



Submission to Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for those working in suicide prevention, engaging with Member organisations, governments, businesses, researchers, practitioners and those with lived experience, seeking to reduce the impact of suicide on the community.

We believe that through collaborative effort and shared purpose, we can achieve our shared vision of a world without suicide.

We've been providing national support for Australia's suicide prevention sector for more than 25 years.

As the national peak body our role is to support, facilitate collaboration and advocate for the suicide prevention sector. We support our Members to build a stronger suicide prevention sector.

We're committed to driving continual improvement in suicide prevention policy, programs and services to achieve better outcomes for all Australians.

Suicide Prevention Australia promotes the importance of an integrated and multi-faceted approach to understanding suicidal behaviour and suicide prevention, drawing on the national and international evidence as collected in the World Health Organisation's Report on Suicide 2014. We advocate for a whole-of-government approach to reducing suicide. We are focused on an integrated approach to suicide prevention encompassing mental health, social, economic and community factors. A public policy approach that addresses public health related and the social determinants of suicide is required.

Acknowledgement Statement

Suicide Prevention Australia remembers those we have lost to suicide and acknowledges the suffering suicide brings when it touches our lives. We are brought together by experience and are unified by hope. Suicide Prevention Australia acknowledges the traditional owners of country throughout Australia, and their continuing connections to land, sea and community. We pay our respects to them and their cultures, and to elders past, present and emerging.

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

Lifeline: 13 11 14

Suicide Call Back Service: 1300 659 467

www.lifeline.org.au

www.suicidcallbackservice.org.au



Suicide in Australia

The preliminary Causes of Death data released by the Australian Bureau of Statistics (ABS) showed a total of 3,128 people died by suicide in 2017: 2,348 males and 780 females¹. That's over 8 deaths by suicide every day. In 2016, there were a total of 2,866 deaths by suicide.

By way of comparison, the national road toll was 1,226 in 2017².

The annual number of deaths by suicide has been increasing over the past two decades.

- For each death by suicide, research studies estimate that up to 125 other persons are adversely affected through the grief, loss and trauma that these sudden and tragic deaths invoke;
- Every year it is estimated that over 65,000³ Australians make a suicide attempt – this translates to more than 180 every day.

Of particular concern is the tragedy of suicide amongst Indigenous communities in Australia. In 2017, the suicide rate among Aboriginal and Torres Strait Islander people was approximately twice that of non-Indigenous Australians. This has remained constant for more than a decade.

What these numbers show is that suicide is a growing concern for all Australians. We recognise that these statistics represent community members, family members, friends, neighbours, work colleagues, and loved ones.

The experience of suicide and its impacts are felt by many people in many ways. For some it's about the loss of a loved one, for others it's the experience of surviving an attempt to end their life, and for others it's about caring for a person experiencing a suicidal crisis. With this in mind, we acknowledge everyone who has been impacted by suicide.

Suicide is also an economic cost with estimates that suicide deaths and attempts account for between \$1.6 and \$6 billion per annum in direct and indirect costs.

Current Situation in Suicide Prevention

As challenging as the situation seems, there are encouraging signs.

There are thousands of Australians working collaboratively to achieve a meaningful reduction of suicide. This includes governments, the suicide prevention and healthcare sectors, workplaces, schools and communities.

¹ Australian Bureau of Statistics. "Intentional Self-Harm, Key Characteristics." Causes of Death, Australia, 2017. September 26, 2018.

<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>

² Australia. Department of Infrastructure, Regional Development and Cities. Bureau of Infrastructure, Transport and Regional Economics. Road Trauma Australia: 2017 Statistical Summary. Canberra, ACT, 2018.

https://www.bitre.gov.au/publications/ongoing/files/Road_Trauma_Australia_2017III.pdf p. 1

³ Australia. Department of Health. The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra, NSW, 2009.

[https://www.health.gov.au/internet/main/publishing.nsf/Content/A24556C814804A99CA257BF0001CAC45/\\$File/mhaust_2.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A24556C814804A99CA257BF0001CAC45/$File/mhaust_2.pdf) p.2



Australia has approximately a 30-year history of Commonwealth public policy in the prevention of suicide. The initial suicide prevention strategy, the National Youth Suicide Prevention Strategy was commenced by the Keating Government in 1995.

In 2000, the National Suicide Prevention Strategy (NSPS) was established by the Australian Government. Also in 2000, the Howard Government released the LiFE Framework (Living is for Everyone) and by 2006, most States and Territories in Australia had adopted their own suicide prevention strategies largely based on the LiFE Framework.

