Suicide Prevention Australia

2022-23 Pre-Budget Submission

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Patron: His Excellency General the Honourable David Hurley AC DSC (Retd)

Introduction

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 400 members, we represent the largest, and many of the smallest organisations working in suicide prevention. Suicide Prevention Australia supports and strengthens the services of our members, is an information channel connecting the sector and the voice of lived experience to government, as well as providing leadership, policy services, and research support to the suicide prevention sector.

Every year, over 3,000 Australians die by suicide and over 65,000 Australians attempt suicide. Suicide is complex, multi-factorial human behavior, it is more than simply an expression of mental ill-health. Factors that contribute to suicide may include stressful life events, trauma, mental or physical illness, drug or alcohol abuse and poor living circumstance. The link between unemployment, financial distress, and suicide is, sadly, well established.

While Australia has not reported increases in suicide rates during the COVID-19 pandemic, this is in part a result of boosts to healthcare and suicide prevention supports during the pandemic. In particular, JobKeeper and JobSeeker have acted as effective social supports by providing necessary financial safeguards during the COVID-19 pandemic to relieve distress for many people who found themselves suddenly unemployed or on significantly reduced income.

We provide a clear, collective voice for the suicide prevention sector. We're advocating for systemic change through core pillars of a whole of government approach, lived experience, data and evidence, and workforce, sector and community capability. This Budget submission is consistent with these key policy directions.

This submission covers the following priority areas:

1. Whole of government approach
2. Lived experience
3. Data & evidence
4. Quality, Workforce and Workplace
5. Early intervention and prevention
    - 5.1 Aftercare
    - 5.2 Postvention
    - 5.3 Support after a suicide attempt or suicidal distress
    - 5.4 Safe Spaces
6. Vulnerable population groups
    - 6.1 Survivors of suicide attempts
    - 6.2 Youth Suicide
    - 6.3 Aboriginal and Torres Strait Islander Peoples
    - 6.4 Male Suicide
    - 6.5 Culturally and Linguistically Diverse Communities
    - 6.6 LGBTQI+
    - 6.7 Veterans
7. Strengthening protective factors

7.1 Welfare Support
7.2 Social Isolation & Loneliness
7.3 Childhood Trauma
7.4 Housing Insecurity
7.5 Disaster Planning

We're confident the measures we've proposed for the 2022/23 Budget will help the Commonwealth Government make real progress against our shared commitment to zero suicides.

Together, we can achieve a world without suicide.

For more information

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Summary of Recommendations

Priority Area	Recommendations	Costing
1. Whole of government approach	1.1 A Suicide Prevention Act should be implemented 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.	$0.9 million over three years enable consultation and drafting of the Act
2. Lived experience	2.1 Fully fund implementation of the recommendations of the Final Advice of the National Suicide Prevention Advisor to ensure people with lived experience are integrated in all aspects of suicide prevention policy development, design, delivery, research and evaluation. This includes integrating lived experience leadership, knowledge and insights into the design, delivery and evaluation of any 2022 Budget measures related to suicide prevention. 2.2 A National Workforce Strategy for Suicide Prevention should include key priorities and investment for growing, supporting and sustaining the suicide prevention lived experience and peer workforce.	Any additional funding required to be determined in co-design process with people who have a lived experience. $1.9 million over three years plus implementation funding.
3. Data & evidence	3.1 Government commit $4 million over four years to build capability in suicide prevention sector to access, interpret and use increasing amounts of suicide prevention data. 3.2 Develop outcomes to measure suicide prevention programs efficacy in the community and provide data on program impacts to provide for future learnings.	$4 million over four years.
4. Quality, Workforce and Community	4.1 National Office develop a suicide prevention workforce strategy and implementation plan that is fully-funded and provides long-term vision and strategy for workforce and specific actions to ensure capability, skills, supply, retention and sustainability across the sector and is integrated appropriately with other related sectors and strategies under development.	$1.9 million over three years plus implementation funding.
	4.2 Fund the extension of the Quality Improvement Program into a fully-fledged sector led accreditation system.	$1.8 million over three years.

	4.3 To support efforts to build capacity on responding to suicide risk, Government should fund the development of industry-specific competency frameworks in high-risk sectors. Building on the Suicide Prevention Australia Framework this can provide a tailored approach to build on the evidence of 'what works' regarding the knowledge and skills required for workforces in suicide prevention across diverse settings.	$0.55 million over three years.
	4.4 As the formal and informal suicide prevention sectors grow, there is a need to support sustainable skill development from orientation through to professional development. Building on the competency framework, Government should work with the sector to explore quality, evidence-based "on-boarding" and "orientation" opportunities for individuals working in suicide prevention.	$1 million for consultation and implementation.
5. Early intervention and additional support	**5.1 Aftercare** 5.1 Urgently implement the commitment to universal aftercare. Universal aftercare should be delivered in partnership with States and Territories and individuals with lived experience of a suicide attempt. Any additional funding required to achieve universal access should be included in the 2022 Budget.	Any additional funding on top of the existing $158.6 million commitment.
	5.2 Postvention 5.2 Continue to increase investment in universal access to national postvention services including the establishment of postvention peer support programs.	$16 million per annum.
	5.3 Support after a suicide attempt or suicidal distress 5.3 Invest in national support for those whose loved ones attempt suicide or are impacted by suicidal distress	
	5.4 Safe Spaces 5.4 The Commonwealth Government should partner with States and Territories to develop and fund a national network of Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking.	Funding required to be developed through co-design with States and Territories and people with lived experience.
6. Vulnerable population groups	**6.2 Youth** 6.2.1 Commonwealth to prioritise investment in youth-specific early intervention strategies, with particular priority on programs and services that are co-designed with young people. This should include suicide prevention	Funding requirement to be confirmed in co-design process.

	training for those who work directly with young people and in 'gatekeeper roles'. 6.2.2 Commonwealth to invest in ensuring that support services are equipped to respond to the needs of young people in suicidal crisis, by having services informed by co-design with young people and research evidence on how best to address suicide risks in young people.	
	6.3 Aboriginal & Torres Strait Islander Peoples 6.3.1 Utilise an equity and needs-based approach to fund targeted, specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities will address these gaps to access, as the majority of Aboriginal people (63%) live outside major urban areas. 6.3.2 Utilise an equity and needs-based approach to 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. 6.3.3 Allocate sufficient funding with an equity and needs-based approach so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement, recognise and promote the importance of Aboriginal and Torres Strait Islander leadership by supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. 6.3.4 Invest in youth suicide prevention by enhancing mental health and wellbeing support for Aboriginal and Torres Strait Islander children who are in care of the state/territory. 6.3.5 Allocate funding to ensure commitment to cultural competency and inclusion of Aboriginal and Torres Strait Islander peoples is achieved by all mainstream mental health and suicide prevention services.	Apply an equity and needs-based formula to existing expenditure with increased funding committed as required and in line with the upcoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. $75.2 million over four years. $7.7 million over three years.
	6.4 Males 6.4.1 The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy that is co-designed with those with lived experience and with support providers, and is informed by Research and Data. 6.4.2 Provide mechanisms to give resources to effective grassroots community supports, including proactively	Funding requirement to be confirmed in co-design process.

	identifying and evaluating effective supports that could be enhanced by government funding. 6.4.3 Fund male-specific connector training to be available to people who regularly encounter men at risk of suicide. 6.4.4 Fund support providers to undertake collaboration and coordination activities, including relationship-building, coordinated case management and resource co-ordination at a sector level, with a focus on reducing drop-out rates for men from support services.	
	6.5 Culturally & Linguistically Diverse Communities 6.5.1 Government health systems should be augmented by funding a range of organisations within the CALD service delivery sector including those organisations that have links within specific CALD communities, with at this time a focus on the impact of COVID-19 pandemic.	$20 million over two years.
	6.6 LGBTQI 6.6.1 Establish national architecture to coordinate LGBTQI health through the appointment of a Senior Staff within the Health portfolio 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. This work should be supported by a National LGBTQI Health Advisory Committee consisting of lived experience to provide advice on policy direction. 6.6.2 Establish a national LGBTQI lived experience network to provide information, support, and knowledge to governments and sectors on suicide prevention and include LGBTQI people across policy development in Australia. The national lived experience network should be funded through a LGBTQI community control organisation who are supported and trained to provide advice and report to a National LGBTQI Health Advisory Committee. 6.6.3 There should be greater investment in general and specialist community-controlled organisations to develop tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience. 6.6.4 Australia needs population-level data and accurate recording of deaths by suicide through improving data collection by coroners to inform policy, service program and development, and by counting LGBTQI people in the	$1.1 million over the forward estimates.

