Targeted consultations with groups disproportionately impacted by suicide

Consultation Report

Commissioned by the National Suicide Prevention Office

May 2023

Suicide Prevention Australia

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Introduction

To inform the development of the National Suicide Prevention Strategy (the Strategy), Suicide Prevention Australia were commissioned to facilitate targeted consultations with some of the population groups in Australia that are disproportionately impacted by suicide. Additional consultations were facilitated by LGBTIQ+ Health Australia and by the National Suicide Prevention Office (NSPO).

The Strategy is being developed with two working groups, as well as the NSPO Lived Experience Partnership Group and Advisory Board. The Strategy builds on previous work related to suicide prevention, including Compassion First which outlines the experiences of 3,000 people with lived and living experience of suicide. A public consultation on the approach of the Strategy occurred in October 2022 via a scoping paper. Further public consultation on a full draft of the Strategy will occur before it is finalised.

Suicide Prevention Australia conducted consultations with the following population groups: men, culturally and linguistically diverse communities, people with disability, residents in regional, rural and remote areas, and older people (aged 65 years and over).

Men

Culturally & Linguistically Diverse

People with Disability

Regional, Rural & Remote

Older people

Project Aims

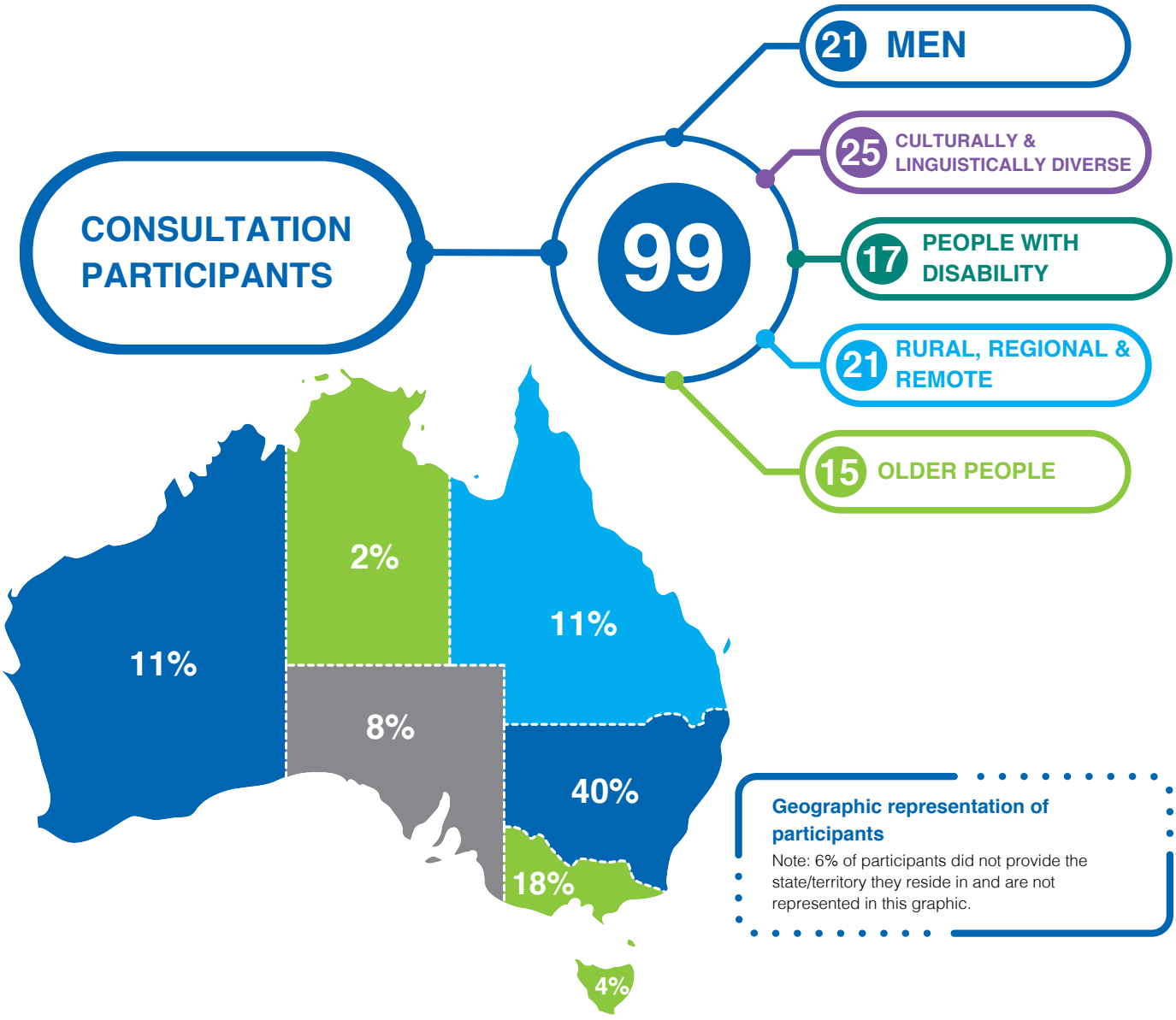
- **To inform the NSPO of the suicide prevention needs of population groups specific to populations outlined in the scope.**
- **To deliver 10 consultations of 2 hours duration in length with the population groups identified in the scope of this plan to inform an Australian suicide prevention system that meets their needs.**
- **As part of a report to the NSPO, the project will identify a small number of high-priority, high impact and implementable actions that are critical in the short/mid-term. Ideally, these actions required will relate to the intersectional issues brought forward through the consultation.**

This report provides an overview of key themes and priority actions to address key drivers of distress and wellbeing protective factors for specific populations.

The report will be set out by key themes/issues discussed in consultations for each population group. Within each key theme, recommendations with links to the focus area in the draft Strategy and allocated agency responsible will be provided. All content within the populations sections is drawn from consultations. Key issues were themed by frequency of mention in consultations for each population group. While all actions are included, priority actions were identified through frequency of identification by participants and group consensus on what would be most impactful. Where relevant, SPA has added supplementary research related to actions suggested by consultation participants under separate headings for background of the NSPO.

Consultation Participation

Of 97 participants, 67 had lived experience of suicide (69%). Participants who work in the sector to support people disproportionately impacted by suicide accounted for 31% (30 participants). Cross-over occurred where some people who work in the sector also had lived experience of suicide which accounted for 43% of total participants (42 participants). Written submissions were provided by 2 participants, resulting in 99 participants in total.



Considerations for participation

During the expression of interest process, the CEO of Deaf Australia identified to SPA that people who are deaf or hard of hearing predominantly identify as culturally and linguistically diverse (CALD) communities. With respect to intersectionality and valuing lived experience expertise, we took lead from Deaf Australia and included deaf and hard of hearing participants in our CALD population consultations.

This should be considered when examining the participation numbers as the CALD consultations had significantly higher participant numbers compared to consultations for people with disability including those who are deaf or hard of hearing. Older people with lived experience were challenging to reach through the expression of interest process. When examining key issues impacting older persons with lived experience of suicide in consultations, low technology literacy and limited access to computers and phones was raised in each session. We conclude this was a contributing factor that was further compounded by the short timeframe allocated for participant recruitment. In future, we suggest providing a minimum of 8 weeks instead of 4 for the expression of interest process as this will allow the capacity to further adapt recruitment processes as challenges arise.

Methodology

Facilitator selection

Suicide Prevention Australia utilised the NSPO funding grant to hire an independent external facilitator through communication consultancy SenateSHJ. Consultants from SenateSHJ have deep expertise in a range of facilitation techniques including Appreciative Inquiry, World Café and Force Field Analysis techniques. Suicide Prevention Australia has utilised SenateSHJ facilitators in the past for stakeholder roundtables and workshops with members. SenateSHJ provided the lead facilitator for the consultations, with responsibility for guiding discussions in alignment with the agreed consultation structure, principles and timings.

Given the critical importance of including people with lived experience of suicide in the consultations, Roses in the Ocean were engaged to provide lived experience co-facilitators. Roses in the Ocean is Australia's national lived experience of suicide organisation, recognised internationally for developing best practice in lived experience integration. Lived experience co-facilitators were responsible for supporting participants during the consultation to share lived experience safely, to assist with equity in discussions and to keep a watch out for discomfort or distress that may be caused by engagement with other participants or the content of the discussions. The lived experience co-facilitators provided an acknowledgement of lived experience upfront to illustrate the shared experience, helped communicate the support available to participants and introduced the support mentors.

Support mentors were also made available for the consultations via Roses in the Ocean. The role of the support mentor was to provide support to individual participants in the case that conversations during the consultation activated strong emotions for someone. The support mentor was introduced to participants at the beginning of the session and participants were able to request contact from the support mentor during the session via the lead and co-facilitators. If someone left the consultation in distress or facilitators determined there was a need for support to be offered to a participant during the session, the support mentor was contacted and asked to reach out to the individual to see if they wanted to have a chat.

Sourcing participants

Suicide Prevention Australia sought participants via an Expression of Interest process and direct approaches, utilising member networks and other inter-sector connections.

According to the brief, each consultation was to include approximately 10 representatives from organisations such as peak bodies and lead service providers as well as researchers, plus a minimum of 2 representatives with lived experience for each population. The goal was to include as many representatives as possible not otherwise involved in the strategy development through NSPO Advisory Boards or working groups.
Through the expression of interest process, participants were asked to identify any specific needs or preferences regarding their engagement. This included guidance on days and times that consider people's culture, health, family, social, study and/or work commitments.

See appendix A for the expression of interest form.

Pre-reading

A plain-language discussion paper (i.e. consultation pre-read) was shared with participants one week in advance of their consultation to help them frame their thinking and to make effective use of the time available.
The discussion paper outlined the goals for Focus Areas 1 and 2 and the key steps currently identified. Participants were asked to consider, from their perspective:

- What are the key actions that governments can take to
  - Reduce distress
  - Improve wellbeing
- Which of these actions will have the most impact?
- Which of these actions are most achievable?

See appendix B for the discussion paper.

