Submission to the Select Committee on Mental Health and Suicide Prevention Inquiry

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Summary of Recommendations

Whole of Government	1. Pass a Suicide Prevention Act, providing a legislative framework for a three-yearly National Suicide Prevention Plan. 2. Commonwealth Government to fund a permanent National Suicide Prevention Office, responsible for a whole-of-government approach to suicide prevention. 3. Commonwealth to fund the National Suicide Prevention Office to develop a National Suicide Prevention Plan. 4. Commonwealth to fund the National Suicide Prevention Office to produce a suicide prevention workforce strategy and implementation plan.
Financial distress and unemployment	5. Permanently increase JobSeeker to $65 per day to ensure vulnerable people can meet basic life necessities. 6. Maintain payment support for industries at similar levels to JobKeeper until June 2022 for industries that continue to see the most significant impacts.
Homelessness	7. Support State and Territory Governments to ensure access to secure and affordable housing for people with severe mental illness.
Domestic and family violence	8. Invest in targeted suicide prevention training for domestic and family violence frontline personnel, delivered by organisations with expertise in both suicide prevention and domestic and family violence.
Aboriginal and Torres Strait Islander peoples	9. Development of a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan, led by Aboriginal and Torres Strait Islander people.
Male suicide	10. The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy as a core stream within a national suicide prevention strategy; including specific actions to address male suicide.
People from Lesbian, Gay, Bisexual, Transgender, Queer and Intersex communities	11. Establish national architecture to coordinate LGBTQI health, coordinate funding for peer-led community-controlled organisations, identify disparities at the national level and research into LGBTQI suicide, and coordinate national health responses for LGBTQI Australians. 12. Provide population-level data and accurate recording of deaths by suicide through counting LGBTQI people in the Census, and improving data collection by coroners to inform policy, service, and program development.
People from Culturally and Linguistically Diverse backgrounds	13. Fund improved data collection, including creating a national minimum dataset for cross-generational CALD communities inclusive of mental health, suicide, and self-harm data. 14. Fund the co-design of culturally appropriate mental health services and suicide prevention programs, which would be jointly implemented by CALD community organisations to address stigma, target vulnerable groups and increase utilisation of mental health and suicide prevention services in cross-generational CALD communities.
Responding to future disasters	15. Budget for approximately $30 million annually in discretionary funds to respond to increased need for suicide prevention in the event of future disasters or economic crises, such as bushfires, floods, or epidemics, for extended time periods after a disaster.
A human-centred approach	16. Use a human-centred design approach, that takes into account consumer insights, to ensure that the design and delivery of future services enhances consumer participation and service effectiveness.
Peer work	17. Ensure that suicide prevention workforce strategy and planning includes a focus on integrating peer workers.

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Introduction

Suicide Prevention Australia is the national peak body for the suicide prevention sector. Our members include the largest and many of the smallest organisations working in suicide prevention, practitioners, researchers and community leaders. Suicide Prevention Australia supports and strengthens the services of our members, is an information channel connecting the sector and the voice of lived experience to government, as well as providing leadership, policy services, and research support to the suicide prevention sector.

The COVID-19 pandemic is a watershed event in the history of Australia and the world: challenging our public health systems and experts, and bringing unprecedented shifts in our global economy, society and how we live as families and individuals. The pandemic and recent disaster events in Australia such as bushfires, floods, and droughts, have further demonstrated the need for resources to be available to respond to multiple and compounding disasters.

Major scale disasters, like the 2019 bushfires and the COVID-19 pandemic, affect people's employment, finances, and everyday lives in the medium to long term. These impacts sometimes manifest as a lasting experience of trauma and mental ill health. Several studies have shown the risk of trauma, mental health impacts and, sadly, suicide increases more significantly in the months after a disaster, rather than when the crisis is still acute[1,2].

While Australia has not reported increases in suicide rates during the COVID-19 pandemic, this may be due to the robust Government-led public health response which has seen significant boosts to healthcare and suicide prevention supports during the pandemic. In particular, JobKeeper and JobSeeker have acted as suicide prevention interventions by providing necessary financial support during the COVID-19 pandemic to relieve distress for many people who found themselves suddenly unemployed or on significantly reduced income.

The suicide prevention sector has experienced significant increases in service demand throughout periods of disaster events and the pandemic. For example, during the bushfires Lifeline experienced a 10-15% service increase and a 25% service increase during the pandemic[3,4].

It is crucial that Government supports continue into the recovery phase of the COVID-19 pandemic to prevent increases in suicide rates and work towards zero suicide in Australia.

In keeping with our role as the national peak body for the suicide prevention sector, our submission is focused on suicide prevention aspects of the Productivity Commission Inquiry Report into Mental Health, the Report of the National Suicide Prevention Officer, the Victorian Royal Commission, in light of the COVID-19 pandemic and other disaster events.

Together, we can achieve a world without suicide.

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[1] Matsubayashi, T.S. Y. & Ueda, M. (2013). Natural disasters and suicide: Evidence from Japan, *Social Science & Medicine*, 82, 126-133.

[2] Kessler,R., et al. (2008). Trends in mental illness and suicidality after Hurricane Katrina, *Molecular Psychiatry*, 13, 374-384.

