Suicide Prevention Australia

Submission on the National Suicide Prevention Adviser's Initial Findings

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Phone 02 9262 1130
admin@suicidepreventionaust.org
www.suicidepreventionaust.org
GPO Box 219 Sydney NSW 2001
ABN 64 461 352 676
ACN 164 450 882

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National Suicide Prevention Adviser's appointment and work to foster a whole of government approach Fifth Mental Health and Suicide Prevention Plan as a key mechanism to drive inter-governmental collaboration	Lack of systems architecture and machinery of government to drive a whole of government approach	A clear plan for systems architecture to foster a whole of government approach, including: • Suicide prevention legislation • A three-yearly National Suicide Prevention Strategy and Implementation Plan • A National Suicide Prevention Office, housed within a central agency • A new intergovernmental National Suicide Prevention Strategy and Agreement
Availability of evidence-based services and programs that improve the lives and wellbeing of Australians in distress	Lack of a clear model for suicide prevention, including an understanding of key touchpoints and opportunities for service intervention	Develop a human-centred model for suicide prevention that: • Comprehensively maps the person journey • Highlights key opportunities for service and program intervention • Provides a clear understanding of the outcome interventions should achieve • Highlights social factors and areas of disadvantage that contribute to suicide • Drives Government investment decisions
Priority 2: Strategies to respond to early distress using community and government touchpoints.		
Strengths	Gaps	Opportunities and solutions
Investment in expanding and evaluating the outcomes achieved by the National Suicide Prevention Trial Sites	Lack of information about the outcomes achieved	Publish the results of the National Suicide Prevention Trial sites evaluations Use the results of the National Suicide Prevention Trial and the LifeForce evaluations to inform policy and practice
	Lack of information on the quantum, training and professional development needs of the suicide prevention workforce	Develop a suicide prevention workforce strategy and implementation plan Invest in three incremental strategies: • Industry-specific peer support • Pre-service training for emergency services workers • Training 'connectors' to provide locally specific, tailored support

Priority 3: Improve responses to the all communities and groups who are more vulnerable to suicide.		
Strengths	Gaps	Opportunities and solutions
Work underway to develop specific strategies to address the needs of priority groups	Need to take in LGBTQI voices and priorities within a whole of government approach Need for systemic data collection mechanisms to measure LBTIQI+ populations	Ensure the inclusion of LGBTQI advocacy groups in the development of a whole of government approach to suicide prevention Develop training resources and invest in education to build the cultural competency of mainstream service providers Update the Census to include questions on gender, sexual orientation and intersex status
Intention to create targeted measures to address male suicide	Need for assertive support for men who are not interacting with mental health services	Create a male suicide prevention strategy as a core stream within the national suicide prevention strategy, with funding and accountability attached to measures
Priority 4: Enhance and better coordinate health response to suicidal distress and behaviours		
Strengths	Gaps	Opportunities and solutions
Expansion of Way Back Support Program	Need for alternatives to emergency department presentations	Fund expanded pilots of innovative approaches that provide safe space alternatives to emergency departments Provide universal aftercare support
Intention to enhance the role of Aboriginal and Torres Strait Islander Community Controlled Health Organisations	Lack of cultural competency across mainstream clinical and non-clinical support services	Invest in broader cultural competency training and the involvement of Aboriginal and Torres Strait Islander peer workers across mainstream clinical and non-clinical support services
Priority 5: Increase support for family and friends along the entire continuum of suicidal behaviour		
Strengths	Gaps	Opportunities and solutions
Expansion of evidence-based postvention services	Need for specific strategies to boost the lived experience of suicide peer workforce	Continue to invest in and expand evidence-based postvention services Address the needs of the lived experience of suicide peer workforce in national guidelines Support the development of nationally recognised qualifications in partnership with lived experience organisations.

Priority 6: Improve data and evidence and its application to whole-of-government initiatives		
Strengths	Gaps	Opportunities and solutions
National Mental Health and Wellbeing Survey provides an understanding of the underlying factors for mental ill health and distress	Lack of timely information mapping the linkages between social determinants, distress and suicidality	Increase the frequency of the National Mental Health and Wellbeing Survey and Child and Adolescent Mental Health and Wellbeing Survey and complete the next iterations in 2020
National Suicide Prevention Adviser is overseeing an information management initiative	Lack of systems level coordination for suicide prevention-related data Lack of timely access to data	Task a National Suicide Prevention Office with the responsibility to oversee information management for suicide prevention, including providing timely access to data by expert researchers
Suicide Deaths Registers in Victoria, Queensland and Tasmania	All other jurisdictions lack Suicide Deaths Registers	Influence the jurisdictions to create nationally consistent Suicide Deaths Registers
	Need for standardised nomenclature to describe and classify presentations in emergency departments	Develop a standard classification system for emergency department presentations

Priority 1: Implement the shift to a whole-of Government suicide prevention approach