Agenda

To ensure consistency across each consultation, a standardised consultation structure was agreed upon with the NSPO. The agenda was structured in a way that created space for lived and professional experience to be shared, whilst also setting the intent of the sessions upfront i.e. to identify actions that build on important bodies of work including, but not limited to, the National Suicide Prevention Adviser's Final Advice, Productivity Commission Mental Health Inquiry and Victorian Royal Commission, not reinterrogate their findings. The most impactful and achievable actions that governments can take that will create the largest reduction in suicide for each particular community, or priority population, were sought.

An NSPO representative provided an introduction to the Strategy at the beginning of each consultation. A second NSPO representative attended the consultations in an observer capacity.

The bulk of the two-hour consultations focused on eliciting ideas from the group on actions relating to focus areas 1 and 2 of the strategy, starting with actions to reduce drivers of distress (i.e. life stressors) and what governments must do to reduce the impact and prevalence of these, before moving onto promoters of wellbeing, and government actions to enhance wellbeing as a protective factor for suicide.

See appendix C for the consultation agenda.

Facilitation

A consultant from SenateSHJ led the facilitation of the consultations, with the support of a Roses in the Ocean lived experience co-facilitator and a colleague responsible for notetaking and logistics support. The facilitation style of the consultations drew from the Appreciate Inquiry technique, overlaid with the values and principles for stakeholder engagement and consultation identified by Roses in the Ocean[1], WA Mental Health Commission[2] and VIC Health and Human Services[3].

This included:

- Safety-focused
  - Acknowledgement of lived experience.
  - Facilitators assumed that participants may be impacted by trauma of some type and the lived experience co-facilitators were responsible for actively listening during the consultations and addressing any potential for unintentional harm.
  - Established principles communicated at the beginning of the session regarding the scope of the discussion, encouragement to speak openly and safety requirements including adherence to Mindframe principles for communicating about suicide values and ensuring facilitators are made aware if someone needed to leave the Zoom (briefly or permanently) and that they were OK.
  - A defined process for responding to and supporting people in distress as per Roses in the Ocean safety procedures.
  - Ensuring participants are reminded about the importance of self-care including finding ways to debrief.

- Authentic
  - The objectives of the consultation were identified and how it feeds into the broader strategy development.
  - People were encouraged to say what they thought, and this was validated, with a constructive, action-focused frame.
  - Differences and the importance of diversity in opinions were actively recognised.

- People-centred
  - People's experiences, perspectives, knowledge and beliefs were valued by asking people what perspective(s) they brought to the consultation. Time was also allowed in the agenda for people to be deeply listened to, have their difficulties and challenges acknowledged and share their unique journeys for discussion and decision-making.
  - The impact of trauma, stigma and discrimination, amongst other adverse experiences were recognised and the intent of the consultations to recommend specific actions to help address these issues was reiterated.

- Fair and equitable
  - The expectation of fair and equitable input into the consultation was outlined from the outset, so participants are aware there may be times when a facilitator may respectfully interject to move discussions on.
  - Multiple points were built into the consultation session for participants to be directly asked if there was anything they wanted to contribute to discussions.
  - The lived experience co-facilitator was given responsibility during the sessions for assessing whether contributions to discussions were equitable and bringing other voices into the discussions if some participants had not had an opportunity to contribute to discussions.
  - Participants were offered multiple ways to provide input including verbalising them to the group, posting in the chat and sharing follow-up thoughts via email.

- Inclusive and flexible
  - Discussions were framed to create an environment where people feel welcomed, valued and respected.
  - A degree of flexibility was allowed in the time allocated for specific agenda items within the overall consultation window of two hours to ensure cultural safety.

Paid Participation

In line with Suicide Prevention Australia's Lived Experience Engagement and Participation Guidelines and the National Mental Health Commission's guidelines on paid participation, all participants with lived experience will be paid for their time and contribution.

Observations and learnings

Timeframe

The short-lead time for the consultations and the timing of the consultations during April, when three of the four weeks were short weeks due to public holidays, plus school holidays during this period proved tricky for the recruitment of participants. Some participants (and potential participants) expressed frustration at the short timeline, and concern that the process was being rushed. This may have some impact on the perception of the validity and the merit of the process.

Accessibility and identification

Some deaf and hard of hearing participants found the format of the consultations hard to engage with despite the availability of AUSLAN interpreters and closed captions. As a result, follow-up individual consultations have been offered to these participants to ensure their input is received. Ideally, these would be conducted in person, but given the timelines and budget, they were conducted via Zoom.

Of note, some participants who are deaf preferred to identify as culturally and linguistically diverse rather than a person living with a disability.

Agenda structure

The structure of the consultations - working backwards from focus area 2 to focus area 1 was based on the hypothesis that participants may be more easily able to call to mind drivers of distress, based on their lived experience (personal or professional).

This hypothesis, by and large, proved to be correct during the consultations, however, it did prove to be counterproductive in the first consultation focused on people living with a disability. This group found it challenging to consider drivers of distress and instead fixated on circumstances of distress that they felt were systemic and immovable, either due to the nature of living with a disability or the scale of the problem. This mindset made it difficult for the group to move forward to concrete, achievable actions that promoted wellbeing.

This may have been influenced by the size of the group (four participants attended from a group of seven confirmed on the day of the consultation and nine the day prior) and the specific personalities and experiences of the individuals. However, based on this experience, the decision was made to switch the flow of the agenda in the second disability consultation to start with wellbeing first and then move to drivers of distress. This helped set a more positive, future-focused frame within the second consultation group.

Actions that will have the greatest impact and be achievable in the short-term

In both pre-reading materials and during the consultation, participants were asked to focus on actions outside of a crisis response and beyond the health/mental health system. It was noted that some participants struggled to think from this lens and consider a broader whole of government perspective, or to focus on the social determinants of health, potentially as a result of their own lived experiences. With some guidance, some individuals were then able to think of general actions beyond the health system / crisis response but were unable to give these actions much specificity.

In terms of 'achievability', it is noted that everyone has a different idea of what this means. For those who have not worked within or with governments, it should be recognised that the machinations of government may not be well understood, and this can limit people's ability to determine the 'achievability' of the actions they propose.

This observation was noted to the NSPO following the first week of consultations. It was agreed to keep this framing in the consultation set-up and structure in case there was an opportunity to hone particular 'blue sky' ideas that may get raised into more pragmatic, achievable actions, whilst also recognising 'achievability' of proposed actions may not be something participants were best placed to comment on.

1. Men

1.1 Addressing workplace challenges which lead to distress

Workplace is a key driver for distress among men. For example, 80% of the transport industry workforce are men. The transport industry experiences complex stressors such as long hours of isolation (particularly for long-haul truck drivers), exposure to trauma, limited job control (e.g. traffic, unloading vehicle times). Under-employment and discrete periods of employment and un-employment which happens in the construction industry can lead to financial stress. A greater focus on addressing psychosocial hazards in workplaces for men is required, but no recommendations on achieving this were given.

Recommendations	Agency Responsible
1.1.1 Invest in suicide prevention funding to industries men work in to provide support to their workers through initiatives such as gatekeeper training tailored for men. [PRIORITY]	Dept. of Employment & Workplace Relations
1.1.2 Reduce casualisation and insecurity of the workforce and gig economy by reviewing labour laws to reduce suicide risk among men engaged in precarious employment.	Dept. of Employment & Workplace Relations

1.2 Need for tailored suicide prevention supports for men

Risk factors prevalent among men can include social isolation, relationship breakdown, alcohol and other drug use, and childhood trauma. In addition, men may have different help-seeking needs, such as being more likely to seek support out of business hours. Supports for men must address these unique factors specifically.

Social isolation

Social connection can be a protective factor for suicide among men. As men age, they tend to find it more difficult to disclose which increases isolation and separation from social connection. Peer workers are a crucial preventative measure in preventing distress before men reach suicidal crisis. A collaborative approach is needed to address male suicide prevention in Australia.

Childhood trauma

Greater understanding of trauma informed care is required to reduce distress experienced when accessing mental health care. No specific actions were identified to address this issue.

Alcohol and other drug use

Participants reported some men use alcohol and other drugs to 'self-medicate' mental health and distress. Among men who want to seek treatment for alcohol and other drug (AOD) use issues, they are unable to find places in treatment facilities due to limited availability of AOD service capacity.

Help-seeking behaviour among men

Mental health and suicide prevention services are commonly available between standard working hours (9am – 5pm) and men are more likely to access support services outside of standard work hours.
Solutions to address suicide prevention among men should be developed by men, for men with greater coordination of care between clinical (e.g. GPs) and the non-clinical workforce (e.g. peer workers).

Recommendations

	Agency Responsible
1.2.1 Government to prioritise building capacity of the lived experience of suicide peer workforce for men including support measures to prevent burn out among peer workers. [PRIORITY]	Dept. of Health & Aged Care
1.2.2 Government to fund local community suicide prevention programs and activities for men equitably based on evidence of need. [PRIORITY]	Dept. of Health & Aged Care
1.2.3 Expand Medicare items to incorporate social prescribing to provide holistic and preventative care for men. [PRIORITY]	Dept. of Health & Aged Care
1.2.4 Government to fund the establishment of a network that coordinates support services and social connection points in local communities for men. [PRIORITY]	Dept. of Health & Aged Care
1.2.5 Fund suicide prevention training for GPs across Australia which includes education on the value and support the non-clinical workforce provides.	Dept. of Health & Aged Care
1.2.6 Fund male peer mentors for young men who can help men navigate health, mental health and social service systems. [PRIORITY]	Dept. of Health & Aged Care
1.2.7 National campaign to encourage young men to attain health-related education qualifications and select careers in social-care roles.	Dept. of Health & Aged Care
1.2.8 Increase the number of available beds in treatment centres for alcohol and other drug rehabilitation to ensure equitable access to recovery.	Dept. of Health & Aged Care

1.3 Address relationship breakdown

Relationship breakdown is a well-established risk factor for suicide impacting men. Many men are left without contact with their families, homeless, job loss, and experience feelings of shame at the relationship breakdown. Bias against men in the Family Law system was reported and the view expressed that a review was required by funding a Royal Commission into the Family Law system in respect of men.