	Census. Data on LGBTQI deaths by a Senior Staff within the Health portfolio. 6.6.5 Fund a Principal Policy Analyst within the ABS to incorporate the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across data collection. 6.6.6 Fund investment for national research projects undertaken in LGBTQI suicide prevention and mental health. Specifically: ○ Allocate $600,000 over 3 years to La Trobe University to continue iterations of key research projects Writing Themselves In and Private Lives that provide critical data on LGBTI health. ○ Undertake an evaluation evidence check into LGBTQI suicide prevention programs in Australia. 6.6.7 There should be greater investment in the education and training of LGBTQI community control, mainstream healthcare and social services to build a workforce able to respond and meet the needs of LGBTIQ+ communities and other priority populations. This includes sector development toward a LGBTQI lived experience workforce.	$0.6 million over the forward estimates. $0.6 million over 3 years.
	6.7 Veterans 6.7.1 Continue funding the Joint Transition Authority to complete its implementation phase, identifying how transition services can be better connected and improved. 6.7.2 Increase the numbers of ADF Transition Coaches to ensure sufficient numbers to fully assist all transitioning ADF personnel. 6.7.3 Ensure equity of funding for psychologists and psychiatrists with veteran clients.	
7. Strengthening protective factors	**7.1 Welfare Support** 7.1.1 Maximum rates of JobSeeker, Youth Allowance and related payments ('Allowance Payments') for all single people, including single parents, should be raised by an	

	absolute minimum of at least $75 per week with indexation[1]. 7.1.2 Increase the base rate of JobSeeker Payment to at least $69 a day so everyone can cover the cost of basic living. 7.1.3 Indexation of payments in line with wage movements at least twice er year. 7.1.4 Increase Commonwealth Rent Assistance by 50%. 7.1.5 Introduce a Single Parent Supplement that recognises the additional costs of single parenthood. 7.1.6 Establishment of a Social Security Commission to advise the Parliament on the ongoing adequacy of income support payments.	
	7.2 Strengthen social connection & reduce loneliness 7.2.1 Commonwealth Government to develop a national strategy to address loneliness and social isolation and allocate responsibility for implementation to a senior minister. 7.2.1 Commonwealth Government to plan and deliver a national survey on loneliness and social isolation to provide a national dataset to enable targeted prevention and intervention.	
	7.3 Childhood trauma 8.3.1 Fund implementation of tailored programs focused on improving children's mental health and wellbeing based on the key characteristics of successful place-based approaches.	
	7.4 Housing Insecurity 8.4.1 Increase Commonwealth investment in housing affordability, social housing and homelessness services.	
	7.5 Disaster Planning **7.5.1 Recommendation:** Commonwealth budget annually in discretionary funds to respond to need for suicide prevention including addressing the social determinants of	

[1] The $75pw figure needs to be updated, based on wage and price movements since this target was first adopted using June 2016 figures.

	health that heighten risk factors for suicide in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods after a disaster. These funds should be administered without delay through PHNs, Emergency Management Australia or other mechanisms as required to reach those in need. **7.5.2** Planning is undertaken to support helplines and online services respond to increasing demands when disasters strike. Additional budgeted discretionary funds should include additional resources for helplines that can be activated as required. **7.5.3** Commonwealth to join with State and Territory Governments fund research into population groups to identify at-risk groups vulnerable to disasters to enable development of evidence-based targeted responses which are tailored to diverse demographic, gender, and cultural needs.	$30 million $1.5 million.

1. Whole of Government Approach

1.1 Recommendation: A Suicide Prevention Act should be implemented 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.

Cost: $0.9 million over three years. This cost is estimated by comparison to funding allocated to recent strategies with similar scope, such as the *National Injury Prevention Strategy*.

Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. Only half of those who tragically lose their life to suicide each year are accessing mental health services at the time. Recent modelling released by the Australian Institute of Health and Welfare revealed socio-economic factors such as being widowed, divorced or separated, being not in the labour force or being unemployed, being a lone person household and being male, to be risk factors that had the strongest associations with suicide.

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".[2]

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. This includes consideration of suicide prevention in issues as diverse as housing, employment, and helping people to build healthy social connections. with deaths by suicide.[3]

We welcome the Commonwealth Government's record investment into mental health and suicide prevention, with the Morrison Government announcing $64 million for suicide prevention, $74 million for preventative mental health services, and $48 million for the National Mental Health and Wellbeing Pandemic Response Plan. The Federal Government's $298.1 million commitment to suicide prevention, in the 2021 Budget, including $12.8 million set up a National Suicide Prevention Office, signals a major step towards significant system change that could lead to a meaningful reduction in lives lost to suicide.

This commitment to whole-of-government suicide prevention should be legislated. *Suicide Prevention Acts* have proven successful overseas in legislating whole-of-government prevention priorities. An Act is necessary to ensure decision-makers across Government are united in working to prevent suicides.

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[2] 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>.

[3] AIHW. (2021). Social factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/social-factors-suicide.

Legislation can ensure clear shared and individual accountability and focus agencies on practical and measurable steps to reduce and prevent suicide.

Implementation of a Suicide Prevention Act would 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. At this crucial recovery phase, it can ensure work across portfolios to address the social determinants of health that lead to suicide to prevent increases in suicide rates and work towards zero suicide in Australia.

2. Lived Experience

2.1 Recommendation: Fully fund implementation of the recommendations of the Final Advice of the National Suicide Prevention Advisor to ensure people with lived experience are integrated in all aspects of suicide prevention policy development, design, delivery, research and evaluation. This includes integrating lived experience leadership, knowledge and insights into the design, delivery and evaluation of any 2022 Budget measures related to suicide prevention.

Cost: Any additional funding required to be determined in co-design process with people who have a lived experience.

2.2 Recommendation: A National Workforce Strategy for Suicide Prevention should include key priorities and investment for growing, supporting and sustaining the suicide prevention lived experience and peer workforce.

Cost: $1.9 million over three years plus implementation funding.

Lived Experience Leadership

People with lived experience should be integrated in all aspects of suicide prevention. Their leadership, knowledge and insights are uniquely placed to inform suicide prevention policy and practice. The voice and knowledge of individuals with lived experience is diverse. Individual experiences of suicide - whether through experiencing ideation, attempts, caring for or bereaved loved ones are varied. Listening to these diverse voices and views are essential to ensuring policies and practice meet the needs of those at-risk or impacted by suicide.

As outlined by the Prime Minister's National Suicide Prevention Advisor, "positioning knowledge from lived experience at the forefront of research, policy and practice has the potential to richly communicate the complexities of suicidal behaviour and highlight key considerations for preventing suicide and better supporting people".[4]

[4] National Suicide Prevention Adviser. (2020). Compassion First: Designing our national approach from the lived experience of suicidal behaviour, Canberra, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/national-suicide-prevention-adviser-final-advice-compassion-first.pdf.

Suicide Prevention Australia's strongly supports the recommendations of the Final Advice of the National Suicide Prevention Advisor to integrate lived experience in all aspects of suicide prevention. This should extend to integrating lived experience leadership, knowledge and insights into the design, delivery and evaluation of any 2022 Budget measures related to suicide prevention.

Suicide Prevention Peer Workforce

The suicide prevention peer workforce is key to improved suicide prevention outcomes. Suicide prevention workers have unique lived experience including as survivors of suicide attempts, those bereaved by suicide or as carers. The employment of suicide prevention peer workers ensures unique lived experience insights, knowledge and understanding are embedded at the service level and can improve trust, support and outcomes for those accessing suicide prevention services.

As outlined in the recently released National Lived Experience (Peer) Workforce Development Guidelines, the benefits of the lived experience workforce extend to people accessing services, families, social networks, organisations and the broader community. Lived experience within individual services settings can improve rates of engagement and retention in treatment, reduce critical incidents or need for restrictive practices, improve self-management, reduce the need for re-admission or acute care and improve staff retention, safety and wellbeing.

There are particular benefits in peer-led models for those that are hard-to-reach or most at-risk. Workers in the construction industry have, for example, benefited from the peer-led, industry-based MATES in Construction program: the delivery of which coincided with a 10 percent reduction in the suicide rate for construction workers in Queensland.[5]

We support the recommendations made in the National Suicide Prevention Advisor's Interim Report to build the lived experience and peer workforce to help break down stigma and provide person-centred supports[6]. This is consistent with findings from the Victorian Royal Commission into mental health included a focus on the importance of peer worker roles in suicide prevention and called for dedicated peer worker roles to be established for families and others involved in supporting people experiencing suicidality[7].

The increased adoption of peer-led models, including Safe Spaces/Safe Havens and peer-led industry programs are positive developments. As are related sector developments including the National Lived Experience (Peer) Workforce Development Guidelines and the recruitment of Peer Support Workers to Head to Health Centres. There remain significant opportunities to involve peer workers in the full range of suicide prevention programs including aftercare, postvention and industry-based peer support initiatives.

To fully embed lived experience leadership, knowledge and insights across suicide prevention, further planning and investment in workforce development will be required. This will ensure we can both grow the lived experience and peer workforce and put in place supporting structures to sustain and support

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[5] Doran, C., Ling, R., Gullestrup, J., Swannell, S. & Milner, A. (2015). The impact of a suicide prevention strategy on reducing the economic cost of suicide in the New South Wales construction industry, *Crisis*, 37, available online: https://doi.org/10.1027/0227-5910/a000362.

[6] Vechakul. (2015). Human-Centered Design as an Approach for Place-Based Innovation in Public Health: A Case Study from Oakland, California, *Maternal Child Health Journal,* 2552–2559.

[7] Ibid.

that workforce. As part of a fully-funded National Suicide Prevention Workforce Strategy (see section 4), we recommend key priorities and investment is included to grow, support and sustain the suicide prevention lived experience and peer workforce.