[3] Lifeline Australia. (2020). Lifeline welcomes the Federal Government's National Mental Health and Wellbeing Pandemic Response Plan, available online: https://www.lifeline.org.au/resources/news-and-media-releases/media-releases/lifeline-will-continue-answering-calls-through-covid-19.

[4] Lifeline Australia. (2020). Lifeline Annual Report 2019-20, available online: https://www.lifeline.org.au/media/azln5z4y/web_lifeline-areport-2019-2020.pdf.

1. Background: Impact of COVID-19 on the Suicide Prevention Sector

Australia's response to the COVID-19 pandemic has had far-reaching impacts on millions of Australians. In mid-April, Suicide Prevention Australia launched a survey[5] to help inform the National Suicide Prevention Adviser about the impact the COVID-19 pandemic is having on program and service delivery within the sector. The goal was to gather intelligence to inform the national response as well as provide an opportunity to identify ways to build sector capacity during this challenging period.

More than 50 organisations responded to the survey, providing important intelligence concerning shifts in the ways they deliver their services; changes in demand; their training and capacity building needs; and early results from their own research concerning the impact of COVID-19 related changes on the consumers they support. We undertook a second iteration[6] of the survey in May 2020 to monitor changes during the continually changing landscape which received over 60 responses from organisations in the sector.

The key challenges identified in the first iteration of the survey in April 2020 remained largely unchanged in the second iteration with organisations continuing to identify the absence of face-to-face support, issues with technology access, literacy and security, and funding to resource their transition to providing services virtually as the main factors impacting service provision during COVID-19.

Intelligence gathered from our members informed us that consumers were reporting financial hardship even as lockdown measures were easing; while others reported people continuing to refrain from accessing some forms of preventative healthcare due to fears of contracting the virus, despite relatively low Australian caseload numbers.

Key highlights from our intelligence gathered:

- Significant increases in service demand in the suicide prevention sector were experienced in both iterations of the survey.
- Lack of funding and resources available to adapt timely to alternative methods of service delivery to accommodate COVID-19 physical distancing measures. This was largely experienced among smaller organisations who are typically supported by volunteers.
- Challenges experienced by frontline workers in ability to provide appropriate risk assessments to determine client safety via online forms of service delivery due to COVID-19 measures in place.
- Consumers continued to experience high levels of anxiety, isolation, and distress. Pressures of isolation such as financial stress emerged, with clients reporting difficulties accessing welfare support payments and financial hardship as a major driver of fear and distress.
- A digital divide in connection and accessibility was experienced among vulnerable people who lack access to phones or internet leaving them at risk of social isolation and inaccessible service provision, difficulties achieving stable network connections, issues with technology literacy among staff and consumers, and concerns ensuring confidentiality over webchat services.

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[5] Suicide Prevention Australia. 2020. Impact of COVID-19 on the sector, April, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2020/09/Impact-of-COVID-19-on-the-sector-first-report.pdf.

[6] Suicide Prevention Australia. 2020. Impact of COVID-19 on the sector, May, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2020/09/Second-Iteration-COVID-19-Sector-Impact-Survey-Report-May-2020_Website-2.pdf.

2. Whole of Government approach

Now more than ever, Australia needs a whole-of-government approach to suicide prevention.

Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. As noted in the Interim Report of the National Suicide Prevention Advisor: "no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress"[7]. Preventing suicide therefore requires a holistic, cross-governmental approach that effectively coordinates funding and policy attention to address the social, economic, health, occupational, cultural, and environmental factors involved.

The Interim Report recommends the adoption of national whole-of-government governance structure for suicide which would include a National Office for Suicide Prevention, a stand-alone whole of government National Suicide Prevention Strategy and a long-term workforce strategy for suicide prevention[8].

In addition, the Productivity Commission's Final Report makes two recommendations touching on governance arrangements for suicide prevention[9]:

- A National Mental Health and Suicide Prevention Strategy involving the health and non-health sectors, and creating 'a truly whole-of-government approach to suicide prevention'.
- Extend the National Suicide Prevention Implementation Strategy to include non-health portfolios that have influence over suicide prevention.

At core of the model for whole of government outlined in our National Policy Platform, developed with our members, is the need for a standalone National Office of Suicide Prevention. The National Office of Suicide Prevention would be responsible for implementing a National Suicide Prevention Strategy. We have also called for First Ministers to lead, and all Ministers to take shared responsibility for suicide prevention.

For all government agencies to work towards a unified action plan, a Commonwealth Suicide Prevention Act is needed to cement commitment to suicide prevention. Recently South Australia proposed a Suicide Prevention Act which would embed governance arrangements such as the establishment of a Suicide Prevention Council with lived experience representation to oversee the State's Suicide Prevention Plan, and the requirement for prescribed state authorities to develop their own suicide prevention plans and report on them annually.

Prioritising individual department plans as a legislative requirement will ensure government agency will develop and report on their specific suicide prevention plans tailored to their priority groups. These mechanisms will create cross-portfolio responsibility and accountability for suicide prevention which we believe is critical if we are to reduce suicides in Australia and ultimately, save lives.

An Act would further provide a level of permanency to plans and actions to ensure a consistent whole of government approach over time.