Participants reported there are minimal support services for men, particularly around relationship breakdown. Support services are largely geared towards women, and men are often told their problems are 'too complex' which increases distress. This also extends to crisis accommodation services where housing is prioritised for women over men.

> **I have been working directly with an increasing amount of men who are going through incredibly biased treatment in the family law system. – Consultation Participant**

Recommendations	Agency Responsible
1.3.1 Government to undertake review and reform of the Family Law System with a view to better support men interacting with the system.	Attorney-General's Dept.
1.3.2 Relationship support services to be trained in male suicide prevention and promoted to men. [PRIORITY]	Dept. of Health & Aged Care

1.4 Address mental ill-health and suicide stigma

Concepts of masculinity and stoicism were raised in both consultations as key issues impacting stigma and help-seeking behaviour among men. Enhancing men's capacity for resilience will help reduce suicide risk. Greater mental health and suicide literacy will aid resilience. In addition, increased emotional intelligence can act as a protective factor for suicide.

Recommendations	Agency Responsible
1.4.1 Invest in suicide prevention programs for men (e.g. men's caves, men's sheds, health ambassador programs/community leadership development roles). [PRIORITY]	Dept. of Health & Aged Care
1.4.2 Fund wellbeing leadership and ambassador training for men to enable more community leaders to build capacity of communities and reduce stigma. [PRIORITY]	Dept. of Health & Aged Care
1.4.3 Fund gatekeeper training tailored to male suicide prevention to increase community capacity to respond to men in distress. [PRIORITY]	Dept. of Health & Aged Care
1.4.4 Deliver national health promotion campaigns to address stigma and encourage help-seeking behaviour among men delivered through multi-media e.g. television, billboards, social media. Printed materials should be displayed in places men go to e.g. pubs, workplaces, hospital waiting rooms, and sporting clubs.	Dept. of Health & Aged Care

1.5 Prioritise male suicide prevention

Men account for three quarters of death by suicide in Australia. Male suicide prevention must be prioritised in Australia across governments if we are to meaningfully reduce suicide among men. Consultations identified the need for enhanced coordination of male suicide prevention and men's health more broadly at the government level.

Recommendations	Agency Responsible
1.5.1 Appoint a Government official or Minister to prioritise male suicide prevention in a dedicated position and lead coordination of male suicide prevention efforts in Australia. [PRIORITY]	Dept. of Prime Minister & Cabinet
1.5.2 Establish a high-level and broadly representative governance structure for men to provide a mechanism for the suicide prevention sector and people with lived experience to directly advise Ministers on implementation of the National Suicide Prevention Strategy in respect of male suicide prevention. [PRIORITY]	NSPO
1.5.3 Introduce procurement requirements to demonstrate how tenders would address suicide prevention of at-risk populations for PHNs. [PRIORITY]	Dept. of Health & Aged Care
1.5.4 Government to undertake gender responsive budgeting for men and boys similar to the approach taken for women and girls.	Dept. of Health & Aged Care
1.5.5 Establish a Strategic Alliance for Men consisting of key organisations and peak bodies with a focus on male suicide prevention to connect community-based organisations, health professionals and researchers to provide a wrap-around approach to male suicide prevention. Key roles of the Alliance could include health promotion, advocacy, research, training and education for sectors and industries.	NSPO

1.6 Data and research

There is a lack of data on the scale of impact among intersectionality of men. More granular data is required if we are to meaningfully address male suicide.

Recommendations	Agency Responsible
1.6.1 Government to fund research on suicidality among men, including focus on intersectionality with other at-risk population groups. [PRIORITY]	AIHW, ABS

2. Culturally and Linguistically Diverse Communities

2.1 Deaf and hard of hearing

The deaf and hard of hearing community largely identify as culturally and linguistically diverse (CALD) communities and should be included in co-design processes with CALD populations to recognise that that they have their own language and culture. Deaf and hard of hearing people are commonly viewed as people with disability without recognition of CALD backgrounds. By doing so, it ignores, neglects and denies community access to culture and language.

Key drivers of distress for people who are deaf and hard of hearing include: a lack of culturally and linguistically appropriate services, lack of accessibility among services and communities, and lack of social connection to other deaf and hard of hearing people. Deaf people can experience further isolation in their families when they are the only deaf person in the family. Participants reported web chat functions in suicide crisis support services are not appropriate for deaf and hard of hearing people. Direct communication with Auslan interpreters is needed in crisis support services.
Of priority concern for deaf and hard of hearing people is limited access to Auslan interpreters. Without Auslan interpreters, deaf and hard of hearing people are denied communication accessibility in all areas of life. From crisis points (e.g. police, ambulance, hospitals) to social services, health services, and community spaces.

Not all deaf people have the same level of Auslan/English/other language comprehension, and this means that there is a need for Auslan interpreters that are appropriate to the capacities of those being interpreted. Deaf and hard of hearing people should be able to communicate directly with services, not via interpreters. There is a need for language policies that recognise that deaf people have their own language and culture to strengthen acceptance, create employment opportunities and further pathways for Auslan interpreters.

Recommendations	Agency Responsible
2.1.1 Targeted workforce investment to grow the amount of Auslan interpreters available in medical settings, mental health, and suicide prevention services, and broader social and support services to enable deaf and hard of hearing people to communicate and access support. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services
2.1.2 Health and mental health resources should be developed in Auslan, by deaf and hard of hearing people, and not designed in English then translated to Auslan. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services
2.1.3 Government to fund Auslan training to mental health professionals, frontline social service employees staff, frontline employment services staff, and police. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services
2.1.4 Create leadership positions in policy and service design for deaf and hard of hearing multicultural communities to lead suicide prevention for their communities and ensure services are accessible and appropriate. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services, Dept. of Home Affairs, Attorney-General's Dept.
2.1.5 Fund the development of language policies led by deaf and hard of hearing people that recognise their language and culture diversity and experiences, and which create further pathways for Auslan interpreters.	Dept. of Health & Aged Care, Dept. of Social Services
2.1.6 Invest in suicide prevention crisis support that is appropriate and accessible for deaf and hard of hearing people that enables direct communication with an Auslan interpreter. Accessible crisis support services should be provided for deaf adults and children. [PRIORITY]	Dept. of Health & Aged Care

2.1.7 National campaign communicating the diversity of disabilities (e.g. not only the wheelchair symbol) and diversity of identities (e.g. CALD, Aboriginal, LGBTQIA+) and experiences which promote the benefits of being bilingual (person who can use sign language and lip read).	Dept. of Health & Aged Care

2.2 Stigma

Intersectionality of identities for those who experience discrimination contributes to multiple levels of stigma e.g. CALD, LGBTQIA+, living with a blood borne virus, people with disability, and intergenerational conflict.

Suicide and mental health stigma are more prevalent in some cultures and belief systems. Individuals from multicultural communities may feel compounded shame or reluctance to seek help for mental health issues. This can lead to delayed or inadequate treatment and can increase the risk of suicide. Cultural competency training for frontline workers is not sufficient in creating safety and accessibility of services.

Recommendations	Agency Responsible
2.2.1 Enhance understanding of the importance of intersectionality across all levels of government and provide support for interdisciplinary and intersectoral collaboration	CTH Government
2.2.2 Create leadership positions in policy and service design for multicultural communities to lead suicide prevention for their communities. [PRIORITY]	CTH Government
2.2.3 Australian Department of Home Affairs to incorporate a mental health and wellbeing component in Citizenship tests to address stigma and wellbeing literacy including information on existing services. [PRIORITY]	Dept. of Home Affairs

2.3 Risk factors

Language barriers, financial pressure, limited opportunities for employment and community engagement are prevalent risk factors for people with a CALD background. Unique factors that can exacerbate stress include racial discrimination, family separation through migration, acculturation gaps, discrimination, and intergenerational conflict.

Participating in the workforce is a significant stressor for immigrants and refugees. For many, the careers and skills they had in their home country aren't recognised in Australia. There is a requirement to undergo education in their profession again to become qualified in Australia. This poses a significant barrier to engaging in meaningful work and impacts self-esteem, sense of purpose, and overall wellbeing.

Australia is experiencing a workforce shortage of psychologists. Recent data (2022) from the APS reports that 1 in 3 psychologists were unable to take new clients, up from 1 in 5 (22%) in June 2021.[4] Recognising international qualifications could help fill the gap whilst increasing the capacity of the CALD mental health workforce.

Recommendations	Agency Responsible
2.3.1 Funding contracts for ethno-specific services to be extended to 3-5 years to allow for sustainability and evaluation. [PRIORITY]	Dept. of Health & Aged Care
2.3.2 Expand existing programs dedicated to helping people get international qualifications recognised in Australia (e.g. STARTTS) for national roll out. The programs need to be appropriately resourced and promoted to communities. [PRIORITY]	Dept. of Home Affairs
2.3.3 Australian Health Practitioner Regulation Agency to revise processes for managing applications for registered health professionals from overseas to enable greater access to qualification recognition. [PRIORITY]	Dept. of Health & Aged Care
2.3.4 Expansion of existing employment settlement services to help people find appropriate work to alleviate financial distress among migrants, immigrants and refugees. [PRIORITY]	Dept. of Home Affairs

2.4 Social isolation and loneliness

Connection to cultural identity can act as a protective factor for suicide. Acculturation and bicultural stress can include language barriers, difficulty navigating social norms, and feeling isolated from a person's community. Inclusion and accessibility were identified as protective factors.

It was consistently identified in consultations that CALD community leaders which may include religious leaders, are best placed to support CALD people and families in times of distress, and in communicating key health information and referral pathways.

Recommendations	Agency Responsible
2.4.1 Expand the National Suicide Prevention Leadership and Support Program to include a stream for partnership grants with multicultural community leaders and multicultural community organisations to deliver wellbeing and suicide prevention activities, including initiatives to address social isolation and loneliness. [PRIORITY]	Dept. of Health & Aged Care

2.4.2 Increase funding for services focusing on prevention and early intervention for multicultural mental health, including social inequities. This can include providing free professional services and education within schools and communities and addressing socioeconomic determinants. [PRIORITY]	Dept. of Health & Aged Care
2.4.3 Establish universal screening process agencies that provide service to multicultural communities for suicidality including services outside of mental health. A universal screening process should be sensitive to the complexities of understandings of mental health and suicide among diverse cultures and belief systems, and be administered by staff who have undertaken compassionate cultural competency training which addresses intersectionality.	Dept. of Health & Aged Care, Dept. of Social Services

Note: Recommendation 2.4.3 was debated in the consultation. One participant felt strongly in favour and discussed existing practices where it has proven effective in service provision, and one participant raised risks involved in insensitively asking questions about suicide. We suggest the NSPO undertake further consultation into the concept of universal screening with CALD communities including examining existing evidence.

