellbeing Survey should be conducted afresh within the next twelve months (i.e. during 2021) to obtain data on population-level suicidality and suicidal behaviour. Increasing the frequency of the National Mental Health and Wellbeing Survey would also help assess the extent to which suicide prevention strategies and policy/program mechanisms are working effectively.

Recommendation: Fund the ABS to conduct a National Survey of Mental Health and no less than every 10 years.

Budgetary impact: Not costed.

Priority Area 3: Equip the Suicide Prevention Workforce

For suicide prevention to be effective, key people in the community from clinicians to frontline service workers and teachers must be actively engaged. With the right training, these connectors within communities are capable of having a conversation with a patient, customer, student or neighbour that could shift their mental health, wellbeing or suicide risk.[12]

[9] Suicide Prevention Australia. (2019). Turning Points.
[10] Ibid.
[11] Ibid.
[12] Christensen, H. et al. (2018). 'The role of community campaigns', *The Black Dog Institute*, Sydney, originally published in MJA Insight +, accessed at <https://blackdoginstitute.org.au/news/news-detail/2018/09/10/suicide-prevention-the-role-of-community-campaigns>.

As recommended by the Interim Advice of the National Suicide Prevention Adviser,[13] Government, under the leadership of the National Suicide Prevention Office, should create a standalone suicide prevention workforce strategy and implementation plan. This should be funded within the FY2021/22 Budget period.

The plan would quantify and identify the training needs of the suicide prevention workforce, which takes in:

- The clinical workforce, encompassing doctors, nurses, and allied health professionals who interface with individuals at risk of suicide and in suicidal crisis,
- The lived experience and peer support workforce in suicide prevention (distinct from the mental health lived experience workforce)
- The formal suicide prevention and mental health workforce, encompassing those explicitly working in a mental health and suicide prevention or crisis response setting e.g. emergency first responders, counsellors, social workers and other mental health workers
- The informal suicide prevention workforce, which includes personnel from across Government Departments, social services, employer groups, miscellaneous service providers and other settings where individuals at risk of suicide may present, or which provide services that address the social determinants of suicide.

Specific training strategies would be aligned to the skills needs of each part of the workforce, with a clear funding commitment tied to each strategy.

We share the view that particular priority should be placed on adequately resourcing the suicide prevention peer workforce. This should include investing in "an appropriate and comprehensive system of qualifications and professional development… in partnership with suitable lived experience organisations."[14] This priority is warranted, given the value that a well-equipped lived experience workforce can offer not only to their peers in crisis, but to informing a user-centred approach to the delivery of suicide prevention programs, services and activities.

Recommendation: Create a suicide prevention workforce strategy and implementation plan

Cost: Not costed. Potential to resource within existing envelope.

[13] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention. Canberra; August 2020, p 7. Accessed online at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/3.%20Interim%20Advice%20Report.pdf>.

[14] Roses in the Ocean. (2020). Submission to the Productivity Commission Inquiry into the Mental Health System, shared with the author of this submission.

Priority Area 4: Quality improvement for the suicide prevention sector

With the support of the Commonwealth Government, and in collaboration with the suicide prevention sector, Suicide Prevention Australia is implementing a Quality Improvement Program. The Quality Improvement Program provides a pathway to accreditation that supports organisations implement safe, high-quality, and effective suicide prevention programs and services.

Assuring the safety, quality and efficacy of Australia's suicide prevention programs is a central concern for government and the suicide prevention sector. Governments have already committed to making safety and quality central to mental health and suicide prevention service delivery: highlighting this as a key priority of the *Fifth Mental Health and Suicide Prevention Plan*.[15] The *Fifth Plan* also recognises the importance of standards to assuring services and programs are safe, quality and outcomes-based.

The Quality Improvement Program has been designed to help organisations implement safe, high quality and effective suicide prevention programs in Australia. This will deliver on the *Fifth Plan's* priority on making safety and quality central to mental health and suicide prevention service delivery.

Programs registered under the Quality Improvement Program are measured against six suicide prevention standards. Importantly, the suicide prevention standards provide a level of confidence for the community, that programs are a high-quality and provide a consistent standard of care to the people they're designed to help. The Quality Improvement Program provides a full pathway of assessment allowing service providers to progress their programs to certification and/or accreditation, after completing the initial self-assessment phase. Providers are assisted in this by a user-friendly online best practice register and a self-directed quality improvement mechanism. Service providers are expected to maintain compliance with differing levels of evidence as their programs progress through each stage of assessment, aligning their offerings the best practice quality standards already established. Organisations that receive accreditation or are registered to work towards accreditation will have the opportunity to be listed in the national register of suicide prevention accredited organisations.