Strengths	Gaps	Opportunities and solutions
National Suicide Prevention Adviser's appointment and work to foster a whole of government approach Fifth Mental Health and Suicide Prevention Plan as a key mechanism to drive inter-governmental collaboration	Lack of systems architecture and machinery of government to drive a whole of government approach	A clear plan for systems architecture to foster a whole of government approach, including: • Suicide prevention legislation • A three-yearly National Suicide Prevention Strategy and Implementation Plan • A National Suicide Prevention Office, housed within a central agency • A new intergovernmental National Suicide Prevention Strategy and Agreement
Availability of evidence-based services and programs that improve the lives and wellbeing of Australians in distress	Lack of a clear model for suicide prevention, including an understanding of key touchpoints and opportunities for service intervention	Develop a human-centred model for suicide prevention that: • Comprehensively maps the person journey • Highlights key opportunities for service and program intervention • Provides a clear understanding of the outcomes interventions should achieve • Highlights social factors that contribute to suicide • Drives Government investment decisions

Systems architecture to foster a whole of government approach

Suicide Prevention Australia strongly supports the shift toward a whole of government approach the National Suicide Prevention Adviser is leading. Her appointment has elevated suicide prevention to its rightful place: at the forefront of the nation's agenda. The Commonwealth Government has also put in place temporary machinery for whole of government collaboration. This includes forming a cross-governmental committee, a small but nimble Taskforce to support the Adviser in her work, as well as an Expert Advisory Group involving key peak bodies and providers, including Suicide Prevention Australia. The National Suicide Prevention Adviser's appointment is, however, term limited to the end of 2020. The supporting structures of the Expert Advisory Group, Taskforce and cross-governmental committee are also

temporary. There is no provision for ongoing whole of government coordination for suicide prevention beyond 2020.

The *Fifth Plan* reinforces the position that suicide is a complicated, multi-factorial human behaviour: more than an expression of mental ill health. Importantly, the Plan highlights that addressing the risks and protective factors for suicide should not be confined to mental health and clinical treatment options. 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. As outlined in our *National Policy Platform,* this demands a governance structure at the Commonwealth level separate to, and distinct from, the mental health system.

Suicide Prevention Australia submits that the National Suicide Prevention Adviser should consider including within her final report a clear plan for machinery that will provide a permanent, ongoing architecture to drive a whole-of-government approach to suicide prevention. As outlined in our National Policy Platform, we are of the position these reforms should include:

- Passing a Suicide Prevention Act to provide a legislative framework for a whole of government approach, agency accountability and reporting
- Making the National Suicide Prevention Adviser's role permanent by setting up a well-resourced National Suicide Prevention Office, preferably housed within the Department of Prime Minister and Cabinet
- Tasking the National Suicide Prevention Office with developing, delivering and monitoring performance against a National Suicide Prevention Strategy and Plan to supplement the Fifth Plan, including coordinating cross-portfolio policy approaches and supporting Primary Health Networks (PHNs) in their suicide prevention focus.
- Supplement this machinery with other mechanisms to foster a whole of government approach at the Federal level, including:
    - tasking central agencies to monitor Cabinet submissions for potential suicide prevention impacts, and requiring submitting agencies to outline mitigation strategies;
    - Including social benefit via mental health and suicide prevention as a compulsory outcome of Government procurement initiatives, and building this into tendering and contract evaluation processes. This mechanism is in place in at least one jurisdiction, Queensland (Queensland Mental Health Commission 2019).

International case studies

Our proposals are supported by several international case studies showing a whole-of-government approach with statutory support is essential to driving coordinated action to address the suicide rate at a national level:

- **Japan:** In 2006 Japan, recognising the urgent need to drive down the nation's high suicide rate, passed legislation to organise the machinery of government to coordinate suicide prevention strategy and activities (World Health Organisation, 2018). Responsibility for suicide prevention shifted from the Ministry of Health, Labour and Welfare to the central department of the Cabinet Office (World Health Organisation, 2018). The issue of suicide prevention received national prominence and, crucially, became a responsibility shared by all Ministers. The new government arrangements were followed by progressively released, regularly reviewed strategies to address key issues such as means

restriction, youth suicide, and aftercare for suicide attempt survivors (World Health Organisation, 2018). Japan has since seen a significant, progressive decline in its suicide rate, with 2018 marking the ninth consecutive year of decrease in the nation's suicide rate and the first time since 1978 the total number of suicides in Japan had fallen below 21,000 (Ministry of Health, Labour and Welfare 2018).

- **Republic of Ireland**: The Republic of Ireland has a whole of government approach to suicide prevention and has seen a progressive decline in its suicide rate for more than a decade. Ireland reports the rate of suicide in 2016 was 9.2 per 100,000, compared with 11.8 per 100,000 in 2008 (National Office for Suicide Prevention, 2018). Ireland formed a National Office for Suicide Prevention in 2005 to collect and report on suicide related data, as well as oversee the implementation of Reachout, the nation's first suicide prevention strategy (World Health Organisation, 2018). In 2015, Reachout was replaced by *Connecting for Life*, a five-year strategy that takes a whole of society approach to suicide prevention (National Office for Suicide Prevention, 2015). *Connecting for Life* sets out a suite of population level, community based and indicated interventions, as well as policy initiatives to support them. A government agency or funded service provider is assigned lead responsibility to implement each initiative, and is accountable for the outcomes achieved (National Office for Suicide Prevention, 2015).