2.5 Language and literacy barriers

There is limited health literacy among CALD communities. Typically, health information is translated from English to another language and the meaning doesn't translate or resonate.

Language barriers are not limited to lack of proficiency in English, but rather mental health literacy and education about navigating health and social service systems.

For individuals who are not proficient in the dominant language or mental health literacy of the country they reside in, language barriers can contribute to social isolation, difficulties accessing resources, and difficulty communicating with healthcare providers. Mental health screening questions are English based and use language that does not translate across all languages or cultures, including Auslan.

> **"Navigating support systems is very stressful and completely disempowering to CALD and aged populations who are not tech savvy or have English language competency – Consultation Participant**

Recommendations	Agency Responsible
2.5.1 Develop health and mental health resources and screening questions in diverse languages including Auslan to ensure accurate communication to target audiences. [PRIORITY]	Dept. of Health & Aged Care
2.5.2 Government to fund suicide prevention training courses e.g. ASIST tailored to CALD communities and invest in community leadership to enable training delivery by CALD community leaders and influencers. [PRIORITY]	Dept. of Health & Aged Care
2.5.3 Increase development and delivery of English language skills and other programs by community leaders in recognition that multicultural communities are more likely to want to learn from a member of their community. [PRIORITY]	Dept. of Health & Aged Care
2.5.4 Increase bilingual and multilingual healthcare professionals who are trained to deliver appropriate care to CALD people to address communication barriers.	Dept. of Health & Aged Care

2.6 Lack of equitable access to healthcare

Visa restrictions can prohibit access to trauma-informed recovery and support services. Visa insecurity is linked to key drivers of suicide-related distress such as income, employment, stigma and discrimination. Lack of access to Medicare, challenges navigating complex systems to access education, finance, employment, and legal services contribute to elevated levels of distress among CALD populations.

Many CALD communities are unfamiliar with the Western concept of counselling. Generally, CALD people are familiar with support being delivered through a collective group/community activity. The biomedical model can be a barrier to accessing healthcare. Families and communities can play a significant role in mental health care and suicide prevention.

A key concern in mitigating distress is the move to automated responses and AI technology to navigate and access government services including housing, social security, justice system and health. This technology can provide a barrier to access and increase preventable distress among CALD people.

Recommendations	Agency Responsible
2.6.1 Government to invest in increasing multicultural lived experience of suicide peer workers to address help-seeking barriers experience by CALD communities. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services
2.6.2 Government to extend availability of settlement services beyond the current cap of five years in recognition that acculturation extends beyond the first five years and fluctuates over many years. [PRIORITY]	Dept. of Home Affairs
2.6.3 Government to fund development and sustainability of tailored suicide prevention services to multicultural communities to address unique stressors and barriers to help-seeking faced by CALD communities. [PRIORITY]	Dept. of Health & Aged Care

2.7 Build community capacity to respond to distress

CALD communities value and trust their CALD community leaders, community influencers, and religious leaders. For programs and services to reach CALD communities in language that will resonate, Governments need to involve CALD community leaders/influencers in design, implementation, and evaluation stages of policy, program and service development for CALD populations.

A fundamental barrier identified by participants is governments historical and ongoing assimilation approach to policy and service provision. If wishing to meaningfully reduce distress among CALD communities, governments need to challenge the concept of conforming to mainstream and instead adopt an integration approach in policy and service design. While FECCA exists as the national peak body for culturally and linguistically diverse populations in Australia, participants identified the need for a CALD mental health and suicide lived experience peak body to drive suicide prevention and wellbeing initiatives.

Recommendations	Agency Responsible
2.7.1 Train CALD community leaders, influencers and religious leaders in suicide prevention to respond to distress in the community. [PRIORITY]	Dept. of Health & Aged Care
2.7.2 Government to establish and fund a CALD mental health and suicide lived experience peak body to advise Government on policy and service design, drive research into CALD suicide, and oversee development and delivery of suicide prevention training tailored to CALD communities.	Dept. of Health & Aged Care
2.7.3 Government to invest in grassroots, community-based multicultural organisations that provide peer support, health and mental health services and programs, and community education on navigating systems and accessing services that are designed by multicultural people, for multicultural people. [PRIORITY]	Dept. of Health & Aged Care

2.7.4 Grants for multicultural community organisations and/or community leaders, and multicultural deaf and or hard of hearing communities should be made available, and have sustainable funding cycles e.g. 3-5 years. [PRIORITY]	Dept. of Health & Aged Care
2.7.5 Government to adopt the integration of CALD people as a guiding principle in whole of government policy and service design.	NSPO, Dept. of Health & Aged Care, Dept. of Social Services, Dept. of Home Affairs
2.7.6 Strengthen partnerships between CALD community leaders and influencers with governments and PHNs responsible for funding local community-level suicide prevention. [PRIORITY]	Dept. of Health & Aged Care

2.8 Addressing the needs of ageing CALD people

For many CALD communities, it's common and accepted that elderly people live with families and not in aged care facilities. It is also commonly understood that CALD people are more likely to receive support from their community as a group, rather than in a one-on-one support setting.

Community social connection activities should be targeted across all ages and focus on utilising the relationship with community leaders and influencers to reach people in the community who may be experiencing distress.

The aged care system isn't inclusive of various religious practices, and ethno-specific care is limited in availability. Participants expressed older CALD people would be appropriate to consider social equity housing models for. An example suggested by participants included housing elderly CALD people in the same apartment block to provide each other with social connection in locations with nearby support and health services available.

Supplementary research provided by SPA on social equity housing models in Australia:

Australia currently has over 8,000 people living in co-operating housing models across the country to address the widening gap between social housing delivery and private market options.[5] In Queensland, the Brisbane Housing Company has delivered a suite of housing projects aimed at older people on low incomes.[6] In South Australia, the Aboriginal Community Housing Limited will deliver an Elders Village to provide long-term culturally appropriate housing near Warriparinga.[7] In New South Wales, Northern Rivers Community Gateway is working to build housing for older women in Lismore to address older women at risk of homelessness.[8]

Similar models have been implemented in other countries. For example, Korea has social housing for students and young professionals who otherwise are unable to afford safe housing.[9] Another example of a whole-of-government approach to addressing social determinants of health is the Barcelona Superblocks which have been estimated to prevent 667 premature deaths annually.[10]

Recommendations	Agency Responsible
2.8.1 Expand Commonwealth Home Support Programme to include older CALD people who are well living in the community. [PRIORITY]	Dept. of Health & Aged Care
2.8.2 Government to fund a social equity housing model for CALD older people. [PRIORITY]	Dept. of Health & Aged Care

3. People with Disability

3.1 Loneliness among people with disability

Loneliness can be experienced in relation to a person's disability, inter-personal challenges, societal judgement, and accessibility issues. People with disability need to be able to connect with other people with disabilities, and extend beyond crisis helplines (e.g. people need to be able to call someone for connection and support).

Recommendations	Agency Responsible
3.1.1 Government to fund online peer support, networking and community connections programs and activities for people with disability to enhance social connection as a protective factor for suicide. [PRIORITY]	Dept. of Health & Aged Care
3.1.2 Government to establish a national phone service that provides connection and support to people with disability that is compassionate and holistic in its approach to providing support. [PRIORITY]	Dept. of Health & Aged Care
3.1.3 Training for community touchpoints in compassionate understanding of people with disabilities, including a lens to loneliness. [PRIORITY]	Dept. of Health & Aged Care

3.2 Financial disadvantage among people with disability

People with disabilities commonly experience financial distress and are financially disadvantaged. Lack of Government financial support and lack of support for people with psychosocial disability to access employment that is supportive of disability can further increase loneliness among people with disability. The cost of healthcare including medications was identified as a key financial barrier that can increase distress levels among people with disability.

The current income support payment schemes available to people with disability is not standardised and varies in funding, classification of disability, and in length of provision. Income support is often received through various Government systems that differ from one another and differ in their administration. The people employed to administer these systems lack education in disability, and the people accessing these systems lack education in how to navigate social services. The current system is inequitable and requires reform. The NDIS only covers 10% of people with disability in Australia.

There is a shortage of allied health practitioners in hospitals due to higher salaries awarded within the NDIS. The systems undermine each other in that some people with disability have access to better quality care via the NDIS rather than hospitals.

For those who can't access the Disability Support Pension due to eligibility criteria, many end up going on Newstart which requires people to study or seek employment. The reality of these obligations is people with disability may not have the means to meet these obligations and are attempting to access social income support payments for basic needs. Mutual obligations contribute to feelings of hopelessness and worthlessness among people with disability who are forced to apply for work that they can't perform the roles due to disability.

> **"I feel a bit frustrated when trying to think about this. Everything comes back to the base needs - housing and having enough money. I am currently experiencing quite a bit of loneliness and frankly can't afford to go out and meet people. There are so few spaces and things to do, that appeal to me, that are free or low cost. Most community events that are free, are centred around families. – Consultation Participant**

The income support payment partner income test poses risks for people with disability who may wish to live with their partner, but can lose DSP or other income support payment accessibility. When this is lost, it can create vulnerability for the person with disability to depend financially on support from partners, and increase vulnerability to intimate partner violence. In some cases, people with disability avoid romantic relationships due to the risk of their DSP payment reducing. Relationships can be a protective factor for suicide.

Models that are deficit based i.e. people have to prove how much a disability has hindered their life to be able to access social services and mental health care is debilitating for people with disability. The evidence required to prove disability is costly and requires a number of specialist appointments that are financially out of reach for many people with disability.