We are seeking additional Commonwealth Government investment of $1.8m over three years to extend the program to a fully-fledged sector led accreditation system. This will involve working with all Australian Governments to embed the Quality Improvement Program in procurement processes to provide quality assurance of government funded suicide prevention programs. It will also involve support and subsidy of service providers (especially smaller service providers) to have their programs pass through the pathway of assessment. This investment will capitalise on the existing infrastructure already delivered by Suicide Prevention Australia, including the self-assessment phase of the program and the supporting quality standards.

The further Commonwealth Government investment for the Quality Improvement Program will deliver a significant return via the benefits outlined in Table 1 below.

[15] Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Commonwealth of Australia.

Table 1: Benefits of the Suicide Prevention Sector Quality Improvement Program	
Government and commissioning agents will have:	a potential mechanism for allocating funding to suicide prevention programs that are high quality and effective, within the key streams of awareness, early intervention, crisis management, aftercare and postvention
	a clear understanding of the compliance of services and programs with national quality standards
	improved capacity for standardised data collection and data informed decision making
	content to support Primary Health Networks and other organisations to select programs tailored to the needs for their communities
	the ability to identify suitable services and programs across type and purpose and outlining the evidence for these as well as the 'best practice' considerations to be used in any commissioning process.
The community will have:	assurance that programs passing through the quality improvement process are high quality, safe, effective and outcomes based
	information about programs and their commitment to quality improvement
	a reliable source of information about the attributes of safe and appropriate programs and services for suicide prevention
The suicide prevention sector will have:	increased capacity to reduce the suicide rate and enhance the quality of care of those affected by suicide
	the opportunity to participate in a self-directed quality journey which is purposeful, user friendly and relevant to their needs
	the ability to deliver more quality, outcomes-based programs in awareness, early intervention, crisis management, aftercare and postvention
	systematic and coordinated approach for building the capabilities and continual improvement of programs, including measuring workforce training needs
	access to evidence-based research and resources, including education and training support
	guidance on the importance and inclusion of lived experience expertise across various program and service types.
	the capacity to align their suicide prevention programs and services with new research and evidence
	for smaller, less mature organisations, the benefit of tools and advisory support to improve the quality and efficacy of their service and program offerings

Recommendation: Fund the extension of the Quality Improvement Program into a fully-fledged sector led accreditation system.

Cost: $1.8m over three years.

Priority Area 5: Suicide Prevention Research Fund

The Commonwealth Government in 2017 resourced the first National Suicide Prevention Research Fund (the Fund). The Commonwealth Government appointed Suicide Prevention Australia as manager of the Fund. This appointment recognised the close alignment between new research knowledge and its application to improvements in suicide prevention programs and community services. With $9.6 million over three years Suicide Prevention Australia will have funded more than 30 grants from the initial envelope. These grants have significantly enhanced the capacity of the suicide prevention research community and our role as administrator has been crucial to this outcome.

An independent Research Advisory Committee, under the leadership of Professor Don Nutbeam, has ensured excellence in scientific value of the research, adherence to the fund priorities, and given recommendations for the future priorities of the research fund to facilitate the rapid translation of knowledge into more effective services for individuals, families and communities. The Committee includes leading research experts, those with lived experience of suicide and experts in service delivery settings.

We request the Commonwealth Government to invest $15 million in the National Suicide Prevention Research Fund (the Fund) for a further four years (FY2021/22-FY23/24- FY2024-2025- FY 2025-2026).

Research Achievements

To understand the gaps in research, especially in implementation science needed, a series of commissioned evidence checks and research reports were prepared for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce, commissioned through the National Suicide Prevention Research Fund. Based on these evidence reviews it commissioned research into experience of people with lived experience, role of housing insecurity and homelessness, alcohol and other drugs, child protection and justice systems.

Suicide Prevention Australia has provided research grants based on the Suicide Prevention Advisor's recommendations, namely: two larger-scale research collaborations of programs aligned to current national reform under the National Suicide Prevention Implementation Strategy and aligned with the Pandemic Response Plan.

In additional it has provided a number of research grants to emerging scholars investigating knowledge gaps. For instance, one research grants is funding research behind the high suicides rates of many military servicemen and women, and future diagnosis and treatment approaches.