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[7] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention in Australia.
[8] Ibid.
[9] Productivity Commission. (2019). Mental Health Draft Report, Canberra.

A Commonwealth Suicide Prevention Act would provide a legislative framework for:

- The development of an outcomes-based National Suicide Prevention Plan within 12 months of the new Act commencing, with the plan to be tabled in Parliament.
- Requirement for government agencies to have suicide prevention plans which respond to not only their employees but also their consumers.
- Governance arrangements to ensure suicide prevention action is pursued effectively, including arrangement to embed the voice of expertise and lived experience.

A further key aspect of building a whole of government capacity should be a standalone suicide prevention workforce strategy and implementation plan; a complement to, rather than as a stream within the National Mental Health Workforce Strategy.

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 working in a suicide prevention, response, crisis support or postvention setting
- The informal suicide prevention workforce, which includes (but is not limited to) 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
- The lived experience workforce, including people with direct experience of suicidality, with experience caring for someone who is suicidal, as well as those who have been bereaved by suicide

Recommendation: Pass a Suicide Prevention Act, providing a legislative framework for a three-yearly National Suicide Prevention Plan.

Recommendation: Commonwealth Government to fund a permanent National Suicide Prevention Office, responsible for a whole-of-government approach to suicide prevention.

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

Recommendation: Commonwealth to fund the National Suicide Prevention Office to produce a suicide prevention workforce strategy and implementation plan.

3. Responding to heightened risk factors for suicide

3.1 Financial distress and unemployment

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

The Australian Bureau of Statistics (ABS) reported 45% of Australians aged 18 years and over have been financially impacted by COVID-19 over the period mid-March to mid-April 2020, and 31% of household

finances have worsened[10]. The ABS further identified changes in mental health and wellbeing throughout COVID-19, in comparison to data from 2017-2018 National Health Survey, reporting almost twice as many Australians experienced anxiety during physical distancing measures[11].

The impacts of the COVID-19 pandemic have proven to be wide-reaching, with the effects on the Australian economy growing increasingly apparent. The number of Australians receiving main unemployment welfare support payments (JobSeeker & Youth Allowance) for the period December 2019 to May 2020 grew from approx. 820,000 to 1,640,000[12]. A significant increase among people estimated to be of working age receiving these payments was further witnessed[13]. Business confidence has declined sharply, with estimates showing small businesses experiencing cumulative impacts from the bushfires and COVID-19 measures are the most affected[14].

While suicide is not a typical response, links between unemployment, financial insecurity and suicidality are well established. Several systematic reviews have provided strong evidence of the relationship between unemployment and suicide, with the risk at its highest in the first five years of unemployment[15]. Research found levels of personal debt are also associated with suicidal ideation, suicidal attempts and suicide even after adjusting for socioeconomic factors, lifestyle behaviours and other risk factors[16].

A survey undertaken by ReachOut of 1000 young people in July 2020 found the proportion of young people in Australia concerned about work and/or finding a job has increased from 25.0% in January 2020 to 37.5% in July 2020[17]. 42% indicated money as a top stressor[18]. Research undertaken by headspace further identified 77% of young people reported a negative impact on their work, study, or financial situation[19].

The National Suicide Prevention Taskforce identified 'people more vulnerable to suicide as a result of COVID-19 measures include: people who have experienced unemployment and/or financial distress', and further identified the importance of economic and social policies in reducing financial distress[20]. The Productivity Commission similarly identified those experiencing financial distress or unemployment at higher risk of developing mental illness, and those on income support payments are more likely to

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[10] Australian Bureau of Statistics. (2020). 4940.0 – Household impacts of COVID-19 Survey, 14-17 Apr 2020, *Australian Bureau of Statistics*, Canberra.
[11] Ibid.
[12] Klapdor, M. & Giuliano, C. (2020). The impact of COVID-19 on JobSeeker payment recipient numbers by electorate, *Parliament of Australia,* available online: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2021/COVID-19JobSeekerRecipientNumbersElectorate.
[13] Ibid.
[14] NSW Business Chamber. (2020). NSW Business Conditions Survey, March quarter, available online: https://www.businessnsw.com/content/dam/nswbc/businessnsw/bcs-reports/BCS%20Report%20-%20March%202020%20-%20COVID19%20Special%20Edition%20(V2)%20.pdf.
[15] Milner, A., Page, A. & LaMontagne, A.D. (2013). Long-term unemployment and suicide: a systematic review and metaanalysis. *PloS one*, 8(1), e51333, available online: https://doi.org/10.1371/journal.pone.0051333.
[16] Meltzer H, Bebbington P, Brugha T, Jenkins R, McManus S, Dennis MS. (2011). 'Personal debt and suicidal ideation', *Psychological Medicine*, 41(4):771-8, available online: https://pubmed.ncbi.nlm.nih.gov/20550757/.
[17] ReachOut. (2020). New support for young people stressed about work and money during COVID-19, Press Release, September.
[18] Ibid.
[19] headspace. (2020). Coping with COVID-19: the mental health impact on young people accessing headspace services, August.
[20] Ibid.

experience poverty[21]. The Productivity Commission reported there are significant long term economic benefits to improving people's overall quality of life, in particular in areas of mental health, employment, and income[22].

