Suicide Prevention Australia

2022 Pre-Budget Submission

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Introduction

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 300 members, we represent the largest, and many of the smallest organisations working in suicide prevention. Suicide Prevention Australia supports and strengthens the services of our members, is an information channel connecting the sector and the voice of lived experience to government, as well as providing leadership, policy services, and research support to the suicide prevention sector.

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

While Australia has not reported increases in suicide rates during the COVID-19 pandemic, other measures of distress, self-harm and suicide attempts demonstrate ongoing suicide risks in the community. As we emerge from the pandemic and compounding natural disasters, research shows suicide rates can peak 2-3 years after a crisis. Accordingly, this Budget is handed down at a critical juncture.

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

This submission covers the following priority areas:

1. Whole of government approach
2. Lived experience
3. Data & evidence
4. Quality, Workforce and Workplace
5. Early intervention and prevention
    - 5.1 Aftercare
    - 5.2 Postvention
    - 5.3 Support after a suicide attempt or suicidal distress
    - 5.4 Safe Spaces
    - 5.5 Regional Response Measures
6. Vulnerable population groups
    - 6.1 Survivors of suicide attempts
    - 6.2 Youth Suicide
    - 6.3 Aboriginal and Torres Strait Islander Peoples

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

Together, we can achieve a world without suicide.

For more information

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Summary of Recommendations

Priority Area	Recommendations	Costing (where available)
1. Whole of government approach	1.1 A *Suicide Prevention Act* should be implemented to legislate a whole-of-government approach including a national suicide prevention plan, cross-agency accountability and governance arrangements including lived experience 1.2 The proposed Wellbeing Budget include measure of suicide, distress and a range of risk and protective factors.	$0.9 million over one year to enable consultation and drafting of the Act (including $300,000 for consultation on Act)
2. Lived experience	2.1 Fully fund implementation of the recommendations of the Final Advice of the National Suicide Prevention Advisor to ensure people with lived experience are integrated in all aspects of suicide prevention policy development, design, delivery, research and evaluation. This includes integrating lived experience leadership, knowledge and insights into the design, delivery and evaluation of any 2022 Budget measures related to suicide prevention. 2.2 A National Workforce Strategy for Suicide Prevention should include key priorities and investment for growing, supporting and sustaining the suicide prevention lived experience and peer workforce.	$1.9 million over three years for the development of strategy, significant additional funding will be required to implement the strategy million over three years plus implementation funding.
3. Data & evidence	3.1 Government commit $4 million over four years to build capability in suicide prevention sector to access, interpret and use increasing amounts of suicide prevention data.	$4 million over four years.
4. Quality, Workforce and Community	4.1 National Office develop a suicide prevention workforce strategy and implementation plan that is fully-funded and provides long-term vision and strategy for workforce and specific actions to ensure capability, skills, supply, retention and sustainability across the sector and is integrated appropriately with other related sectors and strategies under development.	$1.9 million over three years plus implementation funding.
	4.2 Fund the extension of the Quality Improvement Program into a fully-fledged sector led accreditation system.	$1.8 million over three years.

	4.3 To support efforts to build capacity on responding to suicide risk, Government should fund an Online Suicide Prevention Learning Platform that builds the suicide prevention capability of diverse sectors across the social determinants of suicide.	$250,000 over one year to extend trial $1 million for consultation and implementation.
5. Early intervention and additional support	**5.1 Aftercare** 5.1.1 Fund the Government's election commitment to aftercare services in South Australia. 5.1.2 Provide additional funding to development a peer work element as part of the universal aftercare system.	$18.7 million investment commitment in addition to existing $158.6 million Commonwealth commitment to aftercare funding
	5.2 Postvention 5.2 Fund the Government's election commitment to increase postvention services in South Australia and ensure equitable national coverage for all people bereaved by suicide in Australia.	$13.7 million investment commitment in addition to existing $22 million Commonwealth commitment to postvention funding
	5.3 Support after a suicide attempt or suicidal distress 5.3 Invest in national support for those whose loved ones attempt suicide or are impacted by suicidal distress.	$8.7 million over three years
	5.4 Safe Spaces 5.4 The Commonwealth Government finalise the development of national standards for Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking and progress national coordination to support a network of Safe Spaces.	$500,000 over one year
	5.5 Regional Response Measures 5.5 The Commonwealth Government double funding for the Regional Response Suicide Prevention measures, include funding to embed accreditation into commissioning and extend the funding from a two to four year period.	$43.2 million
	6.1 Survivors of suicide attempts	$320,000 over three years

6. Vulnerable population groups	6.1 The Commonwealth Government provide funding for a national network for people who have survived a suicide attempt.	
	6.2 Youth 6.2.1 Commonwealth to prioritise investment in youth-specific early intervention strategies, with particular priority on programs and services that are co-designed with young people. This should include suicide prevention training for those who work directly with young people and in 'gatekeeper roles'. 6.2.2 Commonwealth to invest in ensuring that support services are equipped to respond to the needs of young people in suicidal crisis, by having services informed by co-design with young people and research evidence on how best to address suicide risks in young people.	Funding requirement to be confirmed in co-design process.
	6.3 Aboriginal & Torres Strait Islander Peoples 6.3.1 Utilise an equity and needs-based approach to fund targeted, specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities will address these gaps to access, as the majority of Aboriginal people (63%) live outside major urban areas. 6.3.2 Utilise an equity and needs-based approach to fund Aboriginal Community Controlled Health Organisations to provide the Aboriginal community with suicide prevention, postvention and aftercare programs, as well as funding for COVID mental health initiatives. 6.3.3 Allocate sufficient funding with an equity and needs-based approach so that all the Federal government targets will be met under the recently signed 2020 Closing the Gap agreement, recognise and promote the importance of Aboriginal and Torres Strait Islander leadership by supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. 6.3.4 Invest in youth suicide prevention by enhancing mental health and wellbeing support for Aboriginal and Torres Strait Islander children who are in care of the state/territory. 6.3.5 Allocate funding to ensure commitment to cultural competency and inclusion of Aboriginal and Torres Strait Islander peoples is achieved by all mainstream mental health and suicide prevention services.	Apply an equity and needs-based formula to existing expenditure with increased funding committed as required and in line with the upcoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. $75.2 million over four years. $7.7 million over three years.

