



Submission

Productivity Commission
Mental Health Inquiry 2019

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ConNetica Team

ConNetica Consulting Pty Ltd

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We also wish to acknowledge the contributions made (in previous work) and incorporated into this submission by Professor Luis Salvador Carulla (Centre Director, Centre for Mental Health Research, ANU); Asso Professor Lisa Woods (Centre for Social Impact, UWA; and Dr Martin Harris (Strategic Transitions and UTas).

ConNetica is a member of the Behavioural Health in ED Community of Practice with the Institute for Healthcare Improvement (Massachusetts), and a partner with ANU's Centre for Mental Health Research in Psicost Scientific Association Australasia.



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“If you always do what you’ve always done, you always get what you’ve always gotten.”

Jessie Potter, opening speaker, 7th Annual Woman to Woman Conference, 1933.

“In treating a suicidal risk, scrupulously maintain continuous contact with the patient and enlist the help of all possible interested persons”

Soloman & Patch, Handbook of Psychiatry, 1974

“It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy

“It is the distribution of economic and social resources that explains health and other outcomes in the vast majority of studies.”

WHO Europe, 2009

Abbreviations

Abbreviation	Definition
AAD	Alliance Against Depression
ABC	Act-Belong-Commit (Campaign)
ABS	Australian Bureau of Statistics
ACE	Adverse Childhood Experiences
ACSQHC	Australian Commission for Safety and Quality in Healthcare
AIHW	Australian Institute for Health and Welfare
AOD	Alcohol and Other Drugs
APMC	Agile Psychological medicine Clinic
ASDR	Age Standardised Death Rate
ASIST	Applied Suicide Intervention Skills Training (Program)
BDI	Black Dog Institute
CALD	Culturally and Linguistically Diverse
CAMS	Collaborative Assessment and Management of Suicidality program
CASE	Chronological Assessment of Suicide Events
CDC	Centers for Disease Control and Prevention (USA)
DALYs	Disability-Adjusted Life Year
DHHS	Department of Health and Human Services (Victoria)
DoH	Department of Health (Australia)
DSH	Deliberate Self Harm
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAAD	European Alliance Against Depression
ED	emergency department
EMPHN	Eastern Melbourne PHN
GFC	Global Financial Crisis
HOPE	Hospital Outreach Post-Suicidal Engagement
ICP	Integrated Care Pathway
ISH	Intentional Self-Harm
IHI	Institute for Healthcare Improvement
IRSD	Index of Relative Socio-economic Disadvantage
LGA	Local Government Area
K10	Kessler 10
LiFE	Living is for Everyone Framework

LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MAS	mood, anxiety and somatoform (disorders)
MHA	Mental Health Australia
MHFA	Mental Health First Aid
MHR	mental health related
MHS	Mental Health Services
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NSSI	Non-suicidal self injury
NT	Northern Territory
NYC	New York City
NZ	New Zealand
PHIDU	Public Health Information Development Unit
PTSD	Post-Traumatic Stress Disorder
RTC	Randomised Controlled Trial
SAMHSA	Substance Abuse and Mental Health Services Administration (USA)
SEAL	Social and Emotional Learning
SEMPHN	South Eastern Melbourne PHN
SEYLE	Saving and Empowering Young Lives
SPRC	Suicide Prevention Resource Centre (USA)
SPRS	suicide prevention regional strategy
SUB	Substance Use Disorder
STB	Suicidal thinking and behaviour
TRAIC	Tackling Regional Adversity through Integrated Care
UK	United Kingdom
UN	United Nations
USA	United States of America
WAPHA	Western Australian Primary Health Alliance
WBSS	Way Back Support Service
WHO	World Health Organisation
WIS/WIC	Walk in Service or Walk in Clinic

This Submission

The Productivity Commission (the Commission) has been tasked by the Australian Government to “consider the role of mental health in supporting economic participation, enhancing productivity and economic growth” and make “make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.”

The Commission joins a long list of statutory authorities, parliamentary committees and other reviewers to examine the Australian mental health care system in the recent past. Indeed in 2018 alone, there were no fewer than 14 enquiries or independent reviews of aspects of the mental health care system in Australia since January 2018 – almost one a month.

As some commentators have stated since the announcement of this Inquiry, it must be different¹ and that the review must achieve more than just ‘band-aids and confetti’ but “radical reform of structure and culture”.² We agree with these views. In a report to be released shortly ConNetica and the Brain and Mind Centre have identified a plethora of reviews and inquiries most of them in the period since the Council of Australian Governments agreed to a National Action Plan on Mental Health in June 2006.

Too often the recommendations from inquiries are not acted on or only partially implemented. Governments and the responsible Health or Mental Health Ministers respond with discreet program or service initiatives rather than structural and systemic responses that build capability and strengthen the health and social care systems. Even in the period since the Federal Government accepted the almost all the recommendations stemming from the National Mental Health Commission’s Review³, we continue to see the same failed policy and strategy response of funding flowing to more discreet services and programs often rolled on a national basis and largely disconnected from the needs of communities and the existing services.

In this submission, we note particularly note the Commission’s statement of “(intending) to give greatest consideration to where there are the largest potential improvements in population health, participation and contribution over the long term”.

We argue therefore that the greatest impact will be by ensuring a suite of government policies address growing inequality and intergenerational disadvantage – the social determinants of mental illness and suicide. A structural shift is required to enable national mental health strategy and policy effort to focus on the ‘drivers of despair and disadvantage. The second structural shift, a core element of the NMHC review, is the devolution of responsibility for service planning, commissioning and monitoring to regional authorities such as PHNs and Local Hospital Boards.

In the submission we address the following aspects of the Commission’s Terms of Reference and matters set out in the Issues Paper, released on 30 January 2019:

- **Assessing the current and potential interventions to improve mental health outcomes** with a focus on the structural weaknesses in mental health care including some aspects of the framework to enhance mental health and improve participation and workforce contribution

¹ Doggett, J (2018). Do it better or do it differently?

² McCauley, D. (2018) Mental health review must achieve ‘radical reform’: Patrick McGorry. *Sydney Morning Herald*, 8 November

³ National Mental Health Commission (2014) Review of Programmes and Services. NMHC Sydney.

- **Contributing components to improving mental health and wellbeing** with a focus on mental health promotion, suicide and self-harm prevention and facilitating social participation and inclusion, and briefly
- **Skills acquisition, employment and healthy workplaces**

When the Australian Government announced this Inquiry, it was linked to the continuing high suicide rate. The focus of the submission is therefore, on suicide and suicide prevention.

We will also address some of the challenges for small and medium businesses operating in areas where organisations receiving substantial government funding. This section will be sent as 'in confidence' element.

Our submission is informed by decades of work in mental health, alcohol and other drug and health promotion and education. We also bring a lived experience of suicide to our evidence-informed work.

About ConNetica

ConNetica is a mental health, suicide prevention and social services consultancy, that has been in operation since 2007. Our mission is to strengthen individuals/organisations/ communities well being and mental health and to reduce suicide. Our vision which is to create **“better futures for all”** is the ethos that underpins all our endeavours.

ConNetica’s key service streams include:

1. Design and delivery of Australian early and imminent risk of suicide prevention, resilience and mental health leadership training programs (attended by over 5000 people),
2. Integrated demographic and service maps (mental health, homelessness, alcohol and other drugs and chronic disease).
3. Program evaluation and best practice advice – mental health, suicide prevention, employment, homelessness, leadership
4. Social policy and service/strategy design and advice – stepped care, service collaboration, change management, systems reform
5. Mental health research and advocacy.

Our team has undertaken over 300 projects for communities and organisations, Indigenous and non indigenous, in metropolitan, rural and remote locations across Australia and internationally in mental health, suicide prevention, primary healthcare, disability, aged care, employment, education and corporate governance and strategy.

A hallmark of our work is empowering and mentoring local communities, often rural and remote to develop the necessary skills to continue to deliver training programs and or services post ConNetica’s initial engagement.

Since our inception, ConNetica has committed over \$1million of earnings in the areas of mental health research, policy advocacy, the development of free Suicide Prevention Apps and coordinating and hosting affordable, national forums and community suicide prevention training programs. While a family owned business, ConNetica operates as a social enterprise.

ConNetica collaborates with a range of universities, not for profit entities and research centres to ensure that our work is evidence informed, training programs are evaluated and all our work is reflective of contemporary best practice. We have partnerships, alliances and collaborations with:

- Centre for Mental Health Research at Australian National University,
- Brain and Mind Centre Sydney University,
- Engage Laboratory and within the University of the Sunshine Coast,
- Act Belong Commit Campaign, Curtin University,
- Centre for Social Impact University of WA
- Loyola University, Spain
- Oz Help Foundation
- Stronger Smarter Institute

ConNetica was also a founding member of the Young and Well CRC.

Our thought leadership in mental health and suicide prevention is recognised and awarded in Australia and internationally, with ConNetica's Directors having awards for their work in suicide prevention, customer service, community engagement and innovation.

ConNetica has undertaken over 250 projects specifically in mental health and suicide prevention since establishment. These range from individual community engagements, the development of education programs, to national pilot programs and reviews. Most notably among them are:

- The development and delivery of a suite of Australian suicide prevention programs and digital resources (in collaboration with NGO and academic partners) to over 5,000 people across Australia;
- The research, publication and media campaign for Suicide Data for 28 Federal Electorates (2016)
- The development and teaching of units of study for Master in Brain and Mind Science (University of Sydney) and Psychiatry Registrars in NSW;
- The Review of Suicide and Self Harm Prevention for Serving and Former Members of the Australian Defence Force and their Families for the National Mental Health Commission in 2016-7 (ConNetica undertook all field work, data collection, analysis and prepared all but one of the published reports);
- The Independent Review of Mental Health Services in Papua New Guinea for the Australian and PNG Governments (2016);
- The development of Integrated Atlases of Mental Health for Eastern Melbourne PHN, South Eastern Melbourne PHN, all of WA for WA Primary Health Alliance, North Sydney PHN, Western NSW PHN, and Brisbane North PHN (2014-2018);
- Completion of systems analyses of hospital transition pathways for people presenting to ED for 10 hospital catchments in 3 states;
- The development of the first Integrated Atlas on Mental Health, Alcohol and Drugs and Homelessness for South Eastern Melbourne PHN (2016);
- The research and publication of the 3-volume *Obsessive Hope Disorder: Reflections on 30 Years of Mental Health Reform and Visions for the Future* report (2012-3);
- The development of the Movember Men's Health Foundation Global Mental Health Strategy (2012);
- The review of Australian Disability Enterprises and development of workforce development strategy for the Australian Government (2013-4);
- The national demonstration project, Family Centred Employment Program (FCEP), for the Australian Social Inclusion Board (2010-2013);
- The research and publication of the *Breaking the Silence: Suicide and Suicide Prevention in Australia* (2010).

ConNetica Director, John Mendoza, is a former CEO of the Mental health Council of Australia and oversaw the landmark *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia* in 2005. In his role at the MHCA, he initiated and co-authored a wide range of reports on specific aspects of the mental health care system for reform purposes including *Time for Service*, *Smart Services*, *Where There's Smoke*, *Weaving the Net*, and *Quality Use of Medicines*.

In 2008, Adjunct Professor Mendoza was appointed as the inaugural chair of the National Advisory Council on Mental Health. In that role he initiated and oversaw nearly a dozen reports for the Rudd Government as it overtook national health and hospital reform. He is also served as Deputy President, Alcohol and other Drugs Council of Australia, Foundation Board Member Young and Well CRC, inaugural chair headspace Maroochydore and Foundation board member Qld Mind and Neuroscience Institute, University of the Sunshine Coast.

Adjunct Professor Mendoza presently teaches and coordinates units of study in Leadership and Mental Health Policy at the University of Sydney and is a regular contributor to courses at the Centre for Mental Health Research, ANU.

1 Assessing the current and potential interventions to improve mental health outcomes

The focus in this section of the submission is on suicide prevention. It will also focus on the structural issues evident and the work ConNetica has undertaken, in partnership with the Centre for Mental Health Research (ANU) and Brain and Mind Centre (Sydney University), in mapping the mental health needs and services across various regions.

Key Points

1. Australia has pursued a **centralist approach** to both national and state mental health and suicide prevention since the early 1990s.
2. The **Fifth National Mental Health and Suicide Plan** includes suicide prevention as one of eight priority areas. Unlike the approach taken in almost every other developed nation, Australia has explicitly linked mental health and suicide prevention strategy.
3. The Lifespan model, the Alliance Against Depression and the Tackling Regional Adversity through Integrated Care (TRAIC) program represent **three suicide prevention strategies** being applied on a regional level in Australia at present.
4. In addition to these, there are a number of both **national and state initiatives** at present. This includes the place based suicide prevention approaches and the HOPE program in Victoria, ZEROSuicide in several Queensland hospitals and national initiatives such as the Way Back Support Service, Standby Response and improved crisis support telephone and internet services.
5. A number of **other innovations** have also been implemented in some areas including the Walk in Service model in South Australia, Hospital Transitions Pathways involving 10 hospitals in 3 states, the Agile Psychological Medicine Clinic in Monash Health, and the HOPs, Housing Mental Health Pathways Program and Transitions Team at The Alfred Hospital.
6. There are a **significant number of training programs** and professional development resources available for the workforce. Almost all of them focus on persons at imminent risk of suicide. Most of the programs, particularly those targeting the professionals in health and social care sectors, do not employ sound adult learning principles or practices and it was not possible to ascertain the utilisation or impact of these materials.
7. Almost every developed nation has a national suicide prevention strategy and like in Australia, most federated nations have strategies at the state or provincial level. Despite this, there is **little evidence** that shows such national or provincial strategies actually reduce suicides. Three exceptions to this are Scotland, the Republic of Ireland and Quebec. Each of the three strategies have common features most notably a focus on data and reporting, clear measurable objectives and priorities, whole of government-whole of community engagement and strong governance.
8. **Regional strategies** appear to be more effective in reducing suicidal behaviour through better coordination and the empowerment of residents and civic participation. Collective Impact and community action research models provide a basis for engaging new players and new settings in suicide prevention efforts at a regional or sub-regional level.

1.1 National Context

1.1.1 Suicide prevention strategy in Australia

Australia was one of the first countries to establish a specific national suicide prevention strategy and accompanying dedicated program of funding. The initial strategy (1995-1999) focused on youth suicide and later was broadened to address suicide across the life course. The National Suicide Prevention Strategy, NSPS, has continued since that time. The NSPS is promoted as the ‘*Living is for Everyone*’ (LiFE) Framework (2007)⁴. The broad elements and parameters of the LiFE Framework are:

- Whole population interventions to:
 - reduce access to the means of suicide
 - reduce negative stigma of suicide
 - improve resilience of families, and communities
- Interventions for identified at risk groups to build resilience, and build an environment that promotes self-help and access to support
- Identification of signs of a person at risk of suicide and provision of relevant support
- Interventions for those showing signs of high risk for, or imminent likelihood of suicide
- Accessing early care and support when treatment and specialised care is needed
- Integrated professional care when needed for treatment, management and recovery
- Long term treatment and support to prepare for a positive recovery and future, and
- Ongoing care and multi-layered support.

In 2014, the National Mental Health Commission was tasked to conduct a Review of Mental Health Programs and Services (the Review). The Review highlighted the existing complexity, inefficiency and fragmentation of the mental health system. The Review found that current efforts around suicide prevention were fragmented, lacked focus and were largely unevaluated. The Review concluded that a new approach to suicide prevention was needed, with strong national direction backed by comprehensive, coordinated planning and implementation at a regional level. The Government is now in the process of re-orienting suicide prevention services and devolving the responsibility for implementation to Primary Health Networks (PHNs).

In addition to the national government actions, most Australian states and territories have had and/or have suicide prevention strategies or frameworks in place. While these are largely consistent with the LiFE Framework, there are important differences in emphasis, approach and time periods.

1.1.2 Fifth National Mental Health and Suicide Prevention Plan

The Fifth Plan, unlike the four previous plans, specifically includes suicide prevention. It identifies eight priority areas, with suicide prevention being one. This is in marked contrast to other countries which have developed separate strategies in recent years.

The suicide prevention priority sets out 11 elements “consistent with the WHO’s Preventing Suicide: a global imperative”.

⁴ A comprehensive outline of the Australian Government’s past and present role in suicide prevention is provided in Volume 3 (Submissions section) of the NMHC’s Review.

The plan includes governance arrangements which are largely government controlled by intergovernmental committees. Like NMH Plans 2, 3 and 4, there are **no funding commitments**.

Across all the state and territory governments, the linkages to the national plans **lack clarity** and **fail to clearly allocate roles, responsibilities, resources or accountability**. These deficiencies have been sighted many times over the past decade, yet there is little change in the approach.⁵

1.1.3 National Examples of Suicide Prevention & Mental Health Promotion

Strategies

There are at least three examples of what might be deemed **integrated suicide prevention strategies** in development or application in Australia at present. These are outlined here.

Lifespan

Lifespan is the new name for the 'systems approach' to suicide prevention promoted by the Black Dog Institute (BDI). Lifespan is a multi-site, multi-level trial that **BDI claims**:

- “combines 9 strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community, and
- will result in a reduction of 21% in suicide deaths, and 30% in suicide attempts.”

