Helping the Helpers:

Sustaining the Suicide Prevention Workforce

AUGUST 2025

Suicide Prevention Australia

Contents

Executive Summary

There is strong support across the suicide prevention sector for ensuring the sustainability and prioritisation of the suicide prevention workforce.

While efforts have been made to increase workforce capacity and expand resourcing, many gaps still exist. This paper is intended to provide an overview of the landscape of the suicide prevention workforce, highlight the urgent need for workforce development in the sector and identify evidence-based actions to address priority areas. The key gaps identified within the suicide prevention workforce include:

- Sustainability concerns
- Funding uncertainty
- Skill gaps in the workforce
- Limited training and education pathways
- Lack of support for the lived experience workforce
- Diversity of workforce

Consultations provided recommendations on how to better support and sustain the workforce, with four key priorities emerging:

- Creating and investing in a thriving, valued and sustainable workforce.
- Lived experience should be recognised for its unique value alongside clinical and non-clinical support.
- Investment needs to be put into the workforce to develop and attain skills that reflect the needs of the people they are supporting.
- Representation needs to be diverse and reflective of the communities it supports.

Recommendations

Recommendation 1: The Commonwealth Government should support the National Suicide Prevention Office (NSPO), in collaboration with State and Territory Governments, sector peak bodies, and community-led organisations in leading the development of a National Suicide Prevention Workforce Initiative. This initiative must articulate national, regional, and local strategies for accessibility, capability, skills, supply, retention, sustainability, support and workforce safety, with dedicated funding allocations for implementation.

Recommendation 2: The Commonwealth, State and Territory Governments must embed a universal wellbeing support framework for all suicide prevention workers, including clinical, peer and non-clinical roles – within funding agreements. This must include provisions and accompanying resources for supervision, training of leaders to support staff wellbeing, debriefing, mental health leave, flexible work arrangements and trauma-informed practices. In collaboration with the sector, governments must also revise workload standards and KPIs to prioritise quality of care, workforce wellbeing and client outcomes over volume-based metrics.

Recommendation 3: The Commonwealth, State and Territory Governments must commit to long-term, multi-year funding arrangements for the suicide prevention workforce to ensure sustainability, sector stability and continuity of care. All such funding must include mandatory provisions for targeted professional development, sector-wide capacity building and access to evidence-based resources, embedded as standard requirements within funding agreements across all jurisdictions.

Recommendation 4: The Commonwealth, State and Territory Governments should provide funding incentives to employers who accept trainees in suicide prevention roles to cover the cost of mentoring, supervision, onboarding resources and workplace learning supports.

Recommendation 5: All vocational education, training and tertiary programs specifically preparing individuals for suicide prevention roles, including peer work, should be reviewed and redeveloped in partnership with people with lived experience, community service providers and sector experts. Curricula should include modules on suicide risk complexity, crisis response, trauma-informed care, cultural safety, systems of care, and social determinants of suicide, tailored to the roles these professions play in suicide prevention. All TAFE courses should include suicide prevention as a core model of competence.

Recommendation 6: All suicide prevention organisations and relevant social sectors (such as health, education, domestic and family violence, justice and housing) must embed mandatory lived experience education into onboarding, ongoing training and daily practice standards ensuring every worker understands and values the role of lived experience within the sector.

Recommendation 7: Sector stakeholders, including NGOs, community organisations, and peak bodies, must collaborate to expand career pathways for the lived experience workforce, creating designated advocacy roles, leadership development programs and peer-led policy consultation mechanisms to embed lived expertise into service and policy design.

Recommendation 8: The Commonwealth Government should provide sustained funding to support the creation and expansion of paid lived experience and peer work roles across the suicide prevention sector. This investment must prioritise equitable remuneration, job security and access to professional development for lived experience workers in both clinical and non-clinical environments.

Recommendation 9: Develop a targeted mentoring initiative to support men – particularly those transitioning from blue-collar or non-human services backgrounds – into roles within the suicide prevention sector. This program should pair new entrants with experienced peer mentors who can guide them in navigating the language, systems, and practices of the sector.

Recommendation 10: The Commonwealth and State Governments should fund diversity-focused workforce development grants to support the recruitment, training and retention of individuals from underrepresented communities, including First Nations peoples, culturally and linguistically diverse (CALD) backgrounds, LGBTQIA+ communities, young people, and men.

About us

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We exist to provide a clear, collective voice for suicide prevention, so that together we can save lives. We believe that through collaboration and a shared purpose, we can work towards our ambition of a world without suicide. We are a member-based organisation that is guided by people with living and lived experience of suicide. We have over 350 members which include some of the largest and many of the smallest organisations working in suicide prevention, practitioners, researchers and community leaders.

Suicide Prevention Australia

Introduction

A well-trained and capable workforce is essential for an effective and sustainable suicide prevention system. However, Suicide Prevention Australia's 2024 annual State of the Nation in Suicide Prevention survey identified that two thirds (67%) of the sector don't have the staff and/or volunteers they need to meet workforce needs, and eight out of ten (84%) believe Australia needs a comprehensive, fully funded Suicide Prevention Workforce Strategy.[1]

This clear indication of the need for action to build and support the suicide prevention workforce is also reflected in a range of government plans and frameworks. The National Suicide Prevention Office (NSPO) identified a capable and integrated suicide prevention workforce as a critical enabler of the National Suicide Prevention Strategy.[2] While the National Mental Health and Suicide Prevention Agreement identified that improving quality, safety and capacity in both the Australian mental health and suicide prevention systems requires a capable and sustainable workforce.[3] In addition, the need for prioritisation of workforce and governance was one of the five key pillars within the Fifth National Mental Health and Suicide Prevention Plan, 2021.[4]

Despite the acknowledged importance of the need for further efforts to ensure the sustainability and prioritisation of the suicide prevention workforce, the sector continues to report significant challenges. Feedback from member organisations and trends across Suicide Prevention Australia's State of the Nation surveys identified that Suicide Prevention Australia should undertake a project to develop the workforce for the sector. [5,6]

The key objectives of this project have been to:

- Build upon workforce data captured in Suicide Prevention Australia's State of the Nation annual survey to provide a robust landscape of the suicide prevention workforce to guide sector development.
- Highlight the urgent need for workforce development in the sector.
- Identify evidence-based actions to address priority areas

Does Australia need a comprehensive, fully-funded Suicide Prevention Workforce Strategy?