Cost of medications and aids, cost of living, and cost of housing pose significant challenges to accessing support for mental health or wellbeing among people with disability. When all the money from income support payments goes to rent for housing, there's nothing left to support other wellbeing needs. Income support payments need to keep up with the increasing cost of living and the housing market. People with disability are further less likely to be able to afford private health insurance.

> **"It is critical that we address the social security income support payments for people with disability to be able to meet basic needs. This will impact ability to secure housing which leads to employment by being able to provide a permanent address to employers. – Consultation Participant**

Recommendations	Agency Responsible
3.2.1 Government to establish a connection point across income support payment streams for people with disability to support navigating the system and assisting with access to income to meet basic needs.	Dept. of Health & Aged Care, Dept. of Social Services
3.2.2 Government to review eligibility requirements for accessing the Disability Support Pension to ensure it is accessible to people with disability, including psychosocial disability. [PRIORITY]	Dept. of Social Services
3.2.3 Increase income support payments for people with disability to meet basic needs and alleviate distress in the community. [PRIORITY]	Dept. of Social Services
3.2.4 Remove partner income test to access income support payments for people with disability to maintain independent income support and prevent risk of family and/or domestic violence circumstances from occurring. [PRIORITY]	Dept. of Social Services
3.2.5 Abolish mutual obligation requirements for accessing income support payments for people with disability to increase accessibility of financial support. [PRIORITY]	Dept. of Social Services
3.2.6 Government to increase funding and capacity of the NDIS to meet the needs of every Australian with disability. Including reviewing disability criteria to recognise more disabilities through the NDIS and create greater access. [PRIORITY]	Dept. of Social Services

3.2.7 Increase number of medications available through the PBS for people with disability. [PRIORITY]	Dept. of Health & Aged Care
3.2.8 Remove the hours of work cap on DSP recipients to strengthen employment as a protective factor for suicide among people with disability where capable. [PRIORITY]	Dept. of Social Services

3.3 Stigma experienced among people with disability

Stigma is experienced among people who have 'invisible' disabilities by mainstream services. Participants identified greater compassion and education among mainstream agencies who service people with disabilities is required to help reduce stigma.

Compassion and education should extend beyond health services and include social services such as Centrelink, employment agencies, and the hospitality industry. A whole of government lens needs to be applied to all services and points of connection. Participants recommended that the National Suicide Prevention Strategy should link in with the National Stigma Reduction Strategy.

While workplace anti-discrimination policies exist to protect people with disabilities in employment, people with disability who want to work remain under-employed. Employers consider people with disability a risk or liability rather than valued for the contribution they can make.

Recommendations	Agency Responsible
3.3.1 Training in education on people with disabilities for frontline workers in health, employment and social services to promote compassionate responses to people with disability and reduce stigma. [PRIORITY]	Dept. of Health & Aged Care
3.3.2 Funding to support increasing the number of people with disability who work in the mental health and suicide prevention sectors. This investment should include increasing availability of Auslan interpreters in mental health and suicide prevention services and safe spaces. [PRIORITY]	Dept. of Employment & Workplace Relations

3.4 Housing insecurity among people with disability

Increased housing affordability is a key concern for people with disability. The current DSP payment is not enough to cover rent in the current rental market. There are many people with disability who are able to live alone with NDIS supports but cannot afford to do so. Participants reported social housing can take over 10 years to access.

Participants suggested social equity housing models for people with disability where the person with disability provides a portion of their income to the owner but are provided a place to live long term could provide a housing solution for people with disability in Australia. A social equity housing model could provide a communal space for people with disability to stay connected and provide mutual support to one another. Supplementary examples of this model are outlined in section 2.8.

Recommendations	Agency Responsible
3.4.1 Government to fund a social equity housing model trial for people with disability in Australia. [PRIORITY]	Dept. of Health & Aged Care

3.5 Addressing the health of people with disability

Disabilities are diverse in nature and in the way they impact the individual. Participants highlighted key concerns for immune-compromised people, invisible disabilities such as neurodivergence, and chronic pain.

The gap fees for Medicare subsidised psychological sessions are unaffordable for people with disability, particularly those who rely on the DSP.

Immune-compromised

Many immune-compromised people have self-imposed isolation due to the COVID-19 pandemic restrictions ceasing. This has heightened social isolation and loneliness among this population.

Invisible disabilities

Hidden disabilities among adults can be debilitating and are routinely left out of government funding, for example, people with ADHD. ADHD is not supported by the NDIS as it's considered 'treatable' with medication, however, the cost of diagnosis and medication pose barriers to access.

Chronic pain

Chronic pain is a significant issue for people with disability and can contribute to poor mental health. Programs and services available for people with disability should be inclusive of people with chronic pain. By addressing underlying drivers, protective factors such as social connection and employment can be strengthened. When it comes to service access and eligibility for support, being labelled as highly functioning can be a disadvantage.

Recommendations	Agency Responsible
3.5.1 Government to reinstate COVID-19 mandates to wear masks and isolate when positive for COVID-19 to protect the health of immune-compromised people in the community.	Dept. of Health & Aged Care
3.5.2 Reduce gap fees for Medicare subsidised psychological sessions for people with disability to address financial barriers to accessing mental health support. [PRIORITY]	Dept. of Health & Aged Care
3.5.3 Government to review workplace accidents and work-cover practices with a lens to better supporting people who acquire disability through workplace injuries.	Dept. of Employment & Workplace Relations

3.5.4 Government to fund suicide prevention services for neurodivergent people led by neurodivergent people with sustainable funding cycles. [PRIORITY]	Dept. of Health & Aged Care
3.5.5 Invest in carer and family support services for people caring for someone with a disability including psychosocial disability. Carer support services should be outreach based in recognition that often carers are unable to seek support due to needing to be home with the person they care for. [PRIORITY]	Dept. of Health & Aged Care
3.5.6 Anti-discrimination training on people with disabilities for all levels of education workers from primary through to tertiary including vocational training educators.	Dept. of Health & Aged Care
3.5.7 Increase the number of safe spaces/safe havens available as alternatives to emergency departments in Australia. All safe spaces/safe havens should have Auslan interpreters available for people who are deaf or hard of hearing. [PRIORITY]	Dept. of Health & Aged Care

3.6 Valuing lived experience of disability

People with disability should be valued for their expertise, knowledge and insights and as such be involved in policy and service design for people with disability. People with disability should assume roles in leadership positions to support suicide prevention among people with disability.

Government Ministers and senior officials should be educated in understanding people with disability. Co-design needs to start in the identification and development stage with people with disability, rather than being consulted after a draft policy or service design has been developed.

Recommendations	Agency Responsible
3.6.1 Create leadership positions for people with disability across government portfolios for inclusion in policy and service design. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services, Dept. of Employment & Workplace Relations, Dept. of Communities & Justice
3.6.2 Fund disability advocates and disability peer workers, including those who are from CALD backgrounds, to help support people with disability navigate support systems including those outside of health. [PRIORITY]	Dept. of Health & Aged Care
3.6.3 PHNs should include requirements in tenders for developing services with people with lived experience of disability using trauma-informed approaches in commissioning processes.	Dept. of Health & Aged Care
3.6.4 Government agencies to allocate funding for co-design of services and programs for people with disability. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services, Dept. of Employment & Workplace Relations, Dept. of Communities & Justice

3.7 Culturally and linguistically diverse communities with disability

Many people with disability identify as being part of CALD communities. There is a need for better supports that recognise intersectionality of identities and address the needs of CALD people with disability.

Recommendations	Agency Responsible
3.7.1 Education programs for newly arrived families who have a family member with disability on how to navigate health, employment and social services to access supports for the person with disability. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Home Affairs
3.7.2 Invest in community-based programs and activities that provide support to CALD people with a disability throughout the lifespan that foster social connection. [PRIORITY]	Dept. of Health & Aged Care
3.7.3 Provide free Auslan training for frontline workers in health, education, employment, justice settings and social services. [PRIORITY]	Dept. of Health & Aged Care, Dept. of Social Services, Dept. of Education, Dept. of Employment & Workplace Relations

4. Residents in Regional, Rural and Remote Areas

4.1 Stigma is prevalent in regional, rural and remote areas

Concepts of stoicism and mental ill-health stigma are prevalent in regional, rural, and remote (RRR) areas. Key issues include a lack of practical understanding around normalising mental ill-health, narratives that people are alone in how they feel, fears experienced by people in country towns are labelled and don't want to be seen accessing support services, and a lack of compassion in emergency department/hospital presentations for suicidality (which can lead to additional trauma).

Participants advised schools and local councils are well placed to increase community knowledge and awareness of suicide prevention and reduce stigma. Teachers are currently already overworked in RRR areas and require additional resources to address this need, and to be able to support the wellbeing of their staff.

Case Study from Consultation Participant

One participant described a local community event which targeted mental health education for farmers. The workshop was branded as 'having a chat with a football player' rather than 'mental health workshop' and had 50 farmers attend. By strategically branding the workshop they were able to reach more farmers.

Recommendations	Agency Responsible
4.1.1 Government to formalise definition of stigma in anti-discrimination legislation to shift the impact on RRR communities and create accountability.	Dept. of Health & Aged Care
4.1.2 Government to invest in additional resources for education on community awareness of suicide prevention in school programs and local councils for RRR areas. Peer workers would be well suited to deliver education workshops. [PRIORITY]	Dept. of Education, Dept. of Social Services
4.1.3 Develop resources for parents on tools to support their children experiencing mental ill-health in RRR areas to address early intervention. [PRIORITY]	Dept. of Education, Dept. of Social Services
4.1.4 Develop a peer support program for parents transitioning to first-time parenthood to receive support in the adjustment stage to address stigma experienced in RRR areas entering clinical services in the community. The program could be available in key community spaces. [PRIORITY]	Dept. of Health & Aged Care

4.1 Stigma is prevalent in regional, rural and remote areas

Limited service provision

There is limited choice of service in RRR areas. Often only one GP or psychologist is available to service an RRR area, and when they leave there's no one to go to. A large number of people in rural and remote areas are most likely to receive mental health care from a GP, both in the first instance and for ongoing treatment. GPs are an underutilised key community touchpoint for residents living in RRR areas.

