Submission to the Productivity Commission

February 2020

Contents

Executive Summary

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We count among our members the largest and many of the smallest suicide prevention and mental health not-for-profits, practitioners, researchers and leaders. We advocate on behalf of our members for better policy in the sector, serve as an information conduit between the sector and Government, as well as providing leadership, policy and advocacy services, training and research support to the suicide prevention sector.

The Productivity Commission Inquiry into the Mental Health system presents an unmissable opportunity for reform.

Taken together, the Commission's Inquiry, the Commonwealth Government's 'Towards Zero' ambition for suicide rates in Australia, the appointment of a National Suicide Prevention Adviser and the Mental Health Royal Commission in Victoria constitute a watershed moment for suicide prevention. The critical task for us as a nation and community is to take advantage of this opportunity and reshape the system to drive down Australia's suicide rate.

Suicide and suicidal behaviours exact an economic toll in addition to their immense emotional and social impacts. The Productivity Commission's Draft Report shines a light on the immensity of this impact, which is estimated to equate to between $16 billion to $34 billion lost to our economy. We believe the Commission's recommendations, if adopted, will go a long way toward addressing this cost.

As outlined in this submission, however, there is room for an expanded program for reform in the Commission's Final Report.

Suicide Prevention Australia's National Policy Platform sets out a clear agenda for Government to pursue. We are advocating for systemic change across the three pillars of whole of government collaboration, workforce strategy and reliable data. This submission is organised primarily around these pillars, while noting the specific areas of information or reform highlighted in the Commission's Draft Report. We have also included special commentary on areas of emerging suicide risk for the Commission's consideration.

The appointment of a National Suicide Prevention Adviser has brought a much-needed level of oversight, coordination and strategic direction for suicide prevention. Suicide Prevention Australia is also heartened by the Commonwealth Government's recent announcement of a $64 million suite of suicide prevention measures.

We believe, however, long term, systemic change is the best way to deliver a significant, meaningful reduction in suicide deaths.

A **whole of government** approach is the mechanism on which every other national suicide prevention strategy depends. While the Commission has recommended a rebuild of the mental health system, we are of the view the suicide prevention sector also requires fundamental reform. This is in recognition that up to one in five suicide deaths in Australia do not involve any co-morbidities, whether with mental ill health or other health issues.

We ask the Commission to consider a model involving a permanent coordination function by setting up a National Suicide Prevention Office. This resembles the centralised, cross-portfolio models applied by the Republic of Ireland and Japan: two nations that have seen a significant decline in their suicide rate over the past ten years.

Suicide Prevention Australia is proposing **two key mechanisms for prioritising suicide programs and services for funding**.

The first involves a **National Gateway to Quality Improvement**, a pathway from self-assessment to certification or accreditation which should be driven by the suicide prevention sector. This Gateway will mean suicide prevention services and programs can follow a clear pathway for quality improvement, providing Government with a method for deciding which programs and services should be supported by the taxpayer.

Suicide and suicidality is an intensely human tragedy, which is why the second mechanism we are proposing puts the 'consumer' at the centre of the system. This human-centred approach would involve comprehensively **mapping the journey of the 'consumer'** of the suicide prevention system (distinct from the mental health system), and using this information to prioritise programs and services which best reflect consumer need.

The second pillar of our National Policy Platform covers **workforce strategy.** Quantifying and properly training the suicide prevention workforce will provide our society with the means to assist in the lives of people even before they reach crisis point. We have asked the Commission to pay special attention to the needs of peer workers with lived experience of suicide, who should be equipped to work in close partnership with clinicians and the 'formal' suicide prevention workforce.

Having **access to reliable, accurate data** on who, where, why and how people take their own lives or might be at risk of doing so is absolutely crucial to designing suicide prevention strategies that work. We have responded to the Commission's request for information on under-utilised data sets in detail, focusing on underutilised data on suicide, suicide attempts and psychosocial risk factors.

There is very strong evidence that attentive, high quality care after someone has attempted suicide can reduce the risk that they will attempt again. The recently announced $6 million Commonwealth Government investment to expand Beyond Blue's Way Back Support Service is a welcome step in the right direction. We agree with the Productivity Commission, however, that **we need universal aftercare**, co-funded by the Commonwealth, State and Territory Governments, so that every person who has survived a suicide attempt has the help they need to recover and thrive.

Australia needs to take immediate action to drive down the rate of suicide experienced by our First Nations. We agree with the Commission that there should be a **new national suicide prevention strategy for Aboriginal and Torres Strait Islander peoples**. While the strategy is being developed, we believe **Aboriginal Community Controlled Health Organisations** should receive the resourcing they need to strengthen their key role within Aboriginal and Torres Strait Islander communities.

Finally, we ask the Commission to consider solutions to addressing two emerging areas of suicide risk first highlighted in our 2019 *Turning Points* white paper (Suicide Prevention Australia 2019). We believe **Government needs to act to curb the 'shadow' debt market** which has a significant impact on the financial and emotional wellbeing of people who are over-indebted. **Workers in the gig economy also need more support** to navigate their role in the changing economy, while gig economy employers should be encouraged to take on greater corporate social responsibility. More broadly, we agree with the National Council of Social Services that we need to see an increase to Newstart so that people experiencing the challenges of employment insecurity can meet their basic needs and have the support they need to find meaningful work.