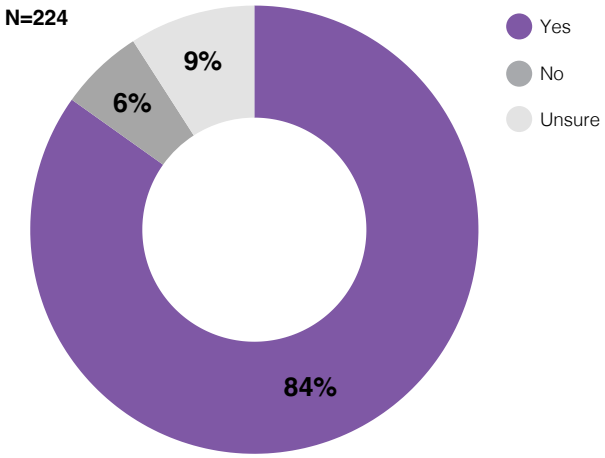


Figure 1: The Suicide Prevention Workforce Survey, 2024

Methodology

Phase One: Sector survey

A Suicide Prevention Workforce Survey (the Workforce Survey) was co-designed with two people with lived experience, from Suicide Prevention Australia's Lived Experience Panel. The survey was open for participation to Suicide Prevention Australia Members over a two-week period in late 2023 with a response rate of 65% (n=285). This level of response was remarkably high for this survey type, indicating that members thought the workforce to be an important topic.[7] A copy of the survey questions can be found in Appendix A.

Phase Two: Roundtable

A discussion paper was developed off the back of the Workforce Survey in consultation with lived experience representatives which set the foundations for a roundtable consultation in 2024. A total of eight individuals representing seven organisations across the suicide prevention sector attended the two-hour roundtable consultation which was co-facilitated by the Lived Experience Panel members involved in the co-design of the Workforce Survey. A copy of the discussion questions can be found in Appendix B.

Phase Three: Individual consultations

Members of the Lived Experience Panel helped identify key stakeholders and co-developed targeted consultation questions with Suicide Prevention Australia's policy advisor. Individual consultation representatives were selected based on relevant experience and involvement with the suicide prevention workforce, in alignment with the four priorities outlined in Phase 1 and 2. Representatives from six organisations were consulted during 2024. A copy of the consultation questions can be found in Appendix C.

Findings from the consultations were consolidated into this final report. In early 2025, the National Suicide Prevention Strategy 2025-2035 was released. The recommendations and considerations in this national strategy were also used to inform this Whitepaper. The Lived Experience Panel members who supported the co-design of this project reviewed this final report.

Defining the Suicide Prevention Workforce

While there is currently no single definition of the suicide prevention workforce, advocacy efforts in recent years have highlighted that despite sharing commonalities, the suicide prevention workforce is discrete and different from the mental health workforce.

Historically, the suicide prevention workforce has unfortunately often been regarded as only an addendum to the mental health workforce. For example, the National Lived Experience Peer Workforce Guidelines 2021 includes only brief mention of the extent to which experiences of suicide differ from mental health experiences.[8] The guidelines refer to the "mental health and suicide prevention" workforce throughout, often grouped and without differentiation.

Suicide Prevention Australia takes a broad view of the suicide prevention workforce in that suicide prevention requires a whole-of-community approach. This broad scope of the suicide prevention workforce includes everyone who is likely to interact with or make decisions that affect someone who might be vulnerable to suicide.

This includes three broad domains:

- The clinical workforce (including but not limited to doctors, nurses, and health professionals).
- The formal suicide prevention and mental health workforce (including but not limited to the peer workforce, the lived experience workforce, counsellors and personnel involved in the delivery of digital health services).
- The informal workforce (including but not limited to personnel from across government departments and other settings where individuals vulnerable to suicide or suicidality are likely to present).[9]

This aligns with the suggestion in the National Suicide Prevention Strategy that the suicide prevention workforce should include people working in emergency services and health care (including general practitioners, nurses and psychologists), frontline workers delivering income and psychosocial supports, personal support networks and policymakers who develop and deliver population level interventions.[10]

Pathways

The suicide prevention workforce includes people working in roles across policy, advocacy, training, and development, and those providing frontline, clinical and peer-based support. Individuals are often required to have a combination of formal qualifications and experience within the industry.

Formal qualifications that are recognised or used within the suicide prevention sector include:

- Bachelor of Medical Studies/ Doctor of Medicine
- Bachelor of Nursing
- Bachelor of Psychology
- Bachelor of Social Work
- Diploma of Community Services
- Diploma of Mental Health
- Certificate IV in Mental Health
- Diploma of Mental Health Peer Work

Most clinical avenues require a combination of applied study, placement hours and registration with a peak body, with the number varying across certifications.[11] While non-clinical pathways such as the Diploma of Community Services and the Diploma of Mental Health exist as alternate avenues for entering the workforce, they often require comparable time and financial commitments to their clinical counterparts.

There are limited recognised qualifications for lived experience identified roles, with the Certificate IV in Mental Health Peer Work (Consumer Peer Work) acting as the primary pathways into the suicide prevention peer workforce. Roses in the Ocean is one of the few organisations currently offering targeted training designed to meet the needs of the suicide prevention peer worker and the sector in which they work.[12]

The Suicide Prevention Workforce and Mental Health Workforce

The mental health and suicide prevention workforces share many foundational principles, such as being holistic, compassionate, trauma-informed, and evidence-based. The National Mental Health Workforce Strategy outlines these principles, which are also reflected in the National Suicide Prevention Office's (NSPO's) vision for a future suicide prevention workforce.[13] The National Suicide Prevention Strategy 2025-2035 recommends that a future national workforce strategy should support the workforce to be holistic in its capacity to support across roles and settings, diverse, compassionate and trauma-informed, integrated, coordinated and evidence based.[14]

Both workforces have substantial overlaps across occupations and roles, with psychologists, psychiatrists, nurses, social workers and peer workers often engaging in suicide prevention activities.[15, 16] There are however roles that are specific to the broader suicide prevention workforce, including targeted peer workers, postvention workers, and those working in aftercare. With greater understanding of the socio-economic and environmental determinants of suicide, we also know that agencies responsible for housing, communities and justice, education and health all play a role within the suicide prevention workforce's ecosystem.

The core functions of a suicide prevention workforce are inherently unique and require different skills, training, and experience. Consultations have highlighted that the suicide prevention workforce requires sufficient suicide literacy and applied intervention skills, and in many instances appropriate training and experience in safety planning that is unique to suicide risk. In addition, the clinical and peer suicide prevention workforce requires the capacity to recognise the appropriate and relevant avenues for escalation that are deeply person-centered.