Whilst COVID-19 research funds have been used to fund 5 research projects which investigate different solutions for suicide prevention in the case of adverse events for adolescents, rural residents, and young people. For instance, one research project will investigate a suicide app for suicide ideation.

Using a human-centred approach to service and program prioritisation SPA funded KPMG to conduct qualitative research to comprehensively map the 'customer' journey to better understand the needs of people who interact with (or should interact with) suicide prevention services and programs.

Funding for co-designing the system with users should be provided around:

- Ensuring resources and supports are accessible and easy to navigate. *Action: Co-design an awareness campaign that assertively tackles stigma*
- Embedding lived experience throughout system touchpoints. *Action: Implement a peer workforce across key touchpoints.*
- Establishing a suicide prevention competency framework. *Action: This requires the development of a suicide prevention and postvention competency framework for both the clinical and non-clinical workforce.*
- Building a strategy that integrates activity across the system.

Research Priorities

An additional $15 million in the Fund will enable Suicide Prevention Australia to deliver an enhanced research program that will address three main priorities:

- Closing the knowledge gap
- Fostering innovation
- Building capacity

The Fund would specifically be used to address the following research needs, as per table 2 below.

Table 2: Research Fund Priorities

Research Priority	**Research proposals**
Closing the Knowledge Gap	A larger-scale research collaboration to better understand the transition from suicidal thoughts to suicide attempt, considering social determinants, life events and key risk factors (from the National Suicide Prevention Advisor's report)
	Research into care programs for people who have attempted suicide, and for alternatives to hospital-based care for people attempting suicide
	Future priorities e.g. suicide prevention for alcohol and other drugs, justice, housing/homelessness, child protection, Aboriginal and Torres Strait Islander populations
	Suicide prevention and protective factors
	Build a one-stop evidence shop

Fostering Innovation	Support Implementation Science research through cross-portfolio program/service provider and research partnerships
	Fund further postdoctoral fellowships to increase research an evaluation outcomes connected to existing services and programs
Building Capacity	Ability to strengthen partnerships between researchers and service delivery organisations, current evaluations etc.
	Education package for service providers about implementing co-designed evaluation and knowledge translation plan

Recommendation: Fund the Suicide Prevention Research Fund to conduct a second phase of the Suicide Prevention Fund Research Grants Program.

Cost: $15m over four years.

Priority Area 6: Universal access to aftercare

A person surviving a suicide attempt is at heightened risk of a future attempt, particularly in the first six months after the attempt was made.[16] Despite this, the follow-up or 'aftercare' provided to people who are known to have attempted suicide is patchy at best. Our emergency departments and other acute care settings are overstretched, with demand for services often exceeding the resources available.

Our vision is a world without suicide: where people never reach the point of crisis of making an attempt to take their own life. At the same time, there is a critical need to ensure attempt survivors receive regular, personalised and high-quality support after discharge. This is a commitment recognised in the *Fifth Mental Health and Suicide Prevention Plan*[17] and agreed to by all Australian Health Ministers.

Every person who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours should be proactively provided with aftercare support. Relying on help seeking behaviours is unconscionable when the evidence informs us that the risk for suicide after an attempt is significantly elevated compared to the general population.[18] The evidence also shows that the key factors in successful aftercare services are the timeliness, quality and human connection an attempt survivor establishes with their carers.[19]

[16] Christiansen, E. & Jensen, B. F. (2007). Risk of repetition of suicide attempt, suicide or all deaths after an episoded of attempted suicide: a register-based survival analysis. *Australian and New Zealand Journal of Psychiatry,* 41, pp. 257-265.
[17] Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Commonwealth of Australia.
[18] Shand, F. Woodward, A., McGill, K., Larsen, M. & Torok, M. (2019). Suicide aftercare services: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health.
[19] Ibid.

High quality aftercare programs with these characteristics already exist. The Way Back Support Service provides non-clinical, one-on-one care to guide people safely through the critical risk period of up to 3 months.[20] The Hospital Outreach Post-suicidal Engagement (HOPE) program, a State Government initiative in Victoria, also provides intensive support following discharge, with first contact made within 24 hours from the patient leaving hospital and continuing for up to three months.[21] Beyond Blue's Way Back Support Service has been rolled out communities in South Australia, Northern Territory, New South Wales, Australian Capital Territory, Queensland and Victoria since 2014.

We acknowledge the strength brought to the suicide prevention system by the Commonwealth Government's $7 million investment to expand Way Back Support Service (WBSS) and other aftercare programs. We agree with the National Suicide Prevention Advisor that Australia requires broader access to aftercare,[22] there is an opportunity to provide every person who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours with access to aftercare support.