	6.4 Males 6.4.1 The Commonwealth Government should fund the creation and implementation of a national male suicide prevention strategy that is co-designed with those with lived experience and with support providers, and is informed by Research and Data. 6.4.2 Provide mechanisms to give resources to effective grassroots community supports, including proactively identifying and evaluating effective supports that could be enhanced by government funding. 6.4.3 Fund male-specific connector training to be available to people who regularly encounter men at risk of suicide. 6.4.4 Fund support providers to undertake collaboration and coordination activities, including relationship-building, coordinated case management and resource co-ordination at a sector level, with a focus on reducing drop-out rates for men from support services.	Funding requirement to be confirmed in co-design process.
	6.5 Culturally & Linguistically Diverse Communities 6.5.1 Government health systems should be augmented by funding a range of organisations within the CALD service delivery sector including those organisations that have links within specific CALD communities, with at this time a focus on the impact of COVID-19 pandemic.	$20 million over two years.
	6.6 LGBTQI 6.6.1 Establish national architecture to coordinate LGBTQI health through the appointment of a Senior Staff within the Health portfolio responsible for consolidating best practice standards, national data, identifying disparities at the national level, and coordinate national health responses including for mental health and suicide prevention. This work should be supported by a National LGBTQI Health Advisory Committee consisting of lived experience to provide advice on policy direction. 6.6.2 There should be greater investment in general and specialist community-controlled organisations to develop tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience. 6.6.3 Australia needs population-level data and accurate recording of deaths by suicide through improving data collection by coroners to inform policy, service program and development, and by counting LGBTQI people in the	$1.1 million over the forward estimates.

	Census. Data on LGBTQI deaths by a Senior Staff within the Health portfolio. 6.6.4 Fund a Principal Policy Analyst within the ABS to incorporate the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across data collection. 6.6.5 Fund investment for national research projects undertaken in LGBTQI suicide prevention and mental health. Specifically: ○ Allocate $600,000 over 3 years to La Trobe University to continue iterations of key research projects Writing Themselves In and Private Lives that provide critical data on LGBTI health. ○ Undertake an evaluation evidence check into LGBTQI suicide prevention programs in Australia. 6.6.6 There should be greater investment in the education and training of LGBTQI community control, mainstream healthcare and social services to build a workforce able to respond and meet the needs of LGBTIQ+ communities and other priority populations. This includes sector development toward a LGBTQI lived experience workforce.	$0.6 million over the forward estimates. $0.6 million over 3 years.
	6.7 Veterans 6.7.1 The Commonwealth Government should increase investment in supporting social connections for veterans through service navigation support, social prescribing and increased access to community bodies providing support.	
	6.8 Victim-survivors of historical child abuse 6.8.1 The Commonwealth Government should identify specialist services across Australia working with victim-survivors of historical childhood abuse. This should includes fund to provide wrap around services and programs including professionally facilitated peer support groups, individual planned support and peer support lines.	$25 million over 3 years
7. Strengthening protective factors	**7.1 Welfare Support** 7.1.1 Commonwealth Government to permanently increase the base rates of income support payments to adequate levels as outlined in the Raise the Rate campaign.	
	7.2 Strengthen social connection & reduce loneliness 7.2.1 Commonwealth Government to develop a national strategy to address loneliness and social isolation and	

	allocate responsibility for implementation to a senior minister. 7.2.1 Commonwealth Government to plan and deliver a national survey on loneliness and social isolation to provide a national dataset to enable targeted prevention and intervention.	
	7.3 Childhood trauma 8.3.1 Fund implementation of tailored programs focused on improving children's mental health and wellbeing based on the key characteristics of successful place-based approaches.	
	7.4 Housing Insecurity 8.4.1 Increase Commonwealth investment in housing affordability, social housing and homelessness services.	
	7.5 Disaster Planning **7.5.1 Recommendation:** Commonwealth budget annually in discretionary funds to respond to need for suicide prevention including addressing the social determinants of health that heighten risk factors for suicide in the event of future disasters or economic crises, such as bushfires, floods, epidemics for extended time periods after a disaster. These funds should be administered without delay through PHNs, Emergency Management Australia or other mechanisms as required to reach those in need. **7.5.2** Planning is undertaken to support helplines and online services respond to increasing demands when disasters strike. Additional budgeted discretionary funds should include additional resources for helplines that can be activated as required. **7.5.3** Commonwealth to join with State and Territory Governments fund research into population groups to identify at-risk groups vulnerable to disasters to enable development of evidence-based targeted responses which are tailored to diverse demographic, gender, and cultural needs.	$30 million $1.5 million.

1. Whole of Government Approach

1.1 Recommendation: A Suicide Prevention Act should be implemented to legislate a whole-of-government approach including a national suicide prevention plan, cross-agency accountability and governance arrangements including lived experience.

Cost: $0.9 million over three years (including $300,000 for consultation on Act). This cost is estimated by comparison to funding allocated to recent strategies with similar scope, such as the *National Injury Prevention Strategy*.

1.2 Recommendation: The proposed Wellbeing Budget include measure of suicide, distress and a range of risk and protective factors.

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

As noted in the Interim Report of the National Suicide Prevention Advisor: 'no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress'.[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. This includes consideration of suicide prevention in issues as diverse as housing, employment, and helping people to build healthy social connections.[2]

We welcome recent investments in suicide prevention and mental health as part of a new National Agreement and in consecutive Budgets. This commitment to whole-of-government suicide prevention should however be legislated. *Suicide Prevention Acts* have proven successful overseas in legislating whole-of-government prevention priorities. An Act is necessary to ensure decision-makers across Government are united in working to prevent suicides. Legislation can ensure clear shared and individual accountability and focus agencies on practical and measurable steps to reduce and prevent suicide.

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[1] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention. Canberra; August 2020, p 8. Accessed online at <https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/3.%20Interim%20Advice%20Report.pdf>.

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

Implementation of a *Suicide Prevention Act* should legislate a whole-of-government approach including a national suicide prevention plan, cross-agency accountability and governance arrangements including lived experience.

