Suicide Prevention Australia

South Australian Suicide Prevention Plan Submission

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Introduction

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, and we advocate on behalf of our members for better policy in the sector.

We recognize that reducing the number of suicides in South Australia is a priority for the government, and that the SA government have taken concrete steps towards developing and implementing some of the best practice for suicide prevention within Australia.

Suicide Prevention Australia welcomes the opportunity to provide input on the development of the new Suicide Prevention Plan. Our advice is based on our members input on what is needed for effective suicide prevention. We believe the plan should incorporate the following focus areas and interventions:

- Whole of government approach;
- Strategies to respond to early distress;
- Workforce strategy;
- Targeted support for vulnerable groups;
- Response to suicidal distress and behaviours;
- Increase support for those bereaved by suicide;
- Improved data;

Summary of Recommendations

Whole of Government	• SA's Suicide Prevention Plan should include an integrated approach encompassing mental health, social, economic and community factors • The Suicide Prevention Plan should align with the proposed Suicide Prevention Act • The Suicide Prevention Plan should facilitate the use of a mechanism for allocating funding to suicide prevention programs that are high quality and effective
Strategies to respond to early distress	• Evaluate the results of the National Suicide Prevention Trial sites and expand the trial to beyond Country SA • Cultural adaptation and a strong commitment to ongoing evaluation and refinement of the trials for Aboriginal and Torres Strait Islander communities, in line with evidence-based recommendation • Consider using the evidence-based Distress Brief Intervention model from Scotland
Workforce Strategy	• Include in the plan the development of a specific suicide prevention workforce strategy which includes the clinical, lived experience, and formal and informal suicide prevention workforce • Develop an industry-specific peer workforce which works with high-risk industries such as construction • Train community connectors or 'gatekeepers' in suicide prevention training such as emergency services workers, GPs, and pharmacists
Targeted Support for Vulnerable Groups:	• Continue to prioritise male, Aboriginal and Torres Strait Islander, and youth suicide prevention, through the National Suicide Prevention Trials in Country SA
Male suicide	• Create a diverse range of services that facilitate community connections for men provided at scale, which should include peer to peer, and workplace programs
People from LBTQI+ communities	• Fund peer-led community-controlled organisations to develop tailored mental health and suicide prevention initiatives, services, and programs to build community capacity and resilience, and overcome barriers LGBTQI people face accessing healthcare services
Aboriginal and Torres Strait Islander people	• Use the renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan, led by Gayaa Dhuwi, as a model for the SA's Aboriginal & Torres Strait Islander actions in the plan • Include in the Plan funded programs to meet the 2020 Closing the Gap targets for SA • Support the expansion of Aboriginal Controlled Community Organisations to provide culturally safe, culturally competent consumer crisis support and aftercare services
People from Culturally and Linguistically Diverse backgrounds	• Fund the co-design of culturally appropriate mental health services and suicide prevention programs, which would be jointly implemented by CALD community organisations to address stigma, target vulnerable groups and increase utilisation of mental health and suicide prevention services in CALD communities.
Young People	• Adopt a life-cycle approach to suicide prevention and include preventative policies for key points in a child and adolescent's development
Response to suicidal distress & behaviours	• Improve and expand the aftercare programs beyond Country SA PHN, to include Adelaide PHN
Increase support for those bereaved by suicide	• Continue to fund services for those bereaved by suicide in Country SA regions and expand it to urban areas
Improved data	• We recommend the Strategic Plan should support the register by setting out how it will be developed to collect information and statistics in relation to suicide deaths but also suicide attempts

Whole of Government Approach

South Australia needs a whole-of-government approach, which should be a central component of any new suicide prevention plan.

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

SA's Suicide Prevention Plan should include an integrated approach encompassing mental health, social, economic and community factors. Recent evidence in Australia showed increases in suicide rates in areas of low socioeconomic areas and decreases in areas of high socioeconomic areas.[2,3] Suicide prevention should address the social determinants of health which can lead to suicide – and this extends beyond the health portfolio.