We welcome the scope of the Productivity Commission's Draft Report, as well as the Commission's openness to new ideas for reform. We are confident the measures we have proposed in this submission will help shape the Final Report into a prime tool for Government and the sector to make real progress on a Toward Zero suicide rate.

Together, we can achieve a world without suicide.

Summary of recommendations

	Recommendations

Pillar One: Whole of government collaboration	1. Put in place systems architecture to support a whole-of-government, cross portfolio approach to suicide prevention, including:
	  a. A National Suicide Prevention Office, led by the National Suicide Prevention Adviser
	  b. Passing a Suicide Prevention Act to provide a legislative framework for a three-yearly National Suicide Prevention Plan
	2. Use funding mechanisms with the jurisdictions to secure nationally consistent approaches to suicide prevention and ongoing funding for programs and services
	3. Integrate postvention support into measures for whole of government reform
	4. Support a sector-led, National Gateway to Quality Improvement for suicide prevention programs
	5. Enhance consumer participation and service effectiveness through a human centred design approach

Pillar Two: Workforce	6. Commonwealth Government should produce suicide prevention workforce strategy and implementation plan 7. Include specific strategies to address the needs of the lived experience of suicide peer workforce within a national suicide prevention workforce strategy 8. Expand Draft recommendation 11.5 to propose specialist registration for GPs who have advanced specialist training in mental health and suicide prevention
Pillar Three: Reliable data	9. Every State and Territory Government should establish a suicide register which is nationally consistent 10. Make the National Office for Suicide Prevention responsible for leading improvements in data collation, distribution and monitoring 11. Increase the frequency of the National Mental Health and Wellbeing Survey to every three years 12. Implement standardised classification systems for suicidal ideation and behaviour presentations in emergency departments across Australia
Priority areas for reform	13. Commonwealth, State and Territory Governments should invest in a universal aftercare, and build this commitment into key co-funding mechanisms 14. Resource Aboriginal Community Controlled Health Organisations to develop community-led solutions
Emerging areas of suicide risk	15. Review strategies to support priority population groups in the gig economy 16. Introduce a code of practice to regulate payday lenders and buy-now-pay-later services 17. Increase the base rate of Newstart

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Pillar One: Whole of government collaboration

Response to: Information request 23.1 — Architecture of the future mental health system

Australia needs a whole of government approach to mental health and suicide prevention.

Suicide and suicidal behaviours exact an economic toll in addition to their immense emotional and social impacts. The Productivity Commission's Draft Report shines a light on the immensity of this impact, which is estimated to equate to between $16 billion to $24 billion lost to our economy. We agree with the Commission that Governments must act to address the social and economic cost of suicide.

We also agree with the Commission that mental health structures require a fundamental rebuild, rather than merely 'renovating' the current system. As observed in the Draft Report, this will ensure accountability, clarify responsibilities and ensure funded programs and services take a user-centric approach.

We are of the view, however, that the suicide prevention sector also requires a rebuild, incorporating system architecture complementary to, but distinct from the architecture put in place for the mental health system. This is in recognition of the fact that there are two overlapping but distinct populations: people experiencing or at risk of mental ill health; and people who are at risk of suicide, who have attempted suicide, who have died by suicide, or have been bereaved by suicide. While mental ill health is a risk factor for suicide, not everyone experiencing mental ill health is suicidal (World Health Organisation 2014). Similarly, a significant minority of people who die by suicide have never come into contact with mental health services, and appear to have decided to take their own lives in response to life crises such as financial difficulties, the breakdown of an intimate relationship, or experiencing chronic illness (World Health Organisation: 2014).

As a result, there are also two overlapping but distinct systems: the suicide prevention and mental health systems. Many programs and services overlap both, but there are programs and services that reside solely the suicide prevention sphere: for example, postvention services supporting those bereaved by suicide.

A whole of government approach for suicide prevention

Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. The *Fifth National Mental Health and Suicide Prevention Plan* (National Mental Health Commission 2017) reinforces this position, highlighting that the risks and protective factors for suicide are not 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 a result, our position is that suicide prevention requires a governance structure at the Commonwealth level separate to, and distinct from, the mental health system.

We welcome the Commonwealth Government's appointment of a National Suicide Prevention Adviser to progress the Prime Minister's commitment to a Towards Zero suicide rate. This 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 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. As a result, there is no provision for ongoing whole of government coordination for suicide prevention beyond 2020.

The Commonwealth Government should reform its existing machinery of government to provide a permanent, ongoing whole-of-government approach to suicide prevention. As outlined in our National Policy Platform, these reforms should include:

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

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

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

Suicide Prevention Australia also recommends Government supplement this machinery with other mechanisms to support a whole of government coordination approach, including:

- assessing of suicide prevention and mental health impacts as a compulsory part of the Cabinet submission process;

- 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.

As outlined above, a particularly important aspect of the work of a National Suicide Prevention Office would be delivery of a National Suicide Prevention Strategy and Implementation Plan. The model proposed by the Commission for a National Mental Health Plan is indicative of the approach Suicide Prevention Australia believes the suicide prevention plan should take.

We again, however, emphasise the need for a separate, actionable, complementary strategy for suicide prevention, in recognition of the differences between the populations dealt with by the mental health system and the suicide prevention sector.

Evidence in support of a whole of government approach

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

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).

Similarly, the Republic of Ireland has a whole of government approach to suicide prevention and has also seen a progressive decline in its suicide rate. 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).