In 2013 the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched.

Local government involvement has been largely focused on measures to curb suicides and suicide attempts at particular public places, specially means restriction.

More recently the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) released in 2017 is the first to give a specific focus to suicide and under the auspice of the Fifth Plan a National Suicide Prevention Implementation Strategy is expected to be launched in 2020.

The World Health Organisation's 2014 Report 'Preventing Suicide, a global imperative' is also an excellent resource on suicide and suicide attempts, as well as outlining actionable steps for countries based on their current resources and context to move forward in suicide prevention.

Recent key reforms have included:

- Increased knowledge about suicidal behaviour and suicide prevention, with Australia having some of the world's most renowned researchers in this field;
- Adoption of responsive, regional approaches through Primary Health Networks (PHNs) and local health and hospital networks as a sound way of planning suicide prevention to meet local factors;
- Funding increases to suicide prevention programs;
- Suicide prevention trials, including the LifeSpan model and the trials of regional approaches;
- The Fifth National Mental Health and Suicide Prevention Plan;
- Australia has been recognised by the World Health Organization (WHO) as a global leader in safe reporting of suicide in the media. This includes adherence to language guidelines and evidence-informed resources to guide conversations about suicide as developed by Suicide Prevention Australia Member EveryMind's work on the National Mindframe Media Initiative;
- National Research Fund for Suicide Prevention;
- Commencement of quality improvement program through The Hub, with Suicide Prevention Australia and its Members.



The Economic Impact of Suicide in Australia

As well as the significant social impact of suicide, there is also an economic impact. Suicide Prevention Australia recommends that as part of this inquiry, the Productivity Commission turn its attention to the methodology and measurement of the economic cost of suicide. Following is a brief summary of some reports which seek to calculate the economic impact of suicide.

A 2018 report by Mental Health Australia (MHA) and KPMG states that suicide cost the Australian economy more than \$1.6B in 2016 with 2,866 lives lost annually⁴. This figure represents direct costs such as coronial, ambulance and policing costs, combined with loss of potential future earnings⁵.

This figure is consistent with the findings of research by Kinchin and Doran, published in the *International Journal of Environmental Research and Public Health* which estimated death resulting from suicide cost the Australian economy approximately \$1.52B based on data from 2014⁶. This research looked at data for both suicide and non-fatal suicide behaviour (NFSB), estimating the combined cost to be \$6.73B⁷. Of this total, 22.5 per cent of this cost is associated with death whilst 77.3 per cent and 0.2 per cent accounts for NFSB.

The Productivity Commission's issues paper refers to the death rate of suicide per year, noting that there has been no significant reduction over the last decade. However, as research by Doessel et al notes, a more appropriate measure of the impact of suicide is by potential years of life lost⁸. Using that methodology, The Australian Institute of Health and Welfare (AIHW) estimates that in 2015, 136,740 years of life were lost to suicide and other self-inflicted injuries across Australia⁹. This is estimated to be the third largest contributor to years of life lost after lung cancer and coronary heart disease¹⁰.

The Kinchin and Doran study estimated the average cost of a suicide resulting in fatality to be \$1.69M per incident of fatality and \$2.25M per incident resulting in full incapacity¹¹. These costs are made up primarily of lost income (and therefore taxes) and in the case of incapacity the costs of welfare payments supported by the Government¹².

⁴ *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*. Report. Mental Health Australia and KPMG. May 2018. https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. p. 55

⁵ Ibid

⁶ Irina Kinchin and Christopher M. Doran, "The Economic Cost of Suicide and Non-Fatal Suicide Behaviour in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy.," *International Journal of Environmental Research and Public Health* 14, no. 4 (March 27, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409548/> p. 9

⁷ Ibid

⁸ Doessel, DP, RFG Williams, and H. Whiteford. "A Reassessment of Suicide Measurement Some Comparative PYLL-Based Trends in Queensland, Australia, 1920-2005." *Crisis* 30, no. 1 (2009): 6-12.

⁹ Australia. Australian Institute of Health and Welfare. *Australian Burden of Disease Study 2015: Fatal Burden Preliminary Estimates*. May 01, 2018. <https://www.aihw.gov.au/reports/burden-of-disease/fatal-burden-2015-preliminary-estimates/contents/summary>.