The strength of the evidence supporting each of the nine components and the ability to determine the impact of the total effort have been subject to some criticism⁶ and is at odds with results from a large RCT meta-analysis.⁷ However, in the absence of independent advice, many PHNs have adopted the Lifespan model with more limited support. The four trial sites are all located in NSW.

The nine suicide prevention components include areas where **further evidence is required** to evaluate effectiveness. At present, there is insufficient evidence concerning screening for suicide in primary care, general public awareness campaigns and media reporting guidelines. Further investigation of education of GPs, gatekeeper training and internet and phone line supports is also required.⁸

European Alliance Against Depression (EAAD)

There are now several regional trials of the EAAD model underway in Australia including on the Sunshine Coast, in South Metro Perth (centred on City of Rockingham) and in the Midwest of WA.

The Alliance Against Depression (AAD) is an approach based on evaluated trials and is recognised as the world's best practice for the care of people with depression and in the prevention of suicide. The initial implementation of the framework in the trial region of Nuremberg (The Nuremberg Alliance Against Depression) resulted in a 24% reduction of suicidal acts within a two- year period.

The West Australian Primary Health Alliance (WAPHA) supports local Alliances with resources, tools, case studies and co-ordination support. The Alliance Against Depression Co-ordination Centre at WAPHA is continually adding to the resources for local Alliances. These support materials are being informed by the National Suicide Prevention Trial Sites in Western Australia, the European Alliance Against Depression Coordination Centre (Germany) and from other Alliances globally.

Local Alliances start with a small number of people wanting to improve the mental health and wellbeing of their community. Those 'initiators' then follow three stages to work with networks across the community to plan, prepare and implement their local Alliance.

⁵ Mental Health Council of Australia, 2005, *Not for Service*.

⁶ Hegerl, 2017

⁷ Riblet et al 2017

⁸ Zalsman et al. 2016

FIGURE 2 THE AAD MODEL



Source: <https://phexchange.wapha.org.au/34927/documents/79944>

Tackling Regional Adversity through Integrated Care (TRAIC)

In 2017, the Queensland Government initiated the *Tackling Regional Adversity through Integrated Care (TRAIC) program* designed to support regional communities experiencing adversity due to prolonged drought, major natural disasters (such as Cyclone Debbie) or significant economic changes. The aim is to enhance community capacity and ability to withstand and recover from adversity.

The TRAIC program encompasses suicide prevention, building resilience, and fostering recovery among people and communities affected by drought, disaster and other community crises. The program is delivered in communities in nine Hospital and Health Services (HHSs) in Queensland: Cairns and Hinterland, Townsville, Mackay, North West, Central West, Central Queensland, Wide Bay, Darling Downs, and the South West.

Key elements of the TRAIC program coordinated by the Mental Health Alcohol and Other Drugs Branch within Queensland Health include:

- Integrating mental health support throughout the patient journey by strengthening the connection pre, during and post contact with a mental health or emergency department service.
- Enabling frontline workers to better respond to people experiencing mental health issues through tailored training packages on suicide prevention and other mental health conditions.
- Increasing mental health literacy and improving help-seeking behaviour by implementing locally based strategies which increase resilience at the individual and community level.
- Interagency collaboration to build community resilience by fostering an inter-agency approach to improving resilience and referral pathways to treatment and support programs.

Funding has provided for local TRAIC coordinators, initiatives to improve access to and continuity of mental health care and community grants to build local capacity. Under the grants, training has been provided to community workers and leaders in resilience and suicide prevention.⁹

It is not clear what evaluations beyond those associated with the training programs are being undertaken.

Other Notably Health Promotion Initiatives

Act Belong Commit (ABC)

Act Belong Commit is originally **The Mentally Healthy Campaign for WA** established in 2006. ABC is the world's first population-wide, community-based mental health promotion campaign. The ABC campaign has grown to engage communities and partners across Australia and has now been adopted in Denmark and Norway as the basis for national suicide prevention and mental health promotion and also in Ireland.¹⁰

The ABC campaign is a **social marketing program** making extensive use of **social franchising** to promote the mental health and wellbeing of individuals and communities. The campaign targets individuals with respect to engaging in activities that strengthen and maintain good mental health. At the same time, the campaign targets organisations that offer mentally healthy activities to act as social franchises for the campaign, promoting the messages internally to their staff and/or externally to their clients or local communities. Act-Belong-Commit's overarching framework allows for implementation at the population level, as well as in specific settings and for targeted groups. The campaign has a mass and targeted media presence and is implemented through partnerships with local governments, schools, workplaces, health services, state government departments, community organisations, and local sporting and recreational clubs.

The Act-Belong-Commit 'philosophy' similarly states that "we become mentally healthy by engaging in mentally healthy activities". The Act-Belong-Commit brand is therefore a simple message to act on.

The three verbs, 'act', 'belong', and 'commit' were chosen as they not only provide a colloquial 'ABC', but also represent the three major domains of factors that both the literature and people in general consider contribute to good mental health. They are articulated as follows:

Act: Keep alert and engaged by keeping mentally, socially, spiritually and physically active

Belong: Develop a strong sense of identity and belonging by keeping up family relationships, friendships, joining groups, and participating in community activities

Commit: Do things that provide meaning and purpose in life, such as taking up challenges, supporting causes and helping others.

Based on evaluations of ABC and its impact on people experiencing STB and mental illnesses, the campaign can act as a framework for suicide prevention.¹¹

⁹ ConNetica has undertaken community capacity building in five of the nine TRAIC regions. This has involved: identifying and training 10 community workers and leaders (half of which are indigenous); providing them with 3 days of facilitator training to deliver 2 programs – Conversations for Life and Stronger Smarter Yarns for Life; mentoring, going coaching and webinars and co-planning of community programs over 8 months. Forty five community workers have undertaken the training and as at 31 March, they had delivered 15 regional training courses to over 220 people.

¹⁰ McHenry et al. 2012; Santini et al. 2018

¹¹ Donovan, 2018

Specific Australian Initiatives

The increased investment by the Federal and many state governments has seen a profusion of suicide prevention initiatives in the past 12 months in Australia.

Appendix A provides a summary of these initiatives and selected innovations from across Australia.

Training Programs

There are a small number of well-established training programs in the suicide prevention 'space'. A number of less well known programs have also become available in Australia. These are shown here.

TABLE 1 A SUMMARY OF SELECTED SUICIDE PREVENTION TRAINING PROGRAMS

Name of Program & Provider	Primary Focus	Target	Time	Materials	Evidence
ASIST – Applied Suicide Intervention Skills Training (Livingworks)	To provide guidance & 'suicide first aid' to a person at risk and suicide safety action planning	General community members; mental health professionals those in human services.	2 days	Participant handbook, flyers, web, video	Evidence from studies in Canada, US, Aust, UK
SAFETalk (Livingworks)	Alertness, to become a suicide-alert helper.	General community anyone over age 15		Flyers, web, video	Based on ASIST
suicideTALK (Livingworks)	Improving helper competencies to intervene with persons at risk of suicide	General community	90mins-4 hrs		Based on ASIST
esuicideTALK	A virtual classroom to explore questions around suicide, its causes, & how it can be prevented	General community	na	online	Based on ASIST
Mental Health First Aid for the suicidal person (MHFA Foundation & Wesley LifeForce & other providers)	How to identify warning signs for suicide; confidently support a person in crisis; have a conversation with a person experiencing STB	General community	4 hrs	Guidelines	Consensus developed
Wesley Lifeforce - SALT (Wesley Mission)	Educating people about suicide, challenging attitudes and teaching basic engagement skills.	General community Health care professionals Community agencies	4-7 hrs	Participant materials, website, newsletter	Not stated
Conversations Matter (Everymind)	Online materials to assist communities have discussions about suicide prevention, assist people with STB & affected communities	General community Health care professionals Community agencies	n/a	Guidelines, video vignettes, information sheets, website	Unknown
Conversations for Life (ConNetica/OzHelp)	Early suicide prevention. Assisting others who more becoming overwhelmed or unable to cope before crisis develops (Participant and Train the Trainer)	General community members; tailored programs for Property Managers, Pharmacists, Teachers & School Support Staff; University student Services; Defence, et al	4 hrs	Varies	3 years of evaluations from ANU, Centre for Mental Health Research
Stronger Smarter Yarns for Life (ConNetica/Strong Smart Solutions)	An understanding of the unique factors contributing to thoughts of suicide for Indigenous people; a strengths based approach to social	Indigenous and Non-Indigenous Communities, Community Health & Social Care Workers,	1 day	Varies	Evidence from some 200 participants

	support & suicide intervention (Participant and Train the Trainer)	Teachers and School Support Staff			
Strengthened for Life (ConNetica/OzHelp)	Suicide crisis intervention (Participant and Train the Trainer)	People working in settings where they are more likely to encounter a person in crisis	1 day	Varies	Evidence from some 200 participants

There are a number of variations on a number of the programs – for example, there are several versions of Mental Health First Aid for different population groups.

A Note on Suicide Prevention Research

As has been noted, suicide prevention has gained considerable political attention in recent years at both national and state levels. Boosting research has been part of that political focus and is seen as an important aspect to improved strategy development and implementation. Yet despite this, a recent study shows that while the quantum of funding has increased (off a very modest base), the focus of the research has changed little in the past 15 years.¹²

In the eight years, 2010 to 2017, a total of 36 grants and fellowships were awarded where suicide was the primary focus. These totalled \$10.68million or just over \$1.322/year. The number of grants and fellowships had almost doubled when compared with the 8-year period, 1999-2006. However, the focus of the research had remained on **descriptive epidemiological studies** (34% in 2010-17 compared to 22% in 1999-2006). Significantly less attention was given to **evaluating the efficacy of interventions** in 2010-17 (30%) to the previous period (52%). As the authors of the earlier study noted, research in suicide prevention must move to focus on intervention studies. Despite this, the situation in Australia has, if anything, deteriorated.

1.2 International Examples & Innovations in Suicide Prevention

In the following section, a range of integrated or systems type strategies and specific innovations in suicide prevention are presented from a range of countries.

1.2.1 World Health Organisation (WHO)

The WHO published a framework for a Public Health Action for the Prevention of Suicide¹³. The framework provides both a process and an outline of key components of a public health approach. Like most SPS frameworks, the WHO example is **a multi-level strategy not a systems approach**. Two components included in the WHO framework that are not as frequently cited are:

- Improving the reporting and registering of suicide deaths and suicidal behaviour – better, more timely and systematic monitoring, and
- The need for robust evaluation.

The WHO has emphasised the critical and urgent need to identify interventions with proven efficacy for prevention death by suicide.

ConNetica has undertaken recent analyses of suicide prevention and mental health promotion strategies in Europe, UK (England and Scotland), Ireland, New Zealand, Japan, Taiwan and Canada.

¹² Reifels et al, 2018

¹³ WHO, 2012

1.2.2 USA

Suicides in the USA in 2016 accounted for nearly 45,000 deaths (15.6/100,000 ASDR). Over 7,500 of these deaths are veterans, most of whom served in the period of Middle East conflicts from 1991 to the present. Suicide rates have **increased by 30 per cent** in the period 1999 to 2015.¹⁴

In recent years there have been many notable systems and programmatic responses to the crisis in **'behavioural care'** in the US.

ConNetica has reviewed these and undertaken study tours of services in the NE of the United States. Space does not permit a full outline of these developments here. However, caution has to be exercised in 'transplanting' any initiatives from the US to Australia given the vastly different architecture in the healthcare systems.

A number of these are briefly outlined in **Appendix A**.

1.2.3 Do 'National Suicide Prevention Frameworks' make a difference?

Variability exists when evaluating suicide prevention frameworks and their ability to reduce suicide deaths and attempts. Whilst there is significant overlap and agreement across frameworks within and outside of Australia, the effectiveness of any given framework is highly dependent upon its implementation.¹⁵ Fragmented implementation can reduce effectiveness and in the long term may not show a reduction in suicide rates. As such, prevention strategies that target specific areas in isolation may be ineffective and be extremely difficult to evaluate.

Thus, suicide prevention frameworks must be detailed based on a systems approach to suicide prevention, and to be successful, must be implemented at a whole-of-system level. A successfully implemented suicide prevention strategy can expect a 10-17% reduction of suicide deaths within 3 years.¹⁶ These strategies must be systemic and include approaches at individual, community and population levels. Broadly, national strategies have shown effectiveness in reducing suicide deaths amongst young and old populations, but tend to have small to no effect in working age populations, suggesting that those within this population need greater consideration.¹⁷ Successful suicide prevention frameworks depend upon comprehensive implementation and action, and buy-in from all involved from **policy makers to health professionals**.

Effectiveness of a suicide prevention framework is also contingent upon the **integration of services**, not only mental health, but ancillary social services such as Centrelink, homeless organisations, education sites, workplaces and the places in which people live. The NMHC asserted in their 2013 report card on mental health that Australia's current strategies 'do not offer any sense of what interventions should be prioritised' (p. 90), which means that any suicide prevention strategy moving forward cannot be a general guideline document, but a focussed, assertive and direct framework for action and implementation.¹⁸

1.3 Structural Issues Identified from Integrated Atlas Studies

Another set of analyses on the state of mental health in Australia, to which we draw to the Commission's attention is the development of **Integrated Atlases of mental health**, alcohol and other drugs and other chronic conditions. The Integrated Atlas methodology was first undertaken in western

¹⁴ For details on US suicide rates a recommended report comes from the CDC see <https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm>

¹⁵ Christensen 2016

¹⁶ National Office for Suicide Prevention 2015

¹⁷ Matsubayashi and Ueda 2011

¹⁸ NMHC 2013

Sydney commissioned by WentWest in 2014. Since then a further 19 atlases have been produced covering PHNs and LHDs in Western Australia, Victoria, NSW, the ACT and Qld. Both urban and rural regions have been analysed. This data can be compared with regions from over 20 countries where the same methodology has been applied.

Importantly, dozens of peer reviewed papers on the Integrated Atlas have now been published over the past decade.

The Atlas reports focus on the universally available services – that is, there is no out-of-pocket cost to accessing the service. Some of the Atlas reports include analyses of **Medicare subsidised services**.

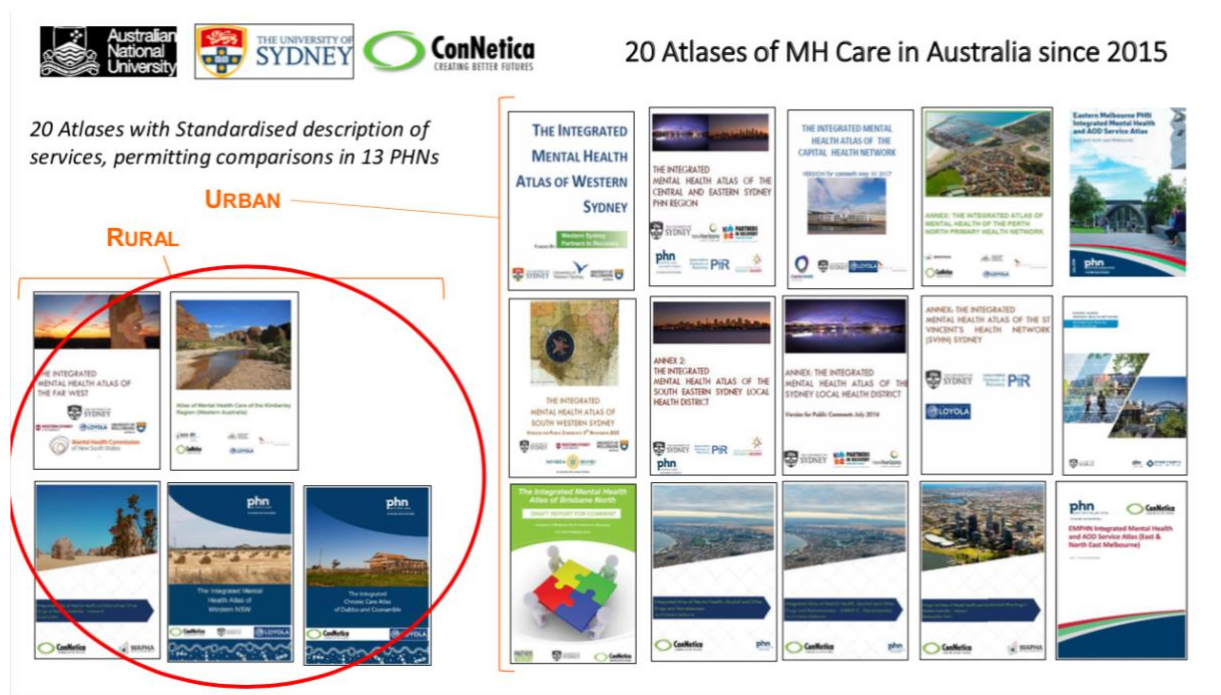


FIGURE 3 INTEGRATED ATLASES OF MENTAL HEALTH & CHRONIC CARE IN AUSTRALIA¹⁹

While there are significant differences between the Australian regions, there are also **several important consistencies evident** with some types of care almost completely absent and other characteristics. These include:

- Alternatives to hospital based residential services
- A shortage of sub-acute care residential services
- Few employment mental health related services
- Almost no structured high intensity rehabilitation day care (the exception being for veterans provided through Veterans Affairs)
- Grossly inadequate child mental health services in almost all areas
- Inadequate alcohol and other drug services
- A large number of small, short term funding arrangements for NGO-managed community mental health programs

¹⁹ Presentation by Luis Salvador Carulla at Rural Health Conference, Hobart, March 2019.