The Scottish Distress Brief Intervention model also demonstrates agencies have an improved capacity to respond to people in crisis where they work in concert at the community level. The Distress Brief Intervention program, a key facet of the Scottish Government's ten-year mental health strategy, involves a lead agency facilitating cooperation between a large number of local partners within a community (site) (Health Scotland 2019). This ensures individuals in distress receive timely referral to support services, follow up support in the fortnight following presentation, and longer term support if required.

Two years of the pilot program remain, with encouraging early results: more than 3,000 people were supported in the first two years of the Distress Brief Intervention model, all receiving rapid and intensive support (Health Scotland 2019).

Response to information request:

While Suicide Prevention Australia endorses the 'rebuild' model for the mental health system, we propose a separate, complementary structure for suicide prevention. This structure is described by the recommendations below.

Recommendation
1. Put in place systems architecture to support a whole-of-government, cross portfolio approach to suicide prevention, including:
   a. A National Suicide Prevention Office, led by the National Suicide Prevention Adviser
   b. Passing a Suicide Prevention Act, providing a legislative framework for a three-yearly National Suicide Prevention Plan

Collaboration between Governments

We endorse the Commission's proposal for a new intergovernmental National Mental Health and Suicide Prevention Agreement.

The Agreement 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 Commission to consider mechanisms to achieve collaboration between Governments in the shorter term, and to encourage system change at the local level. 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.

We recommend the Commonwealth use these lower level agreements and contracts to negotiate nationally consistent approaches to suicide prevention funding and policy with the States and Territories. This would influence system change, avoid duplication, and provide a more seamless service to consumers.

Recommendation

2. Use funding mechanisms with the jurisdictions to secure nationally consistent approaches to suicide prevention and ongoing funding for programs and services

Supporting rational decision making on suicide prevention funding

Suicide Prevention Australia is of the view that funding and policy attention for suicide prevention services and programs should be organised in a logic-based way around the following streams:

The Commonwealth Government should prioritise programs and services for funding based on their proven capacity to deliver outcomes or, in the case of new, innovative initiatives, on evidence supporting the outcomes they are likely to achieve. Programs would be prioritised within a specific funding envelope for their grouping or stream, and in close consultation with the jurisdictions. Prioritisation should be evidence-based (that is, clinical and cost-effective, with implementable programs receiving preference. Where possible, funded programs should be paired with supporting initiagives from the other streams: for example, Actions like awareness campaigns should be accompanied by broader actions like aftercare, community and gatekeeper training.

We propose two key mechanisms for Government to organise programs and services for funding *within* each stream:

- after assessment by an independent, sector driven, non-government 'gateway'

- a human centred design approach through comprehensive 'customer journey' mapping.

We note the absence of attention on the postvention stream in the Commission's draft recommendations for whole of government reform and funding. As highlighted in the submission made by StandBy, a Suicide Prevention Australia member, bereavement by suicide raises suicide risk by two to five times the rate of the general population (World Health Organisation 2014). For this reason, we support StandBy's recommendation to integrate postvention support into the Commission's final recommendations for whole of government reform and as a key contributor toward a zero suicide rate (Standby 2020).

> **Recommendation**
>
> 3. Integrate postvention support into measures for whole of government reform

A 'gateway' to quality and standards

The most effective mechanism for making safety and quality central to mental health and suicide prevention service delivery is via a sector-wide Quality Improvement Program.

Assuring the safety, quality and efficacy of Australia's suicide prevention programs should be a central concern for Government and the suicide prevention sector. Governments have already committed to making safety and quality central to mental health and suicide prevention service delivery: highlighting this as a key priority of the Fifth Mental Health and Suicide Prevention Plan (National Mental Health Commission 2017). The *Fifth Plan* also recognises the importance of standards to assuring services and programs are safe, quality and outcomes-based (National Mental Health Commission 2017).

Suicide Prevention Australia is creating a sector-led Quality Improvement Program along these lines. This is a typical role for a peak body, and leverages the benefits of our intimate connection with the suicide prevention sector; our independence; understanding of the suicide prevention evidence base; and role in building sector capacity and capability.

The first phases of the pathway to assessment are already complete: comprising of a user-friendly online best practice register, a self-directed quality improvement mechanism, and supporting the development of quality standards.

Ideally, a quality improvement program would provide a full pathway of assessment. This pathway would involve allowing service providers to progress their programs to certification and/or accreditation, after completing the initial self-assessment phase. Service providers would be expected to maintain compliance with differing levels of evidence as their programs progress through each stage of assessment, aligning their offerings the best practice quality standards already established.

The final phase of the Gateway's development will deliver significant benefit to Government, the community and suicide prevention sector. These benefits are summarised in **Table 1** overleaf.

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

A human-centred approach

Commentary on: Draft recommendation 22.3 — Enhancing consumer and carer participation

We need a clear understanding of the experience of people moving through the suicide prevention system. As established by the Commission, there is a significant level of duplication and a lack of coordination across the multiplicity of mental health and suicide prevention programs and services (Productivity Commission 2019). We agree with the Commission that a key mechanism for ensuring Government funded programs and services meet the needs of consumers is to take a co-design, human centred approach.