3. Data and Evidence

3.1 Recommendation: Government commit $4 million over four years to build capability in suicide prevention sector to access, interpret and use increasing amounts of suicide prevention data.

3.2 Recommendation: Develop outcomes to measure suicide prevention programs efficacy in the community and provide data on program impacts to provide for future learnings.

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. 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.

In the transition from the COVID-19 pandemic and reforms to policy and practice, ongoing translational research is key to understand what works for whom and when. While 96% of the suicide prevention sector respondents to the 2021 State of the Nation survey agree their organisation needs access to reliable, accurate suicide prevention data, only 23% agree they have access to the data they need right now

More reliable, timely and robust data can improve policy development and planning as well as enable immediate prevention and postvention responses at a local level. The establishment of the Suicide and Self-Harm Monitoring System is a step forward, there remain major gaps in the availability of data relating to suicide attempts and other priority cohorts including Aboriginal and Torres Strait Islander, LGBTQI+ and culturally and linguistically diverse communities. There is also a need to develop outcomes to measure suicide prevention program efficacy in the community and provide data on program impacts to guide future learning.

While increasing availability of data is critical, better outcomes are reliant on sector capability to access, understand and interpret the available data. As the suicide prevention sector grows, it's critical the capability to make use of increased data is supported. Small, but wise and strategic, investment in data capability building through grants for easy to use resources and staff training can unlock the potential of this data. The funding would align with recent important progress made through the National Suicide and Self-Harm Monitoring System.

4. Quality, Workforce and Community

4.1 Recommendation: Suicide Prevention Workforce Strategy: National Office develop a suicide prevention workforce strategy and implementation plan that is fully-funded and provides long-term vision and strategy for workforce and specific actions to ensure capability, skills, supply, retention and sustainability across the sector and is integrated appropriately with other related sectors and strategies under development.

Cost: $1.9 million over three years to develop Strategy plus funding for implementation. This cost is estimated by comparison to funding allocated to recent workforce strategies with similar scope, such as the *Aged Care Workforce Strategy (A Matter of Care)* and the *National Agriculture Workforce Strategy*.

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

Cost: $1.8 million over three years.

Workforce

The suicide prevention workforce includes the clinical workforce who interact with those at risk of suicide (e.g. medical professionals), the formal suicide prevention and mental health workforce (e.g. working in suicide prevention, crisis support and postvention) and the informal suicide prevention workforce (e.g. those working with individuals who might be vulnerable to suicide).

This is a broad, diverse and growing workforce. As the sector grows and funding increases, there is a critical need to develop a Suicide Prevention Workforce Strategy. Alongside a fully-funded implementation plan, this would provide long-term vision and strategy for workforce and specific actions to ensure capability, skills, supply, retention and sustainability across the sector and is integrated appropriately with other related sectors and strategies under development.

Quality

The Fifth Mental Health and Suicide Prevention Plan recognises the importance of standards to assuring services and programs are safe, quality and outcomes-focussed. There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability factored into their design. Communities need to have the assurance that Australia's suicide prevention programs provide a consistent, high quality and safe standard of care.

Embedding accreditation and standards into commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason Suicide Prevention Australia partnered with people with lived experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

As outcome-oriented standards, the Standards are designed to support the suicide prevention sector and provide assurance to consumers that the suicide prevention programs developed by an organisation are safe, high-quality and effective. The Standards offer an opportunity for organisations to participate in an accreditation program that will provide consistency in delivery and quality improvement. These are bespoke, fit-for-purpose standards reflecting the unique aspects of suicide prevention.

Over 70 programs and services are working towards accreditation, including major organisations including Beyond Blue, Roses in the Ocean and Standby – Support After Suicide and LivingWorks. More information about the standards can be found here: https://www.suicidepreventionaust.org/suicide-prevention-quality-improvement-program/. Accreditation standards should be embedded in

commissioning processes for suicide prevention services in particular services commissioned by all levels of Government.

Accreditation standards should be embedded in commissioning processes for suicide prevention services in particular services commissioned by Primary Health Networks and other commissioning authorities and funding that is delivered over long-term cycles to support sustainability and quality. There is a significant opportunity to fund the extension of the Quality Improvement Program into a fully-fledged sector led accreditation system.

Community

For suicide prevention to be effective, key people in the community from clinicians to frontline service workers and teachers should be actively engaged. With the appropriate evidence-based suicide prevention 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. As a sector, we must always be pushing for continuous improvement and looking for ways to raise the bar collaboratively. The result is improved access to services for people who are in distress.

4.3 Recommendation: To support efforts to build capacity on responding to suicide risk, Government should fund the development of industry-specific competency frameworks in high-risk sectors. Building on the Suicide Prevention Australia Framework this can provide a tailored approach to build on the evidence of 'what works' regarding the knowledge and skills required for workforces in suicide prevention across diverse settings.

Cost: suicide risk is significantly elevated in a number of industries that are also impacted by COVID (such as the Arts/Entertainment, Agricultural, and Transport sectors) and industries that have a key role in early intervention such first responders.[8] Indicative costing for projects to development of industry-specific competency frameworks in these high-risk sectors would be $550,000 over three years, consisting of:

- Agricultural: $100,000
- Ambulance Services: $50,000
- Firefighting: $50,000
- Arts and Entertainment: $50,000
- Transport: $300,000

4.4 Recommendation: As the formal and informal suicide prevention sectors grow, there is a need to support sustainable skill development from orientation through to professional development. Building on the competency framework, Government should work with the sector to explore quality, evidence-based "on-boarding" and "orientation" opportunities for individuals working in suicide prevention.

Cost: $1 million for consultation and implementation

Everyone has a role in suicide prevention. With people spending so much of their lives at work, this framework is an important building block to help employers recognise suicidal behaviour and

[8] Case R, Alabakis J, Bowles K-A, Smith K: High-risk occupations—Suicide: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2020.

respond appropriately. We want to ensure that every person who needs support can access a consistent, high-quality, and safe standard of care. As the national peak body for suicide prevention, we launched Australia's first national framework for suicide prevention in the workplace, called Suicide Prevention: A competency framework.

The framework was created in collaboration with experts in workplace suicide prevention and suicide prevention training and over 50 of our members were involved. It provides a starting point for employers and staff to ensure they are promoting wellbeing in the workplace and have the skills and confidence to intervene when someone is in distress.

The framework is designed to provide organisations with the knowledge and education to respond appropriately to people experiencing suicidal thoughts and behaviours at work. It could be one of their staff or a customer or consumer. Many workplaces have programs to learn CPR or first-aid in the same way, the Suicide Prevention competency framework provides a roadmap for workplaces to learn the skills and knowledge in suicide prevention.

The framework can also be used by employers to identify gaps in the workplace when it comes to induction, education, training and most importantly the support and wellbeing of their staff.

5. Early intervention and additional support

5.1 Aftercare

5.1. Recommendation: Urgently implement the commitment to universal aftercare. Universal aftercare should be delivered in partnership with States and Territories and individuals with lived experience of a suicide attempt. Any additional funding required to achieve universal access should be included in the 2022 Budget.

Cost: any additional funding on top of the existing $158.6 million commitment).

A suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population[9]:

- Between 15 and 25% of people who make a non-fatal attempt at suicide will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[10]
- The relative risk for suicide after attempted suicide is between 20 to 40 times higher than in the general population[11]

[9] 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

[10] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf.

[11] Sax Institute. (2019). Suicide aftercare services, Evidence Check, available online: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf.

- The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'. [12]

However, around half of the people discharged from hospital following a non-fatal suicide attempt do not receive follow-up treatment.[13] Universal aftercare is urgently required to address this risk. The Commonwealth Government announced $158.6 million for universal aftercare services in the 2021 Budget, subject to State and Territory partnership in a new National Agreement on Mental Health and Suicide Prevention.

The implementation of universal aftercare for those who have attempted suicide is urgently needed. This should be delivered through evidence-based programs and provide immediate and ongoing support. This includes both clinical and non-clinical elements in a stepped-care model that provides both medical support and broader non-medical and social supports for a person's recover journey.

It is critical that individuals with a lived experience of suicide attempts are central to the development and implementation of universal aftercare. Their voice and insights are essential to ensuring services can effectively support those at-risk. Any additional funding required, beyond the existing $158.6 million commitment should be included in the 2022 Budget.

5.2 Postvention

5.2 Recommendation: Continue to increase investment in universal access to national postvention services including the establishment of postvention peer support programs.

Cost: $16 million per annum.

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. Bereavement by suicide has been evidenced as a risk factor of subsequent suicidal behaviour, making postvention services an essential component of suicide prevention.[14]

An effective form of support is peer support groups, meeting with others bereaved by suicide.[15] There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[16] Other postvention services include tailored responses through direct compassionate, person-centered,

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[12] AIHW. (2021). Psychosocial risk factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide.

[13] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf

[14] Andriessen, K., Krysinska, K., Kolves, K., & Reavley, N. (2019). Suicide postvention service models and guidelines 2014-2019: a systematic review, *Frontiers in Psychology,* 10:2677.