Indeed, **even in rural regions**, there is a high reliance on:

- Acute inpatient care
- Acute health related mobile outpatient care
- Non acute outpatient care (mostly mobile, low intensity in nature), and
- A significant investment in accessibility – assessing needs and then trying to find services

The **distribution of the services** in most regions is also mis-aligned with the locations of highest demand – meaning that consumers have to travel some distance to access care. Western Sydney is one exception in this regard.

The **inequities in access to Medicare** subsidised services highlighted earlier, generally compound the difficulties in accessing care and compromise the quality of care. Putting this in simple terms it means that consumers, or their carers, will all too often be unable to:

- find **the range of services necessary to prevent** a deterioration in their mental health
- **access alternatives to an Emergency Department** presentation when a mental health crisis occurs
- **access longer stay residential services** for recovery following a period of acute hospital based care
- find **services to enable them to return to their roles** in the community – be these in undertaking training and education, employment and community social life

General Practitioners are the gateway for most consumers to access health care across Australia. GPs, but particularly those in lower socio-economic urban areas, regional cities and rural and remote locations, will have great difficulty in being able to connect their patients with skilled primary and specialist care providers, with community care services, and all too often rely on the over-extended acute care services.

The **imbalance of care** in the Australian mental health ‘system’ lies at the heart of the poor mental health outcomes seen in the available outcomes data. The Atlas analyses – which now cover over 40% of the nation -provide a clearer understanding of ‘what is’ and a sounder basis for planning ‘what needs to be’, region by region.

1.3.1 Other Structural and Systems Approaches

Hospital Flow Model, Institute for HealthCare Improvement

The Institute of Healthcare Improvement (IHI), based in Boston Massachusetts, have developed system models and tools to improve **hospital-wide patient flow**. These models apply Flow Theory, Lean Thinking and Quality Improvement to optimising patient flow through a hospital. Additional tools and strategies have been developed by IHI in partnership with major US healthcare organisations such as Cincinnati Children’s Medical Centre, Northwell Health (NYC) and Kaiser Permanente to reduce or shape demand for ED presentations and hospital admissions.

The IHI model²⁰ for achieving hospital wide patient flow (**right care, right place, right time**) is based on:

- The integration of various approaches (e.g. quality improvement, Lean management, operational engineering, complex systems analysis, operations research) to achieve hospital-wide patient flow.

²⁰ Rutherford et al, 2017.

- The utilisation of advanced data analytics to reduce artificial variation in elective surgical scheduling, forecast patient demand patterns, and match capacity and demand.
- A focus on reducing demand, with change ideas to reduce hospital utilisation by relocating care to less costly and, in many cases, higher-quality care; and on shaping demand by expansion of operating room scheduling system capabilities to predict and plan for patients who need intensive care and care in other inpatient units.
- A system-wide approach to patient flow, with a few “simple rules” to govern complex systems. Simple rules are design principles to guide system-wide improvement (e.g., no delay greater than two hours in patient progression, based on clinical readiness, from clinical areas/units throughout the hospital; available capacity on each unit or clinical area at the beginning of each day).
- A learning system that utilises the science of improvement to understand and prioritise solutions to mitigate “flow failures.”

IHI argues that improvements made in one clinical unit or even several, will not necessarily improve patient flow, patient experiences of care and to gain sustainable improvements, **a whole systems approach** is needed. They posit three key approaches for optimising the system: shape or reduce demand, match capacity and demand, and redesign the system.

Beyond Suicide Prevention Strategy – Mental Health in all Policy

The discussions on both risk and protective factors, later in this submission, and the approaches to date in suicide prevention strategies, highlight that much of what we do under the banner of ‘suicide prevention’ is not prevention in a public health strategy context. There is almost a complete absence in suicide prevention strategies on addressing the **distal risk factors** and **social determinants** of both mental illness and suicide and self harm.

Complex societal issues are commonly addressed with multiple strategies generated from a variety of sectors and individual organisations but with little cohesion, consistency or long-term outcome. Throwing best practice responses, or “isolated impact” to chaotic problems does not work, neither does addressing complex issues with simple solutions. Research indicates that complex societal problems require **large scale collective strategies** to create lasting positive change.

While the Australian social system is able to identify pockets of cross-sector collaboration that have resulted in lasting change there has been little documentation and dissemination of the systems and frameworks that have enabled this to occur.²¹ There is growing evidence emerging that the process that underlies collective impact is significantly contributing to identifying solutions to bring about significant change. This review will identify the key components and critical success factors that contribute to a successful collective impact process.

The Community-Based Collaborative Action Research Framework

A specific model of community action research is another robust framework for guiding the development, implementation and monitoring of a multi-level, inter-sectoral strategy for suicide prevention. The Community Based Collaborative Action Research Framework (CBCAR) is a dynamic, **community-driven partnership model** utilising action research methods. It is particularly applicable to complex health and social problems with multiple contributing factors and understanding that within its

²¹ ConNetica undertook a three year evaluation of a place based national demonstration project called Family Centred Employment Program in Goodna, Qld. The FCEP program provided wrap-round services for 150 jobless families. The results exceeded all benchmarks set by the Government. Despite this and the recommendation of both PM&C and DEEWR, the program was not extended to other regions nor has the report ever been released.

context. It is effective in addressing systemic and structural barriers to health and well-being. CBCAR supports long-term commitments with ongoing social action processes within defined communities.

TABLE 2 SUMMARY OF KEY FEATURES OF CBCAR FRAMEWORK (GELDEREN ET AL, 2018)

Development	Pavlish & Pharris (2012)	Process leaders	Community driven – facilitated by key community stakeholders
Model flow	Fluid and Dynamic	Emphasis on Community voice	Strong
Underpinnings	Unitary participatory paradigm with social justice & assurance of human rights	Assessment phases	Dialogue & pattern recognition
Purpose	Understand patterns of health Problems & inequities from an ecological perspective	Implementation phases	Insight into action
Phases	1. Partnership 2. Dialogue 3. Pattern recognition 4. Dialogue on meaning of pattern 5. Insight into action 6. Reflecting on evolving pattern	Evaluation phases	Reflecting on evolving pattern

Key assumptions of the CBCAR framework relevant to the context of the **Place Based Suicide Prevention** initiatives and the boarder regional strategies are:

- that people and communities have the best insight into their own situations
- CBCAR invites community members into the decision-making process to ensure that all voices are given the opportunity to be heard, and
- the framework generates context relevant knowledge while engaging people in creating meaningful systems change.²²

TABLE 3 CBCAR FRAMEWORK DESCRIPTION²³

Phase	CBCAR Framework Principles
Partnership	Collaboration forms/re-forms: Once an issue arises, the first step is to consider who should be involved in the CBCAR process that will explore causes and resolutions to a problem. The team must invite those who are most affected by the issue.
Dialogue	Research question and direction determined: Dialogue enhances equity of voice for all group members, promotes curiosity and an open exchange of ideas, and nurtures meaningful relationships through the sharing of thoughts that result in a deep and meaningful understanding. Open dialogue helps identify the research question and direction and how to best respond to the challenge, identify who should take responsibility for the action, and reflect on the process and outcome(s) of the CBCAR project. When the process of dialogue is used to discern the issue at hand, just as a key unlocks one's front door, the process of dialogue unlocks endless possibilities by establishing a new way of thinking and viewing the world.
Pattern recognition	Data collection and analysis: "CBCAR researchers should scientifically collect data that is oriented toward deeper understanding of problem situations and their potential solutions" (p 151). Principles of CBCAR data collection include a process that is rigorous and action oriented that yields practical information to guide an action plan (p 152). Data collection is seen as an active learning process that is circular and is generally collected when interacting with people within the community.

²² Pavlish & Pharris, 2012; Burns, Crooke et al 2011

²³ Gelderen et al, 2018

Dialogue on meaning of pattern	Representation of research findings: This focuses on the constructionist paradigm & representation of patterns. “Through dialogue, multiple worldviews are shared & understood; life becomes richer & more fulfilling for all” (Pavlish & Pharris, pp xx-xxi). The emergent process of CBCAR encourages the research team to identify the root cause behind health disparities. Patterns can be seen through epidemiologic & demographic data that elicit broader context.
Insight into action	Community dialogue about meaning of research findings—Action planning: After data are collected, analyzed, and presented to the community, the next step is to engage the wider community to develop an action plan that will shape a healthier community and support social justice. The discernment of action steps involves an interactive process incorporating visual representations of the community pattern that was revealed through the research process, and ensuring all voices are being heard. Dialogue occurs through reflecting on the patterns, developing an action plan, and choosing an evaluation method. Part of action planning is developing sustainable partnerships. The process of developing and maintaining sustainable partnerships takes time and energy. All members need to be committed to the collaborative. “A strong partnership will reach the end of a project only to realize that they are faced with a new burning issue and increased capacity to take it on”
Reflecting on evolving pattern	Evaluating actions and considering new questions: Researchers must be open to explore new unfolding patterns of meaning within the community. They must look for ideas and messages in the dialogue and data findings that might not be evident at first. Next, researchers must reflect on the topic and community of concern and then confirm current understandings of the tenants of human rights and social justice. The research team needs to invite new dialogue in search of deeper, underlying and sometimes hidden meanings.

Dynamic Modelling Tools

A number of researchers have advanced the view that effective suicide prevention efforts will need to be based on **machine learning** or **dynamic modelling** approaches.²⁴

Page and colleagues have been developing and applied a dynamic modelling or simulation tool to suicide prevention planning in Western Sydney. Like, Eastern Melbourne PHN, Western Sydney PHN has undertaken the development of the Integrated Atlas of Mental Health Services and continued to develop decision support capability.²⁵

Andrew Page and colleagues describe the development and application of the dynamic simulation model that aimed to inform the most appropriate combination of suicide prevention activity in the population catchment covered by WSPHN. Specifically, the paper sets out to (1) conceptualise a model of the Western Sydney population, with particular emphasis on pathways to mental health care and suicidal behaviour; (2) operationalise this model and calibrate outputs to represent current incidence of suicide and attempted suicide in Western Sydney; and (3) incorporate a range of potential suicide prevention activities and service priorities to identify the combination of services and activities associated with the greatest potential reductions in suicide over the period 2018–2028.

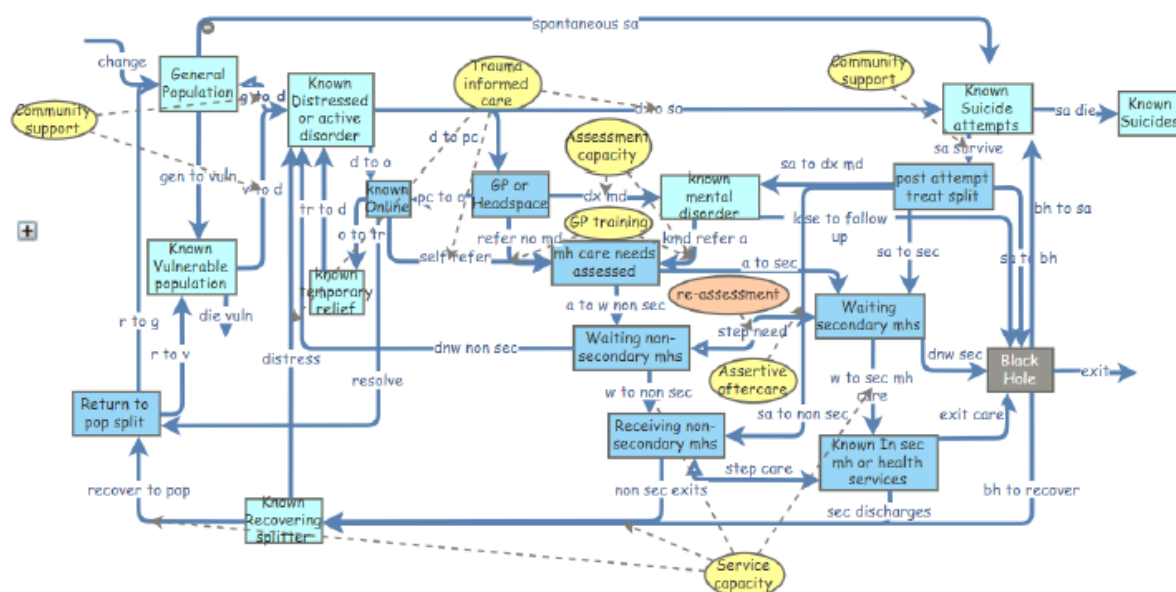
The simulation tool was informed by a series of workshops and meetings between April and November 2017. The workshops mapped key suicide and mental health service pathways, the factors that influenced the flow of the population along these pathways, and the mechanisms by which selected interventions were hypothesised to have their effect. Findings from this mapping exercise were developed into a conceptual model based on current policy priorities identified by the PHN, which included a ‘stepped care’ approach to the provision of mental health care in primary health settings (based on Cross and Hickie, 2017²⁶). The conceptualised model, incorporating research evidence and local secondary data sources, facilitated the construction, quantification, calibration and validation of the computational model using standard approaches for system dynamics models (applying the Stella Architect® software).

²⁴ Insel, 2016; Salvador-Carulla, 2017; Page et al 2017; Page et al 2018

²⁵ Salvador-Carulla, 2015

²⁶ Cross and Hickie, 2017. This is the same stepped care with clinical staging approach now being deployed by Eastern Melbourne PHN.

FIGURE 4 CONCEPTUAL MODEL DERIVED FROM PARTICIPATORY MAPPING OF SUICIDE PATHWAYS



Results

A total of 13 interventions were included in the model along with estimates of effects of the interventions based on the literature. The dynamic tool then produced estimates of cases averted over the ten-year period, 2018-2028 for the region.

The **largest number of forecast cases averted for both suicide and attempted suicide** were associated with 1) post-suicide attempt assertive aftercare, 2) improving community support and reducing psychological distress in the community (5.1% for attempted suicide and 14.8% for suicide) and (3) reducing the proportion of those lost to services following a mental health service contact (10.5% for both attempted suicide and suicide). **Infrastructure** and **workforce capacity** interventions were also associated with a significant number of cases averted over the forecast period.

Increased spending on community infrastructure (relating to improved access to services, employment, transport and housing) was estimated to result in a 5.7% reduction in suicide cases; however, this had limited impact on attempted suicide cases. Also, increased staff (approximately 2% per annum) and training relating to trauma-informed care was also estimated to avert approximately 7% of attempted suicide and suicide cases.

Interventions to identify those at risk of suicidal behaviour (GP/gatekeeper training; headspace) had limited impact on averting cases of attempted suicide or suicide cases over the forecast period, unless combined with a commensurate increase in capacity in mental health service pathways.

Limitations

There are several limitations to this model which need to be understood:

- The model aggregates population data – it is not a tool for assessing the risk of an individual or the best approach to adopt to prevent suicide or self-harm with an individual.
- The predictive ability of the model is based on the existing evidence on what works in relation to suicide prevention. As has been stressed earlier, in section 2 of this report, there is a lack of quality data on the effectiveness of suicide prevention and interventions.
- Further to this point, is the prevalence of psychological distress, suicidal behaviour and suicide deaths. These are all, to varying degrees, likely to be under-estimated. Hospital and health data (e.g. presentation, service utilisation and quality of care data) is also highly variable.

Nonetheless, the dynamic modelling tool is a promising support to better decision making about the placement of limited resources for suicide prevention and intervention activity at a regional level.