Suicide Prevention Australia recommends a human-centred approach to service and program prioritisation across the suicide prevention sector. This initiative would involve the Commonwealth Government funding a project to comprehensively map the 'customer' journey so that we better understand the needs of people who interact with (or should interact with) suicide prevention services and programs. This would directly meet the Commission's recommendation of involving consumers and carers as co-designers of programs and services.

This is a major project in the context of suicide prevention and mental health services, where there are multiple cohorts of consumers for any one part of the system. A person reaching the point of suicidal crisis, for example, requires intensive support: in many cases, so do their carers and support people. The mapping exercise would need to take place with people with lived experience (and their supporters) at each part of the system so that the way in which each 'customer' moves through and experiences the suicide prevention system can be accurately understood. At its fullest extent, 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).

Investment in a comprehensive customer journey mapping exercise would deliver significant return. 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 and Breland 2018). Human-centred design (of which customer/patient journey mapping forms a part) also provides a structured process for systematising innovation and creating opportunity for partnership (Vechakul 2015).

A clear understanding of the customer experience within the suicide prevention system will help Government to prioritise services and programs which will best meet the needs of the end user. If supported, the initiative would leverage the unique insights of people with lived experience for suicide prevention; and would support co-designing the system with them. This would be particularly useful for assessing the likely efficacy of new, innovative programs and services which may not yet have strong evidentiary support for their outcomes.

Pillar Two: Workforce

Commentary on: Draft recommendation 11.1: The National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services.

The Commission's recommendations to quantify, upskill and manage the mental health workforce will do much to ensure people experiencing or at risk of mental distress can access the support they need.

As with our earlier commentary, however, we draw the Commission's attention to the need for specific strategies to build the capacity of the suicide prevention system which shares many of the features of, but is distinct to the mental health system. For this reason, our 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 strategy and implementation plan. The plan would complement the National Mental Health Workforce Strategy currently in development.

Developing a specific suicide prevention workforce strategy aligns with the Commonwealth Government's Towards Zero suicide commitment. A central element of a Zero Suicide model incorporates strategies to develop and equip the suicide prevention workforce; with every member trained in recognising and responding to the signs of suicide risk, with differing levels of competency according to their role (Labouliere, et al. 2018) .

Suicide Prevention Australia is advocating for a suicide prevention strategy and plan strongly aligning with the Zero Suicide Model. As outlined in our original representations to the Commission, the plan would quantify current and future suicide prevention workforce need; the types of occupations and geographic spread of personnel required; and identify their training needs of the suicide prevention workforce.

The National Office for Suicide Prevention would ideally lead the suicide prevention workforce strategy and implementation plan, in close consultation with the National Mental Health Commission. 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 and other settings where individuals at risk of suicide are likely to present.

The implementation plan attached to the strategy would 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 strategy.

Training measures would address the skills needs of each workforce cohort through targeted pre-service tertiary training and education, ongoing professional development, mentoring and other supports. Recruitment and retention strategies would address areas of critical need, particularly in rural and remote locations with thin service provision; and meeting the needs of priority populations, particularly Aboriginal and Torres Strait Islander peoples.

> **Recommendation**
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> 6. The Commonwealth Government should produce a suicide prevention workforce strategy and implementation plan

Special attention for the peer support – lived experience workforce

> **Commentary on:**
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> Draft recommendation 11.4 — Governments should strengthen the peer workforce.

We welcome the Commission's recognition of the need to strengthen the peer mental health workforce. Placing people with lived experience of mental ill health at the centre of service delivery recognises that they bring unique insights and capacity to understand the best way to support peers who are experiencing similar struggles. We support the Commission's recommendations to expedite delivery of the national peer worker guidelines, to establish a professional peer worker organisation, and educate health professionals about the value brought by the peer workers to the mental health space.

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 behavior or people bereaved by suicide (Salvatore 2010).

We share the view that particular priority should be placed on adequately resourcing the suicide prevention peer workforce. This should include investing in "an appropriate and comprehensive

system of qualifications and professional development…in partnership with suitable lived experience organisations" (Roses in the Ocean 2020). The latter requires specific attention and recognition within national and state-based peer workforce frameworks.

As outlined in our commentary on recommendation 11.1, Suicide Prevention Australia also recommends development of a standalone suicide prevention workforce strategy and implementation plan, which would include specific actions to upskill, train, recruit and retain the lived experience peer workforce.

> **Recommendation**
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> 7. Include specific strategies to recruit, retain, and address the training needs of the lived experience of suicide peer workforce within a national suicide prevention workforce strategy

Training for General Practitioners

> **Commentary on:**
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> Draft Recommendation 11.5 — Improved mental health training for doctors

Doctors are key touchpoints for people at risk of suicide. Equipping medical practitioners with specialist training in mental health and suicide prevention is one of the few interventions shown to significantly reduce suicide risk (Atkinson, et al. 2017).

The Commission's recommendation to improve mental health training for doctors is well supported by the evidence. Mental health training provides recipients with the capacity to detect the signs someone may be experiencing a mental health or wellbeing issue, the confidence to refer them to external support, and the capacity to secure crisis support for someone who may be at risk of suicide (Schwab-Reese, Kovar and Brummett 2018). Recent research by experts from the Sax Institute, Western Sydney University and Synergia found that mental health and suicide prevention training for General Practitioners was associated with a 6% reduction in suicide over a ten year period (Atkinson J, et al. 2017).