Mechanisms for driving inter-governmental collaboration

While Australia's federated system of government presents its challenges for a uniform approach to suicide prevention, national suicide prevention legislation could also serve as an important mechanism for driving Commonwealth Government collaboration with the jurisdictions. A practical example of Commonwealth-State collaboration is in the area of means restriction: a jurisdiction could, for example, identify through its coronial data that a certain chemical compound had become a common means of suicide. The Commonwealth, which regulates drugs via the Therapeutic Goods Administration, could swiftly respond with restriction or banning of the identified compound; and, if the drug were already banned, could equip the Department of Border Protection and Immigration to engage in targeted monitoring and surveillance at customs. While collaboration of this nature currently takes place, legislation requiring accountability and regular reporting by Commonwealth Government Departments would drive a timely, effective Commonwealth response.

We endorse the Productivity Commission's proposal for a new intergovernmental National Suicide Prevention Strategy and Agreement; a proposal taken up in the National Suicide Prevention Adviser's Initial Report. This will be an important mechanism for ensuring Commonwealth, State and Territory Governments pool funding and policy attention. Development of the Agreement is, however, likely to take some time; and the difficulty of negotiating intergovernmental agreements is often cited as a key roadblock for reform (Productivity Commission, 2005).

We advise the National Suicide Prevention Adviser to also consider other mechanisms to achieve collaboration between Governments, and to encourage system change. The first is via suicide prevention legislation at the Commonwealth level; thereby setting the scene to influence the jurisdictions to introduce their own instruments to drive accountability for suicide prevention. Secondly, we suggest using other agreements the jurisdictions have other agreements with the Commonwealth to organise funding: for example, the Hospitals Agreements that were recently negotiated. These are supplemented by contracts between Governments for individual programs and services.

There is an opportunity for the National Suicide Prevention Adviser to recommend the Commonwealth use these lower level agreements and contracts to negotiate nationally consistent approaches to suicide

prevention funding and policy. This would influence system change, avoid duplication, and drive seamless service provision to consumers.

A model for suicide prevention

Suicide Prevention Australia wholeheartedly endorses the intention to develop a model for suicide prevention that, in combination with the *Fifth Plan,* will drive suicide prevention investment. We suggest that the optimal way to develop a model for suicide prevention is via a human-centred design approach. This would involve:

- Developing a comprehensive **map of the journey of the person** (in other contexts, referred to as the 'consumer') through the suicide prevention system. The map would need to encompass the experience of, and would be co-designed with, people with lived experience of suicide, people with experience caring for someone who is suicidal, those bereaved by suicide, as well as clinicians and service providers.
- Using the person-centred journey map to **highlight key touchpoints and opportunities for service and program intervention**, as well as a clear understanding of the outcomes the desired interventions should achieve.

While human-centred design has not been trailed in a suicide prevention context, it has been used successfully internationally in a variety of public health settings to drive service design, innovation and outcomes. A review of design studies across public health initiatives, systems and treatment options found design thinking interventions demonstrated improvement in patient satisfaction and effectiveness, when compared with traditional interventions (Altman M, Huang, & Breland, 2018). Human-centred design (of which consumer/patient journey mapping forms a part) also provides a structured process for systematising innovation and creating partnership opportunity (Vechakul, 2015).

The Productivity Commission has expressed support for a customer-based, human-centred model to resolve the current significant level of duplication and a lack of coordination across the multiplicity of mental health and suicide prevention programs and services (Productivity Commission, 2019). The design approach we are proposing would identify existing entry points within the system as well as gaps that should be addressed by additional entry points or 'doors' to support: ultimately, providing an accurate understanding not only of the way each person moves through and experiences the suicide prevention system, but how each person *should* experience the suicide prevention system. This understanding of the ideal experience within the suicide prevention system would equate to a clear, cohesive model for suicide prevention in Australia. The model could be leveraged to inform better policy and practice, and guide Government investment decisions.

Priority 2: Respond to early distress using community and government touchpoints

Strengths	Gaps	Opportunities and solutions
Investment in expanding and evaluating the outcomes achieved by the National Suicide Prevention Trial Sites	Lack of information about the outcomes achieved	Publish the results of the National Suicide Prevention Trial sites evaluations Use the results of the National Suicide Prevention Trial site and the LifeForce

		networks evaluation to drive future policy and practice
Intention to consider the needs of the suicide prevention workforce	Lack of information on the quantum, training and professional development needs of the suicide prevention workforce	Develop a suicide prevention workforce strategy Prioritise: • Industry-specific peer support • Compulsory pre-service training for emergency services workers • Training 'connectors' to provide locally specific, tailored support

Evaluation of current community-based trials

Suicide Prevention Australia welcomes the Government's $13.4 million investment to extend and evaluate the results of the National Suicide Prevention Trial sites.

