Executive Summary

Australian Government

December 2020

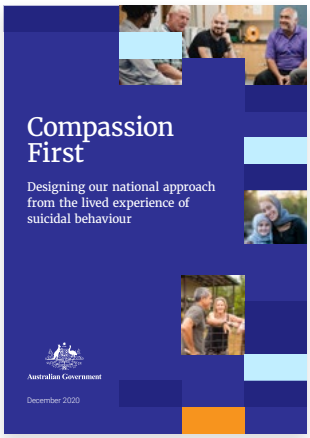
Each and every suicide is a tragedy. It is the loss of a person whose reasons for living have been outweighed by the need to end their pain and isolation. It represents a total loss of hope. Further, each suicide attempt and experience of suicidal distress also comes with significant impacts, for the individual and for those who care about them.

We are missing opportunities to reach people earlier in suicidal distress and prevent the onset of suicidal behaviour. Australia needs a more connected and compassionate approach which takes support to people – where they are when they experience such distress. This calls for a focus on prevention and early intervention, together with more integrated and compassionate service options that strengthen and extend current supports.

This will only be achieved if suicide prevention becomes a shared responsibility for all levels of government, all portfolios and all communities. Each has an essential role for people who are vulnerable to suicide – reducing distress, building a sense of connection and strengthening hope.

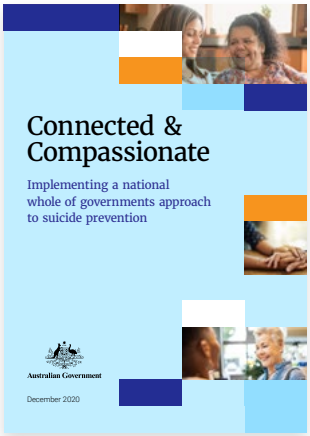
In July 2019, Prime Minister Scott Morrison announced the commitment of the Australian Government to working 'towards zero suicides' and the appointment of the First National Suicide Prevention Adviser. Over 18 months, the Adviser and the National Suicide Prevention Taskforce engaged with different levels of government and portfolios, organisations working in suicide prevention, researchers, leaders in Aboriginal and Torres Strait Islander suicide prevention, community members and, most importantly, many people who have lived experience of suicide. This broad engagement focused on better understanding the needs of people who experience suicidal distress, and identifying how Australia's services, systems and government structures at all levels could change to compassionately meet their needs and avoid a suicide trajectory.

This Final Advice consists of three complementary reports building on the Initial Findings submitted in November 2019 and the Interim Advice submitted in August 2020.



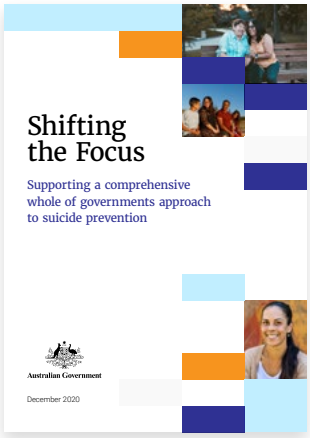
Compassion First

This first report captures the voices of over 3,000 people with lived experience of suicide, particularly those who have survived suicide attempts or lived with suicidal distress. It also provides insights from commissioned research focused on families, caregivers and those bereaved by suicide. The clarion call from people with lived experience is for more comprehensive and connected approaches that address vulnerabilities long before a crisis, and for more compassionate responses that do not treat them as a 'medical problem' but rather provide them with assistance through their distress, connecting them to the right supports.



Connected and Compassionate

This second report details eight practical and achievable recommendations and actions for driving change across Australia. Informed by lived experience, the report identifies how a more connected and compassionate approach to suicide prevention will assist people vulnerable to suicide by leveraging the full range of services, touchpoints, policy drivers and resources available to all governments. Its approach focuses on the whole picture of a person's life, identifying and using appropriate life turning points to engage with people to prevent escalation into suicidal crisis, taking help to people – where they are, and in a way that relates to their needs.



Shifting the Focus

The third report demonstrates a model for operationalising a comprehensive whole of government approach to suicide prevention, including a decision-making tool to be used by government portfolios to identify targeted distress reduction initiatives. It highlights the critical role that multiple sectors and government portfolios have in suicide prevention, and provides practical guidance on the steps government agencies can take to embed this into targeted initiatives, service planning, design, implementation and evaluation.

Driving change

There is a compelling case for change: to improve how we approach suicide prevention so we save lives and avoid people reaching suicidal crisis. If we listen to lived experience and couple this with the evidence base developed over decades we will accelerate shifting to where all governments and agencies, not just health, join forces to address suicidal distress and its causes.