Participants expressed concerns that people who live in RRR areas are not valued in the same way as metropolitan areas in terms of service provision accessibility. These feelings are heightened when key community services such as banks and post offices are removed from RRR areas, or the minimal health and suicide prevention services that do exist receive significant funding cuts that impact their ability to continue operating. People rely heavily on rotary and local volunteers.

Capacity building

Local communities are best placed to design and deliver suicide prevention programs and services as local knowledge is key to effectiveness. Existing community-based networks and organisations rely heavily on unpaid volunteers and have strong relationships with communities. Improved resourcing could create job opportunities in RRR areas and strengthen the capacity of local communities to respond to distress in their communities.

Community leaders in RRR areas reported facing barriers to applying for grants due to not having NFP or Incorporated status which limits their ability to source funding for expansion or sustainability. A flexible approach that acknowledges the leadership role in a community and assesses applicants based on impact rather than business status is needed.

A wellbeing framework that is adaptable to community needs and is supported by funding for communities to deliver wellbeing activities such as cold-water swims, men's sheds, walking clubs, and library book clubs, should be established.

Case Study from Consultation Participant

We've Got Your Back is a peer lived experience program in Far West NSW in partnership with RFDS and Lifeline. The program involves developing 'champions' among rural farmers who are paid to be contacted for support. The champions visit people on their properties and refer people to services in the area. They have recently experienced GP's referring people to the champions for support as part of treatment plans.

Recommendations	Agency Responsible
4.2.1 Government to invest funding to support local community suicide prevention services, community action plans, programs and community connection activities in RRR areas. Funding opportunities should be flexible and include sustainable cycles of 3-5 years to allow for meaningful impact and evaluation. Funding should also be available to deliver non-clinical supports and place-based approaches. [PRIORITY]	Dept. of Health & Aged Care
4.2.2 Government to invest in funding the lived experience of suicide peer workforce in RRR areas to increase community capacity to respond to distress. [PRIORITY]	Dept. of Health & Aged Care

4.2.3 Government to establish a fund to be accessed through a suicide prevention network to enable upskilling and resilience building, such as Mental Health First Aid training, among RRR communities to support people in distress in their community. [PRIORITY]	Dept. of Health & Aged Care
4.2.4 Establish a wellbeing framework supported by funding investment to deliver wellbeing activities which promote mental health in RRR communities.	Dept. of Health & Aged Care
4.2.5 Governments to revise current incentives for healthcare workers to move to RRR areas to build capacity of service provision in RRR areas.	Dept. of Health & Aged Care
4.2.6 Introduce social prescribing for GPs to provide holistic care to people living in RRR areas. [PRIORITY]	Dept. of Health & Aged Care
4.2.7 Upskill GP clinics and Urgent Care Centres in RRR areas with mental health expertise to better respond to distress in RRR communities. [PRIORITY]	Dept. of Health & Aged Care

4.3 Social determinants that lead to suicide

Key factors contributing to suicidal distress among people who live in RRR areas are climatic events (e.g. natural disasters), financial distress, housing, family and/or relationship breakdown, and childhood trauma.

Relationship breakdown

Family and/or relationship breakdown has a greater impact in RRR areas as often the communities are small where all residents know each other. This can mean that sometimes, communities divide in support of one person or the other which can contribute to social isolation and loneliness.

Financial distress

Social security income support payment mutual obligations require regular access to technology, transport, and job opportunities in communities – all of which are key barriers for people living in RRR areas and add to feelings of hopelessness and distress.

Participants identified challenges in accessing support services in their region due to being unable to afford the upfront costs and gap fees associated with Medicare subsidised psychological sessions.

Supplementary research provided by SPA on Better Access Evaluation:

Recent evaluation of the Better Access Scheme found affordability to be a key barrier to access, with poorer access to treatment estimated to be associated with exacerbated increases in out-of-pocket costs.[11] While uptake was higher among people living in major cities, we interpret inequity in affordability of the Scheme to contribute to uptake among at-risk populations.

Housing

AirBNB has impacted housing availability in RRR areas significantly. Many residents are locked out of housing. AirBNB also impacts the ability for communities to grow as they block potential new permanent residents access to housing.

Childhood trauma

Childhood trauma was identified as a driver of distress for people living in RRR areas which can lead to suicidality in adolescence or later life. Early prevention should be prioritised in RRR areas including the promotion of positive mental health, resilience and help-seeking in schools and educational environments.

Additional support is needed for dedicated prevention programs and youth workers in mental health outreach teams and broader primary healthcare teams providing services in rural and remote areas, as well as better availability of postvention support for families following incidences of suicide or self-harm.

Recommendations	Agency Responsible
4.3.1 Government to review mutual obligations and accessibility processes for accessing social security income support payments. [PRIORITY]	Dept. of Social Services
4.3.2 Peer workers to be employed in Family Court systems to provide support to people experiencing family and/or relationship breakdown. [PRIORITY]	Family Court of Australia, Dept. of Health & Aged Care
4.3.3 Staff existing community hubs that are led by local community members in RRR areas with a full-time social worker. The social worker would provide information on available health and support services in the community, provide practical support for accessing government services (e.g. social security, disability support, and housing issues), and provide counselling to community members to reduce stigma experienced in entering mental health services in small communities. [PRIORITY]	Dept. of Health & Aged Care
4.3.4 All frontline workers in social services to be trained in suicide prevention to identify people at risk in the community and refer them to social workers on staff. [PRIORITY]	Dept. of Health & Aged Care
4.3.5 Increase funding contract cycles to 3-5 years to provide employment stability for people in RRR areas and enable evaluation of impact of suicide prevention activities. [PRIORITY]	Dept. of Health & Aged Care
4.3.6 Place a cap on the percentage of properties in an RRR area that can provide AirBNB services.	Dept. of Infrastructure, Transport, Regional Development, Communications and the Arts
4.3.7 Increased investment in child wellbeing support services (under 12 years of age) including for immunisation, psychoeducation, prenatal and post-natal care in RRR areas for early intervention and prevention which are affordable and accessible.	Dept. of Health & Aged Care
4.3.8 Investment in attraction and retention incentives for youth workers in RRR areas to increase early intervention and prevention in local communities. [PRIORITY]	Dept. of Health & Aged Care

4.3.9 Investment in community-based postvention services in RRR areas to support families experiencing bereavement by suicide. [PRIORITY]	Dept. of Health & Aged Care
4.3.10 Increase Medicare sessions from 10 to 20 and remove gap fees for people living in RRR areas to address financial barriers to accessing psychological support. [PRIORITY]	Dept. of Health & Aged Care

4.4 Workplace as a contributing factor for elevated distress

Consultations identified workplace issues unique to residents in RRR areas that can contribute to distress.

Agriculture industries

Mental ill-health and suicide are prevalent among farming communities. Stressors that are unique to farmers include: lack of control as livelihood is dependent on climate and natural disasters, lack of control in the market, and mental ill-health is exacerbated by physical geographic isolation.

Mentally healthy workplaces

There is a need to improve wellbeing across the workforce in RRR areas. Participants reported employers don't feel it is their duty to provide support for mental health and wellbeing, and the link between wellbeing and productivity is not well understood as not all businesses and industries have dedicated human resource management in RRR areas.

Given recent updates to Safe Work Australia's work health and safety (WHS) regulations which name potential psychosocial hazards, there is accountability for employers to support the mental wellbeing of their employees. This should be supported by funding for businesses and industries to upskill in how to be a mentally health workplace.

Recommendations	Agency Responsible
4.4.1 National roll out of free education and training for workplaces in how to create mentally healthy workplaces. [PRIORITY]	Dept. of Health & Aged Care
4.4.2 Investment in local community driven peer support programs and activities for farmers. [PRIORITY]	Dept. of Health & Aged Care

5. Older People

5.1 Loneliness and social isolation among older people

Loneliness and social disconnection are prevalent for older people. Key factors contributing to loneliness include end of relationships, bereavement, family and friends moving locations, loss of purpose from retirement, lack of employment, life transitions e.g. moving into residential aged care and loss of independence, and hearing loss (isolating from family).

Recommendations	Agency Responsible
5.1.1 Government to fund national research study into the key drivers of loneliness among older people, including journey mapping crisis points for older people experiencing suicidality. [PRIORITY]	Dept. of Health & Aged Care
5.1.2 Upskill healthcare professionals in awareness of non-clinical workforce e.g. peer workforce and community-based supports to improve pathways to social connection in the community. [PRIORITY]	Dept. of Health & Aged Care
5.1.3 Government to fund targeted approaches to older people such as community-led action groups to address social isolation that are tailored to older people living in residential aged care, living in independent living units, and those who live in the community independently or with families. [PRIORITY]	Dept. of Health & Aged Care
5.1.4 Create volunteer roles for older people in the community to foster sense of purpose and community contribution through community gardens. [PRIORITY]	Dept. of Health & Aged Care
5.1.5 Fund volunteer opportunities for people in aged care facilities and retirement villages to enhance sense of purpose, self-esteem, and social connection.	Dept. of Health & Aged Care

5.2 Ageism and stigma for older people

Older people have different needs to the broader adult population, and suicidality often is not recognised due to focus on physical health issues, ageism and stigma surrounding underlying mental ill-health conditions.

Ageism among health practitioners can result in many older people being misdiagnosed, or in failure to identify suicide risk due to 'normalising' depression among older people due to aging.

Participants further identified there is an assumption that older people in residential aged care have access to regular quality care however that is not always the case.

Recommendations	Agency Responsible
5.2.1 Government to deliver national campaign to address ageism and suicide awareness of older people. Campaign should be multi-tiered and challenge ageism, elder abuse, mental health among older people and have a range of audiences and groups across the continuum of older people. The campaign should embed evaluation and subsequent steps to alter messaging as needed, and feature voices of older people impacted by suicide and mental ill-health. [PRIORITY]	Dept. of Health & Aged Care
5.2.2 Provide a voice for older people with lived experience of suicide in Government decision-making to drive addressing ageism and other risk factors for suicide for older people. [PRIORITY]	Dept. of Health & Aged Care, NSPO

5.3 Challenges of the digital world

Digital literacy and digital connection are significant barriers impacting the ability of older people to engage and connect with support services and communities. With services transitioning to online modes of delivery due to the COVID-19 pandemic, many older people have faced challenges in accessing support.