The results of this evaluation would be an invaluable tool for informing better policy and practice; not only within Government, but also within the suicide prevention sector and broader community. We ask the National Suicide Prevention Adviser to take the opportunity to publish the evaluation results so that all program and service providers can benefit from the lessons learned. We understand that there is also an evaluation underway of Wesley's LifeForce networks, and suggest the results of this evaluation should also be used to inform future policy and practice.

Workforce strategy

Suicide Prevention Australia's National Policy Platform (2019) emphasises the need to build workforce capacity in suicide prevention, beyond the bounds of the mental health sector and acute care system. A key aspect of building this capacity should be a standalone suicide prevention workforce strategy and implementation plan; a complement to, rather than a stream of the National Mental Health Workforce Strategy currently in development.

The Strategy would address current and future need for:

- The clinical workforce, encompassing doctors, nurses, and allied health professionals who interface with individuals at risk of suicide and in suicidal crisis,

- The formal suicide prevention and mental health workforce, encompassing those explicitly working in a suicide prevention, response, crisis support or postvention setting: for example, emergency first responders, the peer lived experience workforce, postvention workforce, counsellors, social workers, and other mental health workers

- The informal suicide prevention workforce, which includes personnel from across Government Departments, social services, employer groups, miscellaneous service providers, community-based organisations and other settings where individuals at risk of suicide are likely to present. Notably, the employment support sector, for example, is a particularly important touchpoint for many due to the impact of COVID-19 on jobs. Mental health and suicide prevention training for frontline workers in employment support settings is, however, limited to non-existent: despite the positive outcomes such

training could achieve not only in terms of referral to support services, but in improving the employability of those receiving support. This is a critical gap that a comprehensive workforce strategy would identify and address.

We suggest an implementation plan attached to the strategy to set out a clear timeline for delivery of training, retention and recruitment initiatives aligned to each area of workforce need, with a clear funding commitment tied to each component.

Developing a specific suicide prevention workforce strategy aligns with the Commonwealth Government's Towards Zero suicide commitment. Workforce strategy is a central element of a Zero Suicide model; within which every member of the suicide prevention workforce is trained in recognising and responding to the signs of suicide risk, with differing levels of competency according to their role (Labouliere, Vasan, Kramer, & Brown, 2018).

Incremental strategies to strengthen the workforce

We also ask the National Suicide Prevention Adviser consider recommending investment in two incremental strategies to bolster the suicide prevention workforce in the short to medium term:

- **Industry-specific peer support:** We believe there is an opportunity for Government to fund industry-based peer support initiatives targeted toward workers in occupations with the highest rates of suicide. 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 (Doran and Ling 2015). The MATES in Construction program involves training construction workers to notice behaviour changes or signs in conversations with their colleagues that might indicate they needed help; and then pointing them in the direction of support services such as psychologists and social workers (MATES in Construction 2020). Drawing from the MATES in Construction model, the industry-based, peer support initiatives for other high risk occupations would involve providing regular connection and assertive support via mechanisms tailored to the industry involved. For a geographically dispersed sector, for example, this could involve online technology.

- **Compulsory pre-service training for emergency services workers**: We submit there is a need for government investment in pre-service suicide prevention training for frontline workers. Immediate priority should be placed on emergency services personnel who are likely to come into contact with people who are suicidal or who have made a suicide attempt: for example, paramedics. We refer to the recent *Beyond the Emergency* study conducted by Beyond Blue in collaboration with Turning Point, which found that many paramedics lack the training to provide appropriate care for people in suicidal crisis (Turning Point 2019).

- **Training key connectors or 'gatekeepers':** Suicide Prevention Australia strongly supports the intention to extend the National Suicide Prevention Trial and evaluate the outcomes achieved by the trial sites. We also echo the position of Lifeline Australia that equipping touchpoints or 'gatekeepers' with suicide prevention training is an important intervention for reducing suicide (Mann et al 2005).

  A systematic review of gatekeeper training outcomes in the United States of America found that gatekeepers had developed knowledge, skills and referral skills; and larger studies involving physicians and military personnel reported that suicidal behaviours, ideation and attempts were reduced, at least in the medium term. Orygen's analysis of Australian trials of gatekeeper training outcomes reported similar findings, while noting the need for population-based studies in Australia

(2019). The training provided should, however, be locally specific; tailored to the demographics of the local population; and should prioritise key touchpoints within the community for the local population, in addition to those within the health system (for example, GPs and pharmacists). This would be a complement to the compulsory pre-service training proposed for emergency services workers.

The human-centred journey map mentioned earlier in this submission could offer a template for touchpoints across the broader population and within priority groups. Each cluster of agencies involved in the LifeSpan Trials should then be involved in refining the touchpoints most relevant to their local community, and then prioritising them for training. We propose this initiative would, however, form part of an overarching, end-to-end workforce strategy for suicide prevention.