Suicide Prevention Australia also welcomes the Treasurer's proposed development of a Commonwealth Wellbeing Budget. This presents a once-in-a-generation Budgetary reform to support a whole-of-government focus on suicide prevention. The social determinants of health and wellbeing are strongly linked to the risk of suicide, for example:

- Domestic violence and childhood sexual abuse are the most common risk factor after mental illness
- 63% of suicide deaths have a history of alcohol and other drug usage
- 42% of those who die by suicide were under financial distress and 45% were unemployed
- Housing insecurity and homelessness are linked to higher rates of suicide
- Social isolation and loneliness ranked highest risk factor for suicide in 2022
- Relationship breakdown is a preceding life event for 1 in 4 suicide deaths.

The New Zealand Wellbeing Budget approach includes measures of suicide and associated risk and protective factors. The age-standardised suicide and the percentage of adults with high or very high levels of psychological distress are included. Other well-known risk and protective factors are also included such as housing affordability; food insecurity; education attendance; loneliness; environmental access; financial wellbeing; employment and family violence.

The proposal for Budget Statement Four to include wellbeing options must include a clear focus on suicide prevention. Any Commonwealth Wellbeing Budget should consider metrics for:

- Suicide deaths (e.g. age-standardised suicide deaths)
- Suicide attempts and distress (e.g. emergency department, ambulance call-out and severe distress rates)
- Risk and protective factors (e.g. alcohol and other drugs, housing, family and domestic violence, poverty, loneliness)

2. Lived Experience

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

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

Cost: $1.9 million over three years for the development of strategy, significant additional funding will be required to implement the strategy

Lived Experience Leadership

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

As outlined by the Prime Minister's National Suicide Prevention Advisor, 'positioning knowledge from lived experience at the forefront of research, policy and practice has the potential to richly communicate the complexities of suicidal behaviour and highlight key considerations for preventing suicide and better supporting people'.[3]

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

Suicide Prevention Lived Experience Workforce

The suicide prevention lived experience workforce include a broad range of roles including lived experience coordinators and directors, people with lived experience contributing to advisory, policy and program development processes and the peer workforce that provides direct support to people in crisis. The lived experience workforce is diverse and offers unique experience of suicidal behaviours including as survivors of suicide attempts, those bereaved by suicide or as carers.

The benefits of the lived experience workforce extend to people accessing services, families, social networks, organisations and the broader community. Lived experience within individual service settings can improve rates of engagement and retention in treatment, reduce critical incidents or need for restrictive practices, improve self-management, reduce the need for re-admission or acute care and improve staff retention, safety and wellbeing.

There are particular benefits in peer-led models for those that are hard-to-reach or most at-risk. Workers in the construction industry have, for example, benefited from the peer-led, industry-based MATES in Construction program: the delivery of which coincided with a 10 percent reduction in the suicide rate for construction workers in Queensland.[4]

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

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

[4] 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.

supports.[5] This is consistent with findings from the Royal Commission into Victoria's Mental health System, which 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.[6]

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

To fully embed lived experience leadership, knowledge and insights across suicide prevention, further planning and investment in workforce development will be required. This will ensure we can both grow the lived experience and peer workforce and put in place supporting structures to sustain and support that workforce. As part of a fully-funded National Suicide Prevention Workforce Strategy (see section 4), we recommend key priorities and investment is included to grow, support and sustain the suicide prevention lived experience workforce.

3. Data and Evidence

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

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. Access to consistent and accurate data enables Government and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions.

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

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

[5] 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.

[6] Ibid.

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

4. Quality, Workforce and Community

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

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

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

Cost: $1.8 million over three years.

Workforce

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

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

Quality

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

Embedding accreditation and standards into commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason Suicide Prevention Australia partnered with people with lived experience of suicide, consumers,

clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

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

Around 120 programs and services have registered for accreditation, including major organisations including Beyond Blue, Roses in the Ocean and Standby – Support After Suicide, and LivingWorks. More information about the standards can be found here: https://www.suicidepreventionaust.org/suicide-prevention-quality-improvement-program/. Accreditation standards should be embedded in commissioning processes for suicide prevention services in particular services commissioned by all levels of Government.

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

Community

People experiencing suicidal distress interact with workforces across diverse sectors. The first time a person discloses their distress or thoughts is a critical moment, so it is vital to build suicide prevention skills and knowledge across workforces.

Research highlights the need for targeted suicide prevention learning and development for workforces that intersect with the social determinants of suicide – alcohol and other drugs; housing; justice; child protection and out-of-home care services. For example, suicide was 4.9 times more likely for people who interact with the child protection system compared to people without a history of child protection or neglect.

However, evidence highlights the need for tailored suicide prevention learning and development for workforces in these systems. Research commissioned for the National Suicide Prevention Taskforce through the National Suicide Prevention Research Fund highlighted that in pilots of tailored learning and development there was an increase in participants' knowledge, preparedness, and self-efficacy and an increase in referrals to support services.

Suicide Prevention Australia has piloted an online suicide prevention learning platform. The learning platform, called The Learning Hub is an ongoing and supported learning-based program for individuals to identify learning needs, fulfil learning goals, and apply that learning to suicide prevention.

The program was created in collaboration with experts in suicide prevention and suicide prevention training and provides a place for individuals and organisations to identify and access a variety of learning options. A small investment would extend this pilot to create tailored online learning pathways for key sectors and provide access to around 5,000 people in workforces interacting with people at increased risk of suicidal behaviour.

The proposed initiative includes: development of a tailored online learning pathways that target the social determinants of suicide; extension of a National directory of learning resources and online learning events.

4.3 Recommendation: To support efforts to build capacity on responding to suicide risk, Government should fund an Online Suicide Prevention Learning Platform that builds the suicide prevention capability of diverse sectors across the social determinants of suicide.

Cost: $250,000 over one year to extend trial

5. Early intervention and additional support

5.1 Aftercare

5.1. Recommendation: Fund the Government's election commitment to aftercare and postvention in South Australia.

5.2. Recommendation: Provide additional funding to development a peer work element as part of the universal aftercare system.

Cost: $18.7 million investment commitment in addition to existing $158.6 million Commonwealth commitment to aftercare funding

A suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population:[7]

- Between 15 and 25% of people who make a non-fatal attempt at suicide will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[8]
- The relative risk for suicide after attempted suicide is between 20 to 40 times higher than in the general population.[9]
- The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'.[10]

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

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

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

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

However, around half of the people discharged from hospital following a non-fatal suicide attempt do not receive follow-up treatment.[11] Universal aftercare is urgently required to address this risk. The Commonwealth Government announced $158.6 million for universal aftercare services in the 2021 Budget, subject to State and Territory partnership in a new National Agreement on Mental Health and Suicide Prevention.