Key to a whole of government approach is a suicide prevention act which includes a requirement for prescribed state authorities to develop their own suicide prevention plans and report on them annually. We hope this will include both health and non-health portfolios that have an influence over suicide prevention included in the plan, which was one of the key recommendations made in the Productivity Commission's final report. [4] Any strategic plan should provide a platform for joint service planning and/or mapping across jurisdiction for suicide prevention, which is also aligned with the Suicide Prevention Bill.

Also critical in a whole of government approach is assuring the safety, quality and efficacy of Australia's suicide prevention programs. 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.[5] The Fifth Plan also recognises the importance of standards to assuring services and programs are safe, quality and outcomes-based. Importantly, the suicide prevention standards provide a level of confidence for the community, that programs are a high-quality and provide a consistent standard of care to the people they're designed to help.

The Suicide Prevention Plan should facilitate the use of a 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. This would include:

- 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

[1] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention. Canberra; August 2020, p 8.
[2] Too LS, et al., Widening socioeconomic inequalities in Australian suicide, despite recent declines in suicide rates. Soc Psychiatry Psychiatr Epidemiol. 2018;53(9):969-976.
[3] Shand, F., Yip, D. & Darwin, T. (2020). The impact of social determinants on suicide and how policy settings can help, *Black Dog Institute*.
[4] Ibid.
[5] Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Commonwealth of Australia.

Strategies to Respond to Early Distress

As part of SA's Suicide Prevention Plan we urge the SA Health to use the results from the National Suicide Prevention Trial in Country SA PHN sites such Whyalla, Port Augusta, Port Pirie, Port Lincoln and the Yorke Peninsula, as a basis for the new plan. We urge SA Health to determine whether and how to develop and tailor the roll-out of this National Suicide Prevention program in other locations, as part of the SA Suicide Prevention Plan. Given that these are regionally-based programs which have been adapted to respond to local needs, any evaluation should consider how they respond to local needs. It is also noted that the trials in Country SA PHN adopted BlackDog's LifeSpan model, using a systems-based approach, which is evidenced-based.[6] It is also to be commended that the trials have targeted three at risk groups:

- Young people aged 12-24 years
- Adult males
- Aboriginal Torres Strait Islanders.

However as the Centre for Best Practice in Suicide Prevention points out much of the evidence informing the LifeSpan model remains untested in Indigenous settings.[7] Therefor the LifeSpan model is likely to require cultural adaptation and a strong commitment to ongoing evaluation and refinement during the initial implementation stage to ensure it responds effectively to community need. Further, additional elements and/or recommended interventions may be required to meet the different suicide prevention needs of particular Indigenous communities. SA Health should consider the significant evidence on the components of effective models of suicide prevention for Aboriginal and Torres Strait Islander communities in the Solutions That Work report produced by Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.[8]

Other Early Distress Models

As part of the SA Suicide Prevention Plan, SA's Wellbeing Department should consider using the Scottish Distress Brief Intervention model, which embeds an early distress intervention across government services and agencies, and aims to provide people with access to immediate support at times of acute distress, followed up with care coordination that links them to ongoing supports within 24 hours.[9] This is in line with recommendations from the Suicide Prevention Advisor's final report.[10]

Any early distress model, should consider developing, implementing and evaluating a scalable early distress intervention for people experiencing:

- intimate relationship distress (for both people experiencing family violence, as well as those experiencing relationship breakdowns)
- employment or workplace distress;
- financial distress; and
- isolation and loneliness.

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[6] https://www.countrysaphn.com.au/about-us/primary-mental-health-care/suicide-prevention-services-3/national-suicide-prevention-trial/

[7] Dudgeon, P., 2019 A Guide for Primary Health Networks. Published by Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Accessed at: https://cbpatsisp.com.au/clearing-house/policy-frameworks/part-2-systems-based-approaches-to-suicide-prevention/

[8] Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. 2016 Solutions that Work: What the Evidence and Our People Tell Us. School of Indigenous Studies University of Western Australia

[9] Distress Brief Intervention. Distress Brief Intervention. DBI Scotland; n.d. Available at: https://www.dbi.scot/

