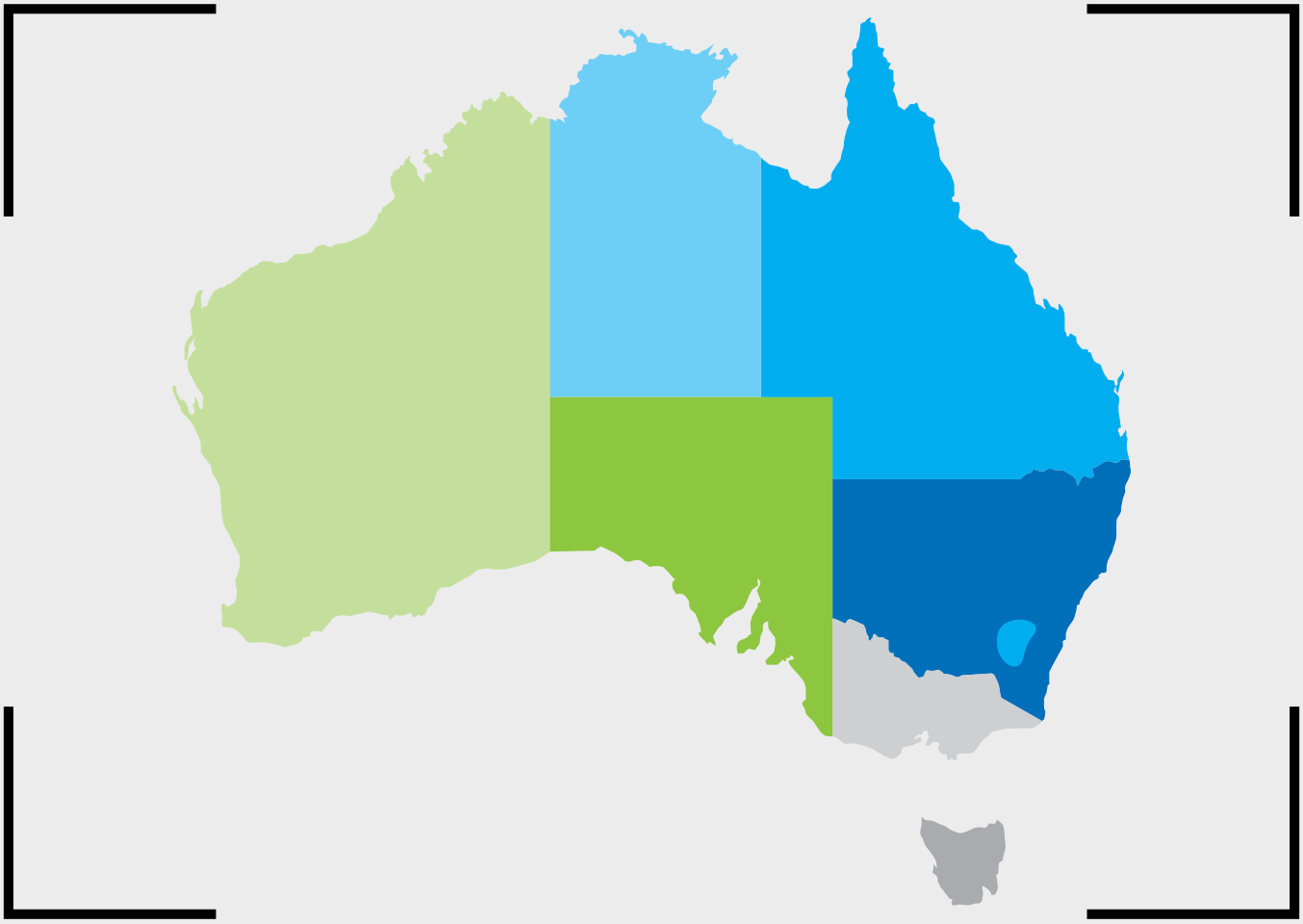
STATE OF THE STATES

IN SUICIDE PREVENTION

A snapshot of suicide prevention reform in Australian states and territories



Suicide Prevention Australia

March 2023

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 400 members representing more than 140,000 workers, staff and volunteers across Australia, we provide a collective voice for service providers, practitioners, researchers, local collaboratives and people with lived experience.

More than 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Over 7.5 million Australians have been impacted by suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity.

Purpose of this report

Research into suicide prevention reforms by jurisdictions for this report was undertaken during September 2022 – December 2022. The National Agreement on Mental Health and Suicide Prevention and subsequent Bilateral Agreements had only been finalised in the months prior to research commencing. We acknowledge that many governments may have had suicide prevention reforms on their agenda for future development that may not be captured in this report. As suicide prevention activities continue to develop, we hope this report is used as an advocacy tool to champion further reform at the state and territory government level to strengthen suicide prevention across Australia.

Suggested citation: Bambridge, C. & McLean, M. (2023). State of the States in Suicide Prevention, Suicide Prevention Australia, Sydney, Australia.

There are crisis services available 24/7 if you or someone you know is in distress

Lifeline: 13 11 14
www.lifeline.org.au

Standby Support After Suicide: 1300 727 247
www.standbysupport.com.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

Acknowledgement Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Expertise and knowledge from members of our Lived Experience Panel, and people with lived experience who participated in two policy roundtables helped guide the development of indicators used in this report to measure suicide prevention reform and provide guidance on future reforms.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our policy work. Suicide Prevention Australia thanks all involved in the development of this report.

We acknowledge the Aboriginal and Torres Strait Islander peoples as the first inhabitants of this nation and the traditional custodians of the lands where we live, learn and work. We pay respects to all Aboriginal and Torres Strait Islander Elders past, present and emerging from all nations across this country.

Contents

Introduction

Momentum for suicide prevention reform has been steadily building in Australia in recent years. Since the COVID-19 pandemic reached Australia in January 2020, we have witnessed record investment into mental health and suicide prevention by commonwealth, state and territory governments.

Key funding investments included $64 million for suicide prevention, $74 million for preventative mental health services, $48 million for the National Mental Health and Wellbeing Pandemic Response Plan, and $12.8 million to establish a National Suicide Prevention Office to oversee the national approach to suicide prevention. Funding announced since 2021 saw in total almost $300 million to deliver critical suicide interventions such as universal aftercare, national postvention and distress interventions.

Alongside record national funding investments in suicide prevention, key reports driving systemic change have been released such as the Productivity Commission's Final Report on the Inquiry into Mental Health (November 2020), National Suicide Prevention Adviser's Final Advice (April 2021), and the Select Committee on Mental Health and Suicide Prevention's Final Report (October 2021).

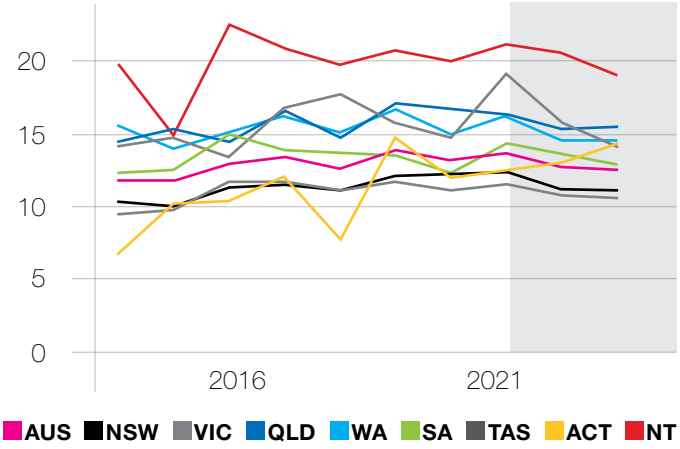
In March 2022 a new National Agreement on Mental Health and Suicide Prevention was announced signalling a positive step towards making progress on systemic reforms, in particular for progressing whole-of-government, lived experience, data and workforce priorities. The National Agreement however required further bilateral agreements between states and territories, and in some cases resulted in gaps in critical suicide prevention services, such as aftercare and postvention being left out of the mix.

In alignment with national leadership by the Commonwealth Government in suicide prevention, we have seen milestone achievements in working towards implementing a whole-of-government approach to suicide prevention across jurisdictions led by state and territory governments. For example, in December 2021, the South Australian Suicide Prevention Act 2021 (The Act) received assent, the first suicide prevention legislation in Australia. The Act is an important piece of legislation to prevent suicide, ensure a whole-of-government focus and improve suicide prevention data, policy and practice. As another example, Victoria's 2021-22 State Budget announced commitment to establish a Suicide Prevention and Response Office including dedicated positions for people with lived experience.

Suicide is a complex, multifactorial behaviour underpinned by a range of vulnerabilities, risk factors and life events. Increasingly, the evidence is clear that the social determinants of health and wellbeing, including social, economic and physical environments, play a critical role in suicide rates. Suicide rates vary over time and are influenced by a range of local and national factors.

Suicide deaths by states and territories, Australia, 1979 to 2021

Death by year of registration
Age-standardised rate (per 100,000)



*Age-standardised rates are not shown where there were fewer than 20 deaths in an area due to unstable rates. Source: AIHW National Mortality Database and ABS Causes of Death, Australia 2022 Supplementary Table: NMD S4, NMD S5
Latest data: 2021 (annual release)

It is clear that we as a nation are moving towards reforming our suicide prevention systems across federal, state and territory governments to reduce distress and save lives. That's why Suicide Prevention Australia on behalf of Australia's suicide prevention sector has undertaken a stocktake of key suicide prevention activities and reform initiatives across states and territories in Australia to provide a map of where we currently are, and where we still need to go.
The objective is to shine a light on reform progress, and gaps to date, and in doing so, advocate ways to raise the national standard for suicide prevention across jurisdictions and ensure all Australians have equitable access to a world-class suicide prevention system.

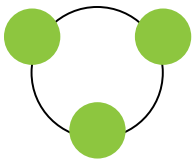
Through consultation with over 50 of our members and people with lived experience, we developed a set of indicators by which to measure progress in suicide prevention reform. Each of the seven key areas in this report provides a stocktake of which states and territories have either implemented or committed support towards achieving suicide prevention indicators, context and national developments, and an outline of the initiatives at state and territory level that embody the actions governments have taken against each indicator. The structure of the report is designed to highlight where each jurisdiction is modelling best practice, and to facilitate cross-state/territory learnings.

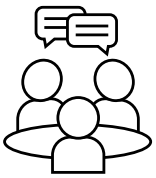
Total number of people consulted across all jurisdictions: 73

PHASE ONE CONSULTATIONS: JULY 2022 – SEPTEMBER 2022

10x individual consultations

2x policy roundtables





3x advisory group meetings

(2x Lived Experience Panel meetings, 1x Policy Committee meeting)

Total Consulted: 51

PHASE TWO CONSULTATIONS: OCTOBER 2022 – DECEMBER 2022

of contacts **with government departments, sector experts and PHNs: 22**

Chapter 1

LIVED EXPERIENCE

What we're trying to achieve: Lived experience leadership, expertise and insights are integrated in all aspects of suicide prevention.

Jurisdiction	Indicators		
	Lived experience of suicide partnerships in government decision making	KPIs for incorporating lived experience in policy and service design	Capacity and capability training of lived experience peer workforce
ACT	No	In development	No
NSW	Yes	In development	Yes
NT	No	In development	Yes
QLD	In development	In development	Yes
SA	Yes	Yes	Yes
TAS	Yes	In development	Yes
VIC	Yes	Yes	Yes
WA	In development	In development	Yes

Context

The release of the National Suicide Prevention Adviser's Final Advice in 2021 shone a light on the need for lived experience knowledge and leadership in suicide prevention policy and planning, service design and delivery, and program implementation and evaluation. While the suicide prevention and mental health sectors have been championing co-design processes which value the expertise of lived experience for decades, the National Suicide Prevention Adviser's Report provided national guidance to align state and territory priorities.

The 2022 National Agreement on Mental Health and Suicide Prevention resulted in Bilateral Agreements among all states and territories. All schedules across jurisdictions included commitments to adopting a consultative approach with people with lived experience in all matters of service design, planning, implementation, evaluation, data and governance, and to building structures and supports for the lived experience workforce.

Among the Bilateral Agreements, the Victorian Government outlined the most commitments to lived experience compared to other Bilaterals, significantly in building the capacity of the lived experience workforce. Key highlights included commitment to providing scholarships and subsidised vocational training for lived experience peer workers, inclusion of lived experience peer workers in multidisciplinary teams, and delivering organisational supports for lived experience. Victorian Government appointed its first Executive Director of Lived Experience in 2021, however it is important to note that while there are designated Lived Experience positions within the Victorian Suicide Prevention and Response Office the Executive Director role is located in the broader Mental Health and Wellbeing Division of the Department of Health.

While Queensland, New South Wales, Northern Territory, South Australia, Australian Capital Territory and Tasmania schedules all included basic commitment to including lived experience, Western Australia went a step further to include commitment to establishing a Joint Service Planning and Governance Committee which will include one consumer lived experience member and one carer lived experience member on the Committee. The Committee will provide advice to the Commonwealth and Western Australian Government on the initiatives delivered through the Bilateral Agreement.