Similarly, a study of mental health practitioners in Colorado in the United States found requiring them to have specialist suicide prevention training enhanced their preparedness to assist at risk patients (Schwab-Reese, Kovar and Brummett 2018). The study recommended mandatory training in suicide prevention for all mental health practitioners (Schwab-Reese, Kovar and Brummett 2018). While the cohort involved in this study consisted of professional counsellors, psychologists and social workers, we believe the same principle should apply to doctors and all other clinicians who are regular touchpoints for people who are at risk of suicide or suicidal behaviour.

We suggest the Commission expand its recommendation to advise specialist registration for GPs with advanced specialist training in mental health *and* suicide prevention.

Pillar Three: Reliable Data

Accurate, reliable and timely data is critical to enabling evidence-based policy development, the planning and resourcing of suicide prevention activity, the improvement of service delivery and outcomes, and informed research. We support the WHO recommendation that 'improved surveillance and monitoring of suicide and suicide attempts is required for effective suicide prevention strategies' (World Health Organisation 2019).

Despite the sophisticated nature of our data systems and information management frameworks in Australia, data on mental health and suicide prevention is fragmented, inconsistent and – in many cases – delayed. Australia has sophisticated collection systems and vast information is already stored by multiple Government departments. These systems must be harnessed and information brought together so we can target suicide prevention services where they're needed, monitor their success and – ultimately – save lives.

The Commission's report notes 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.

The ABS annually releases Causes of Death data. The National Coronial Information System (NCIS) is the database for storage and access of coronial service data. In Australia, all states contribute data on deaths by suicide via their coroners. While all states contribute coronial data, there are inconsistencies between jurisdictions and a 'lack of clarity in the law guiding coroners in their practice' (Jowett, Carpenter and Tait 2018). The coronial system is governed by the Coroners Acts by state and territory legislation, and the Coroners Acts 'require coroners to make an explicit determination of suicide or of a deceased's intent, making a ruling on intent is generally at a coroner's discretion' (Jowett, Carpenter and Tait 2018). These inconsistencies can significantly impact the quality of ABS mortality data.

There are a number of inter-related factors that impede the accurate collection of suicide data in Australia. The Senate Community Affairs Reference Committee identified 'difficulties in determining the intent of a person who might have died by suicide', and concerns in determining the differences 'between recklessness and intent', both of which contribute to underreporting and inaccuracy in data collection (Community Affairs References Committee 2010).

Delays in coronial processes and inconsistencies in practices in determining cause of death can mean that the data returned may 'delay final counts and the benefit of this information by several years' (Life in Mind Australia 2019). Australia has witnessed trends in increases in the number of incomplete coronial cases, which has resulted in increases in the number of 'open cases' which may be suicides (Community Affairs References Committee 2010). The inconsistencies in data collection across jurisdictions fails to provide prevention strategies and service providers with a clear picture of suicide in Australia, and impacts the ability for agencies to effectively measure change.

State Suicide Registers

Suicide Prevention Australia calls for suicide registers to be established in every state and territory across Australia to increase the accuracy of the provision of mortality data to the ABS. Suicide registers should 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 and Kolves 2019).

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.

We urge the Commission to make specific recommendations as to data, including a recommendation that the funding within the National Mental Health and Suicide Prevention Agreement is tied 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, short term action we recommend is the Commonwealth build these requirements into other agreements that cover joint funding and policy action as a matter of course.

> **Recommendation**
>
> 9. Every State and Territory Government should establish a suicide register which is nationally consistent in data collection systems across jurisdictions

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 NMHC. 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).

> **Recommendation**
>
> 10. Make the National Office for Suicide Prevention responsible for leading improvements in data collation, distribution and monitoring

Under-utilised Datasets

Response to: Information request 25.1 – under-utilised datasets in respect of suicide prevention in Australia

Suicide prevention requires an integrated approach encompassing mental health, social, economic and community factors. Our recent white paper *Turning Points – Imagine a world without suicide* has identified through an online survey of 1064 Australians aged 18 and older, that economic security and changes to family and relationships will be some of the biggest risks to suicide rates over the next 10 years (Suicide Prevention Australia 2019).

The link between suicidality and the social determinants of health will be critical if we are to work towards a zero suicide goal. In recent years Australia has seen emerging trends in housing affordability and the casualization of the workforce ('gig economy') (Suicide Prevention Australia 2019). Research is required into how these structural changes are impacting the mental health and wellbeing of Australians, some of which are now, struggling to buy or rent housing, and who are subject to the minimal workforce benefits and financial security associated with casual employment.

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 ABS National Mental Health and Wellbeing Survey should be conducted within the next year months to obtain data on population-level suicidality and suicidal behaviour, with a regular schedule of follow-up surveys. Increasing the frequency of the National Mental Health and Wellbeing Survey will help assess the extent to which suicide prevention strategies and policy/program mechanisms are working effectively.

Recommendation

11. Increase the frequency of the National Mental Health and Wellbeing Survey to every three years

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 and Turner 2020) (Hedegaard, et al. 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 and De Leo 2018).

> **Recommendation**
>
> 12. The Commonwealth should work with the States and Territories to create a standardised classification systems for suicidal ideation and behaviour presentations in emergency departments across Australia

Priority areas for reform

Aftercare

> **Commentary on:** Draft recommendation 21.1 — universal access to aftercare

A suicide attempt is the strongest risk factor for subsequent suicide. We agree with the Commission that Australia requires a robust, high quality, coordinated approach to improving the care of people after a suicide attempt.