[10] Australian Government December 2021 National Suicide Prevention Adviser-Final Advice Connected and Compassionate report. Released April 2021. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf

Workforce Strategy

Developing a specific suicide prevention workforce strategy should be part of SA's new Suicide Prevention Plan; within which every member of the suicide prevention workforce is trained in recognising and responding to the signs of suicide risk, with differing levels of competency.[11]

The Strategy would address current and future needs of:

- The clinical workforce, encompassing doctors, nurses, and allied health professionals who interface with individuals at risk of suicide and in suicidal crisis
- The lived experience and peer support workforce in suicide prevention (distinct from the mental health lived experience workforce)
- The formal suicide prevention and mental health workforce, encompassing those explicitly working in a suicide prevention, response, crisis support or postvention setting: for example, emergency first responders, the peer lived experience workforce, postvention workforce, counsellors, social workers, and other mental health workers
- The informal suicide prevention workforce, which includes personnel from across Government Departments, social services, employer groups, miscellaneous service providers, community-based organisations and other settings where individuals at risk of suicide are likely to present

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

Peer Lived Experience Workforce

Placing people with lived experience of suicide at the centre of service delivery recognises that they bring unique insights and the capacity to understand the best way to support peers in distress.

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.[12] The peer workforce in the suicide prevention, intervention and postvention contexts has two major roles: recognising when someone may be at risk of suicide, and directing them to support; and supporting people recovering from suicidal behaviour or people bereaved by suicide.[13]

In line with recommendations from the National Suicide Prevention Advisor's final report[14] we share the view that particular priority should be placed on adequately resourcing the lived experience of suicide prevention peer workforce. This should include specific recognition of state-based peer workforce frameworks; and the development of professional development initiatives in partnership with lived experience organisations.

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[11] Labouliere CD, Vasan P, Kramer A, Brown G, Green K, Rahman M, Kammer J, Finnerty M, Stanley B. "Zero Suicide" - A model for reducing suicide in United States behavioral healthcare. Suicidologi. 2018;23(1):22-30. PMID: 29970972; PMCID: PMC6022755.

[12] Roses in the Ocean. 2020. "Lived experience of suicide." *Roses in the Ocean.* Accessed January 22, 2020. https://rosesintheocean.com.au/lived-experience-suicide/.

[13] Salvatore, T. 2010. "Peer specialists can prevent suicides: properly trained peers play a vital role in regional suicide prevention effort." *Behavioral Healthcare* 31-42.

[14] Australian Government December 2021 National Suicide Prevention Adviser-Final Advice Connected and Compassionate report. Released April 2021. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf

Incremental Strategies to Strengthen the Workforce

We recommend investment in two incremental strategies to bolster the suicide prevention non-health based workforce, as part of SA's Suicide Prevention Plan, in the short to medium term:

Industry-specific peer support: We believe there is an opportunity for the South-Australian 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 reduction in the suicide rate for construction workers in Queensland. [15]We call on the government to continue funding the roll-out of this program in SA, and to use this model to support 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.

Training community connectors or 'gatekeepers' Equipping touchpoints or 'gatekeepers' with suicide prevention training is another possible intervention for reducing suicide rates. A systematic review of gatekeeper training outcomes in the United States of America found that if gatekeepers in formal settings were trained they had developed knowledge, skills and referral skills; and larger studies involving physicians and military personnel reported that suicidal behaviours, ideation and attempts were reduced, at least in the medium term, however there needed to be more evaluation of long-term impacts.[16] Orygen's analysis of international trials of gatekeeper training outcomes for young people reported improvements in knowledge, and possible mental health literacy, while noting the need for longer-term evaluations to measure length of training required, and to include population-based outcomes such as reductions in suicidal behaviours.[17] The training provided should, however, be locally specific; and co-designed with the specific population; and should prioritise key touchpoints within the community for the local population, in addition to those within the health system (for example, GPs and pharmacists), and any evaluation should monitor referral pathways, and improvements in referrals.