1.4 Issues Arising from this Summary

- Too few of the **initiatives in suicide prevention** funded by governments in Australia are strategies as such – most are single, short-term, narrowly scoped or disconnected initiatives. Too many lack integration, incorporate robust monitoring and evaluation and fail any reasonable test of good health promotion or public health strategy.
- Few of the **training programs** or professional development modules currently offered in Australia, either in face-to-face formats or e-learning, align with sound adult learning principles or practices and there is no publicly available evidence on the utilisation of the resources or their efficacy.
- Almost all of Australia's suicide prevention funding is focused on those individuals who have developed STB, and consequently are more focussed on **crisis intervention** than prevention in public health terms. Training a range of community members and so-called gatekeepers in recognising the signs and what to say is the dominant theme in the available training programs. New initiatives have been developed in recent years that focus on the discharge or exit from acute care and in some instances ED. **There is almost a complete absence of investment** or effort on prevention and early intervention programs or programs that address **social determinants** of suicide or join with efforts in reducing poverty, homelessness, domestic and family violence, gambling or other social problems that act in concert with other risk factors to overwhelm the coping skills and resources of vulnerable individuals.
- The **separation of funding** through the Local Hospital Districts, PHNs, Medicare subsidised services and Private Health Insurance presents multiple barriers within the Australian healthcare system to developing sustainable, integrated care for people with mental illnesses, suicidal behaviours and comorbid conditions. State government agency initiatives, Federal initiatives funded through NGOs like beyondblue, and other domestic violence, homeless and other community services, further complicate the development of integrated, person-centred care.
- There is still no Australian national standard treatment pathway defined in Emergency Medicine for those presenting to EDs with self-harm or risk of suicide.²⁷
- Few efforts look at **whole of system flow** in a regional or hospital catchment context. Wilhelm and colleagues suggest that a clinical pathway for suicide and self-harm would need to look beyond the ED and 'anticipate longer-term solutions for people presenting in crisis and to decrease the reliance on ED for those with repeated suicidality and crisis presentations'. Developing a pathway that retains specificity and eschews generalities is seen as critical for effective response to acute mental health crises in EDs. This view is certainly consistent with the view of experts in the UK, US and Europe.
- Based on the review presented here, there is a case for investing in the following **ten initiatives** in relation to suicide prevention at a regional level:
 - Improved, ongoing and networked surveillance of STB but also earlier indicators such as family violence, school suspensions and expulsions, psychological distress, crisis help line calls and relevant hospital separation data. The Colorado Suicide Prevention Dashboard offers an example of transparent and comprehensive data related to suicide prevention planning and evaluation on a state wide and county level.
https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=

²⁷ Wilhelm et al, 2016

- Applying **additional planning frameworks** with the LifeSpan Model to better target and integrate community responses to suicide and self-harm. The Collective Impact framework, or higher fidelity models such as Community Based Collaborative Action Research, can be applied to address the social determinants of STB and engage a broad coalition in upstream prevention work that address community infrastructure, community cohesion and inclusion (or isolation) and general services.
- Supporting a **community mental health promotion program** that acts to support social connection and cohesion, physical activity and purposeful living such as the Act-Belong-Commit program.
- Ensuring that all schools implement evidence based **social and emotional learning programs** from K-12 that teach interpersonal skills, respectful relationships, and intrapersonal skills such as problem solving and resilience. These might include peer led aspects in high school.
- Developing **hospital catchment-wide patient flow models** that reduce the numbers of crisis presentations to ED and then connecting every person who presents to an ED to appropriate and timely supports.
- Developing **alternatives to ED** for suicidal crisis presentation. This might be based on the “Living Room” (Illinois) or Maytree (London) models or the extended Walk-in Service model (Salisbury South Australia or in other places around the world).
- Promoting the **use of dialogue based suicide assessment** methods – the CASE (Shea) and CAMS (Jobes) models having the strongest evidence at this point – in all ED, acute care and stepped care services. Overtime increasing the capacity of Practice Nurses and others in primary care to use this methodology.
- Ensuring that a **region wide protocol** using the WHO Brief Intervention and Contact intervention is applied to all persons presenting to any health unit following a suicide attempt. Overtime this should be extended to cover those presenting with self-harm.
- **Workforce capacity building** – both in relation to higher level skills (such as CASE and CAMS risk assessment, BIC and trauma informed care) but also skilling community members in the ‘human-touch point’ roles in ways to support others experiencing hardship, loneliness or vulnerability.
- **Trailing dynamic modelling** methods to better define the most effective interventions.

2 Contributing components to improving mental health and wellbeing

In this section we focus on mental health promotion, suicide and self-harm prevention and facilitating social participation and inclusion. The issues are dealt with in an integrated manner and not separately.

Key Points

1. In recent years, the relationship between **social and structural determinants** and mental disorders has gained increasing research focus, particularly in relation to the frequency, severity and duration of stressful environments and experiences in early childhood.
2. **Disadvantage starts before birth** and accumulates throughout life. ConNetica believes this is a critical issue for addressing the drivers of mental illness and suicidal behaviour.
3. The **main individual factors** shown to have a significant independent association with worse mental health were low income, not living with a partner, lack of social support, female gender, low level of education, low socio-economic status, unemployment, financial strain and perceived discrimination.
4. The **area level factors** associated with mental health were neighbourhood socioeconomic conditions, social capital, geographical distribution and built environment, neighbourhood problems and ethnic composition.
5. A recent **meta analysis on income inequality and depression**, the findings demonstrated greater risk of depression in populations with higher income inequality relative to populations with lower inequality.
6. An **ecological framework** has been proposed with mechanisms operating at national level (the neo-material hypothesis), neighbourhood level (the social capital and social comparison hypothesis) and individual level (psychological stress and social defeat hypothesis) to explain these associations.
7. Risk of suicide is the result of a **complex interchange** between a wide range of **personal and contextual factors**.
8. Suicide prevention and self-harm mitigation is a global public health priority. Globally, suicide rates are declining, but **in Australia and the US, age standardised suicide rates are rising**.
9. **Self-harm** should be seen as a distinct behaviour from suicide, though the two may co-occur.
10. **Stigma** can be reinforced, often unintentionally, through language and thus acts as a barrier to prevention and help seeking behaviours.
11. Despite the amount of research conducted, suicide research is considered to be in a '**pre-paradigm phase**' without a dominant paradigm to focus research and prevention efforts.
12. **Risk factors** for suicide can be related to individual, social and contextual variables, for which there is **no clear 'check list'** to determine whether an individual is likely to die by suicide.
13. An **ideation-to-action framework** represents an emerging paradigm that can explain the progression from consideration of suicide (based on an accumulation of risk factors) to the behaviour of suicide.
14. A broader understanding of **mental wellbeing, resilience and social connection** affords stronger evidence of protective factors relevant to suicide and self-harm. Social connection plays a key role

in increased life expectancy and resilience. **Resilience** plays a key role in maintaining mental wellbeing, particularly in response to adverse life events and traumatic experiences.

15. Another protective factor is **access to quality mental health care**. Quality care involves an integrated system with cross-sector health professions working together to deliver care in a non-stigmatised and respectful manner. Several initiatives implemented together, such as 24-hour crisis care, assertive outreach, 7-day follow up and frontline staff training have shown reductions in suicides.
16. The **lived experience** of someone who has survived a suicide attempt, or those bereaved by suicide, are extremely important in informing what can be done to prevent suicidal behaviour. The stigma associated with suicide is a strong risk factor. Major life events and traumatic experiences can be key indicators of suicidal behaviour.
17. **Support** for family, friends and work colleagues after a suicide or suicide attempt is imperative.

2.1 Suicide and Self Harm

A discussion on risk and protective factors relevant to suicide is fundamental to appreciate the challenges involved in designing and implementing a sound suicide prevention strategy and service responses. A short discussion on intentional non-suicidal self-harm is also included.

2.1.1 What is Suicide and Self-harm

Suicide is a complex problem and carefully described as ‘... a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution’.²⁸ Added to this is the important consideration of the processes that differentiate between suicidal thoughts and suicidal behaviour.²⁹

Suicide is a response to overwhelming conditions, both personal and contextual. It is often a perceived solution to the accumulation of problems over time, but sometimes the result of impulsive and precipitous behaviour. The complexity of the pathways towards suicide makes them difficult to predict, however early intervention and prevention ought to be prioritised above crisis management.

Suicide prevention and self-harm mitigation is an emerging global public health priority.³⁰ It is a phenomenon that is preventable and should be addressed by every government and civil society.

2.1.2 Risk Factors

Risk of suicide is the result of a **complex interchange** between a wide range of **personal and contextual factors**. These can be described as ‘distal’ factors that might predispose an individual to risk, and ‘proximal’ factors that may persuade an individual to consider suicide as a solution.³¹ Proximal factors are often referred to as ‘warning signs’ in the literature. In this summary, both ‘warning signs’ and ‘risk factors’ are discussed as risk factors.

Distal factors can be described as (a) the contextual social, economic, environmental, and familial factors (in public health terms, **‘social determinants’**), (b) the presence of a clinically diagnosed psychiatric disorder, (c) personality traits and/or genetic disposition. It is common for risk factors to arise from each of these domains, and to combine to increase the level of risk.³²

²⁸ Leenaars 1999, p.155

²⁹ Klonsky and May 2015; Mars et al, 2019

³⁰ Aleman and Denys 2014; WHO 2014

³¹ Moseicki 1997; Nock et al. 2008; van Heeringen 2012

³² Beautrais 2000

Certain **social determinants of suicide** exist including those living in rural and remote geographical locations, level of educational attainment and occupational status. For men living in rural and remote locations suicide risk is considerably higher than for their metropolitan counterparts.³³ Low educational attainment is also associated with higher suicide risk, with those in Australia with low educational attainment more likely to make a suicide attempt, though this was only the case for working-age employed.³⁴ Similar observations have been made in other cultures, with education attainment in Japan being associated with suicide deaths.³⁵

Job loss, financial difficulties and living alone, all increase the risk of suicide.³⁶ In reality, risk of suicide is much more complex, multifaceted and dynamic. The following section will provide an overview of significant risk factors and conclude with how in ConNetica's view they may intertwine to escalate risk.

Social Determinants, Mental illness and Suicide

Social, environmental and economic factors play a significant role in shaping the health and wellbeing of individuals and populations and are commonly referred to as the **social determinants of health** (SDH) as shown in Figure 3.³⁷

The contribution of the SDH to population health outcomes is well established and undisputed, leading international, national and regional health authorities to act to address these factors. The links between SDH and the development of diseases such as chronic conditions are complex, although usually associated with **access to opportunities and resources** such as quality education, adequate and meaningful employment, safe and affordable housing, accessible transport, nutritious food, safe local environments and accessible health services. **Income** also plays a critical role as it provides flexibility and options, enabling people to access the SDH they need. SDH underpin health and influence the movement of individuals and populations across the Population Health disease continuum.

Evidence dating back to the 1950s shows the impact of social determinants (education, housing, occupation and income) on an individual or community's mental health and suicidal behaviour.³⁸ It is increasingly clear that levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing.³⁹

Disadvantage starts before birth and accumulates throughout life.⁴⁰ We believe this is a **critical issue** for addressing the drivers of mental illness and suicidal behaviour to be addressed by the Commission.

The more recent research emphasises it is not poverty per se, but **relative disadvantage** that impacts adversely on the mental wellbeing of individuals, families and small communities that have fewer economic, social and environmental resources.

³³ Caldwell et al. 2004

³⁴ Taylor et al. 2004

³⁵ Kimura et al. 2016

³⁶ Coope et al. 2015, Chang et al 2013; Buron et al. 2016

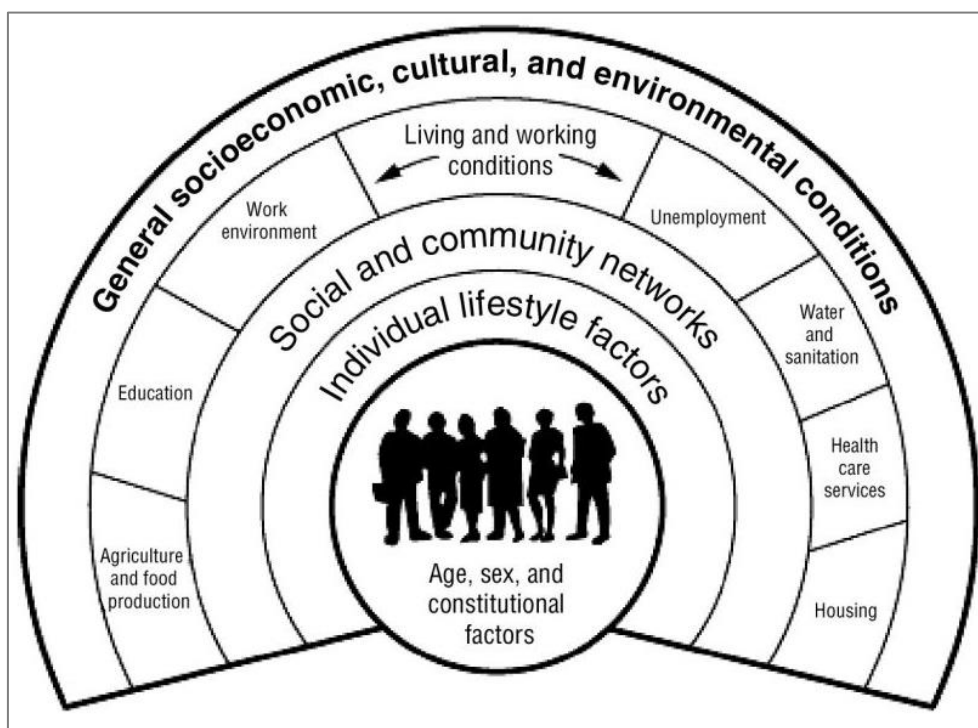
³⁷ Dahlgren G & Whitehead M, (1992). *Policies and strategies to promote social equity in health*. Copenhagen: WHO

³⁸ Hollingshead and Redlich 1958; Langner & Michael 1963

³⁹ Wilkinson 1997; Pickett 2006; WHO Europe 2009

⁴⁰ WHO 2014

FIGURE 5 THE DAHLGREN-WHITEHEAD MODEL OF SOCIAL DETERMINANTS OF HEALTH



A review of the evidence in 2016 found the **main individual factors** shown to have a significant independent association with worse mental health were low income, not living with a partner, lack of social support, female gender, low level of education, low socio-economic status, unemployment, financial strain and perceived discrimination. The **area level factors** associated with mental health were neighbourhood socioeconomic conditions, social capital, geographical distribution and built environment, neighbourhood problems and ethnic composition (i.e. a lack of diversity and a high indigenous proportion of the population).⁴¹

*"It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy It is the distribution of economic and social resources that explains health and other outcomes in the vast majority of studies."*⁴²

Lower educational attainment, living alone, unemployment, home ownership, low income and poverty are all associated with higher rates of mental illness and suicide but the strength of the association varies in different countries.⁴³

Homelessness is a consistently strong indicator. Being homeless increases an individual's risk of dying by suicide,⁴⁴ and alarmingly, colleagues at the Centre for Social Impact at UWA⁴⁵ found that in Australia young homeless females are more likely to attempt suicide than young homeless men – a reversal of the general population trend.

Since 2000, the evidence has strengthened in support of the **two-way relationship** that exists between mental disorders and socioeconomic indicators. Factors such as low income, unemployment and social

⁴¹ Silva M, Loureiro A & Cardoso G (2016). Social determinants of mental health: a review of the evidence. *Eur J Psychiat*; 30(4): 259-292.

⁴² WHO Europe, 2009

⁴³ Lorant et al. 2003; Kessler et al. 1994; Blakeley et al. 2003; Page et al. 2013

⁴⁴ Noel et al. 2015

⁴⁵ Flatau et al 2015

exclusion are all positively associated with common mental disorders⁴⁶ and are similarly implicated in alcohol and other drug (AOD) abuse, problem gambling as well as in a range of other comorbidities.⁴⁷

In a recent **meta analysis on income inequality and depression**, the findings demonstrated greater risk of depression in populations with higher income inequality relative to populations with lower inequality. Multiple studies also showed greater impacts of income inequality among women and low-income populations.⁴⁸ Patel et al posit an **ecological framework** with mechanisms operating at *national level* (the neo-material hypothesis), *neighbourhood level* (the social capital and social comparison hypothesis) and *individual level* (psychological stress and social defeat hypothesis) to explain these associations.

They go on to say, **mental health professionals should champion policies** to reduce income inequality as well as promote the delivery of interventions which target the pathways and proximal determinants (building life skills, psychological therapies and packages of care with demonstrated effectiveness for settings of poverty and high income inequality). That is, they should advocate for policies that reduce inequality.

In recent years, the relationship between social and structural determinants and mental disorders has gained increasing research focus, particularly in relation to the frequency, severity and duration of stressful environments and experiences in early childhood.⁴⁹ There are emerging theories to suggest that adverse childhood experiences (ACEs) can be moderated by personal and social ‘scaffolding’ – self-agency, self-regulation, emotional, informational, social connections and instrumental resources.⁵⁰

Mental Disorders and Suicide

The connections to **mental health or wellbeing** are undeniable⁵¹, and the presence of a mental illness or disorder is a long-acknowledged risk factor for suicide across all age groups, genders and a wide range of locations.⁵² However, it is important to understand that:

- The relationship between mental illness and suicide is not necessarily causal and that not all mental illnesses have the same level of suicide risk,
- The vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours, and
- A person does not have to have a diagnosable mental illness to have a suicide risk.⁵³

Several diagnoses of mental illness, including mood disorders, schizophrenia, personality disorders and childhood disorders, and a history of psychiatric treatment in general have been established as risk factors for dying by suicide.

Depression is a very common mood disorder worldwide. In Australia over 20% of adults will have at least one episode of major depression in their lives and over 6% in any one year. Between 60-70% of people who die by suicide have symptoms consistent with major depression at the time of death and the suicidal risk is 20 times greater than for people with no depressive disorder.⁵⁴

⁴⁶ WHO & Calouste Gulbenkian Foundation 2014; Lund et al., 2011

⁴⁷ Marmot, 2015; Marmot 2017; Kim et al., 2016

⁴⁸ Patel et al 2018

⁴⁹ Schalinski et al., 2016

⁵⁰ Bell et al., 2013; ConNetica, 2015

⁵¹ Beautrais 2000; Cantor and Neulinger 2000; Joiner 2005

⁵² McLean et al. 2008

⁵³ Haw & Hawton, 2015; Mendoza et al 2010.