A person surviving a suicide attempt is at heightened risk of a future attempt, particularly in the first six months after the attempt was made (Christiansen and Jensen 2007). Despite this, the follow-up or 'aftercare' provided to people who are known to have attempted suicide is patchy at best. Our emergency departments and other acute care settings are overstretched, with demand for services often exceeding the resources available.

Every person who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours should be proactively provided with aftercare support. Relying on help seeking behaviours is unconscionable when the evidence informs us that the risk for suicide after an attempt is significantly elevated compared to the general population.[1]

A national population-based case-control study in the UK found 43% of suicides occurred within a month of discharge (Hunt, et al. 2008). The study further identified that suicide cases were more likely to have disengaged with healthcare services, and people that were provided appropriate aftercare were less likely to die by suicide (Hunt, et al. 2008).

Characteristics of effective aftercare services

It is essential that aftercare encompasses both immediate and continuous support. A US cohort comparison study design of 1640 patients who presented across 9 emergency departments assessed whether a Safety Planning Intervention (SPI) provided in emergency departments was associated with

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[1] Shand, F. et al., 2019. *Suicide aftercare services: an Evidence Check rapid review,* s.l.: Sax Institute for the NSW Ministry of Health

reduced suicidal behaviour after discharge (Stanley, et al. 2018). The SPI included evidence-based clinical intervention and telephone follow up for monitoring and support (Stanley, et al. 2018). Patients in the intervention group were less likely to engage in suicidal behaviour during the 6-month follow up period (Stanley, et al. 2018). The study further identified that the SPI 'was associated with 45% fewer suicidal behaviours, approximately halving the odds of suicidal behaviour over 6 months' (Stanley, et al. 2018).

The Sax Institute brokered an Evidence Check for the NSW Ministry of Health on aftercare services and found brief interventions and case management models were effective in reducing repeat suicide attempts (Shand, et al. 2019). The key variables to effective aftercare services are the timeliness, quality, and human connection established with the person who has attempted and their carers (Woden Community Service 2018) (Shand, et al. 2019).

Existing Aftercare Services

Aftercare programs with the capacity to provide high quality support for attempt survivors already exist in Australia. Beyond Blue's Way Back Support Service provides non-clinical, one-on-one care to guide people safely through the critical risk period of up to 3 months (Beyond Blue 2019). The Way Back Support Service is available in selected communities in South Australia, Northern Territory, New South Wales, Australian Capital Territory, Queensland and Victoria; and the Commonwealth Government has recently announced an investment of $7 million to increase the coverage of Way Back and other aftercare services.

The Hospital Outreach Post-suicidal Engagement (HOPE) program, a State Government initiative in Victoria, also provides intensive support following discharge, with first contact made within 24 hours from the patient leaving hospital and continuing for up to three months (Victoria State Government 2020). HOPE makes contact with attempt survivors within 24 hours of discharge and provides support for up to 3 months (Victoria State Government 2020). The program supports people to address life stressors, for example, housing, employment, education, and welfare support, while also working with the families and carers of the person who has made an attempt (Victoria State Government 2020).

Next steps

We agree with the Commission that the Commonwealth, State and Territory Governments should put in place universal aftercare: where anyone who presents to a hospital, GP or other government service following an attempt receives at least three months of follow up support. This is a commitment already recognised in the *Fifth Plan,* and agreed to by all Australian Health Ministers.

In addition to the $7 million expansion of the Way Back Support Service already announced, we believe the Commonwealth Government should negotiate with the states and territories to assure the universal provision of aftercare. Aftercare should be accessible by all people who survive a suicide attempt including people who present to emergency departments with suicidal behaviours.

> **Recommendation**
>
> 13. The Commonwealth, State and Territory Governments should invest in a universal aftercare, and build this commitment into key co-funding mechanisms

Aboriginal and Torres Strait Islander peoples

Commentary on: Draft recommendation 21.2 — Empower indigenous communities to prevent suicide

There are high rates of suicide among Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander peoples die from suicide at double the rate of the rest of the Australian population, with 169 Aboriginal and Torres Strait Islander people taking their own lives in 2018. Rates are still higher among Aboriginal and Torres Strait Islander peoples living in remote communities and among children and young people (Australian Bureau of Statistics 2018). Suicide is the leading cause of death for Aboriginal and Torres Strait Islander young people aged 15-35, who die from suicide at five times the rate of their non-Aboriginal and Torres Strait Islander peers (Australian Bureau of Statistics 2018).

We need to see immediate action to drive these rates down.

Self-determination as an underpinning principle

We agree with the Commission that Aboriginal and Torres Strait Islander peoples should be empowered to lead efforts to drive suicide rates in their communities.

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.

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 community and loss of autonomy can only be minimised if Aboriginal and Torres Strait Islander peoples themselves decide how best to address them. Suicide Prevention Australia wishes to draw the Productivity Commissions' attention to the New Zealand's *Every Life Matters Suicide Prevention Strategy 2019-2024*, which highlights the need to support Māori leadership and participation in all areas of suicide prevention from service design to implementation and evaluation.

Embedding the self-determination principle at a policy level means working with Aboriginal and Torres Strait Islander peoples at every stage of designing, developing, implementing and reviewing the proposed Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Community tailored, culturally safe and competent services

We support the Commission's view that suicide prevention programs for Aboriginal and Torres Strait Islander people should have Aboriginal and Torres Strait Islander controlled organisations as preferred providers. This will increase the likelihood that program provision is sensitive to the experiences, culture and specific social issues faced within particular communities.