Key Areas for Action

Strategic Investment in the Suicide Prevention Workforce

Consultations for this project have highlighted several key opportunities and considerations for ensuring a supported and valued workforce. While strategies like the National Suicide Prevention Strategy emphasise the need for developing a holistic, integrated workforce, Australia's progress in achieving these outcomes has been lacking. Though there have been advancements in training programs and recognition of lived experience, challenges remain in workforce sustainability, ongoing funding, diversity and the integration of targeted suicide prevention training across education pathways. Limitations and lack of consistency around the monitoring and evaluation of these efforts highlight ongoing gaps in fully meeting the strategic goals set out for the sector.

Consultations identified a strong need for a funded National Suicide Prevention Workforce Initiative that can deliver an actionable roadmap across national, state, regional, PHN and local levels, built on clear targets, evaluation mechanisms and accountability structures. The development and implementation of a strategy or initiative must embed actions for accessibility, capability, skills, supply, retention, sustainability, support and workforce safety across the sector.

To succeed, this initiative must be underpinned by long-term, reliable funding and intergovernmental collaboration. Governments at all levels must commit to strengthening the full suicide prevention workforce pipeline, from early career practitioners, peer workers and community connectors to specialist clinicians and researchers.

This includes investment in workforce infrastructure (such as education pathways, practice support, and technology), service delivery settings and the roles of people with lived and living experience, whose contributions remain essential but are often under-resourced and inconsistently supported. Workforce planning must also align with data on population needs, service demand, and emerging risk factors, to ensure investment is both equitable and effective.

Given the breadth of the suicide prevention workforce extends beyond health portfolios to areas such as education, justice and social services, any workforce initiative must be integrated appropriately with other related sectors and strategies under development. This requires adequate and ongoing funding and commitment by all governments to grow and support the suicide prevention workforce.

Recommendation 1:

The Commonwealth Government should support the National Suicide Prevention Office (NSPO), in collaboration with State and Territory Governments, sector peak bodies and community-led organisations in leading the development of a National Suicide Prevention Workforce Initiative. This initiative must articulate national, regional and local strategies for accessibility, capability, skills, supply, retention, sustainability, support and workforce safety, with dedicated funding allocations for implementation.

Sustainability and Workforce Support

Have you experienced any of the following in the past 12 months? (n=202)

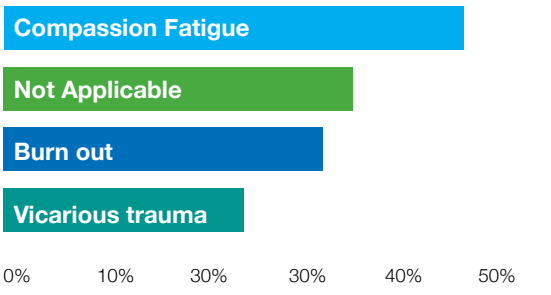


Figure 2: The Suicide Prevention Workforce Survey, 2024

Have you ever access an Employee Assistance Program whilst working in the suicide prevention sector? (n=200)

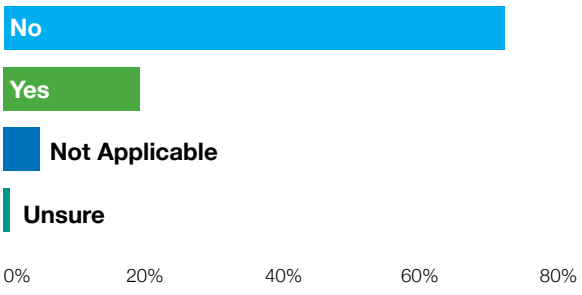


Figure 3: The Suicide Prevention Workforce Survey, 2024

The National Suicide Prevention Strategy calls for the development of a compassionate workforce. It also recognises the need for specific support for the suicide prevention workforce.[17] Responses from the Workforce Survey highlighted that the suicide prevention workforce is experiencing high rates of vicarious trauma (25%), burnout (33%), and compassion fatigue (47%).[18] Respondents raised further concerns over the lack of support for volunteers and staff pertaining to staff burnout, vicarious trauma, managing stress levels and individual mental health.[19]

Roundtable discussions echoed these concerns and further identified that a lack of recognition and insufficient regard for the value of the peer workforce is prominent across the suicide prevention workforce. Given that employees in the suicide prevention sector will experience high exposure to suicide and suicidality, roundtable participants highlighted the need for more targeted support. The National Suicide Prevention Strategy also argues that a suicide prevention workforce strategy should, "Identify priorities for attracting, training, maximising, supporting, retaining and sustaining key workforces that deliver culturally safe and inclusive suicide prevention services."[20]

Workforces require consistent and targeted support to thrive and remain sustainable. Workforce Survey results highlighted that 84% of respondents believe that well-being support is essential to retaining and sustaining a suicide prevention workforce.[21] Consultations highlighted that creating adequate support systems and providing role-relevant resources and development opportunities are integral to reducing the likelihood of vicarious trauma and burnout in the suicide prevention workforce.

Approximately one in five (20%) of respondents from the Workforce Survey said they had used an employee assistance program (EAP).[22] Access to ongoing and diverse support is crucial for ensuring the workforce has access to role relevant and suicide prevention specific support. For individuals working directly in, or who have high exposure to suicide, supervision and de-briefing should be an essential support that is provided. This should be appropriately resourced and considered within funding arrangements underpinning the resourcing of these roles.

The roundtable consultations emphasised how flexible working conditions have been effective in supporting the suicide prevention workforce. Participants reported that providing employees with the choice to work from home where possible and the opportunity to engage in adjusted working hours had a positive impact on the retention of staff and reducing burnout.

Roundtable participants said effective governance structures play a role in ensuring that workplaces support workers to manage their time and energy meaningfully and safely. This includes intentionally embedding support for employees to maintain boundaries, providing supportive management to manage risk and burnout, and developing clear risk management procedures into company processes.

Participants also suggested organisational and project-planning staff need to consider how key performance indicators (KPIs) impact workforce sustainability. While funding agreements can have strict KPIs attached, they need to be protective and take into consideration the psychosocial risk associated with high exposure to suicide. Project planning must ensure that appropriate workloads are identified, and in cases of frontline or consumer facing roles, caseloads may need to be reduced.

Recommendation 2:

The Commonwealth, State and Territory Governments must embed a universal wellbeing support framework for all suicide prevention workers, including clinical, peer, and non-clinical roles – within funding agreements. This must include provisions and accompanying resources for supervision, training leadership teams to support staff wellbeing, debriefing, mental health leave, flexible work arrangements, and trauma-informed practices. In collaboration with the sector, governments must also revise workload standards and KPIs to prioritise quality of care, workforce wellbeing and client outcomes over volume-based metrics.