Our current approach misses many opportunities to reach and support people because it predominantly focuses on a health services response at the point of crisis. We need to intervene earlier when suicidal distress is developing and the only way to do this is to leverage every arm of government and every service touchpoint. We need to reach people with the right supports, where and when it can make a real difference.

This refocused approach does not wait for people to seek help. It strengthens and builds on currently available supports through community organisations and the health systems to expand reach into every agency and service with which people interact. It implements early distress interventions as a critical tool in addition to – but not as a substitute for – clinical interventions and broader public health prevention initiatives.

It requires a change in how we think about suicidal behaviour. We must acknowledge and understand the role of life stressors like unemployment, relationship breakdown and insecure housing, recognising how they contribute to people feeling trapped and overwhelmed. For some people, these life stressors interact with mental illness and alcohol or other drug problems to heighten suicidal distress. For others, they are the primary driver of such distress. Integrated and connected approaches across all services will respond to people's complete needs, throughout their lives.

The *Final Advice* identifies four essential enablers and four further priority shifts that are needed:

Key enablers

- Leadership and governance to drive a whole of government approach
- Lived experience knowledge and insight
- Data and evidence to drive outcomes
- Workforce and community capability

Key shifts

- Responding earlier to distress
- Connecting people to compassionate services and supports
- Targeting groups that are disproportionately affected by suicide
- Delivering policy responses that improve security and safety

> *I believe that more literacy and keeping communication channels open about suicide would make a difference. People [die by] suicide when they have no hope. If we can teach people how to have hope-engendering conversations – not wantonly optimistic conversations, but conversations that can have space to hold the real complexity of both the person's distress and the hope to be heard, understood and feel connected to the helper – then I think* ***we have a chance to make a difference.***
>
> – Personal story, Private Voices study

Enablers of this new approach

Governments have made significant investments in suicide prevention in recent years, with much work being available to build upon. However, to enable the shift to a whole of governments approach we must undertake system reform and create the authorising environment for a more connected and compassionate approach.

> *Suicide prevention efforts require coordination and collaboration among [...] both health and non-health sectors such as education, labour, agriculture, business, justice, law, defence, politics and the media. These efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide.*
>
> – Lived experience statement

1. Leadership and governance to drive a whole of government approach

Suicide prevention is historically the portfolio responsibility of Health or Mental Health Ministers. Although investment is undertaken by all levels of government (Commonwealth, State/Territory and, increasingly, local government) the central focus has been on the health system. While health has a key role no single government portfolio can undertake the breadth of actions required to reduce suicides and suicide attempts, and respond to distress. A model encompassing 'whole of governments', can only be possible if authorised by First Ministers. At the national level, a *National Suicide Prevention Strategy* is required and the establishment of a National Suicide Prevention Office would facilitate the setting of strategic directions, build capabilities, support cross-jurisdictional and cross-portfolio actions, and report on agreed outcomes.

2. Lived experience knowledge and leadership

People and their lived experience are central to best practice in suicide prevention. Broadening the suicide prevention approach must be informed by what people experiencing suicidal distress really need. In reality, lived experience knowledge and insights are the 'not negotiable' component at all stages, from research that builds the evidence base and guides government policy and program planning, to service design and delivery, program implementation and evaluation. The knowledge and insights of caregivers and people who have been bereaved by suicide are also critical in designing new and better supports, services and approaches. Most importantly, lived experience must inform and shape the development of agreed national outcomes. Success will only come, in terms of preventing suicide and its impacts, by Governments, communities and stakeholders working closely with and allowing all levels of suicide policy and service development to be co-designed with those who have lived experience.

3. Data and evidence to drive outcomes

Governments require data to make informed decisions, respond to emerging vulnerabilities, and demonstrate the effectiveness of shifting to a national 'whole of governments' approach to suicide prevention. To achieve this, a national and joined up approach to collecting, sharing and using suicide data, evaluating funded programs, setting research priorities and undertaking knowledge translation is required. Agreement on shared priority outcomes at the strategic and program level will help ensure collective effort is working in the same direction and for the same outcomes. This approach requires durable cross-agency coordination, with close-in-time monitoring of suicide deaths, suicide attempts and other key risk indicators.

4. Workforce and community capability

People experiencing suicidal distress interact with workforces across various sectors, at different times and in different ways. Many are likely to talk to friends and family before seeking professional help. The first time a person discloses their distress or suicidality is a critical moment, so it is vital to build capability and knowledge across workforces and within communities to ensure a shared understanding about suicide distress, and the criticality of a consistent and compassionate approach. This requires strengthening capacity within all government services and community networks in touch with people at times of distress, transition or disconnection. Every interaction an individual has with a department, agency, service provider, worker or community contact is an opportunity to identify suicidal distress and to intervene to ensure they get the right supports at the right time.