¹⁰ Ibid

¹¹ Kinchin and Doran, *The Economic Cost of Suicide and Non-Fatal Suicide Behaviour...* p. 8

¹² Ibid



A further study by Kinchin and Doran, published in 2018, found that the total economic cost of suicide by young people aged 15 – 24 in Australia was \$511.1M per year¹³ based on research conducted in 2014. The study found that approximately 18,744 years of life were lost, 7,869 of those years would have been under the assumed age of retirement (66)¹⁴.

These costs are made up of indirect costs such as lost economic productivity as well as the cost of coronial, ambulance and police services and intangible costs such as bereavement.

More recently, a report by Mindgardens, a neuroscience network focused on neurological, mental health and substance abuse disorders released in March 2019, states that “Mental health disorders and suicide cost the nation over \$33.6 billion each year.”¹⁵

Of the \$33.6B figure, \$5.9B was attributable to suicide¹⁶. This is significantly more than the MHA report which estimated suicide cost the economy \$1.6B in 2016 however the Mindgardens report is based on analysis of the loss of productivity by persons due to suicide including factors such as “loss of productivity, decreased participation in the workforce, increased need for provision of treatment and support services and premature death and disability”¹⁷.

Both the MHA report and Kinchin and Doran estimate that various suicide prevention strategies would have a positive impact on the economic costs associated with suicide in Australia.

For example, Kinchin and Doran found that the potential impact of workplace based prevention strategies would amount to an estimated saving of \$61.26M each year with the majority of the benefits flowing to the government¹⁸. The authors estimate this to represent a benefit cost ratio of 1.5:1¹⁹.

MHA estimates that assertive outreach models of suicide prevention can have an economic saving of \$347M per year resulting in a return on investment of 1.3:1 and reducing suicide rates by 20 per cent²⁰.

Funding for Suicide Prevention

In addition to examining the cost of suicide in Australia, Suicide Prevention Australia submits that another important area for examination by the Productivity Commission is the amount and direction of suicide prevention funding by governments. There are two parts to this recommendation; the first relates to our recommendation that the Productivity Commission consider the appropriate level of investment by government for suicide prevention, commensurate with economic cost. For instance, the Mindgardens White paper states that, “In 2017, \$174.8 million was invested into cancer research

¹³ Kinchin, Irina, and Christopher M. Doran. "The Cost of Youth Suicide in Australia." *International Journal of Environmental Research and Public Health* 15, no. 4 (April 04, 2018 (Online)). <https://www.mdpi.com/1660-4601/15/4/672/htm>

¹⁴ Ibid

¹⁵ Mindgardens Neuroscience Network. *White Paper: Review of the Burden of Disease for Neurological, Mental Health and Substance Use Disorders in Australia*. 2019 p. 3

¹⁶ Ibid p. 18

¹⁷ Ibid p.10

¹⁸ Kinchin and Doran, *The International Journal of Environmental Research and Public Health* 2017 p.10

¹⁹ Ibid

²⁰ MHA and KPMG, Investing to Save p.55



and \$103.8 into cardiovascular disease, compared with \$67.3 for mental health and \$50.7 for dementia (NHMRC 2018)²¹.

The second part of our recommendation for the Productivity Commission to examine suicide prevention funding, relates to the need for an examination of the co-ordination and allocation of suicide prevention activity funding by both federal and state and territory governments.

Public Health and Well-being Approach to Suicide Prevention

We believe suicide is preventable, viewing it as a result of complicated human behaviours, the causes of which are multifactorial and inter-related – there is no single reason for a person to become suicidal or take steps to end their life.

Suicide prevention should be understood in terms of the broader perspective that a public health based, holistic view of mental health and well-being can offer rather than only focusing on diagnosing an illness and providing treatment for that illness.

It is also useful to view suicide deaths as preventable in a similar way to the views and strategies adopted on road accident deaths, industrial and workplace deaths and avoidable deaths from destructive behavioural responses to personal and social factors, e.g. family and domestic violence. Accordingly, there is a case to be made for investment in suicide prevention akin to investment in prevention of accidents and avoidable deaths in other contexts.

Governments must retain a significant role if the costs associated with suicide are to be minimised, and the participation and productivity benefits of population level mental well-being are to be maximised.

Proper attention to the Australian population mental well-being is likely to decrease suicides as a result of an overall improvement in those factors that may foster suicidal behaviour. In particular, a focus on addressing the issue of mental illness in young Australians. Half of all lifetime mental illnesses develop before the age of 14.²² 75% of mental health disorders will have emerged for the first time by the age of 25 years²³ highlighting the need to address the issue early in life. Interventions targeted to prevent and reduce mental illness and suicidal ideation amongst children and young people are critical.