[15] 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

[16] 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).

trauma informed and coordinated local support services matched to individual needs, which can also include support from a peer companion, and outreach by trained support teams.[17] 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.[18]

Funding should be allocated to ensure postvention is available to those impacted by suicide nationally. Bereavement by suicide raises suicide risk by two to five times the rate of the general population.[19] Postvention support is an important method for addressing this risk, encouraging healing and reducing suicide contagion among those who have lost a loved one.

5.3 Support after a suicide attempt or suicidal distress

5.3 Recommendation: Invest in national support for those whose loved ones attempt suicide or are impacted by suicidal distress.

Suicide attempts and suicidal distress have significant impacts not only on the individual experiencing suicidality but also on the carers, family and friends surrounding them. While aftercare services support survivors of suicide attempts and postvention supports those bereaved by suicide, there is a major gap in the support available to those loved ones impacted by a suicide attempt or suicidal distress. These friends, families and communities are missing out and need support.

With an estimated 65,000 people who attempt suicide each year and many more who experience suicidal thinking and distress, there is a need to address this major service gap. A peer-led model, co-designed with individuals with lived experience including across other priority cohorts, should be developed. Similar to effective postvention models, a non-clinical model that offers counselling, emotional and practical supports and can connect individuals in need with relevant services is required. These services should be delivered in tandem with, and connected to, existing aftercare and postvention services.

Investment in support services of this kind would be expected to reduce psychological distress, promote help-seeking and improve wellbeing for individuals whose loved ones face suicidal distress or attempt suicide. It will also support understanding and relationships between those experiencing suicidal distress and their loved ones and could in-turn support the recovery journey of suicide attempt survivors.

5.4 Safe Spaces

[17] Harrington-LaMorie et al. (2018). 'Surviving families of military suicide loss: Exploring postvention peer support', Death studies, 42(1):1-12

[18] Andriessen, K., Krysinska, K., Hill, N.T.M. et al. (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.

[19] World Health Organisation. (2014). Preventing suicide: A global imperative, Geneva.

5.4 Recommendation: The Commonwealth Government should partner with States and Territories to develop and fund a national network of Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking.

Cost: Funding required to be developed through co-design with States and Territories and people with lived experience.

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environments are not the most appropriate point of care for people experience mental distress and people with lived experience report distress can be exacerbated by this setting.[20]

Safes Spaces aim to provide an alternative and are an umbrella term referring to non-clinical, peer-led supports for people in suicidal crisis. They are also known in some areas as safe havens or safe haven 'cafes'. They do not replace clinical mental health interventions but support people to navigate the mental health system, connect to local services and develop self-management skills.[21]

The original concept was trialled as the Safe Haven Café in 2014 in Aldershot, United Kingdom. Individuals experiencing a mental health problem were able to visit the centre and converse with mental health professionals and peer workers. An evaluation found a 33% reduction in the number of admissions to acute in-patient psychiatric beds within the Safe Haven's catchment areas.[22]

Safe Spaces been recently emerged in Australia, including a recent Commonwealth commitment to develop national standards for Safe Spaces. Roses in the Ocean have been a leader in supporting the co-design of these spaces and variations of Safe Spaces now exist across Australia. This model is being adopted given the unsuitability of emergency department for people experiencing suicidal thinking as well as the opportunity for a peer-led alternative drive better individual, economic and community outcomes.

It is important to note there are different types of Safe Spaces that operate in different ways and support individuals at different times and with different needs. Roses in the Ocean have developed a tiered approach that extends Wesley Mission Queensland's three tier model for mental health Safe Safes to include additional tiers focused on suicide prevention:[23]

- Tier 5 – a non-clinical peer run resident safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience

[20] Roses in the Ocean. (2021). Discussion Paper: A National Safe Spaces Network, available online: https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf.
[21] Life in Mind. (2021). Safe Spaces, available online: https://lifeinmind.org.au/safe-spaces.
[22] National Health Service UK. (2016) Case study: Safe Haven Café in Aldershot. Available from: https://www.england.nhs.uk/mental-health/case-studies/aldershot/
[23] https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf

- Tier 4 – a non-clinical peer run safe alternative to emergency departments with a suicide prevention focus, staffed by suicide prevention peers with lived experience
- Tier 3 – a Safe Space to access psychosocial support and safety planning primarily existing mental health services enhanced with peer workers
- Tier 2 – a Safe Space to talk to someone and access a referral (e.g. community centres/services/chemist) in settings that are already operation with staff who are trained to identify risks and connect people to supports
- Tier 1 – a safe 'refuge' to sit in (e.g. library, coffee shop, hairdresser, barber) that are community based non-clinical supports

There is a particular need for investment in Tier 4 and Tier 5 Safe Spaces that have high-fidelity to the concept and to the lived experience co-design process. The key components of this model are:[24]

- A trauma-informed 'no wrong' door approach
- Non-clinical support that meets the holistic needs of guests
- A compassionate and capable peer-led workforce
- A safe and accessible location
- A warm welcoming environment
- Warm connections to other appropriate and reliable supports
- Shared governance and management

The Commonwealth Government should work with states and territories to progress a national network of Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking. This should ensure existing Safe Spaces under development are genuinely aligned to the Safe Space concept and have fidelity to the co-design process. It should also include the delivery of new Tier 4 and Tier 5 Safe Spaces that are non-clinical, peer-led alternatives with a suicide prevention focus.

6. Vulnerable population groups

Risk of suicide is multi-layered and complex when identities intersect and minority stress including stigma and discrimination is compounded. Suicide Prevention Australia's advocates for additional investment and support for those most at-risk of suicide in our community. We have outlined evidence and recommendations to address suicide prevention for a number population groups at higher risk of experiencing suicidality than the general population.

6.1 Survivors of suicide attempts

[24] Roses in the Ocean. (2021). Discussion Paper: A National Safe Spaces Network, available online: https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf.

As outlined in section five, a suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population[25]. Given this risks, there is a need to prioritise investment and support for survivors of suicide attempts. In particular, recommendation 5.1 to urgently deliver universal access to aftercare.

As recommended in section 2, the leadership, knowledge, and insights of people with lived experience should be integrated in all aspects of suicide prevention policy development, design, delivery, research and evaluation. Survivors of suicide attempts have a unique voice and experience that is essential to improved services and outcomes for this high-risk cohort.

6.2 Youth suicide

6.2.1 Recommendation: Commonwealth to prioritise investment in youth-specific early intervention strategies, with particular priority on programs and services that are co-designed with young people. This should include suicide prevention training for those who work directly with young people and in 'connector roles'.

Cost: Funding requirement to be confirmed in co-design process.

6.2.2 Recommendation: Commonwealth to invest in ensuring that support services are equipped to respond to the needs of young people in suicidal crisis, by having services informed by co-design with young people and research evidence on how best to address suicide risks in young people.

Suicide is the leading cause of death among young Australians 15-24 years with over one third of deaths in this cohort due to suicide.[26] Particular groups of young Australian's are at elevated risk. Young males aged 15-24 years have a suicide death rate of 21.2 per 100,000, compared with 6.7 for young females. For Aboriginal and Torres Strait Islander young people aged 15-24, the rate of death by suicide per 100,000 was 58.9, compared with 18.5 for non-indigenous young people.[27] Other groups of young people at higher risk include those in rural and remote areas, those in contact with the justice system, those leaving statutory care, those who have been exposed to suicide or suicide-related behaviour, and LGBTIQ+ young people.[28]

The COVID-19 pandemic has been incredibly disruptive for young people. It has impacted their schooling, saw the loss of key milestones and created great uncertainty for the future. During this time, Kids Helpline have reported significant increases in calls from young people experiencing suicidality.[29]

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[25] Shand, F, A Woodward, K McGill, M Larsen, and M Torok. 2019. Suicide aftercare services: an Evidence Check rapid review. brokered by the Sax Institute for the NSW Ministry of Health

[26] Australian Bureau of Statistics (2021) *Causes of Death, Australia, 2020,* available online at <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2020>.

[27] Ibid

[28] Robinson, J, Bailey, E, Browne, V, Cox, G, & Hooper, C. *Raising the bar for youth suicide prevention*. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

[29] Batchelor, S., Stoyanov, S., Pirkis, J., & Kõlves, K. (2021). Use of Kids Helpline by Children and Young People in Australia during the COVID-19 Pandemic. *Journal of Adolescent Health*, *68*(6), 1067-1074.

Self-harm and suicidal ideation-related hospital admissions have also increased for young people in some jurisdictions.[30]

Youth suicide prevention requires a multifaceted approach with targeted and co-designed early interventions and programs to support the health and wellbeing of young Australians. This approach helps address the risk factors and barriers to help seeking young people experience. Early intervention and prevention supports for young people are needed to capture at-risk young people before they reach crisis point.

6.3 Aboriginal and Torres Strait Islander Peoples

6.3.1 Recommendation: Utilise an equity and needs-based approach to fund targeted, specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities will address these gaps to access, as the majority of Aboriginal people (63%) live outside major urban areas.

> **Cost:** apply an equity and needs-based formula to existing expenditure with increased funding committed as required and in line with the upcoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

6.3.2 Recommendation: Utilise an equity and needs-based approach to 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. Aboriginal and Torres Strait Islander organisations should be the preferred providers of local suicide prevention activities for their communities.