⁵⁴ Terra 2008

For those with **bipolar depression**, suicide risks are approximately 15 times that of the general population.⁵⁵ Suicide, for people with a diagnosis of bipolar, often first occurs when work, study, family or emotional pressures are at their greatest.

Just under 1% of the Australian population will develop **schizophrenia**. It is estimated there is a 4-10% lifetime risk for suicide among persons with schizophrenia and a 40% lifetime risk of suicide attempts. A 1996 WHO study found the most common cause of death for those with schizophrenia was suicide. Several risk factors for suicide amongst those suffering from schizophrenia have been identified: positive symptoms, co-morbidity with depression, lack of treatment, downgrading in level of care, chronic illness, a good educational background and high performance expectations. Suicide is more likely to occur earlier in the course of the illness.⁵⁶

Importantly, in the context of developing **effective regional suicide prevention strategies**, a number of studies have shown that systemic improvements to mental health services can reduce death due to suicides in a defined catchment.⁵⁷

Chronic pain or physical illness⁵⁸ also increases the risk of suicide.

Stigma, Mental Illness and Suicide

Higher suicide rates are associated with **public stigma** toward mental illness.⁵⁹ While it's true that stigma toward those experiencing mental illness has reduced over the past 30 years, the level of public stigma is often related to the type of illness. For instance, perceptions of discrimination and 'dangerousness' are often high for those diagnosed with chronic schizophrenia.⁶⁰

The **social isolation and stress** associated with the public stigma of mental illness may play a role in increased suicide rates. For those who survive a suicide attempt, the stigma felt from others can also be a significant burden and may result in social isolation, reduced psychological and somatic functioning, concealment of the attempt and grief.⁶¹

A number of studies, including in Australia, have shown very high levels of stigma and/or discrimination toward those presented to ED.⁶²

Health professional stigma however is not as pervasive as that from friends and family. Equally important are the perceptions of suicide stigma from family and friends following a suicide attempt. **Three clear patterns of stigmatising** from friends and family including: statements that indicated the individual was a burden; reactions that sought to avoid or excessively monitor future behaviours in order to conceal a suicide attempt; and actions that sought to project strength, communicating that the individual was not a burden on those close to them. These differential reactions may reduce or increase risk for subsequent suicide attempts.⁶³ Stigma may also be felt by those close to someone who has died by suicide.⁶⁴

⁵⁵ Harris & Barraclough 1997

⁵⁶ World Fellowship for Schizophrenia ; McGorry et al. 1998

⁵⁷ Kapur et al. 2016; Hegerl et al. 2013

⁵⁸ Fishbain 1999; Fuller-Thomson et al. 2016; Ratcliffe et al. 2008; Haw and Hawton 2015

⁵⁹ Schomerus et al. 2015

⁶⁰ Reavley and Jorm, 2011

⁶¹ Hanschmidt et al. 2016

⁶² Cerel et al. 2006; Milner et al 2013

⁶³ Frey et al. 2016

⁶⁴ Peters et al. 2016

In addition, the individual experiencing suicidal thoughts may **self-stigmatise** or internalise the stigma of those around them. Four themes from interviews⁶⁵ with suicide attempters concerning personal stigma have been identified:

- internalised beliefs that suicide attempts were simply ‘attention seeking’ behaviours prevented seeking or accepting treatment,
- lack of serious consideration when presenting to health services were internalised,
- being perceived as bad or dangerous resulted in self-stigmatic feelings, and
- distance and/or avoidance was another prominent theme.

Self-stigma has been shown to be a significant predictor of suicide ideation longitudinally after controlling for mental illness symptoms, age and gender.⁶⁶

Adverse Childhood Experiences (ACEs) and Suicide

Adverse Childhood Experiences (ACEs) have been linked to suicide amongst adolescent and later life adulthood.⁶⁷ Across the lifecourse, ACEs have been found to increase the likelihood of dying by suicide by 2-5 times, whilst those with 7 or more ACEs were found to be at increased odds of suicide attempt by a magnitude of greater than 30 times.⁶⁸

ACEs influence physical and mental health throughout the lifespan and can be seen in Figure 6.

ACEs particularly linked to **increased suicide risk** include those of a sexual nature, with emotional abuse, neglectful parenting and general maltreatment heightening risk of suicide.⁶⁹ Sexualised abuse is of particular interest as links are now emerging between the environmental aetiology of suicide risk and its effects upon neurological development. The interaction between the two are emerging as potent risk factors for suicide throughout the lifespan.

The **stress-diathesis model** has recently been advanced as a clear causal link between ACEs and suicide. In particular, the model stresses that ‘suicidal behaviour results from the interaction of a behavioural and biological predisposition to act on self-destructive urges, paired with a stressor or trigger such as a recent life event’ (Brodksy p. 85).

A cross sectional study compared suicidal and non-suicidal clients with mood, anxiety and somatoform (MAS) disorders. They reported that the suicidal MAS clients mostly had one or more mood disorders, multiple diagnoses, worse functional capacity, more self-harm and greater childhood abuse and neglect. Consequently, they recommend routine screening and monitoring of childhood abuse and suicidality for MAS clients.⁷⁰

Another 2016 study examined the relationship between ACEs and the mental health of over 3,300 Canadian Armed Forces personnel following deployment. Results showed that those with a history of ACEs were more prone to negative psychological and social impacts following combat exposure. These findings have wider relevance given the number of occupations exposed to acute and vicarious trauma. Finally, another recent Canadian study⁷¹ identified several individual and relationship level factors that

⁶⁵ Rimkeviciene et al. 2015; Mendoza et al 2010.

⁶⁶ Oexle et al. 2016

⁶⁷ Isohookana et al. 2012; Carlier et al. 2016; Sachs-Ericsson et al. 2016

⁶⁸ Dube et al. 2001

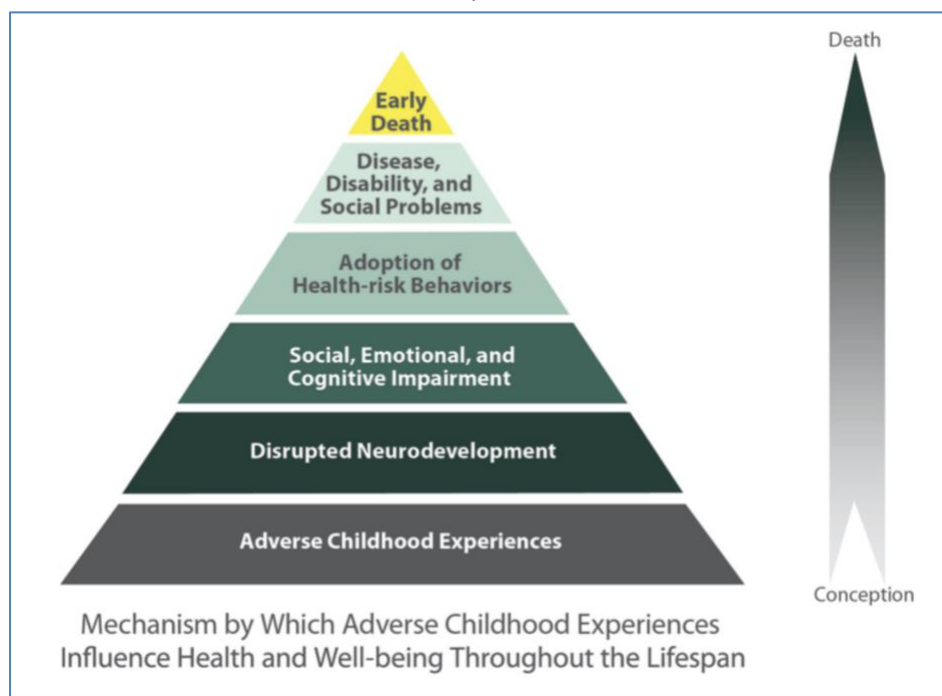
⁶⁹ Brodksy 2016

⁷⁰ Carlier et al 2016

⁷¹ Afifi et al. 2016

could be targeted for intervention strategies for improving mental health in adults with a history of child abuse.⁷²

FIGURE 6 ACEs INFLUENCE OVER THE LIFE COURSE (SOURCE: CENTERS FOR DISEASE CONTROL, ATLANTA 2016)



Adverse Life Events

Adverse life events and exposure to continued **trauma** also exacerbates risk of suicide in an individual. The correlates between stress, trauma and suicide are varied and complex. Links have been observed between sleep disturbances/insomnia and suicide with feelings of hopelessness mediating this relationship.⁷³ For those **imprisoned**, suicide rates are significantly higher when compared with the general population, and in Australia it is estimated that between 30 and 50% of deaths in prison are due to suicide.⁷⁴

Loss of a loved one to suicide may increase subsequent suicide risk for the bereaved. In a study of over 3,000 UK participants aged 18-40 those who were bereaved by suicide by either a direct family member or close friend were 1.65 times more likely to die by suicide when compared to bereavement of someone close dying by natural causes.⁷⁵

Intimate partner problems and **domestic violence** have also been found to precipitate suicide with one leading researcher pointing out that 'intimate partner problems' are one of the key differentiations between those who think and even plan suicide and those who act.⁷⁶ Both men and women have been found to be at increased risk of suicide when experiencing domestic violence,⁷⁷ and similar links are

⁷² Lee et al. 2016

⁷³ Woznica et al. 2015; Woosley 2015

⁷⁴ Carli 2015; Grigg 2016

⁷⁵ Pitman et al. 2016

⁷⁶ Comiford et al. 2016; Logan et al. 2015; O'Connor 2015

⁷⁷ Dufort et al. 2014

drawn in Australian immigrant and refugee populations.⁷⁸ Police also report a high correlation between violent acts, including family violence, and suicide by the perpetrator.⁷⁹

Often associated with trauma, stress, and adverse life events is the co-morbidity of alcohol and other drug abuse. **Alcohol Use Disorder** has been linked to suicidal ideation, attempts and deaths by suicide. Chronic and occasional cocaine use and chronic amphetamine use have also been linked to attempted suicide.⁸⁰

Indigenous People

It is important to note that 'Indigeneity' itself is **not a risk factor for suicide**, but the ancillary effects of colonisation, developed over time, contribute to significantly higher rates of suicide within Indigenous populations across the globe.⁸¹ Indeed, in relation to Australian Aboriginal peoples, there are no recorded suicides prior to the 1960s and no cultural history of suicide at all.⁸² The erosion of language, **intergenerational trauma**, loss of culture, identity, practices, and connection to country all contribute to significant risk factors for suicide.⁸³

In the Kimberley region of Western Australia, Indigenous suicide rates have increased over the last decade, with a marked increase in youth and female suicides. The complex erosion of culture, happening steadily over time, necessitates culturally specific and sensitive approaches to suicide prevention that go deeper than gatekeeper training, and promote and empower Indigenous communities.⁸⁴

Personality

Perfectionism and **impulsivity** are two well documented personality traits associated with suicidal behaviour.

Perfectionism has been shown to be a significant predictor of suicide risk within undergraduate populations through some researchers point to a more complex pathway concerning perfectionism and suicidality. Perfectionism has also been observed as an important variable interacting with symptoms of PTSD. Concern over mistakes from the past has been observed in the link between perfectionism and PTSD.⁸⁵

Impulsivity as a personality trait is on the other hand a well-documented risk factor for serious suicidality. The literature often implies that a key mechanism associated with suicide is a 'spur of the moment' decision in response to an adverse life event. However, the relationship between impulsivity and suicide is complex. Thomas Joiner (2005) explains:

"Impulsivity is implicated not so much at the time of death, but beforehand, leading to experiences that allow people to get used to pain and provocation ... Through repeated impulsive acts, suicidal and otherwise, impulsive people may become experienced, fearless and competent regarding suicide and thus capable of forming plans for their own demise".

⁷⁸ O'Connor et al. 2016; Procter et al. 2013

⁷⁹ The lead author has held discussions with Police Area Commanders in a number of regions in Australia in Qld, WA and NSW.

⁸⁰ Britton et al. 2015; Darvishi et al. 2015; Artenie et al. 2014

⁸¹ Tatz 2004; Hatcher 2016

⁸² Hunter and Milroy, 2006

⁸³ Ferguson et al. 2016; Tempier 2016

⁸⁴ Kuipers et al. 2016; Wexler et al. 2014

⁸⁵ Bender et al. 2012), Flamenbaum & Holden 2007; Flett et al. 2016

Neurological and Genetic Factors

Genetic and epigenetic (non-genetic influences on gene expression) risk factors for suicide have come under increasing investigation in recent times, and present complex understandings of how an individual's genes and heritability can affect suicide risk.⁸⁶

Twin and family studies have shown that identical twins of suicide victims have an increased risk of suicide themselves, when compared with non-identical twins, suggesting that suicidality has a genetic component, which may be independent (although related) to the genetic predisposition for mental illness.

Suicidality may occur due to a reduction in the brain's synaptic function in the frontal lobes – that is, the connections between the different parts of the brain are reduced – particularly following the onset of mental illness (e.g. major depression) and/or the occurrence of stressful or traumatic life experiences, such as sexual and/or physical abuse. The **reduced synaptic connections** and communication between different parts of the brain may also lead to the disintegration of the brain's grey matter, causing further dysfunction. This dysfunction within the brain may then increase the likelihood that an individual will experience suicidal thoughts and behaviours.⁸⁷

Importantly, whilst mental health may elevate risk for suicidal behaviour, specific genes and their interactions with each other may explain elevated suicide behaviour risk in the absence of mental illness.⁸⁸ The plethora of gene's being investigated is beyond the scope of this submission, however Lin and Tsai provide an overview of genetic and neurochemical research.

The emergence of **epigenetic research**, whereby environmental factors influence the development and expression of gene make up, presents further fertile ground for exploration regarding risk factors for suicide. As discussed earlier, the impact of ACEs is being investigated for their effects on gene expression. Of critical importance are the **early years of a child's life**, whereby *"the social and physical environment defines lifelong trajectories of physical and mental health"* (Brodsky 2016, p. 86).⁸⁹ Trauma in the early years can impede DNA methylation (the process of genes adapting to their environment), and as a result, influence future suicidal behaviours.

Multiple Risk Factors

A great deal of research focussing on risk factors in isolation can be problematic, in part due to the geographical and historical heterogeneity of suicide risk and the lack of external validity that arises from poor sampling methods. To overcome these limitations there have been promising efforts in epidemiological studies that assess **constellations of risk factors** for suicide behaviours.⁹⁰

As highlighted here:

"Several predisposing and precipitating risk factors such as marital and interpersonal relationship disruption, occupational and financial stressors, recent heavy substance use and intoxication as well as a history of previous suicide attempts and sexual abuse combine in an additive fashion with personality traits and mental illnesses to intensify risk for suicidal behaviour".⁹¹

In a recent Australian case–control, psychological autopsy study, the suicidal characteristics of young males without a psychiatric diagnosis were examined. A number of indicating behaviours were more frequently displayed, including evidence of previous attempts, disposing of possessions and making

⁸⁶ Yin et al. 2016

⁸⁷ Bennett 2009a; Fu et al. 2002; Glowinski 2001; Bennett 2009b

⁸⁸ Sokolowski et al. 2015

⁸⁹ Turecki 2016

⁹⁰ Nock 2016; Borges et al 2010; Yuodelis-Flores & Ries 2015

⁹¹ Yuodelis-Flores & Ries p. 98

statements of hopelessness. These individuals also presented with higher levels of neuroticism and aggression and had experienced relationship difficulties and poorer quality of life.⁹²

Combining risk factors with **real-time machine learning** analytics is seen as a positive step forward to accurate prediction of suicide attempt, an avenue which is currently being explored.⁹³

2.1.3 Caution on Risk Factors

In a recently completed **seminal work** examining risk factors for suicidal thoughts and behaviours, a large team of researchers at Harvard, Boston and Vanderbilt Universities, conducted a meta-analysis of 365 studies from the past 50 years. The meta-analysis reviewed over 4,000 risk/protective factors. The key finding from this enormous study is stark:

“... that, at least within the narrow methodological limits of the existing literature, existing risk factors are weak and inaccurate predictors of STBs. Analyses also revealed the following: predictive ability has not improved over the past 50 years ...”

To be clear: the **predictive ability** across **odds ratio**, **hazard ratio** and **diagnostic accuracy** analyses was **only slightly better than chance**. This is a profoundly important finding from this exhaustive study with significant implications for any suicide prevention strategy.⁹⁴

It is important to note that most studies only evaluated one risk factor, rather than analysing multiple factors that may contribute to suicide deaths. The aetiology of suicide in reality is a constellation of varied risk factors that vary in intensity over time, and as such, a personalised approach to prevention is as important as a generalised one. Nonetheless, there is value in examining here some of the factors identified prominently in the literature.

2.1.4 An Analysis of Protective Factors

As with risk factor analyses, there are few robust studies showing strong effects in relation to individual protective factors (Franklin et al) state:

There were many fewer protective factor effect sizes than risk factor effect sizes, and studies rarely set out a priority to investigate protective factors. The majority of these effect sizes were demographic factors that we coded as protective factors based on their expected associations with each outcome according to epidemiological statistics on STBs (suicidal thoughts and behaviours)”

Stronger research evidence exists in related fields of mental wellbeing, social connection and resilience and these are discussed here.