More recently, the Commonwealth Government committed $8.5 million to support those with a lived experience of mental health in policy and service development by funding the establishment of two

independent national mental health lived experience peak bodies.[1] One will represent mental health consumers and the other mental health carers, families and kin. Of the total funding investment, $7.5 million is allocated to the two peak bodies, $900,000 to Lived Experience Australia to continue leading lived experience research and capacity building of consumers and carers, and $100,000 to establish a regular stakeholder forum to increase partnership and accountability with the sector.[2] We currently do not have a specific peak body for lived experience of suicide at the national level.

Commonwealth, State and Territory Governments have commissioned a lived experience co-design process to further develop aftercare, post-vention and distress supports being delivered under the National Agreement. The 2022 edition of Suicide Prevention Australia's annual State of the Nation in Suicide Prevention report demonstrated a broad consensus that lived experience expertise should be embedded in governance structures, be key partners in designing and delivering suicide prevention efforts, and not be tokenistic in nature.[3] Initiatives to embed lived experience in policy decision-making and service design need to be supported by government funding. Funding is required to create and develop more opportunities for paid peer worker roles, to support co-design processes, to provide support training to the lived experience workforce, increase opportunities to hear from a diverse range of lived experience expertise, and employ lived experience advisors in all levels of service provision and government departments.[4]

Lived experience partnerships in government decision-making has largely to date been focussed on mental health lived experience, without specificity of lived experience of suicidality. While suicidality can be a result of mental ill-health, we know that many individuals with mental ill-health are not affected by suicidal thoughts and not all people who attempt or die by suicide have a mental health problem. Among people who die by suicide, 50-60% are unlikely to have received help from a health professional before they died.[5] Governments should commit to inclusion of lived experience of suicide in all levels of suicide prevention decision-making.

Indicator: Lived experience of suicide partnerships in government decision making	
NSW	NSW Health partnered with Roses in the Ocean to develop and implement the Towards Zero Suicides Initiatives.[6] Roses in the Ocean is an organisation dedicated to empowering people with lived experience to share their expertise in suicide prevention.
QLD	QLD Government established the Mental Health Lived Experience Peak Queensland (MHLEPQ) in July 2021. MHLEPQ is funded by Queensland Department of Health and provides policy advice and systemic advocacy. The MHLEPQ will provide policy advice and system advocacy that represents the common interests of mental health consumers of all ages across Queensland.
SA	SA Government Suicide Prevention Act 2021 describes the establishment of a Suicide Prevention Council consisting of members with lived experience, including diversity among at-risk populations e.g. Aboriginal and Torres Strait Islander, veteran, LGBTQI+, survivors, first responder or carer.[7] The Suicide Prevention Council is a statutory body.[8] The Suicide Prevention Act commenced 5 September 2022 and members of the Suicide Prevention Council were appointed late September 2022.
TAS	The Tasmanian Suicide Prevention Strategy 2023-2027 outlines new governance arrangements including a Premier's Mental Health and Suicide Prevention Advisory Council (Premier's Council) which will include lived experience representation.[9] The Premier's Council will replace the Tasmanian Suicide Prevention Committee. An Executive Leadership Group which will include leaders of the Department of Premier and Cabinet, Tasmania Department of Health. And Primary Health Tasmania, will work with the Premier's Council to support implementation of the Strategy.[10] The Tasmanian Suicide Prevention Community Network which originally launched in 2010 will continue to retain an independent non-government organisation lead role in implementation of the strategy.[11] The Tasmanian Suicide Prevention Committee and the Tasmanian Suicide Prevention Community Network were responsible for implementing and monitoring the previous Tasmanian Suicide Prevention Strategy 2016-2020 in partnership with the Tasmanian Department of Health and Human Services.[12]
VIC	VIC Government has established an Expert Advisory Committee comprising lived experience representatives and other stakeholders to provide advice to the Suicide Prevention and Response Office. It will be co-chaired by a lived experience representative.[13] VIC Government is working towards further improving partnerships with people with lived experience. In 2022, VIC Government reported working with Roses in the Ocean to develop a lived experience partnership and engagement strategy, and staff participation in lived experience training delivered by Roses in the Ocean. The VIC Government has designated lived experience roles in the Mental Health and Wellbeing Division and Suicide Prevention and Response Office.
WA	WA Government is in the process of establishing a Joint Service Planning and Governance Committee with two members of lived experience of mental health/suicide related issues and caring. The Committee will support implementation of the WA Bilateral Schedule on Mental Health and Suicide Prevention.

Valuing lived experience knowledge, expertise, and insights

The National Suicide Prevention Adviser's Final Advice Report recommended all governments include a requirement for demonstrated engagement and co-design with people who have lived experience of suicide in funded research, services and programs.[14] Our consultations yielded strong support for the implementation of KPIs for incorporating lived experience in policy and service design to ensure accountability across government, services, and sectors to meaningfully value lived experience knowledge, leadership, and expertise.

It was not definitive in our research and consultations for this report whether KPIs are currently being used for lived experience by governments in the development of suicide prevention and mental health policy and service design. With the recent introduction of the Bilateral Agreements on Mental Health and Suicide Prevention in 2022 which embeds lived experience in consultation processes as well as regular evaluation processes, it is possible this is currently in development.

There does appear to be independent work with a focus on including lived experience in service design being undertaken by Primary Health Networks (PHNs) who are funded by the Commonwealth Government to commission services across jurisdictions. While this is an example of good working partnerships between the commonwealth and states and territories, they are commonwealth-led rather than jurisdiction-led.

For example, New South Wales South Eastern PHN has developed a Framework for Mental Health Lived Experience (Peer) Work which includes an Employer of Choice Tool with KPI criteria for embedding the lived experience workforce in organisations.

Queensland Brisbane North PHN has a Lived Experience Engagement Team in their Mental Health, Alcohol and Other Drugs (MHAOD) unit. Their MHAOD tenders seek information from applicants on involvement of lived experience in governance, service delivery/ design, implementation, and evaluation. People with lived experience are further involved as part of the tender panel in decision-making processes. Their process is currently in review to further enhance inclusion of lived experience by linking tenders to the contract and reporting KPIs.

PHNs play a key role in ensuring lived experience is integrated into service design and implementation. While this work is occurring in some PHNs across Australia, it appears inconsistent across states and territories and requires government-led strategies for including lived experience in suicide prevention and mental health service and policy design among jurisdictions to align with the National Suicide Prevention Advisor's Final Advice report. This area may develop further due to government commitment to inclusion of lived experience and development of the lived experience workforce in Bilateral Agreements met in 2022.

Through discussions with government departments, it was not evident that using KPIs for lived experience integration was common practice, but this was not necessarily reflective of whether they were including lived experience or not. There is a need for further development of the use of KPIs for incorporating lived experience in policy and service design by governments in Australia to ensure consistency in valuing the knowledge and expertise of people with lived experience.

For governments to meaningfully include people with lived experience in all levels of policy and service design, a culture change is needed to support people with lived experience in the workplace. The organisation Roses in the Ocean has produced a suite of resources on suicide informed and inclusive culture change designed to guide service providers, organisations, and governments to engage and partner with people with lived experience of suicide.[15]

For this indicator, jurisdictions where it is unclear have been recorded as 'in development' on the basis that Bilateral Agreements were met in 2022, and initiatives may still be undergoing development. Suicide Prevention Australia will continue to work with governments to ensure lived experience is integrated into policy and service design.

Indicator: KPIs for incorporating lived experience in policy and service design	
QLD	QLD Government had a Lived Experience Engagement and Participation Strategy 2018-2021 focussed on consumers as central to improving services. It is unclear if a new version of this strategy is being developed. A key objective of the strategy was to develop the lived experience workforce across mental health and drug and alcohol sectors which lead to the development of the Queensland Health Mental Health Framework Peer Workforce Support & Development 2019.
SA	South Australian Government's Commissioning Framework includes co-design in planning, design, monitoring and evaluation as a key enabler.
VIC	VIC Government reported it has a rigorous reporting processes across government for accountability of lived experience inclusion which is supported by an accountability framework and implementation plan. These developments are in response to the Royal Commission into VIC's Mental Health System which recommended the VIC Government employ people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide (recommendation 26.2.e).[16]

Capacity and capability training of lived experience peer workforce

Our consultations highlighted the need to develop the capacity and capability of the suicide prevention peer workforce. This view is supported broadly by the suicide prevention sector with 80% of respondents reporting the peer workforce is not appropriately funded or resourced in our 2022 iteration of our State of the Nation in Suicide Prevention survey of the suicide prevention sector.

The National Suicide Prevention Adviser's Final Advice Report recommended all governments commit adequate funding and implement support structures to build the lived experience workforce including the lived experience peer workforce (recommendation 2.3).[17]

In the 2020-21 Federal Budget, the Commonwealth Government invested $500 million matched by state and territory governments for the establishment of the JobTrainer Fund.[18] JobTrainer provides up to 300,000 either free or low fee enrolments for job seekers in education courses. The program was extended to 31 December 2022.[19] The courses included in the fund vary across jurisdictions. The Certificate IV in Mental Health Peer Work was only available in New South Wales, Northern Territory, South Australia, Victoria, and Western Australia as part of the JobTrainer Fund.[20] Whilst there has been national investment in the mental health peer workforce, this has not been matched in the suicide prevention peer workforce.

Given almost half of people who die by suicide do not have contact with hospital services in the year prior to their death, a suicide prevention peer workforce is needed to support those who do not present to the acute mental health system.[21]

Some state governments have demonstrated their value of the knowledge and expertise people with lived experience provide the mental health workforce through specific funding to support the capability development of peer workers. As there is limited government investment into the suicide prevention peer workforce, only the mental health peer workforce has been assessed for this indicator. Examples include:

Indicator: Capacity and capability training of lived experience peer workforce	
NSW	Department of Health fund 100 scholarships for peer workers to complete a Certificate IV in Mental Health Peer Work (Cert IV) in partnership with the Mental Health Coordinating Council (MHCC). In 2020, NSW Government invested $2.8 million in community gatekeeper training over three years as part of the Towards Zero Suicides initiative.
QLD	The Queensland Mental Health Commission released the Queensland Framework for the Development of the Mental Health Lived Experience Workforce in 2019.[22] Professional development and training is a key focus area of the framework.[23]
TAS	TAS Government invested $375 000 over three years for Connecting with People Suicide Prevention Training in the 2022-23 State Budget. Tasmania have a Peer Workforce Development Strategy 2019 and an Implementation Plan 2022 to support the actions of the Strategy.[24]
VIC	VIC Government announced $40.7 million in its 2021-22 Budget to expand lived experience workforces including continuation of free TAFE course for Certificate IV in Mental Health Peer Work. Victorian Government announced $11.45 million to the Lived Experience Workforce Development Program targeting development, capacity, and retention of the lived experience workforce.
WA	WA Government invested $12.9 million for additional peer support workers in the 2022-23 State Budget.

While subsidising the Certificate IV in Mental Health Peer Work is a good start to building capability of the mental health peer workforce, development is needed across jurisdictions to build capability of the suicide prevention peer workforce.

We know that 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.[25] The suicide prevention sector needs dedicated peer workers with specific lived experience of suicide to support suicide attempt survivors, and people who are impacted or bereaved by suicide. Participants in our consultations identified a gap in the sector where often peer workers may have a lived experience of mental illness, but not suicidality.

Dedicated peer workers with lived experience of suicide who can relate to the complexities involved in suicide would strengthen the capability of the suicide prevention sector to respond to distress in the community.

Existing peer worker training and courses could be strengthened by inclusion of meaningful suicide prevention content and existing crisis distress intervention training to equip peer workers with the skills needed to respond to someone in distress in the community.

Chapter 2

Suicide Prevention Australia

WHOLE-OF-COMMUNITY, WHOLE-OF-GOVERNMENT

What we're trying to achieve: A whole-of-government approach to suicide prevention that addresses the social determinants of health and wellbeing.

Jurisdiction	Indicators				
	Suicide Prevention Act	Stand-alone Suicide Prevention Strategy	Dedicated Minister for Suicide Prevention in government	Office of Suicide Prevention	Social determinants of health addressed by governments in suicide prevention responses
ACT	No	No	No	No	Yes
NSW	No	Yes	No	No	Yes
NT	No	Yes	Yes	No	Yes
QLD	No	Yes	No	No	Yes
SA	Yes	In development	Yes	No	Yes
TAS	No	Yes	No	No	Yes
VIC	No	In development	Yes	Yes	Yes
WA	No	Yes	No	No	Yes

Context

The challenges faced by Australians in recent years are unprecedented. The COVID-19 pandemic, economic challenges and compounding natural disasters place us at risk of an increase in suicides in our community. International research shows suicide rates can peak two to three years after a disaster strikes.[26,27]

The Final Advice of the National Suicide Prevention Advisor was clear, government actions across a range of portfolios, including welfare, housing, and education, can impact suicide risks. Preventing suicide therefore requires a holistic, cross-governmental approach that addresses these various factors.

Ninety-six per cent of Australia's suicide prevention sector believe a whole-of-government approach to suicide prevention is required to address the social determinants of health that can lead to suicide.[28] This figure remains consistently high, with a similar percentage of respondents supporting a whole of government approach to suicide prevention in 2020 and 2021.[29]

The 2021 National Mental Health and Suicide Prevention Plan responded to 21 recommendations from the Productivity Commission's Inquiry into Mental Health, and eight recommendations from the National Suicide Prevention Adviser's Final Advice.[30] The National Plan sets out clear direction to work towards a whole-of-government approach to suicide prevention that responds earlier to distress.