The shifts we need

In addition to the reform needed to enable an appropriate authorising environment, we also need to address interactions that occur with people who are vulnerable to suicide. We need to step back from the point of crisis to look at all the ways we can reach and engage with people to prevent suicidal distress and divert them from a suicidal trajectory. It also means governments working together to provide coordinated care across the life journey, addressing people's needs holistically.

5. Responding earlier to distress

People encounter a range of stressors, transition points and times of disconnection from friends, family and community through different life stages. Consequential distress can develop into suicidal behaviour in the context of other risk factors. Governments provide, or fund, a range of services that support people through many of these difficult times, including family crisis, intimate relationship breakdown, financial distress, health concerns, job loss or business failure. Proactively using these touchpoints and coordinating across the different services provides a new approach of outreach and distress intervention with a specific focus on reducing suicidal behaviour and risk.

6. Connecting people to compassionate services and supports

People with a lived experience of suicide emphasise the importance of coordinated care to support them through crisis, together with ongoing therapeutic approaches and peer support. Services that engage with people at times of acute distress, such as those within our health systems, need better links with ongoing supports to address the underlying drivers of their distress. Health and mental health service responses to suicide need to be augmented by other complementary service offerings so that people experiencing suicidal distress, their caregivers and those bereaved by suicide have access to compassionate and coordinated support in different settings and contexts to meet their diverse needs.

> *Helpful responses are those that see our humanity, offer time and a safe space to be deeply listened to and validated, provide genuine* ***compassion,*** *free of judgement and agendas. This empowers a person to find their own meaning and the answers to problems in their own life.*
>
> – Lived experience statement

7. Targeting groups that are disproportionately affected by suicide

While suicidal behaviour can be experienced by anyone, some population groups can be disproportionately affected. It is important to consider all the factors that may increase distress and work to address these through targeted responses where required. These groups include men (who continue to have the highest rate of suicide), young people experiencing significant levels of distress and self-harm, Aboriginal and Torres Strait Islander people, the LGBTIQ+ community, those from culturally and linguistically diverse backgrounds, people living with mental illness and alcohol and other drug problems, veterans and their families, emergency services workers, and people bereaved by suicide. We also need to ensure that our approaches work for rural and remote communities.

8. Delivering policy responses that improve security and safety

While each person's experience of suicidal distress is unique, the social, economic and physical environments in which we live also shape suicidal behaviours. The relevant factors are frequently in the social determinants of health and wellbeing and include: economic, employment and housing security; safety from violence, abuse and discrimination; and social connection and participation in community life. An important component of suicide prevention therefore involves governments delivering on their core business by providing people with good access to basic supports, services and resources, addressing security and safety, and investing in programs that support wellbeing.

The Adviser and Taskforce gratefully acknowledge the many jurisdictional, sector and lived experience representatives, and members on the Expert Advisory Group, whose input and feedback has informed this Advice. While many different voices contributed to this conversation, they share a unified desire to work together to ensure that individuals, households and communities get the support they need as early as possible. This shared intent is the fuel that will drive collective action on the reforms laid out through this advice.

Summary of recommendations

1. Leadership and governance to drive a whole of government approach

Recommendation 1: All governments work together to deliver a whole of government approach – at the national (cross-jurisdictional), jurisdictional (cross-portfolio) and regional levels; with national outcomes to be developed and adopted by all governments.

This includes the following **priority actions:**

1.1 All governments to continue or shift to a whole of government approach, with suicide prevention authorised by First Ministers and mechanisms to drive cross-portfolio action implemented.

1.2 A *National Suicide Prevention Strategy* is developed to align with the National Agreement on Mental Health and Suicide Prevention, identifying initiatives, which require a strategic national approach.

1.3 A National Suicide Prevention Office is established in 2021 to set strategic directions, build capabilities, support cross-jurisdictional and cross-portfolio action and report on agreed outcomes.

1.4 The National Agreement on Mental Health and Suicide Prevention to include strengthened and resourced regional arrangements for suicide prevention.

2. Lived experience knowledge and leadership

Recommendation 2: All governments commit to integrate lived experience knowledge into national priority setting, planning, design, delivery and evaluation of suicide prevention services and programs.

This includes the following **priority actions:**

2.1 All governments integrate lived experience expertise into leadership and governance structures for suicide prevention.

2.2 All governments include a requirement for demonstrated engagement and co-design with people who have lived experience of suicide in funded research, services and programs.

2.3 All governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce.

2.4 All governments increase lived experience research, particularly focused on people who have experienced suicidal distress and/or attempted suicide.