Suicide Prevention Australia and Superfriend - a leading workplace wellbeing organisation - recently conducted a further piece of work that highlights the need for workforce support. A survey measuring levels of burnout was undertaken by suicide prevention sector workers across several organisations. That survey indicated that 13% of the workforce is currently experiencing burnout, with a further 20% at risk. A forthcoming report presents these findings, as well as the results of in-depth consultations on workplace changes to address challenges. The above recommendation calls for government support for organisations to enable them to do more to support their staff. The forthcoming report on burnout in the sector provides advice on how organisations can implement this.

Funding Environment

A large proportion of suicide prevention organisations face difficulties in securing long-term funding, according to the findings from Suicide Prevention Australia's annual State of the Nation report 2024. A significant share of funding remains short-term, with close to seven in ten funding contracts (69%) secured for under three years.[23] In addition, four-out-of-five respondents (80%) reported a need for increased funding to meet changing demands for services. While over a third of respondents intend to increase their staffing levels in 2025. The proportion of organisations reporting staffing uncertainty due to external factors such as funding insecurity remains high (41%).[24]

Lack of funding and long-term investment into the suicide prevention workforce is a key concern highlighted in the Workforce Survey. Respondents noted that the workforce requires increased funding to enhance sustainability and retention of staff and volunteers.[25] Respondents said employment uncertainty and job security were the largest barriers to employee retention. The Workforce Survey also found funding limitations impact on organisational capacity to ensure staff numbers adequately reflect the increasing demand for services. Findings from the roundtable consultation conducted in Phase 2 of this project highlighted similar concerns; noting that the current investment in the workforce lacks long-term planning and subsequently has impacted the sustainability of the workforce and will do so in the future. Considering that regional and rural areas have higher rates of suicide and often struggle to find suitable staff for suicide prevention programs, shorter contracts can create additional challenges in these areas.[26]

Roundtable consultations with the sector highlighted an urgent need for longer funding cycles and greater investment at Federal, State and Local Government levels into the suicide prevention workforce. Roundtable participants also pointed to the need for funding allocation which can cover the cost of supporting organisations and services to provide staff access to supervision, translation services, ongoing education, and training.

Over three quarters (77%) of Workforce Survey respondents identified that funding is a critical principle for supporting the suicide prevention workforce.[27] Those consulted identified that a high proportion of the workforce are leaving the field due to role uncertainty and short-term contracts. Compounded by the pressures of cost of living and financial insecurity, short-term funding cycles impact on individuals' abilities and inclinations to both find work in the sector and remain in the sector securely.

Recommendation 3:

The Commonwealth, State and Territory Governments must commit to long-term, multi-year funding arrangements for the suicide prevention workforce to ensure sustainability, sector stability and continuity of care. All such funding must include mandatory provisions for targeted professional development, sector-wide capacity building, and access to evidence-based resources, embedded as standard requirements within funding agreements across all jurisdictions.

Workforce Skills and Training

Improving education pathways and upskilling the suicide prevention workforce is essential for reducing suicide rates and enhancing the effectiveness of suicide prevention activities. Research has demonstrated that suicide prevention training for general practitioners (GPs) has led to reductions in suicide rates and suicidal behaviours at the population level.[25] Additionally, while the evidence base for the peer workforce's impact on suicide risk, engagement, and participant satisfaction is still emerging, early studies indicate a positive contribution to reducing overall suicide risk.[29, 30] These findings underscore the importance of expanding and strengthening education pathways for individuals entering the suicide prevention field.

Suicide Prevention Australia's State of the Nation Report 2024 found that 25% of respondents felt they did not have access to the skills and training necessary to meet service delivery needs.[31] These findings echo sentiments from Workforce Survey respondents, highlighting that the suicide prevention workforce lacked investment into staff training. Concerns around skill gaps included shortages of clinicians with the knowledge and skills to work within suicide prevention, limited resources within crisis telephone services to provide adequate support, and limited services offering postvention support.

Workforce Survey respondents highlighted that healthcare workers (including frontline workers) require improved skills relating to trauma-informed care, delivering culturally appropriate servicing, and improving understanding of the role of social determinants in suicide risk.[32] Key skills required for frontline workers outside the suicide prevention sector (e.g. social services, employment services, child protection, housing services, teachers, nurses) included suicide prevention training and de-escalation training. In addition, key skills to support peer workers and volunteers included training in suicide prevention interventions and professional development opportunities for continual learning.[33]

Are there skill gaps in the current suicide prevention workforce? (n=276)

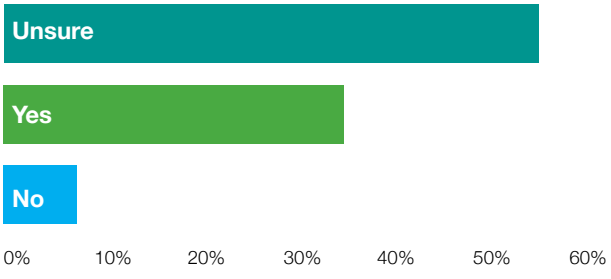
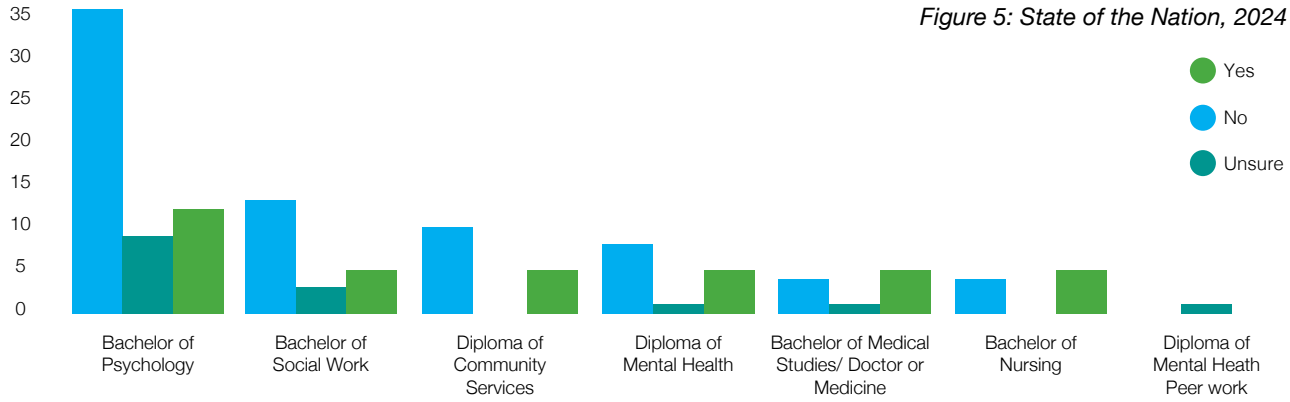