We know from previous recessions and pandemics that that social safety nets play a crucial protective role in reducing distress and suicide risk. We ask the Commonwealth Government ensure the many Australians who are seeking work – many of them unemployed for the first time - have adequate basic support.

We welcome the Government's recent announcement of a permanent increase to JobSeeker to $615.70 a fortnight, however this is still $99.30 less than the current rate with the coronavirus supplement which ends in March. ACOSS reports vulnerable people currently on the temporary coronavirus supplement are already forced to make decisions between crucial life necessities such as 'housing, food, medications, basic toiletries and paying bills'[23].

Increasing the base rate means the thousands of Australian people experiencing the challenges of unemployment can meet their basic needs and have the support they need to find meaningful work when it becomes available. We agree with ACOSS that the Australian Government should increase JobSeeker permanently to $65 a day to ensure people are able to meet basic life necessities, and meet the clothing, transport, and communications costs involved in job searching[24].

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

Recommendation: Permanently increase JobSeeker to $65 per day to ensure vulnerable people can meet basic life necessities.

Recommendation: Maintain payment support for industries at similar levels to JobKeeper until June 2022 for industries that continue to see the most significant impacts.

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[21] Ibid.

[22] Ibid.

[23] ACOSS. (2021). A heartless betrayal of millions – Government JobSeeker decision, Media Release, available online: https://www.acoss.org.au/media_release/a-heartless-betrayal-of-millions-government-jobseeker-decision/.

[24] ACOSS. (2021). Permanent JobSeeker increase must raise rate to at least $65 per day and ensure everyone has enough for the basics of their life, Media Release, available online: https://www.acoss.org.au/media_release/permanent-jobseeker-increase-must-raise-rate-to-at-least-65-per-day-and-ensure-everyone-has-enough-for-the-basics-of-their-life/.

3.2 Homelessness

The Australian Bureau of Statistics reports there are more than 100,000 people who are homeless across Australia.[25,26]

Individuals who are homeless or at-risk of homelessness are at higher risk of exposure to COVID-19. Lacking access to basic hygiene and sanitation facilities, living in congregate spaces such as shelters or encampments, and being more transient and mobile, prevents effective monitoring, quarantining and opportunities for disease treatment[27,28].

The House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into COVID-19 and homelessness reported increases in demand for services and assistance due to the COVID-19 pandemic and a result of the bushfires[29]. Many submissions to this Inquiry recommended housing supports continue into the recovery phase of the pandemic[30].

The bushfires in 2019-2020 destroyed the homes of thousands of Australians across the country, many of whom due to financial reasons were unable to insure their homes and are still struggling to rebuild their lives. Disasters exacerbate existing inadequate housing issues placing additional stress on already vulnerable people[31].

We support the priority action identified in the National Suicide Prevention Taskforce Interim Report for 'all governments to consider further investments in low-cost, secure and good-quality public housing, linked where necessary with suitable support services. In consultation with jurisdictions, relevant experts and stakeholders, priorities should be set for suicide prevention approaches focused on people experiencing or at risk of homelessness'[32].

We further support the Productivity Commission calls for housing services to increase their capacity to reduce the risk of people with mental illness experiencing housing issues or losing their home (Action 20.1), and for state and territories to provide mental health training to social housing workers, to review their policies with consideration for people with mental illness to reduce the risk of eviction, and to ensure that tenants with mental illness who live in the private housing market have the same ready access to tenancy support services as those in social housing by meeting any unmet demand for these services[33].

Recommendation: Support State and Territory Governments to ensure access to secure and affordable housing for people with severe mental illness.

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[25] AIHW. (2020). Homelessness and homelessness services, *AIHW*, available online: https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services.

[26] Suicide Prevention Australia & Wesley Mission. (2020). Reducing distress in the community following the COVID-19 pandemic, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2020/09/Reducing-distress-in-the-community-following-the-COVID-19-pandemic.pdf.

[27] Tsai, J. & Wilson, M. (2020). COVID-19: a potential public health problem for homeless populations, *The Lancet Public Health*, 5:4, 186-187, available online: https://doi.org/10.1016/S2468-2667(20)30053-0.

[28] Ibid.

[29] House of Representatives Standing Committee on Social Policy and Legal Affairs. (2020). Shelter in the storm – COVID-19 and homelessness, Interim report of the inquiry into homelessness in Australia, *Parliament of the Commonwealth of Australia*, Canberra.

[30] Ibid.

[31] Mission Australia. (2020). Inquiry into homelessness in Australia 2020, *Mission Australia.*

[32] Ibid.

[33] Ibid.

3.3 Domestic and family violence

Domestic and family violence involves a variety of abusive and controlling behaviours that can be physical or non-physical. Evidence shows that women who experience intimate partner violence (IPV) are at higher risk for suicidal ideation and attempts, with research linking the severity of IPV with suicidality[34].

Analysis of previous disasters and catastrophic events has shown an increase in domestic violence cases for many months after their conclusion[35]. Examples include:

- an increased chance of IPV one to two years following the 2010 earthquake in Haiti
- close to 50% increase in reports of domestic violence in Othello, Washington post-eruption of Mount St. Helens
- partner physical abuse nearly doubling in some counties in Mississippi post-Hurricane Katrina[36].

