Suicide Prevention Australia

DECEMBER 2023

# NFP Sector Blueprint

## Submission

# Introduction

Suicide Prevention Australia welcomes the opportunity to provide input to the Not for Profit Sector Blueprint
Suicide Prevention Australia is the national peak body for the suicide prevention sector. We have over 430 members representing more than 140,000 employees, workers, and volunteers across Australia. We provide a collective voice for service providers, practitioners, researchers, local collaboratives, and people with lived experience.

More than 3,000 people tragically die by suicide and an estimated 55,000 people attempt suicide each year. Over 7.5 million Australians have been close to someone who has taken or attempt suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

Our members cover the full range of the not-for-profit sector, with some of the largest and many of the smallest organisations working in suicide prevention, practitioners, researchers and community leaders.

At Suicide Prevention Australia, our priorities include policy reform, facilitating education, building best practice, enabling meaningful collaborations, and representing the voices of our members to governments and agencies.

This is achieved through a number of methods discussed in the Blueprint which form the basis of this submission. The sections of the Blueprint we will address are:

- Section 3: Measurement, outcomes and quality of services; and
- Section 4: Policy, advocacy, communications and engagement

## Summary of Recommendations

**Recommendations regarding outcomes-based funding:**
1. Outcomes funding should not apply to prevention services if it unreasonably diminishes the capacity of the service to provide its core purpose.
2. Funding cycles should be lengthened to a minimum of 5 years to ensure sustainability, continuity of care, and worker retention.
3. Funding payments need to be timely and reliable to ensure service providers can continue to operate effectively.
4. Transparency of contract expiry and renewal negotiations needs to be embedded in processes to ensure organisations can plan with confidence, stability, and best use of staffing and resources.
5. There needs to be flexibility in the funding processes to account for the essential variety of services needed to provide choice of service for communities. Funding should encourage this diversity of service scale through recognising the impacts on capacity for compliance, and ensure smaller organisations are not disadvantaged by the imposts of the process.
6. Reporting should have consistency between agencies to reduce the impact of multiple system navigation on service providers.
7. Funding reporting needs to be designed around recognition of the difficulty of outcomes measurement in prevention work, particularly when data for evaluation is subject to inconsistency and lags.
8. Funding processes need to account for the increasing diversity of populations, and the value in targeted services to deal with priority populations, as a vital specialisation in funded services.

**Recommendations regarding the importance of advocacy:**
9. Promote and value advocacy to enable innovation and ensure effective service provision.
10. Engaging people with lived experience should be included as criteria for tender applications to embed their voices in continued service provision.

## Measurement, outcomes and quality of services

Suicide Prevention Australia is a peak body for organisations that employ staff varying from in the hundreds through to numbers in the single figures.

This variation in size is related to the purpose of organisations, with some dealing with dedicated services in small communities, others multiple programs and services nationwide.

This variation in size also cuts to very real differences in capability and compliance. The ability of a very small organisation to comply with funding administration can be more onerous than for a larger organisation who may employ staff to deal specifically with that need. Compliance to multiple systems and requirements takes significant amounts of resourcing, which can detract from the ability to provide core services to the communities they support.

The capacity for a larger organisation to budget for gaps and bridges in contracted funding could be more sustainable than for a smaller organisation. The affordability of digitisation also impacts organisations differently.

A Suicide Prevention Australia report (SPA 2023) gathers the input of members and the sector to reflect on issues and concerns. This report found that 77 per cent of respondents were facing increased demand for their services, and 81 per cent required increased funding to meet demand. Collaboration with Government or other not-for-profits occurred for 77 per cent of respondents, and 60 per cent rely on external funding to remain viable.

Government funding had arrived late for 43 per cent of respondents, and 51 per cent said the funding climate had changed in the last 12 months. This had implications for staffing and job security, and fewer multi-year funding opportunities. A concern included that funding may increasingly be allocated on evidence based and outcome related criteria, and that providers with financial strength and rigorous risk management systems are being favoured for funding.

Funding agreements for suicide prevention in Australia are complex, and divided between the Commonwealth, state and territory Governments, and philanthropic sources. The Commonwealth represents a significant source, particularly through contributions to the National Agreement for Mental Health and Suicide Prevention, Primary Health Networks, and the National Suicide Prevention Leadership Support Program. States and territories support the Commonwealth Government's suicide prevention activities with their own locally delivered plans and programs, as well as contributing funds under the National Agreement on Mental Health and Suicide Prevention. Private and corporate philanthropic donations also constitute an important source of funding.