Figure 4: The Suicide Prevention Workforce Survey, 2024

Training and Education Pathways

Is suicide prevention content adequately addressed in the qualification you have the best understanding of (n=118)

Figure 5: State of the Nation, 2024



According to the Workforce Survey results, there is a growing need for embedding suicide prevention specific training across common education pathways. Almost one third (31.71%) of survey respondents identified that suicide prevention content was not adequately addressed within clinical and allied health education qualifications.[34] Similarly, almost 40% of respondents said they faced barriers in undertaking university and TAFE qualifications in education institutions relevant to the suicide prevention sector.[35]

Barriers include the cost of undertaking training, accessibility, lack of suicide prevention training components, lack of qualifications with a focus on suicide prevention and the time required to undertake training (including unpaid placement).[36] Participants in the roundtable discussion also echoed these concerns, stating that key challenges for people entering the suicide prevention workforce included the financial burden associated with undertaking placement and the small number of placement positions available, particularly in regional and rural areas.

Training and education challenges differ across each field of work in relation to suicide. Roundtable participants pointed to the different challenges for General Practitioners to those for crisis volunteers, psychologists, or peer workers. This highlighted a clear need for tailored approaches to education pathways for the suicide prevention sector.

Entry to the suicide prevention workforce must be accessible and recognise the value of both formal and alternative educational pathways. Traditional qualification pathways often require considerable time and financial investment and may be inaccessible to prospective workers.

Programs like batyr's Being Herd workshop,[37] Beyond Blue's Speaker Program training[38] and Roses in the Ocean's Lived Experience Expertise workshops,[39] exemplify the value of community-led initiatives and lived experience expertise. Expanding such evidence-based, community-led training programs and recognising them as integral to the workforce may help make the field more accessible to a broader range of individuals with lived experience.

For individuals pursuing formal qualifications in suicide prevention, there must be a concerted effort to enhance psychosocial and economic support during training. Educational bodies, training services, and governments must collaborate to ensure that individuals undergoing workplace-integrated learning (such as student placements) have access to appropriate supervision, mentoring, and workplace support. Additionally, there are inherent challenges in maintaining employment and income during student placement periods. It is vital that individuals receive regular and ongoing financial support through government payments or subsidies that reflect the economic environment during their placement or study periods.

Recommendation 4:

The Commonwealth, State and Territory Governments should provide funding incentives to employers who accept trainees in suicide prevention roles, to cover the cost of mentoring, supervision, onboarding resources, and workplace learning supports.

Finally, existing education and training pathways for those entering the suicide prevention workforce must include more comprehensive content on suicide prevention, particularly for individuals in fields with frequent exposure to suicide, such as psychology, psychiatry, nursing, and medicine. This expansion of content should also extend to qualifications in fields related to the broader socio-economic and environmental determinants of suicide, such as teaching, child protection, domestic and family violence, law and justice domains. For those directly entering the suicide prevention workforce, course content must better address the complexities surrounding suicide, suicide risk, and crisis management. TAFE currently offers a Certificate IV in Mental Health, and suicide prevention is a unit of competence, but it is not a core component of the course. Suicide prevention could be made a core unit of competence for all students undertaking courses not just in care professions, such as community services, but across all TAFE courses. For example, for people undertaking courses in construction, mining and other areas with predominantly male workforce, and high rates of suicide such as frontline emergency service workers.

Roundtable consultations identified several key competencies for the peer workforce. Peer workers must be adept at recognising when escalation is necessary, ensuring that care remains person-centred, while facilitating access to the appropriate support pathways.

Furthermore, peer workers must be trained to navigate cases of increasing complexity, employ safety planning techniques, and identify where clinical intervention can provide support. Beyond these technical competencies, soft interpersonal skills are essential for establishing trust and providing effective support. This requires peer workers to be able to share their lived experiences safely and responsibly, ensuring that storytelling remains a tool for connection and healing, rather than potentially retraumatising or overwhelming those they support.

Recommendation 5:

All vocational education and training and tertiary programs specifically preparing individuals for suicide prevention roles, including peer work, should be reviewed and redeveloped in partnership with people with lived experience, community service providers and sector experts. Curricula should include modules on suicide risk complexity, crisis response, trauma-informed care, cultural safety, systems of care, and social determinants of suicide, tailored to the roles these professions play in suicide prevention. All TAFE courses should include suicide prevention as a core model of competence.

Supporting Lived Experience

Is the suicide prevention peer workforce (including peer workers) appropriately funded and resourced?

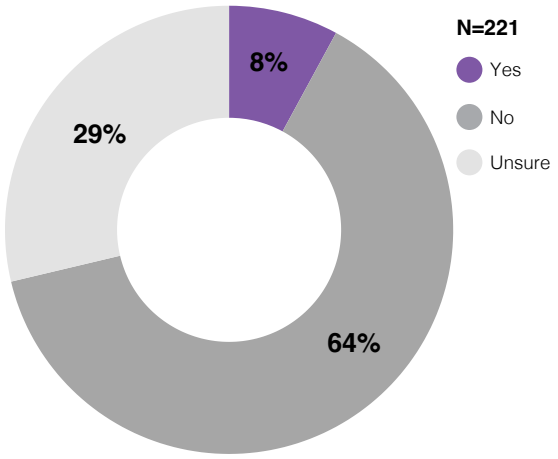


Figure 6: State of the Nation, 2024

Lived experience and peer worker roles are integral in the care system for people experiencing suicidality, suicidal crisis and for those supporting individuals experiencing suicidality or suicide attempt. More than half of respondents within Suicide Prevention Australia's 2024 State of the Nation survey said the peer workforce (including peer worker roles) are not appropriately funded and resourced.[40]

The National Suicide Prevention Adviser and Taskforce's 2021 reporting recommended that "all governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce".[41]

A Roses in the Ocean report found that up to 290 scholarships and opportunities for professional collaboration allocated in the 2021-22 Budget, were directed through State Governments towards peer work in the acute mental health system, rather than suicide prevention. As a result, an important opportunity to build a national peer workforce that is uniquely intended for suicide prevention was missed.[42] While the National Lived Experience Guidelines provide a sound platform for embedding lived experience roles into the service system, it is not contextualised for the suicide prevention workforce.[43]