Universal aftercare should be an immediate priority for the 2021 Federal Budget, acknowledging that the program should be co-funded by the Commonwealth, State and Territory Governments. As recommended by the Productivity Commission, this would involve providing aftercare to every suicide attempt survivor for a minimum of three months from the date of discharge. Ideally, the aftercare programs would be embedded within the mainstream mental health infrastructure of each state and territory, and delivered in partnership with service providers who have demonstrated success.

A commitment to achieve universally available aftercare is already included in the *Fifth Plan* and agreed to by all Australian Health Ministers.[23] In addition to the $7 million expansion of the WBSS already announced, we therefore believe the Commonwealth Government should negotiate with the states and territories to achieve this commitment as a priority for 2020/21.

Recommendation: Ensure, in collaboration with State and Territory Governments, funding for a national, universal aftercare program providing a minimum of three (3) months of personalised support after a suicide attempt.

Cost: Not costed.

[20] Beyond Blue. (2019). South Australia supports The Way Back, available onlnie at: <https://www.beyondblue.org.au/media/media-releases/media-releases/south-australia-supports-the-way-back>.

[21] Victoria State Government. (2020). *Suicide prevention in Victoria,* available online at: <https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria>.

[22] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention. Canberra; August 2020, p 54. Accessed online at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/3.%20Interim%20Advice%20Report.pdf>.

[23] Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan, *Commonwealth of Australia*.

Priority Area 7: Universal access to postvention

Suicide rates in Australia have continued to increase over the last decade.[24] In 2019, 3,318 Australians died by suicide which is 12.9 deaths per 100,000 people.[25] With each person who dies by suicide, up to 135 others will be impacted, which is estimated to equate to over 400,000 Australians per year.[26,27,28] Black Dog Institute defines postvention as 'an intervention conducted after a suicide has occurred and usually targeting those bereaved by suicide including family, friends, professionals, community members, colleagues, and peers.'[29]

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. The most common form of suicide postvention support is peer support groups, and receiving support from others bereaved by suicide.[30] There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[31]

Other postvention services include individual mental health therapy and outreach by trained survivor teams.[32] Postvention supports also mitigate adverse impacts including the risk of a bereaved person engaging in suicidal behaviour. People who are bereaved by suicide are themselves at elevated risk of suicide, particularly if they have a history of prior trauma, suicidal behaviour or depression.[33]

The National Suicide Prevention Advisor's Interim Advice Report released in August 2020 calls for targeted responses for communities impacted by suicide, through more coordinated and timely postvention responses.[34] We need better collaboration between national organisations and PHNs to ensure a national strategy has local input, and enhanced integration and liaison with state-based mental health services.

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[24] Andriessen, K., Krysinska, K., Kolves, K. & Reavley, N. (2019). Suicide postvention services: an Evidence Check rapid review brokered by the Sax Institute for the *NSW Ministry of Health,* Accessed online at <https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Postvention-Report.pdf>.

[25] Australian Bureau of Statistics. (2020). Causes of Death, Australia. Accessed online at <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-suicides-key-characteristics>.

[26] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention in Australia. Canberra.

[27] Cerel, J., Brown, M.M, Maple, M., Singlton, M., Van De Venne, J., Moore, M. & Flaherty, C. (2019). How many people are exposed to suicide? Not six, *The American Association of Suicidology,* 49(2).

[28] StandBy. (2018). StandBy National Client Outcomes Project: Summary of project results. Accessed online at <https://standbysupport.com.au/wp-content/uploads/2018/09/StandBy-Program-Evaluation-2018_Summary-Report.pdf>.

[29] Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., Sheedy, M., Crowe, J., Cockayne, N., Christensen, H. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring, *Black Dog Institute*, Sydney.

[30] Harrington-LaMorie, J., Jordan, J.R., Ruocco, K. & Cerel, J. (2018). Surviving families of military suicide loss: Exploring postvention peer support, *Death studies*, 42(1):1-12

[31] Bartone, P., Bartone, J. V., Violanti, J. M., Gileno, Z. M. (2017). Peer Support Services for Bereaved Survivors: A Systematic Review, *Journal of Death and Dying*, 80(4).

[32] Ibid.

[33] Andriessen, K., Krysinska, K., Hill, N.T.M., Reifels, L., Robinson, J., Reavley, N. & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes, *BMC Psychiatry*, 19, 49.