Suicide Prevention Australia supports the principle of building more consistent layers of support for people in distress across Australia, as a community based capacity building exercise. On the basis that, better care for people in distress is a legitimate outcome in itself, and also in recognition that earlier responses and de-escalation of distress can perform a role in improved suicide prevention.

Upstream and preventative benefits of activities that result in a de-escalation of a distressed state can be seen as boosting the population health approach of mental health and suicide prevention.

²¹ Mindgardens, Review of the Burden of Disease, p. 27

²² Kessler, RC, Berglund, P, Demler, O, et al. *Archive of General Psychiatry* (2005), 62 (6). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication.

²³ Ibid



There is also an economic case for preventing high cost and sometimes ineffective use of more specialised health services or Accident and Emergency units at hospitals.

The Productivity Commission's inquiry offers a real opportunity to substantially address a population based approach to suicide prevention, mental health and well-being.

Areas for Reform

There are two key areas which Suicide Prevention Australia believes require change.

1. The first is the need to apply an informed and coordinated approach to suicide prevention in Australia, a whole-of-government approach to suicide prevention. It's time to concentrate on the link between suicidality and the social determinants of health, as suicide prevention is more than a mental health issue. Structural change is essential to elevate suicide prevention to a cross-portfolio focus. In accordance with this, we welcome the Productivity Commission's approach of examining both health and non-health matters.
2. The second area requiring attention is the need for infrastructure investments and capacity building to support a national suicide prevention strategy.

Further details about these recommendations follow.

1. Whole-Of-Government Approach

Global evidence as contained in the World Health Organisation Report on Suicide 2014 and in evaluations of the Australian suicide prevention strategies and the 2015 National Mental Health Commission Review, all identify that a fragmented, and mental illness-specific approach to suicide prevention is less effective than an integrated approach that encompasses primary health, mental health, social, cultural, economic and community factors.

Further, national suicide prevention strategies are likely to achieve greater impact if they balance a mix of promotion, prevention, early intervention, crisis response and aftercare/recovery functions.

Although there has been an increased focus and concerted effort in government policy and funding for suicide prevention in recent years, this has largely been limited to the health portfolio, without a clear policy stance on priorities across the mix of prevention/intervention/recovery, and has not been a whole-of-government approach with responsibilities for actions shared across portfolios.

Suicide Prevention Australia believes better cross-portfolio coordination is essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention.

Suicide Prevention Australia recommends a whole-of-government approach to suicide prevention so that all government agencies are working towards a unified, strategic national suicide prevention plan. To facilitate a whole-of-government approach we recommend the introduction of four key elements:

- The passage of a Commonwealth Suicide Prevention Act to cement bi-partisan commitment to suicide prevention and provide a legislative framework for the



development of an outcomes-based National Suicide Prevention Plan within 12 months of the new Act commencing.

- The development of a National Suicide Prevention Plan that encompasses cross portfolio approaches to suicide prevention and includes a focus on specialised interventions for identified priority population groups with a section specifically addressing Aboriginal and Torres Strait Islander suicide prevention.
- The appointment of a Federal Minister for Suicide Prevention to champion a whole-of-government approach. Remembering that suicide is not just a health responsibility, a Federal Minister for Suicide Prevention would facilitate a cross portfolio approach to prevention measures.
- The establishment of an Office of Suicide Prevention located within the Department of Prime Minister and Cabinet to enable a whole-of-government approach. The Office's work to be informed by input from people with lived experience and scientific expertise, and to include liaison with States and Territories.

2. Supportive Suicide Prevention 'Infrastructure' And Capacity Building

There is strong need to invest in a variety of supportive suicide prevention 'infrastructure' such as: data, workforce, local community mental health and outreach services, peer networks, localised and culturally relevant aftercare services, postvention responses and other community-led initiatives. Improving infrastructure and capacity building will help to support national suicide prevention strategy.

Suicide Data

Data collection for suicide is inconsistent across jurisdictions and as such we are not able to fully gain a clear picture of suicide in Australia - until we have access to that information we are limited in how we can effectively measure change. We also have limited information on people who cannot or do not access the services they need at the right time.

Data is not readily accessible to inform prevention efforts and deliver improvements and most importantly to determine whether there are more efficient and effective ways of supporting those who are suicidal.