Workforce Survey respondents highlighted that there is a lack of proper involvement of people with lived experience and their lived experience knowledge within the suicide prevention sector. As the graph below illustrates, 76.7% of respondents thought there was a need for recognition and value, while 70% thought there was a need for supervision and training. More than two-thirds of respondents (67.14%) identified lack of funding to create and support opportunities as an issue.[44]

What is needed to support the lived experience workforce? (N=210)

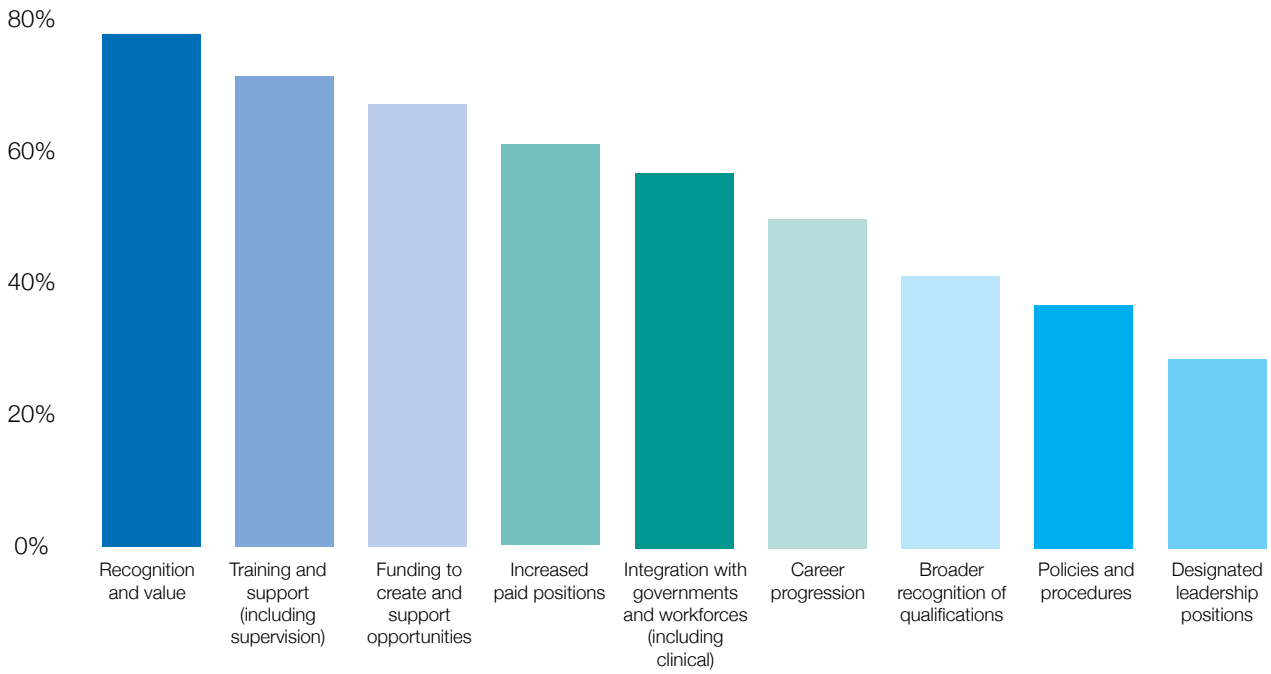


Figure 7: State of the Nation, 2024

These points were echoed within the roundtable conversations, highlighting that to achieve better recognition, the suicide prevention sector needs to build a shared understanding of the skills and competencies of the lived experience workforce, and the value that is added when lived experience is embedded into sector culture.

Meaningful engagement with the lived experience workforce requires a shift in language and recognition. It was emphasised that organisations need to explicitly recognise and value lived experience as a legitimate form of expertise, ensuring that job advertisements, training materials, and workplace policies reflect this understanding.

Recommendation 6:

All suicide prevention organisations and relevant social sectors (such as health, education, domestic and family violence, justice and housing) must embed mandatory lived experience education into onboarding, ongoing training and daily practice standards across ensuring every worker understands and values the role of lived experience within the sector.

Roundtable consultations highlighted that culture change is crucial for ensuring that the lived experience workforce is better valued within suicide prevention services. Participants said there is a need for consistent communication and support from leadership.

They also called for workplaces to implement wellbeing-focused policies to support the peer workforce and lived experience workforce's wellbeing, particularly those in emotionally demanding lived experience roles. Key recommendations included providing wellbeing leave, access to psychological support and creating a culture that normalises taking breaks to prevent burnout and vicarious trauma.

Roundtable participants underscored the importance of supervision and mentoring structures, suggesting that regular support for peer workers through supervision is vital for professional development and safeguarding against burnout.

Similarly, the Roses in the Ocean 2023 whitepaper argued that a strong suicide prevention peer workforce requires a work environment that is strongly supportive in both policy and operational senses. Managers that value peer workers, provide opportunities for reflection and supervision and provide ongoing professional development, career opportunities and planning, were highlighted as important cultural components of such change.[45]

Roundtable participants also called for increasing lived experience leadership. Ensuring that representation of people with lived experience exists at senior levels, including in leadership and board roles, is essential for creating a culture that values their contributions.

To deliver compassionate and person-centred care, an established and well-supported lived experience workforce is required. This workforce must be peer-led and appropriately embedded within relevant suicide prevention services. To achieve this, lived experience workforce arrangements require an increase in paid positions, access to career progression opportunities and increased funding. To keep services accountable, there may be scope to include lived experience resourcing within tender applications and include lived experience KPIs within the subsequent contracts.

Recommendation 7:

Sector stakeholders, including NGOs, community organisations, and peak bodies, must collaborate to expand career pathways for the lived experience workforce, creating designated advocate roles, leadership development programs and peer-led policy consultation mechanisms to embed lived expertise into service and policy design.

Adequate recognition of the lived experience and peer workforce further requires adequate payment and reimbursement standards. This should be reflective of the broader suicide prevention sector, best practice and include considerations of pay increase pathways as individuals gain experience within the lived experience field of expertise. While frameworks exist that help guide remuneration parameters for lived experience employment within the mental health sector, there is no clearly defined benchmark for lived experience roles and peer work roles in suicide prevention.

Recommendation 8:

The Commonwealth Government should provide sustained funding to support the creation and expansion of paid lived experience and peer work roles across the suicide prevention sector. This investment must prioritise equitable remuneration, job security and access to professional development for lived experience workers in both clinical and non-clinical environments.