> **Cost:** apply an equity and needs-based formula to existing expenditure with increased funding committed as required and in line with the upcoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

6.3.3 Recommendation: Allocate sufficient funding with an equity and needs-based approach so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement, recognise and promote the importance of Aboriginal and Torres Strait Islander leadership by supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.

> **Cost:** apply an equity and needs-based formula to existing expenditure with increased funding committed as required and in line with the upcoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

6.3.4 Recommendation: Invest in youth suicide prevention by increasing mental health and wellbeing supports available for Aboriginal and Torres Strait Islander children who are in care of the state/territory.

> **Cost:** $75.2 million over four years. This represents $1,000 per annum additional investment for each Aboriginal and Torres Strait Islander child in care (18,862 as at June 2021) to supplement existing expenditure through additional mental health and wellbeing supports.

[30] Australian Institute of Health and Welfare (2021) *Suicide & self-harm monitoring: Intentional self-harm hospitalisations*, available online at <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations>.

6.3.5 Recommendation: Allocate funding to workforces to ensure commitment to cultural competency and inclusion of Aboriginal and Torres Strait Islander peoples is achieved by all mainstream mental health and suicide prevention services.

Cost: $7.7 million over three years. This would match recent Commonwealth funding of $7.7 million over three years to develop the cultural competency and trauma responsiveness of the Indigenous and non-Indigenous child and family sector workforce. This costing assumes a roughly similar size of workforce but more detailed analysis would be required to understand whether the scale of competency investment should differ significantly.

Recent data from the Coroners Court of Victoria report the number of suicides of Aboriginal and Torres Strait Islander people increased by 75% in 2021.[31] Given the extremely high rates of suicide in Aboriginal and Torres Strait Islander communities, especially amongst young people we request funding for Aboriginal and Torres Strait Islander- specific interventions. 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. 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.

The rights of Aboriginal and Torres Strait Islander peoples to self-determination, justice and autonomy should underpin everything we do in suicide prevention. Our strategies to tackle Aboriginal and Torres Strait Islander suicide should combine whole of population approaches with targeted programs and services led by and tailored to the needs of Aboriginal and Torres Strait Islander communities, such as those that strengthen cultural identity and belonging.

We know the social determinants of suicide for the general population also affect Aboriginal and Torres Strait Islander peoples. Issues such as employment status, social support, and social inclusion impact Aboriginal and Torres Strait Islander individuals and communities, just as they impact the broader Australian community.

Policymakers also need to take into account the risk factors unique to Aboriginal and Torres Strait Islander peoples. Intergenerational trauma, social marginalisation, dispossession, loss of cultural identity, community breakdown and the artefacts of colonialism have had a profound impact on the mental health, wellbeing and lives of Aboriginal and Torres Strait Islander peoples. Suicide Prevention Australia is signatory to the Uluru Statement from the Heart. The Statement articulates the aspirations of Aboriginal and Torres Strait Islander peoples for self-determination, justice, truth telling and respect.

That's why self-determination must be the underpinning principle of any action to address Aboriginal and Torres Strait Islander suicide. The risk factors stemming from dispossession, breakdown of

[31] Coroners Court of Victoria. (2022). New report shows Victorian Aboriginal and Torres Strait Islander suicides nearly doubled in 2021, available online: https://www.coronerscourt.vic.gov.au/new-report-shows-victorian-aboriginal-and-torres-strait-islander-suicides-nearly-doubled-2021.

community and loss of autonomy can only be minimised if Aboriginal and Torres Strait Islander peoples themselves decide how best to address them.

6.4 Male Suicide

6.4.1 Recommendation: The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy that is co-designed with those with lived experience and with support providers and is informed by Research and Data.

Cost: Funding requirement to be confirmed in co-design process**.**

Male suicide is an issue requiring targeted policy and funding attention by all governments. More than three-quarters of suicide deaths occur in males; in 2020, 3,139 Australians died by suicide, 2,384 (76%) of whom were males.[32] Ambulances respond to over 16,800 calls each year from males experiencing suicidal ideation and a further 9,000 ambulances respond to a suicide attempt.[33] These statistics show that many men are in crisis and current supports are not reaching enough men. We need to be providing more supports that engage with men specifically.

Discussions on masculinity are frequently contested and there is ongoing research into how masculinity is best understood, the forms that different masculinities can take, and the ways in which masculinities can include both risk factors and protective factors for suicide. However, it is clear that across a range of different groups (e.g. ages, cultures, sexuality, region) males are more likely to die by suicide, and that Australia requires a diverse range of effective, evidence-based supports to drive down male suicide. Masculinities are diverse, and so there is a need for a person-centred approach.

Data indicates that men who die by suicide have fewer contacts and later within the suicidal trajectory with health and mental heath systems, meaning there is a need to identify opportunities to intervene outside the health and mental health systems. For example, despite men being far more likely to die by suicide, there are fewer ambulance attendances for male suicide attempts than for female.[34] And men who die by suicide are less likely to have had contact with mental health services,[35] or have a diagnosis

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[32]Australian Bureau of Statistics (2021) *Causes of Death*, *Australia*, https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release.

[33] Turning Point. (2019). Beyond the Emergency: A national study of ambulance responses to men's mental health, available online: https://www.beyondblue.org.au/docs/default-source/about-beyond-blue/beyond-the-emergency-report.pdf?sfvrsn=5b6db0ea_4.

[34] Australian Institute of Health and Welfare. (2021). Ambulance attendances: suicidal and self-harm behaviours, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/ambulance-attendances/ambulance-attendances-for-suicidal-behaviours.

[35] Iapperton, A., Dwyer, J., Millar, C., Tolhurst, P., & Berecki-Gisolf, J. (2021). Sociodemographic characteristics associated with hospital contact in the year prior to suicide: A data linkage cohort study in Victoria, Australia, *Plos one*, *16*(6), e0252682, https://doi.org/10.1371/journal.pone.0252682; Sveticic, J., Milner, A., & De Leo, D. (2012). Contacts with mental health services before suicide: a comparison of Indigenous with non-Indigenous Australians, *General Hospital Psychiatry, 34*(2), 185-191, https://www.sciencedirect.com/science/article/pii/S0163834311003574; Fitzpatrick, S. J., Handley, T., Powell, N., Read, D., Inder, K. J., Perkins, D., & Brew, B. K. (2021). Suicide in rural Australia: A retrospective study of mental health problems, health-seeking and service utilization, *PloS one*, *16*(7), e0245271, https://doi.org/10.1371/journal.pone.0245271.

of mental illness.[36] There is ongoing debate as to what extent these statistics are affected by fewer presentations, masking of symptoms, diagnostic practices, and gender differences in the level of risk from non-mental health risk factors. But regardless of the extent to which suicide attempts by men are less likely to result in hospitalisation, or the extent of under diagnosis of mental illness in men, what these statistics show is that for men there is less opportunity to provide support triggered by a suicide attempt, a diagnosis or a mental health service contact. This means that in addition to providing support based on these, it is critical that we focus on the situations that put men at risk of dying by suicide. To do this we need to consider the range of social determinants and situational stressors that can put men at risk of suicide and make a concerted effort to address the underlying issues that might lead men to the point of crisis.

A national male suicide prevention strategy, that incorporates actions by all governments, is needed to ensure the right approach is taken. This could be implemented as part of a national suicide prevention strategy, but it is important that male suicide prevention is specifically recognised as a priority and addressed. The following principles and recommendations for government action are designed to guide the creation and implementation of such a strategy. They are a result of multiple consultations with stakeholders from the suicide prevention and mental health sectors, researchers and people with lived experience.

6.4.2 Recommendation: Provide mechanisms to give resources to effective proactively identifying and evaluating effective supports that could be enhanced by government funding.

Grassroots and peer-led services can be critical in providing support where men are because they are embedded in the communities of the men at risk of suicide and have the local knowledge of where they can be reached. Such supports are often created and operate without government funding. However, in many cases such supports could be more effective with some level of government resourcing.

6.4.3 Recommendation: Fund male-specific connector training to be available to people who regularly encounter men at risk of suicide.

Connector training involves equipping people who regularly come into contact with a target group, with suicide prevention skills. (This is often termed “gatekeeper training”, but that term implies the person is permitting or denying support; the term “connector” is used here instead.) Examples of those who might be most likely to encounter men exhibiting signs of distress include:

- Supervisors and human resources personnel in male-dominated industries
- Judges, lawyers, dispute resolution practitioners, and other service providers involved in legal disputes, especially family and criminal law

[36] Yeh, H. H., Westphal, J., Hu, Y., Peterson, E. L., Williams, L. K., Prabhakar, D., Frank, C., Autio, K., Elsiss, F., Simon, G. E., Beck, A., Lynch, F. L., Rossom, R. C., Lu, C. Y., Owen-Smith, A. A., Waitzfelder, B. E., & Ahmedani, B. K. (2019). Diagnosed Mental Health Conditions and Risk of Suicide Mortality, *Psychiatric services (Washington, D.C.)*, *70*(9), 750–757, https://doi.org/10.1176/appi.ps.201800346; Kolves, K., Potts, B., & De Leo, D. (2015). Ten years of suicide mortality in Australia: Socio-economic and psychiatric factors in Queensland, *Journal of Forensic and Legal Medicine 36*, 136-143.