The Women's Safety NSW survey on the impacts of COVID-19, report more than 40% of survey respondents have witnessed an increase in the number of people requesting support, and 44.9% identified 'escalating and worsening violence' as being a major issue impacting those in need[37].

Problem gambling, substance abuse, alcohol consumption and financial hardship are key indicators for the prevalence of domestic violence. These indicators increase the likelihood, frequency and severity of domestic violence cases[38]. The Women's Safety NSW survey showed that 36.2% of respondents stated that violence and abuse stemmed from financial pressures and stresses, due to the pandemic. Compounding risk factors such as financial distress and lack of social support leads to an increased risk of domestic and family violence [39].

The National Suicide Prevention Taskforce Interim Report identified increases in domestic and family violence during the pandemic and within Priority Area 5, call for 'domestic violence services to take into account the restrictions people face in accessing help is 'trapped' in the household by perpetrators and any surge in violence as a consequence of the pandemic'[40].

The Australian Government has already shown significant leadership in upscaling support for victims of domestic violence[41]. There are reports from leading domestic and family violence organisations that

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[34] Cavanaugh, C.E., Messing, J.T., Del-Colle, M., O'Sullivan, C., & Campbell, J.C. (2011). Prevalence and correlates of suicidal behaviour among adult female victims of intimate partner violence, *Suicide & life threatening behaviour*, 41(4), available online: https://doi.org/10.1111/j.1943-278X.2011.00035.x.

[35] Ibid.

[36] Campbell A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives*, Forensic Science International*, available online: https://doi.org/10.1016/j.fsir.2020.100089.

[37] Foster, H. & Fletcher, A. (2020). Impact of COVID-19 on Women and Children Experiencing Domestic and Family Violence and Frontline Domestic and Family Violence Services, *Women's Safety NSW*, available online: https://www.womenssafetynsw.org.au/wp-content/uploads/2020/03/COVID-19-DV-Responses_WSNSW-Survey.pdf.

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] Prime Minister of Australia. (2020). $1.1 billion to support more mental health, medicare and domestic violence services, Media Release.

social distancing measures have exacerbated the conditions that increase risk for victims of domestic and family violence, and the Australian Government's investment is a step in the right direction.

More needs to be done however, to support workers in this challenging field to recognise the signs where families may be at risk of suicidal behaviours. We call on the Commonwealth Government to consider an investment in targeted suicide prevention training for these frontline personnel, in addition to other key touchpoints for vulnerable members of the community.

Recommendation: Invest in targeted suicide prevention training for domestic and family violence frontline personnel, delivered by organisations with expertise in both suicide prevention and domestic and family violence.

4. Vulnerable populations

4.1 Aboriginal and Torres Strait Islander peoples

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.[42] 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.[43]

Before the COVID-19 pandemic reached Australia, our First Nations peoples already experienced higher rates of poor mental and physical health than non-Indigenous Australians, which is compounded by intersecting identities with other vulnerable groups and a lack of appropriate culturally sensitive supports[44]. Our First Nations peoples have a long history of inequity and disadvantage stemming from colonization and sustained by a lack of adequate response from Australian Governments to address the social determinants of health experienced by Indigenous Australians[45].

Self-determination is 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. We sought 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.

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[42] Australian Bureau of Statistics. (2018). 'Intentional self-harm in Aboriginal and Torres Strait Islander people', ***3303.0 - Causes of Death, Australia,*** accessed online on 31 October 2019 at <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~4>.

[43] Ibid.

[44] Dudgeon, P., Derry, K.L. & Wright, M. (2020). A national COVID-19 pandemic issues paper on mental health and wellbeing for Aboriginal and Torres Strait Islander Peoples, *Transforming Indigenous Mental Health and Wellbeing Grant, The University of Western Australia Poche Centre for Indigenous Health*.

[45] Ibid.

The Commission has supported this call, recommending development of a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan that addresses age demographics, led by Aboriginal and Torres Strait Islander peoples. The Commission has also recommended that Aboriginal and Torres Strait Islander organisations are the preferred providers of local suicide prevention activities supporting their communities; aligning broadly with our recommendation to resource Aboriginal Community Controlled Health Organisations to develop community-led solutions.

Recommendation: Development of a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan, led by Aboriginal and Torres Strait Islander people.

4.2 Male suicide

Male suicide is an issue warranting targeted policy and funding attention. Australia requires a concerted effort to address the underlying issues that might lead men to the point of crisis.

More than three-quarters of intentional self-harm deaths occur in males[46]. In 2018, 3,046 Australians died by suicide, 2,320 (76.2%) of whom were males[47]. Ambulances respond to over 16,800 calls each year from males experiencing suicidal ideation and a further 9,000 ambulances respond to a suicide attempt[48]. Aboriginal and Torres Strait Islander men are particularly at risk, with males nearly three times more likely to die by suicide than Aboriginal and Torres Strait Islander females; and twice as likely to take their own lives as non-Aboriginal and Torres Strait Islander males[49]. Males who identify as gay, bisexual, transgender or intersex are at higher risk of suicide and have been reported to be four times more likely to have attempted suicide[50].