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

All States and Territories have now agreed with the Commonwealth progress universal aftercare commitments in bilateral agreements, except for South Australia. During the 2022 election campaign the Labor Party matched a $13.7 million commitment to expand access to vital suicide prevention services including aftercare.

It is critical that individuals with a lived experience of suicide attempts are central to the development and implementation of universal aftercare. Their voice and insights are essential to ensuring services can effectively support those at-risk. A collaboration between Roses in the Ocean, Beyond Blue and Wellways implemented a peer-based enhancement to the Way Back Service in Murrumbidgee. Results showed people who accessed the peer support available through the program were more likely to continue in the program and not drop out. Investment in the peer workforce for aftercare should be made alongside the development of the universal aftercare model and a dedicated Workforce Strategy.

5.2 Postvention

5.2 Recommendation: Fund the Government's election commitment to increase postvention services in South Australia and ensure equitable national coverage for all people bereaved by suicide in Australia

Cost: $13.7 million per annum in addition to existing $22 million funding commitment

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. Bereavement by suicide has been evidenced as a risk factor of subsequent suicidal behaviour, making postvention services an essential component of suicide prevention.[12]

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

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

An effective form of support is peer support groups, meeting with others bereaved by suicide.[13] There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[14] Other postvention services include tailored responses through direct compassionate, person-centered, trauma informed and coordinated local support services matched to individual needs, which can also include support from a peer companion, and outreach by trained support teams.[15] 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.[16]

Funding should be allocated to ensure postvention is available to those impacted by suicide have equitable access to postvention supports nationally. Bereavement by suicide raises suicide risk by two to five times the rate of the general population.[17] Postvention support is an important method for addressing this risk, encouraging healing and reducing suicide contagion among those who have lost a loved one.

Bilateral agreements with NSW, Queensland, Victorian and Northern Territory Governments include commitments to expand postvention services. During the 2022 election campaign the Labor Party matched a $13.7 million commitment to expand access to vital suicide prevention services including postvention. This commitment should be funded in the Budget and expanded to cover any gaps in postvention services in Tasmania, the ACT and Western Australia to ensure equitable access across Australia.

5.3 Support after a suicide attempt or suicidal distress

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

Cost: $8.7 million over three years

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

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[13] 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

[14] 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).

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

[16] Andriessen, K., Krysinska, K., Hill, N.T.M. et al. (2019). 'Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes'. BMC Psychiatry, 19, 49.

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

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

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

A potential model is *Stand Together*, a new national non-clinical program targeted at the families, friends and communities of people who experience suicidal distress or have made a suicide attempt. The proposed program fills a significant gap in Australia's suicide prevention system by combining the experience, expertise and organisational infrastructure of Roses in the Ocean - the national lived experience of suicide organisation; StandBy - the national service supporting people bereaved or impacted by suicide; and Everymind – a national organisation dedicated to the prevention of mental ill-health and suicide.

The Stand Together program combines a peer-led support service coordinated and delivered in communities (to be trialled in identified sites from 2023) with a scalable online education and support program to be delivered free of charge to families and friends through Everymind's Minds Together program and digital portal.

5.4 Safe Spaces

5.4 Recommendation: The Commonwealth Government finalise the development of national standards for Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking and progress national coordination to support a network of Safe Spaces.

Cost: $500,000 over one year

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environments are not the most appropriate point of care for people experience mental distress and people with lived experience report distress can be exacerbated by this setting.[18]

Safes Spaces aim to provide an alternative and are an umbrella term referring to non-clinical, peer-led supports for people in suicidal crisis. They are also known in some areas as safe havens or safe haven

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

'cafes'. They do not replace clinical mental health interventions but support people to navigate the mental health system, connect to local services and develop self-management skills.[19]

The original concept was trialled as the Safe Haven Café in 2014 in Aldershot, United Kingdom. Individuals experiencing a mental health problem were able to visit the centre and converse with mental health professionals and peer workers. An evaluation found a 33% reduction in the number of admissions to acute in-patient psychiatric beds within the Safe Haven's catchment areas.[20]

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

It is important to note there are different types of Safe Spaces that operate in different ways and support individuals at different times and with different needs. Roses in the Ocean have developed a tiered approach that extends Wesley Mission Queensland's three tier model for mental health Safe Safes to include additional tiers focused on suicide prevention:[21]

- Tier 5 – a non-clinical peer run resident safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience
- Tier 4 – a non-clinical peer run safe alternative to emergency departments with a suicide prevention focus, staffed by suicide prevention peers with lived experience
- Tier 3 – a Safe Space to access psychosocial support and safety planning primarily existing mental health services enhanced with peer workers
- Tier 2 – a Safe Space to talk to someone and access a referral (e.g. community centres/services/chemist) in settings that are already operation with staff who are trained to identify risks and connect people to supports
- Tier 1 – a safe 'refuge' to sit in (e.g. library, coffee shop, hairdresser, barber) that are community based non-clinical supports

The Commonwealth Government has previously commissioned initial consultation and feasibility assessment of a national Safe Spaces network. The 2021-22 Budget included $6.6 million to towards national standards for Safe Spaces. This work should be finalised ahead of further national coordination towards a national network of Safe Spaces.

Regional response and suicide prevention leaders

[19] Life in Mind. (2021). Safe Spaces, available online: https://lifeinmind.org.au/safe-spaces.

[20] National Health Service UK. (2016) Case study: Safe Haven Café in Aldershot. Available from: https://www.england.nhs.uk/mental-health/case-studies/aldershot/

[21] https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf

The March 2022-23 Budget investment of $42.7 million on regional suicide prevention initiatives is a welcome commitment to implement system wide responses to reduce the risk of suicide in a region. Building on the Suicide Prevention Trials, this is an important investment to support local commissioning across PHNs. SPA has provided Government advice on how to effectively implement agreed funding to date including key responsibilities and enablers of success.

This Budget does however present an opportunity to better fund these initiatives and to ensure sector certainty in their implementation. The Trial Site evaluations found the time-limited nature of the Trial hindered the ability to develop and implement long-term strategies needed for system-level change and made some services reluctant to refer individuals in need. The two-year funding allocation for these measures risks a similar impact and the need for medium-term funding certainty should be considered by Government.