- GPs
- Police and other first responders
- Staff at prisons and correctional centres
- Employment and welfare services
- Those supporting young men transitioning from out of home care
- Those supporting male students in schools, universities, TAFES and other educational settings
- Those in community roles of significance to men such as barbers, publicans, male elders, etc.

Skilled connectors can recognise suicidal behaviours or signs of distress, provide immediate support, and direct the person in crisis to support services.[37] It is important that such training includes ensuring that connectors have knowledge of self-care, and the limits of their own abilities; their primary role should be to guide and support men to access existing support services. It is also important that connector training is available that is male-specific or has a gender lens and takes into account the unique factors that impact male suicidality (including masculinity), how different male suicidality can look when it manifests, and diversity among and between men. In some cases delivery of male-specific connector training by men and peer-led community-controlled organisations can be more effective.

6.4.4 Recommendation: Fund support providers to undertake collaboration and coordination activities, including relationship-building, coordinated case management and resource co-ordination at a sector level, with a focus on reducing drop out rates for men from support services.

Cross-agency collaboration is vital to reach men at risk before, during and after a suicidal crisis. A whole of government and sector approach, such as a no-wrong-door requirement, to male suicide prevention is required to improve the coordination of services and ensure continuity of care. This is also critical for one of the characteristics of a service system that engages effectively with men as having an integrated and collaborative, approach across all support services.

Collaboration and coordination between services is not resources-free. It requires service providers to invest in building relations and in activities such as case coordination, as well as put in place systems and protocols to protect privacy and ensure consent. Ultimately these investments save resources as those providing particular supports are able to quickly and efficiently link their clients with a broader range of supports as needed.

6.5 Culturally and Linguistically Diverse Communities

[37] De Silva, S., Simpson, R., & Parker, A. (2020). Research Bulletin: Does Gatekeeper Training Prevent Suicide in Young People? (Issue 06), *Orygen*, available online: https://www.orygen.org.au/Training/Resources/Self-harm-and-suicide-prevention/Research-bulletins/Does-Gatekeeper-Training-Prevent-Suicide.

6.5.1 Recommendation: Government health systems should be augmented by funding a range of organisations within the CALD service delivery sector including those organisations that have links within specific CALD communities.

> **Cost:** $20 million over two years. This funding equivalent to recent Commonwealth investment of $20 million to aged care and disability support providers to older Australians from CALD backgrounds through the Commonwealth Home Support Program.

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.

Governments should ensure that a range of organisations and individuals with expertise in culturally appropriate service delivery are involved in the design, implementation and evaluation of services. This should include people with lived experience – including carers and persons involved in family and international student support – and cover a range of needs from settlement support to the needs of older persons including second and subsequent generations and people with expertise in transcultural, torture and trauma-informed services.

6.6 LGBTQI+

6.6.1 Recommendation: Establish national architecture to coordinate LGBTQI health through the appointment of a Senior Staff within the Health portfolio 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. This work should be supported by a National LGBTQI Health Advisory Committee consisting of lived experience to provide advice on policy direction.

> **Cost:** $1.1 million over the forward estimates. This estimate is based on resources supporting the National Suicide Prevention Taskforce. The Taskforce was supported through existing Department of Health appropriations and an additional $0.54 million allocated over two years (2019/20 and 2020/21). Funding provided the National Suicide Prevention Adviser with appropriate subject matter expertise and resourcing to prepare the final advice package. Funding supported the role of the Special Adviser, external consultants, research, consultations including the Towards Zero Suicide forum, the Expert Advisory Group, and on-costs.[38]

6.6.2 Recommendation: Establish a national LGBTQI lived experience network to provide information, support, and knowledge to governments and sectors on suicide prevention and include

[38] *Connected and Compassionate*: Implementing a national whole of government approach to suicide prevention (Final Advice). Canberra; December 2020 – Appendix 4: National Suicide Prevention Taskforce – supports.

LGBTQI people across policy development in Australia. The national lived experience network should be funded through a LGBTQI community control organisation who are supported and trained to provide advice and report to the National LGBTQI Health Advisory Committee.

6.6.3 Recommendation: There should be greater investment in general and specialist community-controlled to develop tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience.

6.6.4 Recommendation: Australia needs population-level data and accurate recording of deaths by suicide through improving data collection by coroners to inform policy, service program and development, and by counting LGBTQI people in the Census. Data on LGBTQI deaths by suicide should be reported on by a Senior Staff within the Health portfolio.

6.6.5 Recommendation: Fund a Principal Policy Analyst within the ABS to incorporate the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across data collection.

> **Cost:** $0.6 million over the forward estimates. Estimated salary and oncosts for a full time Executive Level 1 role.

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

- Allocate $600,000 over 3 years to La Trobe University to continue iterations of key research projects Writing Themselves In and Private Lives that provide critical data on LGBTI health.
- Undertake an evaluation evidence check into LGBTQI suicide prevention programs in Australia.

6.6.7 Recommendation: There should be greater investment in the education and training of LGBTQI community control, mainstream healthcare and social services to build a workforce able to respond and meet the needs of LGBTIQ+ communities and other priority populations. This includes sector development toward a LGBTQI lived experience workforce.

People from LGBTIQ+ communities have higher rates of mental ill-health and suicide than the general population in Australia. In particular, LGBTIQ+ 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.[39]

Recent research into the mental health and wellbeing of LGBTIQ+ Australians demonstrated we are not seeing parallel improvements in LGBTIQ+ mental health. 41.9% of study participants reported considering attempting suicide in the previous 12 months, 74.8% had considered attempting suicide at

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

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.[40]

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.[41] We also know that LGBTIQ+ people are less likely to access help when in crisis. Research undertaken by La Trobe University found 75.3% of LGBTIQ+ participants did not use a crisis support service during a recent personal or mental health crisis.[42]

Currently there is a lack of national architecture and coordination for LGBTIQ+ 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 LGBTIQ+ people.

6.7 Veterans

6.7.1 Recommendation: Continue funding the Joint Transition Authority to complete its implementation phase, identifying how transition services can be better connected and improved.

6.7.2 Recommendation: Increase the numbers of ADF Transition Coaches to ensure sufficient numbers to fully assist all transitioning ADF personnel.

6.7.3 Recommendation: Ensure equity of funding for psychologists and psychiatrists with veteran clients.

Suicide is often the manifestation of complex social and situational factors in a person's life.[43] In the case of service-people and veterans the transition between the structured environment of active service to civilian life is a uniquely vulnerable period. The need for change in this area is clearly demonstrated by data on defence and veteran suicide from the Australian Institute of Health and Welfare (AIHW). After adjusting for differences between the veteran population and the general population AIHW found that rates of suicide were 18% higher for ex-serving men.[44] Suicide is also the

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[40] 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*, available online: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf.

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

[42] 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*.

[43] World Health Organisation. (2014). Preventing suicide: a global imperative, Geneva: WHO Press, available online at: https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/.

[44] Australian Institute of Health and Welfare. (2019). *National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2019 update,* available online at: https://www.aihw.gov.au/reports/veterans/national-veteran-suicide-monitoring/contents/summary. Note that the statistics given here are for males only. The smaller number of female veterans means that statics on female veteran suicide are less reported due to confidentially concerns, and where reported may be problematic due to the small sample size. Indications are that suicide is at least as significant a risk for female veterans as for male

leading cause of death ex-serving men and men in the reserves, as well as being the second highest cause of death for serving men.[45] Previous inquiries and reviews on veteran suicide, including those by the National Mental Health Commission[46] and the Productivity Commission,[47] have all identified the challenges of the transition period for long-term wellbeing.

These challenges include, for example, finding post-military employment, securing housing, the loss of camaraderie and friendships with other service-people, and difficulties in restoring or renewing prior relationships.[48] We recognise that the Australian Defence Force provide frameworks and supports to ensure positive mental health during service but highlight the fragmentation and at times lack of necessary and appropriately skilled supports upon service exit. A key issue highlighted to us in our consultations is that services and supports are readily accessible in service by undertaking simple chain of command processes. Upon leaving service, many don't possess knowledge of how to access support in the broader community, and experience difficulty navigating the mental health system.

Feedback from our members and stakeholders indicates a critical need to improve access to services through better service coordination, integration and navigation support. The array of government and non-government services is disjointed and it is difficult for those leaving Defence to know what support is available or which service/s across government and non-government are appropriate for them. This is even harder to navigate for people when they are experiencing psychological impacts. While some members pointed to a lack of resourcing for veteran support agencies, most pointed to lack of coordination as limiting effective use of current resources.

Members emphasised the need for a collaborative response across government, ex-service organisations, broader non-government services, community and businesses. It was suggested that one coordinating body should be responsible for connecting services and making referrals, this may sit with the Joint Transition Authority. The Joint Transition Authority is currently in its implementation phase, identifying how transition services can be better connected and improved.