Digital provision of services assumes people have access to phones and computers. Many older people don't have these. If Government services expect older people to use technology, older people need to receive technology education in a face-to-face context.

Recommendations	Agency Responsible
5.3.1 Subsidise phone line connections for people aged 65 years and over to increase access to crisis support helplines and community connection support lines to reduce loneliness and social isolation.	Dept. of Health & Aged Care
5.3.2 Provide in-person workshops on using technology including phones and computers for older people in the community to increase technology literacy among older people. [PRIORITY]	Dept. of Health & Aged Care

5.4 Social determinants of health that lead to suicide

Key social determinants of health that lead to distress impacting older people identified in consultations include financial distress, lack of transport, homelessness and insecure housing, and unemployment.

Financial distress

Financial distress and lack of control were identified as a key driver of distress. Financial distress can emerge in the form of elder abuse which is difficult to talk about for older people, especially for Aboriginal and Torres Strait Islander families. Participants reported older people experience shame over their lack of financial literacy and vulnerability to financial abuse by family members.

People need to understand what abuse is, that it's not acceptable, and that there are avenues of support that are culturally appropriate. Information and support should be handled carefully and delivered by people with peer experience.

In addition, the cost of psychological therapy was cited as a barrier to access for older people who are unable to meet the upfront costs or subsequent gap fees.

Transport
Transport is a key cost concern for older people. Not everyone can afford to own a car or has the mobility required for public transport. This can add to social isolation and loneliness experienced by older people.

Housing and homelessness
Some older people are in precarious living situations due to housing insecurity and many older women face homelessness. There is a need for supports for people who rent, especially older women who are vulnerable to homelessness.

Some older people have large houses that are empty due to family moving out. Participants suggested a social equity housing model where other older people in the community could live together in those houses to promote social connection and provide secure housing. The model could be subsidised for the person who owns the house and not impact pensions.

Employment
Employment is a protective factor for suicide. It provides older people with a sense of purpose, financial stability, and builds self-esteem. For many older people, transitioning to retirement can be a significant life stressor. Volunteering opportunities are a way to provide a sense of purpose among older people out of the workforce. There is also opportunity to invest in the older peer lived experience workforce in paid work where older people can provide support to others.

Education
Participants identified tertiary education in later life as a protective factor for suicide as it provides a sense of purpose and builds self-esteem in expanding skills and knowledge. It was further discussed that older people could benefit from education on supports available for key life stages e.g. transitions to retirement and aged care residential living, and bereavement in later life; and mental health and suicide awareness education.

Case Study from Consultation Participant:

Anglicare reported recently meeting with an older man who runs coaching sessions on how to retire well which is emotions focused rather than financial focused. The program is called Redefining Retirement and runs in NSW. It features guest speakers for a range of health issues impacting older people.

Recommendations	Agency Responsible
5.4.1 Fund financial literacy education workshops tailored to older people to build sense of control and self-esteem.	Dept. of Health & Aged Care
5.4.2 Increase subsidises for transport costs for older people (e.g. petrol) to enhance social connection and engagement. Concessions could be linked to the already established concession card.	Dept. of Social Services

5.4.3 Remove gap fees for Medicare subsidised specialist services for people aged 65 years and over and increase sessions to 20 per year. [PRIORITY]	Dept. of Health & Aged Care
5.4.4 Create subsidised university places for people aged 65 years and over.	Dept. of Education
5.4.5 Create subsidised employment positions for people aged 65 years and over.	Dept. of Employment & Workplace Relations
5.4.6 Review process for accessing the pension with a lens to simplify it for older people. [PRIORITY]	Dept. of Social Services
5.4.7 Abolish penalising pension payments for older people based on amount of hours worked to enable employment as protective factor for suicide. [PRIORITY]	Dept. of Social Services
5.4.8 Provide peer workers to help older people navigate social security services in a variety of contexts including residential aged care facilities, independent living units and for people living in the community. [PRIORITY]	Dept. of Health & Aged Care
5.4.9 Develop a directory of services that are affordable and promoted to older people to support older people navigating support systems. [PRIORITY]	Dept. of Health & Aged Care
5.4.10 Invest in community-led tailored programs and activities for older people, including for key life stressors such as retirement, entering residential aged care facilities, and bereavement in later life to reduce distress experienced in key life stages. [PRIORITY]	Dept. of Health & Aged Care
5.4.11 Fund older peer workers to support their ageing communities and prevent distress in the community. [PRIORITY]	Dept. of Health & Aged Care
5.4.12 Trial a social equity housing model for older people to meet housing needs and enhance social connection.	Dept. of Health & Aged Care

5.5 Strengthen community capacity to respond to distress

Older people are less likely to have coping skills to manage mental health and wellbeing in later life due to historical stigmatisation of mental ill-health in earlier life, and ongoing ageism by healthcare professionals. In a digital age, lack of technology literacy can pose significant barriers for older people to connect and engage with support services and communities. Physical mobility limitations can provide further barriers to connecting with friends and family, resulting in increased social isolation. Consultation participants identified the need for community-based supports to address the wellbeing of older people.

Participants identified older people are more likely to engage in community education and supports if the program or workshop is not branded as 'mental health' specific. Participants reported the Government already funds the Community Visitors Scheme but it currently only provides 1 hour of support a fortnight. It was suggested this community-based model is suitable for older people, however, it should be better resourced to meet needs through the provision of more hours of social connection provided.

GPs were identified as a key community touchpoint for older people as not only an entry point into healthcare, but also well-placed to identify older people in distress who can connect them to support before reaching crisis.

Case Study from Consultation Participant:

Programs for older people that encourage looking after both physical and mental health are important for managing wellbeing in later life. The Sons of the West program in Victoria is an example of a model that could be rolled out nationally. The 10-week free program aims to improve men's health and wellbeing through a series of workshops, presentations, events and experiences. Activities are held locally throughout the municipality and cater for all levels of knowledge and fitness. Participants reported many older men attend this program.

Case Study from Consultation Participant

GPs in the UK utilise a personal list system where registered patients are named/accountable to a GP within a group general practice. The named GP is responsible for those patients on their list. This provides community members with the opportunity to build a trusting relationship with their GP which can otherwise be lost if you don't have a regular GP. This model is aimed at providing people with continuity of care and is best applied to large practices with multiple GPs on staff (e.g. medical centres).

Recommendations	Agency Responsible
5.5.1 Invest in capacity building of community-based organisations to support older people in the community to manage wellbeing of older people who require targeted approaches to wellbeing support. [PRIORITY]	Dept. of Health & Aged Care
5.5.2 Expand the Community Visitors Scheme in all jurisdictions to increase the amount of hours of social support provided to older people to address social isolation experienced by older people. [PRIORITY]	Dept. of Health & Aged Care
5.5.3 Appropriately resource local councils to enable a wellbeing development focus on older people to deliver community connection events and ensure community spaces are safe for older people. [PRIORITY]	Dept. of Health & Aged Care
5.5.4 Utilise existing tools such as for encouraging bowel screening checks for mental health checks with links to support for older people to enable identification of older people in distress before they reach crisis.	Dept. of Health & Aged Care
5.5.5 Suicide prevention training to be delivered to all GPs in Australia to increase skill in identifying older people at risk of suicide and refer them to supports. [PRIORITY]	Dept. of Health & Aged Care
5.5.6 Create more safe spaces/safe havens as alternatives to emergency departments for older people in distress who are suitable for community-based care.	Dept. of Health & Aged Care
5.5.7 Government to fund suicide prevention gatekeeper training tailored to supporting older people in distress in the community. [PRIORITY]	Dept. of Health & Aged Care

5.6 Mental health care in residential aged care facilities

Participants identified negative assumptions associated with transitioning into residential aged care including perceptions of low quality of life. Attitudes and wellbeing could be enhanced by building hope and positivity about healthy ageing, and better resourcing residential aged care facilities to take a holistic approach to supporting the wellbeing of older people.

Recommendations	Agency Responsible
5.6.1 Provide green spaces in residential aged care facilities to foster positive wellbeing among older people. [PRIORITY]	Dept. of Health & Aged Care
5.6.2 Provide mental health services and allied health services in residential aged care facilities, including psychologists for family therapy and social workers to increase availability of mental health and wellbeing support for older people and prevent elder abuse. [PRIORITY]	Dept. of Health & Aged Care
5.6.3 Aged care facilities to be trained in inclusivity and compassionate and culturally sensitive care for older LGBTQIA+SB and Indigenous Australians to ensure respect, safety and inclusion of older people. [PRIORITY]	Dept. of Health & Aged Care

6. Key actions across population groups for most impact

Across consultations with the population groups, there were some key drivers of suicide and subsequent actions which would have the most impact in mitigating distress that were repeatedly raised in all population groups. These include:

Responding to financial distress

The processes for accessing social security income support payments are difficult and punitive in nature. Increasing access, the amount of the payments, and removing mutual obligations would alleviate financial distress among populations which would have a flow on impact into other areas of their lives. For example, employment opportunities by being able to provide a permanent address, housing security, and funds to access mental health care services such as psychological therapy.

Responding to housing insecurity and affordability

There were three populations who identified the need for social equity housing models to both provide secure housing and enhance social connection to strengthen these protective factors for suicide. Populations included CALD, people with disability and older people.

Increasing access to mental health care

The current upfront gap fees to access Medicare subsidised psychological therapy sessions pose a significant financial barrier to accessing support. The sessions need to be fee-free for people disproportionately at risk of suicide to address financial barriers. Evaluation of the Better Access Scheme identified the increasing out-of-pocket costs to be the significant barrier to access.[12] This has been an underlying cause of lack of uptake of the Scheme by populations at-risk of suicide.

Sustainable funding cycles for suicide prevention

Short funding contracts for suicide prevention services and community-based supports have limited the ability of providers and organisations to undertake evaluation of activities and services, and significantly impacts the sustainability of services. Many local community-based supports rely heavily on unpaid volunteer work to operate and are in need of greater investment to respond to increasing distress in the community. Consultations identified the need to extend funding cycles to 3-5 years to enable sustainability and evaluation.