[34] Ibid.

Research has demonstrated that people bereaved by suicide are at an increased risk for suicide.[35,36] Postvention support is an important method for addressing this risk, encouraging healing, and reducing suicide contagion among those who have lost a loved one.

An evaluation of the StandBy Support After Suicide (StandbBy) program found significantly lower risk of suicidality among people who accessed their service (38%) compared to people bereaved by suicide who did not access StandBy (63%).[37] StandBy clients were further found to be more likely to be socially supported and experience less loneliness than people bereaved by suicide who did not access StandBy. Funding should be allocated to ensure postvention is available to those bereaved by suicide. Additionally, peer postvention support should be available as in some cases non-clinical support will be needed and peer workers can be a safe means for people to talk through their issues and concerns, with someone who has experienced life-changing mental health issues. There is also a strong need to invest in a variety of supportive suicide prevention 'infrastructure' such as, a compassionate workforce strategy for an inclusive workforce (clinical, non-clinical, lived experience, peer supporters, gatekeepers, tertiary institutions, workplaces and government officials such as health, justice, education, and housing).

Recommendation: Continue to invest in a universal access to national postvention service.

Cost: $12.7M per annum.

Recommendation: Invest in the establishment of postvention peer support programs in every jurisdiction delivered by national postvention services.

Cost: $2.7M per annum.

Recommendation: Develop a compassionate workforce strategy.

Cost: Not costed.

Priority Area 8: Targeted Support for Vulnerable Groups

Males

Male suicide is an issue requiring targeted policy and funding attention. More than three-quarters of intentional self-harm deaths occur in males. Australia requires a concerted effort to address the underlying issues that might lead men to the point of crisis. Many men who are at risk of suicide or who take their own lives have no experience with mental ill health. We need to strategically identify opportunities to intervene with men who may be vulnerable to suicide, but not interacting with the formal mental health or suicide prevention systems. A whole-of-government approach to male suicide

[35] Jordan, J.R. (2017). Postvention is prevention – The case for suicide postvention, *Death Studies,* 41:10.
[36] Pitman, A.L., Osborn, D.P.J, Rantell, K. & King, M.B. (2016). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults, *BMJ Open*, 6.
[37] StandBy.(2018). StandBy National Client Outcomes Project: Summary of project results. Accessed online at <https://standbysupport.com.au/wp-content/uploads/2018/09/StandBy-Program-Evaluation-2018_Summary-Report.pdf>.

prevention is required to improve the coordination of services. Cross-agency collaboration is vital to reach men at risk both before, during and after a suicidal crisis.

In addition, support services are not always accessible and appropriate due to the fact that some males may not engage in help-seeking behaviour. Of concern, 72% of males do not seek help if they are experiencing issues with mental ill-health.[38] Research involving analysis of data from men in the Australian Longitudinal Study on Male Health has highlighted the potential connection between masculine behaviour norms, in particular self-reliance, and a reluctance to actively seek help particularly within a clinical setting.[39] However, tailoring and targeting clinical and non-clinical interventions may increase men's service uptake and the effectiveness of treatments.[40]

To drive a diverse range of effective, evidence-based services to drive down male suicide requires the Australian Government to fund the creation of a national male suicide prevention strategy.

Recommendation: The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy.

Cost: Not costed.

Aboriginal and Torres Strait Islanders

Given the extremely high rates of suicide in Aboriginal and Torres Strait Islander communities we recommend funding for Aboriginal and Torres Strait Islander- specific interventions, especially specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities, as the majority of Aboriginal people (63%) live outside major urban areas. In line with the National Suicide Prevention Adviser's view that Aboriginal and Torres Strait Islander Controlled Health Organisations are the best placed organisations to become preferred suicide prevention providers to their own communities, these interventions should be run by community-controlled organisations. This recognises the rights of Aboriginal and Torres Strait Islander peoples to self-determination; their rights as health consumers to access culturally safe and competent services, and continuity of care. We note that funding is being provided to Gayaa Dhuwi organisation for an Aboriginal and Torres Strait islander led revision of the 2013 Aboriginal and Torres Strait Islander Suicide Prevention Strategy. We also call on the government to provide sufficient funding so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement,[41] because reductions in the crisis-level suicide rates in Aboriginal and Torres Strait Islander Australians, are dependent upon improvements in Aboriginal rights and wellbeing across education, justice, access to land and water resources, and strengthening links to culture.

