



IT'S TIME WE TALKED – LOUDER!

On behalf of those people who read this report ,I wish to acknowledge Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. Further , we acknowledge that Aboriginal communities are steeped in traditions and customs, and we respect this. We acknowledge the continuing leadership role of the Aboriginal community in striving to redress inequality and disadvantage and the catastrophic and enduring effects of colonisation.

(adapted with thanks from the Royal Commission into Victoria's Mental Health System)

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FOREWORD

It was November 2018, and I had been talking with a friend about Suicide Prevention Networks. I was asked to join the local group, starting in 2019. It was about time for me to get involved. I was ready and emotionally strong enough to be more deeply involved. I wanted to see if I could contribute in any small way towards community participation in Suicide Prevention.

We lost our son, Aaron, on Saturday 19th July 2014. Early that morning, he drove down a highway, about a ½ hour from his home. He stopped his car and jumped from a bridge. Two police officers knocked at our door about 1.30 pm and asked if they could come in to talk with us. We had no idea what was about to happen to our uneventful, happy, loving and closely connected family. I can't begin to describe what happened next, the hours, days, weeks and months that followed. Our other children were contacted and came to our home, we visited the coroner's office in Glebe the next day, saw Aaron, we planned and attended the funeral.

Aaron's toxicology report came in. He had no drugs or chemicals in his system, not even coffee. He was 32, single, and lived alone in his three bedroom villa in the same suburb as his parents and his younger brother and his wife. Our daughter lived in the same city, Sydney, while our other son lived with his family in Japan. All four of our children are university educated. Aaron was a Civil Engineer and worked for a local council in Asset Management. He was a highly functioning, highly connected, happy, physically healthy person with a large group of close friends that he saw regularly. He was much appreciated at his work and he had worked there for nine years.

We are a close family; we saw each other very regularly at family events or just when calling by. Aaron was a talented artist who crafted his own guitars and played in a band with friends. We had no idea that anything was wrong, but it was. He left no note. We were left with no idea why.

Aaron had taken his life and, in turn, our lives changed in an unimaginable way. Our lives were shattered. Just to make our lives "more" shattered (if that were at all possible), we had a call from my wife, Lynn's family that her dad had only days to live. That call

came only 10 days after we buried Aaron. We had to leave our family, our son from Japan staying in our house, and fly to the USA. Lynn's father, Jim, passed away only a month after Aaron. Could life events be any more painful in timing?

We had help from our family doctors. They guided us both to take up grief counselling. The counselling helped, though I also required medication for mild depression some months later.

And, then nothing. Nothing.

I have not received a single piece of contact from any member of the public service about Aaron. To this day, we have not filled out any information related to Aaron's suicide.

On the 19th November 2018, I had a meeting with a friend from our local Homeless Steering Committee (we are the fundraising team). My friend has many years of experience of dealing with mental health and has previously attempted suicide. We have talked about our experiences from both sides. I was struck by her belief that we need to look at alternatives in suicide prevention services.

It was then that I knew that, if I was to provide any form of contribution to a Suicide Prevention Group, I had to become informed.

Looking for information on Suicide Prevention Networks proved to be pretty thin as I searched the Internet. I soon found an amazing range of documents from governments on Suicide Prevention/Mental Health . Pursuing this further, I searched for a condensed source of information that explained how government and other services dealt with Suicide Prevention. I then embarked on the somewhat arduous task of cutting and pasting relevant material to provide me with information that I could refer to.

I had heard that there were "issues" in Suicide Prevention, but I did not know of anything specific. I did want to find out why no data had been collected on Aaron from a personal perspective. I assumed that our information was considered irrelevant and this seemed strange, as well as quite hurtful.

So, after 12 long, hard months of reading thousands of pages, I was finally able to bring the second draft to editing and proofreading on the 25th November 2019. The timing of the initial first draft was an ironic coincidence of timing; 19th July 2019 marked exactly five years since we lost Aaron. In a further twist of timing, I saw a post from the Whyalla Suicide Prevention Network, which included a video of our Prime Minister, Scott Morrison. I was quite surprised and very appreciative of the Prime Minister's words and glad to hear of the appointment of the CEO of the National Mental Health Commission, Christine Morgan, to the new role of National Suicide Prevention Adviser, reporting directly to the Prime Minister, Scott Morrison.

The initial purpose of collecting resource material on Suicide Prevention for me to use in my community involvement has now given way to the possibility that others may wish to refer to it, and perhaps more importantly, contribute to it.

It's time to ask those who can make a difference to review this research, reflect on where we are going wrong and what we might be able to do to help those who desperately need our help. Suicide: it's time we talked LOUDER!

Ken Barnard

Written on 19th July 2019, updated on 5th January 2020 .

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For Laura.

I looked at the ending of section 8 (A case for change , and I can see that the last page of the case document is the Conclusion , and section 9 is the conclusion of the whole report , so can “The Case “ be inserted as section 7 ,

The “What people are saying ‘ then is a good separation

DRAFT

SUMMARY

The summary is divided into 3 areas :

1. the various documents produce by the Federal and New South Wales Governments, their agencies and Commissions and a local mental health district. They comprise Reports; Strategies ;Plans;Frameworks and Policies including Inquiries and Royal Commissions
2. A summary on the contents of the documents
3. Where is Suicide Prevention in 2020 , and where is success in prevention and rate reduction headed

1. GOVERNMENT DOCUMENTS ON SUICIDE PREVENTION

The Australian Department of Health has produced a variety of Mental Health Plans commencing 1993 ,culminating in the 5th National Mental Health and Suicide Prevention Plan in 2017. (it's a 5 year plan) .During that time , in 2012 , the Coalition of Australian Governments (COAG) established a wholistic governmental commitment to mental health governance and accountability arrangements.

About the same time , The Federal Government produced a National Youth Suicide Prevention Strategy in 1995, converting to a National Suicide Prevention Strategy in 2000, producing similar documents through to 2015, and a draft is in production for 2020-2025 .

There has also been the establishment of the National Mental Health Commission in 2012 , and a variety of reports have been produced including annual reviews .

Various inquiries have been conducted by committees within the Federal Government by members of parliament , their reports tend to comprise large numbers of recommendations.

In New South Wales , the government formed a Mental Health Branch in 2006 and produced Mental Health reports from 2007, and a NSW Suicide Prevention Strategy 2010-2015 as well as The Strategic Framework for Suicide Prevention in NSW 2018-2023 (noting the absence of a strategy or framework for 3 years — 2016-2018)

In similar fashion , a NSW Mental Health Commission was formed in 2012 , and a variety of reports have been tabled .

There are twenty three (23) Plans etc. provided here ,and references or at least twenty (20) other related documents , listed hopefully in some semblance of an orderly explanation of our Governments overarching involvement in Suicide Prevention .

The documents are not interconnected , or integrated . Indeed , some expire , resulting in gaps that reflect the reality of the gaps in Suicide Prevention services . Many reports have name changes , and their titles move between “Framework “ to “Strategy” , to “Plan” without – a Plan , again a metaphor of the reality of needless changes , programs that end , and at different times a new one starts (usually a trial) initiated by a new decision making group .

The criticisms of the plans etc. are so large , so diverse , and so complete , as to render it impossible to summarise . The explanation of the problem of summarising the various plans lies in the outcome – the rate of suicide in Australia remains at a higher level than in previous years , and there is no downward trend .

2. THE CONTENTS OF THE PLANS ETC.

- Virtually all of the Federal and State reports and Frameworks are aspirational toned , grandiose worded achievements that have not yet happened . Words like “ we will do this “ we will achieve that” are littered through the plan or framework, at times , in a shrill tone of wonderful outcomes about to happen within seemingly the next few months.
- There is also the ultimate aspirational statement of the future achievement “ towards zero suicides” . If the target were to be achievable even by half , even within 5 years , then that would be plausible . But , the decision makers , the people

with power , are not inclined as yet, to permit such an audacious outcome . The reality exposes the failings of the reports , they are meaningless, and damage the psyche of the lived experience who encounter these documents .

- There are also inquiries and findings and reports by agencies of State and Federal Governments , as well as a variety of organisations in Mental Health , peak bodies such as Suicide Prevention Australia , and there are affected communities such as the ATSI community , and the LGBTQI + community, and institutes such as Black Dog, Orygen, Beyond Blue etc.

These documents explain what has gone wrong in the past , what is wrong now , and why . They then explain what is needed to change and why, as well as how to make the changes need to achieve a reduction in suicides . This is the province of recommendations and priorities. They are typically eloquent , well crafted , and at times emotional explanations .

They are also the documents that have spurred achievements , albeit , chipping away at the Governments who administer the services . Yet, we continue to see losses of more than 8 lives a day to Suicide —
A tragic mockery to the espoused change: towards zero .

SIMILARITIES OF THE PLANS ETC.

It is worth noting that the 23 documents in this report have a remarkably similar pattern of contents . They seem to have a universal layout . I'm not referring to the standard formats of Foreword, Summary Conclusion etc , it's about a similar content of the body .

They all seem to repeat the same themes and observations, and most seem to avoid the core component of what is NOT a priority in the hands of those in power . The often repeated contents are :

- Complexity :references to the “ complexity “ of Suicide , and definitions/explanations are located in virtually every report on Suicide .
- Recommendations :There are 759 recommendations in those reports alone , and perhaps as many as half again in priorities and strategies.
- Facts and Figures :Each and every report etc. regurgitates the “key” facts and figures , on Suicide .These are provided in a multitude of versions as though this particular set of figures will help change things in some way. Explanations of prevalence and consequences are most common
- Economic costs: Similarly , costs of Mental Health and Suicide with accompanying hundreds and hundreds of graphs of all descriptions embellish almost every page in this area .
- Aspirations :The main body of the reports etc. comprise aspirational intentions and grand statements such as “ this will be done” and “the #@\$%¥ department or committee will.....”. The level of aspirational language of plans , reports and strategies reach, at times, as mentioned earlier a shrill level. Those aspirational statements are later brought back to the real world by Commissions , inquiries and institutions who , in turn, expose these aspirations to an endless list of failed processes , and inadequacies . well as Government Departments own critical observations . The proof – irrefutable.
- Reform : Is a catchcry postured and exalted with many statements that reiterate/repeat /endorse earlier reports etc.
- Our Mental Health System : Federal and State systems are described and critically observed. This is the province of the word “*complex*”.
- Peoples experiences : There are a variety of contexts , and many are moving examples of what is not happening .there are also examples of what is happening that is working , however , these stories are rare .
- References to especially heavy impacted members of our community: There is a reference in virtually every document on our indigenous community. There are also many references to the LGBTQI +, CALD, Post Traumatic Stress of Military and First Responders . Residents of Rural And Remote communities

There is , however, silence in the matter of *power* in regards to the plans strategies etc. There are fortunately, references by the Productivity Commission , the Royal Commission in Victoria , and the National Mental Health Commission on the matter .

3. WHERE IS SUICIDE PREVENTION IN 2020

The major relevant national planning document , the 5th National Mental Health and Suicide Prevention Plan, 2017; said in its Preamble “the current approach to suicide prevention has been criticised as being fragmented, with unclear roles and responsibilities across governments. This has led to duplication and gaps in services.” p35

The National Mental Health Commission (NMHC) articulately sets the mental health scene as at November 2014 .It is as relevant today as it was 5 years ago.

“The need for mental health reform enjoys long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Our “mental health system”—which implies a planned, unitary whole—is instead a collection of often uncoordinated services introduced on an often ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.

We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity

- rebalance expenditure away from services

which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training

- repackage funds spent on the small percentage

of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care

- reform our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia’s wealth.

From: Where we are now

Stigma persists

People with lived experience, families and support people have a poor experience of care

- A myriad of sources of information and advice
- Distressed individuals having to provide the same information to multiple organisations
- Vulnerable people left to navigate a complex and fragmented service system
- Families and support people excluded from consultations and planning
- Limited choice
- Specialist services where the clients have to come to them

A mental health system that doesn’t prioritise people’s needs:

- The Commonwealth’s main programmes focus on generating activity: not necessarily on making anyone better
- A high level of unmet need, with many people not seeking necessary support. A person’s mental health and circumstances may deteriorate and become more complex

A system that responds too late

A mental health system that is fragmented:

- A myriad of siloed funding streams and programmes focused on providers
- Highly variable access to quality services largely depending on the “luck” of where people live—or their income—leading to great variation in services provided and the outcomes achieved
- Poor planning, coordination and operation between the Commonwealth and the states and territories, resulting in duplication, overlap and gaps in services

A system that does not see the whole person

- People being discharged from hospital and treatment services into homelessness, or without adequate discharge planning
- High rates of 16–25 year olds with a mental health condition who are ‘Not in Education, Employment, or Training’ (NEET)
- Poor physical health among those with severe and persistent mental health problems
- High rates of unemployment among adults with a mental illness and their support people

A system that uses resources poorly:

- A fragmented mental health workforce where many clinicians work in isolation of each other, and do not operate at the top of their scope of practice
- The greatest level of funding goes into high cost areas such as acute care, the criminal justice system, and disability support, indicating that the system has failed to prevent avoidable complications in people’s lives
- Research is carried out in isolation of mental health strategic objectives, with a haphazard approach to evidence translation into practice

Fragmentation of services:

A myriad of providers, many of them with limited capacity and poor economies of scale

In 2015, the Australian Governments Response to : CONTRIBUTING LIVES, THRIVING COMMUNITIES – REVIEW OF MENTAL HEALTH PROGRAMMES AND SERVICES by the NMHC, advised as follows :

“A renewed approach to suicide prevention” :

The Federal government will commit to “A new national suicide prevention strategy (which) will be implemented immediately, with four critical components:

- national leadership and infrastructure, including whole of population activity and crisis support services;

- a systematic and planned regional approach to community based suicide prevention. PHNs will commission regionally appropriate activities, in partnership with LHNs and other local organisations;
 - efforts to prevent Aboriginal and Torres Strait Islander suicide will be refocused; and
 - working with states and territories, including in the context of the Fifth National Mental Health Plan, to ensure people who have self-harmed or attempted suicide are given effective follow-up after discharge.”
- However, the 30th November 2014 - National Review of Mental Health Programmes and Services by the NMHC in its Summary (p17) made the following recommendation:

“19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.”

The earlier stated commitment only resulted in 12 sites being funded for Suicide prevention TRIALS, and those trials are still ongoing 5 years later, with no ongoing commitment by the department of Health, and, within those trials, no roll out of services in other regional centres within those particular 12 PHN regions.

There are other (recent) observations. The Productivity Commissions Inquiry into Mental Health Services articulated some ideas of where there are problems, here are some samples:

“The lack of community-based mental health and suicide prevention services has led some people in severe suicidal distress to seek help at hospitals. However, many submissions expressed concern about the poor treatment of patients presenting to hospital in suicidal distress (p855)

And treatment in hospitals is not necessarily the most effective treatment for people in severe psychological distress. “(p856)

“However, gaps in aftercare remain. For example, some people may present to services other than hospitals following a suicide attempt, such as GPs or other government services, and will not receive aftercare. And anecdotes suggest that many people who do present or are admitted to hospitals are still being discharged without adequate aftercare:

Currently in Australia not everyone who attempts to take their own life and seeks help receives aftercare. When it is provided, while some people with lived experience of suicide report positive experiences, far too many report negative experiences. They report that care was not always intuitive or easy to access, not offered consistently and that the quality, length and amount varies. They report a lack of connection between services and clinicians, meaning that people need to tell their story again and again. (NSPPRG 2019, p. 21)(p859)Productivity Commission Inquiry 2019

Basically, services are fragmented, a hodgepodge, without any real central structure. The following words expose the situation today, one can only assume that those who are concerned and express statements of failures right now are validated:

“Suicide prevention is a complex area of policy with interconnected responsibilities – government agencies, service providers and the community- managed sector all have a role in reducing suicide rates through effective suicide prevention responses”. (p21)

Monitoring Mental Health and Suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2018

NSW State Mental Health services parallel National concerns:

“Our supports are still, in many places, inflexible, ineffective, outdated and under-resourced, and often do not join up well when people’s needs are complex and continuing. The situation is made all the more complex by the lack of clarity about state and Commonwealth responsibility for funding and service quality.”(p5) LIVING WELL: A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014 – 2024

It is important to recognise the two initiatives that are in their 3rd year of their operation. They are Suicide prevention trials located in various places around Australia and are finalising their efforts. The second initiative is to have Mental Health and Suicide prevention services delivered by Primary Health Networks to facilitate better regionally structured programs. They are commendable, and those people involved in the decision making of those strategies and the people in those workplaces should feel that there is some progress happening.

2019 has seen the appointment of Ms Christine Morgan, CEO of the National Mental Health Commission as the Prime Minister's National Suicide Prevention Adviser. The release of Productivity Commission Inquiry DRAFT report into Mental Health, and finally the interim findings of the Victorian Royal Commission into Mental Health Services.

However, in general there are, or have been plans, plans and more plans. Strategies and more strategies, reports and more reports. It is said that governments have commissioned more than 40 inquiries on Mental Health in recent years. This report outlines details from more than 5,900 pages of plans, frameworks, reviews, reports, responses, summaries, strategies, and not to forget inquiries – with 44 being mentioned here alone. There are probably other relevant documents that are missing, but they would surely be superfluous; there is more than enough here.

To conclude the summary, yes, there have been some new initiatives in Suicide Prevention in recent times, however, the process is piecemeal due to the lack of acceptance by those in power to relinquish their control of decision making and levels of funding.

Suicide Prevention is in no better a position to reduce levels than 5 years ago . In that time we have lost more than 15,000 people to Suicide .

RECOMMENDATIONS

(PRIORITISED FROM THE REPORTS ,PLANS , STRATEGIES , FRAMEWORKS, INQUIRIES ETC. HEREIN)

Overview

I have counted a staggering 759 recommendations that are noted in the reports , strategies, inquiries etc of this report.

Whilst counting the recommendations , I noted an additional 296 aspirational “ actions” which , in the context of Mental Health and Suicide Prevention , closely mirrors recommendations . It would be inappropriate for me to provide my own “Captains pick” when so many eminent people have contributed their vast knowledge on the subject of Suicide.

Therefore , their work is honoured , listing the most commonly referred priorities within the context of so many recommendations. The following pertain to Suicide Prevention and the areas that affect suicide . Please excuse the omission of so many other important areas of Mental Health.

1. ADDRESS A CATASTROPHE

There is an immediate priority, irrespective of the urgent needs of the whole community in Suicide prevention. And that is the catastrophic rate of suicide in our indigenous community. My own suggestion within the more than 100 recommendations would be to sit down with the elders, the (far too few) indigenous mental health workers, and other knowledgeable and experienced indigenous members and ask them “what do you need?”, “how can we provide the resources you need?” and then, unconditionally and generously, provide the help. Please, no conditions, no “expertise”. They know how to do what is needed.

I have spent a few hours with our local indigenous community in South Western Sydney. They have been most generous in their inclusion of matters about Suicide prevention. This is what I have learnt. I recommend you, the leaders of our Australian Community, GO TO THE INDIGENOUS COMMUNITY, and not the other way around. That is disrespectful. If nothing else comes from this document, it would be my wish that the larger Australian community would act on these simple words.

2. APPROPRIATE FUNDING

A 17-year-old quote is the appropriate source to validate this second recommendation.

ANOTHER INQUIRY

“The Richmond report had not materialised, the Burdekin report found, while a lack of co-operation among government and non-government agencies, and the private sector had contributed to a lack of appropriate services.

Like Mr Richmond, Mr Burdekin nominated employment opportunities and housing as critical to people who live with mental illness, and called for greater focus on prevention and early intervention and the rights of carers. He highlighted the need for mental health legislation grounded in the human rights of people with mental illness.

In a 2002 report by the NSW Legislative Council’s select committee on mental health, Brian Pezzutti highlighted a need for stronger governance to protect the needs of people with mental health problems within the wider health system.

He called for regional mental health directors to have direct authority over mental health budgets, and for health regions to include in their annual reports both their mental health funding allocations and direct expenditure.”

FROM: LIVING WELL PUTTING PEOPLE AT THE CENTRE OF MENTAL HEALTH REFORM IN NSW: A REPORT October 2014, (page 23)

The second recommendation is to have a complete change in the formulation of sustainability funding (i.e. money) in Suicide Prevention. There is not enough commitment to mental health services, so this subset of Suicide Prevention suffers, and, in turn, the suicide rate continues to climb. This all comes from those who hold the power over money. The recommendation is that the Federal and State cabinets budget decision making process on Mental health needs to be made separately from Primary health. Further, that the funding of mental health is “quarantined” from primary health, so as to prevent the existing “poor cousin” syndrome in funding.

Further, all Mental health programs and services be funded on a 3 by 3 by 3 year program basis, the service providers having the ability to exercise an option to continue in service provisional each 3 year point. All staff would have surety of employment, and all service providers would have a much better managerial resource of retention of specialised expertise, thus fixing the existing problem that new people are coming in to replace staff who have left, and with that, losing the lost expertise. Continuity will inevitably bring better outcomes.

The leaders in our community need to step back and allow SUSTAINABILITY. A single funding direction to provide the necessary resources to create a wholistic attempt. Instead of the piecemeal, multi direction, flavour of the month program, trial or research program handed out by a multitude of bodies, at various times, often driven by the timing of elections. This devalues the statements made by the people who make the decisions. Surely it is time that a single body makes the decisions and is the single reference point for that missing element in Suicide Prevention — “accountability”.

3. A PEAK BODY IN DECISION MAKING

To make a decision as to who will be the peak body in decision making of the allocation of financial resources in Suicide Prevention in Australia, and each state commit to that status. Further, that the peak body will be inclusive to all relevant sub-groups, committees

and the plethora of others in suicide prevention services. The body needs to have the ability to act completely independently, free from political interference. The Productivity Commission has prioritised in its DRAFT 2019 Inquiry , to the following “The National Mental Health Commission (NMHC) should be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs. The NMHC should be tasked with annual monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy.” There can be no more articulate solution , more simple , and more logical .

4. YOUTH SUICIDE

We need to look at youth Suicide prevention in both long term and short term, and not look at the quick fix.

In the long term, it is recommended that sustainability funding be provided to Headspace and High School Mental health programs for EVERY, adolescent age environment and resource centre. It is recommended that the powers that be sit down with organisations such as Headspace and others, and sustainably resource the appropriate Suicide Prevention care models that will facilitate long term reductions of repeated suicidal ideation that could lead to the loss of life. This facilitates part of the longer term solution to suicide, resilience building during the formative adolescence period.

5. OUR LGBTQI+ COMMUNITY,

Current figures show that LGBTQI+ young people between the ages of 16 and 27 are five times more likely to attempt suicide, transgender people over 18 are nearly 11 times more likely and people with an intersex variation over 16 are nearly six times more likely. Another tragedy that has been ignored . A catchup is needed now.

6. PTSD IN MILITARY /EMERGENCY SERVICES

In regard to PTSD and it's high ratio of suicides, we need to immediately fund suicide prevention specialist clinicians to be embedded in the relevant mental health services centres attached to the military, police and other emergency services. The current meagre allocation of resources is disrespectful to those affected by PTSD.

7. RURAL AND REMOTE COMMUNITIES

To assist our distressed communities, they suffer poor governmental support at the best of times , and endure hardship of the essence of their location , that is their remoteness . Mental Health for any of us suffers if we are placed in an isolated environment(to be “placed in isolation” is a statement about punishment). That the community chooses to live in such a harsh place does not mean that we should oblige them by isolating services , yet , that is what Federal , State and Territory governments do . If we overlay environmental factors of severe drought as we endure at present , there should be no surprise that this community suffers a statistically higher rate of Suicide. There are more than enough well considered proposed programs and correct service levels articulated for government to respond to . Yet , they do not .

8. DATA COLLECTION AND REPORTING

To immediately enact legislation and financial capacity to compile all relevant data on suicides in Australia. The relevant structure, process, and pathway should be in the hands of the relevant bureaucrats at all levels of Federal and state governments. The failure to act as promised over past years is extremely distressing to those bereaved.

9. ACCOUNTABILITY – THE MISSING LINK

To enable all relevant members of committees, commissions and CEOs of Suicide Prevention plans, strategies and outcomes, to be accountable. This is not an onerous negative, it is an empowerment that is missing, it is a significant component of the reason that the rate is not dropping. No one is accountable, no one is responsible.

10. PLEASE STOP WRITING NEW PLANS STRATEGIES AND REPORTS

There is one small thing I wish to place as a recommendation , as a lay person, unqualified in Mental Health . In my journey , reading thousands of pages of these documents I soon noted a consistent theme . The content of most of the documents listed here follow a repeated formula of trotting out the same figures with pages of diagrams to explain the crisis, the same foreword, and the same summary (according to the subject either Mental Health or Suicide prevention) and tons and tons of recommendations or strategies. But what follows are virtually the same as preceding reports, just worded differently and presented differently. My personal opinion is that some of the most articulate and well-presented documents were actually written several years ago, and are as relevant today as when they were written. Sadly, there are also reports that fail the test of being relevant to the subject. Virtually every document was written *without any clear authority* to actually do something, to spend something, to hold existing services accountable.

The result? There exists , a plethora of well-meaning , yet sadly meaningless reports strategies , frameworks , and Inquiries . (this point was drafted on the 19th July 2019)

Inserted :24th November 2019: and now we have time to digest the Productivity Commissions Mental Health Draft Report October 2019 , and the Royal Commission of Victoria Mental Health interim Report .

If ever there has been a more in depth, eloquent, concise explanation of Mental Health and the effects of suicide, I am unaware. The Inquiry provided us with the insight of additional information on costs to the economy say \$50 billion and associated costs of say \$150 billion .Yet the voluminous body of work is sadly , no more than a cut and paste of what has been reported, and reported, and reported.The Mental Health reform agenda almost a word perfect copy of past ideals . I sincerely apologise to the Productivity Commission for sounding dismissive of such an in depth inquiry. The problem is that the Inquiry has no power to hold decision makers accountable. The Inquiry cannot prosecute the base problem , the end result is , as noted above , more of the same.

In relation to the Victorian Royal Commission into Mental Health , well, there are always exceptions . If a fully committed government , appoints a Commission with the powers to delve into the real state of affairs of the said Governments Mental Health service , then the outcome will be entirely different than the previously mentioned reports strategies etc. The outcome will be a valuable opportunity to *make* changes , rather than *report* on the desire for change .

*Please Note : the CALD Community did NOT make the top list of recommendations in Mental Health in regards to Suicide Prevention
The omission is noted in protest .*

HOW THIS REPORT IS PRESENTED

WHY PRODUCE THIS REPORT?

AND WHAT COULD IT BE USED FOR ?

The sheer volume of documents on this subject create a logistical difficulty to create a wholistic presentation. In order to provide a pathway through the subject, the report is presented in sections:

- a. The first part looks at the involvement of our governments in Suicide Prevention and in part Mental Health as it applies to those areas that are linked to Suicide Prevention . They fit loosely in the following categories:
 - The National Governments mental health plans, strategies and reports
 - The National Governments Suicide Prevention plans, strategies and reports
 - The National Mental Health Commission and it's work
 - Other National plans reports and Inquiries
 - National Suicide Prevention committees /subcommittees
 - National peak bodies /advisory groups
 - The NSW Government and its role in Suicide Prevention
 - The NSW Mental Health Commission
 - South Western Sydney Local Health District
- b. This report centres around Suicide Prevention, and as such, is inextricably linked to Mental Health. Sections of Mental Health that are relevant to suicide have been cut and pasted in as sequential an order as possible. There are many parts of Mental Health documents that are omitted, the reader may wish to do their own research if clarification is needed.
- c. Due to the volume, this document concentrates on Suicide Prevention in only one state, New South Wales and in particular as it affects the South West Sydney area, as that is where our family is from. There is no capacity here to look at each of the other states' issues. (the Royal Commission into Victoria's Mental Health System, Interim Report exempted)
- d. The report then provides in section 5 , an outline of the impact of suicide on our indigenous community and the impact of PTSD within the military and emergency services, the LGBTQI+ and the CALD community , and finally Rural and Remote communities.

- e. Other relevant reports, and details on other organisations /community groups, sustainability funding/financial control, and other information then follows , with observations on what people are saying about suicide prevention.
- f. A Contemporary look at a local mental health issue presented as a case study
- g. A Conclusion

WHY PRODUCE THE REPORT ?

There was no readily available document that could explain the interaction of the above Governments Organisations and how Suicide Prevention is (and is NOT) dealt with holistically .

The outcome is one person’s interpretation of how things work/don’t work , and the problems we endure in relation to the disaster of suicide in Australia. Relevant documents were cut and pasted , explanations of decision making noted , observations added including what people think is important in “real” Suicide Prevention.

Due to the overall size, and to simplify the presentation , it is divided into 2 parts :

Part A.

Overview

The report looks at the above mentioned groups and their involvement in Suicide Prevention. In order to explain the convoluted and complex involvement of the various groups, the structure of this report follows the various trails of government agencies and their involvement, their plans and strategies. This leads to various government’s commitment to the establishment of “commissions” , committees and sub- committees . Governments have commissioned inquiries , and Royal Commissions.

There are peak bodies and advisory groups and an explanation of the existence of “platforms” of the delivery of Suicide Prevention. This includes directions of research, dealing with peak bodies, and the launching of yet again, new strategy of how to deliver Suicide Prevention services. Each Plan, Strategy, Report or Inquiry is critically scrutinised with observations from within the Suicide Prevention sector. The reader may see constant references to “Suicide Prevention is such a complex matter”, therefore such criticism is not meant to tear down past and present efforts, nor is it meant to belittle the new plans. The report is merely meant to be an overview to explain the “lay of the land”, and to (unfortunately) cast a critical mirror to the factors that affect Suicide Prevention.

The desired outcome is to allow the reader to understand those complexities. There are 4 sections as follows :

Section 1

- A listing of the Federal Governments relevant Plans etc. in Suicide Prevention and associated Mental Health documents
- A listing of the National Mental Health Commissions(NMHC) reports, the Productivity Commissions report and other national government reports
- Details in National Government Suicide Prevention Committees

Section 2

- National peak bodies /advisory groups and other relevant organisations

Section 3

- A listing of the NSW Governments relevant documents similar to Section 1.

Section 4

- Details on a Local Health District in NSW (Mental Health)

WHAT COULD PART A BE USED FOR ?

1. A reference guide to understand the flow of various plans , policies ,frameworks etc. at the government level in relation to Suicide prevention , and Mental Health matters that affect the level of suicides in Australia .
2. An additional reference guide listing the various entities that surround Suicide Prevention , and the interrelationships with governments .
3. A resource document noting critical analysis on the failings of governments in relation to Suicide prevention, and the source reference.

PART B

Part B looks at the consequences of the various Governments involvement in Suicide Prevention .The result is an extrapolation of relevant matters raised in Part A in order to examine matters of interest in Suicide Prevention as at 2019:

This covers the following 4 Sections (from 5 to 9)

- Section 5

Outlines our most severely affected members of our community . They have a much higher statistical rate of Suicide per 100,000 people than the overall national rate .There have been repeated calls in virtually every report, strategy ,plan etc. to prioritise efforts to help these disadvantaged people .

They are :

- Our indigenous community
- Military and first responders affected by PTSD
- Our LGBTQI + community
- Our CALD community
- Rural and Remote communities

There are only the most brief headings in this report , and it is hoped that peak bodies and members of the various communities may wish to provide direct input rather than more observations from people outside.

- Section 6.

Outlines various areas of interaction with Suicide prevention such as :

- Standards of delivery of services
- Various institutes
- Suicide Prevention Networks
- Financial control and expenditure information

- Section 7.

A small contribution about what some people are saying about Suicide Prevention in Australia

- Section 8.

An inclusion of a non academic “case study “ , providing an example at the mental health service delivery point at some Mental Health Hospitals in South West Sydney NSW, as it applies to Post discharge care of people initially admitted with suicidal ideation as a part of their mental health condition .

This has been created to advocate for change in sustainability (i.e. money), and the resources quoted in this section came about as a direct result of the work involved in the creation of this report (please excuse the duplication of references provided in earlier sections).

- Section 9.

A conclusion.

WHAT COULD PART 2 BE USED FOR ?

1. It's an information guide on the most frequently proposed recommendations and observations about the most vulnerable members of our community
2. It may be of assistance as an information source on the factors that are failing to address Suicide Prevention in Australia
3. This may also be of assistance to a person to advocate for change in Suicide Prevention

There are many areas in our Australian community affected by suicide, I am just part of one. In 2019, what is known, is that we have aspirational statements “up the wazoo” on the one hand and, yet, an increase in the rate of suicide that continues year after year after year. The contrast is startling, — one thing is for sure. *What is being done, is not good enough.*

DRAFT

SECTION ONE

THE NATIONAL GOVERNMENT'S INVOLVEMENT IN SUICIDE PREVENTION

Overview

Governments love to have inquiries, and when it comes to suicide prevention, it appears that there has been no end to plans and inquiries. I have personally counted more than 35, and I note the following quote.

“this 5th Plan is just number 20, lumped on top of the 19 extant state and territory plans listed at pages 50 and 51 of the document.” Dr Sebastian Rosenberg, Senior Fellow, Centre for Mental Health Research, Australian National University

If we consider reports, there must be hundreds that deal with “(the) relevant recommendations of previous inquiries, (and) over 40 reports”. (page7 - Learnings from the message stick; The report of the Inquiry into Aboriginal youth suicide in remote areas: www.parliament.wa.gov.au)

The National government is the acknowledged driver of mental Health and Suicide Prevention, and has produced policies, plans and strategies to reflect that dominance. There is also an agreement of a “unified approach” by all governments under a COAG Agreement. However, the NSW government travels down its own path when it comes to money and who gets it.

This report looks at the 23 significant contemporary reports both Federal and NSW and includes reports from Commissions as well as Health Departments. There are notations of earlier relevant plans.

And now, in 2019 there is a “new” Suicide Prevention strategy. This is the *National suicide prevention implementation strategy 2020–2025 Working together to save lives* – authorised for consultation by the Mental Health Principal Committee. This consultation (draft) document was released in April 2019. It was developed by the National Suicide Prevention Project Reference Group (NSPPRG, please refer to page 82 for more information out the NSPPRG). It does allow things to be tied together, allowing scrutiny of comparisons against other suicide prevention plans. The draft serves to highlight past concerns and may even serve to sound some more alarm bells, as has been the case in earlier plans and strategies .

The role of the Australian Government in mental health and suicide prevention

The Australian Government's involvement in Suicide Prevention in 2019 is that of:

- The overarching policy maker
- The principal funding body of services in Mental Health
- The decision maker as to who gets the Federal money
- The decision maker as to how much money
- The decision maker as to when we get the money
- The principal research funder
- The appointee of all important matters that relate to Suicide Prevention

The Department of Health (DoH) controls the budget of Mental Health and, therefore, is the financial control of Suicide Prevention in Australia.

Mental Health policy (and in particular Suicide Prevention policy) at the Federal level flows from diverse sources, but funding and bureaucratic documentation typically emanates from the Department of Health.

DEPARTMENT OF HEALTH

A question asked of Minister for Health Greg Hunt on the 18/02/19 : "Do you have a bureaucratic department of Mental Health within the Department of Health in Canberra ? I have searched the internet , and I'm unable to find any reference to such a Department ?."

The reply from the Suicide Prevention and Mental Health Policy Branch 10 months later illuminates (in part) as follows : "In relation to your query regarding mental health and suicide prevention resources available to the Minister for Health , the Department is responsible for developing and delivering policies and programs and advising the Government on health and aged care and sport. This includes matters relating to mental health and suicide prevention. There is a dedicated Mental Health Division in the Department , which includes a focus on Suicide Prevention . Further information. On the role and structure of the Department is available online at www.health.gov.au by navigating to the 'About Us' section.

Dutiful navigation reveals 4 drop down sections , revealing the following :

1. An overview , but no mention of mental health

Medicare , and Private Health Insurance

Primary Health Networks ,

advising that PHN's :

- a. Coordinate different parts of the health system – for example , between the hospital and GP when a patient is discharged
- b. Assess the health needs of their local area
- c. Provide extra services that are needed such as :
 - ❖ After -hours services
 - ❖ Mental health services
 - ❖ Health promotion programs
 - ❖ Support for primary care (GP's) including continuing education

Government Responsibilities

- Australian Government responsibilities (17 listed , none on mental health)

- State , territory and local government responsibilities (are nominated on their behalf)- there are 8 listed , including :
- ❖ Funding and managing Mental health services
- Shared responsibilities (as nominated on DoH’s behalf).- there are 6 listed , including :
- ❖ Funding public hospital services
- ❖ National mental health reform

Health system challenges

Australian health system challenges include

- ❖ There are 5 challenges listed, none are mental health

Cost of health care in australia

- Relevant information provided

2. A Senior Executive Structure Chart

The top right hand side notes that the Hon Greg Hunt MP is the Minister for Health

There is also a listing of 2 Ministers under the Hon Minister

They are :

Senator the Hon Richard Colbeck- Minister Aged Care and Senior Australians
Minister for Youth and Sport

The Hon Mark Coulton MP – Min for Regional Services , Decentralisation and Local Govt.

The chart advises that there are 3 senior executives :

Secretary (most senior position is assisted by a Chief of Staff and a “Special Advisor “)

Glenys Beauchamp , Secretary , “Glenys has had an extensive career in the Australian Public Service at senior levels with responsibility for a number of significant government programs covering economic and social policy areas.” (profile DoH)

Presently , the special advisor is Dr. Margot McCarthy

Dr Margot McCarthy joined Health in November 2015 after responsibility for the Ageing and Aged Care portfolio transferred to Health from the Department of Social Services.

Margot has held a number of senior positions in the Department of Defence, the Department of Prime Minister and Cabinet (PM&C) and the Department of Social Services.

In February 2013, she was appointed as an Associate Secretary in PM&C, leading the National Security and International Policy Group which provided advice to the Prime Minister, and whole-of-government coordination on national security matters. The doctor is a graduate of Oxford University (DPhil in English Literature) and the London School of Economics and Political Science (MSc in Management).

A chief of staff is the 3rd member of the most senior management

LEADERSHIP (also includes)

- A Chief Medical Officer: Professor Brendan Murphy, A background as a physician, formerly CMO and director of Nephrology at St Vincent’s Health.
- A Deputy Secretary for Health Financing
- A Deputy Secretary for Health Products Regulation
- A Deputy Secretary for Population Health, Sport and Aged Care Royal Commission Taskforce
- A Deputy Secretary for Ageing and Aged Care
- A Deputy Secretary for Health Systems Policy and Primary Care Group
- A Chief Operating Office

A search of the chart reveals that the first reference to a mental health executive position is located under one of the seven (7) sub sections/departments . That is under Health systems Policy and PRIMARY Care

The Director is Tania Rishniw A/G , is an ACTING DEPUTY SECRETARY

THERE ARE FIVE (5) third tier managers in Policy and Primary care , and they are part of twenty eight (28) .

That is where the words “Mental Health” exist in the management structure .

Mark Roddam : First Assistant Secretary

“Health Department of Health Health Systems Policy & Primary Care , Indigenous Health” – (source :directory.gov.au)

10 Oct 2018 · The IPAG is co-chaired by Ms Janine Mohamed, Chair, National Health Leadership Forum, and Mr Mark Roddam, First Assistant Secretary, Indigenous Health Division, Department of Health. (Source www1.health.gov.au/internet/main/publishing.nsf/Content/indigenous-ipag-communique-20180626) However, govtree.io advises “primary care and mental health “ under a different structure, and managed by Dr. Alison Morehead (still a first assistant secretary), however , has a role of principal strategic advisor to the National mental health commission (NMHC), and was a panel member at the National Suicide Prevention Symposium 21st & 22nd May 2019, Canberra . It would appear that the executive chart is not accurate in 2019 .

3. Our Portfolio

It says ,” Health portfolio currently includes 17 agencies and 6 statutory office holders (as follows)

Portfolio Agencies

Rather than waste space, the 23 sections only has the National Mental Health Commission (NMHC) as any relevance . There is the reference to the **National Health Funding Body (NHFB)** . This is responsible for “efficient public hospital funding and reporting”. The reader may wish to reflect on the success or otherwise on this Agency with a relevant contribution reflecting entail health funding levels later in this report [Section 8 page xxxx](#)

4. Committees and groups

It says “ our committees and groups provide a way for people and organisations to help us develop policies and provide advice on specific issues .

There are no mental health committees or groups listed.

That concludes the complete content that the Assistant Secretary advises are the “role and structure “ of the Department .

AN OBSERVATION

There was a reason for asking if there was a Mental Health department.

The question was asked to delve into assessing the weight of influence that Mental Health has in the Primary Health department . And to obtain a perspective on the often called for establishment of a ‘real’ Department of Mental Health , separate from the existing (Primary) Health Department, as well as the need to have a Minister for Mental Health .

There are many references in this report of concerns that Mental Health is not a priority in allocation of *overall* health resources , and importantly the budgetary formulation and decision making is dictated by Primary Health priorities . The publication of espoused “priorities “ of such things as Suicide Prevention are then a matter of concern , and are being called into question of the relevance of declaring such priorities . There are references to real decision makers not being a genuine party to that priority .

The advice from the Health Department , guiding us to their ‘about us’ section of the health.gov.au website has validated those concerns .Applying a litmus test to the claim that answers are there in the ‘about us’ section on the *role and structure* of Mental Health reveals the following :

1. The preamble makes no reference to mental health
2. Primary health networks makes a reference to coordination of system and provides an example of patient discharge . This flies in the face of the document in section 8 , and it is noted that it specifically refers to a primary health situation.
3. Then, mental health services are referred to as an “extra “ service . It is a fact that PHN’s have only commenced support services within the last 3 years , many PHN’s are still struggling to set the basics into operation in 2019 , while others are high functioning .
4. Responsibilities at the Australian Government level clearly DO NOT include mental health.
5. The Federal government passes off the responsibility of mental health services only to the state governments , and managing and administering public hospitals
6. Shared responsibilities ARE acknowledged in public hospital funding (under NHFB) , and for the first time , the use of the words mental health (under reform)
7. Unfortunately, the next heading , CHALLENGES , fail to think that mental health is not a challenge , and the unfolding documents in this report are not acknowledged.
8. Then there is the Senior Executive Structure Chart . With the greatest respect to Dr. Alison Morehead , the position of a 3rd tier position (one of 28) , shows the importance . The tiers ahead , and the omission of mental health in the seven (7) leadership members is the final example of the real priority .
9. At the political level, the already observed absence of a Mental Health Minister is underscored by the selection of 2 Junior Ministers that have more important roles in such things as Local Government.

The observation ?

The real priority of Mental Health in the Department of Health is , well ,not the correct colour of the “litmus test”.

Earlier National Mental Health Plans

The Mental Health Plans provided by the Department of Health (DoH), titled National Mental Health Strategies (any reference to Suicide Prevention was virtually non-existent), commenced in 1992, as follows:

1. The First National Mental Health Plan, 1993-1998. National Mental Health Strategies
2. The Second National Mental Health Plan, endorsed by all Australian Health Ministers in July 1998, provides a five-year (1998–2003) framework for activity at the national and State and Territory levels
3. July 2003, Australian Health Ministers endorsed the National Mental Health Plan 2003-2008, renewing the National Mental Health Strategy for a further five year period. (implied that this is the 3rd Plan)
4. The Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014

“This document sets an agenda for collaborative government action in mental health for five years from 2009, offers a framework to develop a system of care that is able to intervene early and provide integrated services across health and social domains, and provides guidance to governments in considering future funding priorities for mental health”. There were 5 mental health priorities, suicide prevention was NOT a priority.

Our son Aaron died on the 19th July 2014 from suicide, there should have been a 5th National Plan to commence in 2015, however, the launch of the next Plan was delayed until August 2017.

It is disturbing to think that 2,864 people took their lives in 2014. In the last months of the failed National Mental Health Plan in 2014, EIGHT people were dying ON AVERAGE, EVERY DAY, and those of us touched by suicide at that time had only a failed (and now expired) mental health plan to lean on for leadership.

It is a telling statement of the capacity of government to respond to suicide. To realise that people were continuing to take their lives at an even higher rate in 2015 (3,027 suicide deaths) and in 2016, there were a further 2,866 deaths. In 2017, the number rose again to a new high of 3,128.

It transcends belief that, at the time of Aaron’s death in 2014, there should have been only the final touches of the 5th Plan remaining before its imminent release. As you will see in the following pages, that did not happen, and this is only one example of things not being done in this area.

THE FIFTH NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN 2017

Overview

The principal mental health plan as it applies to 2019 is called *The Fifth National Mental Health and Suicide Prevention Plan*. (the 5th Plan). It covers the period 2017-2022 and was launched in August 2017.

Important points are noted as follows:

- The launch of the plan was significant, with the addition of the words “and Suicide Prevention “This latest (fifth) Mental Health plan recognised the crisis in Suicide Levels in Australia, and so made Suicide Prevention a Priority (Priority number 2).
- State and territory governments committed themselves to the plan, “this plan commits all governments to work together to achieve integration in planning and service delivery at a regional level”(p. v)
- “The development of the Fifth Plan built on the extensive consultation undertaken by the National Mental Health Commission in 2014”(p. v)
- The National Mental Health Commission (NHMC) is an Australian government executive agency established in 2012 to provide independent reports to community and government on mental health services and outcomes. It has produced relevant reports on the subject of Suicide Prevention.