A Broader Perspective on Protective Factors.

A **broader conceptual framework of protective factors** for suicide prevention is emerging based on mental wellbeing, social connection, resilience and community assets. This framework recognises that an individual may have a diagnosis of a serious mental disorder, but that they can and do function well and live fulfilling and contributing lives. It recognises that an individual with few social connections living in a community with comparatively few ‘assets’ may be vulnerable to suicidal behaviour.

In a report (unpublished) prepared by the Young and Well Cooperative Research Centre, four conceptual models linking mental wellbeing and social connection with resilient individuals emerged in their review of the literature on the mental wellbeing of young people, being a:

- Socio-economic perspective

⁹² Ross et al. 2017

⁹³ Kessler et al. 2016; Nock 2016; Tran et al, 2013; Page et al 2018

⁹⁴ Franklin et al. 2016

- Social ecology perspective
- Strengths based perspective, and
- Mental capital perspective.

When examining young people and mental wellbeing at a community level, 2 more conceptual models were identified, namely 1) an asset based perspective and 2) a social network perspective.

The model presented in the report makes use of the key principle that “*resilient individuals are more able to contribute to their communities, while resilient communities generate social environments that nurture resilient individuals*”.⁹⁵ This also acknowledges that culture can be a significant factor adding to or dragging on individuals’ and communities’ resilience. To build resilience, rather than focussing on changing individuals, this approach focuses on making **social and physical ecologies** facilitate the development of resilience.

The model in this report parallels the approach provided in an earlier report to the Rudd Government in 2009. It pointed to the need to shift from a focus on mental (ill) health to mentally healthy.⁹⁶ The report, ***A Mentally Healthy Future for All Australians***, emphasised a population health approach building mental wealth (greater cognitive function, eliminating or ameliorating adverse life events, and reduced burdens of disease) across entire communities as opposed to overly focusing on individuals at risk or individuals already experiencing a mental disorder.

An earlier report, ***Weaving the Net***, also shown how relatively inexpensive and simple initiatives could dramatically improve a community’s resilience. In *Weaving the Net* ten regional communities were selected to identify what it was they were doing to boost the mental health of citizens and make their communities good places to live. From the research, 10 principles were set out to guide future investment in building resilient communities:⁹⁷

1. Start with what is right, not what is wrong – look at assets not deficits, wellness not illness - and trust local judgements about assets and needs.
2. In defining community, use the boundaries that people ‘know’ and recognise – this maximises the chance of a shared sense of place, a shared vision and commitment to neighbours.
3. Communities best understand their own needs and what is right and what is wrong for them.
4. Work out how best to use experts – in general they are not best used in top-down design and didactic teaching which tends to stifle local efforts and regiment models. Instead use expertise in a catalytic fashion that promotes self-organising and self-sustaining efforts. Help people create resilience.
5. Do not seek to develop in a community a neat, simple, rational system with clear and well-defined boundaries between the groups and institutions that are providing local help, support and initiative and defined links to centralised, integrated projects at the next level ‘up’ (i.e. State). While such systems look good on paper they are too rigid to allow for emergence and adaptation. Instead, redundancy, fuzziness, overlap and multiple feedback loops are optimal.
6. Nurture and build trust and try to catalyse engagement.
7. Have local volunteers helping an supporting other locals, where possible. Not only do they understand them better, this also builds trust and greater civic engagement.

⁹⁵ Burns et al. 2014 p. 19

⁹⁶ National Mental Health Advisory Council, 2009

⁹⁷ Mental Health Council of Australia 2006

8. Diversity in communities – diversity in regard to skill utilisation and option creation – is vital.
9. Help to create and sustain committed leadership in local communities.
10. Take the time it needs to make things happen. There is no quick fix.

Social Connection and Social Cohesion

It is generally agreed that **social connection** plays a beneficial role in the maintenance of psychological wellbeing and the link between social isolation and suicide dates back to Durkheim's seminal work.

A variety of terms have been used to explain aspects of social connection and the idea that social relationships shape an individual's ability to be happy and healthy – e.g. social integration, social cohesion, social capital and belongingness.⁹⁸

The first **meta-analysis of social isolation and mortality** showed that social isolation is at least as important as other well-known and researched health risk factors such as smoking, sedentary lifestyle, excessive drinking of alcohol and air pollution. This meta-analysis revealed a significant effect of social isolation, loneliness, and living alone on mortality. After accounting for all other causes, the increased likelihood of death was 26% for reported loneliness, 29% for social isolation, and 32% for living alone.⁹⁹

Connectedness therefore increases life expectancy and resilience, contributing to our capacity to collectively work smarter and thrive in a complex and challenging world with significant benefits for the individual, their workplace and the broader community.

Social support is one of the most robust correlates with **PTSD** symptoms. In a longitudinal study of US Iraq and Afghanistan veterans, they found that individuals with more social supports 1 year after deployment will report fewer PTSD specific symptoms later on. The social supports work to increase interactions and provide more opportunity to disclose and undermine avoidance. Naturalistic social interactions could thereby reduce the need for more clinical interactions.¹⁰⁰

There is potentially a flip side to the evidence that social cohesion and social integration are universal protections for individuals against suicidal behaviour where too much cohesion and conformity can increase the risks for an individual. This is particularly important work in the context of tightly knit communities with a serious suicide cluster problem.¹⁰¹

Resilience

A person's **capacity for resilience** is influenced by many factors and includes many of the individual and social protective factors listed earlier. The impact of the immediate and wider community, including personal and family relationships, workplaces, organisations that we connect with, where we live, events we encounter, all have the potential to strengthen or erode personal resilience and wellbeing.

Resilience contributes to mental health and wellbeing, which in turn strengthens resilience. When **resilience is viewed as a process** rather than a trait it provides individuals, families, organisations and communities with the knowledge and confidence that they can learn resilience strategies and skills. Their capacity to proactively and confidently manage their responses to the challenges and setbacks experienced in daily life can be significantly increased.¹⁰²

⁹⁸ Wray et al. 2011; Friedkin 2004; Portes & Vickstrom 2011; Joiner 2005

⁹⁹ Holt-Lunstad et al. 2015

¹⁰⁰ Shallcross et al 2016

¹⁰¹ Mueller and Abrutyn 2016

¹⁰² Keyes 2007; Pettigrew & Donovan 2009

Defining Resilience

Resilience is defined in several ways that identifies a capacity to recover from stress, resist illness, adapt to stressful situations or function above the norm despite stress or adversity. Resilience involves the use of behaviours, thoughts and actions that can be learned and developed.¹⁰³

A broad, straightforward definition of resilience that encompasses all the ways in which the term appears in the literature comes from an influential report on assets-based approaches to community health in the UK:¹⁰⁴

“The ability of individuals, families and neighbourhoods to cope positively with change, challenge, adversity or shock”

Increasingly society has progressed from a focus on survival to the desirable outcome of personal fulfillment and meaningful lives. While ‘bouncing back’ denotes a return to the original state of functioning whether that be from illness or adverse events, the capacity to ‘flourish’ describes a state of superior functioning. Individuals are better able to manage stressors while life satisfaction, mental health and wellbeing are increased.¹⁰⁵

Resilience therefore is ordinary, not extraordinary. People commonly demonstrate resilience as evidenced by individuals’ capacity to rebuild their lives after disastrous events. They are able to maintain their health and wellbeing while managing experiences that may be negative, difficult or even catastrophic.

It is also important to recognise that the diversity of individuals, and cultures, means that the development of resilience will be a **personal journey** and that strategies will vary as people respond differently to stressful life events.

Current **neuroscience research** demonstrates that resilience is a key human function, vital to our capacity to survive. It identifies the neurological and physiological link between our brains and our capacity to build resilience, providing opportunities to apply evidence-based strategies for individual and workplace application.¹⁰⁶

Maintaining resilience and progressing towards thriving requires an ongoing process of assessment, learning, application and reflection. Actively working towards and achieving a balance between physical and mental fitness, physical and mental relaxation and a sense of self and overall wellbeing contributes to the growth of resilience.

The model below illustrates 31 strengths that encourage and enhance individual and community resilience. It emphasises the importance of strong social ties and cultural bonds.

In Australia, **we have no national programs to support and build the resilience** of our citizens.

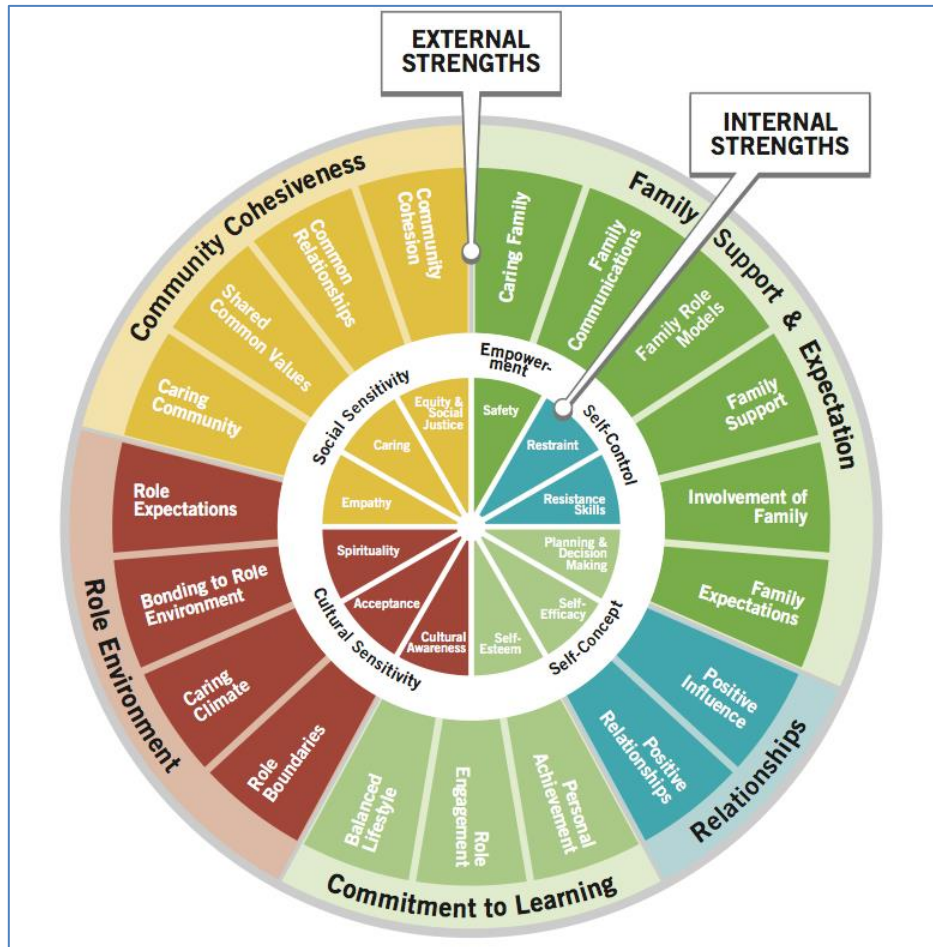
¹⁰³ American Psychological Association, 2014

¹⁰⁴ Foot 2012, p. 45

¹⁰⁵ Fuller 1998; Smith et al. 2008

¹⁰⁶ Karatsoreos et al. 2013

FIGURE 7 THE ADULT RESILIENCE FRAMEWORK (THE RESILIENCY INITIATIVE 2012)



Early Childhood Development

The flip side to Adverse Childhood Experiences is a positive effect of safe and nurturing environments for infants and children. As the Final Report to the World Health Organisation's Commission on the Social Determinants of Health on Childhood Development makes clear, many of the social and health problems, including mental illness and suicide, **"have their roots in early childhood"**.¹⁰⁷

Research into the **effects of neighbourhoods on child and adolescent development** goes back to at least the 1940s.¹⁰⁸ A now classic work, describes five theoretical frameworks for linking individual behaviours with neighbourhood effects have guided more recent research in this area.¹⁰⁹ Little of this work has infiltrated the mental health literature or our mental health or suicide prevention strategies.

The **Australian Kids in Communities Study (KICS)**, led by the University of Melbourne, represents an extension on these earlier studies and focusses on the factors that differentiate ECD outcomes in relatively disadvantaged communities. This is critical work in defining the **contextual elements** that mitigate the generalised effects of social and economic disadvantage. The KICS team has identified the foundational factors for positive early childhood development.¹¹⁰

¹⁰⁷ Irwin et al, 2007

¹⁰⁸ Shaw and McKay, 1942

¹⁰⁹ Jencks and Mayer 1990

¹¹⁰ Goldfield et al, 2018, pg 2

The most recent report states:

“The research into neighbourhood or community effects on children shows that disadvantage is often geographically concentrated and inter-generational. The community level can impact the healthy development of children, particularly on the resources that are available to families to promote good development. Research shows that in disadvantaged communities, lack of resources and opportunities can result in worse child development outcomes that can persist from one generation to the next. However, there are also many factors—such as engaged parents and families, active community organisations, and neighbourhoods that are safe to walk in and have good places to play—that can promote healthy child development even in lower income communities.”

The researchers have a **set of 13 draft factors** that differentiate disadvantaged communities doing well or poorly on ECD and a further 8 important **foundation factors** based on qualitative analysis. These are shown in the table below.

In addition the KICS researchers have identified three additional factors, they have labelled as ‘encouraging FCFs with incomplete analysis’:

- Service coordination – the coordination of services in a local community
- Sense of community – reporting strong community attachment or a sense of belonging and pride in being connected to a local community
- Natural environments - natural spaces as seen as important to young families.

From the **perspective of good mental health and suicide prevention**, this is invaluable research for planning and developing solutions for disadvantaged communities – medium term and local solutions for issues that are often driven by boarder society factors such as globalization.

The KICS project have produced a manual for communities to test the FCFs in planning and developing improved early childhood in communities.

Access to Quality Mental Health Care & Suicide

The ability to **access quality and appropriate care** is key in reducing rates of suicide, and more broadly, the experience of ill-mental health within the community. Access to care that is of high quality and varied in service type is not always straight forward and is highly dependent upon where one lives.¹¹¹ Significant numbers of people with a mental illness do not seek or receive appropriate treatment, and the needs of people who receive treatment are not consistently met.¹¹² A central element in preventing suicide is provision of psychiatric care, especially for mood disorders.¹¹³

Integrated care has been flagged as a tool to address the increasing demands on healthcare services coupled with the stagnation or, in places, contraction of workforce numbers.¹¹⁴

A rapid review of integrated care systems found that **integrated care systems** required a collection of the following elements: “(1) information sharing systems; (2) shared protocols; (3) joint funding/commissioning; (4) co-located services; (5) multidisciplinary teams; (6) liaison services; (7) navigators; (8) research; and (9) reduction of stigma”.¹¹⁵

¹¹¹ Mendoza et al. 2016; Meadows et al. 2015; Endicott et al. 2017

¹¹² McGorry et al. 2013

¹¹³ Hegerl et al. 2013

¹¹⁴ Awan et al. 2015

¹¹⁵ Rodgers et al. 2016

TABLE 4 THE LIST OF FOUNDATIONAL COMMUNITY FACTORS

Differentiating Foundational Community Factor – What KiCS found differentiates disadvantaged communities doing well or poorly on ECD		
<i>Compared with disadvantaged areas doing poorly on ECD, in disadvantaged areas doing well on ECD:</i>		
1	Income	Median household income ¹ and degree of economic diversity ² is greater
2	Highest level of schooling	A higher proportion of the community have completed Year 12 or equivalent ¹
3	Gentrification	Relatively higher income (but still disadvantaged) families are moving into the area ²
4	Housing affordability	Housing is perceived as more affordable ²
5	Housing tenure (stability)	There are less renters compared to private home owners ¹
6	Public housing	There are less public renters ¹ and fewer perceived presence of public housing ²
7	Housing density*	There is less high-rise density housing (three or more storeys) ¹ and fewer perceived higher density housing ²
8	Stigma	There is less community stigma (negative reputation) ²
9	Perceived primary school reputation	Perceived primary school reputation is better ²
10	Perceived Early Childhood Education and Care (ECEC) availability	There is more perceived ECEC services available ²
11	Perceived crime	There is less perceived crime ²
12	Historical events	There is a greater response of leaders to events that bring community members together ²
13	Local decision-making	'Novel approaches' or locally tailored initiatives or solutions (including any with a focus on social capital) have been developed because of local decision-making ²
Important Foundational Community Factor – What KiCS found is important for communities²		
14	Physical access to services	Perceived ability to travel or 'get to' services
15	Walkability	Perceived walkability to facilities and services is important for physical access
16	Public transport availability	Perceived presence of/access to public transport is important for easy access
17	Traffic exposure	Being away from traffic is important for children being safe
18	Public open space – availability and quality	Having local parks is important for young children and families. Having <i>good quality</i> parks was important for use, play and social interaction
19	Facilities – availability and diversity	Having a range of family-friendly destinations and activities is important for young families and children
20	Early Childhood Education and Care (ECEC) cost	Perceived affordability of ECEC is considered important and affects use
21	Leadership	Having local champions, leaders and boundary spanners driving local governance

¹Quantitative; ²Qualitative; *related to Public housing; ECD: Early Childhood Development

Access to such a battery of integrated care is generally not available to people seeking mental health care in Australia. This has been shown repeatedly in the **Integrated Atlases** developed by ConNetica and partners over the past four years.