Reliable data, with a focus on improved and coordinated data collection and retrieval, is critical to enable evidence-based policy development, planning and resourcing of suicide prevention activity, improved service delivery and outcomes, and to inform research.

Data improvements need to be made in partnership with State Suicide Registers and relevant organisations including liaison with the Australian Bureau of Statistics, the Australian Institute of Health and Welfare (AIHW) and the National Coronial Information Service.

We recommend that the proposed National Office for Suicide Prevention would play an important role in improving the integrity (accuracy and timeliness), collation (local and national information including the integration of state based data) and distribution of suicide data to assist service delivery and research.



We also recommend that the ABS National Mental Health and Well-being Survey be conducted more frequently to monitor outcomes on overall community well-being, underlying suicidality levels and suicidal behaviour, in order to help assess the extent to which suicide prevention strategies and policy/program mechanisms are working effectively.

Suicide Prevention Workforce

There is a need to build workforce capacity in suicide prevention, so that more people are trained and confident in providing support to people touched by suicide.

Complementing this, there is a need to ensure resources are allocated to upskilling communities with appropriate training to identify and respond to suicidal behaviours.

Community responses to suicide are critical to the reduction of deaths by suicide. Within communities; families, organisations, social networks and local supports, are well-placed to recognise and respond to people who are suicidal, and to initiate offers of help and support or referral to the health care system.

We recommend the development of a suicide prevention workforce strategy to quantify the size of the suicide prevention workforce needed both now and in the future, the types of occupations and geographic spread of staff required and recommendations for meeting these needs.

We recommend the workforce strategy be conducted in consultation with the National Mental Health Commission, and to include specific consideration of workforce needs as they relate to priority population groups.

We also call for a suicide prevention workforce strategy implementation plan. The plan should include measures needed for ongoing training and support to the entire spectrum of the workforce such as pre-service tertiary training and education and ongoing training needs e.g., continuing professional development, supervision and mentoring support.

We recommend that the National Office for Suicide Prevention would play an important role in leading the development of the Workforce Strategy and Implementation Plan.

Suicide Crisis Response and Aftercare

Suicide crisis response and aftercare should be clear national priorities to ensure that those who attempt to end their lives are provided with timely, appropriate and effective support.

Linkages between hospital and health care services and well-resourced community-based mental health services need to be strengthened to deliver appropriate and timely care following a suicide attempt.

Individuals leaving the healthcare system require a follow-up plan designed in partnership with the individual, their clinician, family and carers and the appropriate community services. This should be organised in a nationally consistent way.

Suicide Prevention Trials

Governments should continue to invest in, monitor and evaluate trials of systems approaches at both the health system and whole-of-community levels.



As these trials progress there will be a growing need to facilitate the co-ordination of findings from trial sites, programs and the organisations involved.

Suicide Prevention Australia would like to see a set of national standards for evaluating and reporting on systems approaches. However, as the trials are mid-stream, the most practical use of resources would be to establish a systems approach community of practice with the aim of sharing information and working toward nationally consistent and reportable evaluation practice.

Digital Health

Information and communication technology (teleweb) services should continue to be supported and resourced. We know that digital mental health services provide a cost effective, easy access pathway to assistance and information, particularly so for young people and those with low intensity mental health issues.

Critical national crisis, information and referral services such as Lifeline as well as online resources such as Mindframe are examples of highly effective public health initiatives. Suicide Prevention Australia encourages governments to further develop coordination and partnership opportunities for teleweb services as part of a strategy which recognises the role of a digital conduit for helping suicidal people.

While research and evidence continues to be generated governments should maintain a watching brief on emerging technological solutions for suicide prevention including artificial intelligence initiatives.

Rural and Remote Mental Health

The prevalence of suicide and suicide-related behaviour is markedly higher outside of the major metropolitan cities in Australia.

Improvements in the accessibility and availability of mental health and health care services, and greater collaboration between primary care and mental health services are fundamental to the early intervention and prevention of rural suicide. However, even where mental health and other services exist in rural areas they are often under-funded and under-resourced compared to those in urban areas. This contributes to delayed diagnosis and treatment of many conditions in rural and remote areas.

Suicide Prevention Australia Member, the Centre for Rural and Remote Mental Health, is an excellent source of information on these matters, including its 2017 position paper, 'Rural Suicide and its Prevention'.

Bereavement and Postvention

Bereavement specific to suicide can be said to be unique from other forms of bereavement following death as a consequence of the societal and individual stigma often associated with suicide.