Targeted Support for Vulnerable Groups

We strongly endorse SA's implementation of the National Suicide Prevention Trials which have targeted three high-risk groups: young people, males and Aboriginal and Torres Strait Islanders. In addition to the prioritizing these three groups in the community prevention trials, we call on the South Australian government to address the needs of all priority groups – in particular men at risk of suicide, LGBTQI+ communities, Aboriginal and Torres Strait Islanders, people from Culturally and Linguistically Diverse (CALD) backgrounds, and young people - in all their suicide prevention strategies and programs.

Male Suicide

Suicide Prevention Australia commends SA Health's targeting of men as a priority group as part of National Suicide Prevention Trials across Country SA PHN. It also recommends SA Health develop targeted strategies to address

[15] Milner, A., King, T., Scovelle, A. *et al.* A blended face-to-face and smartphone intervention for suicide prevention in the construction industry: protocol for a randomized controlled trial with MATES in Construction. *BMC Psychiatry* **19,** 146 (2019). https://doi.org/10.1186/s12888-019-2142-3

[16] Mann, J., Apter, A., Bertolote, J.,et al. 2005 Suicide Prevention Strategies: A Systematic Review. JAMA.;294(16):2064-2074 http://jama.ama-assn.org/cgi/content/full/294/16/2064

[17] Orygen 2019 Does Gatekeeper Training Prevent Suicide in Young People? Research Bulletin no 6. Accessed at: https://www.orygen.org.au/Research/Research-Areas/Suicide-Prevention/Orygen_Suicide_prevention_research_bulletin?ext=.

the rate of male suicide across the whole of the state, which is in line with recommendations from the Suicide Prevention Advisor's final report.[18]

Targeted services for males, particularly early distress-detecting and preventative programs are required for males, due to their low-levels of interaction with mental health services, and low health-seeking behaviours. According to the Queensland Suicide Register (QSR), while nearly two-thirds (63.6%) of women who take their own lives have been diagnosed with at least one psychiatric disorder, less than half of men (44.4%) who die by suicide have been diagnosed with a mental health disorder. Another study found 72% of males do not seek help if they are experiencing issues with mental ill-health.[19]

This demonstrates the need to strategically identify opportunities to intervene with men who may be vulnerable to suicide, but not interacting with the formal mental health or suicide prevention systems. Australia requires a more diverse range of services that facilitate community connections for men and these need to be provided at scale, funded and targeted to men at risk of distress. Emerging ideas and empirical evidence illustrate the characteristics of services which effectively engage with men and boys concerning their mental health and wellbeing. These include:

- Peer support for some men is preferable to professional support, possibly because of issues of trust and potential stigma in using mental health services considered antithetical to masculine norms.[20]

- Collaborative interventions involving action-oriented problem solving. Activity and social based interventions have achieved success for promoting and improving the mental health of older male participants in particular, including initiatives such as the Men's Shed's approach and gender specific social activities in residential care.[21]

- Workplace embedded peer support programs. Programs such as the Mates in Construction Program have successfully shifted suicidality in male dominated industries.[22]

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, and for this reason they should be a target group as part of SA's Suicide Prevention Plan. 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.[23] Elevated risk of suicidality experienced by LGBTQI+ people is strongly linked with their continuing experience of discrimination and exclusion. In addition,

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[18] Australian Government December 2021 National Suicide Prevention Adviser-Final Advice Connected and Compassionate report. Released April 2021. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf

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

[20] Robertson, S, A Gough, M Robinson, A Seims, G Raine, and E Hanna. n.d. *Promoting mental health and wellbeing with men and boys: what works?* Leeds: Centre for Men's Health.

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

[22] Milner, A., King, T., Scovelle, A. *et al.* A blended face-to-face and smartphone intervention for suicide prevention in the construction industry: protocol for a randomized controlled trial with MATES in Construction. *BMC Psychiatry* **19,** 146 (2019). https://doi.org/10.1186/s12888-019-2142-3

[23] National LGBTI Health Alliance. (2020). Snapshot of mental health and suicide prevention statistics for LGBTI people, available online: https://www.lgbtiqhealth.org.au/statistics.

the National Suicide Advisor's final report has also recommended that policies and programs should be developed to address LGBTQI+ people high risk for suicidality.[24]

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 most recent personal or mental health crises, many of whom reported concerns relating to experiencing discrimination or anticipated discrimination.[25]

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.[26] Homelessness, drug and alcohol misuse, and domestic and family violence are risk factors for suicide that can be exacerbated by COVID-19 response measures.