A major concern is stability of funding, both in administrative terms such as timeliness of payments or gaps in funding, and in contractual negotiations. As a program nears the end of contractual funding with no finalised negotiation on renewal, the program will start to wind down. This then increases the cost to the organisation during renewal as it reinstates the workforce and program. Greater transparency in processes of contract expiry and renewal are needed for better continuity of services in the community and better confidence for service providers.

Indexation of funding is also a vital consideration, particularly in a climate of increasing demand and increasing costs. Services which are not receiving adequate indexation, a common occurrence across the sector as there has been no consistent indexation on Commonwealth funding in recent years, are finding their real funding is decreasing. This is creating a funding crisis for the sector, with organisations facing workforce reduction as a result.

Inconsistencies in lengths of contracts and reporting mechanisms for funding are also creating significant issues in the sector and are requiring the diversion of time away from the core purpose of the services to deal with contract administration.

During consultation with members on this Blueprint, we heard that there is a significant administrative burden as each funder requires different outcome measures, the number of KPIs is overwhelming, and the extensive reporting requirements takes time away from work with clients.

There is a recognition of the difficulties too of requiring prevention work to adhere to outcomes-based funding. The Department of Health (DOH 2014) cites difficulties in applying outcomes-based funding to suicide prevention, as the crisis nature of services limits staff capacity to undertake long term behaviour impact analysis nor is funding included in contracts to evaluate behaviour change over time.

> "… it is important to note that no matter how well outcome measurement is undertaken at project level, it is not possible to establish a direct correlation between individual project-level activities and reductions in the suicide rate nationally." (DOH 2014)

The Department also states the issues with data provision in outcomes-based funding creating issues in suicide prevention, such as the need to include suicide attempts and not just deaths by suicide as key indicators of change. The Department explains that this would require consideration of implementing a suicide attempt register and the follow-up of people who used services due to attempted suicide or self-harm, and to establish processes to follow in the 12 months after contact with the service or emergency department.

While data collection is a central feature in suicide prevention, the availability of timely data is more problematic and varies across jurisdictions. The collection and reporting from suicide registries are not universal in approach and its compilation by the ABS contains a 12-month lag (such as for the Australian Bureau of Statistics annual 'Causes of Death' data release). Evaluation and outcome assessment are not possible in immediate time frames.

In addition, diversity of population groups continues to grow, and more targeted and personalised service provision is required. Adopting an intersectionality approach to suicide prevention allows organisations to better meet the needs of priority populations as degree of suicide risk can vary per population group. For example, First Nations people who have double the rate of suicide compared to non-Indigenous populations (AIHW2023a); Veterans who experience an 18 per cent higher rate of suicide (AIHW 2023b); people living in remote and regional communities who die at higher rates than those living in metropolitan areas; and men who account for 75 per cent of deaths by suicide. (ABS 2023)

Risk factors are not confined to population demographics, but also diverse socio-economic aspects, which requires further data disaggregation. For example, research highlights a link between alcohol abuse or other drug abuse and suicide (Amiri, 2020), with autopsy studies identifying between 19-63% of deaths by suicide having a history of diagnosed alcohol and other drug use disorders (Connery, 2020).

The socio-economic factors causing risk, and requiring some specialisation, include links between unemployment and financial insecurity, and suicidality. Access to services is essential to maximise the effectiveness of suicide prevention, especially in regional and remote communities. What localisation might not provide in economies of scale it provides in vital accessibility.

These factors inhibit the ability of outcomes-based funding to be effective in suicide prevention.

The 2021 Select Committee on Mental Health and Suicide Prevention (APH 2021) made recommendations on some broader issues of funding facing the sector.

In recommendation 4 of their report, the Committee urged the Government to ensure the principle of accessibility is at the forefront of all policy and funding programs for the mental health and suicide prevention sector. It urged increased funding for specialist services and frameworks that encouraged co-design and community partnerships to ensure equitable access for priority populations.

In line with stakeholder and the Productivity Commission Report recommendations, the Committee also recommended (Recommendation 28) a transition to five-year funding contracts.