Priority 3: Improve responses to the specific needs of vulnerable communities and groups

Strengths	Gaps	Opportunities and solutions
Work underway to develop specific strategies to address the needs of priority groups	Need to take in LGBTQI voices and priorities within a whole of government approach Need for targeted measures to address the needs of LBGTQI populations Lack of cultural competence by mainstream service providers Need for systemic data collection mechanisms to measure LBTIQI+ populations	Ensure the inclusion of LGBTQI advocacy groups and peaks in the development of a whole of government approach to suicide prevention Develop training resources and invest in education to build the cultural competency of mainstream service providers Update the Census to include questions on gender, sexual orientation and intersex status
Intention to create targeted measures to address male suicide	Need for assertive support for men who are not interacting with mental health services	Create a male suicide prevention strategy as a core stream within the national suicide prevention strategy, with funding and accountability attached to measures

We strongly endorse the National Suicide Prevention Adviser's intention to design targeted measures to address the needs of priority groups: including young people; Aboriginal and Torres Strait Islander peoples, communities affected by drought, bushfire and other adverse events (presumably including those affected by the COVID-19 pandemic); veterans; children and adults who have experienced trauma. We also wholeheartedly support the intention to develop more targeted strategies for men and young women.

Suicide Prevention Australia offers supplementary considerations for the National Suicide Prevention Adviser concerning measures for LGBTQI+ populations and for male suicide prevention.

LGBTQI+ population

We ask the National Suicide Prevention Adviser to consider targeted measures to support LGBTQI+ communities, while ensuring the needs and voices of LGBTQI+ people are prioritised within a whole of government approach to suicide prevention.

We make the following points which amplify the position taken by the LGBTI Health Alliance and other key advocacy groups:

- **LGBTQI people have higher rates of suicide than the general population and need targeted funding and policy attention**: LGBTQI young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, for transgender people aged 18 and over they are eleven times more likely, and for people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over they are almost six times as likely (National LGBTI Health Alliance 2019). The evidence shows the elevated risk of suicidality experienced by LGBTQI people links strongly with their continuing experience of discrimination and exclusion. LGBTQI still face discrimination in their familial, personal and employment relationships, and discrimination has been shown to negatively affect the mental health and wellbeing of LGBTQI people in the workplace (Australian Human Rights Commission 2011). The levels of discrimination faced by LGBTQI people are particularly multi-layered and complex when identities intersect, for example where a LGBTQI person also has a disability, is Aboriginal and/or Torres Strait Islander, or belongs to a culturally and linguistically diverse background (Australian Human Rights Commission 2011).
- **Australia requires population-level data and accurate recording of deaths by suicide by counting LGBTQI people in the Census** and improving data collection by coroners: There is a critical gap in the suicide prevention system that affects support available for LGBTQI+ people: the lack of systemic data collection mechanisms to measure their populations. For effective targeted suicide prevention efforts, we need population-level data, and coordinated systemic data collection among mental health services and programs of LGBTQI communities. This should involve introducing questions on sexual orientation, gender identity and intersex status in the ABS Census to begin capturing population level data, and instituting consistent Suicide Deaths registers and reporting mechanisms across all jurisdictions.

Accurate, reliable and timely demographic data is essential if we are to effectively target suicide prevention efforts to LGBTQI+ communities. LGBTQI+ people, however, are not appropriately accounted for in suicide prevention planning and policy due to the current lack of systemic data collection mechanisms in Australia. The current Australian Bureau of Statistics (ABS) Census does not ask questions on sexual orientation, gender identity and intersex status, and as a result fails to capture LGBTQI communities in population-level data. This has implications as government funding and investment is underpinned by Census data, and is used to inform healthcare and social services planning. We join with the LGBTI Health Alliance is calling for these gaps in the Census to be rectified so that LGTBQI+ communities can be properly quantified, in turn driving better policy and practice to meet their needs.

The National Suicide Prevention Adviser has indicated an intention to influence the creation of consistent suicide deaths registers across the jurisdictions. We ask her to consider recommending standardised questions on sexual orientation, gender identity and intersex status within suicide death

data records. Currently, reporting methods and systems vary between jurisdictions. Without appropriate accurate and available data collection, service providers and policy makers frequently rely on small scale studies undertaken typically by community-based organisations, non-government organisations (NGOs), international research and anecdotal evidence, which are not able to provide a holistic, representative picture of the health of Australian LGBTQI communities.

- **Mainstream providers require education and training to develop the cultural competence** needed to respond and meet the needs of LGBTQI communities, as with other priority populations. Within the broader workforce strategy proposed in part two of this submission, we believe there is a need for resources and training to boost the cultural competence and responsiveness of mainstream providers.

Male suicide

Suicide Prevention Australia strongly supports the National Suicide Prevention Adviser's intention to develop targeted strategies to address the rate of male suicide in Australia. According to the Queensland Suicide Register (QSR), while nearly two-thirds (63.6%) of women who take their own lives have been diagnosed with at least one psychiatric disorder, less than half of men (44.4%) who die by suicide have been diagnosed with a mental health disorder. This demonstrates the need to strategically identify opportunities to intervene with men who may be vulnerable to suicide, but not interacting with the formal mental health or suicide prevention systems.