Diversity of the Workforce

Are programs and services targeted to priority populations at risk of suicide currently appropriately funded, resourced, and responded to?

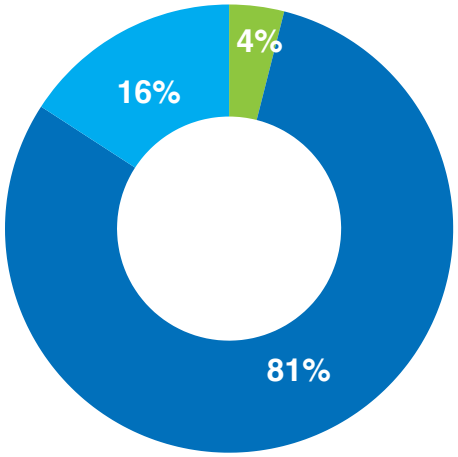


Figure : State of the Nation, 2024

Roundtable participants agreed that the suicide prevention sector needs to accurately represent the populations it serves. Given that 75% of suicides deaths are male,[46] ensuring a diverse workforce includes male suicide prevention workers is key to having a workforce which is representative of the populations which are vulnerable to suicide. Suicide Prevention Australia's 2024 State of the Nation report found that most respondents (81%) agreed that programs and services targeted to priority populations at risk of suicide are not appropriately resourced.[47]

Separately, the Workforce Survey highlighted several barriers to men entering the suicide prevention sector such as a lack of training and education and the stigma associated with discussing suicide. Roughly 20% of the Workforce Survey respondents felt that men faced unique barriers to entering the suicide prevention workforce.[48]

A smaller proportion (11%) further suggested that these barriers may contribute to men leaving the suicide prevention sector. Further underlying barriers for men entering the workforce included short funding contracts and the insecure nature of employment.[49]

In addition to this, the Workforce Survey highlighted that a lack of thorough culturally specific training such as understanding how to work with ethnically marginalised groups, migrants and gender diverse groups may further exacerbate the challenges in gaining diverse representation among the workforce.[50]

Research demonstrates that individuals accessing targeted services often report more positive outcomes when care is provided by a diverse workforce.[51] Over 90% of Workforce Survey respondents highlighted that the suicide prevention workforce needs to be supported to respond to diverse population groups and have access to training for continuing professional development. Individuals and community groups disproportionately impacted by suicide will have unique experiences that influence the way suicidality and experiences of suicide present, are navigated and are processed.[52]

Low remuneration, insecure and part-time work arrangements, and short-term funding cycles were all barriers identified that disproportionately deter male applicants and limit broader workforce participation.[53] During consultations, representatives suggested peer mentoring programs to support men transitioning from trades into human services and called for targeted recruitment strategies. Targeted social media campaigns and community workshops were cited as effective, though resource-intensive, examples of engaging underrepresented groups. The opportunity to provide additional training, ensuring team building and connection opportunities, and be embedded in the community in which you wish to recruit men, in regional and rural locations, was one strategy used to recruit and retain men for a rurally-based aftercare program.[54]

Recommendation 9:

Develop a targeted mentoring initiative to support men – particularly those transitioning from blue-collar or non-human services backgrounds – into roles within the suicide prevention sector. This program should pair new entrants with experienced peer mentors who can guide them in navigating the language, systems and practices of the sector.

Roundtable consultations with stakeholders across the suicide prevention sector underscored the need for systemic reform to foster a more diverse and representative workforce. Participants emphasised that organisations with a strong reputation for cultural safety, staff wellbeing, and values-based leadership are better positioned to attract and retain diverse candidates. Trust in immediate supervisors and alignment with organisational values were seen as critical to staff engagement and retention. Despite this, significant underrepresentation persists – particularly among men, First Nations peoples, trans, and gender-diverse individuals, culturally and linguistically diverse communities (CALD), and young people.

Roundtable participants also highlighted the need for visible and meaningful cultural safety practices, including displaying First Nations flags, holding Acknowledgements of Country and building partnerships with Aboriginal Community Controlled Organisations. These actions, coupled with long-term investment in secure employment pathways and sector-wide collaboration, were seen as essential to addressing structural inequities. Without targeted, sustained action, the workforce will continue to fall short of reflecting the diversity of the communities it is intended to support.

Recommendation 10:

The Commonwealth and State Governments should fund diversity-focused workforce development grants to support the recruitment, training, and retention of individuals from underrepresented communities, including First Nations peoples, culturally and linguistically diverse (CALD) backgrounds, LGBTQIA+ communities, young people and men.

Conclusion

This paper outlines an urgent and strategic opportunity to invest in the future of Australia's suicide prevention workforce. Despite growing recognition of its critical role, the workforce continues to face persistent challenges that impact on its sustainability and effectiveness, including insecure funding, skill gaps, inadequate training pathways, lack of structural support for lived experience roles, and a lack of diverse representation across the sector.

Consultation and sector-wide engagement have highlighted that genuine progress for the suicide prevention workforce will require whole-of-government and whole-of-sector collaboration in:

- Building and investing in a thriving, valued and sustainable workforce.
- Recognising lived experience as a distinct and essential pillar of suicide prevention.
- Equipping the workforce with the skills and capabilities required to meet community needs.
- Fostering diversity and ensuring that the workforce is reflective of the community it serves.

To address these priorities, the recommendations outlined in this paper collectively present a roadmap to not only strengthen the capacity of the workforce, but to embed lasting reform that aligns with national suicide prevention goals and the needs of communities. The breadth of the suicide prevention workforce means that coordinated, cross-jurisdictional action is both essential and overdue.

Appendix A.