What the 5th plan says about Suicide prevention

The Fifth National Mental Health and Suicide Prevention Plan. (the 5th Plan) covers the period 2017-2022, and as noted earlier, was launched in August 2017

The 5th Plan is a Mental Health Plan produced by the Dept. of Health in consultation with the National Mental Health Commission (NMHC). It is a 51 page document plus 20 more pages of addendums. I will leave it to the reader to look at the whole document of their own volition, if other Mental Health areas are considered relevant. The 5th Plan refers to a number mental health aspects, however, there is a significant addition of a reference to Suicide prevention, as signified by the addition of the words “and Suicide Prevention”. More details are provided in the Appendix.

The preamble

There are references to Suicide Prevention within the other aspects of Mental health and these are noted here.

“For the first time this plan commits all governments to work together to achieve integration in planning and service delivery at a regional level. Importantly it demands that consumers and carers are central to the way in which services are planned, delivered and evaluated.

Furthermore, this plan recognises the tragic impact of suicide on the lives of so many Australians and sets a clear direction for coordinated actions by both levels of government to more effectively address this important public issue”.

The Fifth Plan is accompanied by an Implementation Plan that sets out who will be responsible for undertaking the actions agreed in the plan and how implementation will proceed and be coordinated across governments. For the first time, the plan also contains a set of nationally agreed indicators which can be captured and reported on to track the progress of the plan. The Fifth Plan also sets out to achieve outcomes in eight priority areas that align with specific aims and policy directions in the National Mental Health Policy. These priority areas do not reflect all the aims and policy directions in the National Mental Health Policy but align with those that are well positioned for change in terms of both need and opportunity.

The eight priority areas of the Fifth Plan are:

- achieving integrated regional planning and service delivery
- effective suicide prevention
- Co-ordinated treatment and supports for people with severe and complex mental illness
- Improving Aboriginal and Torres Strait Islander mental health and Suicide Prevention
- Improving the physical health of people living with mental illness
- Reduce stigma and discrimination
- Making safety and quality central to mental health service delivery
- Ensuring that enablers of effective system performance and improvement are in place

The 5th Plan covers many areas , however , of particular noteworthy information are the following topics :

PHNs and LHNs

“Activity at the local service delivery level is driven through PHNs and Local Hospital Networks (LHNs). PHNs were established by the Commonwealth Government. They plan and commission medical and health services within defined regional populations and are expected to support service integration at the regional level. LHNs were established by states and territories. They manage public hospital services; may manage other health services funded by states and territories, such as community-based health services; and support service integration at the regional level.

“PHNs and LHNs have strong relationships with the community-managed sector. Collective action by both PHNs and LHNs is necessary to drive effective service integration within a local region.”

The plan also addresses Mental Health amongst the ATSIC community, as well as stigma, discrimination, physical health and other issues. It importantly notes “Primary Health Networks have been established as new service entities that provide primary and specialist mental health care and several state governments have established Mental Health Commissions that focus on a whole of government.” It notes “the extensive consultation undertaken by the National Mental Health Commission in 2014” and, furthermore, that “over the next five years, the Fifth Plan will establish a national approach for collaborative government action to improve the provision of better integrated mental health and related services in Australia.”

“The Fifth Plan is underpinned by several targeted priority areas, which were developed taking into account feedback from key stakeholders and includes supporting actions that enable change.”

The plan goes on to note that suicide prevention is one of the targeted priority areas:

Action ii

Governments will establish a Suicide Prevention Subcommittee that will report to Mental Health Drug & Alcohol Principal Committee (MHDAPC) on priorities for planning and investment. Membership will consist of:

- *representatives from the Commonwealth and each state and territory government*
- *expert representatives from key peak bodies, research and academia and the Aboriginal and Torres Strait Islander health sector*
- *consumers and carers*

- *cross-representation with the new Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee. (page 12)*

“The first priority for the Suicide Prevention Subcommittee will be to develop the National Suicide Prevention Implementation Strategy (NSPIS) for COAG Health Council endorsement. Further detail about the role of the Suicide Prevention Subcommittee is provided in Priority Area 2.” (page 12 of the 5th Plan)

A note from the author, in 2019, the DRAFT National Suicide Prevention Implementation Strategy”(NSPIS) draft 2020-2025 – 54 pages document was tabled for discussion.

Action iii

Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee that will report to MHDAPC on priorities for planning and investment. The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will:

- *be chaired by Aboriginal and Torres Strait Islander representatives*
- *include membership from the Commonwealth and each state and territory government*
- *include cross-representation with the new Suicide Prevention Subcommittee.*

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will work with the Suicide Prevention Subcommittee on the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander peoples, for inclusion in the National Suicide Prevention Implementation Strategy.

Further detail about the role of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee is provided in Priority Area 4. “MHDAPC will meet regularly with relevant ministerial council advisory bodies on the implementation of the Fifth Plan and broader mental health policy issues that require whole-of-government consideration. This will ensure that implementation of the Fifth Plan is supported by an inclusive, whole-of-government approach.”

It is disconcerting that the NMHC provided a 2018 “PROGRESS REPORT “ that advised :

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group(SPPRG) and the MHPC both reported their progress as ‘on track’.” p26

Action iv

Governments will, through the Suicide Prevention Subcommittee of MHDAPC, develop a National Suicide Prevention Implementation Strategy that operationalises the 11 elements above, taking into account existing strategies, plans and activities, with a priority focus on:

- *providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system*
- *providing timely follow-up support to people affected by suicide*
- *improving cultural safety across all service settings*
- *improving relationships between providers, including emergency services*

- *improving data collections and combined evaluation efforts in order to build the evidence base on ‘what works’ in relation to preventing suicide and suicide attempts.*

Action v

Governments will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention: This will include engaging with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan. These regional plans will be consistent with the 11 elements above and informed by the National Suicide Prevention Implementation Strategy as it is developed.

At a regional level, PHNs and LHNs will work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them.

Priority Indicators

The Fifth Plan identified national key performance indicators that can currently be reported on or that could realistically be implemented within the life of the plan. Selection of these indicators was guided by the National Mental Health Commission’s 2014 National Review of Mental Health Programmes and Services. Indicators from the review which can currently be measured have been included, along with additional indicators which are relevant to the commission’s proposed domains. In the domain of “LESS AVOIDABLE HARM”, the 5th Plan itemised the following indicators:

- 19. Rates of suicide
- 20. Suicide of persons in inpatient mental health units
- 21. Rates of follow-up after suicide attempt/self-harm*
- 22. Rates of seclusion in acute mental health units
- 23. Rate of involuntary hospital treatment

The plan then goes on to confirm Suicide Prevention as a priority.

Priority Area 2: Suicide Prevention

The details of this priority start with a preamble about why it (Suicide Prevention) is a Priority, followed by “What will we (the 5th Plan) do?” Rather than cut and paste the whole of this preamble, the following is a dot point summary of the main components:

- Suicide prevention is a complex area of policy with interconnected responsibilities. Government agencies, service providers and the community-managed sector all have a role in reducing suicide rates.
- A previous suicide attempt is the most reliable predictor of a subsequent death by suicide. 29, 30
- The causes of suicide and suicide attempts can be complex and multifaceted. While some mental illnesses can be linked to an increased risk of suicide, not everyone who dies by suicide will have a mental illness.
- There is a much higher suicide rate among Aboriginal and Torres Strait Islander peoples. Among this population, suicide was almost unheard of prior to the 1960s³³, yet in 2014 it was the fifth leading cause of death among

Aboriginal and Torres Strait Islander peoples, and the age-standardised completed suicide rate was around twice as high as the non-Indigenous rate. 34

- By providing intensive follow-up care during the days and weeks after a suicide attempt, or following discharge from inpatient psychiatric care, it is possible to reduce the risk of future suicide attempts.
- Health services should aim for zero suicides within health care settings
- A national approach would draw on existing strategic guidance, including the Living is for Everyone Framework

The plan then poses an answer to the question, **what will we do?**

Consistent with the WHO's *Preventing suicide: A global imperative*, the Fifth Plan commits all governments to a systems-based approach which focuses on the following 11 elements:

1. Surveillance—increase the quality and timeliness of data on suicide and suicide attempts.
2. Means restriction—reduce the availability, accessibility and attractiveness of the means to suicide.
3. Media—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. Access to services—promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
5. Training and education—maintain comprehensive training programs for identified gatekeepers.
6. Treatment—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. Crisis intervention—ensure that communities have the capacity to respond to crises with appropriate interventions.
8. Postvention—improve response to and caring for those affected by suicide and suicide attempts.
9. Awareness—establish public information campaigns to support the understanding that suicides are preventable.
10. Stigma reduction—promote the use of mental health services.
11. Oversight and coordination—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

The plan goes on to ask somewhat obvious questions and post implementation observations that are summarised here:

- How will we know things are different?
- What will be different for consumers and carers?
- System improvements
- Measuring change

That is the end of the direct reference to Suicide Prevention in the 5th National Mental Health & Suicide Prevention Plan 2017 - 2022.

Observations about the 5th Plan

The content from the below observations outline the general problems with the 5th Plans ability to address the problem of Suicide Prevention.

An important component of this report is to reflect on the significant concerns expressed within the Suicide prevention community. Often, the concerns expressed are validation comments, acknowledging the significant problems in Mental Health, and the reports focus on Suicide prevention.

I would like to acknowledge the hard work being done by so many dedicated and talented people, from the eminent committee members, the heads of departments, advisors, researchers and all of the qualified experts in the field of Suicide Prevention. I unreservedly apologise to any person, organisation or Government that may feel unreasonably criticised or harshly referred to. I respect the work being done, and I especially wish to acknowledge the most difficult work being done by the people who work providing the services to consumers and their carers/family. Theirs is a most thankless task when looking at the meagre resources provided to them, and the uncertainty of their employment in many cases. as politicians provide handouts at election times and programs are given finite funding, I am aware of the added strain on so many workers compared to other professions.

Perhaps this is the appropriate point in this report to acknowledge a special group of people who work in Mental health. They are people who are attracted to work in this “calling”, due to their own lived experience in mental health. Over the past 8 or so years, I have met so many people who come from this background. My backgrounds that of small business, and I have been fortunate to have been in businesses that continue to be in operation and were established more than 60 years ago.

However, in mental health services, funding in so many services are finite, leaving highly skilled workers stressed about job security, and forced to move to another position that has fresh funding. There are many people living with mental health issues who provide a productive and deeply insightful contribution to their workplace and their employer. Their wisdom, and personal journey providing an immeasurably valuable resource to our community.

So, how do we treat these valuable resources in the workplace? I feel that they are treated (mistreated) in a most disrespectful way. The provision of unstable, finite funding programs, the scenario of people waiting to find out at the 11th our if there job will continue for another meagre year, to be repeated again, is disgraceful, and must stop. There are people living with mental health issues that have their anxieties unreasonably heightened. Mental health services are and will ongoing, and programs containing staff must have surety of employment. Private enterprise function on the premise that of ongoing basis, and so should employees in Mental health programs,

So, back to the 5th Plan. It is important to show the concerns expressed by various sources to reflect on where things about the 5th Plan are a concern, observations about past failures to reflect the urgency of action and/or, where the plan should be going.

This analysis seeks to take a critical look at the landscape. Inevitably this “What is being said” part will look as though it’s a never ending complaint of what’s gone wrong. It is a rational and necessary observation of the never ending grand statements acknowledging the “tragedy”, the never ending aspirational statements about ending suicide “towards zero” and, yet, it is also the reality of siloing of groups of people with the power of money, the never ending delays betraying the statements of urgency and, in the end, the failure to make inroads on the rates of suicide .

Due to the large volume of the content of observations below, only summaries have been included. Locations of the full content are provided in the Appendix.

As noted earlier , it is disappointing that the 5th Plan was not completed and launched until 2017, with the previous 4th Plan having expired in 2014. This represents an inexplicable gap as the suicide crisis escalated.

The 5th Plans own internal observation of the problems, as they exist, are quoted here in full:

“The current approach to suicide prevention has been criticised as being fragmented, with unclear roles and responsibilities across governments. This has led to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.” p35

“These issues have led to calls to develop a national approach to address suicide prevention that brings together agreed goals and strong national planning and collaboration. A national approach would draw on existing strategic guidance, including the Living Is For Everyone Framework, the Report of the Aboriginal and Torres Strait Islander Suicide Prevention Project, Suicide Prevention Australia’s Strategic Framework for Suicide Prevention, the LifeSpan model, Mindframe’s National Media Initiative and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, that was developed in 2013 by the Commonwealth Government” p24

From NMHC Monitoring mental health and suicide prevention reform: National Report 2018

“SUICIDE PREVENTION

Suicide prevention initiatives currently being implemented in Australia may have a significant impact on the future directions of suicide prevention planning and investment.

In particular, the local area suicide prevention trials are an opportunity to gain insights about the process and outcomes of systematic implementation of suicide prevention programs targeted to local at-risk groups.

As the implementation of the initiatives is in the early stages, there are currently no outcomes available for reporting. However, the ongoing monitoring of these initiatives will be important to determine not only whether the initiatives are effective in reducing Australia’s suicide rate, but also whether a more coordinated approach across governments has been achieved.

The trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps. The NMHC remains concerned that, at all levels of government, significant gaps persist in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.” p8

“WHAT HAS HAPPENED SO FAR

The NMHC is responsible for delivering an annual report, to be presented to health ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators. To inform the report, the NMHC conducted a survey of stakeholders responsible for actions under the Fifth Plan Implementation Plan. Stakeholders were asked to report their achievements, barriers to progress, enablers of progress, and the level of engagement of consumers and carers in undertaking their Fifth Plan actions. The first report, describing the progress achieved as at 30 June 2018 and baseline data for the 13 available performance indicators, is expected to be delivered to the COAG Health Council in October 2018.” p31

“CONCLUSION

Reporting on the progress of mental health reform is essential to show that the commitments in the Fifth Plan are being honoured and are making a difference. The first of the NMHC’s annual reports on the implementation progress of the Fifth Plan actions and performance against the identified indicators is expected to be made publicly available following COAG Health Council approval. The NMHC will continue to engage consumers, carers and other key stakeholders in its ongoing work to monitor the impacts of reforms under the Fifth Plan” p31

From NMHC :Monitoring Mental Health and Suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2018 – PROGRESS REPORT

“BARRIERS

Funding and resources were commonly reported barriers across priority areas for PHNs, with many reporting that they lack the funding necessary to implement the Fifth Plan actions” p7

“ACTION ii

Governments will establish a Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.

The Australian Government Department of Health, the SPPRG and the MHPC reported their progress as ‘on track’. All state and territory government health departments reported their progress as ‘on track’.” p13

In reference to PHNs and implementation of Suicide Prevention measures:

“ACTION 2.5

Developing joint, single regional mental health and suicide prevention plans and commissioning services according to those plans. The MHPC reported their progress as ‘on track’.

This action was further broken down into components for the contributing stakeholders to address:

(a) PHNs and LHNs will jointly develop comprehensive regional mental health and suicide prevention plans.

(b) PHNs and LHNs will use these plans to progressively guide service development and commissioning.

Various PHNS reported not being on track in the above 2 plans and commissioning.

Priority Area 2: Achievements

No significant or common achievements were identified across stakeholder groups at this point in time.

Priority Area 2: Enablers

Enablers of note included the commitment and expertise of the members of the established groups, with both reporting that the willingness of members to collaborate and work together to draft an effective and meaningful strategy is the key enabler at this stage in the process. The inclusion of members with lived experience on the SPPRG was also highlighted as a critical enabler to ensuring that National Suicide Prevention Implementation Strategy is designed to support the cohort it is intended to support” p21

While this appears to be nice, the jargon is disconcerting.

Despite this being a response to the draft 5th Plan, the concerns expressed do show relevance:

“OVERALL POSITION

There is a lack of attention on early intervention, prevention and young people.

The Fifth Plan recognises: a) that one of the key issues in Australia’s mental health system has been the ‘insufficient focus on promotion, prevention and early intervention’ (p14); and b) the underpinning value of promotion, prevention and early intervention”

How can this be addressed?

An additional priority area on early intervention for children and young people should be included in the Fifth Plan.

The Fifth Plan should encapsulate the key commitments to mental health and suicide prevention announced by the Coalition in the lead up to the 2016 election.

More specifically, the Fifth Plan should also describe headspace and the Early Psychosis Youth Services (EPYS) as the Australian Government’s preferred and evidence-based models for youth mental health care. It should identify headspace and EPYS as critical national infrastructure from which governments will continue to build and enhance early intervention services and youth mental health care. There should be a commitment and a plan articulated to ensure all young people (including those experiencing early psychosis) have access to these services.”^{p2}

This response argues that “there is an insufficient response to the ‘missing middle.’” The Fifth Plan does not acknowledge or respond to the growing chasm in care between what is funded and provided by the Commonwealth Government and by state/territory governments.

“In some states/territories insufficient funding for youth mental health systems have seen many young people with significant mental ill-health and suicide risk deemed ‘not unwell enough’ to access state-funded systems care. They then present to headspace, a service designed to care for mild-moderate illness or receive no care at all. This is a critical issue requiring a much stronger commitment from governments to address within the Fifth Plan. It will not be fixed through an assumption that primary care will pick-up, at minimal extra cost, those unable to access state-systems.”^{p3}

“There is a lack of clarity in the roles, responsibilities and accountabilities between and across governments.

*In general, the Fifth Plan lacks implementation details. **There is no implementation plan.** Nor are any outcome measures described which would indicate progress towards short/medium term service system changes and improvements, along with progress towards the long-term outcomes (which are articulated). It is possible that accountability within the Fifth Plan could be diminished with the focus solely on ‘long-term’ outcomes and indicators.”^{p3}*

The response also argues that the 5th Plan is “a ‘kick to touch” in responding to service system shortfalls and funding issues.” Specific to Suicide Prevention, it notes that:

“Devolving responsibility for service system improvements (including follow-up care for high suicide risk following discharge from Emergency Departments and hospitals) to PHN/LHNs with little detail on how they will be supported to deliver this is a shortcoming of the Fifth Plan. While regional responsibility is seen to be a step forward

in rectifying the issues of implementing integration in previous plans (p19), the expectation that the PHN/LHNs will regionally respond to gaps in service provision without addressing the higher level Commonwealth and state/territory responsibilities and the resourcing shortfalls across mental health services and systems is concerning.” p4

The response, notably, argues that the draft plan fails to learn from previous plans.

“Further to this, the decision not to evaluate the Fourth Plan is also a concern. There was an opportunity with the Fifth Plan to identify and address outstanding actions and implementation issues from the previous plans.

How can this be addressed?

Include detailed information in the plan about how the PHNs and the LHNs will be supported to achieve integrated service delivery at the regional level. This includes:

- *releasing the National Mental Health Service Planning Framework alongside the Fifth Plan (if not before);*
- *an agreement on strategies for future alignment of PHN/LHN catchments;*
- *commitments to data and reporting harmonisation; and*
- *a clearer acknowledgement that responsibility has not been devolved, as these networks are funded functions and mechanisms of both levels of government.*

There is also a need to provide direction and scope to the PHNs on integration with other sectors and systems to deliver activities which recognise and respond to the various social determinants of mental ill-health, particularly important in areas of physical health impacts and other comorbidities.” (p4)

“The Fifth Plan is ‘back to the future’.

The Fifth Plan is heavy on rationale for the key reforms announced in late 2015 by the Australian Government in response to the National Mental Health Commission Review of Mental Health Programmes and Services. However, for a plan which will now guide intergovernmental action and investment up to 2022, it lacks detail on the future opportunities and challenges in mental health and suicide prevention and fails to articulate the mechanisms, policy, program and funding levers and timeframes by which governments will respond. In particular, references are almost entirely absent regarding a) online/technological platforms and transformations, b) workforce development.

While placing ‘people and communities at the centre of actions’ (p16), the Fifth Plan still remains heavily health system orientated, with governance arrangements centred on health and mental health ministers. As a result, it doesn’t connect to the other systems central to an individual’s wellbeing such as housing, education and employment. This is despite the articulation early in the document of the importance of these systems in mental health and wellbeing outcomes (p17); and that a number of the national indicators identified in the Fifth Plan fall within the responsibility of other portfolios, e.g. early childhood support and employment service data (p67)” p5

The response provides the following specific feedback on Suicide Prevention strategies addressed in the plan:

1. There is a need for a clear commitment to a new national suicide prevention strategy which also involves the development of a separate Youth Suicide Prevention Implementation Plan, recognising that a different approach is required for this age group than others. p6
2. Concerning that the post-discharge care issue (which in the response to the National Mental Health Commission review was going to be addressed by COAG in this plan) is now a matter for the PHNs/LHNs, who will ‘seek to prioritise’ this (p34).

The Fifth Plan should articulate how this will be done and when. The plan also needs to commit to ensuring what is done is evidence-based. p7

3. The actions are health-centric in their approach, whereas evidence suggests suicide prevention is best responded to through multiple systems and services outside of health. If the agreed scope for the plan is only mental health and health then this will be an issue. p7
4. Need to include self-harm and suicide-related behaviours as a greater focus for actions and reporting within the Fifth Plan. The development of monitoring systems in hospitals across the country, linked to an aggregated national data set for presentations to Emergency Departments is one action that should be included. p7

Black Dog Institute: Submission in response to the Draft 5th National Mental Health Plan, submitted 9th December 2016

Black Dog Institute is a global pioneer in the identification, prevention and treatment of mental illness and the promotion of well-being.

Recommendations on priority areas 1 to 6 are provided in this report, however, only references about recommendations on priority area 2 “Suicide Prevention” are provided here. These recommendations include:

- National, coordinated, standardised evaluation of the twelve PHN trial sites, with detail provided on how these outcomes will feed into improved policy and service delivery.
- Reduce emphasis on awareness, and increase investment into proven, evidence-based strategies such as GP training, aftercare and gatekeeper programs”
- We also support the focus on follow-up care for people who have made a suicide attempt and the strengthening of data collection protocols. These two actions will have a significant impact on the rate of suicide now and in the future.
- “ The power of evidence-based prevention programs must be acknowledged in the 5th NMHP and appropriately integrated into each Priority area.
- Funding and support for critical research into school-based prevention programs must be provided as a matter of urgency”

The response includes the following excerpt:

“The NMHP document provides no information on how the suicide prevention trial sites being undertaken across twelve primary health networks will feed into ongoing policy and service delivery. This is of importance as these trials have involved a considerable investment. We recommend a national, coordinated evaluation of these trial sites to ensure outcomes are useful and comparable. There would be expected to be regional differences in the delivery of the programs, however, we would suggest that the plans for each of these sites is examined by suicide prevention experts and is compatible with culture and scientific evidence. As one of the leading Australian research groups focussed on suicide prevention, we do not agree with NMHP focus on awareness. There is, in fact, very little research evidence available to show that public awareness campaigns reduce suicide attempts or deaths. Awareness programs should link to campaigns that let people know what is happening in their regions and where to get help. Programs of awareness raising are unlikely to be helpful by themselves.”

“Black Dog Institute analysis of international research evidence clearly shows a number of strategies that are significantly more impactful than awareness programs. We strongly recommend that the limited funding available for suicide prevention is directed towards evidence based programs that are suited to the local environment.

“The plan is silent on prevention. Yet prevention is potentially a powerful solution to chronic mental illness and should be included as a key strategy. It has been estimated that up to 22% of adult cases of depression can be prevented using evidence-based prevention strategies. Prevention programs are most effective when implemented early. A global research analysis undertaken by Black Dog Institute showed it is possible to significantly reduce the population burden of depression and anxiety using evidence-based prevention programs delivered in schools. We recently tested this approach in NSW high school students undertaking their HSC. Students that used a CBT-based online “serious game” called Sparx showed a significant drop in anxiety and depression symptoms compared to students who didn’t access the game.

On the basis of these studies, we estimate that around 61, 000 young Australians could be prevented from developing depression each year using CBT. A number of these programs are automated and can be undertaken without the help of a therapist making them cost effective and attractive to young people.

We strongly believe that school-based prevention is critical to reducing the overall burden of mental illness on our community. We recommend that further work be done to identify what programs are most effective, and how best to implement these on a mass scale. It is imperative that this urgent need is captured in the 5th NMHP.”

Croakey.org: Response (independent, in-depth social journalism for health)
November 2, 2017

“It sounds like a bad joke. COAG has released the 5th National Mental Health and Suicide Prevention Plan, stating that it will focus on integration. Yet the Plan itself does not take into account or – indeed – integrate the over 50 other existing mental health plans from state/territory governments and PHNs.”

“In the piece below Dr Sebastian Rosenberg, Senior Fellow, Centre for Mental Health Research, Australian National University discusses this ‘unfunny irony’ and comprehensively analyses other aspects of the Plan, which he sums up as ‘A 20th Century Vision for 21st Century Needs’.”

Sebastian Rosenberg writes:

“With no fanfare, the 5th National Mental Health Suicide Prevention Plan was endorsed by the Council of Australian Governments (CoAG) Health Council at its 4 August 2017 meeting.

Much of the critique I previously provided about the draft version remains valid. This Plan is a disappointing retrograde step, shifting responsibility for mental health firmly back into the health sphere. Issues regarding the social determinants of mental health, the things that often matter most to people, including education, employment, housing and social inclusion, are described but practically ignored. There is no capacity or commitment even to assess these things let alone improve them.

While there is laudable concern for the mental health of Aboriginal and Torres Strait Islander peoples (who get a new national committee) and the LGBTQI community, there is no mention of Australia's vast and under serviced multicultural communities."

Notably, this response argues that there no targets have been included in the 5th plan:

"The Plan offers no targets and is backed with no new resources. Of the five Plans Australia has produced in the past 25 years, only the first in the early 1990s was supported with new resources, incentives from the Federal government to the states and territories to shift their mental health services out of the old asylums."

"These incentives were effective, though even today some states maintain their old specialist psychiatric hospitals. Across the mental health sector, it is widely regarded that these national plans have become decreasingly influential in driving change. This 5th Plan reinforces this view, offering a gestural contribution. There is the sense that governments have discharged their mental health planning obligations now. A pantomime of reform has been described."

"It is an unfunny irony that the key theme of this 5th Plan is integration. Yet mental health has probably never been more fractured. This is not surprising. No holistic analysis of existing strengths, weaknesses, challenges or opportunities has occurred."

"The Plan does not provide an honest statement about the problems it is trying to fix. It draws extensively on the Review conducted by the National Mental Health Commission in 2014 but their focus was Federal engagement in mental health. The massive role played by the states and territories was beyond their remit. Unlike previous national plans, this 5th Plan makes no pretension about any kind of coordinated planning or prioritisation across Australia's nine jurisdictions."

They argue that there are too many plans and too little integration.

"No, this 5th Plan is just number 20, lumped on top of the 19 extant state and territory plans listed at pages 50 and 51 of the document. To this planning heap will soon be added 31 regional mental health plans to be developed by each Primary Health Network – making more than 50 unintegrated mental health plans in operation simultaneously across Australia."

"With almost palpable relief, the Plan really dumps responsibility for change with the PHNs and their Local Health Network (LHN) state counterparts. "

"No detail is provided as to how this miracle will occur. The Plan talks about unprecedented alignment between PHNs and LHNs but most PHNs are dealing with more than one LHN, or vice versa. No tools or resources are identified to assist PHNs and LHNs work together, or develop useful benchmarking or shared quality improvement processes. Yet the real work of change lies here. The Plan's persistent separation of PHNs and LHNs from the governments that fund them is little more than bogus blame shifting."

“Of real concern is the fact that the 5th plan effectively exposes the rationale for this disintegration of our so-called mental health system. Never has it been clearer that PHNs manage primary care, funded by the Feds, while the states manage acute care and the hospitals.”

The authors claim that it is merely “more of the same”.

“Nearly all the actions in the Plan begin with the phrase “Governments will....”. Leaving aside the exclusivity of this approach, there is little reason to suggest this 5th Plan will be any more successful than its predecessors in driving effective change.”

“Responsibility for the Plan remains invested in the same bureaucratic structures which have governed Australia’s direction in mental health for the past 25 years. They have ensured the lack of resources throughout the Plan is assiduously described so as to explain later inactivity, in areas such as surveys or other data to inform accountability. Nothing new here”.

The continued reliance on expensive, often traumatic hospital-based care does not offer sustainable long-term reform, towards earlier intervention. Promotion, prevention and early intervention are barely described. New specialist clinical and psychosocial community services are not emerging, certainly not at scale. The Plan does not detail what role new digital mental health services should play in 21st century care.”

“What is perhaps most stark arising from this 5th Plan is the dissonance between the positive rhetoric throughout the Plan and the overwhelmingly negative experience of people on the ground, either working in or using the mental health system. The five national plans are, after all, outnumbered by the 32 statutory inquiries into mental health that occurred between 2006-12 alone. The current NSW Parliamentary Inquiry into the death of Ms Miriam Merten while in the Mental Health Unit at Lismore Hospital could be added to this list. There would be others.”

Black Dog Institute

Why have we not been able to reduce the terrible rate of suicide in Australia?

According to Dr Fiona Shand, senior researcher at the Black Dog Institute and the NHMRC Centre for Research Excellence in Suicide Prevention, “it is quite simply because we keep doing what we have always done.” She says that, “if we want to be really serious about saving lives, we need to focus on strategies that have been proven to work, not simply rolling out awareness campaigns.”

“If we look to the research evidence from here and overseas, there are clear strategies that have been proven to reduce suicide. Only some of these are currently in use in Australia, and implementation tends to be scattered and disproportionate to their impact.”

“Not surprisingly, the most powerful way to reduce suicide is to improve access to quality mental health care and support GPs to address depression and suicidality in their clinics. Other strategies such as training “gatekeepers” like school counsellors, and restricting access to lethal means are also effective. We know that no single strategy

will solve this incredibly complex issue, and what is needed is a combination of strategies targeting both the individual and the population.”

Black Dog Institute researchers have developed a suicide prevention program that involves all proven strategies being implemented together and tailored to local community need. Called Lifespan, this program is being rolled out in NSW and has formed the basis of suicide prevention activities nationally. Lifespan is expected to reduce the suicide rate by at least 20% in the first few years, improve the lives of thousands of others who were considering suicide, and relieve the huge burden on families, friends and work colleagues. (p6). www.lifespan.org.au

NATIONAL SUICIDE PREVENTION PLANS /STRATEGIES

Background

The Federal Department of Health (DoH) said in January 2014,

“With the development of the National Youth Suicide Prevention Strategy (NYSPS), Australia became one of the first nations to take a nationally coordinated approach to suicide prevention. Operating between 1995 and 1999, the NYSPS was replaced in 2000 by the National Suicide Prevention Strategy (NSPS). The NSPS not only expanded the focus on suicide prevention activities across the life span but also included consideration of specific at-risk groups.” p8

There are no details available on any NSPS publications prior to 2016.

The Department of Health have overseen two (2) major policy statements:

1. NATIONAL MENTAL HEALTH PLANS. The most recent Plan, the 5th National Mental Health and Suicide Prevention Plan is important, in that it added “and Suicide Prevention “ in the Plan as a consequence of the inclusion of Suicide Prevention as a “PRIORITY”. The Australian Government established an executive agency in 2012, The National Mental Health Commission (NHMC). They have monitored reviewed both of the above mentioned strategy documents, and provided reports that have (in turn) provided reviews of the DoH documents.
2. Concurrently, in November 2015, the same department produced The NATIONAL SUICIDE PREVENTION STRATEGY. (NSPS).

The important points include:

- The National Suicide Prevention Strategy (NSPS) is designed to provide the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention.
- In November 2015, as part of its response to the National Mental Health Commission Review of mental health programs, the Government announced a renewed approach to suicide prevention through the establishment of a new National Suicide Prevention Strategy. (noting that there are no details on the web of earlier NSPS publications) The new Strategy involves:

The NSPS (2015 model) was reworked and involved 4 strategies quoted in full as follows :

- a systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool;
- national leadership and support activity, including whole of population activity and crisis support services;
- refocussed efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, taking into account the recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and
- joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support.

As noted in the 5th Plan, an important change in the delivery of Mental Health programs came into effect on the 1st July 2016. PHNs were tasked with commissioning regionally appropriate suicide prevention activities and services. In May 2019, a consultation document, *The National Suicide Prevention Implementation Strategy* (NSPIS) draft 2020-2025, was released. In July 2019, The CEO of the National Mental Health Commission, Christine Morgan was appointed to the new role of National Suicide Prevention Adviser to report directly to the Prime Minister, Scott Morrison. There is a report to be presented in 18 months.

The National Suicide Prevention Strategy (NSPS) 2015

In November 2015, as part of its response to the National Mental Health Commission Review of mental health programs, the DoH announced a renewed approach to suicide prevention through the establishment of a new National Suicide Prevention Strategy.

The strategic policy framework for delivering a “suite of resources and research finding on how to address the complex issues of suicide and suicide prevention” is based on an organisation called Everymind, based in Newcastle (www.lifeinmindAustralia.com.au), which describes itself as a “leading national Institute”. (see page 144 for details)

The Appointment of Primary Health Networks (PHNs) in Mental Health Programs

There is a significant new Suicide Prevention strategy shift that should be noted at this point. That is the establishment of a new delivery system for suicide prevention services at a local level.

The use of PHNs from 2016 means that there is a whole new learning process needed to be developed in Suicide Prevention, and a new arrangement of the service delivery of the many existing services and programs that are delivered from the resources of the DoH.

The NSPS document goes on to explain the decision to appoint PHNs as the delivery point of suicide.

“PHNs have been tasked with commissioning regionally appropriate suicide prevention activities and services from 1 July 2016. PHNs will also work with Local Hospital Networks and other local organisations to support better targeting of people at risk of suicide.”

The plan was resourced by the Department of health funding Suicide Prevention services to act as a resource of information to PHNs using an accreditation system that was developed by the University of Queensland.

“As part of this role, PHNs will be required to identify Aboriginal and Torres Strait Islander communities within their region that may be at high risk of suicide, and liaise with local Indigenous-specific organisations, as well as mainstream service providers at a regional level, to help plan, integrate and target local mental health and suicide prevention funding. It is expected that PHNs will support the implementation of culturally appropriate activity,

guided by the goals and actions identified within the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.”

It should be noted that I, personally, cannot locate which organisation commissioned this. Any details or information on this would be most welcome and will be inserted in a later review.

Commonwealth investment in national leadership and support activities that focus on population level activity is also continuing. This includes support to anti-stigma and awareness campaigns, crisis support services, and activities that will support regional approaches commissioned by PHNs.

“The first component of Suicide Prevention is LIFE Framework: It sets an overarching evidence-based strategic policy framework for suicide prevention activities.”

Details about The LIFE Framework is provided under the section: NATIONAL STANDARDS, SERVICE DELIVERY, DECISION MAKERS, REGIONAL APPROACH SERVICE DELIVERY of SUICIDE PREVENTION (page 144)

The National Suicide Prevention Implementation Strategy (NSPIS) draft 2020-2025

Background

In May 2019, a consultation document, The National Suicide Prevention Implementation Strategy”(NSPIS) draft 2020-2025, was released, “setting out 21 Priority Actions that are proposed for inclusion in the strategy with the intention that all health ministers commit to work together to implement them over the first three years of this new strategy.” There is also a consultation process, more details can be found at (<https://www2.health.vic.gov.au/suicide-prevention-strategy>).

The draft document has been developed by the National Suicide Prevention Project Reference Group (NSPPRG)/(SPPRG) and was authorised by the Mental Health Principal Committee (MHPC).

This draft plan is the outcome of actions 3 and 4, referred to in the 5th Plan noted above which said:

“Governments will establish a new Suicide Prevention Subcommittee of MHDAPC/NHPC “to set future directions for planning and investment “, and that the subcommittee would develop a “National Suicide Prevention Implementation Strategy”

The release of the draft National Strategy makes no reference to or content contribution from the NSPS 2015, the draft also makes no reference to priority 2 “Suicide Prevention” of the 5th Plan.

The Strategy

This draft strategy would appear to be the first National Strategy on Suicide Prevention, and the draft appears to be a most significant document that outlines fundamental strategies needed to have an impact on suicide rates. The main focus of strategies are :

- *increasing the reach and effectiveness of prevention and early intervention activities that build positive wellbeing and resilience in individuals and communities and raise awareness of the warning signs for suicide, where to find help and how to help others*
- *removing the stigma around talking about suicide and seeking help, and when help is sought ensuring that it is provided compassionately and effectively by building the competency of our workforce*
- *ensuring that rapid, high-quality responses that meet the individual needs of the person experiencing suicidal distress are available, as well as effective treatment and follow-up care after the immediate crisis that reconnects the person with their reasons for living and supports family members, carers and friends to help their recovery*
- *better supporting people and communities that are bereaved by suicide*
- *establishing and strengthening local and national suicide prevention infrastructure, such as data and information systems, so we better understand suicidal behaviour, can respond quicker and track outcomes*
- *better coordinate suicide prevention efforts across Australia, with structures in place to enable collaboration, co-investment and information sharing.* ^{p1}

We now know more than ever about what works to prevent suicide. Investments in evidence-informed policies, interventions and responses can prevent suicide and support people that have been suicidal to go on to lead a life they value.

Our health systems across Australia are central to the efforts to reduce Australia's suicide rate. Our hospitals, health services and Primary Health Networks (PHNs) partner with people with lived experience of suicide, communities, service providers and experts to prevent suicide, provide treatment and care to those at risk and, when an attempt does occur, to support people to recover.

It will commit to implementing a targeted set of high-priority actions where the outcomes are greater by working together, rather than trying to achieve implementation alone.

The 21 priorities include:

1. *Priority Area 1: Building individual and community resilience*
2. *Priority Action 2: Using the workplace as a setting for prevention and early intervention*
3. *Priority Action 3: Training more community gatekeepers, including Aboriginal and Torres Strait Islander Elders and community leaders, to support individuals and communities*
4. *Priority Action 4: Improving access to services to better prevent suicidal behaviours and, when they do occur, providing effective care*

4.1 Increasing access to mental health services

The Commonwealth has also extended funding to PHNs for mental health and suicide prevention services, with \$1.45 billion over three years from July 2019 to 2021–22 (\$77 million specifically for suicide prevention)

4.2 Strengthening the support and care provided by crisis helplines

Australia's specialised suicide helpline, The Suicide Call Back Service, received 37,341 calls in 2017–18, with 55 per cent of callers having a diagnosed mental health issue. This helpline goes beyond immediate crisis support by offering six counselling sessions with a psychologist (no referral required), a treatment plan and coordination with existing care.

This strategy presents an opportunity for governments to work together to strengthen: the system design of crisis helplines to improve awareness and entry points; integration between helplines and other access points for help; and the experience people who contact them in distress have, including reviewing co-investments and funding levels so calls do not go unanswered. The relationship between the helplines and digital help-seeking platforms such as Head to Health should also be strengthened.

While each helpline has a data capture system, agreements and mechanisms aren't in place to allow this data to be shared and analysed. The limited feedback that is available illuminates many opportunities for improvement.

Demand is high and, in some cases, is not able to be met. Unfortunately, 13,259 of the 37,341 calls received by the Suicide Call Back Service could not be answered

Callers tend to call multiple helplines to get the help they need, which can be frustrating and risks the caller disengaging.

Many of the helplines refer people to the Suicide Call Back Service given it has the extended offering of counselling sessions. However, these are not 'hot referrals', which risks losing the caller.

Many callers call often and over extended periods (12–18 months). In 2017–18, 69 per cent of all calls to the Suicide Call Back Service were from a small number of repeat callers with complex mental health needs. Males are high users of helplines, which is thought to be driven by the after-hours offering, the mode of communication and the anonymity. Some callers are already receiving treatment in the public mental health system. They call the helpline to access additional help and treatment, especially after hours when their case manager and/or normal treatment options are not available.

4.3 Supporting general practitioners to provide assessment, treatment and timely referral

4.4 Strengthening the assessment and care of people who present to emergency departments in suicidal distress by training every emergency department clinician

5. Establishing a range of options to support people in suicidal distress
 6. Digital technology that enables suicide prevention
 7. Preventing the suicides of people receiving treatment from a Public Health Service
- Priority Area 3: Enabling recovery through post-crisis aftercare and postvention
8. Making evidence-informed, person-centred aftercare following a suicide attempt universally available
 9. Increasing the coverage of postvention bereavement services to support individuals and communities to recover
- Priority Area 4: Community-driven Aboriginal and Torres Strait Islander suicide prevention
10. Developing a new national plan for Aboriginal and Torres Strait Islander suicide prevention
 11. Providing culturally safe post-suicide attempt aftercare services
 12. Developing a culturally appropriate risk assessment tool for assessing risk of suicide in Aboriginal and Torres Strait Islander people
 13. Building suicide prevention competency throughout people's careers

- 13.1 High-quality suicide prevention content in tertiary education
- 13.2 Leveraging continuing professional development programs
- 13.3 Promoting existing professional development opportunities
- 13.4 Supporting the alcohol and other drugs workforce
- 14. Supporting PHNs to commission effective suicide prevention activities
- 15. Co-designing and delivering with people with lived experience of suicide
- 16. Priority Enabler 2: Better use of data, information and evidence to improve outcomes
- 17. Establishing a national monitoring system for suicides and suicide attempts
- 18. When a death occurs, using the data to ensure we learn from it
- 19. Harnessing data to better understand suicidal behaviour and target investments
- 20. Establishing the structures needed to strengthen Australia's suicide prevention approach
- 21. Establishing a suicide prevention digital gateway to centrally capture research and evidence, best practice programs and innovation

"Before the 21 Priority Actions are tested with health ministers, they are being shared with Australia's suicide prevention sector, including people with a lived experience of suicide, for without prejudice consultation". (April 2019:

National suicide prevention implementation strategy 2020–2025: Working together to save lives: Consultation document. P16)

Observations About the NSPIS

Sadly, the draft is even more of the same. There is no description of financial capacity, no description of accountability, nor responsibility. There is no explanation of how past strategies are inadequate, or why they are not "built upon". The document continues in the long tradition of aspirational language "Priority Enabler, Supporting, Promoting, Leveraging, Developing, Increasing, evidence-informed, Strengthening, improve awareness, prevention and early intervention, ensuring, removing, and finally, an excellent catch cry — better supporting". In the context of a tragedy that is not being successfully addressed, the authors of this draft must be more than aware of their inability to deliver meaningful change to the suicide toll, because they do not have the authority nor the power to address the problem.

Yet, the committee has dutifully produced another aspirational strategy, with no explanation of how this will be implemented. I do apologise to the committee for such harsh words, it is not a personal attack, it is meant to draw a line in the sand, and say enough is enough. It would be much, much better to have the draft withdrawn, and the Committee produce a document that explains the following dilemma in Suicide Alternatives: "no description of financial capacity, no description of accountability, nor responsibility."

Comparison Chart of Various National Suicide Prevention Priorities

In order to allow readers to evaluate the various priorities provided in earlier reports and strategies, the following chart uses the 21 priorities of the draft NSPIS 2020-2025. Earlier priorities of the NSPS 2016 and the 5th Plan are then observed, and then finally, actual resources of the NSPL&SP are applied to those earlier plans and strategies reveal a disparity of opinions on what are the “correct” priorities. It shows the diversity of opinion and highlights the point that no one holds the magic recipient to this complex subject. No one group, committee, commission or researcher looks like they hold sway over any other group.

Yet, here we have another strategy that purports to know what is needed for success. Surely, the best start towards reducing the suicide rate would be the provision of appropriate sustainability (read: money) and genuine accountability.