**Recommendations regarding outcomes-based funding:**

1. Outcomes funding should not apply to prevention services if it unreasonably diminishes the capacity of the service to provide its core purpose.
2. Funding cycles should be lengthened to a minimum of 5 years to ensure sustainability, continuity of care, and worker retention.
3. Funding payments need to be timely and reliable to ensure service providers can continue to operate effectively.
4. Transparency of contract expiry and renewal negotiations needs to be embedded in processes to ensure organisations can plan with confidence, stability, and best use of staffing and resources.
5. There needs to be flexibility in the funding processes to account for the essential variety of services needed to provide choice of service for communities. Funding should encourage this diversity of service scale through recognising the impacts on capacity for compliance, and ensure smaller organisations are not disadvantaged by the imposts of the process.
6. Reporting should have consistency between agencies to reduce the impact of multiple system navigation on service providers.
7. Funding reporting needs to be designed around recognition of the difficulty of outcomes measurement in prevention work, particularly when data for evaluation is subject to inconsistency and lags.
8. Funding processes need to account for the increasing diversity of populations, and the value in targeted services to deal with priority populations, as a vital specialisation in funded services.

## Policy, Advocacy, Communications and Engagement

Advocacy plays a vital role in the provision of social and emotional wellbeing services. It provides the opportunity to facilitate equitable access to opportunities, services and resources through systemic change (Saxena 2022). NFPs by the nature of their work see the impact of distress, unanticipated consequences of policy or economies, and pressures on populations who do not feel they have the power to enact change. This is a core purpose advocacy in the suicide prevention sector – to identify ways in which existent issues resulting in suicide and suicide risk can be mitigated to save lives.

Without advocacy, there is no innovation. The mission and vision of the not for profit sector is to change the need in the community and focus on the greater good, placing the sector in a unique position to influence policy and advocate with nuance and compassion.

Recognising the value of that advocacy will help Governments to work effectively with the sector, creating a partnership of the expertise and experience of the sector with the economics and efficiencies of bureaucracy.

People with lived experience of suicide is central to advocacy in the suicide prevention sector. Our role is to uplift the voices of people with lived experience to utilise their expertise and knowledge to inform and enhance the suicide prevention sector. The not for profit sector is an essential channel to hear and raise the voices of people with lived experience.

People with lived experience are uniquely placed to inform how the sector can better identify people before they reach a crisis, support people through a crisis and support those grieving and/or bereaved. Their profound understanding and first-hand knowledge empower organisations to develop comprehensive, inclusive, and impactful solutions that can save lives.

**Recommendations regarding the importance of advocacy:**

9. Promote and value advocacy to enable innovation and ensure effective service provision.
10. Engaging people with lived experience should be included as criteria for tender applications to embed their voices in continued service provision.

## Contact

Rebekah Henricksen
Senior Government Relations Advisor
rebekahh@suicidepreventionaust.org

## References

Australian Bureau of Statistics (2023a) National Study of Mental Health and Wellbeing https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022

Australian Institute of Health and Welfare (2023a) Suicide and Self Harm Monitoring. http://www.aihw.gov.au/suicide-self-harm-monitoring

Australian Institute of Health and Welfare (2023b) National suicide monitoring of serving and ex-serving ADF personnel https://www.aihw.gov.au/reports/veterans/national-veteran-suicide-monitoring/contents/summary

Amiri, S & Behnezhad, S (2020) Alcohol use and risk of suicide: a systematic review and Meta-analysis, Journal of Addictive Diseases, 38:2, 200-213, DOI: 10.1080/10550887.2020.1736757

Parliament of Australia (2021) Select Committee on Mental Health and Suicide Prevention Final Report https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Mental_Health_and_Suicide_Prevention/MHSP/Report/section?id=committees%2freportrep%2f024705%2f76791

Connery, H.S., Korte, F.M. & McHugh, R.K. (2020) Suicide and Substance Use Disorder. Psychiatric Annals. 2020;50(4):158-62

Department of Health and Aged Care (2014) Development and Implementation of an Evaluation Framework for Suicide Prevention Activities https://www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~exec-summary

Saxena A., Chandrapal S. (2022). Social work and policy practice: Understanding the role of social workers. The British Journal of Social Work, 52(3), 1632–1642.

Suicide Prevention Australia (2023) State of the Nation in Suicide Prevention 2023 https://www.suicidepreventionaust.org/our-work/state-of-the-nation

## 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