Support services are not always accessible and appropriate due to the fact that some males may not engage in help-seeking behaviour. Of concern, 72% of males do not seek help if they are experiencing issues with mental ill-health (Seidler, et al. 2016). Tailoring and targeting clinical and non-clinical interventions may increase men's service uptake and the effectiveness of treatments (Seidler, et al. 2016).

Australia requires a more diverse range of services that facilitate community connections for men and these need to be provided at scale, funded and targeted to men at risk of distress. Emerging ideas and empirical evidence illustrate the characteristics of services which effectively engage with men and boys concerning their mental health and wellbeing. These include:

- Arm's length services, such as telephone helplines and on-line chat facilities have been shown to be effective in suicide reduction and first-suicide attempt reduction for men (Seidler, et al. 2016).

- Peer support for some men is preferable to professional support, possibly because of issues of trust and potential stigma in using mental health services considered antithetical to masculine norms (Robertson, et al. n.d.).

- Collaborative interventions involving action-oriented problem solving. Activity and social based interventions have achieved success for promoting and improving the mental health of older male participants in particular, including initiatives such as the Men's Shed's approach and gender specific social activities in residential care (Seidler, et al. 2016).

- Workplace embedded peer support programs. Programs such as the Mates in Construction Program have successfully shifted suicidality in male dominated industries (Doran and Lang, 2015).

To drive a diverse range of effective, evidence based services to drive down male suicide, we recommend the National Suicide Prevention Adviser consider creation of a national male suicide prevention strategy. The strategy should incorporate:

- development of a map of the journey of males who have died by suicide or who have lived experienced suicidality to identify key touchpoints and 'doors' for support (see our response to priority area 1)

- assessing the training development needs of workforces to actively contribute to suicide prevention, and articulate these in a suicide prevention workforce strategy

- prioritising funding for services facilitating community and industry-based connections for men, particularly those targeted at men vulnerable to distress (see our response to priority area 2 for further detail)

- investment in gatekeeper training for employees in frontline roles in non-health related areas such as social services, income support, employment, and the courts system

- consideration of intersectional vulnerabilities: for example, Aboriginal and Torres Strait Islander men; culturally and linguistically diverse men; and gay, bisexual and other men who have sex with men.

Priority 4: Response to suicidal distress and behaviours

Strengths	Gaps	Opportunities and solutions
Expansion of Way Back Support Program	Need for alternatives to emergency department presentations	Fund expanded pilots of innovative alternative approaches, with priority placed on options that provide safe spaces in a range of contexts Provide universal aftercare support
Intention to enhance the role of Aboriginal and Torres Strait Islander Community Controlled Health Organisations	Lack of cultural competency across mainstream clinical and non-clinical support services	Invest in broader cultural competency training and the involvement of Aboriginal and Torres Strait Islander peer workers across mainstream clinical and non-clinical support services

We support the National Suicide Prevention Adviser's recommendation to broaden alternatives to emergency department presentations: an action also included in the *Fifth Plan*. The Suicide Prevention and Recovery Centre trial being developed by Independent Community Living Australia and Roses in the Ocean is an example of a co-designed, peer-led alternative to emergency department or psychiatric care (Independent Community Living Australia, 2019). There is an opportunity for the Commonwealth Government to support Roses in the Ocean and ICLA to expand this trial to multiple sites across Australia to explore the outcomes that could be achieved via a safe, peer-led alternative to emergency department care. More broadly, we believe there is an opportunity to invest in the expansion of a range of safe space pilots to test the effectiveness, scale and outcomes that could be achieved by non-emergency department environments.

Improving and extending aftercare approaches

We acknowledge the strength brought to the suicide prevention system by the Commonwealth Government's $7 million investment to expand Way Back and other aftercare programs. We agree with the National Suicide Prevention Adviser, however, that Australia requires universal aftercare: there is an

opportunity to provide every person who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours with access to aftercare support.

The follow-up or 'aftercare' provided to people who are known to have attempted suicide has historically been patchy. Our emergency departments and other acute care settings are overstretched, with demand for services often exceeding the resources available. This is a critical gap in care in view of the evidence, which informs us that the risk for suicide after an attempt is significantly elevated compared to the general population (Shand et al, 2019). A national population-based case-control study in the UK found 43% of suicides occurred within a month of discharge; conversely, than people who were provided with appropriate care after an attempt were less likely to die by suicide (Hunt, et al., 2008).

A commitment to achieve universally available aftercare is already included in the Fifth Plan, and agreed to by all Australian Health Ministers (COAG Health Council, 2017). In addition to the $7 million expansion of the Way Back Support Service already announced, we therefore believe the Commonwealth Government should negotiate with the states and territories to achieve this commitment as a priority for 2020/21.

Enhance the role of Aboriginal Community Controlled Organisations

We support the National Suicide Prevention Adviser's view that Aboriginal and Torres Strait Islander Controlled Health Organisations are ideally placed 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; and has the broader outcome of community empowerment itself. Providing culturally safe, culturally competent consumer experience and continuity of care is especially important for crisis support services, as doing so can be life-saving (Dudgeon, et al., 2016).