In 2022, the National Agreement on Mental Health and Suicide Prevention was finalised. The National Agreement states parties commit to:

"Recognise the role of social determinants of health on people's mental health and wellbeing, and facilitate a whole-of-system approach that draws together mental health and suicide prevention services and other services delivered by government outside of the health system."[31]

All jurisdictions committed to implementing a whole-of-government approach to suicide prevention and addressing the social determinants of health in Bilateral Agreements. In all Bilateral Agreements, both parties agreed to:

"Recognise the enablers of mental health and suicide prevention system reform are beyond the influence of the health system alone and span all aspects of where people live, work, learn and socialise. The Parties commit to engaging with other portfolios where required to progress the initiatives and activities under this Schedule." [1]

Whole-of-government approaches to suicide prevention have been seen internationally, most prominently in Japan. Japan passed its first suicide prevention legislation in 2006 and shifted suicide prevention from its Ministry of Health to the Cabinet Office.[32] This ensured suicide prevention became a national priority, and a responsibility shared by all ministers.

Nationally led suicide prevention efforts in Japan reduced suicide rates by approximately 40% over 15 years, which included ten straight years of decline from 2009. Japan recorded its first increase in suicide rates in ten years in 2020 – the first year of the COVID-19 pandemic.[33,34]

Key components of their whole-of-government strategy included requiring national and local governments to be responsible for suicide prevention, and national roll out of gatekeeper training. About 80% of Japan's local governments deliver suicide prevention gatekeeper training to communities.[35] Canada, South Korea and Argentina have also progressed suicide prevention legislation.

SUPPORT FOR SUICIDE PREVENTION LEGISLATION IN AUSTRALIA

Source: YouGov poll August 2022, sample size of 1024 adults asked to what extent they agree or disagree that Australia should introduce a standalone Suicide Prevention Act; figures represent total agree (strongly agree and somewhat agree); ACT/NT/TAS figures collated

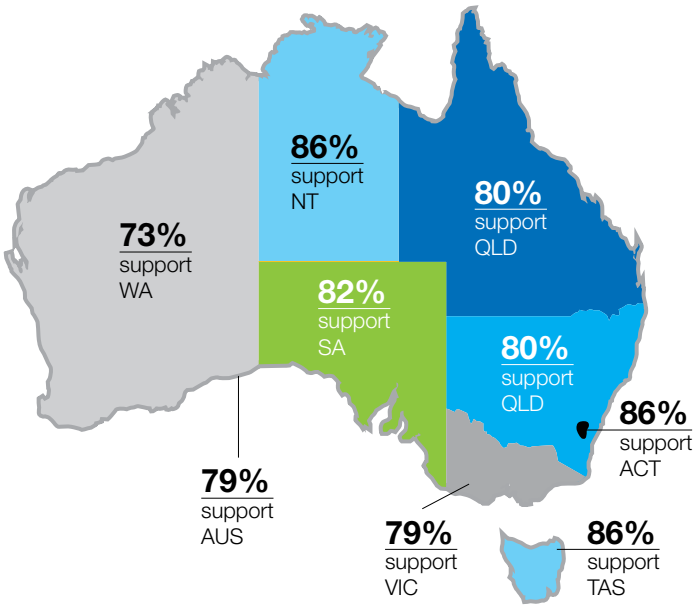
Indicator: Suicide Prevention Legislation in Australia	
SA	South Australia passed the Suicide Prevention Act 2021 with bipartisan support in November 2021.

Suicide prevention legislation

In December 2021, South Australian Government was the first Australian jurisdiction to pass a Suicide Prevention Act 2021 (The Act). The Act enshrines state-wide objectives to reduce suicide including promoting best practice suicide prevention, providing training and education, and supporting priority groups. The Act legislates a Suicide Prevention Council comprising senior public officials, Members of Parliament, and suicide prevention leaders with lived experience. The Act mandates a State Suicide Prevention Plan with performance indicators, annual reporting, and specific measures for priority populations to progress the objectives of The Act.

It's important to highlight that The Act requires every state authority to have regard to the State Suicide Prevention Plan and requires prescribed state authorities to have suicide prevention action plans which set out how they will prevent suicide among their workforce and those they support. This is a critical component to implementing a whole of government approach to meaningfully address the social determinants of health that can lead to suicide.

The NSW Opposition has committed to deliver a Suicide Prevention Act if elected in March 2023.



Stand-alone suicide prevention plans

Jurisdictions which have currently active stand-alone suicide prevention plans include:

- Strategic Framework for Suicide Prevention in NSW 2022-2027
- Every life: The Queensland Suicide Prevention Plan 2019-2029
- Northern Territory Suicide Prevention Strategic Framework 2018-2023
- Western Australian Suicide Prevention Framework 2021-2025
- Victorian Suicide Prevention Framework 2016-2025
- Tasmania Suicide Prevention Strategy 2023-2027

At the time of this report, Victoria was undertaking consultation into developing a new Suicide Prevention and Response Strategy in response to Victoria's Royal Commission into Mental Health which called for a suicide prevention strategy that includes people with lived experience at the core of suicide prevention and postvention responses.[36]

South Australia previously had a Suicide Prevention Plan 2017-2021 which has since expired. The South Australian Suicide Prevention Act 2021 legislates a State Suicide Prevention Plan. As the legislation became operational in 2022, the next State Suicide Prevention Plan is currently in development.

The Australian Capital Territory has a five-year Mental Health and Suicide Prevention Plan launched in August 2020. There is currently no commitment to a stand-alone suicide prevention plan from the ACT Government.

Indicator: Stand-alone Suicide Prevention Strategies with funding allocated for implementation	
NSW	NSW Government invested $87 million over three years into Towards Zero Suicides initiatives that address priority areas under the Strategic Framework for Suicide Prevention in NSW 2018-2023.[37] An additional $143.4 million over four years for Towards Zero Suicides initiatives was invested in the NSW 2022-23 Budget.
QLD	QLD's Every life: The Queensland Suicide Prevention Plan 2019-2029 outlines the government's direction to implement a whole-of-government approach to suicide prevention. The plan was launched with funding of $80.1 million over four years for suicide prevention initiatives. In 2022, QLD Government invested an addition $260 million in mental health and suicide prevention support and services over the next five years following signing their Bilateral Agreement. A key highlight in Every life is that action areas of the plan are assigned to departments responsible.

Dedicated suicide prevention positions in governments

Suicide and suicidal behaviours exact an economic toll in addition to their immense emotional and social impacts. The Productivity Commission's Inquiry into Mental Health Final Report shines a light on the immensity of this impact, which is estimated to equate to between $43 billion to $70 billion lost to our economy.[38] We agree with the Commission that governments must act to address the social and economic cost of suicide.

Suicide prevention requires its own portfolio led by a minister in government to enable whole-of-government collaboration and coordination and elevate suicide prevention on the State's agenda.

Indicator: Suicide prevention ministers or portfolios	
NT	Lauren Moss was appointed Minister for Mental Health and Suicide Prevention in May 2022.
SA	Nadia Clancy was appointed the Premier's Advocate on Suicide Prevention in July 2022.
VIC	Tim Richardson was appointed Parliamentary Secretary for Mental Health and Suicide Prevention in December 2022.

Offices of Suicide Prevention

The 2021-22 Federal Budget committed $12.8 million to set up a National Suicide Prevention Office (NSPO) in response to recommendations made in the National Suicide Prevention Adviser's Final Advice and the Productivity Commission into mental health and suicide prevention.

The NSPO is responsible for developing a National Suicide Prevention Strategy, leading the development of a national outcomes framework for suicide prevention, and working with jurisdictions to set priorities for suicide prevention.[39]

The NSPO will help address funding allocations, reduce duplication, support even spread of services, enable continuity of care, and most importantly increase accountability across all areas of government, not just health.

Victoria has followed leadership by the Commonwealth Government to put in place key machinery required to implement a whole-of-government approach to suicide prevention. Victoria is currently the only jurisdiction in Australia to do so.

Indicator: Office of Suicide Prevention	
VIC	Victorian Government formally established the Suicide Prevention and Response Office (SPARO) in July 2022. Victorian Government worked with Roses in the Ocean to develop a lived experience partnership and engagement strategy for SPARO and are working to establish an expert advisory committee for suicide prevention response to inform the work of SPARO.

Addressing the social determinants of health that can lead to suicide

The World Health Organization defines the social determinants of health as non-medical factors that influence health outcomes.[40] These often relate to social, economic, and physical environments. A growing body of evidence indicates factors such as education, employment status, income level and wealth are associated with risk of suicide.[41]

Eighty-seven per cent of respondents believe that all government decisions should consider the risk of suicide and have clear plans in place to respond to any negative impacts following on from those decisions, and this is similar to responses in 2021.

The Australian Institute of Health and Welfare (AIHW) reports:[42]

- People with higher income uncertainty have higher odds of suicide death relative to those with lower income uncertainty
- People who experienced longer periods of unemployment had higher odds of suicide death relative to those with no periods of employment
- Risk of suicide is higher among people with fewer years of education and lower among people who are employed
- Strongest associations with death by suicide include:
  - Being male
  - Being widowed, divorced or separated
  - Being in a lone person household
  - Being unemployed

Data from state suicide registers demonstrates strong associations among deaths by suicide with social determinants of health. A study into deaths by suicide in Victoria found 42% of people who died by suicide were under financial stress, 45% were unemployed, and 22% experienced family violence.[43] The latest Annual Report of the Queensland Suicide Register identified over a quarter of people who died by suicide were unemployed, 18.3% experienced financial problems, and additional 10.2% experienced workplace problems.[44]

Socioeconomic status is strongly associated with deaths by suicide.[45] Over the past 10 years age-standardised suicide rates were highest for those living in the lowest socioeconomic areas.[46] In 2020, the overall suicide rate for people living in the lowest socioeconomic (most disadvantaged) areas (18.1 deaths per 100,000) was twice that of those living in the highest socioeconomic (least disadvantaged) areas (8.6 deaths per 100,000).[47]

Housing insecurity and homelessness has been linked to increased risks of suicidal behaviour. Research reports homeless populations experience higher rates of suicidality than the general population, and youth homelessness is associated with increased rates of suicide and suicidal ideation.[48] Evidence exists of three main channels by which housing affects suicide: "protracted financial stress due to the cost of housing; loss of security due to eviction, insecure housing and homelessness; and the impacts of adverse life events on children and young people on their present and future mental health."[49]

The link between suicidality and the social determinants of health will be critical if we are to work towards a zero-suicide goal. This indicator was assessed by examining commitment to addressing the social determinants of health that can lead to suicide outlined in the evidence presented in this section (low-income earners, unemployment, education, relationship breakdown, family violence, and housing) in suicide prevention strategies and recent state and territory budgets.

Indicator: Government investments to address the social determinants of health that can lead to suicide	
ACT	The ACT Mental Health and Suicide Prevention Plan 2019-2024 commits to addressing the social determinants of mental health.[50] The ACT Government 2022-23 Budget committed funding to addressing social determinants of health such as housing, cost of living, family and domestic violence, disasters, and alcohol and other drugs. Key highlights include: • $140 million of new funding for social and affordable housing • $71.6 million over 4 years across a broad range of measures to address issues relating to domestic, family and sexual violence • $23.4 million in Utilities Concession for 31,200 households with $750 rebate on utility bills
NSW	The NSW Strategic Framework for Suicide Prevention in NSW 2022-2027 recognises the complex social determinants of suicide, and the need to take a long-term, holistic approach to addressing them.[51] The NSW Government 2022-23 Budget committed funding to addressing social determinants of health such as housing, disasters, rural and regional residents, cost of living, family and domestic violence. Key highlights include: • $37.0 million towards supporting the Community Housing Sector to deliver 120 social housing dwellings for households in the Together Home program • $7.2 billion next financial year to boost family budgets and alleviate cost of living • $43.6 million for expansion and enhancement of Safer Pathway to support victim-survivors of domestic and family violence
NT	The Northern Territory Suicide Prevention Strategic Framework 2018-2023 identifies the need to address social and economic determinants of health to support Aboriginal and Torres Strait Islander peoples and addressing social determinants of health for the broader population.[52] The NT Government 2022-23 Budget committed funding to addressing social determinants of health such as cost of living, education, housing, and family and domestic violence. Key highlights include: • $2.2 million funding towards strengthening vocational education and training in schools • $10.7 million for safe house upgrades and support for people experiencing family and domestic violence • $22.34 million for the Community Housing Growth Strategy
QLD	Queensland's Suicide Prevention Plan 2019-2029 states a social determinants approach to mental health and wellbeing is adopted in suicide prevention.[53] The QLD Government 2022-23 Budget committed funding to addressing social determinants of health such as housing, cost of living, family and domestic violence disasters, and social isolation and loneliness. Key highlights include: • $126 million over 4 years and $19 million ongoing to help address social isolation and support invaluable Neighbourhood and Community Centres throughout Queensland • $541.3 million in 2022–23 for government managed housing rental rebates, supporting approximately 54,700 low-income households • $19.2 million over 4 years for specialist domestic, family and sexual violence support services and programs for women in custody