Postvention responses are most effective when they are coordinated across communities and involve a broad range of stakeholders in development, implementation and review and evaluation.



Suicide Prevention Australia believes the need for improved and ongoing support of those bereaved by suicide in Australia is such that there remains a requisite need for the introduction of additional pragmatic evidence-based interventions and suicide postvention initiatives.

Role of Community

Communities play a critical role in suicide prevention. Within communities, families, organisations, social networks, local supports and workplaces are well placed to recognise and respond to suicidal persons and initiate offers of help and support or referral to the health system.

Moreover, communities play an important role in fostering protective factors for suicide prevention through the provision of social support to vulnerable individuals including follow up support, stigma reduction on help seeking and timely support for those bereaved by suicide.

A connection between government activity and community action on suicide prevention is essential for effective suicide prevention.

We support the exploration of community responses to improving well-being and assisting people in distress, in addition to clinical responses.

We are encouraged by the recent federal budget funding announcement to trial a non-clinical Suicide Prevention and Recovery Centre as it is consistent with our view that suicide prevention requires a multifaceted approach including non-clinical alternatives to care.

The Role of People with Lived Experience

Effective suicide prevention programs and services must be informed by people with lived experience. Suicide prevention activity should recognise the value of engaging lived experience in guiding reform and improving service development and planning, delivery, and evaluation, and research outcomes.

Suicide Prevention Australia believes that engagement of people with lived experience should be initiated from the start and maintained throughout the delivery and evaluation of suicide prevention programs and activities.

In conjunction with Members with lived experience, Suicide Prevention Australia has produced Guiding Principles for Inclusion of Lived Experience Voices in Suicide Prevention as follows:

- People with a lived experience have a valuable, unique and legitimate role in suicide prevention.
- Lived experience helps change the culture surrounding suicide and to preserve and promote life through compassion and understanding.
- Inclusion and embracing diversity of individuals, communities and cultures enriches suicide prevention.
- Empower and support those with lived experience to share their insights and stories with a view to preventing suicide.
- Utilise our lived experience to educate, promote resilience, inspire others and instil hope.



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- People with lived experience support, advocate for and contribute to research, evidence-based practice and evaluation.
- All suicide prevention programs, policies, strategies and services will at all levels include genuine meaningful participation from those with lived experience.
- Encourage and nurture collaboration and partnerships between organisations and stakeholders.



Aboriginal and Torres Strait Islander Suicide Prevention

Of particular concern is the tragedy of suicide amongst Indigenous communities across Australia. In 2017, the suicide rate among Aboriginal and Torres Strait Islander peoples was approximately twice that of non-Indigenous Australians. It is clear that this is a critical issue requiring renewed efforts.

The risk of suicide and self-harm amongst Indigenous communities is complicated and compounded by complex (trans) generational transmissions of violence, trauma, grief, (de) colonisation, racism, family removal, identity and cultural dislocation and loss – the effects of which are known to greatly contribute to sociocultural and economic problems and conditions, which in turn place individuals at greater risk.

Suicide Prevention Australia recognises that strategies aimed at reducing the rate of suicide among Indigenous communities must be culturally based; supporting and respecting the differences between Indigenous groups and include genuine consultation and meaningful engagement with each Indigenous group for which suicide prevention strategies are intended. This enables services to deliver with, rather than to, communities.

In addition, the role and potential of community based, family centred care giving and ‘self-determination’ is central to protection against Indigenous suicide and self-harm.

Suicide Prevention Australia wishes to draw the Productivity Commission’s attention to some of the activity in Indigenous suicide prevention including;

- The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention which has undertaken an evidence based review for what works in Indigenous-led suicide prevention. This includes an identification of success factors for Indigenous suicide prevention and a series of recommendations for all future Indigenous suicide prevention activity,
- the Gayaa Dhuri Proud Spirit Declaration launched in 2015 which comprises of five themes on Aboriginal and Torres Strait Islander Leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander Peoples, and
- The Australian Government’s National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Economic Well-being 2017-2023.

Further Information

Suicide Prevention Australia is the peak body for suicide prevention in Australia, representing over 240 Members and Associates. A large number of Suicide Prevention Australia Members are lead organisations for particular suicide prevention activity, e.g., postvention, lived experience, youth etc. In this submission we have directed the Commission’s attention to the work of some of our Member organisations, however we are able to facilitate introductions to other Suicide Prevention Australia Members working in specific areas of suicide prevention activity the Commission may wish to consider in more detail.