Topic	NSPS 2020	NSPS 2016 (11/2015)	5 TH Plan	The National Suicide Prevention Leadership & Support Program
Continuing to fund awareness-raising campaigns	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Awareness	RUOK
Workplace	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	X	OzHelp Mates in Construction
Training more people (esp. ATSI)	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Oversight and coordination research and training	Wesley training Mental Health First Aid Australia
Improving access to services	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Access to services	X
Strengthening the support and care provided by crisis helplines	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Crisis intervention	X
Supporting general practitioners to provide assessment, treatment and timely referral	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Oversight and coordination research and training	X
Strengthening care of suicidal distressed emergency hospitals by training every emergency department clinician	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Already requested	X
Establishing a range of options to support people in suicidal distress	<input checked="" type="checkbox"/> <input type="checkbox"/>	4. joint commitment by the Australian	Access to services	X

Topic	NSPS 2020	NSPS 2016 (11/2015)	5 TH Plan	The National Suicide Prevention Leadership & Support Program
		Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support. (only part addressed)		
Digital technology	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	X	X
Preventing the suicides of people receiving treatment from a public health service	<input checked="" type="checkbox"/> <input type="checkbox"/>	Also See NMHC Reports	Pl 20 appendix 2 indicators Page 62	X
Enabling recovery through post-crisis aftercare and postvention	<input checked="" type="checkbox"/> <input type="checkbox"/>	4. joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support.	Postvention	X
Community-driven Aboriginal and Torres Strait Islander suicide prevention	<input checked="" type="checkbox"/> <input type="checkbox"/>	3. refocussed efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, taking into account the recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy;	See 5th Plan Priority 4	X

Topic	NSPS 2020	NSPS 2016 (11/2015)	5 TH Plan	The National Suicide Prevention Leadership & Support Program
3. Building suicide prevention competency throughout people's careers e.g. tertiary education	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Training and education	X
14. Supporting PHNs to commission effective suicide prevention activities	<input checked="" type="checkbox"/> <input type="checkbox"/>	1. a systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool;		The National Suicide Prevention Leadership & Support Program (Various funded organisations are separated in this column) PLEASE NOTE THE INADEQUATE FUNDING, AND THE FUNDING EXPIRED 30/06/19
15. Co-designing and delivering with people with lived experience of suicide	<input checked="" type="checkbox"/> <input type="checkbox"/>	Everymind	This is a content in virtually all MH and SP docs	Everymind SPNs
Priority Enabler 2: Better use of data, information and evidence to improve outcomes	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Surveillance—data	X
17. Establishing a monitoring system for suicides and suicide attempts	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Treatment—improve	X

Topic	NSPS 2020	NSPS 2016 (11/2015)	5 TH Plan	The National Suicide Prevention Leadership & Support Program
18. When a death occurs, using the data to ensure we learn from it	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Data	StandBy Support after Suicide (StandBy), a program of United Synergies
19. Harnessing data to better understand suicidal behaviour and target investments	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Data	X
Government leadership that drives structures and partnerships to deliver better outcomes	<input checked="" type="checkbox"/> <input type="checkbox"/>	2. national leadership and support activity, including whole of population activity and crisis support services;	See NSPS 11/15 announcement Strategy 2	X
21. Developing a suicide prevention digital gateway	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	Multiple requests	X
Means restriction	X	X	Means restriction	X
MEDIA	X	X	MEDIA	CBAA suicide prevention Program
STIGMA REDUCTION	X	X	STIGMA REDUCTION	X
4. joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self- harmed or attempted suicide are given effective follow-up support.	X	<input checked="" type="checkbox"/> <input type="checkbox"/>	X	X

ACCOUNTABILITY	X	X	X	X
SUSTAINABILITY	X	X	X	X
YOUTH SUICIDE ACTION	X	X	X	Reachout Orygen youth MH
LGBTI COMMUNITY ACTION	X	X	X	MindOUT National LGBTI Mental Health and Suicide

				Prevention Project
CALD COMMUNITY ACTION	X	X	X	X

DRAFT

OTHER NATIONAL PLANS

COAG (and the COAG Health Council), The Roadmap for National Mental Health Reform 2012-2022

All governments are committed to reducing stigma and discrimination in society; significantly reducing suicide rates; and ensuring that people affected by mental health issues and their families have access to appropriate services and supports, stable and safe homes, and are able to participate successfully in education and employment.

To make this happen, COAG will establish new governance and accountability arrangements that will directly engage stakeholders and ensure that governments are held to account. These new arrangements, including the establishment of a new COAG Working Group on Mental Health Reform, supported by an Expert Reference Group, are set out in the Roadmap. They will maintain commitment, momentum and high level, cross-portfolio involvement across all governments.

“The Council of Australian Governments (COAG) is committed to mental health reform as an ongoing national priority. We are determined to keep working toward creating real improvement in the lives of people with mental illness, their families, carers and communities.

COAG will establish new governance and accountability arrangements with the establishment of a new COAG Working Group on Mental Health Reform, supported by an Expert Reference Group (ERG), are set out in the Roadmap. They will maintain commitment, momentum and high level, cross-portfolio involvement across all governments.”

(endorsed 7 December 2012)

“9. Support the development and maintenance of appropriate suicide prevention actions.”^{p18} comprises the sum total of all reference to suicide, and suicide prevention. It also appears that this document will continue as the roadmap for COAG dealing with suicide for a further 4 years.

Observations about the Roadmap

Note: there is no direct reference to Suicide Prevention efforts /contributions or the crisis

This is a disappointing document stating nothing more than the obvious, and in fact, it provides no roadmap at all. A roadmap spells out where thing is, and HOW TO GET THERE. This document does none of that. It’s worth a read, as it defines the problem that we have in mental health services.

The reform document only notes :

- “an emphasis on suicide prevention, with a focus on increasing community awareness of suicide and help for people at risk of suicide”
- “It is also recognised that mental illness plays a significant role in the incidence of suicide, however suicide is a complex phenomenon and our knowledge and understanding of the links need to be improved”.^{p10}

- “Support the development and maintenance of appropriate suicide prevention actions. Similarly, evidence of systematically effective approaches to suicide prevention is scarce, but there is an imperative for governments, service providers and the community to perform better in this area. Suicide is a complex phenomenon and in 2010 was the leading cause of death for men aged 16–44.”

So, notations of what are recognised as the problems, but absolutely no accountability, responsibility, or capacity to do anything about it.

THE NATIONAL MENTAL HEALTH COMMISSION

Overview

The National Mental Health Commission (NHMC) is an Australian government executive agency established in 2012 to provide independent reports to community and government on mental health services and outcomes.

The NMHC have produced several Mental Health & Suicide Prevention reports, some earlier ones are commented on later in this report

Appointment of the National Suicide Prevention Advisor to the Prime Minister

A transformative moment in Suicide prevention?

In July 2019, the CEO of The National Mental Health Commission was appointed as the National Suicide Prevention Adviser to the Prime Minister.

“The National Mental Health Commission welcomes the appointment of its CEO, Christine Morgan, to the new role of National Suicide Prevention Adviser to report directly to the Prime Minister, Scott Morrison.

The Commission Chair, Lucy Brogden AM, said this appointment recognises the tragic impact suicide is having across Australian communities, and the focus required to ensure that current and future initiatives, and expertise in suicide prevention, is drawn upon to reduce and prevent the devastating number of suicide deaths in Australia.

“The Commission welcomes the Prime Minister’s recognition of Ms Morgan’s exemplary skills in bringing communities and experts together to tackle difficult social and health problems facing our nation,” Mrs Brogden AM said.

“Australia has a number of internationally recognised experts in suicide prevention for Ms Morgan to work with in this new role, including recently appointed Commissioner, Alan Woodward, founding director of the Lifeline Research Foundation.

“There are times when love is not enough to keep our loved ones safe from suicide and self-harm. At those times we need strong connected services available to all Australians, ” said Mrs Brogden AM.

The new role of National Suicide Prevention Adviser to the Prime Minister has four key tasks.

Report on the effectiveness of the design, coordination and delivery of suicide prevention activities in Australia, with a focus on people in crisis or increased risk, including young people and our first nations people.

Develop options for a whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions.

Work across government and departments to embed suicide prevention policy and culture across all relevant policy areas to ensure pathways to support are cleared, and people who are at an increased risk of suicide are able to access support.

Draw upon all current relevant work government and the sector is undertaking to address suicide, including the Fifth National Mental Health and Suicide Prevention Plan and Implementation Strategy, and the findings of the Productivity Commission and Royal Commission into Victoria's Mental Health System inquiries.

"The scope of this new role demonstrates the level of commitment the Government has to addressing the root causes of suicide across our communities, with a focus on at risk communities. It also recognises that many of the responses will need to target building better connected and capable communities, by supporting the programs and initiatives that are working on the ground," Mrs Brogden added.

"Success for this role and the Government's commitment to mental health and suicide prevention will be to have a clear and significant pathway towards zero suicides in Australia."

The Commission looks forward to supporting the Prime Minister in this commitment, as it continues to play an integral role in assisting the Federal Government by monitoring and reporting on its investments in mental health and suicide prevention, and by being a catalyst for change to achieve improvements."

As part of this response, the Commonwealth Government appointed a National Suicide Prevention Advisor, Ms Christine Morgan, in July 2019 to drive a whole-of-government approach to suicide prevention.¹⁰³

A FURTHER MESSAGE

From the Towards Zero Suicide Prevention Forum, Canberra, 13th November 2019

Ms Morgan outlined the importance of governments, service providers and the broader community coming together to prevent suicide, and articulated the opportunities to do things differently in a coordinated way.

"In my view, there is a real opportunity for us to come together on this issue but we must think more broadly than we have been. While it is easy to say that suicide prevention is every body's business, it is harder to really achieve the kind of cross-government, cross-jurisdiction and whole-of-community response that is required. While our health services, community organisations and funded suicide prevention programs certainly have a critical role to play, we must consider the broad range of issues impacting on people's lives and consider all of the touchpoint's where we have an opportunity to make a positive difference [...] It's critical governments, services and the broader community come together to ensure an inclusive and proactive response to suicide. This is a big issue that requires a big response."(Commonwealth Department of Health, 'Commonwealth Towards Zero Commitment'.)

National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report card on Mental health and Suicide prevention

An extensive first report by the Commission, this outlines big picture items such as urgency to address mental health and suicide prevention of ATSIC community, the commitment of the Government, data, and sustainability of funding.

Issues of Alternatives to hospitals must be a priority. And how The National Disability Insurance Scheme must fully cover the psychosocial disability, as well as Governments must be brave enough to set goals and targets for improving mental health and reducing suicide and be judged by the community on their results.

The report covers 14 pages on suicide prevention alone, one of the largest in any document on suicide prevention. Important notes include:

- Mental health must be the business of the Prime Minister, Premiers and Chief Ministers
- We must get a proper understanding of the value of good mental health to drive reform
- Governments must meet their existing commitments
- The mental health and wellbeing of Aboriginal and Torres Strait Islander people needs to be included as one of our national priorities
- Data must be rationalised and the right data collected
- The Australian Government needs to commit to conducting reliable and regular national mental health population surveys to measure progress
- Governments must ensure that announced mental health funding is spent on mental health as promised

All governments must independently and transparently report each year on the actual expenditure on mental health prevention, community based, rehabilitation, recovery and acute care services and compare this with the announced expenditure. This way we will know that money committed to mental health is actually used in mental health, is used in the right areas and is not used to offset funding pressures or subsidise shortfalls in hospital or related budgets. p11

Note: Surely the Commission is not suggesting that primary health expenditure in such things as Mental health hospitals are being diverted to mainstream hospitals?

- We must initially agree on what is good practice across all mental health and support services
- The new Activity Based Funding system should be designed to meet the needs of people with mental health difficulties regardless of whether services are provided in hospitals, in the community or elsewhere.
- Alternatives to hospitals must be a priority.
- The National Disability Insurance Scheme must fully cover the psychosocial disability that results from mental illness
- All governments must prioritise the development and implementation of a nationally agreed mental health service planning framework
- Governments must be brave enough to set goals and targets for improving mental health and reducing suicide and be judged by the community on their results.

Recommendations relating to Suicide prevention and related matters

- Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.
- There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.
- No one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness.
- Access to stable and safe places to live must increase.
- Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting

In 2012 the Report Card chapters have the following focus issues:

Feature: Aboriginal and Torres Strait Islander peoples' mental health and wellbeing

“Australian governments must start thinking about Aboriginal and Torres Strait Islander peoples’ mental health in different ways. The evidence shows a strong support for investing in culture and communities to support social and emotional wellbeing. Supporting self-determination and working in partnership should be part of any overall response. A shift away from top-down policies and programs to those led by communities is vital”

We cannot be complacent about:

- Current levels of suicide and the even higher levels of reported suicide attempts
- Lives lost in our Aboriginal and Torres Strait Islander communities or in rural and remote communities
- The rates of suicide deaths of young men
- Suicides in populations where vulnerabilities exist such as lesbian, gay, bisexual, transgender and intersex people
- The suicide of those from culturally and linguistically diverse backgrounds, about whom we know so little when it comes to mental health p175
- The suicide of people in hospitals, prisons or detention centres
- In a Western Australian study over the period 1980 to 1998, approximately half of people who had suicided had previously used a mental health service p178
- Building personal and community strengths to resist suicidal thoughts and prevent copycat suicides requires greater recognition of the relationship between the lack of access to primary care interventions by people and increased rates of suicide
- This is especially the case for Aboriginal and Torres Strait Islander communities where lack of access to suicide prevention support and support after a suicide has been identified, and where a response needs to be driven by those communities which acknowledges the “whole of community risk factors” p180
- We need evidence to tell us what is most effective in managing and reducing suicide clusters, but we have no timely data on their occurrences or patterns, and little research to inform a best response p183
- The follow-up on suicides and suicide attempts is of most concern to the Commission in 2012
- We need timely information to strengthen the effectiveness of responses to reduce the number of people losing their life through suicide, and to better connect support services with people after a suicide attempt or when bereaved by suicide p136
- Research indicates that reducing suicide rates requires action at the whole population level; interventions in high-risk groups and settings and appropriate and effective responses to individuals identified at imminent risk of suicide

As a matter of high priority, we must focus our interventions on people at imminent risk of suicide. This involves governments and non-government organisations supporting effective interventions which have been shown to be:

- effective in finding and supporting the estimated 41 per cent of people who were at risk of taking their own lives in the past year but had no contact with mental health services in that time p107
- responsive to the early warning signs of suicide among family and friends, school and work colleagues, by strengthening peoples’ awareness and ability to take action
- responsive to the isolation of rural and remote communities
- responsive to Aboriginal and Torres Strait Islander peoples’ cultural and family strengths p189
- responsive to and continuing support for people at imminent risk – those who have attempted suicide or are known to have suicidal thoughts
- fast in responding to emerging suicide clusters in rural and Aboriginal and Torres Strait Islander communities, regional and urban communities, schools and other organisational settings
- Increasing access to GP and support services
- Pro-active and ongoing follow-up suicide prevention support services protect those for whom there is a duty of care
- understanding the role of social media in suicide

Observation about the Report Card

An insightful and articulate document, there are 14 pages in this section alone on Suicide prevention. Only the headings are provided here. A very worthwhile document, clearly articulating the problem, the areas of concern, suggestions on how to improve our situation, and comments on specific areas.

Naturally, and with no criticism, the Commission has no powers to take action, no decision making power. It cannot hold anyone accountable or responsible. That said, it's a timely document. Written in 2012, it is as relevant today as it was seven years ago.

NMHC Contributing lives, thriving communities :Report of the National Review of Mental Health Programmes and Services 2014

In 2014, The Commonwealth Government tasked the National Mental Health Commission with conducting a national review of mental health programmes and services. The focus of the review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.

"This summary presents an overview of the findings of the National Review of Mental Health Programmes and Services. The Review responds to the Terms of Reference provided to the National Mental Health Commission by the Commonwealth Government early in 2014.

On the basis of our findings, it is clear the mental health system has fundamental structural shortcomings. This same conclusion has been reached by numerous other independent and governmental reviews.

The overall impact of a poorly planned and badly integrated system is a massive drain on peoples' wellbeing and participation in the community—on jobs, on families, and on Australia's productivity and economic growth." p1 Executive

Summary

This report is focussing on Suicide Prevention and, so, it is not referred to in detail. A summary in Section 1 provides the relevant reference.

"Despite almost \$10 billion in Commonwealth spending on mental health every year, there are no agreed or consistent national measures of whether this is leading to effective outcomes or whether people's lives are being improved as a result. This Review is framed on the basis of making change within existing resources. We consider that Australia has a once-in-a-generation opportunity to improve the lives of millions of Australians without additional funding."

"To achieve the required system reform, the Commission recommends changes to improve the longer-term sustainability of the mental health system based on three key components:

- 1. Person-centred design principles*
- 2. A new system architecture*
- 3. Shifting funding to more efficient and effective 'upstream' services and supports"*

System reform

The need for mental health reform enjoys long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Our “mental health system” — which implies a planned, unitary whole — is instead a collection of often uncoordinated services introduced on an often ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.

We need system reform to:

- redesign the system to focus on the needs of users rather than providers
- redirect Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- rebalance expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care
- reform our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia’s wealth.

From: Where we are now?

Stigma persists

People with lived experience, families and support people have a poor experience of care

A mental health system that doesn’t prioritise people’s needs

A system that responds too late

A mental health system that is fragmented

A system that does not see the whole person

• People being discharged from hospital and treatment services into homelessness, or without adequate discharge planning

A system that uses resources poorly

• A fragmented mental health workforce where many clinicians work in isolation of each other, and do not operate at the top of their scope of practice

• The greatest level of funding goes into high cost areas such as acute care, the criminal justice system, and disability support, indicating that the system has failed to prevent avoidable complications in people’s lives p8

The NMHC reflection on Future approaches and funding priorities in Mental Health in Australia

This should be based on “A person-centred approach”. The realignment of system architecture as recommended in this report also involves two other important features:

- A stepped care framework that provides a range of help options of varying intensity to match people’s level of need.
- Integrated Care Pathways (ICPs) for mental health, to provide for a seamless journey through the mental health system

The Commission believes one of the most fundamental elements of the stepped care approach lies in prioritising delivery of care through general practice and the primary health care sector.

There is international evidence that national health care systems with strong primary care infrastructures have healthier populations, fewer health-related disparities and lower overall costs for health care than those countries that focus on specialist and acute care.

Indeed, the World Health Organization (WHO) has endorsed this approach: Integration of mental health into primary health care “not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments.”¹²

The development of 30 Primary Health Networks (or Primary and Mental Health Networks—PMHNS) across Australia provides the ideal opportunity to harness this infrastructure and better target mental health resources to meet population needs on a regional basis.

These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis. They can work in partnership and apply targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities

For example :

- *providing timely access when needed to hospital and other acute services*
- *managing the handover from hospital back into the community, step-down care and rehabilitation, aged care and palliative care*
- *reducing adverse events, waste and duplication.*

The NMHC provided the following recommendations:

“The nine strategic directions and associated recommendations are as follows:

1. Set clear roles and accountabilities to shape a person-centred mental health system

Recommendations:

1. Agree the Commonwealth’s role in mental health is through national leadership and regional integration, including integrated primary and mental health care.

2. Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.

3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

Recommendations:

4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.

5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.

6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and eHealth record for those with complex needs.

Recommendations:

7. Reallocate a minimum of \$1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.

8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.

4. Empower and support self-care and implement a new model of stepped care across Australia

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

Recommendations:

18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

Recommendation:

1. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

2. Build workforce and research capacity to support systems change

3. Improve access to services and support through innovative technologies

Conclusion

It is clear that our current mental health system suffers fundamental structural shortcomings that contribute to poor social and economic outcomes for individuals, communities and the nation as a whole.

The only way to address this is through whole-of-system reform to build a better integrated, person-centred system that achieves desired outcomes through the effective use of existing resources, and a flexible approach that recognises diversity of people, culture, circumstance and location. Our consultation and submissions received from the community have confirmed this direction.

We believe that significant change is possible and affordable.

Observations about the review

This is such a major document, and so large. It articulates where things were in 2014, and highlights where things are still wrong 5 years later. I have lost count of the aspirational statements, such as **“Reduce suicides and suicide attempts by 50 per cent over the next decade”**, located in so many reports. My recommendation is that, if the person saying this has absolutely no power to achieve that target, please leave it alone. Those of us shattered from loss or who are dealing with suicide in some way find those statements to be most disturbing.

That said, I do commend readers to look at the volumes 1 to 4 in their own time. It makes compelling, if somewhat harrowing reading.

Relevant Articles

Mental health services reach the tipping point in Australian acute hospitals

The OECD warns about Australia’s low psychiatric bed numbers.

In April 2015, the federal government released the National Mental Health Commission (NMHC) report on the Australian mental health sector. Although the report contained many consensus-driven, consumer-oriented proposals, the media focused on the recommended shift of \$1 billion from public acute-care hospitals over 5 years to expand community mental health programs including subacute beds.

The NMHC schedule reduces mental health funding for acute hospitals progressively from the 2017e18 financial year (Box 1). 1 Given that total funding was \$1.4 billion in the 2012e13 financial year, the reallocation of at least \$300 million in the final year of the schedule (2021e22) could reduce the number of acute-care hospital beds by 15%.

As an independent commission, the NMHC has encouraged debate about their report. In a recent article in the Journal, Professor Ian Hickie, an NMHC Commissioner, supported “shifting the emphasis” from acute hospitals to community-based services, and he urged the federal government to act. 2 The NMHC chair, Professor Allan Fels, echoed these views in his National Press Club Address in August 2015. 3 He criticised federal government expenditure on acute-care hospitals as “payment for failure” and argued that mental health problems should be treated earlier to “catch people before they fall”.

The NMHC report is not without its critics. Australian peak medical bodies suggested that the cuts to acute bed numbers could cost lives. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) argued that the NMHC report ignored the already excessive demand on Australia’s psychiatric wards and emergency departments (EDs). 4 The Australian Medical Association (AMA) has also lobbied against acute bed closures, which can block admissions when the risks of suicide and aggression are higher

These medical experts suggested that Australia’s mental health sector has reached the tipping point of high bed occupancy and extended ED waiting times. If this is correct, Australia needs to commission more acute psychiatric beds and maintain bed occupancy rates below 85%, in order to guarantee the safe functioning of acute hospitals.

5

The debate around the public positions of the NMHC and peak medical bodies raises a series of important questions. Does Australia have too many acute psychiatric beds, and can the nation safely make savings by reducing future funding for acute hospitals? How would acute bed closures affect patient care?

The OECD warning

The NMHC report's recommended acute bed closures would begin from a low base by international standards. Australia is ranked 26th of the 34 countries in the Organisation for Economic Co-operation and Development (OECD) for hospital psychiatric beds per 100 000 population (Box 2). 6 In 2013, Australia had 29 fewer beds per 100 000 than the OECD average. Anglosphere countries such as Australia, Canada, the United States and New Zealand tended to have lower bed numbers than the wealthy European nations, with the United Kingdom showing a European influence by having 15 more beds per 100 000 than Australia.

The OECD warned that Australia's low psychiatric bed numbers increased the risks of worsening symptoms before acute admission. 6 These patient risks depended on the "tricky balance" between inpatient care, community services, primary mental health care, and social capital including cooperative networks of carers, extended families and neighbourhoods.

In Australia, the nation seeks to compensate for low acute bed numbers by funding numerous community mental health services. 6 In these circumstances, community services must be able to assist patients during the acute phase of their illness either to avert admission or to help patients immediately after discharge.

As Australia's acute bed occupancy rates are high and patients have a short average length of stay (LOS), patients are often discharged before pharmacotherapy is optimally effective (Australia's average LOS is 17 days). The 30-day hospital unplanned readmission rate provides a measure of how well community services offset short LOS. In 2011, Australia had the third highest readmission rate among the OECD countries for patients diagnosed with schizophrenia with over 15% being readmitted to hospital within 30 days, and the fourth highest unplanned readmission rate of 15% for patients with bipolar disorder. 7 Australia's readmission rate was higher than that of the UK, where more acute beds allowed longer admissions (the UK average LOS was 30 days versus the Australian average of 17 days); this ensured adequate acute treatment in the UK, which was accompanied by lower readmission rates (5%e10%). 7

There was a significant increase in UK readmission rates from 2006 to 2011, which corresponded with a period of acute bed closures. 7 As Fels3 noted, the UK government was "trying to manage cutting back hospital spending" in mental health. While hospital psychiatric bed numbers remained considerably higher in the UK than in Australia, these spending cuts created debate. In 2011, distinguished community psychiatrist Professor Peter Tyrer contended that the closure of psychiatric beds had gone too far in the UK, and the risk of preventing admissions was becoming too great. 8 He concluded that inpatient care had been "demonised" by community psychiatry advocates who had captured national policy, and he suggested that the UK needed new policies that recognised the unique value of inpatient care. His argument could equally well be applied to Australia.

Conclusion

Australia's low acute bed numbers can block access for mental health patients when the risks of suicide and aggression are higher. The OECD 30-day readmission rates and the SA experience suggest that these problems are not being offset by Australia's numerous community mental health services, including the expansion of subacute beds in SA. Overall, the data support RANZCP and AMA concerns that Australian acute hospitals are facing excessive mental health demand.

When ED waiting times and 30-day readmission rates are excessive, it is not possible to safely reduce acute hospital funding and close beds. Quite the opposite policy is required; more acute beds should be commissioned when mental health patients are waiting far longer for admission than medical or surgical patients, as occurred recently in SA. Clinical opinion suggests that these issues are not isolated to SA but are occurring in acute hospitals around

the country. It is time for policy planners to reflect on the OECD warning, and urgently tackle this huge national problem.

The federal government convened an Expert Reference Group to provide a fresh perspective on the NMHC report. This presents Prime Minister Malcolm Turnbull and the government with an ideal opportunity to carefully evaluate mental health demand on acute hospitals, and to ensure adequate activity-based funding for acute psychiatric beds. This expenditure should not be regarded as “payment for failure”; it is a minimal investment in the compassionate care of mental health patients when they are most unwell, which is the standard required in every area of medicine in Australia.”

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14 December 2015

Time to implement national mental health reform

Professor Ian B Hickie, Med J Aust 2015; 202

“Contributing lives, thriving communities”: The National Review of Mental Health Programmes and Services offers clear advice

At the halfway point of its first term, the Abbott Government has finally released the 700-page report of the National Review of Mental Health Programmes and Services, Contributing lives, thriving communities. 1 Fulfilling a 2013 election commitment, Health Minister Dutton had requested the National Mental Health Commission (NMHC) to recommend specific actions that the federal government could take to directly improve the lives of those affected by mental health problems, as well as to enhance programs for preventing suicide. The terms of reference of the review were restricted to considering how existing resources could be better deployed rather than making requests for new funding.

*The NMHC recruited experts to inform its recommendations, and received more than 2000 submissions. It recognised that the Commonwealth already spends \$9.6 billion on mental health each year, **largely through five direct health or welfare programs (most notably, the disability support pension)**, but found that our “patchwork of services, programmes and systems ... are not maximising the best outcomes from either a social or economic perspective” (page 13).*

The report also concluded that “by far the biggest inefficiencies in the system come from doing the wrong things — from providing acute and crisis response services when prevention and early intervention services would have reduced the need for those expensive services, maintained people in the community with their families and enabled more people to participate in employment and education” (page 14).

Note: The bold italics above is a most important point in relation to funding levels in mental health. Politicians love to trot out huge figures to imply that mental health expenditures are adequate. However, figures are “cooked” to attach expenditure that is actually welfare expenditure. Real funding of actual mental health is terribly low in reality.

A MOST IMPORTANT RESPONSE

FROM : *The Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services -2015*

The National Mental Health Commission’s Review of Mental Health Programmes and Services, Contributing lives, thriving communities, highlighted the existing complexity, inefficiency and fragmentation of the mental health system.

There is a critical need for long-term reform. The Australian Government response to the Review of Mental Health Programmes and Services presents significant system reforms

In relation to Suicide prevention: PAGES 16 & 17

“5.7 A renewed approach to suicide prevention

The Review highlighted a lack of coordination in suicide prevention programmes and duplication between Commonwealth and state and territory efforts.

The Review calls for overall system redesign in this area, focussed on a whole of community approach with regional service integration and better targeting of investment. The Review also notes the need to improve service responses for people who seek help for self-harm, and/or suicidal ideas or behaviours, especially in the high risk period following a suicide attempt.

*The consultation on the Review report confirmed that it is time for a new approach to investment in suicide prevention at the community level. **“While significant progress has been made particularly in reducing youth suicide.”***

Note: THIS ASSERTION CANNOT BE LEFT UNCHALLENGED. THERE IS ABSOLUTELY NO STATISTIC OR EVIDENCE THAT SUPPORTS SUCH A CLAIM. THIS IS AN UNACCEPTABLE AND HURTFUL COMMENT AND WILL BE CHALLENGED WHEN THERE IS AN OPPORTUNITY)

“suicide remains the leading cause of death of Australians aged between 15 and 44 years. The Government is committed to moving towards a regional, systems based approach to preventing suicide. The Government will also commit to measurement of progress on reducing suicide, including developing a key performance indicator to measure progress in implementing the principle of active follow up support for people who have attempted suicide.

“The Government will move to immediately implement a new national suicide prevention strategy with four critical components:

- *national leadership and infrastructure including evidence based population level activity and crisis support services;*
- *a systematic and planned regional approach to community based suicide prevention, which recognises the take-up of local evidence based strategies. This approach will be led by PHNs who will commission regionally appropriate activities, in partnership with LHNs and other local organisations;*
- *refocusing efforts to prevent Indigenous suicide; and,*
- *working with state and territory governments to ensure effective post discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan. p16-17*

In regard to an overall response:

Work will immediately commence on the nine key action areas identified in the Australian Government's Response to the Review of Mental Health Programmes and Services.

These key action areas are:

- Locally planned and commissioned mental health services and a new flexible primary health care funding pool
- PHNs will lead mental health planning and integration at a regional level, in partnership with Local Hospital Networks, non-government organisations, Aboriginal and Torres Strait Islander organisations, National Disability Insurance Scheme (NDIS) providers, and drug and alcohol services.
- From 2016, Commonwealth mental health programme funding will be transitioned to Primary Health Networks (PHNs) to form a newly created mental health flexible funding pool.
- PHNs will have the flexibility to use this funding to commission regionally delivered primary mental health services suited to local needs within a stepped care model.

Mental health priorities for PHNs will include:

- regional mental health plans to identify needs and gaps, reduce duplication and remove inefficiencies;
- improved links and innovative approaches to support clinical care coordination for people with severe mental illness and complex needs, including new joined up assessment arrangements;
- integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services

Note: A note of concern here, I have been advised that this approach is not necessarily welcome if the mental health services are not operated by, and within ATSI controlled services.

- improved services and coordination of care for people with severe and complex mental illness.

Note: Another note of concern: from that date, the Federal Government proceeded to dismantle the PIR program, the final nail in the coffin on the 30th June 2019.

- National leadership in mental health reform

Observations about the response of the Federal Government

In response to "7. Reduce suicides and suicide attempts by 50 per cent over the next decade":

This Australian Government response (from 2 above) has to be challenged, it is inexplicable how a government response can make such ill-considered false statements, only to follow on with aspirational statements that hasn't happened. This goes to the nub of the problem in Suicide prevention in Australia, *aspirations that have no substance, because there is no accountability for the statement.*

The heading should have the word "effective" inserted to read "**Effective** National leadership in Mental health Reform". In the area of Suicide Prevention, well, it's coming up to 5 years now since this was proposed, and yes, maybe those twelve (12) PHNs are possibly closer to setting up an operational Suicide Prevention service, **BUT** and we have only 5 years left to halve the rate of suicides. And during the 5 years of this **THIS NEEDS TO BE REWORDED** aspirational statement, the rate has gone up.

The date of this review was November 2014, it means that during the months earlier when the NMHC was putting together the Mental Health Programs and Services review, our son Aaron took his life. From all that I have read, and all the statistics I've seen, and all of the services cut by governments related to mental health, I'm afraid that the chances of reducing suicide by half is, well, just plain nonsense. It's probably one of the worst "aspirational" "feel good comments I've seen, and it's not a good look for the bereaved, and the people who are trying to genuinely improve the services in Suicide Prevention. Further, what was the response from the Australian Government? Another "system redesign" and "new approach". There is no real new money, only trials in a few locations. There are no references to accountability, and responsibility, and no clarification of the centralised decision making on the allocation of programs and funding. In other words, "more of the same", not to mention completely false statements about youth suicide.

NMHC: Monitoring mental health and suicide prevention reform: NATIONAL REPORT 2018

"In 2014, the National Mental Health Commission (NMHC) conducted a national review of mental health programs and services: Contributing lives, thriving communities – National Review of Mental Health Programmes and Services (the Contributing Lives Review). Some recommendations from the Contributing Lives Review have commenced implementation, while a number have been incorporated in the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)."

There commendations related to :

Primary Health Networks (PHNs), NDIS, Suicide prevention, The Fifth National Mental Health and

Suicide Prevention Plan (Fifth Plan), Mental health–related expenditure, Mental health workforce, Towards the elimination of seclusion and restraint, Consumer and carer engagement and participation, Mental health outcomes, Prevention and early intervention, Housing and homelessness, and Physical health.

This document is critical of several areas of work on Suicide Prevention. On page 8, the Commission notes the trial of Suicide Prevention plans and services delivered via PHNs. The report goes on to say "As the implementation of the initiatives is in the early stages, there are currently no outcomes available for reporting. However, the ongoing monitoring of these initiatives will be important to determine not only whether the initiatives are effective in reducing Australia's suicide rate, but also whether a more coordinated approach across governments has been achieved.

*The trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps. The NMHC remains concerned that, at all levels of government, **significant gaps persist** in the collection and distribution of key real-time data. p8*

There is also a **lack of appropriate care and support** for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors."

This critical report on Suicide Prevention is noted as follows:

Despite ongoing work to improve suicide prevention efforts in Australia, there has been no significant reduction in the suicide rate over the last decade.

The current approach to suicide prevention has been widely criticised as being fragmented, with unclear roles and responsibilities across governments.

In addition, a number of important gaps have been identified, including the absence of data on real-time suicide attempts and deaths, lack of appropriate care and support for people in crisis,

and insufficient training for professionals providing services and support to people at risk of suicide. p27

The National Suicide Prevention Leadership and Support Program (NSPL&SP)

In response to the above and other reports, the Australian Government established the National Suicide Prevention Leadership and Support Program (NSPL&SP)

“The Program supports the Australian Government’s approach to suicide prevention by providing funding for a range of national projects designed to reduce deaths by suicide across the Australian population, and among at risk groups and to reduce suicidal behaviour (i.e. ideation, planning, self-harm and suicide attempts).

One of the aims of Program is to support PHNs to lead a regional approach to service planning and integration for suicide prevention activities which meets the needs of individuals at the local level. This document aims to facilitate information sharing through building sector partnerships and networks, and to build the capacity of PHNs to take action in response to suicide and self-harm in their immediate region.”

The Program commenced on 1 April 2017 after an extensive tender process. All successful applicants are now funded until 2021. The total funding for the program is \$79.9 million.

Under the program, more than \$43 million was allocated to 16 projects from April 2017 to June 2019. p43, 44 (additional \$36.9 million from 2019 to 2021)

Funded projects include :

- the National Leadership in Suicide Prevention Research Project led by The University of Melbourne; (a note of concern here by KB; this money went to a different university than the Griffith University that was endorsed only 12 months earlier as the “preeminent leader I research on matters relating to the framework of strategies “ This gives the appearance of the DoH ignoring its own information base, and the question will be asked to allay that concern)
- the Community Radio Suicide Prevention Project led by the Community Broadcasting Association of Australia;
- and the MindOUT National LGBTI Mental Health and Suicide Prevention Project led by the National LGBTI Health Alliance. p44
- committed to funding a suicide prevention campaign trial, called the Better Off With You Campaign, targeted at people who experience suicidal ideation
- committed to providing \$12 million over four years for a National Suicide Prevention Research Fund
- the Victorian Government is trialling the Hospital Outreach Post-Suicidal Engagement (HOPE) initiative, an assertive outreach support program for people who are leaving hospital following a suicide attempt p46, 47
- the South Australian Government has established a Premier’s Council on Suicide Prevention, which has been tasked with reducing the state’s suicide rate by improving policy and services for people at risk of suicide. p48
- State Governments have agreed to expand the latest iteration of the National Mental Health Plan to include a significant focus on suicide prevention
- Noted the establishment of the SPPRG

- Multiple governments and a single research institute have independently established four local area suicide prevention trials, across a total of 29 sites. The trials are:
 1. the National Suicide Prevention Trial (NSPT), funded by the Australian Government Department of Health (12 sites) ^{p45}
 2. place-based suicide prevention trials, funded by the Victorian Government (12 sites) ^{p46}
 3. the LifeSpan trial, funded by the Paul Ramsay Foundation and facilitated by the Black Dog Institute (four sites) ^{p49}
 4. a place-based suicide prevention pilot funded by the Queensland Mental Health Commission (one site). ^{p50}

ROLL OUT OF THE SUICIDE PREVENTION TRIAL SITES TO 2019

The Commission's report 2018 provides an excellent overview of the roll out of the suicide prevention trial sites. The report is cut and pasted here to allow the reader to refer to the second major initiative in Suicide Prevention, being these trials. The other major initiative being the responsibility of rolling out suicide prevention programs at the regional level to PHNs.

“What is expected under this reform?”

Although the approaches adopted in each of these trials may vary, all of the suicide prevention trial sites have the shared purpose of bringing together important stakeholders to implement evidence-based suicide prevention initiatives in a systematic and coordinated way, with the goal of reducing the suicide rate in their community.

What has happened so far?

Although the information available about each of the trials varies, and all trials are in the early stages of implementation, there has been significant investment in the suicide prevention trials to date.”

The National Suicide Prevention Trials

The NSPT alone involves 11 PHNs covering 12 trial sites, with each site receiving approximately \$4million over four years (until June 2020).

Each of these trial sites is required to identify priority populations for targeted service delivery and is responsible for selecting and implementing a systematic model of suicide prevention that meets local needs. ^{p45}

Seven of the 12 NSPT sites have identified Aboriginal and Torres Strait Islander people as one of their target populations, in recognition of the significantly higher rate of suicide in this population. Other target populations include men (six sites); youth (four sites); lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people (two sites); fly-in-fly-out (FIFO) workers (one site); and ex–Australian Defence Force personnel (one site).

A number of systematic models of suicide prevention are being used at NSPT sites. Eight of the 12 sites elected to implement the LifeSpan model, three sites are implementing the European Alliance Against Depression (EAAD) model and one site is developing a custom model. Each of these models has different areas of focus.

See Table 2 for a comparison of the models. NSPT sites began planning and development in 2016–17, and commenced activities in 2017–18. All trial sites have developed and submitted individual work plans to the Australian Government Department of Health.

Victorian place-based suicide prevention trials

The Victorian Government has partnered with PHNs across Victoria to implement 12 place-based

trials of suicide prevention starting in 2016–17. Each trial site is required to develop a plan based on their current assessment of the needs and concerns in their community. The plan must involve the simultaneous implementation of multiple evidence-based strategies (see Table 2) that are tailored appropriately to the local community.

The Victorian Department of Health and Human Services is acting as a central coordination point and is providing support to each trial site.

As at 30 June 2017, each of the trial sites had commenced reviewing the high-risk priority groups in their communities and establishing how best to tailor interventions to support these groups and meet local needs.

NSW LifeSpan trial sites

In December 2015, the Black Dog Institute received funding from the Paul Ramsay Foundation to deliver the LifeSpan approach to suicide prevention in four sites in New South Wales and to scientifically assess the impact of LifeSpan. The trial involves four sites implementing nine evidence-based strategies in their local region simultaneously. Rollout of the four sites has been staggered; two Sites started in September 2017 and two started in August 2018. 53 Each site has a two-and-a-half year trial period.

As at September 2018, all four sites had completed their establishment phase and commenced their implementation phase. 53

Conclusion

Suicide prevention initiatives currently being implemented in Australia may have a significant impact on the future directions of suicide prevention planning and investment. In particular, the local area suicide prevention trials represent an opportunity to gain insights about the process and outcomes of systematic implementation of suicide prevention programs targeted to local at-risk groups.

As the implementation of the initiatives is in the early stages, there are currently no outcomes available for reporting. However, the ongoing monitoring of these initiatives will be important to determine not only whether the initiatives are effective in reducing Australia's suicide rate, but also whether there is a more coordinated approach across governments.

The trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps. *The NMHC remains concerned that, at all levels of government, significant gaps persist in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.*

An Observation

The comments on the Suicide prevention Trial Sites are the positive part of this report, an explaining the positive outcomes of the contemporary plans and strategies in Suicide prevention. It is important to recognise the efforts that ARE being made in this regard, acknowledging the work being done. The trials look promising, hopefully there will be positive outcomes.

Without in any way tearing down the efforts, it is important to note that there are areas that need to be addressed. It may be frustrating to have concerns expressed on the only bright area of Suicide prevention, but I hope it's taken as a support observation of more needed, and not complaining at all on what is being done here. They are as follows :

1. Great that we have 12 trials being done federally, and the other states, however looking at the NSW commitment perspective, it seems to be a churlish, hypocritical stance to leave it up to philanthropic action, that funds 4 NSW sites. There should have been at least 8 sites funded.
2. As an unqualified person in mental health, it's more of a question than a criticism. Why are there so many different models being trialled? If it is to establish the right model that's great, however it seems to be a question of preferences based on a lack of a central decision making. This potentially looks like "more of the same " in future decision making on the final model outcome.
3. In regards to the funding of "projects including the National Leadership in Suicide Prevention Research Project", this is yet again an example of the "headless chook" at work. The draft *National Suicide Prevention Implementation Strategy* (NSPIS) draft 2020-2025, clearly has other priorities, showing there continues to be no central decision making.
4. Yet another reference to inadequate data, and the reform of its collection and integrity is reaffirmed.

The report says, on page 28, that the trials are ongoing. The conclusion on page 29 notes that "the trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps."

It bears repeating that "The NMHC remains concerned that, at all levels of government, significant gaps persist in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors."

There are no published comments about this. It is a self-critical analysis of Suicide Prevention work being carried out at the Federal level, and the NMHC provides notes of their own concerns. I do, however, have a question regarding the granting of money for a National Leadership in Suicide Prevention Research Project. As per the 5th Plan and ALL RELEVANT DOCUMENTS RELATED TO SUICIDE PREVENTION PLANS, place the Everymind program as the centrepiece of the delivery model in all matters of Suicide Prevention.

To deliver valuable research money to a University in Melbourne is confusing. There are numerous reports earlier of a fragmented decision making process, and the "siloing " of power groups, who in turn, hand out money for programs that meet their own agenda or group belief of where the next best thing should be funded. Perhaps this could be clarified.

NMHC Monitoring Mental Health and Suicide Prevention Reform: Fifth National Mental Health and Suicide Prevention Plan, 2018 PROGRESS REPORT

"The National Mental Health Commission (NMHC) has been tasked with monitoring and reporting the implementation of the Fifth Plan, and we are pleased to present our first report on the progress made since release of the Fifth Plan in August 2017"

To gauge the progress of the implementation actions, the NMHC surveyed 51 relevant stakeholders, including Primary Health Networks (PHNs), Australian Government and state and territory departments of health, national and state mental health commissions, and relevant Australian Health Ministers' Advisory Council (AHMAC) sub-committees.

The report explains barriers, and provides a list of "Actions", noting that they are aspirational, yet are all described as being "on track".

Report Details

“In August 2017, the COAG Health Council endorsed The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). This plan builds on the foundations of previous reform efforts and establishes a national approach for collaborative government effort over the period of 2017 – 2022. Underpinned by eight priority areas, the Fifth Plan is aligned with the current aims and policy directions of the National Mental Health Policy that are well positioned for change in terms of need and opportunity. The National Mental Health Commission (NMHC) has been tasked with monitoring and reporting the implementation of the Fifth Plan.”

“This progress report is the first of a series that will be delivered over the life of the Fifth Plan, and the NMHC is *encouraged* by the progress currently being made against the actions of the implementation plan.”

Priority Area 2: Suicide prevention (only Suicide Prevention Priority 2 is reported here)

There is a clear need to reduce the number of people who die by suicide or attempt suicide each year and to reduce the human suffering associated with these actions. Suicide prevention is a complex area of policy with interconnected responsibilities—government agencies, service providers and the community-managed sector all have a role in reducing suicide rates through effective suicide prevention responses. Stakeholders responsible for coordinating these actions include the MHPC and the SPPRG. As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on ‘collaborating’.

That is the total reference to suicide prevention in this report, there is a reference to Suicide prevention on page 52, however it is meaningless.

ACTION 3

Governments will establish a new Suicide Prevention Subcommittee of MHPC to set future directions for planning and investment. The MHPC reported their progress as ‘on track’.

ACTION 4

Governments will, through the Suicide Prevention Subcommittee of MHPC, develop a National Suicide Prevention Implementation Strategy that operationalises the 11 elements above taking into account existing strategies, plans and activities.

The MHPC and the SPPRG both reported their progress as ‘on track’.

Priority Area 2: Achievements

No significant or common achievements were identified across stakeholder groups at this point in time.

Priority Area 2: Barriers

No significant or common barriers were identified across stakeholder groups at this point in time.

Priority Area 2: Enablers

Enablers of note included the commitment and expertise of the members of the established groups, with both reporting that the willingness of members to collaborate and work together to draft an effective and meaningful strategy is the key enabler at this stage in the process. The inclusion of members with lived experience on the SPPRG was also highlighted as a critical enabler to ensuring that National Suicide Prevention Implementation Strategy is designed to support the cohort it is intended to support (p20)

Barriers

Funding and resources were commonly reported barriers across priority areas for PHNs, with many reporting that they lack the funding necessary to implement the Fifth Plan actions. This includes the funding and resources required to achieve integrated planning and delivery (Priority Area 1), coordinated treatment and supports (Priority Area 3), meaningful engagement with Aboriginal and Torres Strait Islander people. The National Mental Health Service Planning Framework (NMHSPF) was reported as a barrier in three priority areas. Stakeholders noted that the NMHSPF does not currently capture rurality or Aboriginal and Torres Strait Islander status, and many jurisdictions are unable to utilise the NMHSPF as a result.