Another suggestion was for individual care coordinators with lived experience of transition from Defence to provide case management/care coordination support for veterans as they transition. It appears such a service has begun to be implemented with ADF transition coaches. However, feedback from stakeholders is that there is currently insufficient numbers of coaches to meet demand.

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veterans. For example, this AIHW report found that after adjusting for differences between the veteran population and the general population rates of suicide were 115% times higher for ex-serving women.

[45] Australian Institute of Health and Welfare. (2018). *Causes of death among serving and ex-serving Australian Defence Force personnel: 2002–2015*. Access online at < https://www.aihw.gov.au/reports/veterans/causes-of-death-in-adf-personnel-2002-2015/contents/table-of-contents>

[46] Mental Health Commission. (2017). Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families, available online at: https://www.dva.gov.au/sites/default/files/files/publications/health/Final_Report.pdf.

[47] Productivity Commission. (2019). A Better Way to Support Veterans, Report no. 93, Canberra.

[48] Speer, M. Phillips, M. Winkel, T. Wright, W. Winkel, N. Reddy, Swapna.R. *Serving Those Who Serve: Upstream Intervention and the Uphill Battle of Veteran Suicide Prevention in the US,* online article, https://www.healthaffairs.org/do/10.1377/hblog20190709.197658/full/

There are also challenges in some funding arrangements for NGO services for veteran community, for example with multiple contracts and reporting requirements and insecure funding. Concerns have also been raised that private psychologists and psychiatrists are paid less through DVA to see veterans compared to serving personnel, Commonwealth employees or total MBS and gap-fee payments from the general public.[49] Discrepancies in these funding models means service providers can be less likely to take on or limit the number of veteran clients, further narrowing already insufficient service availability.

7. Strengthening Protective Factors

7.1 Welfare support

7.1.1 Recommendation: Maximum rates of JobSeeker, Youth Allowance and related payments ('Allowance Payments') for all single people, including single parents, should be raised by an absolute minimum of at least $75 per week with indexation[50].

7.1.2 Recommendation: Increase the base rate of JobSeeker Payment to at least $69 a day so everyone can cover the cost of basic living.

7.1.3 Recommendation: Indexation of payments in line with wage movements at least twice er year.

7.1.4 Recommendation: Increase Commonwealth Rent Assistance by 50%.

7.1.5 Recommendation: Introduce a Single Parent Supplement that recognises the additional costs of single parenthood.

7.1.6 Recommendation: Establishment of a Social Security Commission to advise the Parliament on the ongoing adequacy of income support payments.

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. The impact of COVID-19 extends to all members of our community, many of whom are at risk of losing their businesses, their jobs, their livelihoods and – perhaps for the first time – are struggling with their wellbeing. At the same time as the COVID-19 pandemic, Australia has experienced a series of natural disasters placing people vulnerable to suicide risks.

While suicide is not a typical response, links between unemployment, financial insecurity and suicidality are well established. Several systematic reviews have provided strong evidence of the relationship between unemployment and suicide, with the risk at its highest in the first five years of

[49] Martin, L. (2019). Psychologists fear for defence troops as Bupa poised to take over contract, available online at: https://www.smh.com.au/national/psychiatrists-paid-less-for-treating-military-veterans-20201103-p56b8s.html; Barlass, T. (2020). Psychiatrists paid less for treating military veterans, available online at: https://www.theguardian.com/australia-news/2019/jun/21/psychologists-fear-for-defence-staff-as-bupa-poised-to-take-over-contract.

[50] The $75pw figure needs to be updated, based on wage and price movements since this target was first adopted using June 2016 figures.

unemployment[51]. Research found levels of personal debt are also associated with suicidal ideation, suicidal attempts and suicide even after adjusting for socioeconomic factors, lifestyle behaviours and other risk factors[52].

The National Suicide Prevention Taskforce identified 'people more vulnerable to suicide as a result of COVID-19 measures include: people who have experienced unemployment and/or financial distress', and further identified the importance of economic and social policies in reducing financial distress[53]. The Productivity Commission similarly identified those experiencing financial distress or unemployment at higher risk of developing mental illness, and those on income support payments are more likely to experience poverty[54]. The Productivity Commission reported there are significant long term economic benefits to improving people's overall quality of life, in particular in areas of mental health, employment, and income[55].

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.

ACOSS conducted a survey into the financial impact of living in Greater Sydney during the COVID-19 lockdown in 2021. 100% of respondents reported struggling with the cost of living.[56] More than half had lost paid work because of the lockdown, and almost half (49%) said they are at risk of losing their homes.[57]

Increasing the base rate means the thousands of Australian 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. We support the Raise the Rate campaign championed by ACOSS and our recommendations are in line with their campaign.

7.2 Strengthen social connection & reduce loneliness

7.2.1 Recommendation: Commonwealth Government to develop a national strategy to address loneliness and social isolation and allocate responsibility for implementation to a senior minister.

7.2.2 Recommendation: Commonwealth Government to plan and deliver a national survey on loneliness and social isolation to provide a national dataset to enable targeted prevention and intervention.

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[51] Milner, A., Page, A. & LaMontagne, A.D. (2013). Long-term unemployment and suicide: a systematic review and metaanalysis. *PloS one*, 8(1), e51333, available online: https://doi.org/10.1371/journal.pone.0051333.
[52] Meltzer H, Bebbington P, Brugha T, Jenkins R, McManus S, Dennis MS. (2011). 'Personal debt and suicidal ideation', *Psychological Medicine*, 41(4):771-8, available online: https://pubmed.ncbi.nlm.nih.gov/20550757/.
[53] Ibid.
[54] Ibid.
[55] Ibid.
[56] ACOSS. (2021). Locked out in lockdown: A report about people with the least trying to survive in lockdown, available online: https://www.acoss.org.au/wp-content/uploads/2021/07/locked-out-in-lockdown-report_final-1.pdf.
[57] Ibid.

Connectedness acts as a significant protective factor for suicide. However, when people become socially isolated and lonely it can have significant impacts and pose harms to both mental and physical health.[58] Research has shown social isolation to pose more significant health risk than 'smoking, poor diet and lack of exercise'[59], and loneliness has been found to increase the risk of premature death by approx. 30%.[60]

The Australian Psychological Society reports approx. 1 in 4 Australians are experiencing an episode of loneliness, and 1 in 2 report they feel lonely for at least 1 day each week.[61] Loneliness is highlighted as a modifiable risk factor for suicide by the Royal Australian & New Zealand College of Psychiatrists.[62]

The estimated prevalence of problematic levels of loneliness among Australians is around 5 million.[63] Loneliness has also been attributed to increasing the risk of health problems such as myocardial infarction and stroke[64], and increases the likelihood of experiencing depression by 15.2%[65], and links exist between social isolation and the experience of psychological harm.[66]

Stigma and discrimination are harmful to mental health and can occur against people with mental illness, and high rates of people with mental ill health withdraw themselves from public spaces due to stigma and discrimination.[67,68] Mental illness is further associated with lower involvement in the labour force and greater discrimination, both of which are risk factors for suicide.[69,70] It is crucial that active efforts should be made to reduce the stigma surrounding mental ill health and loneliness.

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[58] AIHW. (2019). Social isolation and loneliness, *Australian Institute of Health and Welfare*, September 2019, available online: https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness.
[59] Ibid..
[60] Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T. & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A Meta-Analytic Review, *Association for Psychological Science, Sage Journals,* 10(2).
[61] Australian Psychological Society. (2018). Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing, *APS,* Melbourne.
[62] RANZCP. (2020). Suicide prevention – the role of psychiatry, *The Royal Australian & New Zealand College of Psychiatrists,* Position Statement 101.
[63] Ending Loneliness Together. (2021). A National Strategy to Address Loneliness and Social Isolation, *R U OK, Australian Psychological Society,* available online: https://treasury.gov.au/sites/default/files/2021-05/171663_ending_loneliness_together.pdf.
[64] Hakulinen, C., Pulkki-Raback, L., Virtanen, M., Jokela, M., Kivimaki, M., & Elovainio, M. (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK biobank cohort study of 479 054 men and women, *Heart,* 104(18), 1536-1542.
[65] Abbott, J., Lim, M., Eres, R., Long, K. & Matthews R. (2018). The impact of loneliness on the health and wellbeing of Australians, *InPsych*, 40(6).
[66] Ibid.
[67] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report.
[68] SANE Australia. (2020). National Stigma Report Card, available online: https://nationalstigmareportcard.com.au/.
[69] ABS. (2020). General Social Survey: Summary Results, Australia, available online: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2020.
[70] Ibid.

1 in 10 Australians aged 15 and over report lacking social support.[71,72] Response measures to the COVID-19 pandemic to protect community health have subsequently heightened risk factors for suicide such as social isolation, financial distress, and unemployment.

The Commonwealth Government should lead the development of a national strategy to address loneliness and social isolation and allocate responsibility for implementation to a senior minister. A national strategy should acknowledge and include lived experience expertise, and recognise that loneliness and mental ill health and the stigma and discrimination associated barriers to social inclusion and connection.

We need quality, robust data on loneliness and social isolation to better understand who is at risk and how best to support more connected communities. A national survey on loneliness and social isolation that captures key demographics and geographics on populations already at risk of suicide (Aboriginal and Torres Strait Islander peoples, LGBTQI communities, culturally and linguistically diverse communities, veterans, young people, older people) will enable targeted prevention and intervention.