Male suicide is an issue requiring targeted policy and funding attention. Australia requires a concerted effort to address the underlying issues that might lead men to the point of crisis. Many men who are at risk of suicide or who take their own lives have no experience with mental ill health. We need to strategically identify opportunities to intervene with men who may be vulnerable to suicide, but not interacting with the formal mental health or suicide prevention systems. A whole-of-government approach to male suicide prevention is required to improve the coordination of services. Cross-agency collaboration is vital to reach men at risk both before, during and after a suicidal crisis.

In addition, support services are not always accessible and appropriate due to the fact that some males may not engage in help-seeking behaviour. Of concern, 72% of males do not seek help if they are experiencing issues with mental ill-health[51]. Research involving analysis of data from men in the Australian Longitudinal Study on Male Health has highlighted the potential connection between

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[46] Australian Bureau of Statistics. (2019). Australia's leading causes of death, 2018, 3303.0 – Causes of Death, Australia.
[47] Ibid.
[48] Turning Point. (2019). Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health, Richmond, VIC, available online: https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-the-emergency-report.pdf.
[49] Australian Bureau of Statistics. (2016). Australia's leading causes of death, 2015, 3303.0, Causes of Death, Australia.
[50] Skerret D.M. (2014). Mental Health and Suicidal Behaviours in LGBTI Populations and Access to Care in Australia: A Literature Review, prepared for Queensland AIDS Council.
[51] Seidler, Z.E., Dawes, A.J., Rice, S.M., Oliffe, J.L. & Dhillon, H.M. (2016). The role of masculinity in men's help seeking for depression: a systematic review, *Clinical Psychology Review*, 106-118.

masculine behaviour norms, in particular self-reliance, and a reluctance to actively seek help particularly within a clinical setting.[52] However, tailoring and targeting clinical and non-clinical interventions may increase men's service uptake and the effectiveness of treatments.[53]

To drive a diverse range of effective, evidence-based services to drive down male suicide requires the Australian Government to fund the creation of a national male suicide prevention strategy which addresses age demographics. Male suicide prevention would be a core stream within a national suicide prevention strategy; and would include specific actions to address male suicide. Actions could, for example, address:

- 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;
- the training development needs of workforces to actively contribute to suicide prevention, and articulate these in a suicide prevention workforce strategy;
- funding for services facilitating community and industry-based connections for men, particularly those targeted at men vulnerable to distress; and
- 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.

The call for men to be identified as a priority population in suicide prevention planning is a prioritized action within the National Suicide Prevention Taskforce Interim Report[54].

Recommendation: The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy as a core stream within a national suicide prevention strategy; including specific actions to address male suicide.

4.3 People from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) communities

People from LGBTQI communities have higher rates of mental ill-health and suicide than the general population in Australia. In particular, LGBTQI young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, transgender people aged 18 and over nearly eleven times more likely, and people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over are nearly six times more likely.[55] Elevated risk of suicidality experienced by LGBTQI people is strongly linked with their continuing experience of discrimination and exclusion.

Not only do people from LGBTQI communities experience elevated rates of poor mental health and suicidality, but they also face unique barriers in accessing critical services during times of mental health crisis. Research has shown 71% of LGBTQI people chose not to use a crisis support service during their

[52] Pirkis, J., Spittal, M.J., Keogh, L., Mousaferiadis, T. & Currier, D. (2016) Masculinity and suicidal thinking, *Soc Psychiatry Psychiatric Epidemiol*, Vol 52, pp. 319–327.
[53] Ibid.
[54] Ibid.
[55] National LGBTI Health Alliance. (2020). Snapshot of mental health and suicide prevention statistics for LGBTI people, available online: https://www.lgbtiqhealth.org.au/statistics.

most recent personal or mental health crises, many of whom reported concerns relating to experiencing discrimination or anticipated discrimination[56].

Evidence suggests LGBTQI communities experience homelessness and drug and alcohol use at higher rates than the general population; and experience similar rates of intimate partner violence to the general population[57]. Homelessness, drug and alcohol misuse, and domestic and family violence are risk factors for suicide that can be exacerbated by COVID-19 response measures.

Findings from research into the impact of the first three months of COVID-19 on the Australian transgender community reports: more than half experienced symptoms of depression (61.1%), almost half experienced thoughts of self-harm or suicide (49%), almost half experienced financial distress (49.6%), 22% experienced reduced working hours, and 22.4% were unemployed[58].

Equality Australia surveyed over 2600 LGBTQI Australians between April and May 2020 on the impacts of COVID-19 response measures and found: unemployment increased approx. 5% due to COVID-19, almost 1 in 3 lost income, almost 1 in 5 lost more than half or all of their income, and of those living with a mental health issue approx. 4 in 5 reported feeling more lonely due to COVID-19 restrictions[59].

We welcome the recommendation by the Royal Commission into Victoria's mental health system to provide recurrent funding to Switchboard Victoria to deliver its Rainbow Door program, at scale, to support people who identify as LGBTQI to navigate and access the mental health and wellbeing system[60]. Peer-led organisations are best placed to deliver tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience.