Fifth Plan Implementation Progress – Survey Results

ACTION ii

Governments will establish a Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment. The Australian Government Department of Health, the SPPRG and the MHPC reported their progress as 'on track'. All state and territory government health departments reported their progress as 'on track'.

ACTION iii

Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment. The MHPC, the Australian Government Department of Health and the state and territory government health departments all reported their progress as 'on track' and have established the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (the current name for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee). Additionally, the MHPC were tasked with leading the joint development of Terms of Reference and membership for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and establishing a meeting schedule. The MHPC have reported their progress as 'on track'.

ACTION 2

Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level.

ACTION 2.5

Developing joint, single regional mental health and suicide prevention plans and commissioning services according to those plans. The MHPC reported their progress as 'on track'.

This action was further broken down into components for the contributing stakeholders to address:

(a) PHNs and LHNs will jointly develop comprehensive regional mental health and suicide prevention plans.

(b) PHNs and LHNs will use these plans to progressively guide service development and commissioning.

Of the PHNs surveyed, . . . The remaining PHNs reported their progress against both of these actions as 'on track',
All other state and territory health departments reported their progress as 'on track'.

ACTION 2.8

Developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanism, quality processes and review of adverse events.

The MHPC reported their progress as on track, and PHN as well.

Priority Area 1: Barriers

Given the complexities involved with integrating planning and services at a regional level, a number of barriers were reported by PHNs and state and territory government health departments. PHNs noted that shared plans will be difficult to establish due to the diversity across health care systems and health care strategies, and the competing priorities of numerous stakeholder groups. This is further compounded by the diverse and disparate consumer types across jurisdictions and in regional areas.

Funding and resources were also reported as significant barriers to achieving integrated planning and delivery, with multiple PHNs noting a lack of dedicated funding to implement the Fifth Plan. Coordinating approaches across regions and negotiating resource contributions from stakeholders have been more time-consuming and labour intensive than anticipated for PHNs.

A number of PHNs and state and territory government health departments reported the changing timeframes and scope for regional plans, and the availability of guidance from the Australian Government Department of Health as critical barriers to progress.

Observations about this report

This is a most disappointing document, it has no substance or value, a sort of tick the box approach, saying things are on track. Use of a reference to "enablers" sounds trite and almost condescending.

The report lacks a reflection on the state of Suicide prevention in 2018. When it is considered that the Prime Minister appointed the CEO of the NMHC on Suicide prevention a year later, acknowledging that there are fundamental problems. An example of sustainability of funding for the Suicide prevention trials fails to address a most fundamental problem in the delivery of the trials.

COMHWA 17 Nov 2017

Monitoring mental health and suicide prevention reform: National Report 2018

3.2 NMHC Advice and advocacy in early stages of 5th Plan Implementation for strong consumer partnership (co-design and co-production) arrangements;

The 5th Plan's section on Implementation (p49), states that:

"Governments are committed to equitable, practical, authentic co-design with consumers and carers in the implementation of Fifth Plan actions. Collaborative partnership with consumers and carers is integral to successfully implementing changes. . .

The report goes on to say:

Only focusing on PHNs neglects the critical importance of coordination and integration of planning and delivery across national, state, regional and local levels of government. Currently within the Plan the role of states in relation to regionally tailoring national approaches – rather than relying on private organisations, the PHNs, to undertake this work, is poorly articulated. PHNs commission just a subset of required mental health and suicide prevention services, and regional communities are reliant on LHNs, PHNs and local, state and other federal funding bodies to address overall mental health and suicide prevention needs.

The NMHC also needs to be critically aware, proactive and transparent in its reporting on levels of access to community services by those who need it, not just those designated as “severe and complex”. While the Plan attributes severe mental illness to 960, 000 people in Australia, the Plan only commits to planning to address unmet needs of those with “severe and complex” mental illness, which in population planning equates only to a minority of that 960, 000. Failure to consider and aim for access to needed services of all people who need it, rather than subsections of the population, will lead to poor mental health and preventable suicides.

NATIONAL SUICIDE PREVENTION SUMMIT: NEXT STEPS TO REDUCE AUSTRALIA’S SUICIDE RATE, DECEMBER 2018

The National Mental Health Commission made a series of recommendations to the Minister for Health, the Hon. Greg Hunt MP, as a result of the National Suicide Prevention Summit held in Canberra.

Experts and community leaders, including representatives of the Commonwealth, state and territory governments, came together to discuss new approaches to tackling Australia’s rising suicide rate.

Minister Hunt asked the Commission to convene an urgent summit after the release of figures showing that 3128 people took their own lives in 2017, an increase of 9.1 per cent from 2016.

Minister Hunt addressed the summit, urging participants to work together to establish a clear set of actions that he could take forward.

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On Monday, experts and community leaders, including representatives of the Commonwealth, state and territory governments, came together to discuss new approaches to tackling Australia’s rising suicide rate.

Minister Hunt asked the Commission to convene an urgent summit after the release of figures showing that 3128 people took their own lives in 2017, an increase of 9.1 per cent from 2016.

Minister Hunt addressed the summit, urging participants to work together to establish a clear set of actions that he could take forward.

The summit was also privileged to hear from Liane and Tony Drummond about their experience in caring for their son, David, who tragically took his own life in 2016.

During subsequent discussions, participants highlighted the need to integrate mental health and suicide prevention across all areas of government, not just health portfolios, in recognition of the complex interaction between clinical, social and emotional factors in suicide and suicidal behaviour.

The summit also discussed the critical need for a national approach to the collection of much timelier information on suicide and suicidal behaviour to enable resources to be focussed where they are needed most.

Greater community engagement and participation in both treatment and prevention was also highlighted, as was the need to implement measures aimed specifically at Aboriginal and Torres Strait Islander communities.

As a result of the summit, the National Mental Health Commission has today written to Minister Hunt recommending three key actions:

Make suicide prevention a whole-of-government issue and a COAG priority, including consideration of a suicide prevention taskforce, recognising that the social determinants of health are the policy focus of a range of portfolios, including for example, education, employment and housing.

Establish a national system for the collection, coordination and timely delivery of regional and demographic-specific information on the incidence of suicide and suicidal behaviour. Ideally, this system should have an additional focus on collecting data on psychological distress and wellbeing, to enable focused and timely preventive actions to be implemented.

Strengthen support for Primary Health Networks (PHNs) to enable them to respond effectively to this data and deliver tailored approaches, including non-clinical community alternatives and Aboriginal and Torres Strait Islander-led interventions (guided by ATSIPEP.)

National Mental Health Commission chair, Lucy Brogden, said the summit provided much-needed clarity and a way forward, while also providing a powerful reminder of why this task is so important.

“It was extremely moving to hear Liane speak of their love for their son and all the family did to keep him alive. Sadly, their story is one of many,” she said.

“The actions of the meeting on Monday reflect the social determinants of health and strengthening of clinical services through a whole-of-government response – so that when love is not enough, family is not enough – we are ready.

“Reducing the incidence of suicide in Australia is a profoundly important task and we stand ready to work with all governments, stakeholders and the community on this issue,” Lucy said.

PRODUCTIVITY COMMISSION INQUIRY

Inquiry into Mental Health DRAFT 2019

On the 30th October 2019, the Productivity Commission released its draft report ,” about the mental health and wellbeing of Australia’s population, the prevention and early detection of mental illness, and treatment for those who have a diagnosed condition”(p4).

“The Productivity Commission is the Australian Government’s independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission’s independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole”.(P2)

The inquiry was announced on the 13th February, 2019. The tabling of the draft on the 31st October comprised an overview (118 pages) and the draft report in volumes 1 and 2 (1,300 pages).

For the sake of brevity , the draft report will be referred to as PC

The draft report is timely . One observation said : “While there have been many inquiries into mental health since commencement of mental health reform through the First National Mental Health Plan 1993- 1998, the focus of the Productivity Commission on social and economic participation and the clear acknowledgement of the need for better mental health and a better mental health system means that this Inquiry may have some much-needed impact”.(Orygen submission to the Inquiry , p11- April 2019) and

“Inquiries are not new in mental health. There were 32 separate statutory inquiries into the sector between 2006 and 2012 alone, typically gathering first-person experiences. Despite years of stories and recommendations, very few, if any, have been implemented.” In 1983, New South Wales released a report from the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (also known as the Richmond report), which consisted of 400 pages and 102 recommendations. One of these was the establishment of multidisciplinary community mental health teams.”, noting this has not been implemented in NSW. And “In 1993, more than 450 witnesses shared mainly personal stories during the National Inquiry into the Human Rights of People with a Mental Illness. This was established in response to reports these rights were being ignored or violated. The 1008-page report had more than 100 recommendations, which included that mental health care occur in the ‘least restrictive’ setting.”, and finally “In 2006, the Australian Senate conducted another inquiry to assist the Council of Australian Governments’ consideration of mental health. More stories were told and published. The 600 pages and 13 recommendations included advice for national investment in up to 400 new community mental health centres across Australia – again a proposal left unfulfilled.” (News GP Opinion 30 October 2018 sourced from: <https://theconversation.com/profiles/sebastian-sebastian-rosenberg>) In 1992–93, the first year of the National Mental Health Strategy, mental health accounted for 7.25% of the total health budget. In 2015–16 this was 7.67%. That’s a negligible increase and quite out of proportion with the 12% contribution made by mental illness to the total burden of disease. (30 October 2018 Prof Ian Hickie & Sebastian Rosenberg article : The Conversation)

The Overview and Recommendations Document

The PC advised that “The cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of \$43 to \$51 billion per year. Additional to this is an approximately \$130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health.”(Overview preamble)

Please note : Several reform recommendations are not provided here in order to focus on Suicide Prevention and closely associated matters . Please refer directly to the PC Draft document for more details.

Priority reforms are identified and a staged reform agenda are proposed as follows:.

“Reform area 1: prevention and early intervention for mental illness and suicide attempts

- Consistent screening of social and emotional development should be included in existing early childhood physical development checks to enable early intervention.
- Much is already expected of schools in supporting children’s social and emotional wellbeing, and they should be adequately equipped for this task through: inclusion of training on child social and emotional development in professional requirements for all teachers; proactive outreach services for students disengaged with school because of mental illness; and provision in all schools of an additional senior teacher dedicated to the mental health and wellbeing of students and maintaining links to mental health support services in the local community.
- There is no single measure that would prevent suicides but reducing known risks (for example, through follow-up of people after a suicide attempt) and becoming more systematic in prevention activity are ways forward.

Reform area 2: close critical gaps in healthcare services

- The availability and delivery of healthcare should be reformed to allow timely access by people with mental ill-health to the right treatment for their condition. Governments should work together to ensure ongoing funded provision of:
 - services for people experiencing a mental health crisis that operate for extended hours and which, subject to the individual’s needs and circumstances, provide an alternative to hospital emergency departments
 - acute inpatient beds and specialised community mental health bed-based care sufficient to meet assessed regional needs
 - access to moderate intensity care, face-to-face and through videoconference, for a duration commensurate with effective treatment for the mental illness
 - expanded low intensity clinician-supported on-line treatment and self-help resources, ensuring this is consistently available when people need it, regardless of the time of day, their locality, or the locality choices of providers.

Reform area 5: Fundamental reform to care coordination, governance and funding arrangements

- Care pathways for people using the mental health system need to be clear and seamless with: single care plans for people receiving care from multiple providers; care coordination services for people with the most complex needs; and online navigation platforms for mental health referral pathways that extend beyond the health sector.
- Reforms to the governance arrangements that underpin Australia's mental health system are essential to inject genuine accountability, clarify responsibilities and ensure consumers and carers participate fully in the design of policies and programs that affect their lives.
 - Australian Government and State/Territory Government funding for mental health should be identified and pooled to both improve care continuity and create incentives for more efficient and effective use of taxpayer money. The preferred option is a fundamental rebuild of mental health funding arrangements with new States and Territory Regional Commissioning Authorities given responsibility for the pooled resources.
 - The National Mental Health Commission (NMHC) should be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs. The NMHC should be tasked with annual monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy.
 - These changes should be underpinned by a new intergovernmental National Mental Health and Suicide Prevention Agreement. (Overview p2-3),

The overview notes "This inquiry is about a generational change. Community awareness about mental illness has come a long way, but the mental health system has not kept pace with needs and expectations of how the wellbeing and productive capacity of people should be supported. The treatment of, and support for, people with mental illness has been tacked on to a system that has been largely designed around the characteristics of physical illness. And while service levels have increased in some areas, progress has been patchy. The right services are often not available when needed, leading to wasted health resources and missed opportunities to improve lives." (p4)

Key Factors

"Key factors driving poor outcomes in Australia's mental health system include:

- under-investment in prevention and early intervention, meaning that too many people live with mental ill-health for too long
- a focus on clinical services which often overlooks other determinants of, and contributors to, mental health, including the important role played by carers, family and kinship groups, and providers of social support services
- difficulties in finding and accessing suitable support, sometimes because the relevant services do not exist in the regions where the people who need them live
- the support people do receive is often well below best practice, is not sustained as their condition evolves and circumstances change, and is often unconnected with the clinical services received
- stigma and discrimination is directed at both those people with mental illness and those who support them
- a lack of clarity across the tiers of government about roles, responsibilities and funding, leads to both persistent wasteful overlaps and yawning gaps in service provision, with limited accountability for mental health outcomes.

These are long-standing problems that are documented in numerous reports written over the past decades. Substantial reform of Australia's mental health system is needed and there is no quick fix." (P6)

The draft goes on to suggest reforms needed , however , these have been provided virtually identically in previous inquiries and reports. A cost-benefit analysis was also provided .

The PC produced a quick reference table : Early help for people

START NOW

- Incorporate social and emotional well-being checks into existing physical development checks for 0 to 3 year olds
- All schools assign a teacher to be their well-being and health leader

- COAG developed strategic policy on social and emotional learning in the education system , including development of national standards for teacher training.
- Institute a new national stigma reduction strategy
- Reduce stigma amongst health professionals
- Follow -up people after a suicide attempt
- Identify local priorities and responsibilities for Suicide prevention
- Indigenous organisations empowered as preferred providers of local Suicide prevention activities for ATSI people .

START LATER

- Monitor & report on progress towards universal screening
- Expand parent information programs on child social & emotional development
- Strength skills in workforce's of early childhood education and care and schools to support child social and emotional development.
- Use data on wellbeing of school students to build evidence base for future interventions
- Evaluate best practices for partnership between traditional healers and mainstream mental healthcare for ATSI people
- Apply lessons from Suicide prevention Trials ([A COMMENT: no!!!! start now , not later . A disappointing comment](#))

A major factor in relation to the failure to reduce the Suicide rate stems from funding and effective service delivery. The PC noted in their summary, point 5 :

Reforming the funding and commissioning of services and supports

“A range of the reforms canvassed in this draft report, including care coordination and navigation, and the integration of seamless care through the stepped-care model, will involve institutional change covering different tiers of Government. Both tiers will remain responsible for the outcomes of the mental health system. However, the success of reform will, in part, depend on improved clarity as to which level of Government is responsible for funding which services and how that funding translates into incentives for services to be provided (or not provided) to particular people in a particular manner. Success will also depend on the creation of a strong, evidence-based feedback loop so that program effectiveness can be evaluated with the results being used to help determine which activities are funded in the future.”

IMPROVING GOVERNMENT COORDINATION

To deliver seamless care and support for an individual as their mental health circumstances change requires improved coordination over funding and service delivery by all levels of Government. This includes greater clarity over who is taking responsibility for what. While inevitably there will be ‘grey areas’, to minimise both service duplication and service gaps, pragmatic governance arrangements to enable the various parts of the mental health system to come together as envisaged under the Fifth National Mental Health and Suicide Prevention Plan are needed.

Broadly speaking, the Australian Government has generally taken responsibility for primary mental healthcare and State and Territory Governments have taken responsibility for acute mental healthcare (public hospital mental healthcare). Fundamentally, this will not change under our proposed reforms. However, the ‘missing middle’ reflects the failure of clarity and coordination where primary and acute mental health care meet.”(p42-43)

FUNDING AND INSTITUTIONAL REFORM

“Current funding arrangements in the mental health system contribute to poor consumer outcomes and a mix of services that is inefficient. For example, they provide few incentives at a local hospital level to minimise hospitalisations and avoid repeated presentations to emergency departments. Beyond the healthcare system, funding for other supports such as psychosocial services is extremely fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people. Similarly, mental health interventions delivered in schools and other types of community services are funded through a

very wide range of programs, which is leading to duplication, inefficiency and unnecessary red tape. Reforming funding arrangements in the health system and for psychosocial and carer supports to create the incentives to deliver services that are more consumer-oriented, should be a priority for governments. In part this will require recognition that improvements to the mental health system can result in both costs and benefits beyond the healthcare system, and that these benefits may occur over time. In particular expenditure in some parts of the mental health system today (such as in-community supported residential mental healthcare) would not only generate benefits in the wellbeing of those with severe mental illness but generate long term economy-wide benefits. Funding that is efficient and creates effective incentives will require both intra-government and inter-government coordination and cooperation.

Improved clarity over funding and responsibilities requires institutional reform in the mental health system.

There are 2 options provided by the PC , please make your own enquires .

OBSERVATIONS ON INEFFICIENCY OF SERVICE DELIVERY

“Many of the reforms recommended in this inquiry draft report would involve governments spending more taxpayer funds on mental health. But even under current spending levels, governments are obligated to ensure taxpayer funds are used as efficiently and effectively as possible. Throughout this report, we report numerous instances in the mental healthcare system where this is not occurring.

Improvements can be made across the system. For example, improving the efficiency of public community mental health services is desirable and necessary, given the expanded role that our recommendations would have for them. It is not just taxpayers who are losing out. The Commission estimated that, across Australia, only 29% of staff time at community mental health services was spent on consumer-related activities (with or without the consumer present). This falls well short of an agreed national benchmark (that 67% of staff time in community mental health services be related to consumers). Extending activity-based funding to community mental health services should both improve their efficiency and reduce incentives to prioritise hospital-based care.

The Commission supports using activity-based funding to fund both hospital-based mental healthcare and community mental health services to improve incentives across the healthcare system. However, implementing this approach requires care to ensure that funding reflects underlying costs and that reform does not itself create perverse incentives. “(p47)

RECOMMENDATION REGARDING THE ROLE OF THE NMHC

The role of the National Mental Health Commission (NMHC), which already reports on some mental health indicators, should be expanded, so that it can report on whole-of- government shared outcome indicators. Shared outcome indicators should be used to support joint responsibility and funding programs across different portfolios, including health, housing, human and social services, education and training, employment and justice. The NMHC should also monitor and report on system performance and government expenditure on mental health. Performance of mental health services at a regional level should be publicly reported on nationally by the AIHW.

Rigorous evaluations of programs and policies in the mental health system are very important — and very rare. Evaluation should be embedded into program design, not only to ensure that public funds are spent efficiently but also that programs achieve their intended goals and contribute positively to mental health and wellbeing. The role of the NMHC should include preparing and publishing a rolling three-year schedule for evaluation of mental health and suicide prevention programs that are funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors. The evaluation processes should explicitly provide a means by which lessons garnered during program delivery can be incorporated into ongoing program improvements.

To support the NMHC in these new roles and to allow it to report independently on whole- of-government implementation and performance of mental health programs, the NMHC should be afforded statutory authority status as an inter jurisdictional body. (p48)

FURTHER DETAILS FROM THE DRAFT REPORT

The information provided here about the Inquiry Report Parts 1 and 2 will be of a summary overview nature about mental health's it may apply to Suicide prevention . The voluminous size and the vast areas requires brevity here. Therefore, many areas of mental health will only have the heading noted and the relevant page number provided to allow the reader to enquire further if needed. .However , in relation to Suicide prevention, more details about that subject will be provided (see section 21) . There will also be extracts provided about specific findings and recommendations Commission has prioritised, and is considered relevant to SuicidePrevention

PART I

The CASE for MAJOR REFORM p113-135

2. Australia's mental health ... p137

PC FINDING :— THE STATE OF MENTAL HEALTH IN AUSTRALIA

Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. Compared to other developed countries, the prevalence rate of mental illness in Australia is above the OECD average.

PART II

RE-ORIENTING HEALTH SERVICES to CONSUMERS

Primary mental healthcare, GP's, therapy care levelsp203-221

PC Recommendation :— "ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS

In the short term (in the next 2 years)

Commissioning agencies (PHNs or RCAs *i.e.* Regional Commissioning Authority) . In our NSW region this is assumed to mean our Local Health Network – SWSLHN) –*"should promote best-practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model)."*

In the medium term (over 2 – 5 years)

"Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so)."

IMPROVING the ED EXPERIENCE and PROVIDING ALTERNATIVES

People experiencing a severe episode of mental illness often (re)enter mental healthcare via a hospital emergency department (ED). The rate of mental health presentations at EDs has risen by about 70% over the past 15 years, in part due to the lack of community-based alternatives to ED, particularly after hours and in sparsely populated areas.

While only 4% of ED presentations were for mental health, this group comprised 19% of patients waiting in EDs for inpatient beds and 28% of those delayed from leaving the ED due to an inpatient bed not being available. Compared to people with other health conditions presenting at an ED, people with mental illness are: nearly twice as likely to arrive by ambulance; ten times as likely to arrive by police or correctional services vehicles; and twice as likely to be in ED for more than 8 hours.

While reforms are underway at some hospitals, the typical ED experience exacerbates the distress of those with a mental illness, frustrates and diverts emergency clinicians, paramedics and police, and is very expensive. In some cases, people transported by police to EDs or mental health facilities are not admitted because mental illness is considered not to be the primary impairment (drugs or alcohol are involved), the person is behaving violently or mental health inpatient beds are not available.

Timely availability of crisis support services can prevent or reduce emergency department presentations and be an alternative diversion point for police and other crisis first responders. For example, in Queensland mental health clinicians are co-located in the

police communications centre, supported by an on-call forensic psychiatrist; mental health staff accompany police and provide on-site clinical interventions; and police, health and ambulance services partner to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures.

While some other States have similar services, all State and Territory Governments should fund and implement mechanisms for police, health and ambulance services to respond to mental health crisis situations in a coordinated manner, including by embedding mental health expertise in police and emergency service communication centres to provide real-time support for the individual whom police and emergency services are responding to, advise on how the individuals with mental illness can be managed and appropriate referral pathways, and coordinate deployment of co-responder resources to prioritised cases.

Complementing this, State and Territory Governments should aim to provide more and better alternatives to EDs for people with mental health problems, including peer and clinician led after-hours services and mobile crisis services. This may include providing separate spaces in or near EDs for mental health patients, or otherwise creating a more de-escalating environment. The 'Safe Haven' spaces created in Melbourne and more recently in Queensland provide an effective model for this. When Emergency Departments are built or renovated, the design should take account of the needs of people with mental health problems.

(please refer to PC report for details on recommendations)

21 SUICIDE PREVENTIONp841

There are 16 PAGES of detail on the PC's work on suicide. Some example stories were omitted as details on means restriction , the rest included here due to the high quality content .

Provided as follows :

Understanding the relationship of Mental illness and Suicide

Mental illness is a key risk factor for suicide (Ferrari et al. 2014). Almost two thirds of people who die by suicide had a diagnosed mental illness, including depression, substance use disorders and anxiety (figure 21.3). In 2007, about 72% of people who had suicidal thoughts, 78% who planned suicide and 94% who attempted suicide, experienced a mental disorder within the past 12 months (ABS 2008). Yet, most people who experience a mental illness do not experience suicidal thoughts or behaviours.

Of the one third of suicides not associated with mental illness, many occur when the individual is in a moment of crisis or is having difficulty dealing with some of the stresses of their life. Almost two thirds of people who die by suicide had a 'psychosocial risk factor', such as personal history of self harm, separation and divorce, or relationship problems (ABS 2019j). Further, almost half of all suicide deaths were associated with a physical health issue. Many people experienced more than one of these causes.

Many more people attempt suicide and even more have suicidal thoughts (ideation), than die by suicide. In 2007, 13% of the population had thought about suicide at some point during their lifetime, 4% had made a suicide plan and 3% had attempted suicide (Slade et al. 2009).

While not all people who intentionally self harm are attempting suicide, the rate of hospitalisation due to intentional self harm indicates that the rate of suicide attempts in Australia is likely to be significantly higher than the number of suicide deaths (figure 21.4). In 2017/18, there were over 31 000 people hospitalised for intentional self harm (AIHW 2019b); although ambulance data suggests this number may be a substantial underestimate of the scale of the problem. Turning Point (2019) found that ambulance data showed rates of self harm among men (at least) that were almost three times higher than hospitalisation data. That is, not everyone who intentionally self harmed was subsequently transported to, or admitted into, hospital, and some hospital presentations were not coded as intentional self harm.

As a result, estimates of the number of people who attempt suicide (a subset of the number of people who intentionally self-harm) vary widely. Most estimates suggest that for every death by suicide, between 10 to 30 people attempt suicide (COAG Health Council 2017a; Kinchin and Doran 2017; Slade et al. 2009). This suggests somewhere between 30 000 and 90 000 people may have attempted suicide in 2018.

Some groups of people are associated with higher risk of suicide than others.

- About three quarters of people who die by suicide are male (figure 21.1). This may be because males choose more deadly means when attempting to take their own life (Tsirigotis, Gruszczynski and Tsirigotis 2011).
- Over one third of deaths among people aged 15–24 years are due to suicide and it is the leading cause of death for Australians aged 15–44 years (ABS 2019a).
- Aboriginal and Torres Strait Islander people are twice as likely as nonIndigenous people to die by suicide (ABS 2019a). This is largely attributable to young Aboriginal and Torres Strait Islander males who are at much higher risk of suicide (figure 21.5). Suicide is the

fifth leading cause of death for Aboriginal and Torres Strait Islander people, compared with the twelfth cause for nonIndigenous people.

- Regional communities have a significantly higher rate than capital cities (figure 21.6) (chapter 2).
- While females are less likely to die by suicide, they tend to have far higher rates of hospitalisation due to intentional self harm than males (figure 21.4). Aboriginal and Torres Strait Islander females have particularly high rates of intentional self-harm.

21.2 THE COST OF SUICIDE IS HIGH

Suicide has a devastating impact on individuals, families and communities across Australia. Losing one's life is ultimately the greatest cost of suicide. But suicide can have a deep impact on those left behind. Of those left behind, about six people may be profoundly affected (Andriessen 2009). And the impacts can extend up to 135 people for each life lost (Cerel et al. 2019). These impacts were expressed by many inquiry participants:

His suicide has been the most profound single event in my life ... Four years later there are no answers for me and the guilt and sadness are overwhelming. (Lifeline Australia, sub. 87, p. 3)

The personal, social and emotional costs left after the suicide of someone close are immeasurable. In addition to grief, emotions of guilt, blame, anger and frustration are all felt by families, friends and work colleagues. (Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 11)

In rural communities, the ripple effect of suicide appears to be much stronger, reaching further into neighbouring communities, clubs, businesses and schools; far beyond the immediate family and circle of friends. (Foundation for Rural and Regional Renewal, sub. 195, p. 4)

A lady whose son had died by suicide told me that the light had gone out in her world. She felt she had failed him because she didn't know how he felt and blamed herself. She was now considering suicide herself as she saw no reason to live. (Lifeline Australia, sub. 87, p. 10)

The social and emotional costs of people losing their lives through suicide are incalculable.

Many of the economic costs of suicidal behaviour can be calculated. The Commission has estimated some of the economic costs to help galvanise the community and governments to improve culture, policies and strategies to overcome this significant burden and encourage investment in effective suicide prevention activities. But ultimately, the non-monetary costs will more likely act as a call to action.

A handful of studies have estimated the economic costs of suicidal behaviour to Australia (box 21.1). Several international studies have estimated similar costs (McDaid 2016). Estimates vary considerably depending on the methodology used and the target population; for example whether they capture nonfatal suicide behaviour.

The costs of peoples' suicidal behaviour can be split into three broad categories (chapter 3).

- Direct costs — expenditure incurred by people and governments, such as the cost of medical, coronial and police services.
- Indirect costs — the lost productivity (such as wages) of an individual being unable to contribute to society, such as through paid work, volunteering or home responsibilities.
- Intangible costs — the social and emotional costs that are essentially unquantifiable, such as the pain and suffering associated with the loss of an individual.

The quantifiable economic costs of suicide and nonfatal suicide attempts were estimated to be in the order of \$16 billion to \$34 billion each year (table 21.1). This includes the average costs of:

- suicide deaths, which was between \$0.7 million to \$1.6 million per person
- nonfatal suicide attempts that leaves the person permanently incapacitated, which was between \$1.0 million to \$2.2 million per person
- suicide attempts resulting in a short absence from normal activity, which was just over \$1000 per person.

The vast majority of these costs are the result of lost future activity due to an individual's early death or their inability to return to work, education or household duties. These estimates are broadly in line with those reported by others (appendix E).

There were about 78 000 instances of people who had a nonfatal suicide attempt in 2018. That is, for every suicide death, about 26 people attempted suicide — this falls toward the higher end of the commonly agreed range of estimates of 10–30 people (section

21.1). The considerably larger number of suicide attempts drastically increases the cost of suicidal behaviour in Australia. It is estimated that the total cost of nonfatal suicide attempts was \$14 billion to \$29 billion each year (table 21.1).

These estimates are conservative. For example, they do not include the cost of providing mental health services for people who have survived a suicide attempt (estimated in section 21.3). They also exclude government expenditure directly on suicide prevention activities. The Australian Government spent almost \$50 million on suicide prevention under its National Suicide Prevention Program in 2017 (AIHW 2019o). State and Territory Governments also fund their own suicide prevention activities, designed to meet local needs. However, this expenditure is currently not publicly reported in a consolidated and consistent way (AIHW 2018b).

The quantifiable cost of suicide is higher when the person who dies is a young person who has the majority of their life ahead of them (given the high cost of lost productivity). Kinchin and Doran (2018) estimated the average cost of a suicide death for a 15–24 year old was between \$2.1–3.1 million per person in 2014 — significantly higher than the Commission’s average estimate.

While the quantifiable cost of suicides is high, these costs cannot capture the enormity of the consequences of suicidal behaviour. In 2015, suicide was the 2nd leading cause of the total burden of disease for males, behind coronary heart disease, and the 15th leading cause for females (AIHW 2019c). Overall, suicide and self inflicted injuries has remained the 8th leading cause of disease burden in Australia from at least 2003. The burden of disease is often measured in ‘disability adjusted life years’ — the sum of the years of potential life lost due to premature mortality (such as suicide deaths) and years lived with disability (such as incapacity as a result of a nonfatal suicide attempt) (chapter 2).

In 2015, suicide and self inflicted injuries cost Australians 135 373 disability adjusted life years. The majority of this was caused by the years of life lost due to suicide deaths. In 2018, suicide accounted for 105 730 years of potential life lost, making suicide the leading cause of the number of years of life lost (ABS 2019a). This is largely because the median age at which someone dies by suicide is about 44 years old, considerably lower than other causes of death. On average, a person who dies by suicide loses almost 37 years of their expected life.

As illustrated by the economic costs above, the years lived with disability as a result of nonfatal suicide attempts can also be significant. The Mental Health Council of Tasmania (sub. 314, p. 12) noted that ‘approximately 17% of people who attempt suicide will incur a permanent disability from the attempt, limiting their potential to live a full, enjoyable and productive life’.

21.3 WHAT WORKS in SUICIDE PREVENTION ?

Suicide prevention includes any activities that aim to reduce suicide deaths, attempts, plans and thoughts. There are many potential risk factors for suicide, and thus many potential methods of preventing suicide by reducing these risks. Therefore, it is important to rely on the available evidence to understand what works in suicide prevention so as to target activities that are likely to be most effective.

There are many risk factors for suicide ...

Suicidal behaviours are complex. Each person’s risk of suicide is different and there may be many contributing factors and causes. Mental illness is a key risk factor for suicide, but there are many other potential risk factors. Social determinants, including trauma, abuse, discrimination, harmful use of alcohol and job or financial loss, can increase someone’s risk of suicide (figure 21.7). Some inquiry participants provided examples of how these risk factors impacted their loved ones:

Many submissions to this inquiry recognised that some groups are more vulnerable to suicide risk factors than others (for example, FASSTT, sub. 293; Justice Health Unit, sub. 339; OzHelp Foundation, sub. 294) (figure 21.7).

Farmers, young men, older people, and Aboriginal and Torres Strait Islanders in remote areas are at greatest risk of completing suicide ... due to the compounding social determinants of health of these demographics and geographic locations. (Rural and Remote Mental Health, sub. 97, p. 7)

LGBTIQ+ populations are more likely to experience a mental health disorder, attempt suicide and complete suicide than the rest of the population. The National LGBTI Health Alliance states these outcomes are “directly related to experiences of stigma, prejudice, discrimination and abuse ...”. (Mental Health Australia, sub. 407, p. 16)

... but suicide remains difficult to predict

While the risk factors are known, suicide remains difficult to predict. A meta-analysis of suicide risk factors found that ‘prediction was only slightly better than chance’ (Franklin et al. 2017). This may be partly because past studies tend to test risk factors in isolation (Walsh, Ribeiro and Franklin 2017).

However, the growing availability of data and improvements to both technology and techniques show signs that prediction may improve in the future. For example, Walsh, Ribeiro and Franklin (2017) used machine learning to improve prediction of suicide attempts in patients by incorporating combinations of potential risk factors using electronic health records. And Facebook (2019) has used machine learning to monitor user posts and identify those at greater risk of suicide from 2017.

There is scope for governments and researchers to improve the predictive ability of suicide risk assessments by investigating the application of artificial intelligence to existing administrative datasets, such as health records. These data driven approaches can be a useful way to augment existing clinical screening tools, such as clinician rate instruments (Velupillai et al. 2019). If successful, there may be scope in the future to link additional datasets to improve the predictive ability of the screening tool. For example, health records can identify patients who have previously attempted suicide and legal records can identify individuals who have recently separated. However, the ethical and privacy concerns of linking data would need examination and extensive consultation, as well as a sensitive and appropriate method for responding to individuals identified as being at high risk.

This inquiry has proposed that the National Mental Health Commission (NMHC) be tasked with sponsoring relevant research into mental health and suicide prevention (chapter 25). Research to improve the ability to identify individuals at imminent risk of suicide should be high on its list of priorities.

EVIDENCE -BASED INTERVENTIONS

Interventions for suicide prevention are designed to reduce corresponding suicide risk factors. Given the many risk factors for suicide there are many types of suicide prevention activities. They generally fall into three categories (figure 21.7).

- Universal interventions target an entire population. For example, these interventions may involve improving access to health and mental healthcare, restricting access to the means of suicide, and raising awareness to reduce stigma.
- Selective interventions target vulnerable groups based on population characteristics, such as age, sex, culture or family history. For example, ‘gatekeeper’ training for people in a position to identify whether someone may be contemplating suicide.
- Indicated interventions target vulnerable individuals at risk, such as those displaying early signs of suicide thoughts or who have made a suicide attempt. Interventions might include followup support after a suicide attempt or management of mental disorders. A systematic review of suicide prevention strategies around the world identified certain interventions that are likely to be effective at reducing suicide, particularly:
 - a broad range of mental health services, such as pharmacological and psychological treatments of depression
 - support for people who have attempted suicide (‘aftercare’) can reduce further attempts or deaths
 - school based awareness programs can reduce attempts and ideation
 - restricting access to the means of suicide can reduce deaths (box 21.2) (Zalsman et al. 2016).

Restricting access to the means of suicide – (please refer to the draft report on your own enquiry.)

RURAL and REMOTE REGIONS

In some parts of Australia, there is a significant lack of available mental health services (chapters 2 and 5). A Senate inquiry found that people living in rural and remote Australia (where suicide rates are higher) access mental health services at a much lower rate, partly because the right care is not available and partly because stigma in these communities affects attitudes towards seeking help (CARC 2018). Inquiry participants also noted these issues:

[My daughter has attempted suicide and self harm. Although the psychiatrist at Toowoomba Base hospital diagnosed depression and anxiety, we are constantly told she does not have mental health issues. I then \[sought a\] private psychiatrist and psychologist however have to travel to Brisbane 250km away. \(comment no. 16, carers\)](#)

[My 26 year old son committed suicide in March 2019. He was high functioning and held down full time employment in regional NSW. Apart from the issue of not having enough resources for mental health treatment facilities we discovered on his journey that](#)

the services that are available are totally fragmented and difficult to access for working patients especially in regional areas. (comment no. 20, carers)

It's clear the low rates of people accessing mental health services is a contributing factor to the high rates of suicide amongst these cohorts living in regional communities. To address issues in relation to rural suicide, the provision of adequate health services should be addressed. (Queensland Alliance for Mental Health, sub. 247, p. 6)

Aboriginal and Torres Strait Islander people who died by suicide were only half as likely as other Australians to receive professional help for mental health concerns (Sveticic, Milner and De Leo 2012). For example, the WA Coroner's inquiry into the suicide deaths of 13 young people in the Kimberley Region found that most had previously voiced suicidal ideation or intent but had no contact with mental health services (Fogliani 2019).

While some people do not or cannot access mental health services, many people do access either these services or other health services prior to suicide. Therefore, mental health and other health services must not only be accessible but be effective at treating an individual seeking help. This includes the need to refer people to the right service (chapter 10) and for care to be appropriately tailored to different cultures (chapter 4).

The lack of community based mental health and suicide prevention services has led some people in severe suicidal distress to seek help at hospitals. However, many submissions expressed concern about the poor treatment of patients presenting to hospital in suicidal distress (box 21.3).

EXPERIENCES OF PEOPLE GOING TO HOSPITAL IN SUICIDAL DISTRESS

Many inquiry participants expressed their experiences and concerns that people presenting to hospital in suicidal distress are turned away, wait a long time for treatment, are sent home without treatment, or experience stigma from hospital staff.

When "G" was unwell and needed somewhere safe to go because they felt suicidal. The only place available was a Psych Ward in the nearby hospital, but they were given medication and "thrown" out the next morning!! At that immediate time, when feeling so unwell, there was nowhere else to go! (Name withheld, sub. 31, p. 1)

A recent story from a carer was that she presented to [the Emergency Department] with her 18 year old daughter who was very distressed. She was turned away from [the Emergency Department] and not even 24 hours later her daughter suicided. Sadly this story is becoming a common mental health story from families. (Mental Health Carers ARAFMI Illawara, sub. 161, p. 3)

Client A is a 23 year old woman ... She has been referred to the public mental health system for psychiatric review on several occasions, and presented to the emergency department for suicidality and self harm on another occasion, however the intake team at the hospital's mental health unit say she is not eligible for service (her symptoms are "not severe enough") and refer her back into her GP and private psychologist's care each time. (EmmaKate Muir, sub. 338, p. 3)

For a person in suicidal crisis, the experience of sitting for hours on end in the emergency department can be bewildering, triggering and ultimately a barrier to further help seeking. Some experience stigma at the point of entry and many health professionals are not getting adequate support and training themselves. (Beyond Blue, sub. 275, p. 22)

A high proportion of these people will leave hospital without being admitted, so there is no discharge process to prompt a referral. People who have not been admitted are rarely given an onward referral (Mental Health Council of Tasmania, sub. 314, p. 29)

Parents should not have to beg for their children, who are expressing suicide ideation, to be admitted to care because of a shortage of outpatient and inpatient treatment facilities. (NAPP, sub. 495, p. 2)

A doctor asked me if I was doing it for sympathy. A doctor! You'd think he would be someone who would know better. (Orygen and headspace, sub. 204, p. 51)

The patient explained that the emergency treatment staff suddenly announced that the patient had to go home, and they (literally) put the patient out on the street. The staff would not even let the patient wait inside. (Laurence West, sub. 541, p. 2)

And treatment in hospitals is not necessarily the most effective treatment for people in severe psychological distress.

My daughter committed suicide on 10 May 2018 after many years of untreated mental illness. She had well over 20 hospitalisations over a period of 10 years and ongoing involvement with police. There was no consistency of care in any of these hospitals and despite suffering from suicidal depression, bipolar disorder (Type 2), [Post traumatic stress disorder] and Borderline Personality Disorder and despite the regular harm she came to and overdoses, she never received the specialist intensive treatment she needed for her to survive. ... The treatment she needed a long time ago was [Dialectical behaviour therapy] — following detox and rehab and support with real housing. (comment no. 8, carers)

The public hospital emergency department sometimes have areas set aside for mental health patients for observation. These areas do not distinguish between patients in an acute state of agitation because they are on recreational drugs and/or are suffering from an agitated psychosis, or from those who are in a state of despair and have attempted suicide or who are suicidal. The treatment area is frightening for those who are in despair and lacks containment for those who are agitated and psychotic. (Laurence West, sub. 541, p. 2)

There are several reasons why emergency departments are not suited for treating people in severe suicidal distress. They often have stressful environments and mental health patients tend to spend more time in emergency departments than other patients, although efforts are being undertaken to better accommodate patients in distress (chapter 8). There is also a evidence of stigmatisation among some hospital workers towards patients in mental health or suicide distress (box 21.3).

The unpredictability of suicide means that individuals who make the effort to seek help for mental ill health, or suicidal thoughts or behaviours should not be dismissed. Rather than waiting for things to get worse before they get better, mental health and suicide crisis services should act as preventative mechanisms to reduce suicidal distress.

Several submissions recommended the use of mental health and suicide crisis hubs that act as an alternative to emergency departments for people in severe distress (Beyond Blue, sub. 275; ConNetica Consulting, sub. 450; EMHS, sub. 152; Laurence West, sub. 541; Mindgardens Neuroscience Network, sub. 64; NMHC, sub. 118; NMHCCF, sub. 476; Tim Heffernan, sub. 552). These types of alternative services, such as the Safe Haven café located at St Vincent's Hospital in Melbourne, can be beneficial for those in suicide distress as well as avoiding emergency department presentations (chapter 8).

In addition to improving the effectiveness of mental health services received by those presenting at hospitals, this inquiry makes several recommendations to improve access to community based mental health services, including in regional Australia, and to online mental health treatment, in cases where this may be beneficial (for example, chapters 5, 6, 7, 11 and 12).

Improving access to mental health services can prevent many suicide deaths and attempts, avoiding the associated social, emotional and economic costs. Krysinska et al. (2016) estimated that increasing the proportion of suicidal people who receive mental healthcare from 31% to 50% could prevent about 5.8% of suicide deaths and 8.0% of suicide attempts. This could prevent about 5200 people from attempting suicide resulting in short incapacity, 1065 people from attempting suicide resulting in full incapacity, and about 177 people from dying by suicide. This could be expected to reduce the economic cost of suicide and suicide attempts by \$1.3 billion to \$2.6 billion each year. These costs do not include the significant social and emotional costs associated with suicidal behaviour.

AFTERCARE FOR PEOPLE WHO HAVE ATTEMPTED SUICIDE

A previous suicide attempt is considered one of the most reliable indicators of future suicide or suicide attempts (NMHC 2014e; Owens, Horrocks and Allan House 2002; WHO 2014a; Yoshimasu, Kiyohara and Miyashita 2008). For example, a recent metaanalysis found that patients discharged from inpatient psychiatric care who were admitted with suicidal thoughts or behaviours were nearly 200 times more likely to die by suicide than the global average (Chung et al. 2017). The risk of suicide is greatest in the days immediately following discharge and remains elevated for weeks, months and even years (Chung et al. 2017; Meehan et al. 2006). Between 15 to 25 per cent of people who attempt suicide will reattempt, with the risk being highest during the first three months following discharge from hospital after an attempt. Of these, 5 to 10 per cent will die by suicide. Half of the people discharged from

hospital after a suicide attempt do not attend followup treatment. Two thirds of people who do attend follow up treatment cease treatment after three months. (Mental Health Australia, sub. 407, p. 24)

Adequate aftercare for people who have attempted suicide, including discharge planning and followup support, can prevent future suicide deaths and attempts (Luxton, June and Comtois 2013; Zalsman et al. 2016). For example, one study found that providing safety planning resources and follow up intervention for suicide patients in emergency departments approximately halved the odds of suicidal behaviour over six months (Stanley et al. 2018). Ideally, aftercare should include support prior to leaving a service, as well as followup support within the first day, week and three months of discharge. There are several examples of improvements made to aftercare in Australia (box 21.4).

Preventing deaths and attempts through aftercare reduces the associated social, emotional and economic costs of suicide. Krysinska et al. (2016) estimated that adequate aftercare could reduce the prevalence of suicide attempts that reach an emergency department by about 19.8% and all suicide deaths by 1.1%. This could prevent about 5108 people from attempting suicide resulting in short incapacity, 1046 people from attempting suicide resulting in full incapacity, and about 34 people from dying by suicide. Using the Commission's estimated costs, aftercare could be expected to reduce the economic cost of suicide and suicide attempts by \$1.1 billion to \$2.3 billion each year. This is largely driven by preventing the loss of economic activity produced by people whose suicide attempt would be likely to result in full incapacity.