7.3 Childhood trauma

7.3.1 Recommendation: Fund implementation of tailored programs focused on improving children's mental health and wellbeing based on the key characteristics of successful place-based approaches.

The estimated cost to government of late intervention for children and young people in Australia who experience serious issues that require crisis services is $15.2 billion per year, equating to $607 for every Australian or $1912 per child and young person.[73]

In 2019, Australians lost 145,703 years of healthy life due to suicide and self-inflicted injuries, representing around 3% of the total burden of disease and injury in Australia. In 2019, child abuse and neglect during childhood was the leading risk factor contributing to the burden of suicide and self-inflicted injuries in both males and females. It was associated with 33% of total suicide burden in females and 24% in males aged 5 and over.

Research undertaken by ACOSS reports there are 731,000 children living in poverty in Australia, and 1.2 million Australians living in poverty are under the age of 24.[74] Additionally, 1 in 3 children from Australia's disadvantaged communities are not meeting one or more developmental milestones when

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[71] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[72] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[73] Teager, W., Fox, S., & Stafford, N. (2019). How Australia can invest early and return more: a new look at the $15b cost and opportunity. Retrieved from https://www.thefrontproject.org.au/images/downloads/THE_COST_OF_LATE_INTERVENTION/Technical_ReportHow_Australia_can_invest_in_children_and_return_more.pdf.
[74] ACOSS & UNSW Sydney. (2020). Poverty in Australia: Part 1 Overview, *Australian Council of Social Service in partnership with UNSW Sydney,* available online: https://povertyandinequality.acoss.org.au/wp-content/uploads/2020/02/Poverty-in-Australia-2020_Part-1_Overview.pdf.

they start school.[75] Students from low socio-economic status are found to be significantly less likely to complete year 12 schooling than students of high socio-economic status.[76]

Children living in areas of high socio-economic disadvantage experience high rates of unemployment, low education, and have less access to affordable housing.[77] During the period 2017-18, 124,000 children and young people received support from specialist homelessness service, and 45,000 children were in out-of-home care.[78]

During the COVID-19 pandemic in Australia, data from a Kids Helpline six monthly report identifies a 200% increase in counselling contacts from 5 year olds over the first six months of 2021, when compared to 1 January to 30 June 2020[79]. In 2021 Yourtown identified that 1610 contacts to Kids Helpline were from young children aged 5-9 years of age up from 1588 for the first 6 months of 2020[80].

Objective 1.3 of the National Children's Mental Health and Wellbeing Strategy identifies 'for children experiencing significant social and economic disadvantage, the needs of the broader community should be addressed to improve the mental health and wellbeing of the child'. The Strategy highlights priority actions to support communities with the highest levels of need to address social and economic disadvantage (action 1.3.a) by implementing 'tailored programs focused on improving children's mental health and wellbeing based on the key characteristics of successful place-based approaches'. Given the current climate where the COVID-19 pandemic is heightening risk factors for suicide such as financial distress and unemployment, we believe addressing the needs of children experiencing significant social and economic disadvantage to be of critical priority.

7.4 Housing Insecurity

7.4.1 Recommendation: Increase Commonwealth investment in housing affordability, social housing, and homelessness services.

Housing insecurity and homelessness has been linked to increased risks of suicidal behaviour. While more Australian research is required, the Australia Housing and Urban Research Institute have found evidence of three main channels by which housing affects suicide:[1]

1. Protracted financial stress due to the cost of housing
2. Loss of security due to eviction, insecure housing and homelessness

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[75] The Smith Family. (2021). What is poverty?, available online: https://www.thesmithfamily.com.au/poverty-in-australia/what-is.
[76] Australian Curriculum, Assessment and Reporting Authority. (2012). National Report on Schooling in Australia 2010, available online: https://www.acara.edu.au/reporting/national-report-on-schooling-in-australia/national-report-on-schooling-in-australia-2010.
[77] Ibid.
[78] Ibid.
[79] Yourtown. (2021). Increase in children as young as 5 contacting Kids Helpline, Media Release, available online: https://www.yourtown.com.au/media-centre/increase-young-children-contacting-kids-helpline.
[80] Ibid.

3. The impacts of adverse life events on children and young people on their present and future mental health

Global evidence confirms that economic recessions, increased foreclosure, and evictions are correlated with increases in poor mental health and suicide rates at the population level.[2] There is also strong evidence that homeless populations have higher rates of suicidal ideation and suicide than the general population. Australian research utilising the Queensland suicide Register found homeless persons had almost double the suicide rate than their non-homeless counterparts.[3]

Given the link between housing insecurity and homelessness and the risk of suicide, we strongly support increased Commonwealth investment in housing affordability, social housing and homelessness services. Suicide Prevention Australia support the Everybody's Home campaign to reform Australia's housing system through:

- Support for first home-buyers to address current barriers to entry
- A National Housing Strategy including additional social and affordable rental homes
- Greater security for renters including the removal of "no grounds" evictions
- Increase to Commonwealth Rent Assistant for Australians in chronic rental stress
- A Plan to end homelessness by 2030 with investment to halve homelessness in 5 years

7.5. Disaster Planning

7.5.1 Recommendation: Commonwealth budget annually in discretionary funds to respond to need for suicide prevention including addressing the social determinants of health that heighten risk factors for suicide in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods after a disaster. These funds should be administered without delay through PHNs, Emergency Management Australia or other mechanisms as required to reach those in need.

Cost: $30 million

7.5.2 Recommendation: Planning is undertaken to support helplines and online services respond to increasing demands when disasters strike. Additional budgeted discretionary funds should include additional resources for helplines that can be activated as required.

7.5.3 Recommendation: Commonwealth to join with State and Territory Governments fund research into population groups to identify at-risk groups vulnerable to disasters to enable development of evidence-based targeted responses which are tailored to diverse demographic, gender, and cultural needs.

Cost: $1.5 million

Disasters can have negative impacts on overall health and wellbeing, and lead to mental health problems or exacerbate existing conditions. The impacts of disasters are long-lasting and vary depending on the type and nature of the disaster.

From the time the COVID-19 pandemic reached Australia in January 2020 to June 2021, Australia experienced 71 natural disasters (storms, floods, and bushfires) across the country.[81] Research has found people exposed to multiple natural disasters and man-made disasters are at a significantly greater risk of attempting suicide.[82] It is critical that support is targeted to vulnerable areas that have experienced multiple disasters.

Disasters can exacerbate underlying risk factors related to suicide such as financial distress, unemployment, relationship breakdown, domestic violence, social isolation, and can lead to mental health problems placing people vulnerable to suicide.

Disasters have physical, social and emotional impacts on people and communities who experience them, and last for extended periods of time.[83] The link between suicide in the aftermath of disasters is highly evidenced.[84] Research based in on US data found rates of suicide to increase during the first 3 years post-disaster[85], and another study found increases in suicide rates were seen 2 years post-disaster.[86] Evidence is also found of increases in rates of post-traumatic stress disorder and depression following a disaster.[87]

Research indicates that the role of increased social supports to combat risk factors for suicide such as financial distress, unemployment and mental health disorders act as protective factors for suicide and as such, increases in suicide rates immediately after disasters are not commonly experienced.[88] However evidence demonstrates suicide rates can increase years after the disaster which may be attributed to increased disaster supports ending. Protective supports, including housing, financial and welfare assistance, put in place during a disaster should be transitioned out in a careful, staged way. This will ensure communities are supported in the medium-term when suicide rates are at risk of increasing.

Recent events have demonstrated the need for resources to be available to respond, in real time, to multiple and compounding disasters.

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[81] Disaster Assist. (2021). Australian Disasters, *Department of Home Affairs, Australian Government,* available online: https://www.disasterassist.gov.au/find-a-disaster/australian-disasters#.
[82] Reifels, L., Spittal, M.L., Duckers, M.L.A., Mills, K. & Pirkis, J. (2018). Suicidality Risk and (Repeat) Disaster Exposure: Findings From a Nationally Representative Population Survey, *National Library of Medicine,* 81(2).
[83] World Health Organisation. (2016). Psychological First Aid For All: Supporting People in the Aftermath of Crisis Events, available online: https://www.who.int/mental_health/world-mental-health-day/ppt.pdf.
[84] Jafari, H., Heidari, M., Heidari, S. & Sayfouri, N. (2020). Risk factors for suicidal behaviours after natural disasters: A systematic review, *The Malaysian Journal of Medicine*, 27(3).
[85] Cartier, K. M. S. (2021), Suicide rates may rise after natural disasters, Eos, 102, available online: https://doi.org/10.1029/2021EO153699.
[86] 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, *Journal of Crisis Intervention and Suicide Prevention,* 42(5).
[87] Beaglehole, B., Mulder, R.T., Frampton, C.M., Boden, J.M., Newton-Howes, G. & Bell, C.J. (2018). Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis, *Cambridge University Press.*
[88] De Leo, D., San Too, L., Kolves, K., Milner, A. & Ide, N. (2012). Has the suicide rate risen with the 2011 Queensland floods?, *International Perspectives on Stress & Coping,* 18(2).