Evidence from Quebec, Europe and the UK also points to the significant impact of improved access to mental health care and the quality of care in reducing suicides. These are largely epidemiological studies and not Randomised Controlled Trials (RCTs).¹¹⁶

In a meta-analysis of RCTs comparing the efficacy of various interventions to prevent suicide deaths in adults found only the WHO Brief Interventions and Contacts to be statistically significant. Various RCTs (N=53) using complex psychosocial interventions, psychotherapies (CBT and non-CBT therapies), pharmacotherapies or other higher-level care interventions (incl ECT, partial hospital admission) were

¹¹⁶ Fleury et al, 2016; Mishara, 2016), Hegerl et al, 2013; Pirkola et al, 2009; While et al, 2012

unable to show an effective in preventing death by suicide.¹¹⁷ This finding is consistent with the seemingly limited advice offered to clinicians half a century ago in the 1974 Handbook of Psychiatry.¹¹⁸

Connecting health care for people presenting to hospitals with mental health disorders was identified by the **Queensland Chief Psychiatrist** as fundamental to reducing suicides in that state. A significant number of the suicides in 2016 (24.8%) involved persons who had been seen by an ED and/or public mental health service in the seven days prior to their death.¹¹⁹ An estimated 20-30% of all suicides recorded in Australia involve patients who have not been admitted to care on presentation to ED or following discharge from acute care.¹²⁰

The National Mental Health Commission's review (2014) emphasised the need for a stronger, more flexible and integrated system of mental health care in Australia to prevent illness and keep people well. A key element of the Commission's proposed reforms and "rebalancing the system" focussed on "integrated care pathways ..., to encourage the best and most efficient use of resources".

2.1.5 Intentional Self-Harm

What we know about self-harm

There is a growing body of literature regarding intentional self-harm and suicidal behaviour. Although there are links between the two behaviours, it is important that they are not viewed on a linear scale. Intentional self-harm is deliberate injury of body tissue without suicidal intent. While there has been significant literature about risk factors for self-harming, less has been said about their function and the consequent barriers to help-seeking.¹²¹ Klonsky describes 7 functions of self-harm and indicators of associated pathways.

There is also evidence of self-harm in clinical (particularly those with borderline personality disorder/history of childhood maltreatment/neglect) and non-clinical populations. In fact, it is a pervasive and elusive phenomenon that **resists simplistic explanation** and checklists of risk factors.

TABLE 5 FUNCTIONS OF DELIBERATE SELF-HARM (KLONSKY 2007)

	Function	Explanation
1	Affect-regulation	To alleviate negative affect / arousal
2	Anti-dissociation	To end (to 'ground') the experience of dissociation
3	Anti-suicide	To replace, compromise, avoid the impulse to suicide
4	Interpersonal-influence	To seek help from or manipulate others
5	Interpersonal boundaries	To assert autonomy
6	Self-punishment	To derogate or express anger towards oneself
7	Sensation-seeking	To generate exhilaration or excitement

There is a **wide body of literature** which we would bring to the Commission's attention including barriers to help seeking and promising interventions including Cognitive Behaviour Therapy and

¹¹⁷ Riblet et al 2017

¹¹⁸ A limitation of the Riblet et al study is that it focussed specifically on death by suicide and not earlier indicators associated with suicidal thinking or behaviour. Nonetheless, it highlights how little we have advanced the science since the early 1970s.

¹¹⁹ Martin, 2017

¹²⁰ There are no reliable data available but discussions with colleagues at AISRAP indicate that this is probably the extent of suicide associated with non-admission at ED and following discharge from acute psychiatric care within a 3 month period.

¹²¹ Gratz 2003; Skegg 2005; Taliaferro & Muehlenkamp 2015; Ewing, 2016

Dialectic Behaviour Therapy, programs such as the Conversations for Life® training program, The Song Room (<http://songroom.org.au>), and several school-based programs.¹²²

Issues for Self-Harm

Like suicide, the factors that influence self-harming behaviour are complex, and the current literature varies significantly between sources. Furthermore, definitions concerning self-harm are continually under debate, with non-suicidal self-harm recently being introduced into the DSM V garnering proponents for and against the addition.¹²³

In their systematic review of longitudinal research into NSSI and DSH, Plenar et al found that self-harming behaviours peaked around the age of 16 and then declined, with prevalence rates much lower in adulthood when compared with adolescents. An earlier extensive systematic review on risk factors for deliberate self-harm and found that being female, having negative childhood experiences and being diagnosed with some form of psychopathology were all potential risk factors for self-harm. However, much like suicidal behaviours, the complexity of risk factors extends to the varied contextual dynamics people find themselves in combined with the methodological heterogeneity of studies on this topic.¹²⁴

The **link between self-harm and suicide** is equally complex, however it is accepted that those who self-harm are at a significantly higher risk of attempting suicide. The most significant predictors of suicide after an episode of self-harm according to a meta-analysis include suicidal intent, physical health problems and being male. Surprisingly, after adjusting for confounding variables, **alcohol misuse and prior psychiatric history** were not significant predictors of suicide after an episode of self-harm, however the authors caution against this finding given the multiple ways these constructs were measured across studies.¹²⁵

2.1.6 Ideation-to-Action Framework

The notion of a progression or **trajectory in suicide studies** is longstanding and widespread. The progression is steeped from thinking about suicide, to planning, to attempts and finally to death by suicide. However, the hypothesis of a continuum is probably limited to a minority of cases and then within a psycho-pathological scenario such as depression or early psychosis and should not be generalised.¹²⁶

These authors go on to make the important point that **excessive reliance on screening programs** based on the continuum of risk can result in a “*remarkable underestimation of risk*” and wrongly result in the withdrawal of surveillance and or support.

There is a growing body of research that supports an **ideation-to-action framework** based on a lifetime of accumulated risk. It could be argued that this forms the ‘emerging paradigm’ on suicide and suicide prevention.¹²⁷

In differentiating men who thought seriously about suicide and even planned the event, to those that attempted suicide (moved to act), O'Connor (2015) identified some key factors that overlayed the underlying life-time accumulation of risk. These key tipping points were intimate partner problems, cognitive impairment and entrapment.

¹²² Ewing 2016; Gunderson 2009; Ewing 2016; Klonsky 2007; Hawton et al. 2003; Robinson et al. 2013; Plener et al. 2015; Fliege et al. 2009; Galdas et al. 2005; Jones et al. 2013; Hines et al. 2013; Shelef et al. 2014; Nixon et al. 2002; Baumeister and Heatherton 1996; Owens et al. 2002.

¹²³ Plener et al. 2015

¹²⁴ Fliege et al. 2009

¹²⁵ Hawton et al. 2003; Chan et al. 2016

¹²⁶ Svetitic & De Leo 2012

¹²⁷ Joiner 2005; O'Connor 2011; Klonsky & May 2015; O'Connor & Kirtley & 2018; Mars et al 2019

Here the different sources of suffering, together with a sense of **hopelessness**, lead to the consideration (ideation) of suicide as a solution. The moderators of **connectedness** and **belonging** are important early interventions and augur well for positive outcomes. An isolated, despondent individual will be at increased risk, buffered only by the capacity to end his or her life.

2.1.7 Implications for Suicide Prevention Strategies

Despite considerable research and the production of more and more suicide prevention programs, suicide rates continue to increase in almost all regions of Australia. **There is little evidence to indicate the efficacy of routine suicide prevention strategies.**¹²⁸

Indeed in some regions of the world where suicide prevention strategies have been developed and deployed and have shown associated reductions in suicide rates, they have occurred during a period of broader social change – such as a period of renewal/revitalisation in government, national identity and economic prosperity. The cases of Scotland, Ireland and Quebec are all relevant here.

Based on these examples, it is probable that the leadership demonstrated by NZ Prime Minister Jacinda Arden, in recent weeks and if sustained, will have a positive effect on suicide rates in that country.

Models for suicide prevention activity typically look for a balance of (a) reducing risk factors, and (b) increasing protective factors. For any individual (or group) that requires an understanding of the individual, social and contextual factors, and which of these (or combinations) are modifiable. An understanding of risk factors can usefully assist (and no more) the identification of groups for whom a particular concern has been identified (e.g. exposure to trauma).¹²⁹

The risk for suicide is a complex balance of risk and protective factors, particularly when risk reduces the ability to cope with difficult circumstances. Risk and protection factors can exist at three levels:

- The individual's health, personality, and experience
- The social connection to family, friends, and community, and
- The contextual life events and circumstances to which an individual belongs.

Some things can be changed or modified (e.g. an understanding of health); some things are fixed (e.g. an individual's age). Risk is a complex interaction of distal factors (e.g. impulsivity) and proximal factors (e.g. negative life events), and these will vary with individuals and with groups or identifiable sub-populations.¹³⁰

The complexity of the interaction between risk and the individual's circumstances is an important consideration, and simplistic solutions should be rejected.

¹²⁸ Klonsky and May 2015; Riblet et al, 2017

¹²⁹ Gradus et al. 2013

¹³⁰ Platt and Hawton 2000

3 Skills acquisition, employment and healthy workplaces

Regrettably we do not have the capacity at present to address this critical issue within this submission. ConNetica has undertaken extensive work over the past 12 years in relation to employment and workforce development.

This has included four place-based Job Service Australia trials to engage long-term unemployed individuals in enhanced case management and support; an intensive case support program in regional Queensland for 40 very long term unemployed men; a 3 year national demonstration project focussed on jobless or intergenerational jobless families in SE Queensland; a review of the Australian Disability Enterprise sector and development of workforce strategy.

Further, we have undertaken skills audits and workforce analyses for the community mental health workforce in Queensland and the home and community aged care workforce across Queensland. We have also developed and delivered a range of professional development programs on leadership, advocacy, policy analysis and mental health awareness.

We would welcome the opportunity to discuss this work and the generalisable findings with the Commission.

Two points we would make here:

1. There are almost no incentives for Australian workplaces to create, cultivate and maintain a mentally healthy workplace. Where management does not see the costs of doing nothing as greater than the costs of investment, no real change will occur. In the US and some European jurisdictions there is a direct bottom line impact for companies that invest in the wellbeing and mental health of their employees. In Australia, corporations are able to access free resources and programs paid for by taxpayers and pay little attention to the impact of these initiatives – it is a form of corporate welfare.
2. There is also no payment for companies that act in ways that adversely impact on the health of employees. Long extend hours of work, and poorly designed jobs adversely impact many workers mental health. FIFO and DIDO workers are particularly vulnerable with some 'swings' extending to 3 or 4 weeks away from their home and families. We have seen corporations that will use 'mental health promotions' as a way of covering for the poor working conditions. There are no simple answers to address these issues. Worker representative bodies, unions and third party auditors are all possible options to counter the impact of bad workplaces on the mental health and wellbeing of employees.

4 Challenges for small and medium businesses

This section will be provided to the Commission In-Confidence.

Appendix A - A Summary of Selected Innovations from across Australia and Overseas

Innovation	Summary Description	Provider/Place
AGMC	Agile Psychological Medicine Clinic - APMC was developed and implemented as a result of Monash Health's ED meeting key performance indicator targets, yet still observing significant increases in acute mental health ED presentations, and in particular, repeat presentations from the same patients within a 12-month period (Casey, 2015). The staff at Monash Health then tracked the patient journey over time, realising that whilst KPIs were being met, the needs, feelings and experience of the client themselves was overlooked. The APMC operates adjacent to the GP clinic based in Berwick and patients are 'offered an appointment in the Clinic within 72 hours of their presentation to the ED or the telephone triage service' (Casey, 2015, p. 28). The service places emphasis on the patient being actively engaged by a clinician on site in a way that mirrors closely the Collaborative Assessment and Management of Suicidality (CAMS) developed by David Jobes and colleagues (Jobes et al 2005; Ellis et al 2015; Ellis et al 2017). Much like the CAMS service, the 'Clinic's ethos is to optimise the therapeutic alliance between clinician and consumer and all activities are designed to foster this - from joint formulations to shared understandings and collaborative goal setting for treatment' (p. 28). This approach values consumer voice and ensures the consumer plays an active role in recovery formulation. Preliminary evaluations of the APMC program have been positive.	Monash Health
BoC	Behaviours of Concern (BoC) beds (4) in ED enables rapid assessment and stabilisation before decisions need to be made on an IPU admission. Where an admission is not deemed necessary, there is an opportunity to provide connection to community services. In WA these are known as Mental health Observation Area beds (MHOA).	The Alfred et al
CAMS	Collaborative Assessment and Management of Suicidality Program (CAMS) - In the US, post-discharge practices providing assessment and management of suicidal presentations to the ED have shown promise in reducing suicidality and improving wellbeing. Ellis et al (2017) evaluated the CAMS program at a major private hospital in Houston, Texas. CAMS can be described as 'a structured, collaborative framework for alliance-building, risk assessment, case formulation, treatment planning, and risk reduction with suicidal patients'. Importantly, the program champions the voice of the service user in the process, by 'cultivating a spirit of collaboration with the patient on tasks such as planning for stabilization, both during treatment and afterwards'. The improvements observed for those in the CAMS group persisted, with reduced suicidality and improved wellbeing being sustained over the 24-weeks post-discharge period (Ellis et al, 2017; Jobes et al 2005). The CASE methodology is another effective suicide assessment and management model. Both CASE and CAMS are slowly being taken up in Australia.	USA & some Australian settings
CAP	The Crisis Awareness Plan (CAP) Pilot Project is a 'shared intersectoral approach to help highly vulnerable individuals develop their own crisis plan' (McDonald & Tait, 2013, p. 4) established by WA Health. The goal of the program was to align with the 4th National Mental Health Plan and value the input of the patient in defining their recovery and post-acute crisis care plan. However, a number of impediments stood firm in the success of the CAP program, including the scheduling of multiple stakeholder involvement in CAP creation, conflicting views and expectations of the program, the time consumed to develop a CAP, and lack of engagement from key stakeholders. It was found that often CAPs were created primarily between a case manager and the individual, rather than a multidisciplinary team as originally planned. Of primacy was the need for organisational and systemic cultural change toward the way patients are viewed and engaged with when engaging in post-crisis care planning. The review stated that 'developing person centred, connected organisations is an incremental process and there is an ongoing need for strategic change management to reinforce the positive changes that have been made' (p. 7). Such positive changes included consumers feeling empowered by the implementation of a CAP and their involvement in its development - this in itself contributed to the therapeutic process.	WA Health
EPS	The multidisciplinary Emergency Psychiatric Service (EPS) sitting within ED and the links to CATT, PACER and community MHS.	The Alfred
First 1000 Days	The 'First 1000 Days' is a global initiative focussing efforts on improving the lives and environments of vulnerable infants and young children. This is a new approach to looking at early childhood development in Australia. First 1000 Days Australia is the lead agency for the initiative.	Victoria, Qld & NT

	In Australia a landmark report (Arabena, 2014) for the Victorian Government set out the strategy for adopting and implementing the ‘First 1000 days’ approach as a key element of Closing the Gap initiatives to address some of the key health challenges experienced in the ‘First 1000 Days’, especially modifiable health risks (e.g., smoking, STIs, experience of violence, incarceration, mental ill-health, drug and alcohol use, need for nutrition). The knowledge will be generated from pilot studies, data linkage projects, health economic assessments and coordination of services across sites. First 1000 Days Australia recognises that implementing strategies into regional areas not only takes time, but that all regions have differing needs and capacities. To ensure that appropriate governance, training and engagement processes are undertaken, regions implementing First 1000 Days Australia move through three stages – Advocate Site, Champion Site and Alliance Site. Each stage corresponds to specific processes to enable appropriate and regional-specific governance processes to be embedded, and training and development to enable qualified and accountable coordination of First 1000 Days Australia strategies and evidence generation. At present sites in Victoria, Northern Territory and Queensland are working toward becoming Alliance sites.	
HITH	Hospital in the Home services. In a review undertaken by ConNetica, HITH services were “universally praised by service providers, consumers and carers”. In WA there are both Youth Hospital in the Home (YHITH) and adult Hospital in the Home (HITH) services offered which provide assurance to consumers and carers that their mental health and ability to support themselves post-discharge was being monitored in the interim between discharge and returning to the community. HITH staff attend sometimes 3 times a day to provide support for the consumer in the home. HITH has the capacity to take on higher risk consumers.	WA Health / Charles Gardiner Hospital
HMHP	Housing Mental Health Pathways Program - The effective transition out of hospital for an individual with a mental illness is of critical importance. Connecting the individual with support services and ongoing assistance may prevent hospital re-presentations and protect against an escalation in the person’s distress state (King et al, 2001 ; Pirkola et al. 2009). Of import are the social services that are engaged for an individual post-discharge from the hospital environment (Hengartner et al 2016a, 2016b, 2017a, 2017b). At present, there is one service in Victoria (known to the authors) offering housing support for at-risk individuals exiting the hospital system in the South East Melbourne, run by HomeGround Services. Similar services operate in Inner Brisbane with both the Princess Alexandra and Royal Brisbane hospitals and in Perth with the Charles Gardiner. Launch Housing run a Housing Mental Health Pathways Program which supports acute mental health patients with co-occurring history of homelessness at time of discharge. Currently the services assist patients at St Vincent’s and The Alfred Hospitals. At discharge the service can be referred to and assist the patient in accessing accommodation and housing support (Launch Housing, 2016). Eligibility criteria for access to the program include being an inpatient of the psychiatric inpatient unit at St Vincent’s or The Alfred, being homeless or at risk of homelessness and having multiple and complex needs.	
HOPE	Hospital Outreach Post-Suicidal Engagement - The HOPE program is part of an approximate \$27 million funding package from the Victorian Government to reduce suicide and improve transition care for those leaving an ED, hospital or a mental health service following a suicide attempt. The program was initially established to run for four years and be trialled at several hospital sites across the state including metropolitan hospitals (The Alfred, Maroondah, Frankston and St Vincent’s) as well as regional hospital sites (Geelong and Albury Wodonga). Evaluation of the HOPE program is yet to take place, however since programs began over 500 people had received support. The program is progressively being rolled out to other hospitals across the state. The most recent Victorian State Budget (May 2018) provided funding to extend the HOPE initiative to a further six hospitals.	Victoria
HOPS	Homeless Outreach Psychiatric Service - HOPS at The Alfred Hospital in inner Melbourne provides comprehensive mental health assessment, treatment and support to adult clients aged 18-64 who are experiencing mental health issues and are homeless or at risk of homelessness. The HOPS team provides: psychiatric assessment and treatment; clinical case management; family and carer support; and specialist allied health interventions. The team works in partnership with the consumer, their family and the community to reduce the impact of mental illness, improve quality of life and promote recovery. They also work in partnership with local homeless services Sacred Heart Mission and Launch South Bank to provide secondary consultation and assessment to clients that are accessing their services. The HOPS team is also developing stronger links to GPs for ongoing physical and mental wellbeing of clients.	The Alfred & St Vincent’s