Currently in Australia not everyone who attempts to take their own life and seeks help receives aftercare. When it is provided, while some people with lived experience of suicide report positive experiences, far too many report negative experiences. They report that care was not always intuitive or easy to access, not offered consistently and that the quality, length and amount varies. They report a lack of connection between services and clinicians, meaning that people need to tell their story again and again. (NSPPRG 2019, p. 21)

The Commission heard about situations where people had been discharged from hospital following admission for mental illness and/or suicide attempt with no scheduled follow up, or where a follow up had been scheduled but the person had not been contacted if they did not attend. We were told that responsibility and accountability for follow up was unclear and inconsistent. (SA Mental Health Commission, sub. 477, p. 31)

I was in a psychiatric ward for 5 days (for attempted suicide) ... I was not given the opportunity once to speak about why I was feeling the way I was, how they can help when I leave the ward and what we can do to prevent this from happening again. ... Once I had left the ward I was back to the beginning. I had no connections outside of the ward to help me on an ongoing basis, by changing this, people can feel like they are receiving the help they desire. (comment no. 21, consumers)

Many submissions identified the need for effective support for people who have attempted suicide (APS, sub. 543; Beyond Blue, sub. 275; CATSINaM, sub. 75; Jesuit Social Services, sub. 441; Laurence West, sub. 541; Mental Health Victoria, sub. 479; Private Mental Health Consumer Carer Network (Australia), sub. 49; Relationships Australia, sub. 103; Suicide Prevention Australia, sub. 523; your town, sub. 511).

There is a clear need to expand community based assertive outreach services to people who have attempted suicide. (Mental Health Australia, sub. 407, p. 24)

In addition to supporting people with suicide ideations, targeted after care and crisis care must be available to those who have previously attempted to end their life. (Mission Australia, sub. 487, p. 7)

There is a clear net benefit to providing universal aftercare for people who present at a hospital following a suicide attempt. Further, aftercare should extend to people presenting to any health or government service following a previous suicide attempt in order to reach and support as many people as possible.

Aftercare should include support prior to discharge or leaving the service , as well as IMMEDIATE and SUSTAINED follow-up support. (p15 Summary)

SCHOOL-BASED AWARENESS PROGRAMS

Stigma and negative attitudes about mental illness and suicide can discourage people from seeking help (chapter 20). There is significant stigma towards suicide in Australia — a survey found that over one third of Australians thought suicide was 'irresponsible' (SPA 2017). Stigma and a lack of awareness that suicide is preventable can be so strong that many individuals do not seek help at

all. For example, a survey by yourtown (sub. 511) found young people may not seek help because of stigma, lack of parental support or fear of being labelled an attention seeker.

Awareness campaigns aim to reduce stigma, encourage help seeking, and support the community's understanding that suicides are preventable. However, there is insufficient evidence linking whole of population awareness campaigns to a meaningful reduction in suicide deaths (Zalsman et al. 2016).

In contrast, some school based awareness programs appear more effective (Calear et al. 2016; Katz et al. 2013). A large European study found that the Youth Aware of Mental Health (YAM) program significantly reduced suicide attempts and ideation after one year (Wasserman et al. 2015). The Black Dog Institute (2018b, sub. 306, p. 29) has begun trialling the YAM program (evaluations are underway), with '[m]ore than 5000 students across 46 schools [having] completed school based suicide prevention programs'.

Krysinska et al. (2016) estimated that school based programs such as YAM could reduce the prevalence of suicide attempts in Australia by 2.9%, assuming half of all schools participate. This could prevent about 1885 people from attempting suicide resulting in short incapacity and 386 people from attempting suicide resulting in full incapacity. Using the Commission's estimated costs, school based awareness programs could be expected to reduce the economic cost of suicide attempts by \$407 million to \$834 million each year. This may be an underestimate considering that students have their entire working life ahead of them, increasing the cost of foregone wages.

These savings are significantly greater than the estimated cost of implementing YAM. The cost of implementing YAM across half of all schools was estimated be \$9.5 million to \$18.6 million each year. However, these costs are likely underestimated because they do not include the cost of training YAM instructors or their travel expenses. Nevertheless, school programs such as YAM provide a significant positive return on investment of 22:1 to 88:1.

Other school based programs show an increase in help seeking behaviour. For example, an evaluation of 'safeTALK' — a three hour school based workshop — showed increased suicide awareness and help seeking for suicidal thoughts (Bailey et al. 2017). However, this study did not evaluate whether the program reduced rates of suicide attempts or deaths. This highlights the need to build rigorous outcomes based evaluations into these programs to continue to build the evidence base and confidently direct government funding.

Educators have many competing priorities to meet within a limited timeframe. Governments should encourage the use of school based suicide prevention awareness programs and make it easier for schools to choose and run these programs. This inquiry has recommended accreditation of social and emotional learning programs offered to schools, such as those that can encourage help seeking behaviour (draft recommendation 17.3).

For details on findings of the PC on school based awareness programs please refer to the draft document .

DRAFT RECOMMENDATION 21.1 — UNIVERSAL ACCESS TO AFTERCARE

In the short term (in the next 2 years) Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive followup support within the first day, week and three months of discharge, when the individual is most vulnerable.

21.4 EMPOWERING ABORIGINAL and TORRES STRAIT ISLANDER PEOPLE TO PREVENT SUICIDES

Aboriginal and Torres Strait Islander people are significantly more likely to die by suicide than nonIndigenous people and face unique factors that can increase their risk of suicide (box 21.5). For example, Aboriginal and Torres Strait Islander youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth (Dickson et al. 2019).

Suicide is believed to have been rare among Aboriginal and Torres Strait Islander people in precolonial times, but has become increasingly prevalent over recent decades. Research identifies a number of risk factors which are disproportionately or exclusively experienced by Aboriginal and Torres Strait Islander people.

- Lack of 'cultural continuity' — Indigenous self-determination over aspects of culture and community.
- Poor physical health and access to health services, family and relationship difficulties, stress associated with the death of family members, unemployment, homelessness, financial stress, violence and racism.
- Exposure to traumatic stressors and intergenerational trauma associated with cultural dislocation, and loss of identity and practices resulting from colonisation and the effects of the Stolen Generation.
- Alcohol use and Foetal Alcohol Spectrum Disorder. For example, alcohol attributable suicides were estimated to be 30% higher for Aboriginal and Torres Strait Islander males than for nonIndigenous males.
- Suicide 'clustering' — a series of suicides or self-harming acts that occur within a single community over a period of weeks or months.
- Living in regional or remote areas where there are greater levels of social isolation and poorer access to services.
- Comparatively high rates of incarceration, although typically for relatively short periods of time.
- There is a strong element of impulsivity to many Indigenous suicide deaths.

Source: ATSISEEP (2016b); Dickson et al. (2019); Fogliani (2019); Thirilli Ltd, sub. 549; Pascal, Chikritzhs and Gray (2009).

Evidence indicates that suicide prevention interventions for Aboriginal and Torres Strait Islander people are most effective when the relevant Indigenous community is involved and has control over the intervention (ATSISEEP 2016a; Healing Foundation 2018; WHO 2014a). For example, the Yarrabah community came together to respond to high rates of suicide through programs that empowered the community (box 21.6). In another example, Chandler and Lalonde (2008) found that Indigenous communities in Canada that exhibited many key markers of community control, such as control over health or education services, experienced significantly lower suicide rates.

In the 1980s and 1990s, the regional Aboriginal community of Yarrabah in North Queensland experienced several waves of suicide. During the third wave in 1995, the community held a crisis meeting that included community Elders and service providers. The meeting recognised the historical and social determinants that lead to suicidal behaviour and identified a number of solutions to be implemented at the local level, such as closure of the alcohol canteen. A key outcome of the meeting was the development of a feasibility study in 1997, which proposed a community controlled primary healthcare service model as the best way forward to improve the health of the Yarrabah community. The feasibility study ultimately led to three important developments that were considered key to addressing the high number of suicides in the mid1990s:

- Gurriny Yealamucka Health Service — one of the first communitycontrolled primary healthcare services in Queensland
- Family Wellbeing Project Partnership — a personal development course (developed by Aboriginal and Torres Strait Islander people) focusing on problem solving, conflict resolution and other life skills
- Yaba Bimbie Men's Group — a men's group that focuses on men's healing and restoring cultural pride, connection and responsibility.

These programs led to several improved outcomes because they were led by, controlled by and empowered the local community, including:

- improved reflective skills, hope and confidence
- prevention and management of domestic conflict and more positive family relationships
- reduced levels of alcohol consumption and conflict.

Source: Healing Foundation (2018).

Over time, governments have recognised the need to develop a tailored approach to suicide prevention for Aboriginal and Torres Strait Islander people (box 21.7). In 2016, the Aboriginal and Torres Strait Islander Suicide Evaluation Project (ATSISEEP 2016a) evaluated what works for the prevention of suicide by Aboriginal and Torres Strait Islanders. The project made several recommendations to governments including:

- suicide prevention activity should be community led
- the Australian Government should require Primary Health Networks (PHNs) to demonstrate cultural capabilities and standards and include Indigenous representation
- a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded
- Aboriginal Community Controlled Health Organisations (ACCHOs) are the preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people.

In 2010, the Senate Community Affairs References Committee (2010) undertook an inquiry into suicide in Australia. Given the significant impact of suicide on Indigenous communities, the inquiry recommended that the Australian Government develop a separate suicide prevention strategy for Indigenous communities.

In response, the Australian Government developed the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in 2013 to complement the LIFE Framework (discussed in section 21.5) in acknowledgement of the disproportionately high rates of suicide and suicidal behaviour among Aboriginal and Torres Strait Islander people (DoHA 2013).

In 2016, the Australian Government funded the Aboriginal and Torres Strait Islander Suicide Evaluation Project to expand the evidence base for what works in Indigenous community led suicide prevention and develop tools and resources to support suicide prevention activities (ATSISPEP 2016a).

In 2017, The Fifth National Mental Health and Suicide Prevention Plan, established an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee (COAG Health Council 2017a). This subcommittee is responsible for advising and supporting the inclusion of Aboriginal and Torres Strait Islander people in the National Suicide Prevention Implementation Strategy also under development (discussed in section 21.5).

In 2018, the 2nd National Aboriginal and Torres Strait Islander Suicide Prevention Conference (2018) recommended revising the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and developing a related Implementation Plan, as well as allocating funding to Indigenous organisations to deliver these programs.

Many submissions supported pursuing some or all of these recommendations (AHRC, sub. 491; AH&MRC, sub. 206; Healing Foundation, sub. 193; Jesuit Social Services, sub. 441; Mental Health Commission of New South Wales, sub. 486; Mission Australia, sub. 487; NACCHO, sub. 507; NT Mental Health Coalition, sub. 430; Orygen and headspace, sub. 204; Thirrili Ltd, sub. 549; VACSAL, sub. 225; WAAMH, sub. 416; WHV, sub. 318).

But implementation of these recommendations appears slow or non-existent.

Australia is yet to revise its National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and develop an associated Implementation Plan (box 21.7). A revised strategy and dedicated implementation plan is warranted given relatively high rates of suicide in some Indigenous communities. The existing strategy was developed by the Australian Government. A new strategy and plan should extend beyond the Australian Government and secure agreement from State and Territory Governments who are responsible for delivering some suicide prevention activities. To do so, the Council of Australian Governments (COAG) should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan. This will mirror arrangements for the National Suicide Prevention Implementation Strategy under development (section 21.5).

Some participants expressed concern that PHNs are not adequately engaging with Indigenous communities.

The authors are also strongly concerned with the accountability of PHNs to the Aboriginal and Torres Strait Islander communities they serve ... There are 31 PHNs across the country. If the \$196 million allocated to them towards Aboriginal and Torres Strait Islander mental health and suicide prevention since 2015 (as discussed above) is averaged out, that means that each PHN has received \$6.32 million. But we are not clear how this money has been spent, on which organisations, by what processes and with what results. Further, PHN approaches to commissioning or otherwise establishing mental health services in rural and remote areas vary significantly throughout the networks. (NATSILMH, IAHA, AIPA, sub. 418, p. 10)

The national peak body for ACCHOs recommended that its agencies become the preferred providers of all mental health and social and emotional wellbeing programs for Aboriginal and Torres Strait Islander people, rather than PHNs, primarily because:

Some Primary Health Networks do not collaborate well with ACCHOs ... Funding of ACCHO mental health services through PHNs is unacceptable due to the imposition of inappropriate and unacceptable reporting requirements. PHNs also have discretion to allocate Aboriginal and Torres Strait Islander specific funds to non community controlled providers that are not necessarily culturally competent. (NACCHO, sub. 507, pp. 4–6)

The specific needs of consumers from particular communities or backgrounds are likely to be better met with initiatives and services that are sensitive to their experiences, culture and specific issues they face (chapter 4). The Commission supports a greater role for Indigenous organisations in suicide prevention as they are likely better placed to meet the needs of Aboriginal and Torres Strait Islander people.

However, this may not be feasible in all cases, such as areas where there is no appropriate Indigenous organisation. In these cases, there would still be a need for culturally appropriate suicide prevention activities and health workers in available mental health services. One way to achieve this is to develop pathways for Aboriginal and Torres Strait Islander health workers to transition into mental health related professions (chapter 11). But in many cases, capable Indigenous organisations already exist and investing in their capabilities and capacity could give them the opportunity to take on this suicide prevention role.

Indigenous organisations should be the preferred providers of local suicide prevention activities for Indigenous communities. For these organisations — and other providers of programs or services for Aboriginal and Torres Strait Islander people — performance monitoring, reporting and evaluation requirements should be adapted to ensure they are appropriate and responsive to cultural needs.

DRAFT RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

In the short term (in the next 2 years)

- The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities.
- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.

21.5 IMPROVING OUR APPROACH TO SUICIDE PREVENTION

Australia's early approach was not very effective

Australia was one of the first countries globally to take a national approach to suicide prevention, creating the National Youth Suicide Prevention Strategy in 1995 and expanding this into the National Suicide Prevention Strategy in 2000 (AHA 2014). In 2007, the Australian Government, in consultation with State and Territory Governments, developed the Living is For Everyone (LIFE) Framework — the strategic policy document that used an evidence based approach to outline the key elements necessary for suicide prevention activities. In addition, State and Territory Governments have developed their own high level suicide prevention frameworks and programs (for example, the Victorian suicide prevention framework 2016–2025).

However, there have been issues with Australia's approach. For example, the LIFE Framework lacks clear governance arrangements outlining who is responsible for suicide prevention, accountability measures and formal mechanisms for different levels and portfolios of government and the community to work together. Further, the Australian Government Department of Health took a topdown approach to funding suicide prevention activities through grant rounds on an ad hoc basis across the country (AHA 2014). This process was not well coordinated with State and Territory Governments and akin to funding some training in one area and some bereavement support in another.

Australia's post-2015 move to a 'systems approach' holds promise

A 2014 review by the NMHC (2014f, p. 116) pointed to mounting international evidence indicating that a systems approach to suicide prevention is likely to be a more effective means of reducing suicide rates.

It is now time for a new strategy to be rolled out on a regional basis so that programmes reflect the needs of local communities instead of a "one size fits all" approach to preventing suicide.

A systems approach involves devolving decision making to the local community to tailor a local approach that implements multiple suicide prevention activities at the same time. For example, a community may consider it most effective to fund a combination of aftercare, schoolbased awareness programs and bereavement support in their region, given the needs of their area. Growing

evidence indicates that a systems approach to suicide prevention can be particularly effective at reducing suicide rates (van der Feltz-Cornelis et al. 2011; Kryszynska et al. 2016; Zalsman et al. 2016) (box 21.8). Several inquiry participants favoured a systems approach to preventing suicide (Connect Health & Community, sub. 94; ConNetica Consulting, sub. 450; Jesuit Social Services, sub. 441).

In 2015, the Australian Government began moving towards a systems approach for suicide prevention by devolving responsibility for planning and funding local suicide prevention activities (ConNetica Consulting, sub. 450). The Australian Government now provides a flexible funding pool to PHNs to develop and implement suicide prevention activities in their region. PHNs are responsible for leading suicide prevention activities in partnership with Local Hospital Networks (LHNs) and other local organisations. At the same time, the Australian Government retained its role of funding national leadership and population level suicide prevention activities, such as national communication strategies.

In 2017, the Fifth Plan committed all governments to supporting PHNs and LHNs to follow a systems approach. From 2018, PHNs and LHNs have been developing joint regional plans for mental health and suicide prevention services and are required to publicly release these plans by mid2020 (Integrated Regional Planning Working Group 2018b).

Currently, there are 30 local suicide prevention trials that generally follow a systems approach in Australia (box 21.9). These trials are funded through PHNs, State and Territory Governments or charities. *However, implementation of these trials has been slow and uncoordinated. And so far no evaluations have been completed to assess the trials' effectiveness at reducing suicide rates. Most evaluations are expected to be completed in 2020 or 2021 (box 21.9).*

Evaluations of local trials will be key to determining if the systems approach is effective in Australia. Once the majority of trial evaluations have been completed, the NMHC, in its new role as the national body for mental health and suicide prevention evaluation (chapters 22 and 25), will need to assess if these evaluations provide adequate evidence that a systems approach is likely to be successful at reducing suicide rates. If so, this approach should be implemented across all Australian regions.

AUSTRALIAN TRIALS OF SYSTEMS APPROACHES

In Australia, 30 trials are being run that generally use a systems approach to suicide prevention (Black Dog Institute 2019). Many of these trials were established independently of each other.

5 LifeSpan trials — LifeSpan was developed by the Black Dog Institute and the National Health and Medical Research Council. The approach involves using up to nine evidence based strategies operating simultaneously in a community, such as followup care for suicidal crisis, promoting help seeking in schools and training the community to recognise and respond to suicidality. The Black Dog Institute estimated that a systems approach, such as LifeSpan, could prevent 20% of suicide deaths and 30% of suicide attempts (Ridani et al. 2016). LifeSpan is currently being trialled in four sites in New South Wales and one site in the ACT. An evaluation is expected to be completed by 2021 (Black Dog Institute, pers. comm. 26 September 2019).

12 National Suicide Prevention Trials — The Australian Government has funded 12 trials led by select Primary Health Networks (PHNs). Many of these trials have used or adapted the LifeSpan approach, while others have used similar approaches from overseas, including the European Alliance Against Depression. For example, Brisbane North PHN has implemented aftercare programs for Indigenous and LGBTIQ communities, delivered training for health practitioners, and produced resources to develop the lived experience workforce. Evaluations are expected to be completed by the end of 2020 (University of Melbourne, pers. comm. 3 July 2019).

12 Victorian place based trials — The Victorian Government has funded and partnered with PHNs to deliver 12 trials, which have typically used or adapted the LifeSpan approach. Evaluation of these trials is expected to be completed in 2021 (Victorian Government, pers. comm., 25 September 2019).

1 Queensland place based pilot — The Queensland Mental Health Commission (2019b) and Western Queensland PHN have collaborated to deliver a suicide prevention pilot in the Maranoa.

SETTING UP THE NEW APPROACH FOR SUCCESS

The Australian Government's approach of devolving responsibility for most suicide prevention activities holds promise. But this process has been slow and it is still too early to tell if it will ultimately be effective at reducing suicide rates over time.

A PC comment on ACCOUNTABILITY:

Regardless, some longstanding issues remain, such as a lack of clear responsibilities within and across governments, poor accountability mechanisms and a dearth of rigorous evaluations. Without resolving these issues, Australia's approach to suicide prevention is at risk of repeating mistakes of the past.

CLARIFYING RESPONSIBILITIES TO COORDINATE ACTIVITIES

Even as governments devolve some of their responsibilities for suicide prevention, it remains unclear who is responsible for funding and delivering different activities. Undefined responsibilities has led different levels of government to work in isolation, delivering various programs in an uncoordinated and ad hoc way. This can lead to inconsistency and gaps in services in some areas and duplication of similar services in others, creating a lottery based on the standards, personalities, qualifications and relationships of agencies in different regions.

Victoria is an example where a lack of clear responsibilities has led to duplication of similar services. The Victorian Government has funded some hospitals to trial the Hospital Outreach Postsuicidal Engagement initiative, which generally provides clinical follow up support for people who have attempted suicide. However, the Australian Government has also announced that it will increase coverage of The Way Back Support Service across Australia to deliver nonclinical support for people who have attempted suicide (DoH, sub. 556). Ideally, these services would be planned and delivered in a coordinated way to avoid potentially costly duplication. There are other examples too. Many of the 30 regions trialling a systems approach to suicide prevention have been implemented separately from one another (box 21.8), making it difficult to compare experiences. And Lifeline Australia (sub. 87) expressed concern that PHNs are not required to fund suicide bereavement programs consistently, creating gaps in coverage.

Clarifying responsibilities for suicide prevention will require agreement and buy-in from different levels of government. This can be achieved using the framework outlined in this report to clarify responsibilities for funding and delivering mental health services more broadly. This inquiry has recommended that COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, State and Territory Governments that includes (among other things) precise detail about the responsibility over each tier of government to fund and deliver mental health services and suicide prevention activities (draft recommendation 22.1).

The agreed set of responsibilities should be published clearly in the Agreement, balance flexibility and consistency in service provision across Australia, and be informed through consultation with the community, peak bodies, suicide experts and people with a lived experience of suicide. Some underlying principles should guide allocation of responsibilities.

- A systems approach requires local communities to identify, plan and deliver the optimal mix of suicide prevention activities in their area. Therefore, Commissioning agencies (PHNs, LHNs or Regional Commissioning Authorities (chapter 23)) in conjunction with local governments and nongovernment organisations are best placed to deliver local activities.
- The Australian Government should have responsibility over national leadership and coordination across all suicide prevention activities.
- The Australian Government should be responsible for suicide prevention activities that target the entire population and are likely to be more efficiently delivered at scale in a consistent way, such as national awareness campaigns, refining media guidelines, maintaining crisis telephone lines and coordinating nationally consistent data reporting.
- Some suicide prevention activities require coordination and cooperation between multiple parties. For example, providing aftercare to people admitted to hospital after attempting suicide will require hospitals and community mental health services to work together to plan for discharge and followup support in the community. These activities will need clear boundaries where care provided by one party ends and the other begins.

Responsibilities detailed in the proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) should be informed by, and consistent with, the National Suicide Prevention Implementation Strategy (the Strategy) under development to be signed by the COAG Health Council. The Strategy will provide the high level strategic direction for suicide prevention activities for governments and nongovernment organisations. It will focus health sector initiatives on a number of priority actions, such as increasing access to mental health services and providing effective aftercare following a suicide attempt. The Agreement should also be consistent with a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan (section 21.4).

The Commission also recognises that a “whole of government” approach is needed. While the health sector has taken a leadership role in suicide prevention, other government portfolios have a role to play within their direct scope of influence (Suicide Prevention Australia, sub. 523). The Australian Government has signalled the importance of this approach.

The government has also appointed a National Suicide Prevention Adviser to the Prime Minister to ensure a “whole of government” approach to addressing the priority area of suicide prevention. (DoH, sub. 556, p. 4)

This inquiry has recommended that the COAG Health Council should include other COAG Councils or portfolio Ministers in situations where cross-portfolio commitment is necessary to implement reforms (draft recommendation 22.2). To inform “whole of government” responsibilities, the Strategy must be updated to extend beyond health portfolios to include priority actions for other portfolios, such as those concerned with families, communities and the justice system. Further, this inquiry has recommended that COAG Health Council agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve (draft recommendation 22.4).

PERFORMANCE MONITORING AND REPORTING

The performance of governments in contributing to suicide prevention efforts should be monitored. Currently, Australia has a basic performance monitoring framework for suicide prevention — the Fifth Plan lists four indicators specifically related to suicide prevention (presented in black in table 21.2). The NMHC currently reports on the progress of indicators detailed in the Fifth Plan. However, this framework has little use in practice for several reasons. First, two of the four indicators have been under development since the Fifth Plan was released in 2017. Second, the indicator measuring post discharge community care does not distinguish between people in suicidal distress or anyone else admitted to a mental health unit, and is thus too broad to be a meaningful measure of suicide prevention activities. Finally, the outcomes measure of suicide rates does not include information about rates of suicide attempts or suicide ideation.

This inquiry has recommended that the NMHC monitor and report on the performance of governments in meeting system-level outcomes for mental health and suicide prevention, as well as the performance of service providers (chapter 25). There is scope for the NMHC to improve the use of the existing suicide prevention performance framework by including additional indicators to measure performance of suicide prevention activities. This will require the NMHC to consult with Australian, State and Territory Governments to develop strategies to fill *existing data gaps*.

The NMHC should incorporate indicators of population outcomes that measure the rate of suicide attempts and suicide ideation (table 21.2). In Australia, data recording suicide deaths are reasonably well reported, but data recording suicide attempts and ideation are incomplete. Efforts are underway to improve data use and availability, but improvements to reporting will rely on collaboration across governments and portfolios (box 21.9).

Existing performance frameworks for service delivery tend to lack measures related to suicide prevention. For example, the Australian Government Department of Health’s (DoH 2018g) performance framework for PHNs includes just one indicator related to suicide prevention. The NMHC should also collect and report performance indicators at the service level (table 21.2). In particular, there is a clear need for the NMHC to develop a consistent monitoring and reporting mechanism for State and Territory Government expenditure on suicide prevention activity (draft recommendation 25.4). Other measures can also be used to indicate the level of suicide ideation among service users and stigma or literacy across service providers (CRESP & Black Dog Institute 2015). These indicators can measure how effective service providers are at identifying and responding to suicidal thoughts and behaviours and guide the flow of resources to those service providers that are more likely to interact with individuals in distress.

DATA

In Australia, data recording suicide deaths are reasonably well reported, *but tend to lack more contextual information about individual characteristics, such as health and mental health experiences, employment and family circumstances*. Data recording suicide attempts is much less reliable, in part due to the difficulty of accurately recording attempts. For example, some hospital presentations may not result in an admission and some may not visit a hospital or any other government service (Turning Point 2019). Further, data recording the prevalence of suicide ideation generally relies on ad hoc surveys, such as the National Survey of

Mental Health and Wellbeing. Several inquiry participants acknowledged some of these data gaps (AIHW, sub. 370; DLGSC, sub. 78; National LGBTI Health Alliance, sub. 494; Orygen and headspace, sub. 204).

However, there are efforts underway to improve data over time. Some States and Territories have (or are considering implementing) suicide registers that report more comprehensive suicide death data. Further, in 2019, the Australian Government tasked the Australian Institute of Health and Welfare to establish a new collection of data reporting suicide deaths and attempts (DoH, sub. 556). This new collection is intended to link up State and Territory data for suicide and selfharm, provide near realtime monitoring capabilities, improve reporting of suicide attempts (by for example reporting ambulance callouts related to suicidal distress), and use data linkages to analyse contextual information about individual characteristics. These improvements to data collection show promise but will require collaboration across government portfolios to report relevant information, for example police interactions.

PROMOTING BETTER USE OF EVALUATIONS

A lack of outcomes based evaluations was a clear failing of Australia’s previous approach to suicide prevention. This was particularly relevant for Indigenous suicide prevention activities (ATSISPEP 2016a; Clifford, Doran and Tsey 2013). In 2014, the Australian Government Department of Health evaluated its suicide prevention activities from 2006 to 2013. The results were stark. The evaluation found that it was not possible to assess the effectiveness of its suicide prevention activities because programs did not measure outcomes.

Assessing the effectiveness of [National Suicide Prevention Program (NSPP)] activities was hampered by a general absence of quantifiable outcome measurement by NSPP funded organisations. ... Outcome measurement involving validated tools has been rare among NSPP funded activities. Even in cases where independent external evaluations had been undertaken, most reported on the achievement of project objectives rather than on short, medium or longterm outcomes. ... Although significant achievements have been identified, it should be noted that it is not possible to determine the extent to which the NSPP funded activities have impacted on rates of suicide. (AHA 2014, pp. 10–11)

Australia has the potential to become a world leader in suicide prevention research if our mechanisms for adequately evaluating programs can be improved. ConNetica Consulting (sub. 450, p. 17) suggested that the focus of suicide prevention research needs to shift from descriptive studies toward evaluating programs.

In the eight years, 2010 to 2017, a total of 36 grants and fellowships were awarded where suicide was the primary focus. These totalled \$10.68 million or just over \$1.322/year. The number of grants and fellowships had almost doubled when compared with the 8year 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%).

This inquiry has recommended that the NMHC lead and coordinate a national approach to evaluation in mental health and suicide prevention (chapter 25). This approach lays the foundation for evaluations to follow a set of best practice principles, such as planning evaluation at the start of program development and making them public upon completion.

In the short term, there is scope for governments to improve Australia’s approach to suicide prevention by agreeing to and clarifying responsibilities for suicide prevention activities. In the medium term, the NMHC should assess evaluations of current trials to determine whether these approaches should be implemented across Australia.

DRAFT RECOMMENDATION 21.3 — APPROACH TO SUICIDE PREVENTION

Australia’s approach to suicide prevention holds promise, but there are opportunities to improve going forward.

In the short term (in the next 2 years):

- The proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) should identify responsibilities for suicide prevention activities across different levels of government and across portfolios to create a truly “whole of government” approach to suicide prevention. Responsibilities should be informed by, and consistent with, the National Suicide Prevention Implementation Strategy under development.
- The National Suicide Prevention Implementation Strategy should be extended to include strategic direction for non health government portfolios that have influence over suicide prevention activities.

In the medium term (over 2 – 5 years)

• The National Mental Health Commission should assess evaluations of current trials that follow a systems approach to suicide prevention. It should consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia. If so, this approach should be implemented across all Australian regions.

DATA on SUICIDE

Beyond the short term, the linkage of data on agreed risk factors for suicidal behaviour could be useful in preventing some suicides. This may require, however, Australia to place a higher priority on preserving someone's life, than on preserving their privacy.

PART V : PULLING THE REFORMS TOGETHER.....p879

Governance, federal responsibilities, consumer and carer collaboration, Funding arrangements, Improving accountability, Building an evaluation culture through the NMHC, Federal roles and responsibilities, Structural flaws in mental healthcare, Primary mental healthcare funding, Restrictions on regional funding pools, Changes to intergovernmental funding arrangements, Data collection and use, Research, Benefits of reform, Reforms that benefit the whole community — by responding to people's needs, Looking beyond the numbers, Effective implementation is key to realising the benefits of reform:p881-1052

PC Recommendation: — A NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

In the short term (in the next 2 years) COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, States and Territory Governments that:

- *sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians*
- *recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the **accountability** of individual jurisdictions for mental health outcomes*
- *specifies the responsibility of each tier of government to fund and deliver particular mental health services and supports, and suicide prevention activities to ensure maximum separation in responsibilities and maximum coverage of consumer and carer needs*
- *introduces new funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocations*
- *includes consumers and carers as key partners in developing the agreement*
recognises the role of non-health supports in meeting consumer and carer needs,
- *particularly psychosocial supports*
- *sets out clear and transparent performance reporting requirements*
- *sets out the governance arrangements for the proposed Regional Commissioning Authorities, if recommended and accepted by all governments.*
- *The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement.*

PC Recommendation :REVIEW PROPOSED ACTIVITY-BASED FUNDING CLASSIFICATION FOR MENTAL HEALTHCARE

The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification to determine:

- whether the structure of the Australian Mental Health Care Classification and the variables within it should be refined or changed (especially the 'phase of care' variable)
- if the 'phase of care' variable is retained, how the variable can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

As an interim measure, the Independent Hospital Pricing Authority should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided.

In the short term (in the next 2 years)

PC Recommendation: RESPONSIBILITY FOR PSYCHOSOCIAL AND CARER SUPPORT SERVICES

In the medium term (over 2 – 5 years)

State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers.

23.3 What system design features do we want?.....p945

PC Recommendation :STRUCTURAL REFORM IS NECESSARY

The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. *There should be greater regional control and responsibility for mental health funding.*

A COMMENT ON THE PC INQUIRY

The word of "accountability" was only sparsely used . A shame , this document is weakened at every part where accountability is not explored . There is a complete absence of exploring 'power', and it's strangulation in the Mental Health sector over long term sustainability . Again, a shame , and further weakening of the capacity of this document to be a separate document from all of the other *aspirational* reports and inquiries .

A recommendation to the PC draft :

- There should be a more liberal use of the word "sustainably " , for example - so as to read "activities are sustainably funded"
- A far more liberal use of the word "accountability " as noted above
- There is one missing section . The heading should read "Power" , perhaps the PC could provide a critique on the failure of our system at the pointy end of delivering adequate resources . In addition , perhaps exploring accountability in this section , thereby powerfully addressing a sustained set of actions that have been identified and articulated in this draft , and in all those other documents provided earlier , over so many years .

Without that , politicians and the bureaucrats making the initial financial decisions are immune from pressure , and the result is the ever lamented description of failed aspirations .

OTHER NATIONAL GOVERNMENT REPORTS

Department of Health and Ageing, 2007 :Living is for everyone: a framework for prevention of suicide in Australia

The document, Living Is For Everyone (LIFE) Framework (2007), “is the latest in a series of national suicide prevention initiatives in Australia that began in the early 1990s. It provides national policy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives. *The materials aim to support population health approaches and prevention activities that will assist in reducing the loss of life through suicide in Australia*” there is also a quote “Australia was one of the first countries to develop a national strategic approach to Suicide Prevention “, the Department advised.

“The LIFE (2007) materials have been produced for use by people across the Australian community who are involved in suicide prevention activities. The materials aim to improve understanding about suicide, of appropriate ways of responding to people considering taking their own life or who have been affected by suicide, and of the role that people can play in reducing the tragic loss of life to suicide in Australia” it went on to say.

How the LIFE (2007) materials were developed

“In 2000, the Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia(the LIFE Framework) was released. That framework provided a strategic plan for national action to address the tragedy of suicide, to prevent suicide, and promote mental health and resilience across the Australian population. It has played an important role in providing research, evidence and information about suicide and suicide prevention internationally and within Australia, and it remains an important source document.”

The document lists more history including. COAG agreements going back to July 2006.

The framework states statistics, “what is known “about Suicide and explains things like “what is resilience?”. the context of the framework was explained that it was centred around the “Mrazek and Haggerty (1994) adapted Gordon’s model to include the whole spectrum of interventions iii (prevention, treatment, maintenance, recovery).”and to create a model. (not provided here)and

“In order to reduce the loss of life through suicide, activities will occur across eight overlapping domains of care and support” that being : universal, selected, indicated and symptom identification, early, standard and long term treatment and finally, ongoing care and support. The Framework goes on to provide an action plan (not provided here).

Observations about the Framework

A bright cheery document with happy people with little kids, I have made no attempt to research opinions on this superseded document. It made me feel awkward providing the above information with the “Avant Garde “ claims, and the “knowledgeable” aspirations all packaged in a bright, happy document full of photos of smiley people doing things, dogs, children etc, dotted with bold statements about past successes in national strategies.

It is a disrespectful document in so many ways. The tone was patronising, and in keeping with the traditional aspirational statements of government documents on Suicide prevention, fully knowing there is no substance of capacity to deliver the services stated. A document to be dismissed outright.

It also reinforces an opinion I have (admittedly unsubstantiated), that the Department of Health are not properly equipped to be in the business of issuing statements on mental health. Their world is primary health, with a staggering amount of dollars and Human Resources committed to that. Consideration of mental health issues are therefore, potentially dealt with in an almost dismissive “yes, we do that too” way, better left to a collective that has mental health as their core business.

This is the basis of my personal belief that there needs to be a separate National Mental Health Department, with their own budget. Yes, there will be duplications, and inefficiencies in the overarching matter of health, but that is not uncommon in other areas of government business. (Ken Barnard July 2019)

AND THEN: From the Productivity Commission Mental Health Inquiry DRAFT. October 2019

The commission said “In 2007, the Australian Government, in consultation with State and Territory Governments, developed the Living is For Everyone (LIFE) Framework — the strategic policy document that used an evidence based approach to outline the key elements necessary for suicide prevention activities. In addition, State and Territory Governments have developed their own high level suicide prevention frameworks and programs (for example, the Victorian suicide prevention framework 2016–2025). However, there have been issues with Australia’s approach. For example, the LIFE Framework lacks clear governance arrangements outlining who is responsible for suicide prevention, accountability measures and formal mechanisms for different levels and portfolios of government and the community to work together. Further, the Australian Government Department of Health took a topdown approach to funding suicide prevention activities through grant rounds on an ad hoc basis across the country (AHA 2014).” (p874)

Before it’s too late: Report on early intervention programs aimed at preventing youth suicide. 2011, a House of Representatives Standing Committee on Health and Ageing publication.

Recommendation 1

The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for, and the feasibility of, extending the scope of social and demographic suicide data routinely collected and reported on, to include information on:

ethnicity; culture; geography; educational attainment; employment status; and socio-economic status. (para 2.23)

Recommendation 2

*The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for providing increased access to **disaggregated suicide data**. (para 2.24)*

Recommendation 3

*The Committee recommends that the Australian Suicide Prevention Advisory Council liaise with the National Health and Medical Research Council, the Australian Research Council, government departments (including state and territory government departments) and other agencies with a role in this domain, **to develop a priority research agenda for youth suicide**, with a view to jointly supporting a coordinated and targeted program of research. (para 3.42)*

Recommendation 4

The Committee recommends the Department of Health and Ageing, in conjunction with state and territory governments, facilitate the sharing of evaluations of existing programs and youth-suicide research across the entire suicide-prevention sector, through the establishment and maintenance of an online program-evaluation clearinghouse. (para 3.50)

Recommendation 5

The Committee recommends that the Australian Government, in consultation with state and territory governments and other key stakeholders, undertake appropriate consultation and engagement with young people to: further develop approaches to youth suicide prevention as part of the National Suicide Prevention Strategy; development new youth suicide prevention initiatives and programs; to evaluate existing youth suicide prevention measures; and share information. (para 4.19)

Recommendation 6

The Committee recommends that the Australian Government establish well defined linkages with existing programs addressing issues of cultural, educational, employment, social and economic disadvantage, so that initiatives under the National Suicide Prevention Strategy are recognised as an integral part of a holistic approach to youth suicide prevention. (para 4.22)

Recommendation 7

The Committee recommends that the Australian Government, in consultation with state and territory governments and non-government stakeholders, establish partnerships between departments of education and community-based service providers to ensure continuity of care for school leavers by facilitating referral of students to external counselling services where appropriate. (para 4.25)

Recommendation 8

The Committee recommends that the Australian Curriculum, Assessment and Reporting Authority include social development education and mental health as a core component of the national curriculum for primary and secondary schools. (para 4.35)

Recommendation 9

The Committee recommends that social development and mental health education for older secondary school students include specific components to assist them to be better prepared for moving from school into the workforce or higher education, and aware of the full range of services available to assist them as they transition from child to adult services. (para 4.37)

Recommendation 10

The Committee recommends that teachers receive mandatory training on mental health awareness, including specific training to develop their capacity to recognise and assess suicidal risk. (para 4.51)

The following are extracts from parts of this enquiry :

Collecting and Reporting Suicide Statistics

"2.12 Issues relating to the quality of suicide data were a common theme raised in evidence. 23 As indicated above, there is a range of data currently collected around Australia relating to suicide, with the main source of data being the ABS. However, it is also clear that there are difficulties associated with collecting data on suicide. As a consequence, suicide data is acknowledged to be incomplete and of varying quality.

2.13 ABS and AIHW reports on suicide and mortality include frequent references to technical notes which emphasise that suicide statistics must be interpreted cautiously. A significant concern is that official statistics of suicide rates may be an underestimate. As the ABS notes:

... for a death to be determined a suicide, it must be established by coronial enquiry that the death resulted from a deliberate act [emphasis added] of the deceased with the intention of ending his or her own life (intentional self-harm). 24

3.6 Another limitation inherent in indicated interventions concerns the continuity of care, especially after a hospitalisation for a suicide attempt. As explained by Dr Matthews representing the Australian Psychological Society:

We know that discharge from hospital after a suicide attempt is a very high risk time, and I believe we need protocols to support people at that time—the research suggests for up to 12 months. 3

Selective Interventions

3.8 Selective interventions generally involve a specific group whose members are at a higher risk of suicide. These groups are identified according to one or more underlying risk factors that all members share. As noted in Chapter 2, there are many groups within society that are considered to have a higher risk of suicide, although this does not mean that many or even any members of the group will necessarily contemplate suicide.

3.9 These groups include:

- Indigenous youths;
- young people from culturally and/or linguistically diverse or refugee backgrounds;
- gay, lesbian, bisexual, transgender and intersex young people;
- young people living in rural or remote parts of Australia;
- young people bereaved by suicide; and
- young people who have a mental illness or have previously attempted suicide or engage in self-harm. 9

Observations about this report

This 74 page report stands the test of time, and is as relevant now, as it was in 2011. It is recommended reading, as it provides a succinct, well laid out critique on the appropriate path to assist our youth.

The report provides an extensive critique on data collection, as well as other factors too voluminous to provide here, but recommended reading.

The Hidden Toll: Suicide in Australia 2010, The Senate Standing Committee on Community Affairs

The Senate Standing Committee on Community Affairs produced this voluminous 200 page informational finding:

Recommendation 1

2.28 The Committee recommends that the Commonwealth government

commission a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia, for example by the Productivity Commission.

Recommendation 2

3.3 The Committee recommends that Commonwealth, State and Territory governments, in consultation with the National Committee for Standardised Reporting on Suicide, implement reforms to improve the accuracy of suicide statistics.

Recommendation 3

3.63 The Committee recommends that the Standing Committee of Attorneys-General, in consultation with the National Committee for Standardised Reporting on Suicide, standardise coronial legislation and practices to improve the **accurate reporting of suicide**.

Recommendation 4

3.65 The Committee recommends all Australian governments implement a standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 5

3.66 The Committee recommends that the Commonwealth, State and Territory **governments enable timely distribution of suicide data from coroners' offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations.**

Recommendation 6

3.67 The Committee recommends that State and Territory **governments provide additional resources and training to staff in coronial offices to assist in the accurate and timely recording of mortality data.**

Recommendation 7

3.69 The Committee recommends the National Committee for Standardisation of Reporting on Suicide liaise with peak insurance and financial associations, such as the Insurance Council of Australia, regarding exclusionary conditions in contracts which may deter the reporting of suicides.

Recommendation 8

4.78 The Committee recommends that Commonwealth, State and Territory governments ensure that staff in primary care, law enforcement and emergency services receive mandatory and customised suicide risk assessment, prevention and awareness training as part of their initial training and ongoing professional development.

Recommendation 9

4.79 The Committee recommends that Commonwealth, State and Territory governments mandate that hospital emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times.

Recommendation 10

4.80 The Committee recommends that Commonwealth, State and Territory governments review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents.

Recommendation 11

4.82 The Committee recommends that Commonwealth, State and Territory **governments establish mandatory procedures to provide follow up support to persons who have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.**

Recommendation 12

4.84 The Committee recommends that Commonwealth, State and Territory governments provide funding for programs to identify and link agencies and services involved in the care of persons at risk of suicide. These programs should aim to implement agreements and protocols between police, hospitals, mental health services, telephone crisis support services and community organisations

and to improve:

- awareness by different personnel of suicide prevention roles and expectations; and
- handover procedures and continuity of care for persons at risk of suicide.

Recommendation 13

4.86 The Committee recommends that Commonwealth, State and Territory governments provide additional funding for graded accommodation options for people at risk of suicide and people with severe mental illness.

Recommendation 14

4.88 The Committee recommends that the Australian governments oblige health care staff to offer prior consent agreements, such as advance health directives and standing medical powers of attorney, to patients at risk of suicide.

Recommendation 15

4.91 The Committee recommends that Commonwealth, State and Territory governments provide accredited suicide prevention training to all 'front line' staff, including those in health care, law enforcement, corrections, social security, employment services, family and child services, education and aged care.

Recommendation 16

4.94 The Committee recommends that the National Suicide Prevention Strategy promote and provide increased access for community organisation and the general community to appropriate suicide prevention training programs.

Recommendation 17

5.92 The Committee recommends that the Commonwealth government fund a national suicide prevention and awareness campaign that provides information to all Australians about the risks and misconceptions of suicide, and advice on how to seek and provide help for those who may be dealing with these issues.

This campaign should utilise a range of media, including television, radio, print and online, and other methods of dissemination in order to best reach the maximum possible audience. This campaign should also create links with efforts to alleviate other public health and social issues, such as mental health, homelessness, and alcohol and drug use.

Recommendation 18

5.93 The Committee recommends that the development of a national suicide prevention and awareness campaign should recognise the risks of normalising and glamorising suicide, and draw on wide consultation with stakeholders and a solid evidence base.

Recommendation 19

5.94 The Committee recommends that a national suicide prevention and awareness campaign, once developed, should operate for at least 5 years, and with adequate and sustained resources. This should include the provision of additional resources, support and suicide awareness training for health care professionals.

Recommendation 20

5.100 The Committee recommends that the Mindframe guidelines and current media practices for the reporting of suicide are reviewed. Research should be undertaken to determine the most appropriate ways to better inform the Australian public about suicide through the media, including mainstream news reporting, as well as through internet and social networking sites.

Recommendation 21

5.101 The Committee recommends that national figures on suicide should be released to the Australian public, at a minimum, biannually, in an effort to raise community awareness about suicide, and should be provided together with information about available services and support.