SA	The SA Government 2022-23 Budget committed funding to addressing social determinants of health such as cost of living, housing, disasters, family and domestic violence, alcohol and other drugs, social isolation and loneliness, education, and childhood trauma. Key highlights include: • $39.3 million in 2022-23 to double the cost-of-living concession amount per eligible household in 2022-23 • $177.5 million over four years to the Public Housing Improvement Program build 400 new houses • $2 million over four years for family and domestic violence support services
TAS	The Tasmanian Suicide Prevention Strategy 2023-2027 includes focus on addressing social determinants such as housing, financial security, education, and employment.[54] The TAS Government 2022-23 Budget committed funding to addressing social determinants of health such as housing, cost of living, childhood trauma, family and domestic violence, disasters, alcohol and other drugs, and education. Key highlights include: • $1.5 billion commitment that will deliver 10,000 new social and affordable homes by 2032 over 10 years • $305 million in concessions to support vulnerable Tasmanians to meet essential costs of living, including the cost of water and sewerage, electricity and council rates • $15 million to establish new multidisciplinary centres to ensure victim-survivors of family and sexual violence receive immediate and integrated support in a safe place
VIC	The Victorian Suicide Prevention Framework 2016-2025 states focus on the social determinants of health.[55] The VIC Government 2022-23 Budget committed funding to addressing social determinants of health such as employment, cost of living, housing, family and domestic violence, disasters, and social isolation. Key highlights include: • $246 million Sick Pay Guarantee pilot for 150,000 Victorians in insecure work to access up to five days' sick pay every year • $5 million will be dedicated to the establishment of a support service for workers in the gig economy • $9.1 million for Social Inclusion Action groups in 10 LGAs to build on the success of local community mental health groups
WA	Western Australia's Suicide Prevention Framework 2021-2025 identifies the important role social determinants play in a whole of community approach, and that addressing social determinants is a key factor for the Plan.[56] The WA Government 2022-23 Budget committed funding to addressing social determinants of health such as cost of living, employment, housing, family and domestic violence, rural and regional residents, and disasters. Key highlights include: • $5.5 million to help mature-aged jobseekers and ex-offenders into jobs • $7.7 million for the Family and Domestic Violence Response Teams

While state and territory governments have recognised the toll increased cost of living is taking on the lives of Australians and made investments in some concessions to alleviate this, national leadership is needed to increase social security income support payments in line with the Raise the Rate campaign to lift Australians out of poverty and reduce risk of suicide.

Chapter 3

DATA

Outcome/what we're trying to achieve: Reliable, timely and meaningful data and evidence that drives better policy, practice and outcomes.

Jurisdiction	Indicators			
	Real time suicide deaths and attempts data	Suicide register in every jurisdiction	Data sharing on suicide deaths	Standardisation of suicide attempts and self-harm classification
ACT	Yes	Yes	In development	No
NSW	No	Yes	Yes	No
NT	Yes	Yes	In development	No
QLD	Yes	Yes	Yes	No
SA	No	Yes	Yes	No
TAS	No	Yes	Yes	No
VIC	Yes	Yes	Yes	In development
WA	No	Yes	In development	No

Context

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 95% of the suicide prevention sector respondents to the 2022 State of the Nation survey agree their organisation needs access to reliable, accurate suicide prevention data, less than half (48%) agree they have access to the data they need right now.[57]

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 National Suicide and Self-harm Monitoring System was first announced in the Commonwealth Government's 2019-20 Budget and has continued to develop and expand through continued Commonwealth funding. The National Suicide and Self-harm Monitoring System collates data reported through state and territory suicide death registers to provide a national dataset on suicide deaths in Australia. While this data collection mechanism is a step forward, there is an 18-month time lag on the data and experiences inconsistencies in underreporting due to lag in death registrations from time of reporting.[58]

As the national dataset draws on data collected from jurisdictions, data could be improved through enhanced data collection on suicide deaths and self-harm at the state and territory level.

Major gaps remain 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 to measure suicide prevention program efficacy in the community and provide data on program impacts to guide future learning.

Access to real-time suicide deaths and attempts data

A consistent theme throughout all iterations of our State of the Nation Annual Survey Report (2020, 2021, 2022) is the need for access to real-time notifications on suicide suspected and confirmed deaths, and suicide attempts for the suicide prevention sector. Access to timely data will enable coordinated and responsive suicide prevention services i.e. postvention and aftercare providers to respond to distress in the community when it occurs. Localised partnerships for data sharing purposes would significantly improve community driven suicide responses.

Some jurisdictions have implemented partnerships with police to utilise database tools to enable timely referrals to support services for people in the community bereaved by suicide using a consent-based model

Indicator: Real-time suicide deaths and attempts data	
ACT & NT	SupportLink is an IT platform built specifically as a police referral pathway. SupportLink has been operational in the ACT for the last 20 years, and in the NT since 2013. SupportLink has previously worked with QLD and VIC. The referral platform is managed by Referral Coordinators who assist in managing partnerships, following up on unanswered referrals to ensure people are receiving links to support, and manage agency partnership expectation agreements (e.g. there is an expectation that services must follow up a referral within 24 hours). There are a number of referral categories police can make referrals for, including bereavement by suicide.
QLD	Queensland Police Service have contracted a system 'InfoExchange' as IT providers for a referral gateway connecting police referrals to service providers. The system has over 22 categories, including a sudden death category following death by suicide for families and friends. 550 services are connected to the platform to receive referrals. The system has been operational since 2015.
VIC	Victoria Police e-Referral System (VPeR) has introduced a bereavement by suicide category to their referral system which links police referrals to service providers.

Discussions with service providers of police referral data systems highlighted current challenges with the model:

- Consent-based model means a person must provide consent to the police officer attending which is subjective to the officer's ability to provide appropriate support.
- The system is not a suicide notification system which means service providers are unable to draw trends from data in local areas.
- Training is needed for police officers to increase confidence in providing support to people bereaved by suicide. This should be embedded in police interview training.
- Training is needed to upskill coroner's capacity to make referrals.

Suicide death registers and data sharing

Suicide death registers are an integral component to providing suicide data at both jurisdictional and national levels. Suicide registers should be established in every state and territory across Australia to increase the accuracy of the provision of mortality data to the ABS. Currently, suicide death registers exist in Queensland, Victoria, Tasmania, New South Wales, South Australia, and Western Australia. The Australian Institute of Health and Welfare reports they are working with Australian Capital Territory and Northern Territory coroner and health officials to establish suicide registers in their jurisdictions.[59]

Indicator: Suicide register in every jurisdiction and data sharing on suicide deaths	
ACT	The ACT Suicide Register has established a suicide register under a Memorandum of Understanding with the AIHW and became operational in June 2022. Data or reports from the register are not yet available to the sector or publicly.
NSW	NSW Government established NSW Suicide Monitoring System which reports on suspected and confirmed suicides in 2020. Data reports are published eight weeks from the last day of the reporting month, and reports on data monthly.
NT	The NT has established a Memorandum of Understanding with the AIHW to establish a suicide register. Data or reports from the register are not yet publicly available.
QLD	The Queensland Suicide Register (QSR) was established in 1990 and provides public annual reports on suicide death data. To address time delays in confirming deaths by suicide, Queensland utilise the interim Queensland Suicide Register (iQSR) which reports on suspected deaths by suicide. Regular monthly data from the Register is not yet available to the sector or publicly
SA	The South Australia Suicide Register became operational in December 2021. South Australia provides suspected suicide data to the AIHW on a monthly basis, disaggregated by sex and age group.
TAS	Tasmania established a suicide death register in 2017. Data or reports from the register are not yet available to the sector or publicly.
VIC	The Victorian Suicide Register was established in 2012 and is managed by the Coroners Court of Victoria who report on suspected suicide deaths to the AIHW monthly, disaggregated by week, sex and age group.
WA	Western Australia established a suicide death register in 2010. There is no public reporting of deaths by suicide, however the number of confirmed suicide deaths in WA are accessible via the Australian Bureau of Statistics Causes of Death report. It has been reported that the WA Mental Health Commission is progressing the development of a WA Suicide Monitoring System.

The AIHW is in the process of developing an inter-jurisdictional network of suicide registers to facilitate knowledge sharing and collaboration on suicide surveillance data. We welcome efforts to share knowledge across jurisdictions and support national collaboration to ensure timely, accurate and accessible data on suicdie and self-harm.

Standardisation of suicide attempts and self-harm classification

All health authorities across jurisdictions collect data on most public hospital emergency department presentations.[60] This data feeds into the National Non-Admitted Patient Emergency Department Care Database to provide national datasets on emergency presentations.[61] Australia uses the ICD-10 (International Statistical Classification of Diseases) for diagnostic coding to provide internationally comparable data.[62]

While collecting data on general presentations to hospitals, emergency departments and ambulance attendances is common practice, datasets on suicidal ideation, self-harm, and suicide attempts presentations in these settings vary significantly in completeness and quality.

A key factor affecting the differences between emergency datasets is the lack of standardised nomenclature to describe and classify suicidal ideation and behaviour presentations. For example, self-injury could be coded with any other self-harm category.[63] There may also be insufficient evidence to determine a suicide attempt or suicide death at the time of presentation. Research indicates that ICD-10 coding for self-harm may not accurately classify self-harm cases as it lacks sensitivity to distinguish context of the self-harm (e.g. an accidental overdose vs an overdose intended as a suicide attempt).[64]

The National Suicide and Self-harm Monitoring System notes that hospitalisation data may vary among jurisdictions due to varying hospital policy and practices e.g. through changes to care type definitions, reporting of Indigenous status, and changes in the ICD-10 which can impact interpretation of trends.[65,66]

The National Suicide Prevention Adviser's Final Advice recommends the National Suicide Prevention Office develop national definitions of self-harm and suicide attempts (3.3).[67]

Indicator: Standardisation of suicide attempts and self-harm classification	
VIC	In 2021 it was announced that Victoria would be the first jurisdiction to introduce a Self-harm Monitoring System to enhance data accuracy on self-harm presentations to emergency departments.[68] The system is still under development across eight emergency departments in Victoria (six in metropolitan areas and two in regional areas).[69]

In addition to enhancing the quality and accessibility of suicide data in existing systems, further research is needed into understanding the journey of suicidality and crisis intervention points. Australia further needs state-driven data collection on the linkages between the social determinants of health, demographic, and geographic data with suicide deaths, attempts, and behaviours. Participants in our consultations identified data collection on suicidality could be enhanced through educating communities on the methods and purpose of data collection, and by addressing privacy concerns associated with data collection.

Chapter 4

QUALITY AND ACCREDITATION

What we're trying to achieve: Ensure quality and safety in suicide prevention activities

Jurisdiction	Indicators		
	Evidence-based services	Suicide prevention programs are accredited or engaged in accreditation processes to ensure safety and demonstrate how lived experience is embedded in service design	Regular outcomes-based evaluation of services
ACT	Yes	In development	Yes
NSW	Yes	In development	Yes
NT	Yes	In development	Yes
QLD	In development	In development	Yes
SA	Yes	Yes	Yes
TAS	Yes	In development	Yes
VIC	Yes	Yes	Yes
WA	In development	In development	Yes

Context

The fifth Mental Health and Suicide Prevention Plan recognises the importance of standards to assuring services and programs are safe, quality and outcomes-focussed. Similarly, the Victorian Royal Commission into mental health recommended the use of new service standards to select providers of mental health and wellbeing services (recommendation 48).[70]

There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability of funding 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.

There are many organisations and programs dedicated to preventing suicide and supporting those impacted by it, and they vary significantly in size, maturity, and focus. The suicide prevention sector, state and federal governments, commissioning agents, and the Australian community at large expect these programs to be able to demonstrate safety, quality and efficacy. But there is no 'one size fits all'.

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.

Our organisation partnered with people with lived and living experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Standards for Quality Improvement.

The independent accreditation process is designed to support the suicide prevention sector, offering a user-friendly, self-directed pathway relevant to the needs of a wide range of suicide prevention programs. It also acknowledges that providers are at different stages of maturity and program implementation.

Programs are measured against appropriate, necessary and relevant standards that set a nationally consistent quality benchmark. This supports community confidence

in suicide prevention programs, especially for those seeking help for suicidal behaviour.

Quality accreditation also assists governments, Primary Health Networks, and other funders and commissioners to understand the breadth and depth of existing programs.

Evidence-based services

Suicide prevention programs and services should be aligned with evidence, research, and best practice models. We examined statements of commitment to evidence-based suicide prevention in state and territory Bilateral Agreements and Suicide Prevention Plans to assess this indicator.