We recommend funding for SA community-controlled LGBTIQ+ mental health services to address the barriers faced in accessing healthcare services, and to support people who identify as LGBTQI+ to navigate and access the mental health and wellbeing system, as is currently being provided to Victorian LGBTQI+ organisation Switchboard.[27] Peer-led organisations are best placed to deliver tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience.

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander have suicide rates twice that of non-indigenous people. We recommend that the SA government provide funding funding at the state level for National Aboriginal and Torres Strait Islander Suicide Prevention Strategy from 2021, implementing Indigenous leadership and governance, place-based initiatives and building on workforce and community strengths as per recommendations in the National Suicide Prevention Adviser's final report.[28] We also recommend that SA Health use the 2021 strategy as the basis for SA's Aboriginal and Torres Strait Islander actions in the suicide prevention plan, and that these would particularly provide services to remote Aboriginal and Torres Strait Islander communities.

We also call on the South Australia Government to provide sufficient funding so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement,[29] because reductions in the crisis-level suicide rates in Aboriginal and Torres Strait Islander Australians, are dependent upon improvements in Aboriginal rights and wellbeing across education, justice, access to land and water resources, and strengthening links to culture.

We support the National Suicide Prevention Adviser's view that Aboriginal and Torres Strait Islander Controlled Health Organisations are ideally placed to become preferred suicide prevention providers to their own

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[24] Australian Government December 2021 National Suicide Prevention Adviser-Final Advice Connected and Compassionate report. Released April 2021. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf

[25] 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.

[26] 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.

[27] Royal Commission into Victoria's mental health system. (2021). Victoria, available online: https://finalreport.rcvmhs.vic.gov.au/download-report/.

[28] Ibid.

[29] Commonwealth of Australia & Coalition of Aboriginal and Torres Strait Islander Peak Organisations (2020) National Agreement on Closing the Gap Report July 2020.

communities. Providing culturally safe, culturally competent consumer experience and continuity of care is especially important for crisis support services, as doing so can be life-saving.[30]

While Aboriginal Community Controlled Health Organisations play an important role in providing the Aboriginal community with access, however, Aboriginal and Torres Strait Islander organisations and workforces should be complemented by mainstream services and clinicians that are responsive to the needs of Aboriginal and Torres Strait Islander peoples.[31] This requires broader cultural competency training and the involvement of Aboriginal and Torres Strait Islander peer workers across mainstream clinical and non-clinical support services; and should form a component of aftercare services for Aboriginal and Torres Strait Islander peoples.

People from Culturally and Linguistically Diverse (CALD) Backgrounds

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

We recommend a number of approaches to overcome the low utilisation, stigma and inequity for people from culturally and linguistically diverse backgrounds:

- Use a co-design process, starting from the design of services through to the evaluation stage, to ensure cultural and linguistic diversity and responsiveness is integrated within all aspects of planning, delivery and evaluation of suicide prevention services. This would include:
- Co-design for high-risk sub-groups such as refugees, recent migrants, long-standing CALD communities.
- Include those with lived experience, such as carers and family support networks in CALD communities.
- Use a Whole of Government and cross-agency approach to suicide prevention by embedding a preventative approach through adequate settlement support to address acculturation stress associated with adjusting to adapting to a new life and culture.

- Develop a cultural responsive suicide prevention workforce strategy by:
- Investing in the education and training and implementing recruitment activities to attract multilingual and CALD employees at service, program design and policy levels;
- Service agreements and program guidelines to clearly describe cultural responsiveness service delivery expectations and standards as part of all funded government and non-government service.
- Develop a robust evidence base that provides population-level data and accurate recording of deaths by suicide of individuals from CALD communities and improving data collection by coroners to inform policy, service and program development.