Recommendation 22

5.105 The Committee recommends that a national suicide prevention and awareness campaign should include a targeted approach to high-risk groups, in particular young people, people in rural and remote areas, men, Indigenous populations, lesbian, gay, bisexual, transgender and intersex people and the culturally and linguistically diverse communities. This approach should include

the provision of culturally sensitive and appropriate information and services.

Recommendation 23

6.127 The Committee recommends that the Commonwealth government ensure telecommunications providers provide affordable access to telephone and online counselling services from mobile and wireless devices.

Recommendation 24

6.129 The Committee recommends that the Commonwealth government commission an implementation study for a national toll-free crisis support telephone service to assist those at risk of suicide.

Recommendation 25

6.132 The Committee recommends that the National Suicide Prevention Program include funding for projects to reduce access to means of suicide and prevention measures at identified 'suicide hotspots'. These interventions should be evidence based and in accordance with agreed guidelines.

Recommendation 26

6.134 The Committee recommends that the National Suicide Prevention Program should increase the funding and number of projects targeting men at risk of suicide.

Recommendation 27

6.137 The Committee recommends that the Commonwealth governments develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy. This should include programs to rapidly implement postvention services to Indigenous communities following a suicide to reduce the risk of further suicides occurring.

Recommendation 28

6.141 The Committee recommends that the Australian Bureau of Statistics and other public agencies which collect health data record and track completed suicides and attempted suicides of those under 15 years of age.

Recommendation 29

6.143 The Committee recommends that targeted programs be developed to provide community support group assistance for people who have attempted suicide and those who self-harm.

Recommendation 30

6.145 The Committee recommends that additional resources be provided by Commonwealth, State and Territory governments to mental health services. These services are recognised as functioning to reduce the rate of suicide and attempted suicide in Australia.

Recommendation 31

6.147 The Committee recommends that additional 'gatekeeper' suicide awareness and risk assessment training be directed to people living in regional, rural and remote areas.

Recommendation 32

6.149 The Committee recommends that lesbian, gay bisexual, transgender and intersex people be recognised as a higher risk group in suicide prevention strategies, policies and programs, and that funding for targeted approaches to assist these groups be developed.

Recommendation 33

6.151 The Committee recommends that the Commonwealth, State and Territory governments together with community organisations implement a national suicide bereavement strategy.

Recommendation 34

6.153 The Committee recommends the development of a National Suicide Prevention Program initiative targeting assistance to people recently released from correctional services.

Recommendation 35

7.35 The Committee recommends that the Commonwealth government provide funding in the National Suicide Prevention Program for research projects into suicide prevention, including detailed evaluations of suicide prevention intervention.

Recommendation 36

7.39 The Committee recommends the Commonwealth government, as part of the National Suicide Prevention Strategy, create a suicide prevention resource centre to collect and disseminate research and best practice regarding suicide prevention.

Recommendation 37

8.57 The Committee recommends that following extensive consultation with community stakeholders and service providers, the next National Suicide Prevention Strategy include a formal signatory commitment as well as an appropriate allocation of funding through the Council of Australian Governments.

Recommendation 38

8.60 The Committee recommends that an independent evaluation of the National Suicide Prevention Strategy should assess the benefits of a new governance and accountability structure external to government.

Recommendation 39

8.64 The Committee recommends that the Commonwealth government double, at a minimum, the public funding of the National Suicide Prevention Strategy, with further increases to be considered as the research and evaluation of suicide prevention interventions develops.

Recommendation 40

8.65 The Committee recommends that the Commonwealth, State and Territory governments should facilitate the establishment of a Suicide Prevention Foundation to raise funding from government, business, community and philanthropic sources and to direct these resources to priority areas of suicide prevention awareness, research, advocacy and services.

Recommendation 41

8.67 The Committee recommends that, where appropriate, the National Suicide Prevention Program provide funding to projects in longer cycles to assist the success and stability of projects for clients and employees.

Recommendation 42

8.69 The Committee recommends that the Commonwealth government as part of a national strategy with State, Territory and local governments for suicide prevention set an aspirational target for the reduction of suicide by the year 2020.”

Due to the 200 page content, there is no capacity to provide more information on this report.

The contents page is provided here as a guide to the extent of the depth of this enquiry :

“INTRODUCTION

Terms of reference, Conduct of the inquiry, Acknowledgements, Appropriate language, Suicide and euthanasia, Structure of the report, Background to suicide and suicide prevention.

COSTS of SUICIDE

Introduction, Personal costs, Social costs, Financial costs, Conclusion

SUICIDE REPORTING & STATISTICS

Introduction, Data on suicide and trends, The collection of suicide data in Australia, Impediments to accurate suicide reporting, Consequences of underreporting, Scope of reporting, Conclusion

ROLES AND TRAINING

Introduction, Suicide prevention roles, Discharge and follow up support, Stepped care and accommodation services, Coordination of care, Patient information and privacy, Pharmacological issues, Suicide assistance training, Conclusion

PUBLIC AWARENESS CAMPAIGNS

Introduction, Awareness in the community, Stigma, Public discussion of suicide, Suicide awareness programs. Media guidelines and reporting, A National Suicide Awareness Campaign, Targeted awareness-raising programs, Issues for consideration

TARGETED PROGRAMS AND UNIVERSAL INTERVENTIONS

Introduction, Universal, selective and indicated interventions, Universal interventions, Access to means and suicide hotspots, Alcohol and drugs, Targeted programs, Men, Indigenous communities Children and Young People, People who attempt suicide or self-harm, People with mental illness Rural and remote areas, Lesbian, gay, bisexual, transgender and intersex (LGBTI) people, People bereaved by suicide, Culturally and linguistically diverse people (CALD), Prisoners, The elderly, Other groups, Conclusion

SUICIDE RESEARCH (various categories)

THE NATIONAL SUICIDE PREVENTION STRATEGY

Conclusion – Provided here in full

9.1 *The impact of suicide extends beyond those who complete suicide and includes those bereaved by suicide and those who attempt suicide, as well as the broader community.*

9.2 *Accordingly, the Committee's inquiry has highlighted a number of overarching findings that were consistently raised in evidence. These are:*

- *the need for a single national suicide prevention strategy to clearly link the efforts of all levels of government as well as community organisations and an ambitious target for the reduction of suicide in Australia;*
- *the need for increased funding for both universal and targeted programs and projects, including the development of a separate suicide prevention strategy for Indigenous communities, to reduce the prevalence of suicide and suicide attempts in Australia;*
- *the need for better data collection methods to ensure accurate reporting of suicide in order to track rates of suicide and the success of prevention programs;*
- *the need for enhanced and customised suicide assessment, prevention and awareness training for frontline staff;*
- *the need for improved support for people who have attempted suicide, have suicidal ideation or received psychiatric care, including follow up support for those leaving care and affordable telephone crisis and counselling services;*
- *the need for increased community understanding and awareness, and improved media practices to reduce the stigma of suicide; and*
- *the need for direct and increased funding for research on suicide, particularly the evaluation of interventions to guide future suicide prevention activities.*

9.3 *Throughout its inquiry, the Committee was impressed by the work of many community organisations in preventing suicide and assisting those affected by it. Many of these organisations are not optimally funded but rather are supported by many volunteers who have a strong commitment to helping others.*

9.4 *The Committee also recognises the commitment of governments to respond to suicide in Australia, including the commitment of funding for programs and projects. Nevertheless, the Committee strongly considers that much more can be done to reduce the number of Australians attempting and completing suicide. The Committee considers that one of the key areas for action should be ensuring that the development and implementation of the next NSPS be prioritised, coordinated and aligned with action at all levels of government.*

9.5 *This report makes a number of recommendations that will allow for:*

- (a) a better understanding of economic costs of suicide to the Australian community;*
- (b) mechanisms to improve the accurate reporting of the prevalence of suicide in Australia;*
- (c) front line staff to be equipped with the skills and training in suicide prevention;*
- (d) enhanced procedures for the discharge of patients with the aim of providing ongoing support;*
- (e) a dedicated public awareness campaign, promoting greater community understanding of suicide with a particular focus for at-risk groups; and*
- (f) stronger research to provide more targeted interventions.*

Observations about the inquiry

A most profoundly articulate explanation of the actions needed to reduce the impact of suicide. This 2010 document is as relevant today as it was 10 years ago. Some of the recommendations have materialised, yet, sadly, many have not.

Noting the most welcome announcement that in July 2019, by our Prime Minister, requesting that a special advisor on Suicide Prevention report to him in 18 months' time on what needs to be done. However, many documents have been presented to parliament, providing more than enough information over recent years, and still they persist with Productivity Commissions, trials, and other sources of regurgitated facts and aspirations.

Please, the requirements are known, the strategies articulated, the frameworks outlined, the problems articulated.

What is not happening, is holding the government to account on resources, and delivery management between the disparate groups of decision makers.

Dept. of Health and Ageing: Evaluation of Suicide Prevention Activities 2014

Australian Healthcare Associates (AHA) was appointed by the Australian Government Department of Health and Ageing (DoHA) in May 2012, to undertake the Development and Implementation of an Evaluation Framework for Suicide Prevention Activities (the Evaluation). The Evaluation assessed activities funded under the National Suicide Prevention Program (NSPP).

In Australia, the National Suicide Prevention Strategy (NSPS) provides the platform for national policy on suicide prevention. One component of the NSPS is the Living Is For Everyone (LIFE) Framework which provides the overarching evidence-based strategic policy framework for suicide prevention in Australia. Originally developed in 2000 and updated in 2007, the LIFE Framework outlines the vision, purpose, principles, action areas and proposed outcomes for suicide prevention in Australia. In September 2011 the LIFE Framework was adopted in all jurisdictions as Australia's overarching suicide prevention framework.

The NSPS is operationalised through the National Suicide Prevention Program (NSPP). This Australian Government program provides funding to a range of projects, including local community-based projects as well as national projects that take a broad population health approach to suicide prevention, including research. Drawing upon the priorities set out in the LIFE Framework, the NSPP funds universal, selective and indicated suicide prevention activities.

Objectives of the Evaluation

The Evaluation analysed NSPP/TATS-funded project activities from 2006 to 2013 and had two broad objectives:

- Evaluate existing activity under the NSPP and new activities funded under the 2010 TATS package, in order to determine appropriateness, effectiveness and efficiency of these activities within the broader policy context
- Inform the evidence base for future policy direction and implementation of suicide prevention activity and to create and put in place a comprehensive evaluation framework for ongoing use

Key findings are outlined below, under the headings of appropriateness, effectiveness and efficiency:

Appropriateness

Overall, project activities address most of the recognised target groups. Some gaps are evident at state/territory level in terms of the number of projects and the reported coverage of higher risk groups.

Effectiveness

Most projects reported having achieved their objectives. While a lack of outcome data made it difficult for projects to demonstrate their effectiveness, a diverse range of activities and a wide range of project achievements were cited.

Efficiency

The absence of quantifiable outcome data restricted not only the extent to which the effectiveness of the NSPP could be evaluated in this current report, but also the range of economic analysis that could be conducted. This highlights the need for a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia in order to determine the economic benefit of prevention, to help inform future investment decisions.

The initial retrospective evaluation of the projects encountered many data limitations that were addressed through obtaining more comprehensive data about project activities from the MDS (Chapter 6 and Appendix C) and through in-depth consultations with key stakeholders. Direct engagement with funded organisations has been one of the strengths of the current Evaluation and differentiates it from prior evaluations where such engagement was not possible.

Going forward, organisation funded to undertake suicide prevention activities, the government funding these activities and ultimately those at risk of suicide, can mutually benefit from the opportunities for program improvement identified in this report.

Observations about the evaluation

The balance of the evaluation from the above point had no Suicide prevention content. The content (above) in bold italics seems to be an appropriate point to stop, readers can do their own research on this paper.

NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION COMMITTEES AND SUBCOMMITTEES

National Committees

National Decision Makers of Suicide Prevention Activities

It is difficult to establish who or which group(s) are charged with the responsibility of allocating funding , and who actually decides what priorities are selected , resourced , and who are the beneficiaries of the resources .

There was an advisory committee within the Department of Health dating prior to July 2012 . A review was conducted by the Australian Health Ministers Advisory Council (AHMAC), and it was agreed that the MHSC would not continue. The Mental Health, Drug and Alcohol Principal Committee (MHDAPC) took up the work of the MHSC (The National Mental Health Consumer and Carer Forum- Operating Guidelines page 4)

The Australian Health Ministers Advisory Council (AHMAC)

Within COAG, there exists the Australian Health Ministers Advisory Council(AHMAC) and there are 4 principal committees who report directly to them.

One of the 4 relates to Mental Health.

The COAG Health Council refers (on its web site) to :

The Mental Health Principal Committee (MHPC)

Membership

Jurisdictional directors of mental health and related Commonwealth mental health policy senior officials.

Ongoing Role

The MHPC's role is to develop and implement a shared National Mental Health and Suicide Plan in addition to advising AHMAC on mental health and drug service issues of national significance.

MHPC oversees two standing committees:

- Mental Health Information Strategy Standing Committee
- Safety and Quality Partnerships Standing Committee

Secretariat contact :peter.knapp@sa.gov.au | 08 8226 6191

Mental Health Drug and Alcohol Principal Committee (MHDAPC)/(MHPC)

However , there exists the Mental Health Drug and Alcohol Principal Committee (MHDAPC)
C/- Office of the Secretary Department of Health and Human Services

GPO Box 125

Hobart TAS 7001

Phone: (03) 6166 3530

In its 24 January 2017 letter to “stakeholders”, it said :

“When considering the scope of the Fifth Plan, it is important to note that the COAG Health Council tasked the MHDAPC with developing the Fifth Plan as a plan for action by health ministers. The development of the Fifth Plan within this confined scope pragmatically reflects the governance mechanisms set out in The Roadmap for National Mental Health Reform 2012-2022”

“The national direction for reform has been guided by:

☐ the National Mental Health Strategy which has included four successive National Mental Health Plans, the most recent of which established a whole of government approach to reform;

☐ the Council of Australian Governments’ Roadmap for National Mental Health Reform 2012-2022, which foreshadowed the development of the Fifth Plan;

☐ the Australian Government’s response to the National Mental Health Commission’s 2014 Review of Mental Health Programmes and Services which reinforces a whole of government approach at a national level; and

☐ state and territory government plans, which set out how they will work towards mental health reform in their own jurisdictional contexts.”

The MHPC and the MHDAPC may well be one and the same , and will be clarified once the draft of this document is forwarded for comment.

It is noted that the **MHDAPC**, is charged with the responsibility to develop a **National Suicide Prevention Implementation Strategy** that operationalises the 11 core elements noted earlier in this document (P44),

taking into account existing strategies, plans and activities, with a priority focus on:

- providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system
- providing timely follow-up support to people affected by suicide
- Improving cultural safety across all service settings
- Improving relationships between providers, including emergency services
- Improving data collections and combined evaluation efforts in order to build the evidence base on 'what works' in relation to preventing suicide

The 2018 progress report, from the 2014 inception of the 5th Plan, quoted the Suicide Prevention Subcommittee on page 13, saying "the SPPRG and the MHPC reported their progress as 'on track'."

The National Suicide Prevention Strategy was reviewed in 2016, and the core of the review was to reaffirm the commitment to Everymind. Noting however , Everymind is not in the business of IMPLEMENTATION, simply, the guiding principles of mental health models of service delivery.

Within the Australian Gov. Dept. of Health, there is an overarching Principal committee on mental health, the Mental Health Principal Committee. (MHPC) and MAY POSSIBLY be referred to as the Mental Health Drug & Alcohol Principal Committee (MHDAPC).

In the 5th Plan, actions 3 and 4, said:

Governments will establish a new Suicide Prevention Subcommittee of MHDAPC/NHPC "to set future directions for planning and investment", and that the subcommittee would develop a "National Suicide Prevention Implementation Strategy"

The Suicide Prevention Project Reference Group "SPPRG" also referred to as the NSPPRG, was formed from the MHDAPC/MHPC. *The National Suicide Prevention Implementation Strategy (NSPIS) draft 2020-2025* has been developed by the National Suicide Prevention Project Reference Group (NSPPRG)/(SPPRG). It is assumed that this is also the Suicide Prevention Subcommittee (subject to clarification) and was authorised by the Mental Health Principal Committee. (NHPC)

However, a National Suicide Prevention Strategy already exists, the 5th Plan merely inserted the word "implementation" (NSPIS) and the 5th Plan makes no reference to the strategy it produced only 12 months earlier. It may be different, but it makes no reference to the 2015 National Suicide Prevention Strategy (NSPS), and to whether the NSPIS supersedes the latter.

The NSPS also noted the existence of the "Aboriginal and Torres Strait Islander Suicide Prevention Strategy". It is unclear if the "strategy" of the NSPS is the same as the "strategic policy" of the 5th Plan.

Within the Australian Gov. Dept. of Health, there is an overarching Principal committee on mental health, the Mental Health Principal Committee. (MHPC) and MAY POSSIBLY be referred to as the Mental Health Drug & Alcohol Principal Committee

(MHDAPC). An advisory committee, dating back prior to July 2012 following a review of the AHMAC Committee structure was undertaken and it was agreed that the MHSC would not continue. The Mental Health, Drug and Alcohol Principal Committee (MHDAPC) took up the work of the MHSC (The National Mental Health Consumer and Carer Forum- Operating Guidelines page 4) and a Principal Committee (MHDAPC) report noted in 2013 (Workforce Development Theory and Practice in the Mental Health Sector - Smith, Mark; Jury, Angela F., 2016, Psychology (p312))

A Short Explanation

The Australian Health Ministers Advisory Council (AHMAC) was formed : >

The Mental Health Principal Committee (MHPC) also known as (MHDAPC) was appointed :>

They were charged with developing action/reform from the 5th Plan by:

- Whole of government reform, following NMHC 2014 Review of Mental Health Programmes and Services
- Applying the 2012-2022 "Roadmap"
- State plans how they will work towards mental health reform in their own jurisdictional contexts

Further, in relation to Suicide Prevention :

In the 5th Plan, actions 3 and 4, said: *Governments will establish a new Suicide Prevention Subcommittee of MHDAPC/NHPC "to set future directions for planning and investment", and that the subcommittee would develop a "National Suicide Prevention Implementation Strategy"*

The Suicide Prevention Project Reference Group "SPPRG" also referred to as the NSPPRG, was formed from the MHDAPC/MHPC.

It seems that the driving "authority" in relation to Suicide Prevention is the SPRPG, but it is still unclear who controls the decision making on funding, and who decides what is funded.

National Subcommittees

An Advisory Council sub-committee

- National Committee for the Standardised Reporting on Suicide (p38 of NSW Living well Strategic Plan doc)
- Mental Health Expert Reference Group(ERG)

The Mental Health Expert Reference Group provided advice to inform the Government's response to the Review of Mental Health Programmes and Services.

Established to provide advice to inform the development and implementation of the Australian Government's response to the Review of Mental Health Programmes and Services. noted Nov 2015

Noted relevant members of the Committee

Ms. Kate Cornell :Chair

Prof. Jane Pirkis :Suicide prevention and mental health research

Advisory Group for Suicide Prevention (Under NMHC)

The nationally representative group is co-chaired by Sharon Jones from Relationships Australia Tasmania and Lucy Brogden, commissioner with the National Mental Health Commission.

The Advisory Group for Suicide Prevention held its inaugural meeting in June 2016

The National Mental Health Service Planning Framework (NMHSPF)

(basically, the NMHSPF is a project managed under the MHDAPC)

This is a model of the mental health services, and a “tool” has been developed to estimate need and demand of services.

This has allowed the MHDAPC to deliver (via the DoH) licensing and roll out of the NMHSPF Training Program. The DoH gave that to the University of Queensland to deliver the training, and, late 2018, only 202 users had completed the training.

It does provide planning tools “to support integrated mental health service planning and the development of joint mental health and suicide prevention plans”

It does appear that this program is the “reply” to concerns that PHNS are ill equipped to rush into Suicide Prevention plans. This licensing model appears to be the “answer”.

The roll out of the plan and the refinement program has only commenced in March 2018, and won’t be completed until 2021.

DRAFT

Other National Government Organisations with a hand in Suicide Prevention

- Australian Institute of Health and Welfare

SECTION TWO

NATIONAL PEAK BODIES/ ADVISORY GROUPS – MENTAL HEALTH and or SUICIDE PREVENTION

Suicide Prevention Australia (SPA)

This peak org acts as the peak body in PREVENTION, and lists members in its website. The list below of organisations claiming a suicide prevention programs may show the following (SPA), this denotes membership to the peak body.

The SPA would, on the surface, seem to be the natural body to receive all funding in regards to Suicide Prevention acting as an autonomous peak body and to distribute those funds to Suicide Prevention organisations in a coordinated, independent, integrated and targeted due diligence process (following the Everymind Framework guidelines).

There are at this time 53 organisations that list in their website or similar source as providing Suicide Prevention services. There are also associations, interest groups, community groups and others as well as commercial businesses.

Suicide Prevention Australia National Policy Platform in April 2019

A timely document for me, I have been researching the matter of Suicide Prevention from November 2018 to now (April, 2019). I do feel this opinion piece deserves the greatest attention, and so is listed first. The platform states:

“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, and not a whole-of- government approach. Suicide Prevention Australia’s National Policy Platform advocates for immediate changes to government policy architecture. Better cross-portfolio coordination is essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention. Our recommendations look beyond initiatives such as the Fifth National Mental Health and Suicide Prevention Plan and the elevation of suicide prevention to the Council of Australian Governments. We are also calling for improvement in the collection and management of reliable data and a comprehensive suicide prevention workforce strategy. The Suicide Prevention Australia National Policy Platform outlines solutions to effectively and sustainably support suicide prevention in Australia.”

“Suicide prevention is complex and it needs to be addressed as a whole-of-government issue because it’s more than a health issue. Global evidence shows that a fragmented and mental illness-specific approach doesn’t work. An integrated approach to suicide prevention that encompasses mental health, social, economic and community factors is the best evidence-based solution.

Suicide Prevention Australia’s National Policy Platform advocates for immediate changes to government policy architecture. Better cross-portfolio coordination is essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention.”

Policy Platform of SPA

These policy solutions are built on a comprehensive three-pillar approach of *leadership, reliable data and workforce strategy*. It is designed to cement commitment to suicide prevention through the passage of a Commonwealth Suicide Prevention Act. This Act is to provide a legislative framework for the development of an outcomes-based National Suicide Prevention Plan within 12 months of the new Act commencing, with the plan to be tabled in Parliament.

National Suicide Prevention Plan of SPA

- To be developed in consultation with suicide prevention stakeholders and experts, and with people who have lived experience of suicide, as well as taking into account suicide prevention endeavours by the States and Territories.
- To encompass cross-portfolio approaches to suicide prevention, recognising that suicide prevention is broader than just activities under the health portfolio, including, but not limited to, social, economic, occupational, cultural and environmental factors.
- To recognise the importance of customised broad based (biopsychosocial) strategies for Priority Population groups.
- To include a section specifically addressing Aboriginal and Torres Strait Islander suicide prevention.

A Whole-Of-Government Approach

This pillar consists of four key actions as outlined below, to enable a whole-of-government approach to suicide prevention so that all government agencies are working towards a unified action plan.

Appoint a Federal Minister for Suicide Prevention

- Establish a Cabinet function for suicide prevention to champion a whole-of-government approach to suicide prevention, and to oversee the development of the National Suicide Prevention Plan and the National Suicide Prevention Office.

Establish a well-funded and resourced National Suicide Prevention Office

- Located within Prime Minister and Cabinet, the Office to enable a whole-of-government approach including suicide prevention policy, planning and program delivery. The Office's work to be informed by input from people with lived experience and scientific expertise, and to include a focus on specialised interventions for identified Priority Population groups.

National Suicide Prevention Office responsibilities to include:

- Lead the development of the National Suicide Prevention Plan;
- Coordination of funding for suicide prevention activity aligned with policy planning and the National Suicide Prevention Plan;
- Secure cross-portfolio approaches to suicide prevention, including guidance on suicide impact assessments as part of all Cabinet submissions

Commonwealth Suicide Prevention Act

Designed to cement commitment to suicide prevention through the passage of a Commonwealth Suicide Prevention Act.

The Act to provide a legislative framework for the development of an outcomes-based National Suicide Prevention Plan within 12 months of the new Act commencing, with the plan to be tabled in Parliament.

The plan to be reviewed and updated every three years. The review of the plan to focus on progress of achieving outcomes and the Federal Government's response to the review, to also be tabled in Parliament.

National Suicide Prevention Plan

- Lead activity on improving data quality, reporting and linkages;
- Lead activity on developing a suicide prevention workforce strategy and implementation plan;
- Liaise with States and Territories to coordinate early intervention strategies, and aftercare approaches for people who have attempted suicide;
- Facilitate knowledge sharing and support evaluation of suicide prevention programs and service delivery including supporting PHNs in their suicide prevention focus;
- Build upon existing research through the provision of increased funding to suicide prevention research; and
- Lead a whole-of-government approach to the link between suicidality and the social determinants of health.

To be developed in consultation with suicide prevention stakeholders and experts, those with lived experience of suicide, and to take into account suicide prevention endeavours by the States and Territories;

To encompass cross-portfolio approaches to suicide prevention, recognising that suicide prevention is broader than just activities under the health portfolio, including but not limited to social, economic, occupational, cultural and environmental factors;

To recognise the importance of customised broad based (biopsychosocial) strategies for Priority Population groups; and

To include a section specifically addressing Aboriginal and Torres Strait Islander suicide prevention.”

(this is copied and pasted out of order, all of these are a priority as far as I'm concerned)

RELIABLE DATA

“This pillar focuses on improved and coordinated data collection and retrieval. This is critical to enable evidence-based policy development, planning and resourcing of suicide prevention activity, improved service delivery and outcomes, and to inform research”

National Suicide Prevention Office responsibilities to include:

- Lead an initiative on 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;
- Work in partnership with State Suicide Registers and relevant organisations to achieve these improvements in data collection, including liaison with the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the National Coronial Information Service (NCIS);
- Examine and make recommendations on the need for a national suicide register, and national guidelines for coronial recording of suicide;
- Explore expansion of data collection and reporting e. g. data on suicide attempts, self-harm presentations and people accessing help outside of emergency departments including via GPs or private clinicians and non- government/community-based mental health services; and
- Act as a repository to leverage relevant survey data on community, youth and older persons' mental health and wellbeing undertaken by government bodies such as the AIHW and ABS and by other stakeholders.

Suicide Prevention Australia is also seeking a commitment for the National Survey of Mental Health and Wellbeing to be conducted within twelve months to obtain data on population-level suicidality and suicidal behaviour, and for a regular schedule of follow-up surveys.”

This pillar focuses on comprehensive planning for the current and future suicide prevention workforce needed to properly meet demand for suicide prevention, early intervention and response to people in distress. This pillar also focuses on resourcing the suicide prevention workforce.

Suicide Prevention Australia is also seeking a commitment for the National Survey of Mental Health and Wellbeing to be conducted within twelve months to obtain data on population-level suicidality and suicidal behaviour, and for a regular schedule of follow-up surveys.

WORKFORCE STRATEGY

This pillar focuses on comprehensive planning for the current and future suicide prevention workforce needed to properly meet demand for suicide prevention, early intervention and response to people in distress. This pillar also focuses on resourcing the suicide prevention workforce. The Suicide Prevention Office to be allocated funding to:

- Develop 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;
- The workforce strategy to 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;
- Develop a Suicide Prevention Workforce Strategy Implementation Plan. The plan to include measures needed for ongoing training and support to the full spectrum of the workforce addressing suicide and suicide-related behaviour; e. g. , clinicians, lived experience peer workers, first responders, GPs, and frontline roles interacting with people in vulnerable situations etc; and
- The plan to consider pre-service tertiary training and education, and ongoing training needs e. g. , continuing professional development, supervision and mentoring support.

The National Coalition for Suicide Prevention (NCSP)

The NCSP is a group of stakeholders in the area of Suicide Prevention in Australia, emanating from Suicide Prevention Australia, the peak body in Suicide Prevention.

In alphabetical order, Current members of the National Coalition for Suicide Prevention (NCSP) are:

- ARAFMI
- Australian Women’s Health Network
- beyondblue
- Black Dog Institute
- Community Mental Health Australia (is a coalition of the eight peak community mental health organisations from each State and Territory)
- Curtin University
- Headspace

- Hunter Institute of Mental Health (NSPL&SP , please refer below for explanation of this notation)
- Lifeline Australia
- Mates in Construction (NSPL&SP)
- Mental Health Australia
- Mental Illness Fellowship of Australia
- Mental Health First Aid (NSPL&SP)
- Mental Health in Multicultural Australia
- National LGBTI Health Alliance(NSPL&SP)
- On the Line
- Orygen Youth Health (NSPL&SP)
- OzHelp Foundation (NSPL&SP)
- Relationships Australia
- R U OK? Day Foundation (NSPL&SP)
- ReachOut.com by Inspire Foundation (NSPL&SP)
- SANE Australia
- SuperFriend
- The Butterfly Foundation
- Suicide Prevention Australia(NSPL&SP)
- United Synergies (National StandBy support after Response Service) (NSL&SP)
- Wesley LifeForce (NSPL&SP)
- Young & Well Cooperative Research Centre

Note: there are inconsistencies in membership of NCSP – and funding by National Suicide Prevention Leadership & Support Program (NSPL&SP). Details of the program were noted earlier : page 65

In 2017, \$47 million funding to facilitate PHNs capacity building for PHNs to “upskill” their capacity to rollout local Suicide Prevention programs. Of particular interest is the omission of funding to Headspace, Beyond Blue, Sane, the Butterfly Foundation, Black Dog .

IT IS ALSO NOTED that there is an allocation of significant funding to the following organisations: University of Melbourne, University of Western Australia and Community Broadcasting Association of Australia. These 3 organisations are NOT members of the National Coalition for Suicide Prevention.

This is a telling example of the failure of the Department of Health to work with a peak organisation, that is, Suicide Prevention Australia (SPA). Funding to facilitate the proposed PHNs involvement in regional programs must not happen without SPAs overarching decision making, not the DoH, no matter which committee.

Response to World Health Organisation: World Suicide Report One world connected: an assessment of Australia’s progress in suicide prevention, 2014

In 2014, The NCSP reviewed Australia’s performance against the World Health Organisation (WHO) the first international report on suicide prevention (herein referred to as the WHO Report), released on 10 September, 2014.

“This paper offers a brief summary of points of interest from the WHO Report as well as a view on how Australia is performing against some of the criteria set out in this Report as important for a successful national suicide prevention strategy.

For ease of reference, we have used a traffic light system so readers can easily identify where Australia is performing well, where we are heading in the right direction but have work to do; and where serious discussion and action is required.”

The National Mental Health Commission and NSW Mental Health Commission also kindly offer their support in principle to the National Coalition for Suicide Prevention. (NCSP)

“One World Connected: An assessment of Australia’s progress in suicide prevention “

At the beginning, a note about a PRIORITY OF THE NCSP— **DATA**

The discussion paper notes :

“we do not believe that suicide death and suicide attempt data in Australia is of adequate quality nor is it readily accessible to inform prevention efforts and deliver improvements. We do not have a clear picture of suicide in this country and until we have access to that information we are limited in how we can affect change. This remains one of the National Coalition for Suicide Prevention’s top priorities.”^{p4}

In reviewing the WHO Report, Australia’s National Coalition for Suicide Prevention has identified a number of areas that require action. These are summarised below using the traffic light system and discussed in more detail in the subsequent pages of the paper. The National Coalition

for Suicide Prevention has drawn out the typical components of national suicide prevention strategies – as set out on page 57 of the WHO Report – to structure its Australia specific rating and commentary.

Summary of Australia’s current suicide prevention performance

- **Strategy, oversight and coordination RED LIGHT:** Creation of a national strategy to prevent suicide. Establish institutions or agencies to promote and coordinate research, training and service delivery in respect of suicidal behaviours. Strengthen health and social system responses to suicidal behaviour.
- **Data (Surveillance) RED LIGHT:** Increase quality and timeliness of national data on suicide and suicide attempts. Support the establishment of an integrated data collection system which serves to identify vulnerable groups, individuals and situations.
- **Training and education: ORANGE LIGHT :** Maintain comprehensive training programs for identified gatekeepers (e. g. health workers, educators, police). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons.
- **Access to service: ORANGE LIGHT** Promote increased access to comprehensive services for those vulnerable to suicidal behaviours. Remove barriers to care.
- **Treatment: ORANGE LIGHT** Improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions
- **Crisis intervention: RED LIGHT** Ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone helplines or the internet.
- **Awareness and Stigma reduction: ORANGE LIGHT** Establish public information campaigns to support the understanding that suicides are preventable. Increase public and professional access to information about all aspects of preventing suicidal behaviour. Promote use of mental health services, and services for the prevention of substance abuse and suicide. Reduce discrimination against people using these services.

NCSP Assessment of Where we Need to do Better

- In reality, the strategic approach to suicide prevention in Australia is piecemeal, uncoordinated and overly biased on activities falling under the remit of the Department of Health, especially mental health. This must change if we are to significantly reduce the tragedy of suicide. Reducing suicidal behaviour should be seen as a key outcome across a wide

range of areas including drug and alcohol, homelessness, domestic violence, family and relationships, justice, employment, veterans and immigration.

- As outlined in the special section outlining current suicide prevention strategy in Australia, there are a wide range of components to the national picture of suicide prevention but no clear responsibility or accountability for coordinating various components or reporting on outcomes.
- There are only isolated strategic plans to prevent suicide at the regional or local level and no mechanism for the alignment and coordination of these strategies. This is despite the LIFE Framework highlighting the importance of equipping communities to respond to suicide.
- There is no clear mechanism or provision for the private sector to become involved
- in suicide prevention nor responsibility for the provision of up-to-date evidence-based advice for business when stepping out of their core business and into the realm of suicide prevention.
- Despite the significant contribution that NGOs play in the field of suicide prevention (and mental health), coordination and collaboration between these organisations has historically occurred haphazardly and has only just begun to improve: The National Coalition for Suicide Prevention is working to build and focus collaborative effort in suicide prevention
- There is limited shared strategic vision across all sectors to collectively guide investment in activities to make the greatest possible impact on suicide in Australia.

Tailor for Diversity

Where we need to do better:

- Despite identification of groups vulnerable to suicide in Australia, activities funded under the NSPS do not adequately provide for the effective targeting of these groups across the country.
- Limited data or poor quality data is available to accurately identify the number of individuals who fall into some vulnerable groups let alone the occurrence of suicidal behaviour among these populations. For example, national data is not centrally and routinely collected on identification as lesbian, gay, bisexual, transgender, intersex and other sexuality and gender diverse (LGBTI) and there are data quality challenges with Aboriginal and Torres Strait Islander deaths data²¹.
- While the LIFE Framework may identify the importance of cultural diversity within suicide prevention activities and a quarter of Australia's population were born overseas²², the reality is that there are very few suicide prevention activities that specifically target culturally and linguistically diverse groups.
- No funding has been released to support the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The disappointment and disillusionment as a result of the now sixteen month wait for funds acts to reinforce historical trauma and may inadvertently add to suicide risk among our Aboriginal and Torres Strait Islander peoples. A powerful call for urgent understanding and action to improve Aboriginal and Torres Strait Islander wellbeing in Australia as documented in The Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide²³, has gone unanswered. See the special section more information on suicide among Aboriginal and Torres Strait Islander people.

Where we need to do better:

- Much of the research evidence that is generated is not translated to policy nor put into practice. We need to make better use of the knowledge already available and focus on testing the effectiveness of evidence-informed or evidence-based interventions. Based on the existing evidence about what works in suicide prevention, the National Coalition for Suicide Prevention is proposing a systems approach to suicide prevention, implementing a set of eight key strategies simultaneously across systems within a local region. See the box below on the proposed systems approach.
- We need a clear, accurate and up-to-date mapping of the suicide prevention activities occurring on the ground: At present we simply do not know enough about the quantity, quality or distribution of suicide prevention programs and services. Australia's federated system makes it difficult to track pathways to care and the siloed approach to suicide prevention between sectors results in gaps and vulnerable individuals falling through the cracks.
- All service delivery should be culturally safe and respectful. To do this, a good understanding of the diversity of the target population is required and best practice principles on culturally safe and respectful practice must be incorporated. This includes, at a minimum, looking at diverse sexual and gender identity, Aboriginal and Torres Strait Islander culture, and ethnicity

NCSP Assessment of Allocation of Financial Resources

- An appropriate level of sustainable funding and resourcing is required to match the size and seriousness of the problem.
 - i. Suicide prevention requires a significant and sustained increase in funding from all levels of government to ensure our preventative efforts are appropriately aligned with the burden of disease.
 - ii. The private and philanthropic sectors need to understand the priority of suicide prevention in Australia's public health agenda.
 - iii. A clear and measurable national suicide prevention strategy would help guide these sectors make informed investment decisions.
 - iv. Research funding for suicide prevention must be prioritised. A report by Christensen et al. (2011) established that suicide and self-harm research funding per DALY for suicide had not increased between 2001 and 2009, and it received the lowest level of investment than any other mental health category. ^{p32}
 - v. Workforce planning and capacity building must be addressed to ensure we have a highly skilled workforce that is sustainable and meets demand for suicide prevention activities.
- Improvements to the processes for allocating funding is also required.
 - i. Funding surety and appropriate timeframes (at least 3 years) would assist with recruitment, expansion and sustainability.
 - ii. **Funding under the NSPP has been rolled over twice without an open and transparent tendering process. An open and transparent tendering process would ensure that innovative suicide prevention approaches are supported alongside established programs.**
 - iii. Funding arrangements need to promote collaboration rather than competition which dissuades sharing of knowledge and expertise.
 - iv. Opportunities need to be made available for the piloting of programs with clear pathways for upscaling interventions that demonstrate effectiveness.

NCSP Assessment of Effective Collaboration and Planning

Where we need to do better:

- A national planning group should be established to undertake collaborative planning and set the strategic direction of suicide prevention for Australia.
- It is essential that this group be accessible and transparent in decision-making. Previous leadership groups, such as the Australian Suicide Prevention Advisory Council (ASPAC) which worked with the Department of Health to provide national leadership in suicide prevention and policy, have not always met these requirements.
- Lived experience representatives must be included in all processes, recognising the valuable contribution they bring. Work currently being undertaken by Suicide Prevention Australia to develop a Lived Experience Network and guidance on how to include lived experience (see special section on page 10) can inform this process.
- Our approach must be whole-of-government and whole-of-community. We must go beyond rhetoric and develop an actionable strategy that provides clear direction and roles for all levels and portfolios of government, business and industry, research, the community sector, the philanthropic sector, community-based groups and passionate individuals.

Use of Evaluation Findings and Sharing Lessons Learned

- The NSPS is not evaluated for effectiveness and no clear measurable outcomes are captured or monitored. We must invest in evaluation—building workforce capacity, allocating resources for evaluation within funding agreements, and prioritising research that fills gaps in our understanding— so we can learn the most effective ways to support individuals find their own contributing life, a life worth living.
- Evaluation is not routinely built into program design or funding agreements. This is an issue across the spectrum of activities from national services to local community activities.
- Funding contracts (for example under the NSPP) typically require data capture and reporting at a process rather than outcome level. Further, there is limited consistency in what data is captured and used to evaluate suicide prevention activities and no mechanism to ensure consistency between datasets. A best practice standard for data collection is required and must be supported in policy and funding arrangements.
- There is a great deal of expertise available within Australia regarding evaluation and social impact measurement. The suicide prevention sector needs to harness this available expertise.
- There is no independent and central access point or distribution mechanism for best practice information and up-to-date evidence about what works in suicide prevention. This creates unnecessary and frustrating barriers when communities, services, businesses, professionals and individuals try to learn how they can effectively contribute to the prevention of suicide.
- Translating research evidence to practice (while maintaining the rigour that underlies quality evidence) requires particular skills such as communication skills. These skills are not always present in the workforce conducting research or delivering services. Specific investment is required to appropriately resource this task for the suicide prevention sector.
- Technology must be harnessed to disseminate information across Australia and in accessible, culturally appropriate formats

OTHER ADVISORY GROUPS / COUNCILS / COMMITTEES

Australian Suicide Prevention Advisory Council (ASPAC)

Referred to in DoH reports. Postvention Australia had a person who was chair from 1998-2015

Unable to locate any published reports

Fifth Mental Health Plan Strategic Advisory Group (ATSISPEP)

National Advisory Council; Australia.

The Mental Health Advisory Council (MHAC)

Provides strategic advice and guidance to the Mental Health Commissioner regarding major issues affecting people with mental health problems, their families and service provide

Advisory Group for Suicide Prevention (AGSP)

Established in response to a request in December 2015 by federal Minister for Health, Sussan Ley, the group provides advice, expertise and strategic support for suicide prevention policy across Australia by identifying priorities and promoting action. the inaugural meeting was in June 2016, a second meeting was held in September 2016, so, that means that the group meets every 3 months.

Mental Health Research Advisory Committee (MHRAC)

www.nhmrc.gov.au

National Advisory Council on Youth Suicide Prevention

Suicide Prevention Subcommittee

Of the MHDAPC “that will report to Mental Health Drug & Alcohol Principal Committee (MHDAPC)”- referred to in 5th Plan.

National Committee for the Standardised Reporting on Suicide

(p38 of NSW Living well Strategic Plan doc)

Mental Health Expert Reference Group (ERG)

The Mental Health Expert Reference Group provided advice to inform the Government's response to the Review of Mental Health Programmes and Services.

Established to provide advice to inform the development and implementation of the Australian Government's response to the Review of Mental Health Programmes and Services. noted Nov 2015

members of the Committee include:

Ms. Kate Cornell :Chair

Prof. Jane Pirkis :Suicide prevention and mental health research

Advisory Group for Suicide Prevention (Under NMHC)

The nationally representative group is co-chaired by Sharon Jones from Relationships Australia Tasmania and Lucy Brogden, commissioner with the National Mental Health Commission.

The Advisory Group for Suicide Prevention held its inaugural meeting in June 2016

PLEASE NOTE

There was an earlier reference to the Australian Health Ministers Advisory Council (AHMAC) and other committees MHPC/MHDAPC and further the SPPRG also referred to as the NSPPRG. These groups are the decision maker groups.

Therefore , listed separately. The above are purely Advisory groups rather than decision makers .

DRAFT

SECTION THREE

THE NEW SOUTH WALES GOVERNMENT AND ITS ROLE IN SUICIDE PREVENTION

NSW Dept of Health and the Mental Health Branch

The NSW Governments Mental Health structure is similar to the Australian Governments. The Department of Health administers all aspects of Mental Health within their framework.

“The Mental Health Branch (MHB) is the lead agency responsible for coordinating whole-of-government policy development and implementation in the area of mental health.

The work of the MHB is driven by the key strategic directions for NSW Health. These include:

- *making prevention everybody's business*
- *creating better experiences for people using health services*
- *strengthening primary health and continuing care in the community*
- *building regional and other partnerships for health*
- *making smart choices about the costs and benefits of health services*
- *building a sustainable health workforce*
- *being ready for new risks and opportunities.”*

The Mental Health Branch is responsible for developing, managing and coordinating NSW Ministry of Health policy, strategy and program funding relating to mental health. The office also supports the maintenance of the mental health legislative framework.

The work of the Mental Health Branch is delivered mainly through the mental health program in partnership with Local Health Districts, Justice and Forensic Mental Health, Sydney Children's Hospital Network, Non-Government Organisations, research institutions and other partner departments. The Mental Health Branch was formed in 2006. Publications on Mental Health Strategies are noted (in part) :

- the Community Mental Health Strategy, 2007-2012:“ from prevention and early intervention to recovery” (probably the most condescending title of any mental health document sighted in this report – disgraceful)
- the NSW Health Mental Health, Drug and Alcohol Comorbidity Framework for Action, 2008
- The NSW Aboriginal Mental Health and Wellbeing Policy, 2006-2010,
- The NSW Suicide Prevention Strategy 2010-2015
- There is a Mental Health Act (2007), however, that deals with rules relating to holding a person in an institution, not any strategy

NSW Government Suicide Prevention Strategies

On the 28th June, 2019, the NSW Premier set 14 “*new* social Priorities,” to measure and deliver in areas where we need to do better.”. “I’ve chosen to focus on some of the most challenging emerging social issues of our generation,” Ms Berejiklian said. “I look forward to working across all areas of Government to put in place the programs to achieve these ambitious targets” she said .

This contemporary announcement sets the agenda on the Mental Health and Suicide Prevention Strategies located within this announcement. Allowing readers to make their own enquiries on other matters, priority 10. With the following Clear and aspirational statement :”**Towards zero suicides —Reduce the rate of suicide deaths in NSW by 20 per cent by 2023.**”

A request to advise what were the things being “put in place “ in relation to reduction in suicides ,(14/08/19) was advised from the office of the Minister for Mental Health that the action being taken (earlier described as NEW) , was , in fact , a package of a (then) \$87 million investment in new Suicide prevention services , guided by (the then) new strategic framework for Suicide Prevention .

The Strategic Framework for Suicide Prevention in NSW 2018-2023 was launched by NSW Premier Gladys Berejiklian, with the Minister for Mental Health, Tanya Davies on 17 October 2018.