3. Data and evidence to drive outcomes

Recommendation 3: Recognising that measurement of outcomes is essential to monitor impacts of suicide prevention initiatives, all governments commit to work together to identify data needed for such measurement, undertake to improve the quality and timeliness of that data, and enable sharing across agencies.

This includes the following **priority actions:**

3.1 All jurisdictions maintain or, where not already in place, establish a suicide register and mechanisms for the routine collection and timely sharing of data on suicide, suicide attempts and self-harm.

3.2 Regular national surveys to determine the population prevalence of suicidal ideation, self-harm and suicide attempts and to ensure adequate data capture – including in relation to priority populations.

3.3 The National Office for Suicide Prevention to lead: (a) the development of a national outcomes framework for suicide prevention, informed by lived experience, to be applied at the program and service level as well as the national level; and (b) the development of national definitions of, and standards for, self-harm and suicide attempts.

3.4 All jurisdictions work with the National Office for Suicide Prevention to set priorities for suicide prevention research and share knowledge for continual improvement.

4. Workforce and community capability

Recommendation 4: All governments to commit to prioritising evidence-based and compassion-focused workforce development to drive cultural change in and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention.

This includes the following **priority actions:**

4.1 All jurisdictions resource contemporary and evidence-based training for clinical and other health staff.

4.2 All jurisdictions implement contemporary compassion-based training for frontline workers that enable them to respond to distress – especially those providing financial, employment and relationship support to people experiencing distress.

4.3 The National Office of Suicide Prevention works with all jurisdictions and relevant stakeholders to lead the development of a national suicide prevention workforce strategy.

5. Responding earlier to distress

Recommendation 5: As a priority action and reform, all governments work together to develop and implement responses that provide outreach and support at the point of distress, to reduce the onset of suicidal behaviour.

This includes the following **priority actions:**

5.1 Coordinated cross-jurisdictional and cross-portfolio action to intervene early in life to: (a) mitigate the impacts of adverse childhood experiences; (b) strengthen supports for families; and (c) ensure early access to programs, treatment and support for children and young people.

5.2 Developing, implementing and evaluating a scalable early distress intervention for people experiencing: (a) intimate relationship distress; (b) employment or workplace distress; (c) financial distress; and (d) isolation and loneliness.

5.3 Implementing and evaluating interventions that support people through transitions, including: (a) entering or being released from justice settings; (b) leaving military service; (c) finishing or disengaging from education or vocational settings; (d) entering retirement; and (e) engagement with aged or supported care services.

6. Connecting people to compassionate services and supports

Recommendation 6: All governments work together to progress service reform to achieve integrated, connected and quality services for people experiencing suicidal distress, people who have attempted suicide as well as caregivers and people impacted by suicidal behaviour.

This includes all governments working together to implement **priority actions** from the *National Suicide Prevention Strategy for Australia's Health System 2020-2023* and the *National Mental Health and Wellbeing Pandemic Response Plan,* including:

6.1 Integrated digital and face-to-face supports to improve accessibility, service options and appropriate levels of service.

6.2 New service models incorporating compassionate community-based support for people experiencing suicidal distress.

6.3 Aftercare services for anyone who has attempted suicide or experienced a suicidal crisis.

6.4 Timely and compassionate supports for families, friends, caregivers and impacted communities, including bereavement and postvention responses.

6.5 Connecting alcohol and other drug prevention and treatment services to our suicide prevention approach.

7. Targeting groups that are disproportionately impacted by suicide

Recommendation 7: All governments to apply an equity approach to suicide prevention planning and funding to prioritise targeted approaches for populations that are disproportionately impacted by suicide.

This includes the following **priority actions:**

7.1 National funding of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* from 2021, implementing Indigenous leadership and governance, place-based initiatives and building on workforce and community strengths.

7.2 All jurisdictions to commit to identifying priority actions for male suicide prevention to be incorporated into the *National Suicide Prevention Strategy,* including: (a) the Commonwealth government to lead on identifying priority actions that leverage their government services and systems, such as employment services, family law courts, relationship services and aged care; and (b) all jurisdictions to review and report on the accessibility of their funded services and programs for men.

7.3 All jurisdictions contribute to identifying national actions for priority populations to be included in a *National Suicide Prevention Strategy*, including: children and young people; LGBTIQ+ communities; culturally and linguistically diverse communities; veterans and their families; and those living in rural and regional communities impacted by adversity.

7.4 Drawing from regular data reviews and evidence, all jurisdictions contribute to identifying national actions for occupations and industries with higher rates of suicide.

8. Policy responses to improve security and safety

Recommendation 8: Working towards a 'suicide prevention in all policies' approach, all governments: build capabilities within key policy teams and departments and review existing policies to enhance opportunities for improved security and enhanced safety through a National Strategy.