Young People

Research shows that an adult's mental health and risk for suicidality is influenced by childhood experience, in particular adverse childhood events can increase suicide risk by 2-5 fold.[32] There is now extensive research

[30] Dudgeon, P, J Milroy, T Calma, Y Luxford, I Ring, R Walker, A Cox, G Georgatos, and Holla. 2016. Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, University of Western Australia.
[31] National Mental Health Commission. 2017. The Fifth National Mental Health and Suicide Prevention Plan. Report, National Mental Health Commission.
[32] Dube, S., Anda, R., Felitti V., Chapman, D., Williamson, D., Giles, W. 2001 Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study. *JAMA.*;286(24):3089–3096. Available online: https://jamanetwork.com/journals/jama/fullarticle/194504

showing that social, emotional and intellectual wellbeing in adulthood are strongly influenced during a child's first 2,000 days, that is from conception to the first five years of life.[33]

A growing concern is the mental health of our children and young people. The 2017 Youth Mental Health Report[34] found that one in four young people are at risk of serious mental illness. With an increasing number of Australian children suffering from mental health problems and high rates of youth suicide, we call on the South Australian government to adopt a life-cycle approach to suicide prevention and include preventative policies for key points in a child and adolescent's development. In accordance with the Suicide Prevention Advisor's final report's recommendations,[35] SA's Suicide Prevention Plan should include co-ordinated cross-jurisdictional and cross-portfolio action and programs to intervene early in life to:

- mitigate the impacts of adverse childhood experiences
- strengthen supports for families, by providing additional funding and resourcing for infant and maternal care, early childhood and the school programs to strengthen emotional wellbeing and using a suicide-prevention lens
- Provide early access to treatment, programs and support to children and young people

Response to Suicidal Distress and Behaviours

A suicide attempt is the strongest risk factor for subsequent suicide; the risk for suicide after an attempt is significantly elevated compared to the general population.[36]

Australia requires a robust, high quality, coordinated approach to improving the care of people after a suicide attempt. Evidence informs us that people who have been provided with appropriate aftercare after a suicide attempt are less likely to have a subsequent suicide attempt.[37,38]

In line with recommendations from the National Suicide Prevention Adviser, we call on the South Australian government to provide universal aftercare across the whole state. Aftercare services are an opportunity to provide every person who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours with access to aftercare support.

We acknowledge the significant investment that the SA Marshall government has provided for the Way Back aftercare program to be delivered through two major hospitals in Adelaide. We call on the South Australian Government to invest in expansion of the Way Back Support Service to rural and urban areas and ensure that every South Australian who has survived a suicide attempt or has presented to an emergency department with suicidal behaviours be proactively provided with aftercare support.

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[33] https://www.health.nsw.gov.au/kidsfamilies/programs/pages/transcript-first-2000-days.aspx
[34] Mission Australia & Blackdog Institute 2017 Youth Mental Health Report 2012-2016 Accessed at: https://www.missionaustralia.com.au/news-blog/blog/the-five-year-youth-mental-health-report-has-launched
[35] Australian Government December 2021 National Suicide Prevention Adviser-Final Advice Connected and Compassionate report. Released April 2021. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf
[36] Shand, F, A Woodward, K McGill, M Larsen, and M Torok. 2019. *Suicide aftercare services: an Evidence Check rapid review.* brokered by the Sax Institute for the NSW Ministry of Health.
[37] Hunt, I M, N Kapur, R Webb, J Robinson, J Burns, J Shaw, and L Appleby. 2008. "Suicide in recently discharged psychiatric patients: a case-control study." *Psychological Medicine* 39: 443-449.
[38] Stanley, B, G K Brown, L A Brenner, H C Galfalvy, G W Currier, K L Know, S R Chaudhury, A L Bush, and K L Green. 2018. "Comparison of the Safety Planning Intervention with follow-up vs usual care of suicidal patients treated in the emergency department." *JAMA Psychiatry* 75 (9): 894-900.