This approach mirrors recent research, which found a common factor in successful suicide prevention strategies for Aboriginal and Torres Strait Islander peoples were that they were developed and led by Aboriginal and Torres Strait Islander leaders, and in partnership with their 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 (Dudgeon, et al. 2016). Providing culturally safe, culturally competent customer experience and continuity of care is especially important for crisis support services, as doing so can be life-saving (Dudgeon, et al. 2016).

Central to efforts to address Aboriginal and Torres Strait Islander suicide is the Aboriginal Community Controlled Health Sector (ACCHS) and their focus on prevention, early intervention and comprehensive care to reduce barriers to access and progressively improving individual health outcomes for Aboriginal people (Panaretto, Wenitong and Button 2014). Aboriginal Community Controlled Health Organisations are initiated and governed by the local Aboriginal Community to enable delivery of holistic and culturally appropriate healthcare to the respective community. Aboriginal Community Controlled Health Organisations are well placed to be the preferred providers of mental health, social and emotional wellbeing, and suicide-prevention activities in their communities.

While Aboriginal Community Controlled Health Organisations play an important role in providing the Aboriginal community with access, 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).

Recommendation

14. Resource Aboriginal Community Controlled Health Organisations to develop community-led solutions

Emerging areas of suicide risk

We ask the Commission to consider solutions to addressing emerging areas of suicide risk as a key component of suicide prevention.

Suicide Prevention Australia has long called on policymakers to treat suicide prevention in a holistic way. Many people who are at risk of suicide or who take their own lives have no experience with mental ill health. Up to one in five suicide deaths in Australia do not involve any co-morbidities, whether with mental ill health or other health issues (Australian Bureau of Statistics, 2017).

In line with guidance from the World Health Organisation, we believe suicide prevention requires a multifaceted approach (World Health Organisation, 2018):

a. **Suicide prevention should be approached at the population level** through strategies to improve equity and address the social determinants that increase suicide risk;

b. **Suicide prevention should target communities**, especially through strategies designed to increase social inclusion and reduce risk for priority populations;

c. **Suicide prevention should target the individual**, through interventions that go beyond a mental-health based approach and provide a continuum of care to every person at risk (World Health Organisation, 2018).

Historically, policymakers have found identifying strategies that address population level equity issues a significant challenge. Now, we have seen Governments across Australia recognising that we can only work toward a zero suicide rate by identifying and addressing social determinants through whole of government collaboration.

As outlined previously, the survey results captured in our *Turning Points White Paper* highlighted that Australians believe economic security and changes to family and relationships will be some of the biggest risks to suicide rates over the next 10 years (Suicide Prevention Australia 2019).

While economic conditions and financial burdens are rarely the sole cause of suicide, they work in conjunction with other factors to affect an individual. Low control and high demands at work are risk factors for suicide, as individuals develop reactions such as feelings of hopelessness and heightened stress (Milner, et al., 2017). This may disproportionately affect different types of businesses, or different types of employees.

To further explore the results of *Turning Points*, we conducted a series of policy roundtables in 2019 and focus groups in 2020 to explore the key issues impacting consumer debt and people employed in the gig economy who work within precarious conditions. The roundtables and focus groups involved a cross section of our members, industry representatives, consumer bodies and other not for profits focused on social benefit. The results of this consultation effort are captured in brief below, with a full report due for publication in March 2020.

The gig economy

Conditions at work can have a profound effect on mental health and wellbeing (Superfriend, 2019). The 2019 Workplace Indicators Survey by Suicide Prevention Australia member Superfriend identified more than half the Australian workforce reported experiencing an issue with mental ill health, with two in five of these saying their workplace either caused or exacerbated the condition (Superfriend, 2019).

Changes in the nature of employment may intensify the challenge for employers. A growing number of Australians are no longer employed under traditional workplace arrangements. Approximately 2.5 million Australians – or 25% of the total workforce - are employed on a casual basis (Australian Bureau of Statistics, 2018). Of these, a growing number are hired for individual 'gigs', whereby a company pays for a service rather than for an ongoing role.

The rise of these new forms of employment mean workers are increasingly losing access to work supported training, skills development and the social connectedness gained through secure employment. These factors can significantly deepen the career opportunities, financial stressors and isolation experienced by individuals already suffering from loneliness and social exclusion.

The gig economy and the use of contractors in workplaces have the potential to further isolate individuals who suffer from loneliness and a lack of connection by no longer having regular colleagues or fixed work places. A recent poll of young adults showed that over 50% of freelancers surveyed feared a lack of connection to a company's internal culture would leave them feeling like outsiders (Deloitte, 2017).

Our members identified a number of unique challenges that impact the living standards for those who work within the gig economy such as: high work demands resulting in fractured relationships within families, minimal budgeting or financial planning, lack of support systems and connectivity to community, and difficulty in planning for the future.

The provision of a peer support mechanism is key to reducing loneliness experienced in working within the gig economy, and to increase a sense of belonging and connection. Our members identified that this mechanism may best be suited to an online platform where employers can assist in building social connections among their workforce and promote social connectedness and wellbeing activities to employees.