The funding quantum is also very limited when split across all 31 PHNs. Leader funding equates to $167,000 per annum and regional responses $487,000 per annum for each of the two-years. These funds should be increased to ensure maximum impact at this critical time for suicide prevention across communities.

Regional Responses can play an important role in supporting quality and continuous improvement. This includes support for accreditation and the adoption of the National Standards for Suicide Prevention. Leaders should only commission programs and services that are safe, of appropriate quality and are effective. As part of a commissioning framework that prioritises programs and services that are accredited or committed to working towards accreditation under these standards, a $500,000 grant should be available over two-years to provide free registration for accreditation under the standards..

5.5 Recommendation: The Commonwealth Government double funding for the Regional Response Suicide Prevention measures, include funding to embed accreditation into commissioning and extend the funding from a two to four year period.

Cost: $43.2 million

6. Vulnerable population groups

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

6.1 Survivors of suicide attempts

As outlined in section five, a suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population.[22] Given this risks, there is a need to prioritise investment and support for survivors of suicide attempts.

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

To support this objective, a national network for people who have survived suicide attempts should be formed and provided seed funding by the Commonwealth. Funding this initiative alongside existing national lived experience efforts can support lived experience leadership of this priority cohort.

5.5 Recommendation: The Commonwealth Government provide funding for a national network for people who have survived suicide attempts.

Cost: $320,000

6.2 Youth suicide

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

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

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

Suicide is the leading cause of death among young Australians 15-24 years with over one third of deaths in this cohort due to suicide.[23] Particular groups of young Australian's are at elevated risk. Young males aged 15-24 years have a suicide death rate of 21.2 per 100,000, compared with 6.7 for young females. For Aboriginal and Torres Strait Islander young people aged 15-24, the rate of death by suicide per 100,000 was 58.9, compared with 18.5 for non-indigenous young people.[24] Other groups of young people at higher risk include those in rural and remote areas, those in contact with the justice system,

[22] 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

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

[24] Ibid

those leaving statutory care, those who have been exposed to suicide or suicide-related behaviour, and LGBTIQ+ young people.[25]

The COVID-19 pandemic has been incredibly disruptive for young people. It has impacted their schooling, saw the loss of key milestones and created great uncertainty for the future. During this time, Kids Helpline have reported significant increases in calls from young people experiencing suicidality.[26] Self-harm and suicidal ideation-related hospital admissions have also increased for young people in some jurisdictions.[27]

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

6.3 Aboriginal and Torres Strait Islander Peoples

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

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

6.3.2 Recommendation: Utilise an equity and needs-based approach to fund Aboriginal Community Controlled Health Organisations to provide the Aboriginal community with suicide prevention, postvention and aftercare programs, as well as funding for COVID mental health initiatives. Aboriginal and Torres Strait Islander organisations should be the preferred providers of local suicide prevention activities for their communities.

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

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

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

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

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

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

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

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

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

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

Recent data from the Coroners Court of Victoria report the number of suicides of Aboriginal and Torres Strait Islander people increased by 75% in 2021.[28] Given the extremely high rates of suicide in Aboriginal and Torres Strait Islander communities, especially amongst young people, we request funding for Aboriginal and Torres Strait Islander- specific interventions. In line with the National Suicide Prevention Adviser's view that Aboriginal and Torres Strait Islander Controlled Health Organisations are the best placed organisations to become preferred suicide prevention providers to their own communities. This recognises the rights of Aboriginal and Torres Strait Islander peoples to self-determination; their rights as health consumers to access culturally safe and competent services, and continuity of care.

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

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

Policymakers also need to take into account the risk factors unique to Aboriginal and Torres Strait Islander peoples. Intergenerational trauma, social marginalisation, dispossession, loss of cultural

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

identity, community breakdown and the artefacts of colonialism have had a profound impact on the mental health, wellbeing and lives of Aboriginal and Torres Strait Islander peoples. Suicide Prevention Australia is signatory to the Uluru Statement from the Heart. The Statement articulates the aspirations of Aboriginal and Torres Strait Islander peoples for self-determination, justice, truth telling and respect.

That's why self-determination must be the underpinning principle of any action to address Aboriginal and Torres Strait Islander suicide. The risk factors stemming from dispossession, breakdown of community and loss of autonomy can only be minimised if Aboriginal and Torres Strait Islander peoples themselves decide how best to address them.

6.4 Male Suicide

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

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

Male suicide is an issue requiring targeted policy and funding attention by all governments. In 2020, 3,139 Australians died by suicide, 2,384 (76%) of whom were males.[29] 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.[30] These statistics show that many men are in crisis and current supports are not reaching enough men. We need to be providing more supports that engage with men specifically.

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

Data indicates that men who die by suicide have fewer contacts and later within the suicidal trajectory with health and mental heath systems, meaning there is a need to identify opportunities to intervene outside the health and mental health systems. For example, despite men being far more likely to die by suicide, there are fewer ambulance attendances for male suicide attempts than for female.[31] And men

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

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

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

who die by suicide are less likely to have had contact with mental health services,[32] or have a diagnosis of mental illness.[33] There is ongoing debate as to what extent these statistics are affected by fewer presentations, masking of symptoms, diagnostic practices, and gender differences in the level of risk from non-mental health risk factors. But regardless of the extent to which suicide attempts by men are less likely to result in hospitalisation, or the extent of under diagnosis of mental illness in men, what these statistics show is that for men there is less opportunity to provide support triggered by a suicide attempt, a diagnosis or a mental health service contact. This means that in addition to providing support based on these, it is critical that we focus on the situations that put men at risk of dying by suicide. To do this we need to consider the range of social determinants and situational stressors that can put men at risk of suicide and make a concerted effort to address the underlying issues that might lead men to the point of crisis.

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

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

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

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

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

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

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

- Supervisors and human resources personnel in male-dominated industries
- Judges, lawyers, dispute resolution practitioners, and other service providers involved in legal disputes, especially family and criminal law
- GPs
- Police and other first responders
- Staff at prisons and correctional centres
- Employment and welfare services
- Those supporting young men transitioning from out of home care
- Those supporting male students in schools, universities, TAFES and other educational settings
- Those in community roles of significance to men such as barbers, publicans, male elders, etc.