The follow-up or 'aftercare' provided to people who are known to have attempted suicide has historically been patchy. Our emergency departments and other acute care settings are overstretched, with demand for services often exceeding the resources available. This is a critical gap in care in view of the evidence, which informs us that the risk for suicide after an attempt is significantly elevated compared to the general population.[39] A national population-based case-control study in the UK found 43% of suicides occurred within a month of discharge; conversely, than people who were provided with appropriate care after an attempt were less likely to die by suicide[40].

A commitment to achieve universally available aftercare is already included in the Fifth Plan, and agreed to by all Australian Health Ministers.

In addition, as part of the SA Suicide Prevention Plan we recommend actions and programs which broaden alternatives to emergency department presentations: an action also included in the Fifth Plan.[41] The Suicide Prevention and Recovery Centre trial being developed by Independent Community Living Australia and Roses in the Ocean is an example of a co-designed, peer-led alternative to emergency department or psychiatric care.

Increase Support for those Bereaved by Suicide

Suicide Prevention Australia commends the South Australian government's funding for the StandBy Support After Suicide Service in Country SA regions. Providing support to families and communities impacted by suicide is crucial to lower the risk for suicidality and the incidence of suicide. Bereavement by suicide raises suicide risk by two to five times the rate of the general population.[42] Postvention support is an important method for addressing this risk, encouraging healing and reducing suicide contagion among those who have lost a loved one.[43]

We suggest that SA Health expand postvention support to the Adelaide region, in order to ensure thousands of Australians bereaved by suicide will have access to the care they need and will be a key contributor toward a zero suicide rate.

Improved Data

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. This includes accurately recording suicide and suicidal behaviour; and linking data on agreed risk factors for suicidal behaviour.[44] Access to consistent and accurate data enables state government's and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions.

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[39] Ibid.
[40] Hunt, I M, N Kapur, R Webb, J Robinson, J Burns, J Shaw, and L Appleby. 2008. "Suicide in recently discharged psychiatric patients: a case-control study." Psychological Medicine 39: 443-449.
[41] National Mental Health Commission 2019 Fifth National Mental Health and Suicide Prevention Plan. Accessed at: https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/fifth-plan/5th-national-mental-health-and-suicide-prevention
[42] World Health Organisation. 2018. *National suicide prevention strategies: progress, examples and indicators.* Geneva: World Health Organisation. https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/.
[43] Laux, J. 2002. A primer on suicidology: Implications for counselors. *Journal of Counseling & Development, 80,* 380–384. doi:10.1002/j.1556-6678.2002.tb00203.x.
[44] Productivity Commission. (2019). Draft Report of the Productivity Commission Inquiry into the Mental Health System, available at <https://www.pc.gov.au/inquiries/completed/mental-health#report>.

We endorse the establishment of a South Australian state suicide deaths register prescribed within the draft Suicide Prevention bill. Access to accurate population-level data on suicidality and suicidal behaviour from state suicide registers, 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. The lack of standardised nomenclature of suicide attempts and self-harm behaviours in emergency datasets across jurisdictions can cause issues in collecting accurate, timely data.[45,46] The Register could ultimately assist South Australia in developing future strategies, inform local consideration of means restriction interventions, and allocation of funding could be prioritised based on real time data, local needs, and risk.

We recommend the Strategic Plan should support the register by setting out how it will be developed to collect information and statistics in relation to suicide deaths but also suicide attempts.

Research into the impact of disasters shows that providing immediate one-off counselling sessions or debriefing is not effective and may even be harmful,[47] 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.[48] 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.[49]

[45] Sveticic, J., Strapelberg, NCJ. & Turner, K. (2020). Suicidal and self-harm presentations to emergency departments: The challenges of identification through diagnostic codes and presenting complaints, *Health Information Management Journal,* 49(1).
[46] Hedegaard, H., Schoenbaum, M., Claassen, C., Crosby, A., Holland, K. & Proescholdbell, S. (2018). Issues in developing a surveillance case definition for nonfatal suicide attempt and intentional self-harm using international classification of diseases, *National Health Statistics Report* 108.
[47] 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.
[48] 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.
[49] 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***.**