The press announcement advised that the launch of the Framework was accompanied by investment in new and expanded initiatives to implement priorities under the Framework including:

- aftercare services for people who have made a suicide attempt
- alternative services for people presenting to emergency departments in distress
- support services for people bereaved by suicide
- more counsellors for regional and rural communities
- expanded community mental health outreach teams
- suicide awareness skills training
- an evidence-informed innovation fund to bring approaches showing promising results from other jurisdictions to NSW
- strengthening practices in the mental health system to eliminate suicides and suicide attempts among people in care
- resilience building in local communities
- improvements to the collection and distribution of suicide data in NSW.

The announcement advised “The NSW Mental Health Taskforce will provide oversight for the Strategic Framework for Suicide Prevention in NSW 2018–2023, reflecting the diverse membership required to ensure action is taken across agencies.”

A comment

As a bereaved father , observing comments by the most important decision makers in our state , delivering misuse of tense to repeat an earlier announcement on such a traumatic subject is , at the very least , most disconcerting . Requests were made in October and again in December for details on this \$87 million investment in new services . There has not been a reply or acknowledgement of this repeated request .

The current strategies are articulated around the Strategic Framework for Suicide Prevention in NSW 2018-2023 , provided by the Mental Health Commission of New South Wales (NSWMHC) under the oversight of the NSW Mental Health Taskforce . There are no explanations of how the State allowed its Suicide Prevention strategies to expire in 2015 and remain in a void until 2018. There are challenging statements scattered through the following plans and strategies, and will be commented upon as they are quoted rather than here. Sufficient to say , there is little energy for current documents to be amended where words are seen to be lacking in substance or accuracy .

Details on the plans strategies and framework are as follows :

NSW Suicide Prevention Strategy 2010-2015

Strategy details

This NSW Suicide Prevention Strategy 2010-2015 is the NSW Government's statement of intent to work with the community to reduce the rate of suicide and suicidal behaviour in NSW.

This Strategy sets out the NSW Government's Strategic Directions and intended outcomes for suicide prevention in NSW over the next five years, and is aligned with the national suicide prevention framework: Living Is For Everyone (LIFE)

The Strategy sets out six Strategic Directions which are based on the LIFE action areas:

1. Improving the evidence base and understanding of suicide prevention
2. Building individual resilience and the capacity for self help
3. Improving community strength, resilience and capacity in suicide prevention
4. Taking a coordinated approach to suicide prevention
5. Providing targeted suicide prevention activities
6. Implementing standards and quality in suicide prevention

Structure of the strategy

This document is structured to set out *clearly*:

- the policy context in which the Strategy has been developed (chapter 2);
- the principles governing suicide prevention work in NSW (chapter 3);
- the model and priority areas for suicide prevention in NSW (chapter 3);
- the Strategic Directions for suicide prevention, the outcomes we want to achieve, the actions required to do this, the initiatives to support this, and the ways that we will measure the impact (chapter 3);
- the governance, implementation, monitoring and reporting approach for the Strategy (chapter 4); and,
- how we will evaluate our work and apply this knowledge (chapter 5).

The model for suicide prevention

- The NSW Suicide Prevention Strategy adopts a population
- health and whole of community approach to suicide
- prevention. It uses the LIFE Framework's continuum of suicide
- prevention activities, which identifies eight overlapping
- "domains of activity", 157 to address the needs of:
 - the broader population;
 - specific groups identified as being at risk; and
 - people who may be at high risk of suicide.

"Strategic direction 1: Improving the evidence base and understanding of suicide prevention

Additional analysis and collection of NSW data on suicide and attempted suicide, to improve the evidence base and understanding of effective approaches, through initial analysis of data, and consideration by a whole of community Suicide Prevention Advisory Committee, reporting to the Minister Assisting the Minister for Health (Mental Health) through the NSW Mental Health Priority Taskforce. p28

At this point, providing aspirational statements of “initiatives” that contradict impacts on bereaved families, means that no further information on this Strategy document will be provided.

Observations about the strategy

Having read aspirational statement after statement, and the regurgitated statements on suicide statistics and the impacts on the community, at page 28, I felt it was of not worth to provide any more extracts. I’ve read the report 2 times, and there is nothing from pages 28 to 46 that are of value.

NSW State Health Plan: Towards 2021. Launched in June 2014

The Plan notes that there will be a “Whole of government response to the Mental Health Strategic Plan”. There, however, there are no references at all to mental health.

Observations about the Health Plan

Yes, it is clearly a Primary Health Care document, and that is where the whole thing falls over when it comes to a department consumed with physical health, hospitals, and doctors. It fails to have any connection with mental health, and then in turn, suicide prevention.

Suicide Prevention is a MENTAL HEALTH matter. The priority in June 2014 was that of health other than mental health. The loss of a young man the next month to Suicide seems to be inconsequential to the health of people in NSW.

The situation in 2019 is no different, Health is obsessed with PRIMARY HEALTH. The massively big bucks, the huge projects, the energy, the drive and overall obsessive interest. Mental health is ultimately, still tokenism in words, action, and importantly – money.

There appears to be no Mental Health Strategic Plan produced by the Mental Health Branch (MHB) until the production of th

The NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 (Framework and Workforce Plan)

This is designed to “provide overarching guidance for NSW Health strategic action in mental health across the next five years.” The document is for mental health and general health organisations in recognition that people with lived experience of mental health issues commonly have needs that will be met by a range of health and partner care providers”.

“The NSW Government is undertaking a ten year whole-of-government transformation of mental health care to 2024. The NSW Mental Health Reform (the Reform) comes in response to Living Well: A strategic plan for mental

health in NSW 2014–2024. The Reform puts people – not processes – at the centre of the mental health care system.”

“The Framework and the Workforce Plan are actions arising from the Reform and respond to policy directions in the Fifth National Mental Health and Suicide Prevention Plan 2018-2022 (Fifth Plan) and a range of recommendations from recent reviews including the:

- Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities
- Royal Commission into Institutional responses to Child Sexual Abuse
- Review of the Mental Health Review Tribunal in respect to forensic patients.”

The framework at a glance

Vision: Everyone in NSW lives with hope, wellbeing and good health, with fewer lives lost through suicide

Goals:

- Individuals and communities have the strength, resilience and capacity to prevent and respond to suicide
- Individuals and communities are empowered to have safe conversations about suicide and suicidal behaviour, and to know how and where to seek help when needed
- High quality, culturally safe, trauma informed services are available to prevent and respond with compassion when and where they are needed
- Suicide prevention, intervention and postvention programs and services that place people at the centre are co-designed, *inclusive, coordinated and integrated*
- Suicide prevention activities are responsive to the best available evidence and contribute to the evidence base, with new approaches shaping effective action

Guiding Principles

- Suicide prevention is everyone’s business
- Community wellbeing and resilience are fundamental
- Quality interventions are available across the lifespan
- Clinicians are supported and empowered to provide excellence in clinical care
- Activities are effectively coordinated and well-integrated
- People with lived experience are included
- Actions are evidence-based
- NSW supports the eight priority areas of the Fifth Plan, including ‘Priority Area 2: Suicide Prevention’. The priorities align with the NSW Government’s decade-long, whole-of-government enhancement of mental health care – a response to the Living Well: A Strategic Plan for Mental Health in NSW 2014–2024

PRIORITY AREA 3

Supporting excellence in clinical services and care

Action:

- Caring for people with suicidal behaviour and thinking in mental health services
- Providing specific suicide prevention training for the clinical workforce
- Developing a new Mental Health Patient Safety Program

- Empowering and supporting clinicians

PRIORITY AREA 4

Promoting a collaborative, coordinated and integrated approach

What is the NSW Government doing?

Improving whole of government responses to mental health and suicide prevention

The NSW Government supports a whole of government approach to mental health. In addition to monitoring the 10-year mental health reform agenda in response to Living Well: A Strategic Plan for Mental Health in NSW 2012–2014, the NSW Mental Health Taskforce considers key Government priorities and cross-portfolio matters related to mental health, including the significance of regional challenges and implementation, and enhances cross-agency collaboration between NSW Health, NSW Department of Family and Community Services, NSW Department of Justice, NSW Department of Education, NSW Department of Premier and Cabinet, NSW Department of Finance, Services and Innovation, and NSW Treasury to support a whole of government approach to mental health.

The NSW Mental Health Taskforce will provide oversight for the Strategic Framework for Suicide Prevention in NSW 2018–2023, reflecting the diverse membership required to ensure action is taken across agencies.

The NSW Government also supports the *NSW Suicide Prevention Advisory Group*, which was established in 2016 to strengthen the planning, monitoring and coordination of suicide prevention efforts. Convened every six months by the Mental Health Commission of NSW and the NSW Ministry of Health, it brings together key stakeholders including police, emergency services, other government agencies, community organisations, PHNs, industry groups, Aboriginal health organisations, rural and remote communities, LGBTI communities and young people.

The Advisory Group will continue to provide whole of community guidance to the NSW Mental Health Taskforce on issues relating to suicide prevention and implementation of the Framework.

The NSW Government is a signatory to the National Communications Charter: A unified approach to mental health and suicide prevention. The Charter is designed to guide the way organisations talk about mental health and suicide prevention, with each other and with the community. It serves as a formal commitment to working together and developing better structures and processes for collaboration.

NSW Health is also collaborating closely with the Commonwealth Government on the development of the National Suicide Prevention Implementation Strategy. ^{p29}

Supporting regional mental health and suicide prevention planning

At the local level, LHDs are working closely with PHNs and other stakeholders to develop joint regional mental health and suicide prevention plans in line with the Fifth National Mental Health and Suicide Prevention Plan. LHDs and PHNs are mapping providers across the service system to develop stronger referral pathways, build community knowledge of the range of available services, and break down barriers to access.

These regional plans will respond to Action 5 of the Fifth Plan:

Action 5: Governments will support PHNs and LHDs to develop integrated, whole-of-community approaches to suicide prevention:

- This will include engaging with local communities to develop suicide prevention actions as part

of a joint regional mental health and suicide prevention plan.

- Regional plans will be consistent with the 11 elements and informed by the National Suicide Prevention Implementation Strategy as it is developed.
- At a regional level, *PHNs and LHDs will work together to map providers across the service system*, develop stronger referral pathways and build community knowledge of the range of available services and how to access them

Observations about the framework

It is noted that the above plan was prepared by the NSW Mental Health Commission, there is no reference to the Mental Health Branch (MHB). It also took 4 years to produce 2014-2018.

I have not searched for opinions on this “Framework” document. I struggle with the lack of statement on how the framework will be implemented and cannot agree with the aspirational statements of achievements as far as our region is concerned.

NSW MENTAL HEALTH COMMISSION (NSWMHC)

Overview

The NSW government commissioned the NSW Mental Health Commission (NSWMHC) in July 2012. The Mental Health Commission is an independent statutory agency responsible for monitoring, reviewing and improving the mental health and wellbeing of the people of NSW.

The Commission stated, “It works with Government and the community to promote and improve mental health and wellbeing of the community, support Government service planning and provide strategic advocacy.”

Living Well: A Strategic Plan for Mental Health NSW 2014-2024

This was launched by the NSW Mental Health Commission (NOT by the Mental Health Branch (MHB) of Health NSW).

As noted earlier, the Federal Dept of Health produces policies on Mental Health and Suicide Prevention, and the NMHC reviews the plans and strategies, and makes observations and criticisms where needed.

The NSW structure had some earlier plans (in 2006, 07, 08 & 10). From 2012, plans and strategies are formulated by the Mental Health Commission, and there are independent reviews provided on the NSWMHC.

The preamble talks about mental health in general. The role of the commission, local action, vision, who is involved, etc. are all given their place in this document.

On page 14, the Commissioner for Mental Health claims that the indicator for suicide and Suicidal behaviour is “DECREASING”?!

There is a 4 page section on “Aboriginal Communities 2.2” including a page on proposed actions. In an unacceptable omission of one of a number of major impacts, there is only the following words on Page 22 “and suicide”. There are no Actions outlined in relation to suicide prevention.

There is a reference to Suicide as a subset of GETTING IN EARLIER that starts on page 25 but there is no explanation of what that means.

References to Suicide Prevention are as follows:

Section 3.4 of the LIVING WELL Strategic Plan deals with Suicide Prevention. It contains:

- A preamble
- Co-ordinated responses
- Tools for local communities
- Leadership in Suicide prevention
- Evidence-Based approaches
- Centre for Research Excellence in Suicide Prevention
- Action

3.4 Suicide Prevention

The bulk of this section contains the never ending regurgitated facts and figures of suicide, leaving that small part relating to Suicide Prevention copied here in full (page 36)

“Co-ordinated responses

At present, there are clear gaps in the co-ordination and integration of suicide prevention activities and programs across all levels of government. ⁵⁶ There is a need for better governance and more clearly delineated roles and accountabilities for suicide prevention. Funding for suicide prevention is split between federal and state governments. As a consequence, efforts aimed at suicide prevention may be poorly co-ordinated and opportunities for more effective action are easily overlooked. More specifically, some parts of NSW have suicide prevention groups and bereavement support networks but others do not. This reflects a fragmented system made up of isolated programs. ⁵⁷ Significant underlying issues, such as data collection and the dissemination of high-quality information and training, need to be addressed if we are to achieve a significant impact. Taking some key steps towards resolving these issues will reap direct benefits and provide a solid foundation on which we can build and refine further reform aimed at preventing suicide.

Tools for local communities

Local communities are crying out for sound information, tools and support for suicide prevention. People want to be able to help themselves and one another. They want to know how to support those bereaved by suicide and how to become more resilient. Well-informed, community-based action backed by evidence and professional expertise needs to be a cornerstone of suicide prevention activities. Experts hold differing views about community-driven suicide prevention programs and their perceived potential to do harm. ⁵⁸ Yet they also recognise that communities, particularly small towns, are keen to respond to local needs. Experts must engage with communities and build relationships that enable the implementation of evidence-based practices.

In 2012 the NSW Ministerial Advisory Committee on Suicide Prevention consulted communities in NSW about how local suicide prevention responses could be better supported. This resulted in recommendations targeting priority groups, including initiatives such as the development of strategies to prevent suicides in small towns, enhanced community engagement in suicide prevention, application of evidence-based practice, improved local data collection and workplace interventions. ^{p37}

Leadership in suicide prevention

Conversations Matter is a suite of online resources developed by the Hunter Institute of Mental Health which provides practical information for communities and professionals to support community discussion about suicide. The resources have been developed with the support of academics, service providers, people whose lives have been affected by suicide or suicide attempts, and community members in NSW.

Suicide Prevention Australia in partnership with the NSW Mental Health Commission has developed Communities Matter: A toolkit for community-driven suicide prevention. It aims to support local communities, particularly small towns, to turn conversations and interest in suicide prevention into activities that reflect local priorities and needs.

Evidence-based approaches

A challenge for suicide prevention is the need to continue to build the evidence base for effective strategies. While all funded initiatives are required to have an evaluation component, evaluation requirements are not always rigorous enough and funding is not always sufficient for meaningful evaluation, which limits their contribution to the evidence base. p59

Centre for Research Excellence in Suicide Prevention

The Centre for Research Excellence in Suicide Prevention, based at the University of NSW, brings together researchers from Australia and New Zealand to undertake research in suicide prevention. The centre was established in 2012 and is funded by the National Health and Medical Research Council. It focuses on four key areas of research: better delivery of interventions, better knowledge of causes and risks, improved help-seeking and improved prioritisation of suicide funds. The centre's research seeks to produce positive change in lowering suicide rates in Australia.

Suicide prevention needs a systems approach. This requires that all evidence-based strategies are implemented simultaneously and that accountability is clearly delineated for each of the 'systems' used. Agencies and governments must jointly identify and agree on appropriate strategies within each system and operate cohesively to bring about change.

Any attempt to address suicide and suicidal behaviours needs to recognise the differences and risk factors for different population groups and respond accordingly. People from within these groups who have survived a suicide attempt or are bereaved as the result of suicide will have a vital role in shaping prevention efforts. Better, timelier and more localised data on suicide and suicide attempts will also be essential if we are to ensure prevention initiatives address local needs and priorities.

Responses to suicide and suicidal behaviour within the health system also need improvement. All front-line staff – emergency services, community and crisis support, mental health and emergency department staff, as well as general practitioners – need training to know what to do in a crisis and where to point people for further support. Whenever and wherever a person exhibiting suicidal behaviour encounters the health system, ***preventive action and follow-up must be systematic and assured.***

Actions

3.4.1 Establish a NSW Suicide Prevention Forum comprising public, industry and community sector leaders, including those with lived experience of suicide, to strengthen the planning, monitoring and co-ordination of state-wide suicide prevention efforts.

3.4.2 Prepare a NSW Suicide Prevention Implementation Plan to:

- strengthen the common vision for suicide prevention efforts*
- set directions based on a rigorous review of data, evidence and need;*
- strengthen connections among community, regional, state-wide and national activities.*

3.4.3 Ensure that suicide prevention efforts reflect the unique needs and higher rates of suicide in particular communities and populations, especially young people, and that the responsibilities of all agencies to support Aboriginal community responses to suicide are recognised.

3.4.4 Work with the Commonwealth and national suicide prevention agencies to improve the planning, co-ordination and delivery of nationally funded or delivered suicide prevention activities in NSW.

3.4.5 Assess the coverage of suicide prevention activities in NSW regions, cities and communities and ensure local responses are supported by local and state-wide specialist supports.

3.4.6 Assess the data needs of local communities and service providers and provide timely reports to meet those needs, including by considering the recommendations of the National Committee for the Standardised Reporting on Suicide, working with first responders and **assessing whether a suicide register should be established in NSW.**

3.4.7 Ensure that front-line emergency, hospital, primary care and crisis personnel have access to good training about responding to suicidal behaviour, and that this training is strongly supported or mandated by employers.

3.4.8 Assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital. p28

Observations about the plan

In regards to the page 14 reference to the suicide indicator REDUCING , the following may be relevant as a reply :

Our son, Aaron, took his life just 3 months earlier than the date of this publication, I'm just a bit put off at this comment.

So, let's look at suicide rates in Australia. A brief search revealed the following :

"We have seen a 26 per cent increase in the suicide rates among women and the numbers of suicides among women (rise) over the last five year period," Ms Murray said. in Sept 2016, (article from ABC News quoting Chief executive of Suicide Prevention Australia, Sue Murray, " this trend was concerning."

ARTICLE: Australian suicide deaths rising among women and teenage girls, ABS figures show

By Mazoe Ford Updated 29 Sep 2016

FROM ABS: In 2014, suicide was the leading cause of death of children between 5 and 17 years of age. The age-specific rate of suicide in this age group was 2.3 per 100, 000 in 2014. It is important to note that suicide rates in the overall population remain higher than for the 5-17 year age group, with 12.2 deaths per 100, 000 of the overall population in 2014.

Trends were easy to find, I used an Anglicare graph, looking at the rate per 100, 000 population

They were:

2011 – 10.5

2012 —11.0

2013 —10.8

2014 —12.0

The trend from 2006 (10.2) rose in a typical trend line to 2014 (12.0).

So, no matter how you cut and dice it, my reply to "the indicator for suicide and suicidal behaviour is DECREASING" comment in this report, is, well, plainly wrong, and on completion of this report, the question will be asked of the Commission to please clarify this comment.

A contribution from :BEING (Mental Health & Wellbeing Consumer Advisory Group, 10 March 2016

BEING is the independent, state-wide peak organisation for people with a lived experience of mental illness (consumers).

“On 24 February 2016, the Mental Health Commission of NSW released their first progress report on how Living Well: A Strategic Plan for Mental Health in NSW 2014–2024 is being put into practice.

The Strategic Plan was published in December 2014 and is a road map for reform of the NSW mental health system. The progress report One Year On highlights the achievements of 2015, such as:

The announcement of \$115 million funding package to kick start the reform;

Establishment of the Mental Health Implementation Taskforce to oversee the implementation of Strategic Plan across government agencies and;

Increased cross-agency and cross-sector collaboration for a coordinated response to Living Well. For example, Richmond PRA’s Young People’s Outreach Program (YPOP) model has been adopted by the NSW Governments new Youth Community Support Service.

One Year On identifies priority areas for Government action in 2016, such as the development of a Living Well Government communication strategy, a NSW mental health peer workforce plan, and clear annual reporting of mental health system data, funding and resources.

Living Well: Putting People at the Centre of Mental Health Reform in NSW, 2014

“This Report is a companion document to the Strategic Plan for Mental Health in NSW, in which the Commission has developed what we heard about people’s experiences, needs, wishes and priorities for mental health support and community wellbeing into specific advice for government.”

In the preamble, the commissioner said:

“The pages that follow present a powerful and at times emotional case for a new generation of mental health reform in NSW – one that puts people firmly at the centre. I am confident that this Report contains a faithful articulation of the ideas and experiences shared with the Commission during our long and deep conversation with the community, which will continue as we drive reform forward.

People have been let down in the past. Three decades ago, Australia began in earnest to reform mental health care, recognising that isolating unwell people in secure hospitals could not be justified in a humane society. We began to close the asylums; the subsequent history in which we failed adequately to support people in the community is well known. We live with the consequences of that failure every day.”

And, finally, “This Report is a companion document to the Strategic Plan for Mental Health in NSW, in which the Commission has developed what we heard about people’s experiences, needs, wishes and priorities for mental health support and community wellbeing into specific advice for government.”

Observations

This 138 page “companion document”, contains no reference to suicide, any stories about it, nor any persons affected.

There is a section called the Journeys, starting on page 78, that *could* have addressed the problems related to suicide and the treatment of people who were discharged from mental hospitals, and PECC units in Primary Health hospitals, but there are no stories of any journey from a single person who is dealing with multiple suicidal ideation.

In relation to Suicide, the entire one hundred and forty six (146) page report only commented one small paragraph in the preamble, quoted here in full:

SUICIDE & SELF-HARM

Suicide still occurs too often in NSW, though the rate has fallen slightly in the past decade. In 2012, 707 people died by suicide. In the past 20 years, the rates of self-harm have increased among young women aged 15–24, in contrast to both men and the general community whose rates have remained stable. The reasons are poorly understood.

There were 17 Subjects in this report as well as a Preamble, and a conclusion. *This report inexplicably misses the subject of Suicide prevention.*

In an email exchange in July 2019, when questions were asked about the near omission of a reference to suicide, the Commissioner advised,

“These stories were brought together in Living Well: A Report as a companion piece to Living Well: a Strategic Plan for Mental Health in NSW (2014 – 2024). Living Well: A Report was deliberately focused on illustrating a positive framing of the reform agenda to encourage the government and services to see the things that needed to change through the eyes of people who experience mental health issues and families, carers and kinship groups.”

Review of the Mental Health Commission of NSW – over the 5 years 2012-2017

A five-year review of the Mental Health Commission was a requirement when it was established in July 2012 under the Mental Health Commission Act (the Act). The NSW Government released the Review of the Mental Health Commission of NSW - Report to Parliament 2018.

The review was led by Dr. David Chaplow, a former National Director of Mental Health and Chief Advisor, Ministry of Health, Wellington, New Zealand, reporting to the Minister for Mental Health.

The review assessed whether the work of the Mental Health Commission met the objectives, policies and principles of the original Act, in the context of the ongoing implementation of Living Well: A Strategic Plan for Mental Health in NSW 2014-2024, which set the overarching direction for mental health in NSW, the Commission also provided a REVIEW OF THE MENTAL HEALTH COMMISSION OF NEW SOUTH WALES, REPORT TO PARLIAMENT 2018.

The Government supports refocusing the role of the Commission on monitoring, reviewing and improving the mental health and wellbeing of the people of New South Wales, as well as tightening the Commission’s functions to focus on strategic planning, advocacy and systemic reviews. This focuses the Commission’s efforts on key levers for change while not duplicating the work of other agencies. The Review also recommends the Commission must strengthen engagement with stakeholders across government and the sector, and particularly with those with lived experience of mental illness.

Basically, this is a structural analysis of the work of the commission. Disappointing that there are no observations on work being done related to Suicide Prevention, yet other groups are mentioned and observations made. In that regard, it's a flawed document, ignoring a major factor in Mental Health

A substantial document, I will leave it for people to review independently if they are interested.

NSW SUICIDE PREVENTION REPORTS

NSW Suicide Prevention Strategy 2010-2015

In 2010, the NSW Government released the *NSW Suicide Prevention Strategy 2010-2015*. This report predates the formation of the NSWMHC.

It is aligned with the national suicide prevention framework: Living Is For Everyone (LIFE), and has six strategic directions:

1. Improving the evidence base and understanding of suicide prevention
2. Building individual resilience and the capacity for self help
3. Improving community strength, resilience and capacity in suicide prevention
4. Taking a coordinated approach to suicide prevention
5. Providing targeted suicide prevention activities
6. Implementing standards and quality in suicide prevention. p25

The strategy notes that an independent evaluation of the strategy would be carried out on completion, and that this would be made publicly available. p27

An evaluation report has not yet been published.

The subtitle on the front page stated that it is a “whole of government strategy promoting a whole of community approach”.

AUTHOR: NSW Dept of Health

“The NSW Suicide Prevention Strategy 2010-2015 sets out the NSW Government’s direction and intended outcomes for suicide prevention over the next five years. It is built upon NSW’s first suicide prevention strategy Suicide: we can all make a difference, and is aligned with the national suicide prevention framework: Living Is For Everyone (LIFE).”

Outcomes and actions are listed in relation to each strategic direction. For example, outcomes under the fifth strategic direction include:

- Improved responsiveness to hotspots and environmental factors
- Improved access to a range of support and care for people feeling suicidal
- Systematic, long term, structural interventions in areas of greatest need
- Reduced incidence of suicide and suicidal behaviour in the groups of highest risk
- Improved understanding, skills and capacity of frontline workers, families and carers. (p26)

The introduction goes on to comment further on this framework.

Living Is For Everyone (LIFE), 4 which provides a national policy for **action** based on the best available evidence to guide activities aimed at building:

- stronger individuals, families and communities;
- individual and group resilience to traumatic events;
- community capacity to identify need and respond;
- the capability for communities and individuals to respond quickly and appropriately; and
- a coordinated response, and provide smooth transitions to and between care

“The NSW Strategy provides a comprehensive, whole of government approach to suicide prevention in NSW, as well as promoting whole of community involvement through collaboration and partnerships with academics, researchers, non-government organisations, service providers, people bereaved by suicide, and families, friends and individuals.

A major focus of the Strategy is to ensure suicide prevention is a shared responsibility, by further strengthening cross government partnerships and strengthening the capacity of individuals, families, schools, workplaces and local communities to work together and share responsibility in supporting each other and the whole community.”

“Provide timely data on suicide deaths and improve the accuracy of information on suicidal behaviour to assist in planning, monitoring and assessing suicide prevention initiatives.” p5

However, recent consultation with the community has indicated that more needs to be done in terms of:

- further availability of and access to services, especially for people living in rural/remote communities;
- greater focus on at risk population groups;

- *better coordination of non-health sectors;*
- *meaningful reporting;*
- *greater emphasis on evaluation; and*
- *embracing new approaches, learnings and service models* p6

The strategy provides a comprehensive statement of an all embracing strategy of a delivery of service. There is a strategic framework with subcategories, and implementation and evaluation.

The volume is far too great to provide here, so the reader will have to research the contents themselves.

On page 6, in the introduction, the strategy says “The NSW Government is responsible for the provision of a range of services, programs and activities that either specifically focus on suicide prevention or respond to the outcomes of suicide or attempted suicide or aim to enhance the resilience and wellbeing of individuals and the community.

What this means for the NSW Government

The Health system has responsibility for a range of issues across society as a whole, and in particular for people at risk, including the promotion of mental health and wellbeing, the prevention of mental ill health and drug and alcohol ill health, identification and management of risk of suicide, and ongoing care and support. (this is not a specific range of services, it is a general statement that the health system deals with all health)

In addition to prevention and recovery oriented community based mental health services and a range of cross agency preventative health initiatives, a range of protocols and initiatives are in place to identify people at risk of suicide and improve responses to suicide, including:

- A suicide risk assessment and management framework and training program for the Health system to enhance the capacity of health workers to assess and effectively manage people who may be at risk of suicide, including specific protocols and training for clinical staff working in mental health and other hospital and community health settings;
- additional mental health assessment and treatment capacity in NSW hospitals, including the establishment of Psychiatric Emergency Care Centres in major metropolitan hospitals and specialist Mental Health Clinical Nurse Consultant positions in Emergency Departments across NSW; and
- ***a standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings and their families and carers***

NSW Police Force, NSW Health and NSW Ambulance Services have a responsibility to identify and manage situations involving people at risk of suicide appropriately, with a focus on risk management through:

- specialised training for paramedics in the assessment and management of suicide risk, including providing immediate support to people affected by suicide;
- training for police officers to provide immediate support for people affected by suicide;
- the NSW Police Force’s Mental Health Intervention Team program, which includes training to improve awareness by frontline police, and techniques to effectively assist in mental health related incidents and provide strategies to reduce risks to the safety of police, consumers and the community.

To build wellness and resilience, and encourage help seeking behaviour in children and young people, schools:

- take a universal approach to suicide prevention, embedded through all stages of the Personal Development, Health & Physical Education curriculum;
- manage risk through initiatives such as School Link, which builds the capacity of schools to identify risk, enhance the expertise of school and TAFE counsellors and mental health workers, and develop local pathways to care; and
- manage critical incidents and develop emergency plans to deal with the “ripple effects” of suicide.

Children and young people who have experienced abuse and trauma are at increased risk of suicide and self-harm. To minimise this risk the child protection system focuses on a range of prevention activities through *Keep Them Safe: a shared approach to child wellbeing*.

The five year action plan recognises that we need to help families earlier so that they do not escalate into the statutory child protection system.

Those who seek emotional assistance from Victims Services are responded to by support workers or counsellors who have training in suicide risk assessment, via business and after hours support services. Where appropriate, this includes consultation with crisis mental health services or by direct referrals to Emergency Departments if the Police or Ambulance are called.

Suicide prevention in the correctional system is focused on identification and management of suicide risk. All people received into custody are screened for suicide risk in addition to:

- education for staff in the initial identification and management of people at risk, and a Risk Intervention Team policy for identification, assessment and management of ‘at risk’ offenders;
- targeted intervention strategies, with specialist units that assist with the further assessment, treatment and management of offenders with mental health, mental disorder, personality disorder, cognitive impairment, and/or self-harm risk;
- care extending to the transition to release or parole, when the risk of suicide can be heightened, through the Community Offender Support Program which works to house and support otherwise homeless offenders released from prison and help them to integrate into the community and connect with community and other services as needed; and
- Connections Clinical Support Workers to assist those under Justice Health care with reintegration into the community through linkage with appropriate community based service”. There is a second reference to – *A standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings and their families and carers.* ^{p47}

Implementation and Evaluation

“NSW Health will lead and coordinate implementation across government agencies through the Senior Officers’ Group on Mental Health, which reports to the Justice and Human Services Chief Executive Officers’ Cluster.”

This approach will be complemented by the establishment of a whole of community Suicide Prevention Advisory Committee, reporting to the Minister Assisting the Minister for Health (Mental Health) through the NSW Mental Health Priority Taskforce.

The Advisory Committee will include representatives from government agencies, the non-government sector, academia, business sector, and community and carer organisations.

Note: The whole thing is somewhat irrelevant, with the new framework coming into operation in 2018. I will leave the reader to do their own research on this if they wish.

Observations

It is vague, and seems to contain mostly jargon. This is about the 10th government Mental Health/Suicide Prevention Strategy document I have read.

Some parts have excellent statements. However, many parts of the document use a “condescending”, talking down, use of words. Always aspirational, and a cut and paste preamble of sympathetic statements . The result, it generates mistrust.

For example, the introduction says that “these services are suicide Prevention specific programs”, but go on to list (for example) Triple P (Positive Parenting Program) and Safe Start, and The NSW Early Psychosis Program - these are not Suicide prevention programs. The various services that were listed in this suicide report are simply services that form part of the delivery of general health, family, education and justice services as part of the expected work that the NSW government is charged with delivering.

In “Strategic Direction “, there is the reference to the establishment of an advisory committee. This statement is somewhat confronting, in that the reference group will be reporting to a junior minister, who is in turn going to report to the actual minister of Health. I note that, in 2010, the Mental Health Commission was not yet formed in NSW, and it appears that there was no actual Minister for Mental Health. This section alone helps to explain the lack of real commitment to Suicide Prevention, only 9 years ago.

The Mental Health Commission of NSW (NSWMHC): The Strategic Framework for Suicide Prevention in NSW 2018-2023

Noting the FIRST (STRATEGY) REPORT CONCLUDED IN 2015, HOWEVER, THE COMMENCEMENT OF THE SECOND (now called STRATEGIC FRAMEWORK) REPORT IN 2018.

The Minister for Mental Health NSW said in her message:

Building on previous state strategies and frameworks, this Framework complements the Fifth National Mental Health and Suicide Prevention Plan 2018–2023 and commits the NSW Government to working alongside the Commonwealth Government, Primary Health Networks, Local Health Districts, community managed organisations and other stakeholders to achieve integrated planning and delivery of mental health and suicide prevention. By delivering activities coordinated in each region of NSW, there will be a strong focus on supporting local communities to help themselves.

Strategic Framework details

“The Framework has been developed by the NSW Mental Health Commission and the NSW Ministry of Health in collaboration with people with lived experience of a suicide attempt or suicide bereavement, government agencies, mental health organisations and experts in suicide prevention. I am grateful to all those who have contributed to the Framework’s development – members of the NSW Suicide Prevention Advisory Group, non-government organisations, communities and individuals.”

The role of the NSW government is defined as follows:

“The NSW Government delivers and funds programs and services that target the social determinants of health and improve wellbeing at the community, organisational and individual level. These include housing, employment, health, disability and financial support, transport assistance, workplace supports, the justice system and education programs. Targeted suicide prevention initiatives, early intervention programs and evidence-based therapeutic interventions are also offered.”

There is a NSW Mental Health Taskforce, (who) will provide oversight for the Strategic Framework for Suicide Prevention in NSW 2018-2023.

The Taskforce will be supported by the advice from the Suicide Prevention Advisory Group (SPAG). The NSW MHC established SPAG to advise on the issues relating to Suicide Prevention, to improve planning monitoring and co-ordination. SPAG is co-chaired by the NSW MHC Commissioner and the Executive Director MH Branch, NSW Ministry of Health. 16/10/18 Strategic Framework for SP 2018-2023

Vision

The overarching vision of the Framework is that everyone in NSW lives with hope, wellbeing and good health, with fewer lives lost through suicide. The Framework represents the beginning of our journey towards zero suicides in NSW.

Five goals support this vision:

1. Individuals and communities have the strength, resilience and capacity to prevent and respond to suicide.
2. Individuals and communities are empowered to have safe conversations about suicide and suicidal behaviour, and to know how and where to seek help when needed.
3. High quality, culturally safe, trauma informed services are available to prevent and respond with compassion when and where they are needed.
4. Suicide prevention, intervention and postvention programs and services that place people at the centre are co-designed, inclusive, coordinated and integrated.
5. Suicide prevention activities are responsive to the best available evidence and contribute to the evidence base, with new approaches shaping effective action.

Priority Actions

There are 5 priority areas listed as follows The headings are

1. Building individual and community resilience and wellbeing
2. Strengthening the community response to suicide and suicidal behaviour
3. Supporting excellence in clinical services and care
4. Promoting a collaborative, coordinated and integrated approach
5. Innovating for a stronger evidence base

Please refer to the Strategic Framework for the details.

NSW Government Immediate Plans

Critical areas for immediate investment

This Framework supports the NSW Government's existing commitments and sets the scene for future action. However, based on the evidence, gaps in services and approaches, and the priorities for change called for by the community, **three areas have been identified that need the NSW Government's immediate attention.**

The NSW Government will work in partnership with the Commonwealth and PHNs, and the community managed, non-government and private sectors, where appropriate, to deliver on these.

1. *Aftercare services*

Effective follow-up care after a suicide attempt provides longer term support for people who are discharged from general hospitals and community services by rapidly linking them with ongoing support and coordination from a

dedicated team or worker. The NSW Government will work with the Commonwealth and PHNs to ensure investment in aftercare services is complementary and minimises duplication.

2. Trials of innovative and promising interventions

Drawing on international and interstate experience, the NSW Government will trial the most innovative interventions that are most likely to be effective in NSW to fill gaps in the system and add to the evidence of what we know works.

3. Tailored community response packages

The NSW Government will invest in a flexible program that includes gatekeeper training and community-led awareness campaigns to support specific priority populations including, but not limited to, rural and remote residents, young people, Aboriginal communities, LGBTI communities, men in the primary, mining and construction industries and other populations according to local needs. This will build community resilience and wellbeing and support community-led suicide prevention actions in response to their local challenges

Observations

There are no timeframes for many proposals or services. Most of the items nominated are not really Suicide Prevention specific, they generally relate to services that are all encompassing of the service area nominated e.g. homelessness. Most of the framework is aspirational, and piecemeal, punctuated with trials and one-off service providers.

It is a real concern that's the 4 Suicide prevention Trials in NSW located in Newcastle, Illawarra Shoalhaven, Murrumbidgee and Central Coast, were funded NOT by the NSW Government, but by a donation from the Paul Ramsay Foundation (\$14.7 million).

I attended a National Suicide Prevention Symposium in Canberra, May 2019, there many, many expressions real concerns about sustainability of funding.

I struggle with the level of commitment of the NSW Government , as press announcements are made (see Premier Gladys Berejiklian announcement 28 June, 2019 re announcing the priority of Suicide prevention), yet the NSW government has not contributed one dollar for the 29 trials around the nation. The Australian Government has funded 12, and the Victorian government has funded 12, even the ACT government funded theirs, yet the NSW government announces priorities about suicide prevention that are , however, a repeat of earlier aspirations.

“This framework is one of many documents that outline the broad approach to be taken. But to really make a difference we need to connect the work at a local level – ensuring that people can get the support they need, when they need it.”

“While there has been much progress and action in NSW, we know that more needs to be done.”

St George Sutherland Leader 22 Nov 2018 heading “Strengthening Minds during the Movember men’s mental health month”

“Mental Health Minister Tanya Davies says the government’s plan is to reduce the number of lives lost to suicide in NSW.” Evidence shows integrated, community-led activities are more effective in suicide prevention than standalone, isolated activities that are not well linked,” she said.

NSW GOVERNMENT MENTAL HEALTH SUBCOMMITTEES

Overview

NSW Ministerial Advisory Committee on Suicide Prevention

“Held the first meeting of the NSW Suicide Prevention Ministerial Advisory Committee (the Committee) on 22 February 2012. The establishment of this Committee was a key commitment under the NSW Suicide Prevention Strategy 2010-2015.”

On the 2nd February 2016, from the NSWMHC, “Efforts to reduce suicide in NSW took another step this week with the inaugural meeting of the Suicide Prevention Advisory Group”.

The Group was established by the Mental Health Commission of NSW to advise the Mental Health Commissioner on issues relating to suicide prevention and to strengthen the planning, monitoring and co-ordination of state-wide suicide prevention efforts. Its establishment is one of eight key actions relating to suicide prevention identified in Living Well: A strategic plan for mental health in NSW 2014-2024. The Group meets every six months.

Note: There was no advice as to how they would liaison with the NSW Suicide Prevention Ministerial Group.

I discovered the second group after scouring the internet to find a report from the ministerial group for any year from 2013 to 2018. I was unable to find any posted report (annual or otherwise) through NSW Health or general internet searches.

Strategies of the Subcommittees

Consulted with community in 2012, further information from anyone reading this report is most welcome to advise so the report may be amended .

The Ministerial Council for Suicide Prevention (MCSP) provides strategic advice on suicide prevention initiatives to the Minister for Mental Health and the Mental Health Commissioner and leads the state-wide suicide prevention strategy.

NSW SUICIDE PREVENTION TRIALS

There are no NSW Government funded Suicide prevention trials.

There are however, independent trials in NSW, as it would seem that the NSW Govt is content to leave it to the Federal Government to fund 12, and the Victorian Government to fund 12 trials.

In NSW a trial is being conducted of the systems approach, through the Lifespan project. (“Lifespan is an innovative approach to Suicide Prevention initially developed by on behalf of the NSW Mental health Commission by the NHMRC Centre for Research

Excellence in Suicide Prevention (CRESP) and Black Dog Institute “ (p4 Nat Suicide Symposium Canberra May 2019)The project is being run by the Black Dog Institute, in partnership with NSW Health and others. It is funded by a \$14.7 million grant from the Paul Ramsay Foundation. Four locations have been chosen for the trial:

1. PHN Newcastle (commencing October 2016),
2. PHN Illawarra Shoalhaven (February 2017),
3. PHN Central Coast (May 2017), and
4. PHN Murrumbidgee (September 2017). 33

As the 4 Lifespan High Fidelity Suicide Prevention Trials being conducted in NSW are noted that the trials are funded by the Ramsay foundation, and as such, should not be credited here as the NSW Govt hasn't funded it.

Royal Commission into Victoria's Mental Health System Interim report November 2019

The Victorian Royal Commission produced an interim report into their Mental Health System . It was released on the 28th November 2019.

Parts of its interim findings and its scope of work that are relevant to the matter of Suicide Prevention, both at the national level , and at the Victorian state level . Though not a NSW report , it is felt that there is a high level of relevance to any state for the following reasons :

1. A Royal Commission at a state level is a valuable document considering its contemporary date of November 2019
2. It's level of powers and scope of enquiry are far reaching , and relevant to any state .
3. Both states are directly affected by federal health issues , and both have identical hospital (primary and mental health) systems
4. The interim report details address the many issues that seem to affect NSW .
5. Both economies are of similar size and each state capital have similar sizes .
6. The initial findings have , therefore , application to NSW's problems in the Mental Health sector

This preliminary report is a most carefully researched and eminently qualified document outlining the process of change needed in Victoria to start reducing the Suicide rate from a state government perspective

Indeed , this 638 page finding is one of the most far reaching and insightful documents on Mental Health , with so many well considered recommendations . A solid body of work explaining what is wrong at a State level , as well as failure to provide an integrated service with Federal funding .There are excellent notations on prioritisation of remedies. It is a highly recommended read .

Much of the Mental Health content has been omitted from this Suicide Prevention document , to enable fitting in yet another last minute report as 2019 comes to a close . The prodigious work of the Productivity Commission and now, the Royal Commission in Victoria cannot be just noted as an add on at the last minute . Therefore , another 17 pages have been added at the 'last hour' of this document , it cannot be avoided .

It would be a false premise if people in New South Wales felt that this is a "Victorian only " finding , the problems in our post discharge care of a consumer and their carers are well known , and sadly parallel the Victorian failings .So too, our funding models

of the health sector , the revelations confirming the parlous state of decision making in relation to allocation of resources in primary and mental health care .

There is absolutely no evidence AT ALL , of the New South Wales Government addressing the services discipline and integrity of process any differently than has been evidenced in Victoria.

Indeed , the findings in this Royal Commission , if accepted as a reflection of the same problems in New South Wales , adds a validation of the concerns in the report "[A PROPOSAL TO REFORM THE PROVISION OF ESSENTIAL STAFFING LEVELS OF PSYCHOLOGISTS AND CLINICIANS IN NEW SOUTH WALES MENTAL HEALTH HOSPITALS](#), which has been placed before the NSW Minister for Mental Health on the 17th September 2019 (, the contents are contained on page 184 of this report .)

So, the relative parts of the findings and recommendations of the commission are provided here in the New South Wales (state) section to shed light on Prevention Suicide and other relevant state issues .

The Royal Commission into Victoria's Mental Health System has produced a body of work complete with the undertaking of the Victorian Government to create a very substantial fund that will provide a radical overhaul of Mental Health in Victoria .

The Human Resources funding in Victoria will place New South Wales at a precarious , even impossible position in regards to retention of qualified Mental Health personnel. Indeed, there has already been commentary on the possible recruitment of staff from overseas . The long time poorly supported staff in many areas just across the border will , no doubt find the call to Melbournes centre of excellence and other centres irresistible .

So ,a respectful note of caution to the NSW Government.

Ignore what is about happen across the border at your peril . Denial of the same problems in such areas as funding models and post discharge care at Mental Health hospitals in New South Wales , as described in the Victorian Royal Commissions findings would be incredibly inappropriate .

The parts of this Royal Commission that are outlined here are :

1. What the Commission found that the community was concerned about
2. A real change process
3. Gaps in service and delivery
4. The stepped care model and the reality
5. Mental Health investment – a game changer
6. National complexity and control
7. Accountability and Responsibility
8. Coordination and lack of integration
9. Restricted funding
10. Data and Information
11. Underinvestment and Poorly Allocated Funding
12. Culture of Service Delivery Model
13. Fragmented Service System
14. Post Discharge Care
15. Aboriginal Social and Emotional Well -Being
16. SUICIDE – Chapter 11 (a comprehensive extract)

1.What are the TOPICS of concern to the Australian Community in MENTAL HEALTH

As with the community consultations, a number of witnesses brought multiple perspectives to their evidence, having worked in the mental health system and also having lived experience. The topics explored in hearings were done so in some depth but not extensively in scope. The topics were:

- stigma
- prevention and early intervention
- access to and navigation of the mental health system
- families and carers
- rural and regional

- Aboriginal and Torres Strait Islander people
- LGBTIQ+ and culturally and linguistically diverse (CALD) communities
- community resilience
- suicide prevention
- prioritisation and governance of mental health services.