Skilled connectors can recognise suicidal behaviours or signs of distress, provide immediate support, and direct the person in crisis to support services.[34] It is important that such training includes ensuring that connectors have knowledge of self-care, and the limits of their own abilities; their primary role should be to guide and support men to access existing support services. It is also important that connector training is available that is male-specific or has a gender lens and takes into account the unique factors that impact male suicidality (including masculinity), how different male suicidality can look when it manifests, and diversity among and between men. In some cases delivery of male-specific connector training by men and peer-led community-controlled organisations can be more effective.

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

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

Collaboration and coordination between services is not resources-free. It requires service providers to invest in building relations and in activities such as case coordination, as well as put in place systems

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

and protocols to protect privacy and ensure consent. Ultimately these investments save resources as those providing particular supports are able to quickly and efficiently link their clients with a broader range of supports as needed.

6.5 Culturally and Linguistically Diverse Communities

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

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

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

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

6.6 LGBTQI+

6.6.1 Recommendation: Establish national architecture to coordinate LGBTQI+ health through the appointment of a Senior Staff within the Health portfolio responsible for consolidating best practice standards, national data, identifying disparities at the national level, and development of a 10-year National LGBTQI+ Health and Wellbeing Action Plan. This work should be supported by a National LGBTQI Health Advisory Committee consisting of lived experience to provide advice on policy direction.

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

consultations including the Towards Zero Suicide forum, the Expert Advisory Group, and on-costs.[35]

6.6.2 Recommendation: There should be greater investment in LGBTQI+ community-controlled organisations to develop tailored mental health and suicide prevention initiatives, services and programs to build community capacity and resilience.

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

6.6.4 Recommendation: Fund a Principal Policy Analyst within the ABS to incorporate the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables across all health and wellbeing data sets.

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

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

- Allocate $1.185 million over 3 years to La Trobe University to continue iterations of key research projects Writing Themselves In and Private Lives that provide critical data on LGBTI health.
- Undertake an evaluation evidence check into LGBTQI+ suicide prevention programs in Australia.

6.6.6 Recommendation: There should be greater investment in the LGBTQI+ community controlled organisations health and wellbeing sector to increase organizational sustainability, enhance capacity, meet demand and expand geographical reach. This includes sector development toward a LGBTQI+ lived experience workforce.

People from LGBTIQ+ communities have higher rates of poor mental health and suicide than the general population in Australia. In particular, LGBTIQ+ young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, transgender people aged 18 and over nearly eleven times more likely, and people with variations of sex characteristics (sometimes known as intersex) aged 16 and over are nearly six times more likely to attempt suicide.[36]

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

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

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

some point in their lives, 5.2% reported having attempted suicide in the past 12 months, and 30.3% had attempted suicide at some point in their lives.[37]

The evidence shows the elevated risk of suicidality experienced by LGBTQI+ people links strongly with their continuing experience of discrimination and exclusion, and the subsequent trauma from these experiences.[38] We also know that LGBTIQ+ people are less likely to access help when in crisis. Research undertaken by La Trobe University found 75.3% of LGBTIQ+ participants did not use a crisis support service during a recent personal or mental health crisis.[39]

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

6.7 Veterans

6.7.1 The Commonwealth Government should increase investment in supporting social connections for veterans through service navigation support, social prescribing and increased access to community bodies providing support

Suicide is often the manifestation of complex social and situational factors in a person's life.[40] In the case of service-people and veterans the transition between the structured environment of active service to civilian life is a uniquely vulnerable period. The need for change in this area is clearly demonstrated by data on defence and veteran suicide from the Australian Institute of Health and Welfare (AIHW). After adjusting for differences between the veteran population and the general population AIHW found that rates of suicide were 18% higher for ex-serving men.[41] Suicide is also the

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[37] O. Hill, A., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, *Melbourne: LaTrobe University*, available online: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf.

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

[39] 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*.

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

[41] Australian Institute of Health and Welfare. (2019). *National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2019 update,* available online at: https://www.aihw.gov.au/reports/veterans/national-veteran-suicide-monitoring/contents/summary. Note that the statistics given here are for males only. The smaller number of female veterans means that statics on female veteran suicide are less reported due to confidentially concerns, and where reported may be problematic due to the small sample size. Indications are that suicide is at least as significant a risk for female veterans as for male veterans. For example, this AIHW report found that after adjusting for differences between the veteran population and the general population rates of suicide were 115% times higher for ex-serving women.

leading cause of death ex-serving men and men in the reserves, as well as being the second highest cause of death for serving men.[42] Previous inquiries and reviews on veteran suicide, including those by the National Mental Health Commission[43] and the Productivity Commission,[44] have all identified the challenges of the transition period for long-term wellbeing.

These challenges include, for example, finding post-military employment, securing housing, the loss of camaraderie and friendships with other service-people, and difficulties in restoring or renewing prior relationships.[45] We recognise that the Australian Defence Force provide frameworks and supports to ensure positive mental health during service, but highlight the fragmentation and at times lack of necessary and appropriately skilled supports upon service exit. A key issue highlighted to us in our consultations is that services and supports are readily accessible in service by undertaking simple chain of command processes. Upon leaving service, many don't possess knowledge of how to access support in the broader community, and experience difficulty navigating the mental health system.

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

In enhancing the social connections of veterans, both the community sector and government play a role. It is often difficult for people leaving Defence to know what community supports are available in their area, and government funded navigation support can be critical. Further, government investment in social prescribing initiatives is required to expand referral to social supports by community health providers. There are also innovative models of social support interventions being delivered by veteran organisations, health and social service providers which can be boosted by government investment.

Social connection support should include opportunities both to connect with other veterans and the wider community. Some veterans may prefer primarily to connect with other ex-service personnel, and this may provide a unique place of belonging and understanding. However, focusing only supporting veteran exclusive social connection could entrench isolation from the broader community, and miss broader opportunities for social connection and re-integration.

6.8 Victim-survivors of historical childhood abuse

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

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

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

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

6.8.1 Recommendation: The Commonwealth Government should identify specialist services across Australia working with victim-survivors of historical childhood abuse. This should includes fund to provide wrap around services and programs including professionally facilitated peer support groups, individual planned support and peer support lines.

Cost: $25 million over three years.

According to the AIHW 'child abuse and neglect' is recorded as the leading behavioural risk factor contributing to the years of healthy life lost due to suicide and self-inflicted injuries for men and women. [46] This finding is consistent across studies undertaken in 2003, 2011 and 2015.