Indicator: Commitment to evidence-based suicide prevention	
ACT	ACT's Mental Health and Suicide Prevention Plan 2019-2024 identified that suicide prevention requires an evidence-informed approach (ref.6).
NSW	NSW Strategic Framework for Suicide Prevention 2018-2023 identifies innovating for a stronger evidence base as a priority action area.
NT	Northern Territory's Suicide Prevention Strategic Framework 2018-2023 includes focussed and evidence informed support for the most vulnerable groups of people as a goal (ref.3).
QLD	Queensland's Suicide Prevention Plan 2019-2029 includes a joined-up planning approach that reflects population need and evidence as a guiding principle.
SA	South Australia's Bilateral Agreement includes compassionate, evidence-based support be provided for people experiencing suicidal behaviour (ref. 47).
TAS	TAS was in the process of undertaking consultation to develop a five-year suicide prevention strategy at the time of this report.
VIC	Victorian Suicide Prevention Framework 2016-2025 identifies decisions based on evidence and commitment to a cycle of continuous learning as a guiding principle. In addition, evidence-based, compassionate responses to be available for people in suicidal distress is included in Victoria's Bilateral Agreement (ref.70).
WA	Western Australia's Suicide Prevention Framework 2021-2025 includes evidence-informed, integrated, cross-sectoral approaches to suicide prevention as a guiding principle.

Suicide prevention programs are accredited or engaged in accreditation processes to ensure safety and demonstrate how lived experience is mandatory in service design

Currently accreditation standards for suicide prevention services to ensure safety, quality, and efficacy of services are not embedded in Australia. A list of services across jurisdictions who are currently engaged in Suicide Prevention Australia's Accreditation Program for suicide prevention services is available on our website. In our scan, we did not identify suicide prevention accreditation standards that are mandatory in service design and delivery across jurisdictions.

Our consultations reported government funding to support the suicide prevention sector to engage with accreditation processes is needed as part of further investment in the capability of the sector. This is particularly important for grassroots community suicide prevention and postvention supports who require funding support to participate in accreditation and evaluation activities. Accreditation programs for suicide prevention should be scaled to consider the size of the organisation with support provided for local level suicide prevention networks to undertake accreditation.

Accreditation standards for alcohol and other drug services exist in some jurisdictions and can be used as a guiding model to embed accreditation standards for the suicide prevention sector.

Accreditation Standards	
NSW	In 2018 NSW Health embedded accreditation standards for alcohol and other drug services. All services must hold at least one of the accreditation standards and accreditation must be awarded by an accrediting agency that is certified through the Joint Accreditation System of Australia and New Zealand and/or the International Society for Quality in Healthcare.[71]
WA	The Mental Health Commission of Western Australia requires all non-government mental health and alcohol and other drug services to hold accreditation against the National Standards for Mental Health Services 2010.[72]

Under the roll-out of regional targeted suicide prevention responses in all 31 PHNs, the Commonwealth has issued guidance that suicide prevention coordinators should have regard to the accreditation standards and the best practice directory. This is an important first step in embedding these standards to ensure safe, quality, and effective practice. It provides a precedent which state and territory governments should consider.

Regular evaluation of services

The National Suicide Prevention Adviser's Final Advice recommends measurement of outcomes is essential to monitor impacts of suicide prevention initiatives (3), and that all jurisdictions work with the National Office for Suicide Prevention to set priorities for suicide prevention research and share knowledge for continual improvement (3.4).[73]

Evaluation is integrated in all state and territory Bilateral Agreements (Agreements) on mental health and suicide prevention generally. When examining evaluation for key suicide prevention services such as aftercare and postvention in the Agreements, Victoria, Queensland and the Northern Territory outline regular evaluation requirements for both services; and Western Australia, Tasmania, and the Australian Capital Territory outline evaluation for aftercare.

South Australia did not fund aftercare or postvention in their Bilateral Agreement and as such regular evaluation for those services is not included. As South Australia's Suicide Prevention Plan is in development at the time of this report, we are unable to assess South Australia against this indicator.

While routine evaluation has been committed to in the majority of Bilateral Agreements met in 2022, we note that the transparency of evaluation outcomes for suicide prevention services remains an issue to be addressed across jurisdictions.

Participants in our consultations identified the need for longer funding contracts to enable appropriate evaluation of outcomes and impact of suicide prevention programs and services, and that evaluation should be funded as an item in contracts to assist organisations to undertake thorough evaluation processes.

This indicator examined evaluation embedded in Bilateral Agreements and suicide prevention plans:

- New South Wales, Victoria, Queensland, and Northern Territory include evaluation and reporting of aftercare and postvention services in Bilateral Agreements.
- Western Australia, Tasmania, and the Australian Capital Territory include evaluation and reporting of aftercare services in Bilateral Agreements.
- Monitoring and evaluation outcomes for aftercare and postvention services are identified in Western Australia's Suicide Prevention Framework.
- Evaluation is identified as a focus area in Australian Capital Territory's Mental Health and Suicide Prevention Plan.

Chapter 5

SERVICE PROVISION

What we're trying to achieve: Ensure every Australian experiencing suicidality or impacted by suicide has access to the support they need.

Jurisdiction	Indicators			
	Commitment to universal aftercare	Commitment to universal postvention	Crisis or distress services	Safe Spaces / alternatives to emergency departments
ACT	Yes	No	Yes	Yes
NSW	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	TBC
QLD	Yes	Yes	Yes	Yes
SA	No	No	No	Yes
TAS	Yes	No	No	Yes
VIC	Yes	Yes	Yes	Yes
WA	Yes	No	Yes	In development

Context

Indicator: Universal Aftercare

Australia has committed to achieving universal aftercare for suicide prevention. A previous suicide attempt is the strongest risk factor for a subsequent suicide death. The Commonwealth Government announced $158.6 million for universal aftercare services in the 2021-22 Budget. Funding commitments have been matched in almost all states and territories with approximately $300 million allocated towards a universal aftercare system. South Australia did not include aftercare in their Bilateral Agreement and have yet to announce funding allocation towards universal aftercare.

Aftercare services typically provide support for three months post attempt. Feedback from our consultations with people with lived experience and the suicide prevention sector expressed that three months is not long enough.

In 2022, we undertook consultation with our Lived Experience Panel and our members with expertise and lived experience of aftercare and suicide prevention to develop a set of key design features of a universal aftercare system. For further information, our Report, 'Right from the start: Report on the design of Australia's universal aftercare system' identifies the following key design features for a universal aftercare system:

1. Multiple service types

2. Broad eligibility

3. Comprehensive service range

4. Immediate and long-term support

5. Extensive referral pathways

6. Reaching support networks

7. Person-centred service delivery

Further identified in consultation are key enablers to a universal aftercare system in Australia for state and territory governments to address:

- Addressing data gaps
- Workforce development
- Best practice commissioning

- Service and community capacity
- Standardised data collection
- Research and evidence
- Quality and safety

Postvention

The Commonwealth Government invested $22 million towards national postvention services in the 2021-22 Budget to provide in partnership with states and territories. With each person who dies by suicide, up to 135 others will be impacted, which is estimated to equate to over 400,000 Australians per year.[74,74,76]

Funding commitments have been matched in Bilateral Agreements by New South Wales, Victoria, Queensland, and Northern Territory. The Australian Capital Territory 2022-23 Budget included funding for postvention services, however the budget item describes support for people who have survived a suicide attempt, meaning postvention support for those bereaved or impacted by suicide has not been funded. Tasmania, South Australia and Western Australia did not fund postvention services for suicide prevention in their Bilateral Agreements or 2022-23 Budgets.

Indicator: Universal postvention	
NSW	$14.7 million to ensure all people in NSW who are bereaved or impacted by suicide can access postvention support services allocated in Bilateral Agreement.
NT	$1.3 million to ensure all people in NT who are bereaved or impacted by suicide can access postvention support services allocated in Bilateral Agreement.
QLD	$9.4 million to ensure all people in QLD who are bereaved or impacted by suicide can access postvention support services allocated in Bilateral Agreement.
VIC	$5.0 million to ensure all people in VIC who are bereaved or impacted by suicide can access postvention support services allocated in Bilateral Agreement.

Crisis or distress services

Australia has experienced a surge in demand for crisis and distress services in recent years due to the impact of the COVID-19 pandemic compounded with multiple natural disasters across the country.

The average calls to Lifeline Australia have increased by 40% in 2 years,[77] and data from a Kids Helpline six monthly report identifies a 200% increase in counselling contacts from five year-olds over the first six months of 2021, when compared to 1 January to 30 June 2020.[78]

In response, the Commonwealth Government invested $52.3 million in funding for Lifeline Australia over four years to provide additional support services, maintain and improve infrastructure and responsiveness, innovation in crisis, surge capacity and models of care in the 2022-23 Budget.

The National Mental Health and Suicide Prevention Plan highlights commitment to providing, in partnership with states and territories through the National Mental Health and Suicide Prevention Agreement, $31.2 million to pilot a National Distress Intervention program which will reach people in crisis and provide immediate support.[79]

The National Distress Intervention is based on the Scottish Distress Brief Intervention (DBI) which delivers both emotional and practical support based on client needs.[80] DBI has demonstrated success in reducing distress. An evaluation of DBI in 2022 found one in ten evaluation participants reported they may have attempted suicide or continued suicidal thinking if DBI had not been offered to them.[81]

This indicator examined aftercare, postvention, Distress Brief Interventions, and crisis support helplines.

Indicator: Crisis or distress services	
ACT	ACT Government committed to an aftercare pilot program to expand referral pathways from other health settings, and to explore opportunities for implementation of a Distress Intervention Trial in their Bilateral Agreement.
NSW	NSW Government invested $4.9 million to implement a Distress Intervention Trial Program to prevent and reduce suicidal behaviour in their Bilateral Agreement, and $28.5 million to Lifeline over four years to meet increasing demand for mental health crisis services in the 2022-23 Budget.
NT	As part of the $9.3 million invested in universal aftercare, two trial sites in NT for aftercare services for people who have experienced a suicidal crisis without being admitted to hospital will be established.
QLD	QLD Government invested $4.9 million to implement a Distress Intervention Trial Program to prevent and reduce suicidal behaviour in their Bilateral Agreement.
VIC	VIC Government invested $2.4 million to implement a Distress Brief Intervention Trial Program to prevent and reduce suicidal behaviour at two trial sites in their Bilateral Agreement, and funded an 18-month pilot for a peer call-back service for families and carers for people experiencing suicidal distress in their 2022-23 Budget.
WA	WA Government invested $10.5 million over two years to expand Crisis Connect to support children (0-18) and their families and carers waiting to access public specialist infant, child and adolescent mental health services. WA Government committed to an aftercare pilot program in their Bilateral Agreement to expand referral pathways from other health settings.

Safe spaces and alternatives to emergency departments

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 experiencing mental distress and people with lived experience report distress can be exacerbated by this setting.[82]

In 2020, the Commonwealth Department of Health engaged KPMG to undertake a scoping study on the proposal for a National Safe Spaces Network and determined the model has strong potential to strengthen supports for people at risk of suicide.[83] In 2021, the Commonwealth Government committed $6.6 million to implement national standards for Safe Spaces services in the National Mental Health and Suicide Prevention Plan.[84]

Safe 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 '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.[85]

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.[86]

Safe Spaces have emerged in Australia to respond to the number of people presenting to hospitals with suicide and self-harm presentations. In 2020-21, there were more than 29,000 hospitalisations due to intentional

self-harm in Australia,[87] and 33,000 ambulance attendances for suicidal thoughts and behaviours.[88]

Roses in the Ocean has 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 departments 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 has developed a tiered approach that extends Wesley Mission Queensland's three tier model for mental health Safe Safes to include additional tiers focussed on suicide prevention:[89]

- 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 in 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.

There is a particular need for investment in Tier 4 and Tier 5 Safe Spaces that have high-fidelity to the concept and to the lived experience co-design process. The key components of this model are:[90]

- A trauma-informed 'no wrong' door approach
- Non-clinical support that meets the holistic needs of guests
- A compassionate and capable peer-led workforce
- A safe and accessible location
- A warm welcoming environment
- Warm connections to other appropriate and reliable supports
- Shared governance and management

The Police, Ambulance, Clinician Emergency Response (PACER) model was developed to equip police and ambulance with specialist mental health clinicians to attend callouts when responding to people in the community experiencing mental health distress. The aim is to reduce emergency department admissions and connect people with community-based supports.

A study by Black Dog Institute found 43.5% (n=911) of people who presented to emergency departments for suicidal crisis in the past 18 months in New South Wales and the Australian Capital Territory would not return to an emergency department with a future suicidal crisis.[91] Study participants who were the least likely to return reported negative experiences of inadequate psychosocial assessments and long wait times to receive treatment.[92] The study demonstrates a clear link between negative patient experience and adverse help-seeking outcomes.[93,94]

The PACER model has been trialled across most jurisdictions in Australia and has yielded effective results in reducing emergency department admissions for mental health assessments.

A 2020 evaluation of the PACER model in New South Wales saw a 50% decline in police transports to hospitals for mental health assessments compared to the previous year.[95] In Financial Year 2021-22, PACER attendances in the Australian Capital Territory resulted in 70% of patients (n=1602) able to receive care at home instead of hospital admission.[96] In its first week of operation in Tasmania in 2022, PACER responded to 27 callouts for people experiencing mental health and suicidal distress and 63% were supported to remain in the community.[97]

Evaluation of an 18-month trial of the PACER model in Townsville Queensland saw 474 people assessed by a co-responder in their home, 87% of which were connected to support services in their community.[98] Effective trial results lead to the program made permanent in 2022.[99] A trial in Central Adelaide South Australia of the PACER model saw two out of three patients receive treatment at home or connected to community-based supports as opposed to hospital admission.[100]

This indicator examined safe space/haven models and PACER programs across jurisdictions.