[38] Seidler, Z.E., Dawes, A.J., Rice, S.M., Oliffe, J.L. & Dhillon, H.M. (2016). The role of masculinity in men's help seeking for depression: a systematic review, *Clinical Psychology Review,* 106-118.

[39] Pirkis, J., Spittal, M.J., Keogh, L., Mousaferiadis, T. & Currier, D. (2016) Masculinity and suicidal thinking, *Soc Psychiatry Psychiatric Epidemiol,* Vol 52, pp. 319–327.

[40] Ibid.

[41] Commonwealth of Australia & Coalition of Aboriginal and Torres Strait Islander Peak Organisations (2020) National Agreement on Closing the Gap Report July 2020. Accessed at: https://www.closingthegap.gov.au/targets

Recommendation: Fund Aboriginal Community Controlled Health Organisations to provide the Aboriginal community with suicide prevention, postvention and aftercare programs, as well as funding for COVID mental health initiatives.

Cost: Not costed.

Recommendation: Fund targeted, specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities.

Cost: Not costed.

Recommendation: Allocate sufficient funding so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement.

Cost: Not costed.

People from Culturally and Linguistically Diverse (CALD) Backgrounds

Australians from CALD backgrounds generally demonstrate reduced and variable rates of access to mental health services, despite potentially having higher needs due to migration stressors. The lower utilisation of mental health services are likely due to high stigma and poor understanding of mental health illnesses, language barriers, lack of health information, lack of understanding of appropriate healthcare pathways, Medicare ineligibility, healthcare costs, normalisation of distress, under-diagnosis, or mis-diagnosis.

We recommend funding the co-design of culturally appropriate mental health services and suicide prevention programs, which would be jointly implemented by CALD community organisations to address stigma and increase utilisation of mental health and suicide prevention services in CALD communities. This strategy needs to address a number of issues.

Improved data collection is needed. Collection of ethnicity information (rather than country of origin) within existing suicide registers and administrative datasets (e.g. hospital admission, primary health, allied health) would inform an understanding of suicide in CALD communities, as per recommendations from If We Don't Count it, it Doesn't Count.[42] A National Minimum Dataset for CALD communities inclusive of mental health, suicide and self-harm data would provide a more comprehensive picture of service access and gaps.

The needs of long-standing CALD communities should be better addressed. This includes focus on cross-generational issues and ensuring that government works with CALD community organisations to address stigma, target vulnerable groups and increase utilisation of mental health and suicide prevention services in CALD communities.

The unique needs of International students should be addressed by a collaborative approach from universities, Council of International Students Australia, Department of Home Affairs and Health

[42] Federation of Ethnic Communities Council. (2020). If We Don't Count it, It Doesn't Count; Towards Consistent National Data Collection and Reporting on Cultural, Ethnic and Linguistic Diversity, Updated Sept. 2020, accessed online at: <https://fecca.org.au/if-we-dont-count-it-it-doesnt-count/>.

Insurance companies. For example, the City of Sydney's International Student Leadership and Ambassador (ISLA) program or similar programs could be rolled out and expanded in all cities with international student programs.

We need to address trauma facing refugee communities, recent arrivals, and groups at risk such as people in rural locations, women, women experiencing domestic violence, young people. This would include increasing funding to refugee, migrant and multicultural community organisations, service providers and NGOs, especially those in rural or regional locations, where specialist services, such as Transcultural Mental Health Centres are not available This should include the following:

- Funding for gate keeper training to enable early identification through service providers e.g GPs, community leaders/community organisations, refugee health services, domestic violence support services, multicultural community NGOs.
- Specific funding for cultural capability training, including trauma informed training for service providers (across public, primary and NGO sectors as per recommendations in the Framework for Mental Health in Multicultural Australia. Funding to PHNs and public services should be specifically provided for CALD mental health to ensure it is not redirected to general mental health.
- Funding for enhancing mental health literacy and reducing the stigma of mental health problems and particularly the stigma of discussing suicide in CALD communities.

Recommendation: Fund improved data collection, including creating a national minimum dataset for CALD communities inclusive of mental health, suicide and self-harm data.

Cost: Not costed.

Recommendation: Fund the co-design of culturally appropriate mental health services and suicide prevention programs, which would be jointly implemented by CALD community organisations to address stigma, target vulnerable groups and increase utilisation of mental health and suicide prevention services in CALD communities.

Cost: Not costed.