The trend toward 'gig' and other casual forms of working is not likely to be reversed. Digital technology, the automation of unskilled or low skilled occupations and consumer demand mean the gig economy is likely to continue to grow. There are also benefits associated with working in the gig economy: 'gig' employment types, as well as other casual, non-traditional forms of employment, offer workers autonomy, flexibility and greater control over the frequency and type of work they do.

However, it is also associated with an overall casualization of the workforce as employment shifts to casual and contract positions, which do not include superannuation, paid sick leave or annual leave. While unemployment remains at historically low levels, underemployment, which is also associated with financial strain, continues to trend upwards (Suicide Prevention Australia, 2019).

The task for industry and policymakers is to identify solutions that overcome the social exclusion and financial security risks inherent in less secure forms of employment. A major concern identified through our consultation activities is that there is no obligation for gig economy employers to design and implement policies and strategies to support the mental health and wellbeing of their employees, and that there is a lack of training and education in the impacts of working within the gig economy. Gig

economy employers need a commercial imperative, an increase to their corporate social responsibility, or accountability mechanism if they are to be encouraged to take action to better the mental health and wellbeing of their employees.

One option discussed by our stakeholders was development of a government funded and administered social responsibility system would increase awareness and enhance consumer choice, not only within the gig economy but across other sectors. The social responsibility system would also provide a marketing incentive for gig economy employers to implement mental health and wellbeing strategies and initiatives within their workforce. This system could be complemented with a tool kit consisting of resources for gig economy employers on what issues may impact their workforce, and information on how best to support their employees within their unique working environments.

In the interim, Suicide Prevention Australia is of the view that Government should review mechanisms for informing and better supporting people engaged in fee for service or 'gig' employment.

> **Recommendation**
>
> 15. Review strategies to support priority population groups in **the gig economy**

Consumer Debt

While suicide is not a common response to financial crisis, we know people who experience unmanageable debt have an elevated risk of suicide (Australian Bureau of Statistics, 2018).

In 2016, the ABS reported that 29% of Australian households were classified as 'over-indebted', with the most common forms of debt being credit card debt, home loans and student loans (Australian Bureau of Statistics, 2018). In addition to pressures related to overall debt growth, difficulty in accessing loans may compound the financial stress around home ownership, where the Australian Housing Urban Research Institute have already found that the burden of mortgage debt is leading to mental distress and worsening mental health outcomes from those who are faced with unsustainable mortgage repayments (Ong, et al., 2019).

Buy-now-pay-later schemes such as Afterpay and Zipay have also been changing Australia's relationship with money, especially in younger age groups. Data shows that 60% of buy-now-pay-later service customers are aged between 18 and 34, and more than 40% of users had incomes of less than $40,000 (ASIC, 2019). Unlike banks, buy-now-pay-later services are not required to do checks to verify the financial capabilities of their customers, and are not regulated as a credit provider. The lack of credit checks and approvals leaves consumers vulnerable to accumulated debt, and may have long term damaging effects on credit scores that have the potential to compound financial burden and attainability when it comes to future borrowing.

People experiencing problematic levels of debt are twice as likely to engage in suicidal ideation (Evans, 2018). A UK study which sought to investigate the link between consumer debt and suicidal ideation (n=7461) found 'those in debt were twice as likely to think about suicide after controlling for sociodemographic, economic, social and lifestyle factors' (Meltzer, et al., 2011). Suicidal thoughts was also found to be strongly associated with struggling to pay off personal debts e.g. credit cards, rent, mortgage arrears, and mail order repayments (Meltzer, et al., 2011).

The Money and Mental Health Policy Institute report people with significant debt are 1.8 times more likely to experience suicidal ideation, and 'people with multiple debt problems are at significantly higher risk of suicide that those with just one problem debt' (Bond & Holkar, 2018). Long term factors such as persistent poverty and financial insecurity can put people at risk of becoming suicidal, as can sudden triggers like intimidating and threatening communications from lenders (Meltzer, et al., 2011). Financial difficulties can significantly impact a person's resilience, and lead to feelings of hopelessness about the possibility of getting out of debt (Meltzer, et al., 2011).

There are a range of support services available to help Australians who may be experiencing debt-related stress such as the free financial counselling offered by a range of community legal centres, organisations and government agencies. Many people are not aware of these services, or do not become aware of them until they reach the point of crisis.

Our stakeholders identified the need for law reform to capture the 'shadow debt market' of payday lenders and buy-now-pay-later services. In the shorter term, Government should consider introducing a national code of practice for the 'shadow' debt market with debt ceilings and requirements for fair and transparent dealing with consumers, including a set of principles for payday lenders and buy-now-pay-later services who are currently not captured under any code of practice or enforceable rules.

We have also found broad support across our membership for a substantial increase to Newstart payments. As established elsewhere, the base rate of Newstart has not increased in real terms since 1994, despite the increasing cost of basic necessities such as housing, groceries, and utilities (Business Council of Australia 2019).

We agree with the Business Council of Australia and the National Council of Social Services that we need to see an increase to Newstart so that people experiencing the challenges of employment insecurity can meet their basic needs and have the support they need to find meaningful work: whether this is in the gig economy or in more secure forms of employment (Business Council of Australia 2019) (Australian Council of Social Service 2015) .

> Recommendations
>
> 16. Introduce a code of practice to regulate payday lenders and buy-now-pay-later services
>
> 17. Increase the base rate of Newstart

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