Indicator: Safe spaces/alternatives to emergency departments	
ACT	ACT Government invested $1.9 million to extend the PACER team for a further 12 months, and $9.3 million to establish a territory-wide hospital avoidance strategy to strengthen community-based programs in the 2022-23 Budget. The ACT established its first Safe Haven in 2021 and ACT Government has recently advised they are committed to expanding Safe Haven facilities throughout NT.[101]
NSW	In 2022, NSW Government invested $25.1 million in the Safe Haven initiative and $21.35 million in the Suicide Prevention Outreach Teams. In the NSW Government's 2021-22 Budget, $25.8 million over four years was invested into the PACER program.
NT	NT Government introduced a trial of the Mental Health Co-Responder Project in 2020, which involved a mental health clinician supporting emergency responders (police or paramedic) to provide specialised care on a call-out.[102]
QLD	QLD Government invested $10.8 million over four years to establish eight Safe Spaces across QLD in the 2019-20 Budget. Queensland Suicide Prevention Plan includes action (area 3) to prepare options for a state-wide co-responder model linking police, ambulance services and the Department of Health.[103]
SA	In 2021 the Mental Health Co-responder in Emergencies initiative (based on the PACER model) was expanded from Central Adelaide to Northern and Southern Adelaide local health networks.
TAS	Tasmanian Government allocated $6.9 million in 2022-23 for state-wide Safe Spaces in the 2022-23 Budget. TAS Government further allocated $9 million to expand the PACER program aimed to reduce emergency department presentations by equipping emergency call-outs with mental health clinicians to provide timely assessments and referrals to community-based supports.
VIC	As of September 2020, Safe Haven Café was integrated into St Vincent's Hospital Melbourne mental health service. VIC's 2022-23 Budget funded extension of the TelePROMPT program which connects paramedics at the scene of a mental health crisis with a mental health clinician.
WA	Two Safe Havens were established in WA in 2021 to provide an alternative to emergency departments for people experiencing mental health distress.[104] In 2021, WA rolled out the first Mental Health Co-response (MHCR) Program in the Midwest[105] and in June 2022 WA Country Health Service announced the program will roll out in the South West.[106]

Chapter 6

WORKFORCE AND COMMUNITY CAPACITY

What we're trying to achieve: A sustainable workforce, quality sector practice and community-wide capability for suicide prevention.

Jurisdiction	Indicators		
	Evidence based suicide prevention training across community, services and industries	Suicide prevention networks	Suicide prevention workforce attraction and retention
ACT	Yes	Yes	Yes
NSW	Yes	Yes	Yes
NT	Yes	Yes	Yes
QLD	Yes	Yes	In development
SA	Yes	Yes	Yes
TAS	Yes	Yes	Yes
VIC	Yes	Yes	Yes
WA	Yes	Yes	Yes

Context

Workforce and community capability is a key enabler identified in the National Suicide Prevention Adviser's Final Advice Report.[107] Workforces and communities need to be equipped to respond to people in distress or suicidality, as the first time a person discloses can be critical in influencing whether they seek help or choose to disclose again.

Both the Productivity Commission and the National Suicide Prevention Advisor recommend the delivery of compassionate care to be enabled by addressing workforce shortages, development, and capability of the mental health and suicide prevention sectors.[108,109]

The Commonwealth Government invested $58.8 million in the 2021-22 Budget to grow and upskill the mental health and suicide prevention workforce.[110]
Key activities include:

- $3.1 million to boost and support the mental health peer workforce through, up to 390 scholarships and opportunities for professional collaboration
- $2.4 million to continue mental health training for practitioners working in aged care and support professional collaboration through the Mental Health Professionals' Network
- $1 million for initiatives to reduce the stigma associated with mental health among health practitioners, and promote mental health as a preferred career option
- $15.9 million to support GPs and other medical practitioners by providing specialised training and resources to enhance their capacity to address mental health concerns of patients.

In the 2022-23 Budget, the Commonwealth Government invested $64.7 million to implement the first stages of a mental health workforce strategy including to support the psychiatry workforce, pathways to practice, to support the mental health of health workers, to provide general practitioners with access to psychiatrist support, to build capability to respond to people with substance use and stigma reduction.

While some investment has been made for a mental health workforce strategy, specific and strategic focus on the suicide prevention workforce has been less clear.

Evidence-based suicide prevention training

In 2020, the National Suicide Prevention Adviser's Final Advice Report recommended all jurisdictions resource evidence-based and compassionate training for clinical and other health staff, frontline workers, and industries providing financial, employment and relationship support to people experiencing distress (4.1, 4.2).[111]

Following on from the National Suicide Prevention Adviser's Advice, the Royal Commission into Victoria's Mental Health System in 2021 recommended providing training in responses for workforces likely to come into contact with people experiencing suicidal behaviour and providing evidence-informed 'community gatekeeper training' to develop suicide awareness and prevention skills (27).[112]

For suicide prevention to be effective, key people in the community from clinicians to frontline service workers and teachers should be actively engaged. With the appropriate evidence-based suicide prevention training, these connectors within communities are capable of having a conversation with a patient, customer, student or neighbour that could shift their mental health, wellbeing or suicide risk. As a sector, we must always be pushing for continuous improvement and looking for ways to raise the bar collaboratively. The result is improved access to services for people who are in distress.

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 instead.)

Skilled connectors can recognise suicidal behaviours or signs of distress, provide immediate support, and direct the person in crisis to support services.[113] 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 people to access existing support services.

Indicator: Evidence-based suicide prevention training across community, services, education and industries	
ACT	ACT Government fund Question, Persuade, Refer suicide prevention training online and free of charge.[114] The training program was developed by QPR Institute in partnership with Black Dog Institute.
NSW	In 2020, NSW Government invested $2.8 million in community gatekeeper training over three years to equip community members with the skills to recognise suicidal distress and connect people to support.[115] Over half of the 10,000 gatekeepers trained will be based in regional and rural NSW. In 2021, NSW Government invested $14 million to provide suicide prevention training to 275,000 people. The training is aimed at high school peer leaders, teachers and support staff, parents, community groups and youth influencers (e.g. sports coaches and club managers).[116]
NT	Anglicare NT has provided suicide prevention training including ASIST and SafeTALK since 1998.[117] This training is funded by the NT Government.
QLD	QLD Suicide Prevention Plan Action Area 3 identifies all agencies are responsible for providing training to enable public sector employees to recognise and respond to community members in distress.

Indicator: Evidence-based suicide prevention training across community, services, education and industries	
SA	Country SA PHN funded free suicide prevention training delivered by LivingWorks for people impacted by the 2019/2020 bushfires.[118] We note that PHNs are funded by the Commonwealth Government. The South Australia Suicide Prevention Act Objects include providing training and education in relation to suicide prevention. Enactments of the Act are supported by Wellbeing SA.
TAS	TAS Government allocated $3 million to targeted suicide prevention initiatives including development of the Suicide Prevention Workforce Development and Training Plan for Tasmania 2016-2020 to deliver suicide prevention training to people in key occupations.[119]
VIC	In 2018, VIC Government invested $80,000 over three years to Lifeline to deliver suicide prevention training to over 250 local businesses and sporting community groups to improve community capacity to respond to distress in the community.[120] The VIC place-based suicide prevention trials included partnership with LivingWorks to deliver suicide prevention community connector training tailored to population groups at higher risk of suicide, ASIST training, and safeTALK training packages.[121]
WA	In 2016 WA Government invested $560,000 in grants to enable community organisations to deliver suicide prevention training.[122]

Suicide prevention networks

Communities play a key role in suicide prevention. Suicide prevention networks (SPNs) are unique in their ability to provide support, education and training that is tailored to the needs of their community. They provide localised suicide prevention and work towards building the capacity and resilience of their community to respond to people in distress.

The National Suicide Prevention Adviser's Final Advice Report identifies that men prefer to access support through local men's groups and peer-based support networks.[123] We know that three quarters of deaths by suicide in Australia are by men.[124] It's critical that states and territories continue to invest in community suicide prevention networks who are a well placed to provide localised support to vulnerable people in their communities.

Many suicide prevention networks are run by volunteers with lived experience of suicide and are either survivors of a suicide attempt or people bereaved by suicide who want to help others with similar experiences in the community. SPNs often start out self-funded by people with lived experience and grow significantly due to community need.

"Communities play an essential role in suicide prevention when they provide bridges between community needs, national policies and evidence-based interventions that are adapted to local circumstances – World Health Organisation[125]

The Commonwealth Government invested $8.9 million to Wesley Mission to continue funding and expand the Wesley LifeForce Suicide Prevention Network program through the National Suicide Prevention Support and Leadership Program in 2022.[126]

SPNs should be supported by government funding to deliver localised suicide prevention to the community, including funding for community leaders to undertake suicide prevention training and education to upskill their ability to respond to distress and organise suicide prevention community connection initiatives.

Indicator: Suicide prevention networks (SPNs)	
ACT	ACT Health has implemented a trial of LifeSpan over three years in partnership with Black Dog Institute to strengthen local community approaches to suicide prevention.[127] The ACT Government is continuing to implement suicide prevention initiatives from Lifespan. ACT Government fund the Mental Health and Wellbeing Innovation Grants Program which allocates $350,000 across two grant streams – one of which is for proposals up to $10,000 from individuals, community groups and small organisations to deliver local programs.[128]
NSW	In the 2022-23 Budget, NSW Government invested $4.5 billion over four years in our health workforce, including providing 10,000 additional health workers. NSW Government further identify building the suicide prevention workforce as a priority in the 2022-2027 Suicide Prevention Framework supported by $143.4 million to implement the Towards Zero Suicides initiatives.[129]
NT	NT Health provide annual community suicide prevention activity grants for projects that build community capacity and resilience, address stigma and discrimination, and raise awareness of suicide prevention practices.[130] Over $1.22 million in community suicide prevention grants have funded 161 projects across 2018-2022.[131]
QLD	Central Queensland Rural Health works with local communities to establish suicide prevention partnerships to support communities to build capacity and tailored action plans.[132] The Better Futures Grants Program offers up to $200,000 for innovative initiatives targeting mental health and wellbeing, social inclusion, alcohol and other drug use, or those impacted by suicide.[133] The Local Thriving Communities Grants program supports initiatives that are designed with local leadership to improve mental health and wellbeing, respond to substance use issues, and reduce rates of suicide among Aboriginal and Torres Strait Islander Queenslanders.[134] QLD Government invested $1 million towards grants for projects that address the social and emotional wellbeing of Aboriginal and Torres Strait Islander communities.[135]
SA	Wellbeing SA allocated $180,000 to the 2022-23 Suicide Prevention Community Grants scheme to provide community groups and non-government organisations up to $10,000 to deliver localised suicide prevention projects. SA currently has 45 suicide prevention networks established across metro, regional and rural areas. Wellbeing SA supports SPNs in developing action plans and providing education and training to communities.
TAS	Local Government for Burnie, Central Coast and Devonport municipalities provide grants through the Doing Better Together program of up to $3,000 to support community activities that target suicide prevention within communities.[136] The grant program specifically targets initiatives to address men aged 40-64 and people aged 65 and over who experience elevated rates of suicide. TAS Government invested $2.4 million for grants totally $300,000 for eight communities across Tasmania within the Healthy Together grants scheme. The grants are targeted to health and wellbeing solutions.[137]
VIC	In 2021, VIC Government invested $360,000 to Mental Health Victoria to coordinate the Lived Experience Workforce Grants Program.[138]
WA	In 2021 the WA Primary Health Alliance provided grants as part of the National Suicide Prevention Trials to support suicide prevention initiatives to local communities.[139] We note that this activity was federally funded.

Suicide prevention workforce attraction and retention

Suicide Prevention Australia takes the view that the suicide prevention workforce should be defined as broadly as possible. A broad view of the suicide prevention workforce reflects a whole-of-community approach to suicide prevention and includes everyone who is likely to interact with or make decisions that affect someone who might be vulnerable to suicide.

Suicide Prevention Australia defines the suicide prevention workforce across three broad groups:

- The clinical workforce, encompassing doctors, nurses and allied health professionals who interface with individuals at risk of suicide and in suicidal crisis.
- The formal suicide prevention and mental health workforce, encompassing those working in a suicide prevention, response, crisis support or postvention setting. For example, emergency first responders, the lived experience workforce, postvention workforce, personnel involved in the delivery of digital health services, counsellors, social workers, and other mental health workers. In most cases, this segment of the workforce should co-exist and be complementary to the mental health workforce, leveraging and sharing infrastructure where appropriate.
- The informal suicide prevention workforce, which includes (but is not limited to) personnel from across government departments, social services, employer groups, miscellaneous service providers, community-based organisations and other settings where individuals vulnerable to suicide or suicidality are likely to present.

In the 2022-23 Commonwealth Budget, $89.2 million was invested to grow the mental health workforce, with $60.7 million to implement the ten year National Mental Health Workforce Strategy. Key investments into building the capacity of the workforce included:

- $18.3 million to build a contemporary workforce and optimise the existing workforce through developing and piloting the National Mental Health Pathways to Practice Program
- $28.6 million to sustain growth in the psychiatry workforce and build on existing investments
- $2.2 million to further support the mental health of the health workforce, through the Hand-n-Hand program to provide peer support to the healthcare sector, and the extension of the Black Dog Institute's The Essential Network (TEN)
- $409,000 for stigma reduction and career promotion activities to encourage students to choose a career in mental health.