While Aboriginal Community Controlled Health Organisations play an important role in providing the Aboriginal community with access, however, Aboriginal and Torres Strait Islander organisations and workforces should be complemented by mainstream services and clinicians that are responsive to the needs of Aboriginal and Torres Strait Islander peoples (National Mental Health Commission, 2017). This requires broader cultural competency training and the involvement of Aboriginal and Torres Strait Islander peer workers across mainstream clinical and non-clinical support services; and should form a component within a national suicide prevention workforce strategy.

Priority 5: Increase support for family and friends

Strengths	Gaps	Opportunities and solutions
Expansion of evidence-based postvention services	Need for specific strategies to boost the lived experience of suicide peer workforce	Continue to invest in and expand evidence-based postvention services Address the needs of the lived experience of suicide peer workforce in national guidelines Support the development of nationally recognised qualifications in partnership with lived experience organisations.

Suicide Prevention Australia acknowledges the strength of support now available to achieve this priority. The Commonwealth Government announced a $64 million suicide prevention package in response to the National Suicide Prevention Adviser's initial report, including $10 million to expand the StandBy Support After Suicide Service.

Bereavement by suicide raises suicide risk by two to five times the rate of the general population (World Health Organisation, 2014). Postvention support is an important method for addressing this risk, encouraging healing and reducing suicide contagion among those who have lost a loved one (Laux, 2002). The expansion of StandBy will ensure thousands of Australians bereaved by suicide will have access to the care they need and will be a key contributor toward a zero suicide rate.

Peer lived experience workforce

We welcome the National Suicide Prevention Adviser recognition of the need to strengthen the peer mental health workforce. Placing people with lived experience of suicide at the centre of service delivery recognises that they bring unique insights and the capacity to understand the best way to support peers in distress.

We note the National Mental Health Commission's current work to deliver a national peer workforce framework guidelines. The peer workforce framework being developed by the National Mental Health Commission focusses, however, on the mental health peer workforce. As established earlier in this submission, people with lived experience of mental health do not necessarily have lived experience of suicide or suicidality; similarly, people with lived experience of suicide do not necessarily experience mental ill health (World Health Organisation, 2014).

The lived experience workforce in a suicide prevention and response context takes in people with direct experience of suicidality, with experience caring for someone who is suicidal, as well as those who have been bereaved by suicide (Roses in the Ocean, 2020). The peer workforce in the suicide prevention, intervention and postvention contexts has two major roles: recognising when someone may be at risk of suicide, and directing them to support; and supporting people recovering from suicidal behaviour or people bereaved by suicide (Salvatore, 2010).

We share the view that particular priority should be placed on adequately resourcing the lived experience of suicide prevention peer workforce. This should include specific recognition within national and state-based peer workforce frameworks; and the development of nationally recognised qualifications and professional development initiatives in partnership with lived experience organisations.

Priority 6: Improve data and evidence

Strengths	Gaps	Opportunities and solutions
National Mental Health and Wellbeing Survey provides an understanding of the underlying factors for mental ill health and distress	Lack of timely information mapping the linkages between social determinants, distress and suicidality	Increase the frequency of the National Mental Health and Wellbeing Survey and complete the next iteration in 2020 Increase the frequency of the Child and Adolescent Survey of Mental

		Health and Wellbeing and complete the next iteration in 2020
National Suicide Prevention Adviser is overseeing an information management initiative	Lack of systems level coordination for suicide prevention-related data Lack of timely access to data	Task a National Suicide Prevention Office with the responsibility to oversee information management for suicide prevention, including providing timely access to data by expert researchers
Suicide Deaths Registers in Victoria, Queensland and Tasmania	All other jurisdictions lack Suicide Deaths Registers	Influence the jurisdictions to create nationally consistent Suicide Deaths Registers
	Need for standardised nomenclature to describe and classify presentations in emergency departments	Develop a standard classification system for emergency department presentations

We strongly support the National Suicide Prevention Adviser's intention to broaden and strengthen the availability of data and evidence for suicide prevention. Accurate, reliable and timely data is a core pillar of our National Policy Platform, and is critical to enabling evidence-based policy, planning, service delivery and informed research. The World Health Organisation has stated that 'improved surveillance and monitoring of suicide and suicide attempts is required for effective suicide prevention strategies' (World Health Organisation, 2019).

The Productivity Commission recently observed that 'the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides', and that 'this may require Australia to place a higher priority on preserving someone's life than on preserving their privacy' (Productivity Commission, 2019). We believe the linkage and availability of this data is critical if we are to reduce the rate of suicide. This requires attention to the National Coronial Information System; state and territory-based coronial systems and reporting methodologies; and the scope of data-sets currently collected, together with identification of gaps in data availability and provision.