It is positive to see recommendations in Victoria for ongoing funding investment in community-controlled LGBTIQ+ mental health services to address the barriers faced in accessing healthcare services, however, we need national investment in LGBTIQ suicide prevention and coordination to ensure that every LGBTQI Australian receives the support they need.

In order to effectively respond and reduce suicides among LGBTQI populations in Australia, we need access to accurate and reliable data through inclusion in the Census to be able to fund targeted suicide prevention service delivery to LGBTQI communities, adoption of standardized sexuality and gender indicators across health datasets, and appropriate reporting on LGBTQI deaths by suicide in coronial settings. The need for enhanced suicide-related data collection on LGBTQI communities is identified as a priority action by the National Suicide Prevention Taskforce[61].

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[56] Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis, Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health & Society, La Trobe University & Lifeline Australia.
[57] Carman, M., Bourne, A. & Fairchild, J. (2020). COVID-19: impacts for LGBTIQ communities and implications for services, A research briefing paper, *Rainbow Health Victoria*, available online: https://rainbowhealthvic.org.au/media/pages/research-resources/research-briefing-paper-covid-19-impacts-for-lgbtiq-communities-and-implications-for-services/817379592-1605661769/rainbow-health-victoria-research-briefing-paper-covid-19.pdf.
[58] Zwickl, S., Angus, L.M., Wong Fang Qi, A., Ginger, A., Eshin, K., Cook, T., Leemaqz, S.Y., Dowers, J.D. & Cheung, A.S. (2021). The impact of the first three months of the COVID-19 pandemic on the Australian trans community, *International Journal of Transgender Health*, available online: https://doi.org/10.1080/26895269.2021.1890659.
[59] Equality Australia.(2020). Inequality Magnified: Submission to the Australian Senate Inquiry into Australia's response to COVID-19, available online: https://equalityaustralia.org.au/wp-content/uploads/2020/06/Magnifying-Inequality-Submission-to-Senate-COVID19-Inquiry-1.pdf.
[60] Royal Commission into Victoria's mental health system. (2021). Victoria, available online: https://finalreport.rcvmhs.vic.gov.au/download-report/.
[61] Ibid.

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

Recommendation: Establish national architecture to coordinate LGBTQI health, coordinate funding for peer-led community-controlled organisations, identify disparities at the national level and research into LGBTQI suicide, and coordinate national health responses for LGBTQI Australians.

Recommendation: Provide population-level data and accurate recording of deaths by suicide through counting LGBTQI people in the Census, and improving data collection by coroners to inform policy, service, and program development.

4.4 People from Culturally and Linguistically Diverse (CALD) backgrounds

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

The Federation of Ethnic Communities' Councils of Australia (FECCA) reported the impact of the COVID-19 pandemic on people from CALD backgrounds and communities to include: increases in racial discrimination towards Asian Australians during the COVID-19 pandemic, issues in health messaging translation, low technology literacy affecting ability to participate in society, distance from family taking a toll on mental health and wellbeing, and a lack of available appropriate mental health support[62]. The Royal Australian College of General Practitioners (RACGP) reported CALD patients aren't accessing healthcare due to fear of contracting COVID-19, an increase in experiences of isolation and loneliness, and feeling distress due to unemployment[63].

We recommend funding the co-design of culturally appropriate mental health services and suicide prevention programs, which would be co-designed from the conceptualisation of services and include a structural redesign of programs tailored for CALD communities, and not just an adaptation of existing programs or services.

This structural redesign would need to address the following issues:

- Co-design is integral to the whole process including right through to evaluation.
- Designing for different priority groups within the CALD communities due to their higher risk of suicide including: men, refugee communities who have experience trauma, recent migrants, women (perinatal period), women experiencing domestic violence, young people, long-standing CALD communities.
- Taking services to where people are, and providing services and programs outside of health, or community services.

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[62] FECCA. (2020). FECCA submission regarding COVID-19, available online: https://fecca.org.au/wp-content/uploads/2020/06/FECCA-Submission-for-Senate-Inquiry-into-COVID-19-2020.pdf.
[63] Tsirtsakis, A. (2020). Fears CALD patients avoiding healthcare during pandemic, *RACGP*, available online: https://www1.racgp.org.au/newsgp/clinical/fears-cald-patients-avoiding-healthcare-during-pan.

- Specific funding for the integration of cultural responsiveness and trauma-informed approaches in the planning, delivery, and evaluation of suicide prevention services for CALD communities. This would include an organisational plan and funding for government and NGO service providers would be linked to specific KPIs on improving their cultural responsiveness, education and training practices.

Improved data collection for CALD communities is further needed and is identified as a priority action in the National Suicide Prevention Taskforce Interim Report[64]. Collection of ethnicity information (rather than country of origin) within existing suicide registers and administrative datasets (e.g. hospital admission, primary health, allied health) would inform an understanding of suicide in CALD communities, as per recommendations from If We Don't Count it, it Doesn't Count.[65] A National Minimum Dataset for CALD communities inclusive of mental health, suicide and self-harm data would provide a more comprehensive picture of service access and gaps.