Our annual State of the Nation in Suicide Prevention survey of the suicide prevention sector reported 83% or organisations don't have sufficient staff and volunteers to meet workforce needs.[140] Almost eight out of ten respondents (79%) believe Australia needs a comprehensive, fully-funded Suicide Prevention Workforce Strategy.[141]

Indicator: Suicide prevention workforce attraction and retention	
ACT	ACT Health partnered with ACT Mental Health Consumer Network and Canberra Institute of Technology to provide ACT Mental Health Consumer Scholarship Scheme to support mental health consumers to study in the community services area.[142]
NSW	In the 2022-23 Budget, NSW Government invested $4.5 billion over four years in our health workforce, including providing 10,000 additional health workers. NSW Government further identify building the suicide prevention workforce as a priority in the 2022-2027 Suicide Prevention Framework supported by $143.4 million to implement the Towards Zero Suicides initiatives.[143]
NT	NT PHN provides scholarships and bursaries for health professionals in rural and remote areas to build and maintain their skills and practice.[144]

Indicator: Suicide prevention workforce attraction and retention	
QLD	The Queensland Alliance for Mental Health is currently developing a Community Mental Health and Wellbeing Workforce Strategy in partnership with the QLD Mental Health Alcohol and Other Drugs Branch.[145] The Strategy is anticipated to be published in December 2023.
SA	In the 2022-23 Budget, SA Government invested $50 million over four years to provide 100 additional mental health and learning support specialists to support students and staff with mental health needs in government schools.[146] In addition, $3.1 million was allocated over four years to boost funding to public community mental health teams.[147]
TAS	The overarching goal of the Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020) is to support workforces who may interact with people experiencing a suicidal crisis to provide compassionate care.
VIC	In the 2021-2022 Budget, VIC Government invested $206 million to build their mental health workforce including training and scholarships, with $41 million to increase capacity of the state's lived experience workforce.[148]
WA	In the 2022-23 Budget, WA Government invested $12.9 million for additional Peer Support Workers, and $1.3 million for mental health workforce development initiatives.[149]

Chapter 7

POPULATIONS

What we're trying to achieve: Recognise the intersection of population cohorts that can lead to increased risk of suicide.

Jurisdiction	Indicators		
	Integration of priority populations in government strategies	Cultural safety for priority populations embedded	Cultural competency training for health professionals
ACT	Yes	Yes	Yes
NSW	Yes	Yes	Yes
NT	In development	Yes	Yes
QLD	Yes	Yes	Yes
SA	Yes	Yes	Yes
TAS	Yes	Yes	Yes
VIC	Yes	Yes	Yes
WA	Yes	Yes	Yes

Context

Suicide is the 15th leading cause of death for all Australians and the leading cause of death for Australians aged 15-44.[150] Currently the age standardised suicide rate in Australia is 12.0 per 100 000,[151] however there are several population groups at higher risk of suicide.

In 2022, we undertook a literature review to collate evidence on priority populations to guide consistent advocacy efforts.

There are different factors that contribute to the elevated risk of suicide among specific groups. It is important to note that there is often significant overlap between groups/risk factors and rarely can a single group be considered in isolation.

Due to the complexity of suicide and the intersectionality of risk factors among populations, there are many ways to group these priority cohorts. We identified the following groups:

Demographic factors	• Males • Young people • Older people • People living in regional, rural and remote areas
Groups experiencing stigma and discrimination	• Aboriginal and Torres Strait Islander peoples • LGBTIQ+ people • Culturally and linguistically diverse communities • Migrants, immigrants, refugees and asylum seekers • People with disability

Occupational risk factors	• People working in high-risk occupations • Australian Defence Force members and veterans
Mental ill-health risk factors	• Survivors of previous suicide attempts • People experiencing mental illness • People experiencing substance use disorders or harmful alcohol and/or drug use • People experiencing recent bereavement, including those bereaved by suicide – also those impacted by attempts
Circumstantial risk factors	• People experiencing homelessness or housing instability • People experiencing job loss, unemployment, job insecurity and/or financial hardship • People experiencing a loss of relationship or family breakdown • People experiencing, or at high risk of domestic violence and abuse • People experiencing significant physical illness or injury • People who are, or have previously been incarcerated or in contact with the criminal justice system

At the national level, we have witnessed targeted efforts to address suicide among veterans and defence personnel through the Royal Commission into Defence and Veteran Suicide in 2022. The Interim Report of the Royal Commission into Defence and Veteran Suicide was tabled in Parliament in August 2022. The majority of the recommendations made in the Interim Report have been accepted by government.[152]

The Federal Government's 2021-2022 Budget sparked the shift towards achieving universal aftercare to support survivors of a suicide attempt in Australia with $158.6 million over four years for aftercare services, contingent on an agreement with states and territories.[153] Since then, universal aftercare has been funded in seven of the eight jurisdictions via the Bilateral Agreements on Mental Health and Suicide.

At the jurisdictional level, October 2022 saw the first coroners report into deaths by suicide among LGBTIQ+ people by the Victorian Coroners Court.[154] While there are complexities in capturing data on suicide among these populations that can result in underreporting such as identities may not be disclosed to family or friends, or police may not include information on identities in reports provided to the coroner, this data is a welcome step towards understanding suicide among LGBTIQ+ communities and will support funding for targeted suicide prevention.

Insights from our annual State of the Nation in Suicide Prevention survey identified the majority (78%) of respondents indicated priority populations at risk of suicide were not appropriately funded, resourced or responded to.[155] Respondents identified many actions needed to meet the needs of priority groups including:

- Putting lived experience of priority groups at the centre of suicide prevention
- Accessible and appropriate services that better reach the needs of priority groups
- Increased funding and investment
- More training and supports to build capacity
- Greater focus on early intervention and prevention
- Co-design with priority groups

Our policy position on priority populations makes the following recommendations:

1. All suicide prevention initiatives, whether solely targeted at reducing suicides or with this as one of the aims, should identify priority populations for suicide prevention and ensure the needs of these populations are addressed.

2. The lived experience of people from priority populations should help guide suicide prevention activities preventing suicide for those cohorts.

3. When identifying priority populations, the following should be considered:

a. statistical data indicating a heightened risk of suicide

b. experience of factors known to increase the risk of suicide

c. barriers to accessing suicide prevention supports

4. Increased investment in supports and services for priority populations is needed, including additional funding allocated to National Suicide Prevention Leadership Support Program

Integration of priority populations in government strategies

For the scope of this indicator, recognition of priority populations in state and territory health strategies was examined. In addition, examples of government investment in priority populations and targeted strategies are highlighted.

Based on our scan it is evident that priority populations vary across jurisdictions. This could be based on the availability of population demographics for priority groups. For example, LGBTIQ+ communities are not currently captured in census data and as such there is no accurate figures for how many LGBTIQ+ people live in Australia by jurisdiction.

Integration of priority populations in government strategies

ACT

The ACT Health Services Plan 2022-2030 identifies improving health outcomes and access to care particularly for priority population groups as an action area.[156] Priority population groups are listed to include: Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, older people, people with chronic conditions including mental illness, people with disability, LGBTIQ+ people, families with complex needs, children and young people, and carers.[157]

The ACT has the following Government strategic policies targeting priority populations:

- ACT Aboriginal and Torres Strait Islander Agreement 2019-2028
- ACT Carer's Strategy 2018-2028
- Capital of Equality - ACT LGBTIQ+ Strategy 2019-2023
- ACT Women's Plan 2016-2026

In 2022, ACT Government announced $1.28 million over two years for an integrated suicide prevention, postvention and aftercare service for First Nations people to be led by an Aboriginal community-controlled organisation in partnership with local Way Back Support Service.[158]

Integration of priority populations in government strategies	
NSW	The NSW Future Health: Strategic Framework 2022-2032 identifies action 2.4 strengthen equitable outcomes and access for rural, regional and priority populations.[159] Priority populations are defined as: 'includes, but is not limited to, rural and regional communities, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds (CALD), people with mental illness, people with disabilities, children and young people, victims of violence, abuse and neglect, refugees, and people in low socioeconomic deciles.'[160] As part of NSW Towards Zero Suicides initiatives NSW Government provided a Community Response Packages for Priority Groups initiative which provides funding for organisations to deliver suicide prevention activities that target Aboriginal communities, LGBTIQ+ communities, young people, older people, and men.[161] NSW has the following Government strategic policies targeting priority populations: • NSW Carers Strategy: Caring in NSW 2020-2030 • NSW LGBTIQ+ Health Strategy 2022-2027 • NSW Aboriginal Health Plan 2013-2023
NT	At the time of this report the NT Health Strategic Plan 2023-2028 was undertaking consultation processes for development and unable to be examined.[162] The NT has the following Government strategic policies targeting priority populations: • Northern Territory Aboriginal Cultural Security Framework 2016 to 2026 • Child and Adolescent Health and Wellbeing Strategic Plan 2018–2028 • NT Health Inclusion Strategy: Respecting People with Diverse Sexualities and Gender Identities - Plan of actions 2019 to 2022
QLD	Queensland Department of Health Strategic Plan 2021-2025 only includes actions for Aboriginal and Torres Strait Islander people without mention of other priority populations more broadly. QLD Government has the following separate strategic policies targeting priority populations: • Aboriginal and Torres Strait Islander Cultural Capability Action Plan 2019-2022 • Disability Service Plan 2021-2022 • Queensland Multicultural Action Plan 2021-2022 In 2022, Queensland Government committed to establishing an LGBTIQ+ roundtable administered by the Department of Communities, Housing and Digital Economy as a mechanism to provide lived experience to QLD Government.[163] Membership of the roundtable is currently two years commencing in 2023. QLD's Suicide Prevention Plan includes allocation of $6.9 million for an Aboriginal and Torres Strait Islander youth mental health and wellbeing program.
SA	SA Health and Wellbeing Strategy 2020-2025 identifies the following priority population groups: Aboriginal people, people living in rural and regional areas, people who are homeless, and older people.[164]

Integration of priority populations in government strategies	
TAS	TAS Government's Health Tasmania Five-Year Strategic Plan 2022-2026 identifies the following priority populations: people from lower socioeconomic groups, Aboriginal people, people from the LGBTIQ+ community, people from culturally and linguistically diverse backgrounds, and people living with disability.[165] Key announcements for priority populations in the TAS 2022-23 Budget: • $375 000 for the employment of LGBTIQ+ peer worker navigators • $1.5 million is provided to implement our Action Plans for Improving Aboriginal Cultural Respect across Tasmania's Health System • $1.2 million to continue coordinating Seniors Week and implement activities under the Active Ageing Plan • $45 million in our Child and Adolescent Mental Health reforms, including a youth forensic service and a specialist service for children in out of home care • $1 million to progress national veteran's affairs initiatives, such as the work of the Royal Commission into Defence and Veteran Suicide Tasmania has the following government strategic policies targeting priority populations: • Improving Aboriginal Cultural Respect Across Tasmania's Health System, Action Plan 2020-2026 • Diversity, Equity and Inclusion Strategy 2022-25
VIC	Victoria's Health Equity Strategy 2019-2023 identifies underlying drivers and determinants of health inequity as: socioeconomic, political and cultural context that can give rise to disadvantage including income, occupation, education, gender, sexuality, race/ethnicity, Aboriginality or place-based or locational disadvantage.[166] Victoria has the following government strategic policies targeting priority populations: • Ending family violence: Victoria's plan for change is a ten-year Plan released in 2016 in response to the recommendations made by the Royal Commission into Family Violence. • Pride in our future: Victoria's LGBTIQ+ Strategy 2022-32
WA	At the time of this report WA government is in development on their latest health strategy. The draft WA Health Promotion Strategic Framework 2022-2026 was examined however it is important to note that it is subject to change based on consultation processes. The draft strategy identifies groups at greater risk than others to include Aboriginal people, people living in regional and remote areas, people living with a disability, lesbian, gay, bisexual, transgender, and intersex, and culturally and linguistically diverse communities.[167] WA has the following government strategic policies targeting priority populations: • WA Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy 2019 – 2024 • WA Aboriginal Health and Wellbeing Framework 2015–2030 Western Australian Government committed $9.8 million for development of regional Aboriginal Suicide Prevention Plans across WA, and an overarching Aboriginal Suicide Prevention Strategy in 2020.[168]

Cultural safety for priority populations embedded

For the scope of this indicator, Bilateral Agreements on Mental Health and Suicide Prevention were examined for inclusion of cultural safety for diverse population groups.

The following item 'ensure the particular needs of vulnerable population groups, including people in rural and remote locations, Aboriginal and Torres Strait Islander people, LGBTQ+ people and culturally and linguistically diverse communities, are addressed and services delivered in a culturally appropriate manner' is committed to in all Bilateral Agreements met throughout 2022.[2]

For the scope of this indicator, Bilateral Agreements on Mental Health and Suicide Prevention were examined for inclusion of cultural safety for diverse population groups.

There is also important ongoing work on a national Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Cultural competency training for health professionals

Populations with diverse and intersecting identities require culturally competent services that are able to identify suicide risk and provide a person-centred compassionate response. For example, 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.