People from Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) Communities

People from LGBTQI communities have higher rates of mental ill-health and suicide than the general population in Australia. In particular, LGBTQI young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, transgender people aged 18 and over nearly eleven times more likely, and people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over are nearly six times more likely.[43]

[43] National LGBTI Health Alliance, (2020). Snapshot Of Mental Health And Suicide Prevention Statistics For LGBTI People, accessed online at <https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/240/attachments/original/1595492235/2020-Snapshot_mental_health_%281%29.pdf?1595492235>.

Recent research into the mental health and wellbeing of LGBTQI Australians demonstrated we are not seeing parallel improvements in LGBTQI mental health. 41.9% of study participants reported considering attempting suicide in the previous 12 months, 74.8% had considered attempting suicide at some point in their lives, 5.2% reported having attempted suicide in the past 12 months, and 30.3% had attempted suicide at some point in their lives.[44]

The evidence shows the elevated risk of suicidality experienced by LGBTQI people links strongly with their continuing experience of discrimination and exclusion, and the subsequent trauma from these experiences.[45] We also know that LGBTQI people are less likely to access help when in crisis. Research undertaken by La Trobe University found 75.3% of LGBTQI participants did not use a crisis support service during a recent personal or mental health crisis.[46]

Currently there is a lack of national architecture and coordination for LGBTQI health resulting in the under-funding and under-resourcing of community-controlled organisations who are best placed to deliver tailored suicide prevention initiatives, and a need for mainstream services to take a co-design approach to upskill themselves to be able to respond appropriately to the needs of LGBTQI people.

Recommendation: Fund peer-led community-controlled organisations to develop tailored mental health and suicide prevention initiatives, services, and programs to build community capacity and resilience, and overcome barriers LGBTQI people face accessing healthcare services.

Cost: Not costed.

Recommendation: Fund investment for national research projects undertaken in LGBTQI suicide prevention and mental health.

Cost: Not costed.

Recommendation: Establish national architecture to coordinate LGBTQI health through the establishment of a National LGBTQI Commissioner responsible for consolidating best practice standards, national data, identifying disparities at the national level, and coordinate national health responses including for mental health and suicide prevention. An LGBTQI Commissioner should be supported by an LGBTQI Health Taskforce.

Cost: Not costed.

[44] O. Hill, A., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, *Melbourne: LaTrobe University*, accessed online at <https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf>.

[45] Eckstrand, K.L. & Potter, J. (2017). Trauma, resilience, and health promotion in LGBT patients: What every healthcare provider should know, *Springer.*

[46] Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis, Bundoora, VIC & Canberra, ACT: *Australian Research Centre in Sex, Health & Society, La Trobe University & Lifeline Australia*.

Priority Area 9: Responding to future disasters

Recent events have demonstrated the need for resources to be available to respond to multiple and compounding disasters. The Australian Government should provide discretionary funds through PHNs or other mechanisms to respond to need for suicide prevention in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods, e.g., up to 2-3 years after a disaster.

The Federal government recently recognized the need to respond to disasters with funding for mental health support when the Department of Health announced funding for the 2019-2020 bushfires of $76 million. This funding was to provide immediate counselling, ongoing emotional and wellbeing support to communities, expanding telehealth sessions, funding for Headspace and funding for local mental health services.[47]

The World Health Organisation notes that emergency situations such as natural disasters and other humanitarian crises exacerbate the risk of mental health condition, with one in five likely to have a mental disorder such as depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia. These risks are heightened in older people and marginalized groups.

Research into the impact of disasters shows that providing immediate one-off counselling sessions or debriefing is not effective and may even be harmful,[48] however mental first aid training for first responders is beneficial. In the immediate aftermath of a disaster it is important that people are not exposed to additional sources of stress, i.e. their immediate needs for shelter, safety and social connection are met.

Research also shows that serious mental illness, suicidal ideation and making plans for suicide increases as a result of natural disasters.[49] There is evidence that mental illness and suicide rates increase over time after a disaster, with suicide rates reaching the highest level up to two years after the initial disaster.[50]

Recommendation: Budget for approximately $30 million annually in discretionary funds to respond to need for suicide prevention in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods after a disaster.

Budgetary impact: $30 million.

[47] Department of Health. (2020). Australian Government Mental Health Response to Bushfire Trauma, Jan 2020. Accessed online at <https://www.health.gov.au/health-topics/emergency-health-management/bushfire-information-and-support/australian-government-mental-health-response-to-bushfire-trauma>.