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

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

5. Responding to future disasters

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

The Federal government recently recognized the need to respond to disasters with funding for mental health support when the Department of Health announced funding for the 2019-2020 bushfires of $76 million. This funding was to provide immediate counselling, ongoing emotional and wellbeing support to communities, expanding telehealth sessions, funding for Headspace and funding for local mental health services[66].

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

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[64] Ibid.

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

[66] Department of Health. (2020). Australian Government Mental Health Response to Bushfire Trauma, Jan 2020, available online: https://www.health.gov.au/health-topics/emergency-health-management/bushfire-information-andsupport/australian-government-mental-health-response-to-bushfire-trauma.

Research into the impact of disasters shows that providing immediate one-off counselling sessions or debriefing is not effective and may even be harmful[67], however mental first aid training for first responders is beneficial. In the immediate aftermath of a disaster it is important that people are not exposed to additional sources of stress, i.e. their immediate needs for shelter, safety and social connection are met.

Research also shows that serious mental illness, suicidal ideation and making plans for suicide increases as a result of natural disasters[68]. There is evidence that mental illness and suicide rates increase over time after a disaster, with suicide rates reaching the highest level up to two years after the initial disaster[69].

We support recommendation 2.4 'ensuring all responses to national disasters and other declared emergencies, including the COVID-19 response, include strategies that address risk and protective factors for suicide' in the National Suicide Prevention Taskforce Interim Report[70].

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

6. Valuing Lived Experience

6.1 A human-centred approach

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[71]. A key mechanism for ensuring Government funded programs and services meet the needs of consumers is to take a co-design, human-centred approach.

We support recommendation 5.3 in the National Suicide Prevention Taskforce Interim Report to 'build the lived experience and peer workforce to help break down stigma and provide person-centred supports' and integrate lived experience knowledge and expertise and peer support models into suicide policy approaches[72].

We recommend a human-centred approach to service and program prioritization across the suicide prevention sector. 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. This would need to take place with people with lived experience (and their

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[67] Rose, S., Bisson, J., Churchill, R. & Wessely, S. (2002). Psychological debriefing for preventing post-traumatic stress disorder (PTSD), *Cochrane Database of Systematic Reviews*, Issue 2.
[68] Kessler, R., C., Galea, S., Gruber, M.J., Sampson, N.A., Ursano, R.J., & Wessely, S. (2008). Trends in mental illness and suicidality after Hurricane Katrina, *Molecular psychiatry*, 13(4), 374–384.
[69] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, *The Journal of Crisis Intervention and Suicide Prevention*.
[70] Ibid.
[71] Ibid.
[72] Ibid.

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[73].

Investment in a human-centred approach 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[74]. 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[75].

Research conducted by KPMG, commissioned through the National Suicide Prevention Research Fund, managed by Suicide Prevention Australia, maps the journey of people who have attempted suicide, and their continued journey post-attempt. A Human Centred Design methodology was used which places the person with lived experience of suicide at the centre.[76]

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.

Recommendation: Use a human-centred design approach, that takes into account consumer insights, to ensure that the design and delivery of future services enhances consumer participation and service effectiveness.

6.2 Peer workforce

Wherever possible, dedicated peer worker roles should be established in suicide prevention (distinct from the mental health lived experience workforce). Peer workers should also be available to families and carers who are either supporting someone experiencing suicidality or are bereaved by suicide. We support the recommendations made in the National Suicide Prevention Advisor's Interim Report to build the lived experience and peer workforce to help break down stigma and provide person-centred supports[77].

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[73] Roses in the Ocean. (2020). Lived experience of suicide, *Roses in the Ocean,* available online: https://rosesintheocean.com.au/lived-experience-suicide/.
[74] Altman, M.M., Huang, T.T. & Breland, J.Y. (2018). Design Thinking in Health Care, *Preventing Chronic Disease.*
[75] Vechakul. (2015). Human-Centered Design as an Approach for Place-Based Innovation in Public Health: A Case Study from Oakland, California, *Maternal Child Health Journal,* 2552–2559.
[76] Suicide Prevention Austyralia (2021) Leading with empathy: Embedding the voice of lived experience in future service design, available online https://www.suicidepreventionaust.org/wp-content/uploads/2020/12/Leading-with-empathy-final-report.pdf
[77] Vechakul. (2015). Human-Centered Design as an Approach for Place-Based Innovation in Public Health: A Case Study from Oakland, California, *Maternal Child Health Journal,* 2552–2559.

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[78].

This 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. Drawing from the MATES in Construction model, 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.

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. The most common form of suicide postvention support is peer support groups and receiving support from others bereaved by suicide[79]. There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[80] Postvention supports also mitigate adverse impacts including the risk of a bereaved person engaging in suicidal behaviour. People who are bereaved by suicide are themselves at elevated risk of suicide, particularly if they have a history of prior trauma, suicidal behaviour or depression.[81]

The Victorian Royal Commission into mental health included a focus on the importance of peer worker roles in suicide prevention and called for dedicated peer worker roles to be established for families and others involved in supporting people experiencing suicidality[82].

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. Peer workers with lived experience of suicide should be equipped to work in close partnership with clinicians and the 'formal' suicide prevention workforce.

Recommendation: Ensure that suicide prevention workforce strategy and planning includes a focus on integrating peer workers.

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

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

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

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

[82] Ibid.