Among populations who experience stigma and discrimination, feeling safe and free of prejudice is critical to removing barriers to help-seeking behaviour. While there is a need for tailored service provision to populations at risk of suicide, people also need to be able to access mainstream services that are safe and effective.

The Australian Commission on Safety and Quality in Healthcare Standards states in the National Safety and Quality Health Service Standards (NSQHS) that health service organisations must have 'strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients' (ref. 1.21).[169]

The NSQHS define diversity to include 'the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).'[170]

The NSQHS outlines that health service organisations must 'identify groups of patients using its services who are at higher risk of harm', and 'incorporate information on the diversity of its consumers and higher-risk groups into the planning and delivery of care' (ref. 1.15).[171]

Given cultural competency for high-risk population groups among health service organisations is embedded in the NSQHS, cultural competency training for population groups at higher risk of suicide should be standard practice across Australia.

We believe cultural competency should go a step further and extend beyond health services to include industries, workplaces, education settings, and social services that may encounter people in distress.

We encourage state and territory governments to embed cultural competency standards for all population groups at-risk of suicide in industries that may encounter people in distress outside of health service organisations.

Highlighted below are examples of government funded competency training targeted to priority populations for professionals and relevant policies or standards. Based on our scan of online government resources, government-funded cultural competency training is generally targeted for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ communities, and culturally and linguistically diverse communities. Aboriginal and Torres Strait Islander cultural competency training appears to be the training area consistently funded and embedded in practice across jurisdictions.

Integration of priority populations in government strategies	
ACT	ACT Health established the Respect, Equity and Diversity Framework in 2010 which covers the ACT public sector.[172]
NSW	NSW Health in partnership with Aboriginal Workforce provide Aboriginal Cultural Training: Respecting the Difference for delivering health services to Aboriginal people.[173] All NSW Health Staff are able to complete professional development courses deliver through Health Education and Training (HETI) for continuous professional development points. Courses include: • Foundations: Working in Culturally Diverse Contexts on the provision of services to multicultural communities for continuous professional development points.[174] • Promoting inclusive healthcare: LGBT on improving health outcomes for lesbian, gay, bisexual, and transgender people when engaging with the healthcare system.[175]
NT	NT Government introduced a Cross Cultural Training Framework in 2013 to enhance cultural competency across the public sector workforce.[176] The Framework identifies departments which require in-depth cross-cultural training which extends outside the health portfolio. Some departments listed include: first responders, transport, sport and recreation, education, and correctional services.
QLD	QLD Government Aboriginal and Torres Strait Islander Cultural Capability Training Strategy 2016 commits to whole of government training across the public service sector.[177] The QLD Government 'culture and inclusion' website provides a series of resources to promote inclusive workplaces for gender equality, people living with disabilities, and LGBTIQ+ communities.[178] The Queensland LGBTIQ+ Steering Committee supports the implementation of the Queensland Public Sector LGBTIQ+ Inclusion Strategy 2017-2022 (The Strategy).[179] The Strategy identifies providing awareness and inclusion training across the sector within priority area 'Capability and leadership' (ref.1).[180] QLD Government commit to a whole of government approach to equality for diverse populations in their Queensland Cultural Diversity Policy.[181]
SA	SA Health developed an Aboriginal Cultural Learning Framework to help health services meet accreditation requirements for cultural competency and cultural awareness to meet the needs of Aboriginal and Torres Strait Islander people.[182] Part of implementation of the framework included developing an Aboriginal Cultural Learning course appropriate for people who work in the health sector.[183]

Integration of priority populations in government strategies	
TAS	TAS Government has an online module on LGBTIQ+ inclusive healthcare for professionals working in the health system that can be accessed by Department of Health staff and other healthcare workers.[184] In addition, they have provided videos of LGBTIQ+ community members speaking to inclusive healthcare and importance of pronouns, and a suite of resources for services to display inclusive support and practice.[185] TAS Government provide Aboriginal Cultural Respect in Health Services course available for government staff, the community sector, and non-government organisations.[186] Training is supported by a Department of Health statement of commitment to improving Aboriginal cultural respect across Tasmania's health system.[187]
VIC	The VIC Government report annually on multicultural affairs. The latest iteration from 2020-21 reported all Department of Education, Department of Families, Fairness and Housing, and Department of Premier and Cabinet staff must complete an eLearning package on human rights and responsibilities.[188] Department of Transport staff are required to undertake a four-part training program on human rights and the rights of colleagues from culturally and linguistically diverse backgrounds.[189] The Victorian Department of Education is currently advocating for a whole-of-government eLearning module on cultural diversity for all Victorian public servants.[190]
WA	WA Government provide free training to public sector employees and local government staff to assist people to provide appropriate services to people from culturally and linguistically diverse communities.[191] Aboriginal and Torres Strait Islander cultural awareness training is mandatory for public sector employees and board members in WA.[192]

Chapter 8

LOOKING TO THE FUTURE OF SUICIDE PREVENTION

It's clear that Australia is well on its way to reforming the suicide prevention system to create a safer, more cohesive and collaborative sector aimed at reducing distress in the community. Across jurisdictions, there are some areas where state and territory governments are consistently meeting suicide prevention needs, and some areas that require further development by governments to ensure that every person in suicidal distress has access to person-centred, safe, and effective care.

Lived experience

Embedding lived experience in government decision-making processes has continued to progress across jurisdictions but is not consistent across governments and requires further development. Lived experience of suicide as a survivor or a person impacted by suicide should be represented in government decision-making on not only suicide prevention policy and service design, but more broadly across government portfolios if we are to meaningfully adopt a whole-of-government approach to suicide prevention in Australia. At present, the majority of lived experience positions in government decision-making are mental ill-health focussed not specific to suicide lived experience. This is also evident in the peer workforce, which could be further enhanced by including crisis intervention and suicide prevention content in peer worker training and certifications, and through building capacity of the peer suicide prevention workforce.

Whole-of-community, whole-of-government

While the National Agreement confirms a whole-of-government approach to suicide, implementation of key components to a whole-of-government approach are not consistent across jurisdictions. Only one state has introduced stand-alone suicide prevention legislation (South Australia), one state has established an Office of Suicide Prevention and Response (Victoria), and three jurisdictions have appointed dedicated ministers or parliamentarians for suicide prevention (Victoria, South Australia, Northern Territory).

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'.[193] 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. We will continue to work with governments at both federal, state and territory levels to progress a whole-of-government approach to suicide prevention in Australia.

We are pleased to see that addressing the social determinants of health is consistently included across government suicide prevention strategies, as evidence informs that suicide rates are likely to increase two to three years post disaster or event.[194,195,196] Given the heightened distress in the community due to numerous environmental disasters compounded by the COVID-19 pandemic, continuing to address the social determinants of health that can lead to suicide will be critical over the coming years.

Data

While suicide registers now exist in all jurisdictions in Australia, data sharing processes vary, requiring consistency in this area. Access to real-time data on suicide deaths and attempts did not appear to be occurring based on our scan of the evidence and consultations. However, some jurisdictions (Australian Capital Territory, Northern Territory, Queensland, Victoria) utilise police referral pathways to receive referrals for people bereaved by suicide in the community to fast-track connecting people with support services. There remains a need for standardisation of suicide attempts and self-harm classifications across jurisdictions to enhance datasets. Only two jurisdictions (Victoria, New South Wales) make public suicide data on a monthly basis, this information can help sector responses and help save lives, all jurisdictions need to make it available.

Quality and accreditation

At present, suicide prevention standards for accreditation are not embedded in commissioning processes in Australia. Is it critical that suicide prevention services be accredited through similar mechanisms to which alcohol and other drug services are required to complete accreditation to ensure safety and quality. Services and programs should be supported by governments to achieve accreditation. Regular evaluation of services has been committed to in Bilateral Agreements that funded universal aftercare and/or postvention.

Service provision

Our Community Tracker provides a timely health check on the social and economic issues driving distress and subsequent suicide risk in Australia. Our February 2023 report identified 74% of Australians (n=1024) reported experiencing elevated distress in February 2023 compared with the same time last year.[197] Given the high levels of distress in the community, we are pleased to see that alternatives to emergency departments such as co-responder and Safe Space models are operational across the country, along with crisis and distress services.

While universal aftercare has been committed to by seven out of eight jurisdictions in Australia (New South Wales, Victoria, Western Australia, Queensland, Australian Capital Territory, Northern Territory, Tasmania), universal postvention requires further advocacy with only five out of eight jurisdictions having committed to implementation (New South Wales, Victoria, Queensland, Australian Capital Territory, Northern Territory). 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.[198]

Workforce and community capacity

Evidence-based suicide prevention training is being delivered across the country, and suicide prevention networks are established. There is a need for further support by state and territory governments for local suicide prevention activities and networks, and grassroots community-based organisations to deliver suicide prevention initiatives that is tailored to their communities.

Populations

Priority populations are acknowledged in key health strategies across states and territories; however, consistency is lacking in identifying who the priority populations at higher risk of suicide are. Funding for targeted suicide prevention initiatives to priority populations is fragmented across jurisdictions, except for Aboriginal and Torres Strait Islander people which appears to be consistently funded and embedded in core practice. Cultural safety for priority populations has been committed to in Bilateral Agreements which we hope will guide consistency in future.

Appendix

APPENDIX A: USEFUL RESOURCES

- National Mental Health and Suicide Prevention Agreement
- State and Territory Bilateral Agreements
- Historic $2.3 billion National Mental Health and Suicide Prevention Plan Media Release 2021
- National Suicide Prevention Advisor's Final Advice Report
- Right from the start: Report on the design of Australia's universal aftercare system
- State of the Nation in Suicide Prevention, Annual Survey 2022
- Suicide Prevention Australia's National Policy Platform

APPENDIX B: COMPARISON OF JURISDICTIONS

	Lived Experience		
	Lived experience of suicide partnerships in government decision making	KPIs for incorporating lived experience in policy and service design	Capacity and capability training of lived experience peer workforce
ACT	No	In development	No
NSW	Yes	In development	Yes
NT	No	In development	Yes
QLD	In development	In development	Yes
SA	Yes	Yes	Yes
TAS	Yes	In development	Yes
VIC	Yes	Yes	Yes
WA	In development	In development	Yes

Whole-of-government, whole-of-community					
Jurisdiction	Suicide Prevention Act	Stand-alone Suicide Prevention Strategy	Dedicated Minister for Suicide Prevention in government	Office of Suicide Prevention	Social determinants of health addressed by governments in suicide prevention responses
ACT	No	No	No	No	Yes
NSW	No	Yes	No	No	Yes
NT	No	Yes	Yes	No	Yes
QLD	No	Yes	No	No	Yes
SA	Yes	In development	Yes	No	Yes
TAS	No	Yes	No	No	Yes
VIC	No	In development	Yes	Yes	Yes
WA	No	Yes	No	No	Yes

Data				
Jurisdiction	Real time suicide deaths and attempts data	Suicide register in every jurisdiction	Data sharing on suicide deaths	Standardisation of suicide attempts and self-harm classification
ACT	Yes	Yes	In development	No
NSW	No	Yes	Yes	No
NT	Yes	Yes	In development	No
QLD	Yes	Yes	Yes	No
SA	No	Yes	Yes	No
TAS	No	Yes	Yes	No
VIC	Yes	Yes	Yes	In development
WA	No	Yes	In development	No

Quality and accreditation			
Jurisdiction	Evidence-based services	Suicide prevention programs are accredited or engaged in accreditation processes to ensure safety and demonstrate how lived experience is embedded in service design	Regular outcomes-based evaluation of services
ACT	No	In development	No
NSW	Yes	In development	Yes
NT	No	In development	Yes
QLD	In development	In development	Yes
SA	Yes	Yes	Yes
TAS	Yes	In development	Yes
VIC	Yes	Yes	Yes
WA	In development	In development	Yes

Service provision				
	Commitment to universal aftercare	Commitment to universal postvention	Crisis or distress services	Safe Spaces / alternatives to emergency departments
ACT	Yes	No	Yes	Yes
NSW	Yes	Yes	Yes	Yes
NT	Yes	Yes	Yes	TBC
QLD	Yes	Yes	Yes	Yes
SA	No	No	No	Yes
TAS	Yes	No	No	Yes
VIC	Yes	Yes	Yes	Yes
WA	Yes	No	Yes	In development

Workforce and community capacity			
Jurisdiction	Evidence based suicide prevention training across community, services and industries	Suicide prevention networks	Suicide prevention workforce attraction and retention
ACT	Yes	Yes	Yes
NSW	Yes	Yes	Yes
NT	Yes	Yes	Yes
QLD	Yes	Yes	In development
SA	Yes	Yes	Yes
TAS	Yes	Yes	Yes
VIC	Yes	Yes	Yes
WA	Yes	Yes	Yes

Populations			
Jurisdiction	Integration of priority populations in government strategies	Cultural safety for priority populations embedded	Cultural competency training for health professionals
ACT	Yes	Yes	Yes
NSW	Yes	Yes	Yes
NT	In development	Yes	Yes
QLD	Yes	Yes	Yes
SA	Yes	Yes	Yes
TAS	Yes	Yes	Yes
VIC	Yes	Yes	Yes
WA	Yes	Yes	Yes

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