HTP	Hospital Transitions Pathways - In 2015, ConNetica undertook the first of a series of projects with PHNs and hospitals aimed at improving the consumer experiences of transitions to and from hospital (Mendoza et al. 2015). The HTP program methodology has been applied to 4 hospitals in Brisbane North, 4 hospitals in WA & 2 in SE Melbourne. The aims of these projects were to identify strategies to improve the “patient and carer experience”, quality of the transition to, through and from hospital, and health outcomes. A whole-of-systems catchment approach was taken to review these pathways. Each project involves engagement with the respective hospital’s ED and mental health unit, the key community sector agencies and where possible GPs and most importantly, consumers and carers. Interviews, focus groups and a review of hospital documentation are undertaken to understand and accurately reflect the current or “As Is” system of transitions to, through and from hospital for mental health related presentations and admissions. Input from the stakeholders plus regional data and international evidence on improving the experience of care for consumers and carers is then used to create hospital specific “To Be” models of care to guide systems approaches to improvement. The implementation of the “To Be” model and recommended actions is then the responsibility of the local stakeholders. This hospital catchment, systems approach ensures there is a focus on reducing demand or presentations at ED, matching patient flow to in-hospital resources and ensuring there is a consistent process for transitioning (not discharging) consumers to the appropriate forms of continuing care out of hospital.	ConNetica
In-reach	In-reach by community service providers in the lead up to hospital discharge is occurring in a number of hospitals across Australia. However, it is rarely well-coordinated, integrated into practice and highly dependent on individual clinicians. Furthermore, the rollout of NDIS is significantly reducing the capacity of NGOs to work with hospitals in support transitions form acute care to community care.	Various
Illinois Living Room	The Living Room (TLR), is an outpatient, voluntary program for persons in emotional distress, operated by Turning Point Behavioral Health Care Center and funded through the Illinois Department of Mental Health. Findings from a qualitative study of this recovery-based alternative to hospital EDs for persons in emotional distress are supported by anecdotal and empirical evidence that suggests that non-clinical care settings are perceived as helpful and positive. It offers same day support for people experiencing a mental health crisis.	Illinois USA
Maytree Centre	The Maytree Suicide Respite Centre is the only place of its kind in the UK and fills a gap in services, between the medical support of the NHS & the helplines & drop-in centres of the voluntary sector. Founded in 2002, the service runs 24 hours a day, 365 days a year. Maytree offers a free 4-night/5-day stay in a non-clinical setting, & the opportunity to be befriended & heard in complete confidence, without judgement & with compassion and warmth.	London, UK
Nundah House	Nundah House, is the first alternative to admission facility. It is in the Brisbane North PHN region and follows a key recommendation in the HTP report undertaken by ConNetica in 2015. It is a purpose built, 10 bed facility to support the transition between acute and community services for adults with mental health issues, providing short-stay services to support people who are becoming unwell or people who are in the early stages of recovery from an acute illness and need a short period of additional assistance in a residential setting. All consumers to be referred must be open to MNMH. Nundah House will be operated in partnership by a clinical team from MNMH and a psychosocial support team from Neami National.	BNPHN
Place based Initiatives	Place Based Suicide Prevention program - The Victorian Government is supporting local communities to develop and implement coordinated place-based approaches to suicide prevention. These trials will see all relevant organisations and services working together to deliver effective suicide prevention at a local level, this includes: • implementing a range of evidence-based, coordinated strategies at the same time • multi-sectoral involvement by all government, non-government, health, business, education, research and community agencies • governance within a local area, and • demonstrating sustainability and long-term commitment. Place-based trial locations are Ballarat, Brimbank/Melton, Latrobe Valley, Mildura, Mornington Peninsula/Frankston and Whittlesea. The Victorian Government is partnering with PHNs to deliver the place-based trials. PHNs have expanded on this investment establishing six additional sites in Macedon Ranges, Benalla, Great South Coast, Bass Coast, Dandenong and Maroondah.	Victoria

Project Solus	Project Solus is a joint project between the Queensland Forensic Mental Health Service (QFMHS) and Queensland Police Service and has been acknowledged as one of Australia's best in crime and violence prevention. The Queensland Fixated Threat Assessment Centre (QFTAC), part of QFMHS, was awarded gold in the 2017 police-led projects at the Australian Crime and Violence Prevention Awards for the Project Solus initiative. QFTAC is the first service of its kind in Australia. It provides risk assessment and intervention for fixated people, many of whom have untreated or undiagnosed mental disorders. A similar initiative is now underway through Victoria Police Fixated Threat Centre.	Qld Police Service & Victoria Police
PSW	The placement of Peer Support Workers in ED , acute care units and PARC services is increasing across Australia. There is a growing body of evidence to support this in terms of reducing acuity and risk of suicide.	
NPS	Psychosocial Support for People with Severe Mental Illness - the Federal Government has reached agreement with the states and territories to provide an additional \$160 million for four years for Australians with severe mental health illness. The new national psychosocial support measure will provide funding for people with severe mental illness who are not more appropriately supported through the National Disability Insurance Scheme (NDIS). The NDIS will provide comprehensive care for an estimated 64,000 people with severe, persistent and complex mental illness. Mental Health Australia in a submission to the Productivity Commission in 2016, estimated the number of people requiring psychosocial support but ineligible for NDIS, was approximately 229,000 and a further 153,000 carers. The new funding will be allocated to each jurisdiction on a population basis and will be delivered through the Primary Health Networks." The amount of funding needs to be put in the context with the number of people requiring support. The funding for Victoria will amount to \$9.6 million per year. Using the MHA estimates (and excluding carers), there are an estimated 55,100 individuals in Victoria that have severe mental illness not ineligible for NDIS and 13,740 people in the EMPHN region. EMPHN's share of funding is estimated to be \$2.39 million (\$174.23/person/year, or around 4 hours of psychosocial support using the NDIA payment scales.	DoH
Safe Spaces	This is collaborative project supported by Aftercare, Encircle, Richmond Fellowship Qld and Wesley Mission Qld to provide alternative places for people to present to when they require support.	BNPHN
SEYLE	The SEYLE study was one of the most important studies on school-based programs for the prevention of suicide undertaken to date. SEYLE is a multi-centre, cluster-randomised controlled trial. The SEYLE sample consisted of 11,110 adolescent pupils, median age 15 years, recruited from 168 schools in ten European Union countries (Wasserman et al 2015). Schools were randomly assigned to one of three interventions or a control group. The interventions were: 1) Question, Persuade, and Refer (QPR), a US-developed gatekeeper training module targeting teachers and other school personnel, 2) the Youth Aware of Mental Health Programme (YAM) targeting pupils, and 3) screening by professionals (ProfScreen) with referral of at-risk pupils. The findings showed that at 12 months post intervention, the YAM was associated with a significant reduction of the incident of suicide attempts, and severe suicidal ideation, compared with the control group. Neither QPR nor ProfScreen showed any significant effects. The findings from SEYLE have many similarities to the PBIS schools programs developed by John Hopkins University and the SEAL programs developed in the UK by Katherine Weare and colleagues and place the emphasis on personal and social effectiveness rather than mental health and suicide prevention per se..	Europe
n/a	Transitions Team - The Alfred has established a Transitions Team to assist consumers go back to primary and community care and reduce the time and number of clients 'stuck' in the Community Care Unit. Along with CATT, the Transitions Team and Community Care Teams are working to ensure consumers are only hospitalised in acute care, when absolutely necessary.	The Alfred
VPER	Victorian Police Emergency Referral Service – this is an electronic referral service that can be used by Police to refer a person for a range of serious health or chronic conditions. There are 20 categories listed for referral – mental health referrals are the second highest with over 600 referrals a month to the Monash health mental health Triage line. The triage service must respond to the referral within 72 hours of receipt from Victoria Police. Over 70% of referrals follow through with engagement. Jesuit Social Services provide specific postvention support following suicide or attempted suicide.	Victoria Police - statewide
ZERO Suicide	ZEROSuicide initiative is seen as a best practice systematic and programmed response to reducing sentinel events for 'behavioural care' patients in the US. ZEROSuicide is a key	USA & Gold Coast

	concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (NAASP), a project of Education Development Centre's Suicide Prevention Resource Centre (SPRC) and supported by SAMHSA. After researching successful approaches to suicide reduction, the NAASP's Clinical Care and Intervention Task Force identified seven essential elements of suicide care for health and behavioural health care systems to adopt: • Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles. • Train – Develop a competent, confident, and caring workforce. • Identify – Systematically identify and assess suicide risk among people receiving care. • Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means. • Treat – Use effective, evidence-based treatments that directly target STBs. • Transition – Provide continuous contact and support, especially after acute care. • Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. Zero Suicide is a philosophical commitment to relentlessly pursue a reduction in suicide and a systems methodology for improving care in a health care system. It is important to note that almost all the evidence on the effectiveness of the ZEROSuicide comes from vertically integrated healthcare systems in the US. These are healthcare organisations that provide primary, specialist and tertiary care to members.	University Hospital Qld
WBSS	Way Back Support Service - WBSS is funded by donations from the Movember Men's Health Foundation and funding from the Federal Government. The service is run by beyondblue. The service commenced in 2014. WBSS has been developed to support people for the three months after they've attempted suicide. WBSS is delivered to people who have been admitted to a hospital following a suicide attempt or people experiencing a suicide crisis. Partnering hospitals assess and refer people to WB Support Coordinators who then contact the person within 24 hours and work with them to develop a safety plan. The plan includes setting goals tailored to the individual which encourages them to re-engage safely in everyday life. It also reduces barriers to accessing follow-up care and tracks appointments with health and other social support services. Support Coordinators keep in touch with people regularly, either face to face, by phone and/or email. The level of support provided varies according to individual need for up to three months. Evaluations of WBSS - An evaluation of an 18-month trial of the program in Darwin was conducted for beyondblue and NT Health between June 2014 and December 2015. A total of 122 referrals were made and support (engagement) was provided to 87 people. The number of people admitted to Royal Darwin Hospital with suicidal behaviour is not stated in the report (Ernst and Young, 2016). In conclusion, the evaluators reported: <i>The available evidence obtained through this evaluation strongly supports that WBSS was an appropriate and feasible service model that met the needs of people who have attempted suicide, or experienced a suicidal crisis, and has a role in filling a critical gap in the service system. The small sample size and limited range of outcome measures available makes extrapolation to other jurisdictions difficult, and therefore, generalisations on scalability tentative.</i> It does not include any data on suicide deaths or other outcomes for the client group. The lack of data on the WBSS makes it difficult to draw any robust conclusions regarding its efficacy or efficiency. In one region which began services in Jan 2018, it was reported that in the first four months of operations only 1 client had been referred and engaged in support.	beyondblue
WiS	Walk in Service - Metro North Adelaide MHS, under the 2011-12 National Partnership Agreement initiated by the Gillard Government, established a 'walk-in' centre in Salisbury, South Australia, to reduce the number of mental health related presentations at one hospital ED unit. After just 18 months of operation, the service showed significant reductions in the number of presentations to the nearby Lyell McEwen Hospital's ED. Furthermore, clients and stakeholders reported improved outcomes. Consumers were also more likely to have continuing care connections established following presentation to the walk-in service than those who presented to the ED (Lockett, Mendoza & Davenport 2014). Similar walk-in centres in New York City run by Northwell Health have shown a significant impact on ED, with reduced presentations and improved client outcomes.¹³¹	Nth Adelaide MHS

¹³¹ The key authors visited Northwell Health, NYC, in November 2017. See <https://www.northwell.edu/find-care/locations/northwell-health-gohealth-urgent-care-centers/locations>

Appendix B – An Overview of ConNetica Training Programs

Conversations for life - Overview

Conversations for life® is a very early suicide prevention program that provides participants with the knowledge, skills and confidence to have conversations with others who are starting to show signs of distress.

This program provides participants with:

- an awareness of the prevalence of mental health and suicide in Australia
- an understanding of life events and social determinants that contribute to mental illness
- the skills and knowledge to identify signs and debunk social myths
- tailored mental health conversation planning tools
- problem solving and communication strategies that focus on mental health and early suicide prevention, and
- list of suitable referrals, support options and resources at local and national levels.

The theories underpinning the program's content and delivery, includes mental health and suicide prevention, health promotion, population health, social marketing, adult learning and change management. Conversations for life® includes a range of learning mediums - small and large group discussion, personal reflection, conversation planning tool, role plays and available services/resources.

The program can be tailored to meet each client's unique needs and context.

The program was developed by ConNetica, OzHelp Foundation and the Hope for Life program in 2012-3. No government funding was provided for the development and trialling. With our partners at OzHelp Foundation, ConNetica has delivered the program to nearly 5,000 participants across Australia.

Seven independent evaluation reports have been prepared by the Centre for Mental Health Research at ANU.

Stronger Smarter Yarns for life Overview

This program is a very early suicide prevention program, that has been developed with and for Aboriginal and Torres Islanders and non-indigenous people. Programs are always delivered by 2 facilitators, with one always being an Aboriginal or Torres Strait Islander. This training provides participants with:

- an awareness of the prevalence of mental illness and suicide in Australia generally and for Aboriginal and Torres Strait Islanders
- a strengths-based approach to social support and suicide prevention
- an understanding of the unique factors contributing to thoughts of suicide for indigenous people
- the skills and knowledge to identify signs and debunk social myths
- tailored indigenous mental health conversation planning tools
- list of suitable referrals, support options and resources at local and national levels.

The theories underpinning the program's content and delivery, includes mental health and suicide prevention, health promotion, population health, social marketing, adult learning and change

management. Stronger Smarter Yarns for life includes a range of learning mediums - small and large group discussion, personal reflection, yarn planning tool, role plays and available services/resources.

The program was developed by 2016 NAIDOC Person of the Year, Professor Chris Sarra, Adj. Professor John Mendoza and Marion Wands and trialled in three Indigenous communities. Two small grants from the ACT Health and Queensland Mental Health Commission contributed to the development costs.

Over 400 Indigenous and non-Indigenous people have participated in the program. Every course delivered to date has been evaluated.

Strengthened for life Training Program - Overview

Strengthened for life is a one day suicide prevention training program that is focused on increasing participants' skills, knowledge and willingness to support individuals who are at imminent risk of suicide.

The program incorporates:

- up to date information on suicide rates in Australia
- signs and risks factors relating to the incidence of suicide
- identification of the way personal values and stigma:
- impact one's support for people at imminent risk of suicide, and
- at risk individuals' willingness to "reach out" and seek support
- contemporary theories underpinning suicide, in particular Thomas Joiner's and Rory O'Connor's
- strategies that underpin effective support for people who are suicidal
- practical intervention and communication strategies and support services
- strategies to look after one's well being when supporting and or interacting with individuals at risk of suicide.

The theories underpinning the program's content and delivery, include mental health and suicide prevention, health promotion, population health, social marketing, adult learning and change management. The program includes a range of individual, small group and large group activities, videos, personal reflection and action plans, role plays, theory and evidence.

The program has been developed by Dr Martin Harris (UTas), Adj Professor John Mendoza and Marion Wands with support from the OzHelp Foundation. No government funds were obtained to assist the development or trialling of the program.

The program has been delivered to participants in DVA, local government and some regional communities. Every course has been evaluated.

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