Questions asked within the Suicide Prevention Workforce Survey

Membership Base Questions

1. What type of membership do you have with Suicide Prevention Australia?

- ☐ I am an associate member
- ☐ The organisation I work for is a member

2. What area do you reside in?

- ☐ Metropolitan
- ☐ Regional
- ☐ Rural
- ☐ Remote

3. What area(s) does your organisation provide service to? Please select all that apply.

- ☐ Metropolitan
- ☐ Regional
- ☐ Rural
- ☐ Remote

Workforce

4. Have you engaged in community volunteering in the suicide prevention workforce in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Unsure

5. How many hours a week on average do you spend volunteering in the suicide prevention workforce?

- ☐ 1-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16-20
- ☐ More than 20 hours

6. Are there skill gaps in the current suicide prevention workforce?

- ☐ Yes
- ☐ No
- ☐ Unsure

Please describe the current gaps in the suicide prevention workforce. [Open Text Response]

Lived Experience Workforce

7. What is needed to support the lived experience workforce? Please select all that apply.

- ☐ Recognition and value
- ☐ Integration with governments and workforces (including clinical)
- ☐ Funding to create and support opportunities
- ☐ Broader recognition of qualifications
- ☐ Training and support (including supervision)
- ☐ Policies and procedures
- ☐ Designated leadership positions
- ☐ Increased paid positions
- ☐ Career progression
- ☐ Other (please specify)

8. What top 3 actions you would ask governments to take to support the lived experience workforce?

[Open Text Response]

_____

_____

Funding and Resourcing

9. What should governments prioritise to invest funds in to strengthen the suicide prevention workforce?

- ☐ Longer funding cycles for suicide prevention services giving greater employment certainty
- ☐ Increase service funding to increase workforce / numbers of employees
- ☐ Increase service funding to increase employee salaries
- ☐ Peer workers
- ☐ Alternatives to emergency departments (including Safe Haven models)
- ☐ Lived experience leadership positions
- ☐ Suicide prevention training
- ☐ Awareness raising campaigns (including stigma reduction)

10. Do you experience limitations with the length of your organisation's funding contract?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not applicable

11. Please describe the limitations experienced with the length of your funding contract.

[Open Text Response]

_____

_____

Men in the Workforce

12. Do men face unique barriers to entering the suicide prevention workforce?

- ☐ Yes
- ☐ No
- ☐ Unsure

13. How can governments and sectors address the barriers men face entering the suicide prevention workforce?

[Open Text Response]

_____

_____

14. Do men experience unique barriers while working in the suicide prevention sector that may cause them to leave the sector?

- ☐ Yes
- ☐ No
- ☐ Unsure

What actions can government and organisations take to keep men in the suicide prevention workforce? [Open Text Response]

Supporting our Workforce

15. Have you experienced any of the following in the past 12 months? Please select all that apply.

- ☐ Burn out
- ☐ Compassion fatigue
- ☐ Vicarious trauma
- ☐ Not Applicable

16. Are you intending to leave the suicide prevention field in the next 12 months?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

17. Have you ever accessed an Employee Assistance Program while working in the suicide prevention sector?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

What top 3 actions can governments and sectors take to better support the wellbeing of paid and unpaid employees in the suicide prevention workforce? [Open Text Response]

_____

_____

Education

18. Which clinical or allied health qualification do you have the best understanding of?

- ☐ Diploma of Community Services
- ☐ Diploma of Mental Health Peer Work
- ☐ Diploma of Mental Health
- ☐ Bachelor of Psychology
- ☐ Bachelor of Social Work
- ☐ Bachelor of Medical Studies/ Doctor of Medicine
- ☐ Bachelor of Nursing
- ☐ Not applicable

19. Is suicide prevention content adequately addressed in other clinical and allied health education qualifications?

- ☐ Yes
- ☐ No
- ☐ Unsure

20. Is suicide prevention content adequately addressed in the qualification you have the best understanding of?

- ☐ Yes
- ☐ No
- ☐ Unsure

21. Do barriers exist in undertaking qualifications in education institutions (including university and TAFE) relevant to working in the suicide prevention sector?

- ☐ Yes
- ☐ No
- ☐ Unsure

22. Please describe the barriers that exist in undertaking qualifications in education institutions (including university and TAFE) to work in the suicide prevention sector

[Open Text Response]

A supported Suicide Prevention Workforce

23. Which principles best reflect what a well-supported suicide prevention workforce should look like?

- ☐ The workforce is staffed with workers who are employed on a paid basis to meet the needs of the community.
- ☐ The workforce is skilled to respond to diverse population groups and has access to training for
- ☐ continuing professional development.
- ☐ Lived experience is central to planning, design, implementation, and evaluation of polices and services.
- ☐ Wellbeing support is readily available for workers to maintain retention.
- ☐ The workforce is securely funded.
- ☐ The workforce has the data it needs to enable best practice and timely suicide prevention responses.
- ☐ Suicide prevention services are accredited to ensure safety and quality for the community.
- ☐ Suicide prevention services are regularly evaluated to ensure best practice.

24. What other principles should we consider that were not captured in the above statements?

[Open Text Response]

Appendix B.

Questions asked within the roundtable consultation regarding the suicide prevention workforce.

Skill Gaps in the Suicide Prevention Workforce

1. What actions should governments take to address the key gaps in the suicide prevention workforce identified in the survey?
2. Which of these actions will have the greatest impact and be able to be achieved?

Lived Experience Workforce

3. What actions should governments take to support the lived experience workforce identified in the survey?
4. Which of these actions will have the greatest impact and be able to be achieved?

Men in the Workforce

5. How could more men in the suicide prevention workforce help to drive down the suicide rate of men in Australia?
6. What actions should governments take to encourage pursuit and retention of men in the suicide prevention sector?
7. Which of these actions will have the greatest impact and be able to be achieved?

Education pathways to the sector

8. What actions should governments or education institutions take to address barriers experienced in undertaking training in suicide prevention?
9. What actions should education institutions take to ensure suicide prevention content is appropriately addressed in qualifications?
10. Which of these actions will have the greatest impact and be able to be achieved?

Appendix C.

Questions asked within one-on-one consultations across the suicide prevention workforce sector representatives.

1. What key actions do you think governments and sectors should take to better support the suicide prevention workforce?
2. An insight that emerged in our survey was that 70% of workers have never accessed an EAP, however significant amounts of people are experiencing burn out and compassion fatigue. What support is needed for workers to protect their wellbeing?
3. Better recognition and value of the lived experience workforce was identified as a priority area of need in the survey. What actions could governments and sectors take to better value and recognise the lived experience workforce?
4. Culture change was identified as an action to better value the lived experience workforce. What specific actions are needed to address culture change? And what workplaces require culture change?
5. Currently, frameworks exist that outline the skills required for the mental health workforce. Whilst some of these skills are transferable to the suicide prevention sector, suicide prevention may require a distinct set of skills relevant to the field. What skills do you believe are unique to the suicide prevention workforce?
6. How can governments create more accessible education opportunities for people looking to enter the suicide prevention workforce?
7. Having a sector that represents its community was identified as a priority in our roundtable, noting that women make up most of the workforce. Do you have any actions or strategies to better engage a diverse workforce that is reflective of the community it serves? This includes men, those from the LGBTIQA+ community, those from CALD backgrounds.

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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

02 9262 1130 | policy@suicidepreventionaust.org | www.suicidepreventionaust.org