Suicide Prevention Australia notes the Select Committee on Mental Health and Suicide Prevention recommended (28) in its Final Report that the Australian Government fund Primary Health Networks (PHNs) for mental health and suicide prevention services on five-year cycles, and strengthen long- and short-term outcome reporting requirements to enable continuous service evaluation in response to increasing the length of contracts and funding cycles.[13]

Peer workforce

All population groups identified the need for greater investment in the suicide prevention peer workforce for their population group. Based on the unique needs of diverse populations, peer workers with lived experience of suicide are suitable to support people in distress who are at-risk of suicide. Peer workers require greater integration in the clinical and non-clinical workforce.

7. Project Challenges and Limitations

Suicide Prevention Australia (SPA) received the signed grant agreement from the NSPO on 14 March 2023. The first meeting with the NSPO, SenateSHJ and SPA to outline project expectations was held on 17 March 2023. SPA began the expression of interest recruitment process on 20 March 2023. The requirement to deliver consultations in mid-April only allowed for 4 weeks of participant recruitment. This posed challenges in reaching populations who are known to be difficult to reach as they experience a range of challenges with technology literacy, language barriers, and diverse disabilities. While we endeavored to utilise the strength and connections of other peak bodies and community-controlled organisations with links to communities, many responded requiring additional time to source participants which we were unable to provide due to the tight project timeline.

The Project Manager received a number of complaints from the sector and people with lived experience on the short timeframe for execution of the project throughout the expression of interest process. Some people expressed the consultations appeared to be tokenistic in nature due to the short timeframe.

While 115 participants were confirmed to attend consultations prior to them commencing, 19 did not attend on the day of the consultation. Participants who confirmed but did not attend were followed up with the opportunity to either attend the consultation in the second week (where possible) or to make a written submission responding to discussion questions in the discussion paper. Only two participants who did not attend provided a written response to discussion questions. Common reasons for not attending were unexpected caring responsibilities, unexpected work responsibilities, and personal wellbeing reasons. Phone call check ins were offered by the Project Manager to participants who stated personal wellbeing or caring responsibilities.

We suggest the NSPO provide a minimum 2 months to promote consultations and source participants in future consultation work with people with lived experience of suicide, with consultations to be delivered in the third month. This will allow greater time to schedule promotion via organization newsletters to their lived experience communities, and more time to adjust outreach strategies in recruitment.

For more information about this Report contact:
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Suicide Prevention Australia
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Acknowledgements 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. Advice from individuals with lived experience helped guide the analysis and recommendations outlined in this policy position.

Participants with lived experience in consultations and written submission informed the key issues and recommendations to the NSPO identified in this report. These recommendations will be considered for inclusion in the next National Suicide Prevention Strategy.

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 positions. Suicide Prevention Australia thanks all involved in the development of this policy position.

If you or someone you know require 24/7 crisis support, please contact:

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

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

For general enquiries

Appendix A: Expression of Interest Form

EXPRESSION OF INTEREST – NATIONAL SUICIDE PREVENTION STRATEGY TARGETED CONSULTATIONS

The National Suicide Prevention Office (NSPO) has engaged Suicide Prevention Australia to support the development of the National Suicide Prevention Strategy by undertaking one part of a series of consultations with groups disproportionately impacted by suicide. We are seeking to consult with people with lived and living experience of suicide, sector representatives and other relevant stakeholders who support:

- Culturally and linguistically diverse people
- Men
- Older people (aged 65 years and over)
- Residents in regional, rural and remote areas
- People living with a disability including those who are deaf or hard-of-hearing

Consultations with other population groups such as young people, First Nations peoples, and LGBTQIA+ are being undertaken separately and are not within the scope of this initiative.

What you will be asked to do:

Consider the specific needs of the population of focus and identify specific priority actions that governments, government agencies and organisations and communities can take to:

- Enhance aspects of wellbeing which protect against suicide
- Mitigate the impact of drivers of distress and suicide risk factors

A discussion paper will be provided in advance of the consultations to allow time to prepare comments and to guide discussion on the day.

Outcome

Suicide Prevention Australia will produce a report capturing priority actions identified in consultations to be provided to the National Suicide Prevention Office to inform their work on the next Strategy.

What is required:

Attend one 2-hour consultation. Should additional input be required, participants may be asked to provide some follow-up comments or to participate in a second 2-hour session.

Participants with lived experience who aren't an employed organisation representative will be paid for their participation in accordance with Suicide Prevention Australia's Lived Experience Engagement and Participation Guidelines.

Key information

Key Dates: Consultations will run between 11 April to 21 April 2023.
Key Times: Consultations will run during block times of 10am-12pm, and 2pm-4pm.

We hope to finalise dates and times by the end of March.

Project Contact

Caitlin Bambridge, Project Manager
E: caitlinb@suicidepreventionaust.org

How to complete your Expression of Interest

Please answer the following questions and submit responses to Caitlin Bambridge, Project Manager, caitlinb@suicidepreventionaust.org. If you require support in completing your expression of interest, please contact Caitlin by phone.

You only need to share what you feel comfortable with. For privacy purposes, your information will only be shared with Suicide Prevention Australia, SenateSHJ who have been contracted to facilitate the consultations, and the NSPO who requested a copy of final consultation participants. Your information will not be shared with any other parties or for any other purpose.

Question 1. Please provide your name, mobile, email and state/territory of residence.

Name
Mobile
Email
State/Territory

Question 2. Which population group consultation would you like to attend?

We understand there may be more than one group you would like to contribute to. If this is the case please number in order of preference.

Question 3. Please describe your lived experience and/or sector experience in relation to the population group consultation you wish to attend.

Question 4. Are there any dates during the consultation period (11/04-21/04) that you are unable to attend? Please specify. We will attempt to accommodate as best as possible but cannot guarantee.

If you are interested to hear directly of future opportunities for consultation with the NSPO on the draft Strategy please register your interest at this link: https://haveyoursay.mentalhealthcommission.gov.au/hub-page/nspo

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

Lifeline: 13 11 14
StandBy Support After Suicide: 1300 727 247

Appendix B: Discussion Paper

Background

The National Suicide Prevention Office has asked Suicide Prevention Australia to consult with various individuals and organisations to inform the National Suicide Prevention Strategy.

These consultations are part of a broader program of ongoing consultation to ensure the National Suicide Prevention Strategy continues to be informed by people with lived experience of suicide, in addition to data, as it is developed.

The consultation session you have agreed to join will focus on two areas:
1. strengthening wellbeing
2. mitigating the known drivers of distress for your community.

Your role is to help identify the actions for these two areas that you feel will have the greatest impact for your community and be able to be achieved through the Strategy.

Strengthening wellbeing

The goal is to improve the general wellbeing of all Australians to decrease the rate of suicides.

The key steps identified to achieve this goal are to:
- Increase social security and safety so that all Australians live with a sense of independence, hope, and purpose.
- Enhance community connection to build belongingness and a sense of community to help in times of difficulty.
- Ensure all Australians have the skills, knowledge and resources to maintain physical and mental wellbeing.
- Ensure healthy early childhood development so that all Australians start life from a safe, supportive, and secure foundation.
- Equip young Australians (children and adolescents) with the skills and knowledge to build and maintain their own mental wellbeing and resilience over the course of their lives.

Please consider:
1.What are the key actions that governments can take to improve wellbeing?
2.Which of these actions are the most achievable?
3.Which of these actions will have the greatest impact and be able to be achieved?

Reducing causes of distress

The goal is to reduce known causes of distress to lessen the risk of suicide.

The key steps identified to achieve this goal are to:
- Reduce the impact of negative social experiences such as childhood sexual abuse, domestic and family violence, bullying, discrimination, stigma, so that experiences of trauma do not cause an individual distress that could lead to suicide.
- Reduce life stressors such as housing and financial stress, unemployment, problematic interactions with legal and judicial systems, retirement, relationship breakdown exit from the military, so that people in situations of disadvantage and/or life transition have a safety net that prevents them from escalating into distress.
- Reduce problematic or addictive behaviours, such as alcohol and other drug use, gambling, to prevent the onset and exacerbation of events that heighten the risk of suicidal behaviour.
- Improve support for people who interact with systems including prisons, family courts, child protection system, to minimise distress that can arise through involvement and/or engaging with these settings.
- Reduce loneliness and disconnection, especially in disability and aged care, so that people are not driven to distress and despair due to a lack of social connectedness, and to enable others to detect early signs of distress before they become suicidal.

Please consider:
1.What are the key actions that governments can take to reduce distress?
2.Which of these actions are the most achievable?
3.Which of these actions will have the greatest impact and be able to be achieved?

Appendix C: Consultation Agenda

Time	Topic	Approach
10 mins	**Welcome and introductions** • Acknowledgement of country • Acknowledgement of lived experience • Self-care and support • Session overview and purpose • Principles for discussion	*Participants asked to introduce themselves and the perspective they bring in the chat* *Principles for discussion included specific safety aspects (language, communicating if going off-camera, dropping off the call)*
5 mins	**Brief overview of the National Suicide Prevention Strategy** • Objectives • Principles • Actions • Enablers • Development process • Context around scope of consultation (i.e., the need to build on existing reform pieces)	*Short presentation on the draft strategy and development process and where these consultations fit in the process* *Delivered by NSPO Representative*
45 mins	**Mitigating known drivers of distress** • What drivers of distress in the priority population should governments focus on reducing? • What must governments do to reduce drivers of distress in the priority population • What programs, initiatives and policy changes will have the greatest impact? • What is achievable in the next 3 – 5 years?	*Facilitated group discussion*
45 mins	**Enhancing wellbeing as a protective factor for suicide** • To enable the priority population to thrive, what should governments focus on? • What must governments do to help older people thrive? • What programs, initiatives and policy changes will have the greatest impact? • What is achievable in the next 3 – 5 years?	*Facilitated group discussion*
15 mins	**Closing reflections** • Anything we have missed? • One thing you believe must be an action for governments?	*Each participant asked to name one thing that has been missed or one action must be included in the strategy*

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