The need for specialist prevention and support services for male survivors of child sexual abuse (CSA) who are suicidal is significant. Male survivors of CSA form a sizable subpopulation with estimates that up to 1 in 6 males experience sexual abuse in childhood or adolescence. Male survivors find disclosure and coping difficult and are often reluctant to access generalist services for help. They often experience isolation, shame and guilt in the context of masculine stereotypes which can compound into self-harm and attempted suicide.[47]

Whilst survivors of childhood sexual abuse have received increased attention over recent years, this has not been matched by an increase in available and appropriate specialist services for women or men. By orienting the service delivery around the experience of childhood trauma, victim-survivors from diverse backgrounds and vulnerable population groups (e.g. Aboriginal & Torres Strait Islander and LGBTQI etc) can come together and find connection through their shared lived experience.

For example, Survivors & Mates Support Network is a not-for-profit organisation delivering services for male survivors in NSW. Co-founded by male survivors, the design of SAMSN's services is based on lived experience and professional knowledge. SAMSN offers a unique service model through its group work programs, co-advocacy and individual support. As the only specialist male survivor organisation in Australia, SAMSN represents the importance of providing gender-specific specialist services.

7. Strengthening Protective Factors

7.1 Welfare support

7.1.1 Recommendation: Commonwealth Government to permanently increase the base rates of income support payments to adequate levels as outlined in the Raise the Rate campaign.

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

[46] AIHW (Australian Institute of Health and Welfare) 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Cat. no. BOD 22. Canberra: AIHW. DOI:10.25816/5ebca2a4fa7dc

[47] Easton S., Renner, L. & O'Leary, P. (2013). Suicide attempts among men with histories of child sexual abuse: Examining abuse severity, mental health, and masculine norms. Child Abuse & Neglect.

livelihoods and – perhaps for the first time – are struggling with their wellbeing. At the same time as the COVID-19 pandemic, Australia has experienced a series of natural disasters placing people vulnerable to suicide risks.

While suicide is not a typical response, links between unemployment, financial insecurity and suicidality are well established. Several systematic reviews have provided strong evidence of the relationship between unemployment and suicide, with the risk at its highest in the first five years of unemployment.[48] 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.[49]

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.[50] The Productivity Commission similarly identified those experiencing financial distress or unemployment at higher risk of developing mental illness, and those on income support payments are more likely to experience poverty.[51] 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.[52]

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

ACOSS conducted a survey into the financial impact of living in Greater Sydney during the COVID-19 lockdown in 2021. 100% of respondents reported struggling with the cost of living.[53] More than half had lost paid work because of the lockdown, and almost half (49%) said they are at risk of losing their homes.[54]

Increasing the base rate means the thousands of Australian people experiencing the challenges of unemployment can meet their basic needs and have the support they need to find meaningful work when it becomes available. We support the Raise the Rate campaign championed by ACOSS and our recommendation is to reform welfare support in line with the recommendations of their campaign.

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[48] 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.

[49] 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/.

[50] Ibid.

[51] Ibid.

[52] Ibid.

[53] ACOSS. (2021). Locked out in lockdown: A report about people with the least trying to survive in lockdown, available online: https://www.acoss.org.au/wp-content/uploads/2021/07/locked-out-in-lockdown-report_final-1.pdf.

[54] Ibid.

7.2 Strengthen social connection & reduce loneliness

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

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

Connectedness acts as a significant protective factor for suicide. However, when people become socially isolated and lonely it can have significant impacts and pose harms to both mental and physical health.[55] Research has shown social isolation to pose more significant health risk than 'smoking, poor diet and lack of exercise',[56] and loneliness has been found to increase the risk of premature death by approximately 30%.[57]

The Australian Psychological Society reports approx. 1 in 4 Australians are experiencing an episode of loneliness, and 1 in 2 report they feel lonely for at least 1 day each week.[58] Loneliness is highlighted as a modifiable risk factor for suicide by the Royal Australian & New Zealand College of Psychiatrists.[59]

The estimated prevalence of problematic levels of loneliness among Australians is around 5 million.[60] Loneliness has also been attributed to increasing the risk of health problems such as myocardial infarction and stroke,[61] and increases the likelihood of experiencing depression by 15%,[62] and links exist between social isolation and the experience of psychological harm.[63]

Stigma and discrimination are harmful to mental health and can occur against people with mental illness, and high rates of people with mental ill health withdraw themselves from public spaces due to

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[55] AIHW. (2019). Social isolation and loneliness, *Australian Institute of Health and Welfare*, September 2019, available online: https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness.

[56] Ibid..

[57] Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T. & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A Meta-Analytic Review, *Association for Psychological Science, Sage Journals,* 10(2).

[58] Australian Psychological Society. (2018). Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing, *APS,* Melbourne.

[59] RANZCP. (2020). Suicide prevention – the role of psychiatry, *The Royal Australian & New Zealand College of Psychiatrists,* Position Statement 101.

[60] Ending Loneliness Together. (2021). A National Strategy to Address Loneliness and Social Isolation, *R U OK, Australian Psychological Society,* available online: https://treasury.gov.au/sites/default/files/2021-05/171663_ending_loneliness_together.pdf.

[61] Hakulinen, C., Pulkki-Raback, L., Virtanen, M., Jokela, M., Kivimaki, M., & Elovainio, M. (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK biobank cohort study of 479 054 men and women, *Heart,* 104(18), 1536-1542.

[62] Abbott, J., Lim, M., Eres, R., Long, K. & Matthews R. (2018). The impact of loneliness on the health and wellbeing of Australians, *InPsych*, 40(6).

[63] Ibid.

stigma and discrimination.[64] Mental illness is further associated with lower involvement in the labour force and greater discrimination, both of which are risk factors for suicide.[65] It is crucial that active efforts should be made to reduce the stigma surrounding mental ill health and loneliness.

1 in 10 Australians aged 15 and over report lacking social support.[66] Response measures to the COVID-19 pandemic to protect community health have subsequently heightened risk factors for suicide such as social isolation, financial distress, and unemployment.

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

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

7.3 Childhood trauma

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

The estimated cost to government of late intervention for children and young people in Australia who experience serious issues that require crisis services is $15.2 billion per year, equating to $607 for every Australian or $1,912 per child and young person.[67]

In 2019, Australians lost 145,703 years of healthy life due to suicide and self-inflicted injuries, representing around 3% of the total burden of disease and injury in Australia.[68] In 2019, child abuse and

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[64] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report; SANE Australia. (2020). National Stigma Report Card, available online: https://nationalstigmareportcard.com.au/.