The link between suicidality and social determinants

Suicide prevention requires an integrated approach encompassing mental health, social, economic and community factors. Addressing the link between suicidality and the social determinants of health will be critical if we are to work towards a zero suicide goal. At the time of writing Australia is in the midst of the COVID-19 pandemic; and we are witnessing significant structural change to the functioning of industries, communities and the Australian economy (Australian Bureau of Statistics, 2020). There is an urgent need to gather data to determine how these structural changes in our economy and society are impacting the mental health and wellbeing of Australians; many of whom are now struggling to maintain or find employment, service their debts, access affordable housing, or other social supports (Grattan Institute, 2020).

We support the Commission's recommendation 25.2 of 'routine national surveys of mental health' and to increase the frequency of which the ABS National Survey of Mental Health and Wellbeing is conducted to be no less than every 10 years (Productivity Commission, 2019).

As outlined in our National Policy Platform, in order to improve the monitoring of community wellbeing outcomes, underlying suicidality levels and suicidal behaviour, the National Mental Health and Wellbeing Survey should be conducted within the next year to obtain data on population-level suicidality and suicidal behaviour, with a regular schedule of follow-up surveys. In the short to medium term, this will equip Government to measure the effect the social and economic changes resulting from the COVID-19 pandemic have had on mental health and wellbeing; and address strategies to address them. This is particularly important in the months after social restrictions are lifted. We further recommend a new iteration of the Child and Adolescent Survey of Mental Health and Wellbeing be conducted. This will assist the development of a holistic profile of the mental health and wellbeing of the entire population.

Increasing the frequency of the National Mental Health and Wellbeing Survey and the Child and Adolescent Survey of Mental Health and Wellbeing will help assess the extent to which suicide prevention strategies and policy/program mechanisms are working effectively; any effect the social and economic impacts of the COVID-19 pandemic has had on mental health and wellbeing

State Suicide Registers

Suicide Prevention Australia strongly supports the National Suicide Prevention Adviser's intention to investigate methods for assuring consistent suicide registers are present in every jurisdiction. This is a key plank of our National Policy Platform and echoes the position taken by Lifeline and other key suicide prevention and mental health organisations (Lifeline, 2020).

Access to accurate population-level data on suicidality and suicidal behaviour from State Suicide Registers, relevant bodies and agencies including liaison with the ABS, the Australian Institute of Health and Welfare (AIHW) and the NCIS, is crucial for targeted policy, service and program resourcing, development and implementation. Currently State Suicide Registers only exist in Queensland, Victoria and Tasmania. The registers in place in these jurisdictions draw information from police reports, toxicology reports, post-mortem examination and coronial reports to provide a valuable source of information on why suicide deaths have occurred, and how they might be prevented in future (Leske, Crompton, & Kolves, 2019).

We ask the National Suicide Prevention Adviser to make specific recommendations as to data in her final report,. These recommendations should include tying funding within any National Suicide Prevention Agreement to delivery of accurate, reliable, complete Suicide Deaths Registers; and to an information sharing agreement between the Commonwealth and jurisdictions. As the Agreement is likely to take some time to negotiate, we also recommend the Commonwealth build these requirements into other agreements that cover joint funding and policy action as a matter of course.

Data Management & Monitoring

Consistent, accurate data is required to effectively identify, target and reach key at risk populations with suicide prevention interventions.

As outlined earlier in this submission, we propose creation of a National Office for Suicide Prevention separate to the National Mental Health Commission. Among its other responsibilities, the Office would be tasked with overseeing information management and monitoring for suicide.

This role would encompass continuing to lead the initiative currently underway to improve the integrity, collation and distribution of suicide data to assist service delivery and research, working in partnership with state suicide registers and relevant organizations to achieve these improvements, and exploring the expansion of data collection and reporting (e.g. data on suicide attempts, self-harm presentations and

people accessing help outside of emergency departments, and non-government/community-based mental health services). We suggest this expansion should also include considering mechanisms for providing timely access to data for expert researchers in the suicide prevention space, with appropriate ethics approvals.

Presentations at emergency departments

For many years, it has been in protocol and policy to collect standardised data on presentations in emergency departments. Emergency department datasets, however, vary significantly in their completeness and quality. A key factor affecting the differences between emergency datasets is the lack of standardised nomenclature to describe and classify suicidal ideation and behaviour presentations in emergency departments. A lack of accurate, reliable data on suicide-related presentations in emergency departments means a crucial input to inform the design of future suicide prevention policy and care approaches is missing (Sveticic, Stapelberg, & Turner, 2020) (Hedegaard, Schoenbaum, Claassen, Crosby, Holland, & Proescholdbell, 2018).

Implementing a national, standardised classification system for suicidal ideation and behaviour presentations in emergency departments would improve the quality and reliability of these datasets. More broadly, a standardised classification system in emergency departments would assist Governments to enhance suicide research and surveillance systems in Australia (Goodfellow, Kolves, & De Leo, 2018). We ask the National Suicide Prevention Adviser consider recommending the development of a standardised classification system as a key Commonwealth-State and Territory initiative.

For more information

Rebecca Burdick
Director, Policy & Government Relations
Suicide Prevention Australia
rebeccabd@suicidepreventionaust.org
Mob: 0401 619 280

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