[48] Rose S, Bisson J, Churchill R, Wessely S. (2002). Psychological debriefing for preventing post-traumatic stress disorder (PTSD), *Cochrane Database of Systematic Reviews,* Issue 2.

[49] Kessler, R. C., Galea, S., Gruber, M. J., Sampson, N. A., Ursano, R. J., & Wessely, S. (2008). Trends in mental illness and suicidality after Hurricane Katrina. *Molecular psychiatry*, *13*(4), 374–384.

[50] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, *The Journal of Crisis Intervention and Suicide Prevention*.

Priority Area 10: Responding to the economic impacts of COVID-19

The COVID-19 pandemic is a unique health crisis and one that has touched the lives of thousands directly affected by the virus, as well as their loved ones. As a nation, we need to recognise the impact of COVID-19 extends to in our community, many of who are at risk of losing their businesses, their jobs, their livelihoods and – perhaps for the first time – are struggling with their wellbeing.

Employment supports

The Australian Government should extend JobKeeper to employers in industries that continue to see the most significant impacts - such as the tourism, food and accommodation, and arts and recreation industries. This extension for targeted industries would moderate the fiscal impact of JobKeeper, while supporting those businesses and jobs that continue to be directly affected by our pandemic response. The extension should run until June 2022 to allow for ongoing economic impacts even after widespread vaccination is achieved.

We know from previous recessions and pandemics that that social safety nets play a crucial protective role in reducing distress and suicide risk. We ask the Commonwealth Government ensure the many Australians who are seeking work – many of them unemployed for the first time - have adequate basic support. The base rate of JobSeeker (Newstart) has not increased in real terms since 1994, despite the increasing cost of the necessities of life such as housing, groceries and utilities. Business, the not-for-profit sector and we at Suicide Prevention Australia agree that the base rate of JobSeeker needs to increase. Increasing the base rate means the thousands of Australians people experiencing the challenges of unemployment can meet their basic needs and have the support they need to find meaningful work when it becomes available.

The Australian Government should maintain Jobseeker at current levels until June 2022, to allow for ongoing economic impacts even after widespread vaccination is achieved, then reduce to base rate, but base rate should be increased by $95 per fortnight.

Homelessness

Changes to the safe housing arrangements for people experiencing homelessness are likely to impact their wellbeing. The shift to hotel-style accommodation and back to former hostel arrangements will disrupt the lives of an already vulnerable population; in addition to those Australians who may become homeless if the economic downturn continues in the medium term. We ask the Commonwealth Government to take up the recommendation of the recent Report of the Productivity Commission Inquiry into the Mental Health system and support State and Territory Governments, through the National Housing and Homelessness Agreement, to address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness.

Domestic and Family Violence

The Australian Government has already shown significant leadership in upscaling support for victims of domestic violence. There are reports from leading domestic and family violence organisations that social distancing measures have exacerbated the conditions that increase risk for victims of domestic and family violence, and the Australian Government's investment is a step in the right direction. More needs to be done however, to support workers in this challenging field to recognise the signs where families may be at risk of suicidal behaviours. We call on the Commonwealth Government to consider an investment in targeted suicide prevention training for these frontline personnel, in addition to other key touchpoints for vulnerable members of the community.

Substance abuse and alcohol consumption

Recent literature has explored the impact of the COVID-19 response on addiction or substance abuse disorders. Overall, findings show the impact of COVID-19 on people with alcohol and other drug problems has been largely indirect as they evolve from risk factors such as social isolation, housing, incarceration, employment and reduced access to recovery or health services. The increased use of substances in combination with the above risk factors is linked to suicide, which is why the research recommends a multidisciplinary approach to substance abuse. Such an approach provides flexible access to services and reduces risk of relapse and suicide.

We ask government to consider funding tailored (preferably pre-service) suicide prevention training for frontline hospital staff, and funding packages to support screening by alcohol and substance service providers for mental health issues and suicidal ideation in at-risk clients and consumers.

Recommendation: Maintain Jobseeker at current levels until June 2022, then reduce to base rate, but base rate should be increased by $95 per fortnight.

Cost: Not costed.

Recommendation: Support State and Territory Governments to address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness.

Cost: Not costed.

Recommendation: Invest in targeted suicide prevention training for domestic and family violence frontline personnel.

Cost: Not costed.

Recommendation: Fund tailored pre-service suicide prevention training and education for frontline hospital staff, and funding packages to support screening by alcohol and substance service providers for mental health issues and suicidal ideation in at-risk clients and consumers.

Cost: Not costed.