[65] ABS. (2020). General Social Survey: Summary Results, Australia, available online: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2020.

[66] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS; Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.

[67] Teager, W., Fox, S., & Stafford, N. (2019). How Australia can invest early and return more: a new look at the $15b cost and opportunity. Retrieved from https://www.thefrontproject.org.au/images/downloads/THE_COST_OF_LATE_INTERVENTION/Technical_ReportHow_Australia_can_invest_in_children_and_return_more.pdf.

[68] Australian Institute of Health and Welfare (2021) *Behavioural risk factor burden for suicide and self-inflicted injuries*, available online at < https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/burden-of-disease-studies-suicide-self-inflicted>.

neglect during childhood was the leading risk factor contributing to the burden of suicide and self-inflicted injuries in both males and females. It was associated with 33% of total suicide burden in females and 24% in males aged 5 and over.

Research undertaken by ACOSS reports there are 731,000 children living in poverty in Australia, and 1.2 million Australians living in poverty are under the age of 24.[69] Additionally, 1 in 3 children from Australia's disadvantaged communities are not meeting one or more developmental milestones when they start school.[70] Students from low socio-economic status are found to be significantly less likely to complete year 12 schooling than students of high socio-economic status.[71]

Children living in areas of high socio-economic disadvantage experience high rates of unemployment, low education, and have less access to affordable housing.[72] During the period 2017-18, 124,000 children and young people received support from specialist homelessness service, and 45,000 children were in out-of-home care.[73]

During the COVID-19 pandemic in Australia, data from a Kids Helpline six monthly report identifies a 200% increase in counselling contacts from 5 year olds over the first six months of 2021, when compared to 1 January to 30 June 2020.[74] In 2021 Yourtown identified that 1,610 contacts to Kids Helpline were from young children aged 5-9 years of age up from 1,588 for the first 6 months of 2020.[75]

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

7.4 Housing Insecurity

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[69] ACOSS & UNSW Sydney. (2020). Poverty in Australia: Part 1 Overview, *Australian Council of Social Service in partnership with UNSW Sydney,* available online: https://povertyandinequality.acoss.org.au/wp-content/uploads/2020/02/Poverty-in-Australia-2020_Part-1_Overview.pdf.

[70] The Smith Family. (2021). What is poverty?, available online: https://www.thesmithfamily.com.au/poverty-in-australia/what-is.

[71] Australian Curriculum, Assessment and Reporting Authority. (2012). National Report on Schooling in Australia 2010, available online: https://www.acara.edu.au/reporting/national-report-on-schooling-in-australia/national-report-on-schooling-in-australia-2010.

[72] Ibid.

[73] Ibid.

[74] Yourtown. (2021). Increase in children as young as 5 contacting Kids Helpline, Media Release, available online: https://www.yourtown.com.au/media-centre/increase-young-children-contacting-kids-helpline.

[75] Ibid.

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

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

1. Protracted financial stress due to the cost of housing
2. Loss of security due to eviction, insecure housing and homelessness
3. The impacts of adverse life events on children and young people on their present and future mental health

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

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

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

7.5. Disaster Planning

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

Cost: $30 million

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

7.5.3 Recommendation: Commonwealth to join with State and Territory Governments fund research into population groups to identify at-risk groups vulnerable to disasters to enable development of

evidence-based targeted responses which are tailored to diverse demographic, gender, and cultural needs.

Cost: $1.5 million

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

From the time the COVID-19 pandemic reached Australia in January 2020 to June 2021, Australia experienced 71 natural disasters (storms, floods, and bushfires) across the country.[76] Research has found people exposed to multiple natural disasters and man-made disasters are at a significantly greater risk of attempting suicide.[77] It is critical that support is targeted to vulnerable areas that have experienced multiple disasters.

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

Disasters have physical, social and emotional impacts on people and communities who experience them, and last for extended periods of time.[78] The link between suicide in the aftermath of disasters is highly evidenced.[79] Research based in on US data found rates of suicide to increase during the first 3 years post-disaster,[80] and another study found increases in suicide rates were seen 2 years post-disaster.[81] Evidence is also found of increases in rates of post-traumatic stress disorder and depression following a disaster.[82]

Research indicates that the role of increased social supports to combat risk factors for suicide such as financial distress, unemployment and mental health disorders act as protective factors for suicide and as such, increases in suicide rates immediately after disasters are not commonly experienced.[83]

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[76] Disaster Assist. (2021). Australian Disasters, *Department of Home Affairs, Australian Government,* available online: https://www.disasterassist.gov.au/find-a-disaster/australian-disasters#.

[77] Reifels, L., Spittal, M.L., Duckers, M.L.A., Mills, K. & Pirkis, J. (2018). Suicidality Risk and (Repeat) Disaster Exposure: Findings From a Nationally Representative Population Survey, *National Library of Medicine,* 81(2).

[78] World Health Organisation. (2016). Psychological First Aid For All: Supporting People in the Aftermath of Crisis Events, available online: https://www.who.int/mental_health/world-mental-health-day/ppt.pdf.

[79] Jafari, H., Heidari, M., Heidari, S. & Sayfouri, N. (2020). Risk factors for suicidal behaviours after natural disasters: A systematic review, *The Malaysian Journal of Medicine*, 27(3).

[80] Cartier, K. M. S. (2021), Suicide rates may rise after natural disasters, Eos, 102, available online: https://doi.org/10.1029/2021EO153699.

[81] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, *Journal of Crisis Intervention and Suicide Prevention,* 42(5).

[82] Beaglehole, B., Mulder, R.T., Frampton, C.M., Boden, J.M., Newton-Howes, G. & Bell, C.J. (2018). Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis, *Cambridge University Press.*

[83] De Leo, D., San Too, L., Kolves, K., Milner, A. & Ide, N. (2012). Has the suicide rate risen with the 2011 Queensland floods?, *International Perspectives on Stress & Coping,* 18(2).

However evidence demonstrates suicide rates can increase years after the disaster which may be attributed to increased disaster supports ending. Protective supports, including housing, financial and welfare assistance, put in place during a disaster should be transitioned out in a careful, staged way. This will ensure communities are supported in the medium-term when suicide rates are at risk of increasing.

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