2.THE PROCESS OF CHANGE

The Victorian Government has asked that the Commission’s recommendations ‘endeavour to achieve practical, prioritised, Having reflected on the many previous attempts to bring about change in the mental health system, the Commission has resolved that an early and sustained focus on implementation is necessary. It recommends that the Victorian Government immediately establish a Mental Health Implementation Office to support a dedicated focus on delivering the changes proposed in this report. The Office should be viewed as a transitional measure while the Commission continues its work to determine governance for the future of the mental health system in Victoria.(p387-388)

4. THE STEPPED CARE MODEL and THE REALITY

For a person trying to access mental health treatment and support, unclear referral pathways and inadequate coordination can result in them being bounced around the system—or missing out on the care they need altogether.⁴⁶ The result is a system that is increasingly crisis-driven and reactive, that can create a ‘revolving door effect’, and that sees interventions failing to address the underlying causes of mental illness. (p80-81)

The Commission agrees with the assessment of Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health, that:

The system is achieving exactly the results it was set up to achieve, every time a decision was made to take funding out, without keeping track of its impact on patients and their families. It is achieving the results it was set up for, every time decisions were made to fragment the system further by introducing elements that linked poorly with one another and that were not integrated with the broader health system of preventative primary health [...] every time we turned a blind eye to deteriorating hospitals, the sub-standard accommodation, the homelessness, the poverty and the violence that is all too common an experience for people with severe mental illness [...] We all have a hand in where we are today.¹¹⁶ (p98)

5.MENTAL HEALTH INVESTMENT – A CHANGE MAKER

The Royal Commission recommends that the Victorian Government designs and implements a new approach to mental health investment comprising:

- a new revenue mechanism (a levy or tax) for the provision of operational funding for mental health services
- a dedicated capital investment fund for the mental health system.

This new approach should support a substantial increase in investment in Victoria’s mental health system, supplementing the current level and future expected growth of the state’s existing funding commitments.

6.NATIONAL COMPLEXITY AND CONTROL

The complexity and fragmentation of the mental health system is not a new issue; it has been discussed in the many other inquiries, reports, plans, policies and strategies on mental health mentioned above.² The consequences of this complexity negatively affect people living with mental illness, their families and carers, namely through service gaps and poorly coordinated services.

A major contributor to the system’s complexity is the fact that no one entity has complete oversight or control of the mental health system. While numerous agencies deliver mental health services, such as public and private health services and non-government organisations, responsibility for funding and oversight is primarily shared between the Commonwealth and Victorian governments . (p106)

7. ACCOUNTABILITY & RESPONSIBILITY

These changes in roles and responsibilities have unintentionally led to distorted lines of responsibility and accountability.²² As Dr Peggy Brown AO, a psychiatrist who has held a number of leadership roles in the mental health sector, told the Commission: The mental health system is unnecessarily complicated by the fact that the differentiation between the respective responsibilities of the Commonwealth and the States has become increasingly blurred and, partially as a result of that, the system has become even more fragmented and possibly less accountable.²³

The Productivity Commission’s recent draft report on mental health calls for a clearer division of responsibilities and better coordination between primary care (mainly Commonwealth-funded) and acute and specialist services (mainly state-funded). The Productivity Commission articulated: ‘the lack of clarity about how both tiers of government share

responsibility for mental health is an urgent issue that needs to be addressed'.²⁴ While acknowledging that some level of overlap is likely to remain, the Productivity Commission recommends that agreed roles and responsibilities of governments should form the basis of a new intergovernmental agreement on funding.²⁵

AN OBSERVATION

I have read more than 50 reports, Plans etc , thousands of pages , and yet , the word seemed to be avoided , as though it is a mysterious thing that should not be raised . . And ,finally, HERE IT IS ! ACCOUNTABILITY. Thank you Commissioners ,as noted earlier , I think it is an essential process that has been missing in Mental Health .

"21.4.4 ACCOUNTABILITY

Implementation will stand a greater chance of success if the Implementation Office builds community confidence in reform and trust in the institutions leading it.³⁸

Building community confidence and commitment will depend in part on taking early, effective steps towards making improvements to the mental health system. This has been demonstrated in longer term projects such as the program of changes to make Melbourne a more liveable city—when people started to see the benefits of the early changes, their view of the overall initiative became far more positive.³⁹

In this context, the Commission envisages that the Implementation Office's primary purpose will be to effectively deliver on the Commission's recommendations, rather than compliance. It will not be an implementation monitor.

Early and regular public reporting is a feature of timely and effective implementation.⁴⁰ Accountability to the public can best be achieved by the Victorian Government through the Implementation Office, publicly committing to a program of work detailing milestones and specific activities for delivering on the Commission's recommendations. The Implementation Office should produce public reports on its progress and the impact of its work."

8. COORDINATION & LACK OF INTEGRATION

Achieving integrated regional planning and service delivery was a key priority of the Fifth National Mental Health and Suicide Prevention Plan.²⁸ It is difficult to achieve, however, in a context where there is limited statewide system planning.

Dispersed funding arrangements and unclear roles and responsibilities contribute to a poorly coordinated service system. In a submission to the Commission, a group of mental health experts said that a lack of coordination between the Commonwealth and Victorian governments has contributed to an increasingly fragmented system:

Commonwealth monies [are] being expended on mental health in a manner that is not integrated with extant state-funded services: this leads to major problems in terms of dislocated care, complex care systems and lack of knowing who has responsibility for what.²⁹

Further, siloed funding and governance arrangements can lead to disorganisation and inefficiencies across the sector.³⁰ For example, the National Mental Health Commission submitted that a lack of coordination between governments has led to an uncoordinated and fragmented set of programs and policies on suicide prevention. This has resulted in a patchwork of solutions and duplication of effort.³¹ (p109)

9. RESTRICTED FUNDING

It was put to the Commission that the Commonwealth and Victorian governments fund mental health services in fundamentally different ways. The Commonwealth preferences funding based on a fee-for-service market-based system that is driven by individual need, while the Victorian Government tends to fund organisations to provide services within specified geographical areas and within capped budgets.³⁵ Associate Professor Ruth Vine, Executive Director of NorthWestern Mental Health, Melbourne Health, told the Commission:

There is a Commonwealth and state divide in relation to funding [...] These two do not sit easily together, especially when both are under pressure, such that funding is rationed to some extent.³⁶
(p110)

10. DATA and INFORMATION

Inadequacies in information gathering and data collection across all levels of the mental health system also constrain system accountability and monitoring.(p115)

Data and Evidence in SUICIDE PREVENTION

Victoria has a nation-leading approach to suicide data collection with the Victorian Suicide Register, which is managed by the Coroners Court of Victoria. The register helps coroners conduct investigations into suicide deaths and produce data and evidence

to support recommendations. It is also a source of information for organisations developing suicide prevention policy and initiatives and for academic research.

In 2018 the Coroners Court and the Department of Health and Human Services signed a memorandum of understanding to formalise the sharing of information on suicides in Victoria and to facilitate development of evidence-based suicide prevention policy and initiatives.

The memorandum of understanding has allowed the department to consider and analyse data about suicides over time, and by municipality, to guide pillars of its prevention strategy—place-based trial sites and the HOPE program. It has also enabled the department to provide localised information and de-identified data to area mental health services that capture patterns and trends in suicide to support quality improvement and new approaches to care.

With the rollout and expansion of HOPE statewide, the Implementation Office should establish a unit that facilitates the critical linkages between data, evidence, practice and practice improvement to ensure successful, evidence-based design and implementation of assertive outreach programs. This process should bring together multiple streams of work, including existing projects and programs of work such as linked data projects, monitoring and health service benchmarking. This work will help deliver the interim recommendations but also create the functionality for longer term suicide prevention efforts as part of the Commission's continuing work program.(p577)

11. UNDERINVESTMENT and POORLY ALLOCATED FUNDING

Past investment in the mental health system has been insufficient to provide enough treatment, care and support to meet the needs of people living with mental illness. The system has also been increasingly unable to meet its stated objectives for access and effectiveness—and so is providing many people living with mental illness, their families and carers with poor experiences.(p116)

19.3.4 “CROSS SUBSIDISATION” (THE SMOKING GUN OF WHAT WE KNEW WAS HAPPENING)

Due to a lack of transparency inherent in the current funding model, the funding allocated to public mental health care in Victoria has not always found its way from health services' budgets to services for people living with mental illness;100 it has, at times, been co-opted for other purposes.101 Reflecting on his role as Minister for Health in the mid-to-late 1990s, Mr Knowles informed the Commission:

One of the suggestions which we (unfortunately) accepted was to roll funding for mental health into the overall funding of health generally. We ultimately found that this meant mental health services were starved of funding as the funding was swallowed up by physical health services.102

The cross-subsidisation to inpatient services has contributed to the diminishing capacity of services in the community, which in turn has led to increased emergency presentations and a need for more inpatient treatment.106 As Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, explained in relation to Mercy Mental Health:

There's been a slow shift of resources within mental health services from the community to acute services which has left community services in a very difficult position of not having sufficient staff to provide or meet the case management needs of the people that we treat in our catchment area.107

Similarly, Associate Professor Ruth Vine explained the position at NorthWestern Health:

Another driver of unmet need is that the under-funding of inpatient units is cross-subsidised by community teams. This means that community teams are much 'skinnier' than intended and that, for every clinician position that is lost from a community team to fund inpatient units, there is a loss of service availability to approximately 25 patients at any one time.108 (p118)

12. CULTURE OF SERVICE DELIVERY MODEL

The (Victorian) Auditor-General's conclusion was that the findings of past reviews speak to:

... an ingrained culture, developed and reinforced over two decades, of not fulfilling the responsibilities that properly pertain to a system manager—either understood and accepted but not acted upon, or there remains debate and uncertainty as to what is the proper role of the department vis a vis health services.114

That conclusion is consistent with the entrenched nature of the problems discussed in this report. The department did not challenge this.

Where services are operating in crisis mode, it is even more difficult to find a balance in governance. As the Auditor-General said: I [...] wonder how you can properly hold the health services to account, knowing that you haven't fully funded them to deliver the services you've asked them to deliver [...] While it is appropriate to say that the hospital is best placed to manage access [...] if they have to rob Peter to pay Paul to actually pay for that in a sense they are not best placed to manage access so that the system owner must take some accountability and responsibility for that.115 (p119)

COMPETING BUDGET DEMANDS

Mr Martine told the Commission that in a constrained resource environment it is difficult for governments because there are many competing demands.¹³⁰ He explained that:

The funding allocated to deliver services to the Victorian community reflects decisions that are made by Government, generally as part of the annual budget process, to implement the government of the day's objectives and priorities.⁽¹³¹⁾ Witness Statement of David Martine PSM, para. 9. Mr Martine is Secretary of the Victorian Department of Treasury & Finance. He leads the Department providing economic, policy and service delivery advice to the Victorian Government.^(p121)

13. FRAGMENTED SERVICE SYSTEM.

Dr Caroline Johnson, a GP, outlined some of the impacts of a complex and fragmented service system:

Unfortunately, the pathways to better mental health care are overly complex and poorly connected, particularly in the situation where a patient has already accessed some care but has not improved or when there are financial barriers and long waiting times to accessing more expert care. One example of this is that psychologists often move into private practice as they become more experienced, and some people can't afford this type of care. Or sometimes a patient in crisis agrees to get help, but by the time the appointment comes through the crisis has subsided and the patient is no longer willing to follow through with help-seeking (until the next crisis appears and the cycle starts again). Or a service is funded for a while, but then the referral rules or type of service changes just as the service is starting to be known.⁸⁷ (p171)

14. POST DISCHARGE CARE

In recent years, services have become more constrained in their capacity to provide support to people in the community following discharge from public specialist clinical mental health services. Incomplete discharge summaries,¹⁴² time-pressured discharge assessments and inadequate planning can all negatively affect experiences and outcomes of treatment, care and support.¹⁴³ Data from area mental health services suggest that only one in four consumers receive face-to-face follow-up in their own home following discharge from an inpatient unit.¹⁴⁴ The Mental Health Complaints Commissioner submitted that it has received numerous complaints relating to inappropriate discharge arrangements; among them are expressions of concern about consumers being discharged into unsuitable accommodation or unsafe situations without adequate follow-up support.¹⁴⁵ Similarly, the Commission was told of people being discharged from public specialist clinical mental health services without a plan or without their family or GP being told. Some were put on a train leaving town and some had nowhere to go. One person described how it made them feel: 'It's that loneliness in between hospital and going home, having no one'.¹⁴⁶ Many people have described being 'discharged to homelessness'¹⁴⁷ simply because there is nowhere else for them to go. One person described how people are pushed from public specialist clinical mental health services to prevention and recovery care centres, 'and when those are full, people get pushed onto the street and into homelessness'.¹⁴⁸ One mental health worker spoke of the impact of having to discharge people without stable housing, saying, 'We discharge people back onto the streets, and I have to live with that'.¹⁴⁹ (p251)

15. ABORIGINAL SOCIAL and EMOTIONAL WELL-BEING

Recommendation

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years
- scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years
- recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise

in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:

- clinical, organisational and cultural governance planning and development
- workforce development—including by enabling the recommended scholarships
- guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
- developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.

19.3 The mental health of Aboriginal communities

It is 24 years since the Ways Forward report drew the nation's attention to the high levels of unmet need for culturally safe mental health services for Aboriginal people.¹ Since then, numerous reports have concluded that Aboriginal communities continue to live with the effects of trauma wrought by colonisation and post-invasion government activity.²

In Victoria it is estimated that more than 47 per cent of Aboriginal people have a family member who was forcibly removed from their kin under policies that gave rise to the Stolen Generations.³ Western Australia, South Australia and Victoria consistently have the highest proportions of their populations born before 1972 reporting being forcibly removed in multiple surveys conducted from 2002 to 2014—15.4 As the national Healing Foundation submitted to the Commission, Aboriginal people in Victoria carry the significant legacy of trauma caused by the forcible removal of children from Aboriginal families.⁵ A first-of-its-kind study commissioned by the foundation provided comprehensive data to illustrate the direct link between the removal of Aboriginal children and symptoms of trauma in families and their descendants. The study also documented higher levels of health, economic and social disadvantage in the affected families.⁶ The Commission was told of the negative impacts of this trauma:

The prevalence of mental health within Victorian Aboriginal communities can be directly related to the loss of land, culture, identity, self-respect, self-worth and the breakdown of traditional roles within communities. Systemic racism has been a significant factor in ensuring Aboriginal communities remain fragmented and disjointed and has supported the social isolation, trauma and depression of many Aboriginal communities' members.⁷

It is important for the Royal Commission to understand that colonial violence is not a stagnant piece of history. Intersecting systemic racism and systemic sexism keep Aboriginal and Torres Strait Islander women trapped in violent situations and cycles of trauma. The mental health system can present as yet another form of violence.⁸

Post-invasion policies not only disrupted family attachments but severed Australian Aboriginal people's attachment to their land, cultures and identities. The historical trauma of Aboriginal people can be 'transmitted' intergenerationally to entire communities as well as individuals and families.⁹ Today, many Aboriginal communities face problems such as alcohol abuse and forms of violence that did not exist before colonisation.¹⁰ Aboriginal mental health is also affected by racism and discrimination. Research indicates that almost all Aboriginal people in Victoria have experienced racism¹¹ and that those who experience high levels of racism are more likely to also have elevated levels of psychological distress.¹² (p465-466)

16. Chapter 11 SUICIDE

I looked at the opening observations of the Commission on suicide, and crying, dutifully cut and pasted the compellingly distressing contents, surely we have enough content to persuade any person of gravity of the disaster. But, I am biased, a lived experience bereaved father, I see it differently to the politicians, the decision makers, the bureaucrats who allocate the sway of political strategies, the meagre funds, and the unsettlingly finite dates when programs may cease to exist. I'm afraid this report will bloat even more in content. Page after page HAS to be added from this profoundly harrowing document, this is the least I can do:

"The Royal Commission repeatedly heard distressing stories of people who, having experienced overwhelming suffering and feelings of despair, had attempted to or succeeded in ending their lives. These events invariably had profound effects on individuals, families and loved ones.

Compounding these tragedies, many people had attempted to receive support from the mental health system when they or a loved one experienced a suicidal crisis, only to be turned away for not being 'suicidal enough' or for 'not having a plan'.²"

"The Commission heard that even when people do access public specialist mental health services, the pressures on these services means they are unable to offer enough support or the right kind of services.³ The Commission was told about the devastating consequences when people are sent home after the briefest of stays in the emergency department or hospital, and with no follow-up care. "(p315)

My daughter suffered mental health issues and it took 12 years for someone to talk to me but by then the damage was done. She tried to take her life in the hospital and cut herself wrist to elbow. We went to the hospital and it was taped up, and she was sent home. They told us someone would call tomorrow, and no one rang. In early December she got sent into hospital to review her medication and cut her wrists in hospital with a CD. They let her out and she suicided nine days later. Now they all want to talk to me, only once she has died.⁴

We lost our [...] son to suicide [...] this year. He felt that the mental health and private systems let him down. He cried out and reached out for help many times, only to be turned away, because he didn't fit their criteria, [and] didn't have funds to seek help in private facilities.⁵

Currently, if someone has made an attempt on their life, they are taken to an emergency department at the closest hospital, treated, maybe seen by a mental health nurse and then sent home. There is no follow-up, assistance or treatment path provided

to the patient or the carers—everyone is left on their own wondering how to deal with the situation which has just happened and terrified of when and how it may next occur and what they can do to stop it.⁶

To illustrate the impact of suicide in Victoria's communities, comparisons are often made between the number of deaths by suicide each year and the annual road toll. In the past decade in Victoria 6,181 lives have been lost to suicide: this compares with 2,651 lives lost on our roads. On average, there were more than double the number of lives lost to suicide than lost on our roads between 2009 and 2018 (see Figure 11.1). In 2018 the number of suicides was more than triple the number of road accident deaths—720 lost to suicide and 213 lost on the roads. (p316)

The discussion highlights some of the major barriers and problems people at risk of suicide experience when trying to get support. For example:

- Service capacity challenges in public specialist clinical mental health services have resulted in people at risk of suicide being turned away or receiving inadequate or delayed care.
- People are increasingly having to present to emergency departments, which are unsuitable environments for supporting people experiencing suicidal distress.
- Crisis hotlines are unable to manage high levels of demand, resulting in unanswered calls.
- Mental health workers often feel ill-equipped and need training to help them to respond appropriately to potential suicidality and immediate suicidal crises.
- Despite some improvement, Victoria does not have an adequate network of bereavement services available to support people and communities after someone has died by suicide.(p319)

Susan's son, Rowan,* died by suicide at the age of 33 in 2010. Susan, a witness before the Commission, said: This is a difficult story for me to tell. My son had attempted suicide 26 times before he died, but I still always believed he would stay with us. I was totally destroyed when he died. Rowan was diagnosed with attention deficit syndrome at the age of 5 years and a borderline intellectual disability at the age of 10. His mental health seemed to deteriorate in his late teens, and he attempted suicide for the first time when he was 19. It took some time for him to get follow-up support. Rowan was in the emergency department for 48 hours before he was discharged into my care. [He] was not able to see a counsellor straight after release from hospital, as there was a waiting list. Around 2 or 3 months after his first suicide attempt Rowan started counselling. Rowan attempted suicide a further three times between the ages of 19 and 21: Rowan seemed to become more frustrated each time he attempted suicide. It seemed to me like no one was helping him. Each time the hospitals just released Rowan and told him to keep up his medication and treatment. In his late 20s Rowan was in a constant cycle of issues, overdoses and recovery. So for me it was a roller coaster and hospitals after hospitals. I could not believe that after so many suicide attempts there did not seem to be any real help [...] Despite all of this, in family meetings and at the hospitals I was told that Rowan was an attention seeker who would not take his life. Rowan would always cry and say things to me like: 'Why can't anybody help me and stop this stuff inside my head?' It broke my heart. Following a series of distressing events, Rowan overdosed on prescription medications two days before Christmas and was taken to the emergency department. I begged them to hold on to him until Boxing Day, because that's when I could come and pick him up. I begged them, 'Please, hang on to him because he's not in a good way'. They told me they would. Rowan was discharged from hospital on Christmas Day and called Susan telling her not to worry about him. He said, 'Don't forget, mum: love you', and then hung up. About two hours later I started to worry, I had a horrible feeling in my stomach because I hadn't heard from him. Susan was called that evening and told that Rowan had died by suicide. That day absolutely destroyed me and for the rest of my life now all I think of is, why, if, but, if only. And that's why I run these support groups, to help other parents that go through the same pain and suffering that I feel every day of my life.*

** Not their real names*

Mr Alan Woodward, a specialist in suicide prevention and mental health, told the Commission of several reasons why Victoria has been unable to reduce its suicide rate, including that:

- There is inadequate coordination of effort and insufficient resources as well as a lack of universal coverage for a range of important services such as after-care programs, workforce training, supports for people in suicidal crisis, school-based prevention programs and bereavement supports.³¹
- There is a need to ensure suicide prevention funding is provided to a broad range of services—including mental health services, housing, youth justice, family support, education and community and social services—to create a whole-of-government approach to suicide prevention.³²

• There is insufficient coordination between programs and services at the Commonwealth and state levels, leading to duplication and service gaps.³³ (p323)

Despite significant investment in international, national and state/territory suicide prevention strategies, there are still gaps in the evidence on the effectiveness of interventions.⁷⁷ Part of the reason for this lack of evidence is the challenge inherent in research into suicide prevention. One of these challenges concerns the vulnerability of the population at risk of suicide: they cannot form part of a randomised controlled trial, so the effectiveness of an intervention cannot be evaluated against such a control.⁷⁸ While there is still much to learn about what works and what does not,⁷⁹ the profound effects of suicide create an imperative for governments to act. As Professor Pirkis stressed:

“We cannot wait until we have perfect evidence; we must do the best that we can based on the information available”.⁸⁰

Current global best practice in suicide prevention is described in the World Health Organization’s 2014 report *Preventing Suicide: A Global Imperative*.⁸¹ The report emphasises the need for coordination and collaboration across multiple sectors of society, both health and non-health sectors, and public and private sectors: ‘These efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide’.⁸²

The 2019 opening statement by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, positions the protective factors for suicide prevention into a rights-based approach that the Commission supports:

Providing holistic support for individuals and populations as a whole, particularly those who are most vulnerable, enables the attainment of the right to health by addressing the structural and psychosocial determinants of distress, such as childhood trauma and abuse, social inequality and discrimination [...] We must pursue new routes to suicide prevention that invest in fortifying healthy, respectful, and trustful relationships and community connectedness.⁸³

Reviews of the international evidence have supported adopting a multi-component approach.⁸⁴ Initiatives generally fall into three main categories:⁸⁵

- Universal interventions. These target whole populations and are often designed to modify the environment (for example, restricting access to the means of suicide) or encourage responsible media reporting.
- Selective interventions. These target vulnerable groups of people in the population who are not actively suicidal but who have recognised risk factors for suicidal thoughts and behaviours. For example, ‘gatekeepers’ who assist the vulnerable and services such as helplines.⁸⁶ Selective interventions also work with at-risk groups to build resilience and strength in vulnerable groups—for example, children who are survivors of child abuse⁸⁷—and to promote self-help behaviours.
- Indicated interventions. These target individuals who are already having suicidal thoughts or engaging in suicidal behaviour—for example, services offered after a suicide attempt.

The Commission was told that one of the best examples of a comprehensive approach to suicide prevention in Australia is LifeSpan.⁸⁸ This model was developed by the Black Dog Institute and is subject to testing through state-based trials and some primary health networks.⁸⁹ The model (see Figure 11.4) consists of nine evidence-based strategies that cover the spectrum of interventions—from interventions for high-risk individuals through to interventions directed at a population level.⁹⁰

The model emphasises that a systems approach, whereby all strategies are implemented simultaneously, is central to the success of suicide prevention.⁹¹ In her evidence to the Commission, Scientia Professor Helen Christensen AO, Director and Chief Scientist, Black Dog Institute, highlighted the need to take a broad, multifactorial approach:

We cannot predict who will die by a suicide. We have to cast a large net; we can’t just focus on particular people who might have risk factors. We [...] must spread this across the whole community [...] so a universal prevention [...] that requires that you engage the community and that everybody has a place and is aligned in a way for a coherent approach to it.⁹²

Universal prevention approaches and cross-government interventions beyond health are particularly important in reaching people who have no clinical risk factors but who are experiencing situational or environmental stressors.⁹³ As Mr Woodward said: These are important areas for suicide prevention because the issues and life circumstances that they are addressing may be factors in a person’s suicidality, and because they provide points of contact with persons who may be suicidal and could be approached with the offer of help—earlier and more effectively than waiting for a suicide attempt to occur.⁹⁴ (p328-330)

PLACE -BASED SUICIDE PREVENTION TRIALS

The place-based suicide prevention trials are taking place as a partnership between the Victorian Government and Victorian Primary Health Networks.¹⁰⁶

Ms Anne Lyon, Executive Director of Mental Health, Alcohol and Other Drugs at the Eastern Melbourne Primary Health Network, told the Commission that the trials are designed to take a systematic, coordinated approach to suicide prevention, with each site being supported to implement evidence-based suicide prevention initiatives.¹⁰⁷ The operating model parameters, developed by

the Department of Health and Human Services, require the sites to focus on local capacity building and enhancing system effectiveness to reduce suicide, rather than service expansion or new services.¹⁰⁸

The 2018–19 Mental Health Services Annual Report states that more than 300 local partnerships have been established at the 12 trial sites.¹⁰⁹ During that year more than 2,000 people were trained to identify and support people in mental distress or suicidal crisis.¹¹⁰ The trials have delivered activities consistent with the LifeSpan model of building the capacity of local communities, awareness-raising, responsible media training, other targeted training, and health and wellbeing events.¹¹¹

The Commission notes that the Productivity Commission has recommended that the 'National Mental Health Commission assess evaluations of current trials that follow a systems approach to suicide prevention' and 'consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia'.¹¹²

HOSPITAL OUTREACH POST-SUICIDAL ENGAGEMENT PROGRAM

The HOPE program is designed to support people after they are discharged from hospital following a suicide attempt or people who express suicidal ideation or repeatedly intentionally self-harm but who do not meet the threshold for entry to specialist clinical mental health services.¹¹³ Each site has discretion to restrict its eligibility criteria within those parameters, although all sites must provide their target cohort with assertive, tailored 'postvention' support in the community for up to three months.¹¹⁴

WAY BACK SUPPORT SERVICE

Another after-care initiative in Victoria is the Way Back Support Service, operated by Beyond Blue. This is a non-clinical psychosocial support service where support coordinators provide assertive after-care and practical support for up to three months; it includes planning to help people stay safe, connected with their support network, and engaged with health and community services.¹¹⁵ There are two Way Back Support Service sites in Victoria (South East Melbourne and Geelong),¹¹⁶ but the initiative is to be expanded to a further six sites following a recent agreement between the Victorian and Commonwealth governments. This will bring the number of government-funded suicide after-care sites in Victoria to 16.¹¹⁷

DATA COLLECTION and APPLICATION

Reliable data are central to developing evidence-based policy, planning and implementation of suicide prevention activities.¹¹⁸ The Fifth National Mental Health and Suicide Prevention Plan states that improved data on care and outcomes following suicide attempts are a priority and will support 'better identification of suicide attempts in routine health data collections and better measurement of integrated care and follow-up after suicide attempts'.¹¹⁹

Victoria's approach to suicide data collection, through the Victorian Suicide Register, has been acknowledged as nation-leading.¹²⁰ However, the data are not linked, reported or disseminated to suicide prevention services on a regular or continuing basis. This means that suicide prevention services do not necessarily have the information they need to intervene quickly and effectively to support people and prevent (further) suicides.¹²¹

The Commission heard from several people that overcoming the current lag in the availability of information on suicides and attempted suicides would facilitate better follow-up action and prevention.

[We should have] surveillance systems that are far more real-time, that are more localised, that enable local services, communities, first responders, health services, mental health services, schools, to be identifying emerging clusters of suicide, for example, and then to wrap-around supports for a school community.¹²²

Real-time surveillance of suicide, suicide-related behaviour and self-harm would increase the capacity for the health system to prevent further deaths, provide appropriate and timely support, and allow Victoria to accurately track progress against state-wide strategies to reduce suicide rates. This should collect data from state coroners, police, ambulance and hospital emergency departments, and it should be connected to an immediate, coordinated response at the community level.¹²³

The Department of Health and Human Services has developed a memorandum of understanding with the Coroners Court and emergency services to ensure that up-to-date, consolidated and relevant information is provided to the suicide prevention place-based trial sites and to health services.¹²⁴ In 2018 the department supported a project by the Victorian Injury Surveillance Unit that retrospectively links data from the Victorian Suicide Register with Victorian emergency department and hospital admissions data in the year preceding an individual's death.¹²⁵ The Commission understands that this study has recently been expanded to include child protection, family violence and family support datasets.

The research aims to create a better understanding of the utilisation of general health and mental health services among people who subsequently suicide, as well as their health at the time of death. The Commission understands that this information will be used to identify risk factors for suicide, as evidenced from health service use patterns, and potential gaps in service provision.

Commonwealth Government agencies are also working to improve information sharing. The 2019–20 Federal Budget allocated \$15 million over three years to the Australian Institute of Health and Welfare (as part of the National Suicide Information Initiative) to create a national suicide surveillance system.¹²⁶ Among the current areas of interest are: exploring the utility of integrating ambulance data into existing datasets related to suicide, understanding the intersection between suicide data and other demographic factors, and looking at service use in the preceding 12 months for people who die by suicide.¹²⁷

These are all useful first steps, but the Commission considers that efforts should be accelerated. The collection and use of suicide data will be an important area of focus for the Commission as it continues its work. (p333-334)

OUTCOMES TO DATE

Although the Victorian Suicide Prevention Framework is aligned with global best practice approaches,¹²⁸ Victoria's suicide rate has not significantly reduced. The Commission has been informed that this is partly because of issues with the funding and oversight of the strategies: there is a lack of coordination of effort, and the resources are inadequate.¹²⁹

Service providers mentioned the lack of cohesion and consistency in suicide prevention initiatives. Mr John McLaren, the Community Manager at St Vincent's Mental Health, St Vincent's Hospital told the Commission:

Currently, there are numerous initiatives that have been implemented, some long-term and others short-term, but they do not operate consistently across Victoria and they do not seem to operate in a cohesive manner.¹³⁰

The Commission also heard about a lack of robust evaluation of pilots and coherent, appropriately scaled implementation of models shown to be effective. For example, Mr Woodward emphasised the need for consistency across the state:

While some regions in Victoria have benefitted from trials, there needs to be more consistency across the state. As the trials move into the delivery of services phase, there needs to be an application of what is being learnt from them and translation into more consistently improved services for all Victorians, regardless of where they live.¹³¹ (p335)

The Commission heard that timely access to mental health care services and treatments can reduce a person's vulnerability to suicide.¹³⁶ According to the Black Dog Institute, as mental illness is associated with suicide attempts, providing 'accessible and appropriate mental health care is essential to suicide prevention'.¹³⁷ Scientia Professor Christensen emphasised that 'getting people into treatment' is one of the suicide prevention strategies in Black Dog's LifeSpan model that has the greatest impact.¹³⁸ Professor Pirkis said that, because clinical prediction tools for assessing suicide risk are not reliable, there is a need for 'mental health services to provide optimal mental health care to all'. In her testimony, Professor Pirkis described this as a selective intervention in suicide prevention:

Because it's so difficult for mental health services to predict who might be at the absolute most risk, I feel like there's an onus on mental health services to provide optimal mental health care to all: it's kind of the best of the selective interventions.¹³⁹

Health and mental health services can provide interventions to people who are not actively suicidal but who have recognised risk factors for suicidal thoughts and behaviours, including people living with mental illness or showing signs of psychological distress.¹⁴⁰ Interventions may provide direct treatment, care and support for at-risk individuals or equip professionals to detect and assist people who may be at risk of suicide.¹⁴¹ Alongside mental health services, GPs, for example, are well placed to identify the potential for suicidality, even in patients not reporting distress.¹⁴² (p335-336)

As discussed in Chapter 7, demand pressures and lack of capacity have resulted in public specialist clinical mental health services raising their thresholds for service access and rationing treatment. The Commission heard many people speak of experiences of not being 'suicidal enough' to be seen by public specialist mental health services, being dismissed by health professionals, or being sent home from emergency departments without adequate follow-up.

The attitude (or maybe even policy?) is that if you don't have a plan to kill yourself today or aren't able to articulate that plan, then you really aren't that bad and you should go deal with it yourself. I was sent home with my severely suicidal friend after the hospital refused to take them in (I have two small children), they only gave 10mg of Valium and told me to 'keep an eye on them'. I was petrified that I would wake to find my friend dead on our couch [...] People need to be taken seriously and offered real support (aka care) BEFORE they get to be so desperate for help that they make an attempt on their own life or something else to this effect to be taken seriously.¹⁴⁵

Parents should not have to beg for their children, who are expressing suicide ideation, to be admitted to care because of a shortage of outpatient and inpatient treatment facilities.¹⁴⁶

Families and carers identified a gap in supports for people who seek help because they are having suicidal thoughts but who are considered 'not unwell enough' to be admitted to specialist clinical mental health services. The Commission heard that mental health services require a person to be at imminent risk—to have a clear plan for suicide—to qualify for help. One mother despaired:

When I initially rang triage on behalf of my son who was suicidal, they asked 'was he suicidal now, did he have a plan in place?' He didn't right at that moment on the phone, but the weeks or months prior he may have, and tomorrow he may have, but he obviously wasn't triaged as important enough. The responsibility has fallen back onto family to try and support and manage the system.¹⁴⁷ (p338)

19.3.4 Inadequate care

As discussed in Chapter 7, pressures on acute inpatient units in hospitals have led to people being discharged while they are still very unwell.¹⁴⁸

Hospitals will keep you in until you calm down, then eject you with no medication, referrals or promise of follow up.¹⁴⁹

When a family or a young person is in crisis, the only place you can go is the emergency departments or triage if you are lucky. I have had numerous times in [emergency departments] waiting for eight hours and when a doctor finally came to see her, they told her to go home. I have had to battle so hard to get her admitted.¹⁵⁰

Discharging people from emergency departments and hospitals before they are well enough to be in the community¹⁵¹ puts pressure on community-based specialist mental health services to manage people with increasingly complex needs. This raises entry thresholds for everyone and contributes to long wait times before people that are discharged from hospital can access any care in the community.¹⁵²

Evidence presented to the Commission showed that this can have terrible outcomes. The Commission heard about a system that failed parents before the death of their children:

*My lived experience of having a 19-year-old son who desperately was trying to live but had suffered 2.5 years of health intervention that offered him and us no effective support was too much. His suicide and the trauma of our lived experience and him telling me he just wanted to die, is something I will never get over. The health system must change!*¹⁵³

My story of my son's journey over 16 years—he is no longer with us, all this is too late for him, but there are still thousands out there struggling, and I would hope that I could play some little part in bringing about change. Over those years there have been so many times when I felt no-one really listened, I was not heard, despite letters to a Clinic Manager, the Complaints Commissioner, the Premier, and the Minister of Health (it was nearly a year before this letter was answered). Most of the time I felt totally alone, apart from a small support group in a neighbouring town—this group was like a lifeline to me. I suffer the grief of the loss of my son, a loved family member and a person of worth. Even worse is the grief I carry at what he suffered over 16 years, not only from a terrible illness, schizophrenia, but also in the mental health system.¹⁵⁴

We have had family who come to us on their knees, desperately seeking help for their loved one and it just seems like we come up against barrier against barrier. We've had people discharged straight from the high dependency unit only to commit suicide hours later. It's just heart-breaking. We just want to make the system compassionate for families.¹⁵⁵

Relying on risk assessments to ration limited services is problematic in the case of people experiencing suicidal thoughts because there are currently no assessment tools that accurately predict the risk of suicidal behaviour in the short term.¹⁵⁶

An expansion of the range of treatment options is needed to help people at risk of suicide. Associate Professor Peter Burnett from NorthWestern Mental Health told the Commission:

There are currently options for standard hospital admissions or referrals to community care teams, however there is no appropriate treatment option for the portion of patients who do not require hospital admission but require intensive support. These patients may benefit from a more integrated treatment option.¹⁵⁷

The following comments highlighted the current lack of support for someone who has attempted suicide:

Very little is working well to prevent suicide. Currently, if someone has made an attempt on their life, they are taken to an emergency department at the closest hospital, treated, maybe seen by a mental health nurse and then sent home. There is no follow-up, assistance or treatment path provided to the patient or the carers—everyone is left on their own wondering how to deal with the situation which has just happened and terrified of when and how it may next occur and what they can do to stop it.¹⁵⁸

I have found that healthcare services possess extremely limited accountability regarding patient welfare in the immediate post discharge period. Patients readmitting to emergency departments due to suicide attempts within a few days of discharge appears to initiate no formal or informal review procedures regarding if discharge was appropriate. This results in little incentive for mental health units to act in the best interests of patients during discharge planning and promotes the prioritisation of other incentives, such as freeing up immediate resources.¹⁵⁹

While it is difficult to draw a causal link between pressures on mental health services and overall rates of suicide in Victoria,¹⁶⁰ the Commission accepts advice that mental health services must be able to respond more quickly and effectively to reduce the number of people who take their life each year.¹⁶¹ (p338-340)

Katerina Kouselas's story

Katerina Kouselas's husband, Bill, died by suicide in 2016, and she believes that the mental health system failed him: 'Bill had depression for nine to 10 years prior to his death, but we had no experience of the mental health system until the six months before he died'.

Katerina described how Bill had been receiving treatment at an adult prevention and recovery care service but that he really struggled when he was released. Before his death, Katerina took him to an emergency department:

In all our years of marriage I had never seen him like that. People who are suicidal should not be in emergency with all the people with broken legs, you should be in a specialised area.

Katerina described the loss of her husband as isolating, but she said that by contributing to the Royal Commission she hopes to make a difference for someone else in the future.

We had been married for 32 years when Bill passed away. I will never come to terms with it ...

I just hope that by talking about Bill, and by talking about suicide, it might help even just one other person. I hope that it helps to fix the system that let Bill down, a system that is letting other people down too.(p341)

19.3.4 Experiences in emergency departments

With limited options in the community, many people who are in suicidal distress or who have attempted suicide present to emergency departments. However, evidence before the Commission indicates that emergency departments are not optimal environments for supporting people experiencing a mental health crisis, and the experience can be traumatic or distressing for some people.¹⁶³ One person wrote: In order to prevent suicide, there needs to be somewhere people can go and not the emergency department. I have heard more horror stories of judgement and trauma than I can bear to admit about from friends who have fronted up to one.¹⁶⁴ An Australian study found low levels of satisfaction with healthcare services after a suicide attempt, and there was particularly low satisfaction with emergency department care.¹⁶⁵ A study by Orygen, the National Centre of Excellence in Youth Mental Health, also found that young people going to emergency departments after self-harming had negative experiences, including negative reactions from staff.¹⁶⁶ Patients, families and carers commonly report that their emotional distress was not attended to, and many thought they had been discharged too rapidly and were left to seek their own options for ongoing care:¹⁶⁷

I've been told at emergency: 'We're not going to help your daughter as we'll help others first who want help'. The staff said to me, 'If she's going to kill herself, she'll do it whether she's here or not'.¹⁶⁸

The main problem has been in emergency departments. The staff have given very little time to assessing the individual. My daughter presented four times at emergency departments over a three-day period in full psychotic states after several violent extreme episodes, both causing harm to others and threatening to kill herself [...] Upon presentation and the briefest of assessments she was turned away each time with no plan, no medication, no support, nothing. In emergency departments individuals are asked to wait a long time and this can escalate their condition.¹⁶⁹

It was the way we were treated at hospital that was the worst ever experience! Mental health guy takes hours to show up, says a few things, asks me to leave, talks some more then tells me she has issues, needs help from a psychologist but I need to find my own, they have no beds! Take your daughter home but keep her on suicide watch 24/7! Do you know how hard it is to get some help for your child that wants to kill herself, self-harm? It took days to find someone that would help us, in that time I couldn't sleep at all for fear of her doing something! It's a nightmare that continues all the time!¹⁷⁰

The high levels of demand in emergency departments and the high-intensity, high-stimulus environment of such places make it difficult to meet the needs of people in suicidal distress.¹⁷¹ For clinical staff, it can be challenging to deal adequately with complex needs in emergency departments, where consultation settings and short triage times can make building patient–clinician rapport difficult.¹⁷² The Commission recognises the challenges for emergency department staff in meeting the needs of suicidal patients, often in very difficult circumstances and without appropriate training.¹⁷³ (p342)

I have left out areas that relate to training of staff and other prescriptive observations in order to concentrate on areas that identify unmet needs of consumers and carers .

RECOMMENDATIONS – SUICIDE PREVENTION

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands follow-up care and support for people after a suicide attempt by recurrently funding all area mental health services to offer the Hospital Outreach Post-suicidal after Engagement (HOPE) program. To facilitate access to HOPE, the statewide rollout should be complemented by:

- broad referral pathways to give people living with mental illness who are receiving care from clinical community-based teams within area mental health services access to HOPE
- additional clinical outreach services in each sub-regional health service, networked to a regional health service HOPE program, to provide support for people living in rural and regional areas
- extended service delivery that allows access to support whenever it is needed, including outside standard business hours.

The Commission also recommends the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide. (p444)

15.1 Improving suicide prevention

Improving Victoria's response to suicide prevention is fundamental to the design of a new mental health system to ensure people have the right treatment, care and support when they may be becoming, or are, at risk of suicide.

As discussed in Chapter 11, there are many examples where Victoria's mental health system has not responded effectively to the needs of people in deep psychological distress or at risk of suicide, their families, loved ones and carers. This too often manifests as a loss of human life.

The reasons for suicide are complex, and suicide prevention requires a multifactorial, integrated response. Further work is needed to design a new mental health system that effectively works to prevent suicide. However, there is evidence that one of the most effective ways to reduce the suicide rate is to provide follow-up care to people who have attempted suicide, given it is one of the biggest predictors of a future suicide attempt.¹

15.1.1 OVERVIEW of the COMMISSIONS INTERIM RESPONSE

In Victoria some area mental health services provide adults with follow-up care after a suicide attempt through the Hospital Outreach Post-suicidal Engagement (HOPE) program. There are no other programs that offer this type of support,² and access to HOPE services are not available statewide or to children and young people under 18 years of age.

Early insights from a formal evaluation indicate that the HOPE program has been well received and is having positive effects on those it supports. This view was shared by people who have used the program and by service providers:

It is [...] vital that the Victorian Government continues to deliver the HOPE Initiative, to ensure that Victorians at significant risk of suicide post discharge from hospital receive the right care, at the right time, in the right place.³

Recognising the supportive evidence for post-attempt follow-up care and the HOPE model, the Commission recommends that the program be expanded to ensure availability throughout the state, including in rural and regional areas through sub-regional health services.

The Commission also recommends that referral pathways be expanded to improve access and that a new follow-up service is designed and evaluated for children and young people who have self-harmed or who are at risk of suicide.

In parallel, the Commission will continue to develop a broader position on preventing suicide. A Towards Zero approach will be supported in consultation with people with lived experience, academic institutions, research institutes, multiple agencies and government departments, as well as with community organisations.

15.2 THE VALUE of AFTER-CARE and ASSERTIVE OUTREACH

Evidence indicates that a suicide attempt is one of the strongest predictors of future suicide attempts. An individual that has had a non-fatal suicide attempt is at an increased risk of suicide, with the period after a first suicide attempt being the highest risk.⁵ Individuals that have undertaken intentional self-harm are at a significantly higher risk of suicide compared with the general population.⁶

Intervention following a suicide attempt is an important element to preventing subsequent suicide. Contact with a health service immediately after an attempt presents an opportunity to provide treatment to the individual, and support to family and carers.⁷

15.2.1 IMPORTANCE of after-care and assertive outreach

Rapid and proactive support following discharge from hospital is crucial for a person's recovery⁸ and can decrease the risk of future suicide attempts during this particularly high risk period.⁹ Recent studies demonstrate that approximately half of suicides occur within the first month of discharge from a hospital.¹⁰ This risk for repeated self-harm or death by suicide remains high for the first 12 months following discharge.¹¹

One four-year cohort study found that, people who have been treated for or admitted to hospital following deliberate self-harm, have a 30 times greater risk of suicide in the year that follows compared with people who have not self-harmed.¹²

As discussed in Chapter 11, *capacity challenges in public specialist clinical mental health services* mean that many people are discharged from emergency departments or inpatient units too early after attempting suicide, *and without any form of follow-up care. Despite increased risk, approximately 50 per cent of people who attempt suicide do not engage with or attend any follow-up treatment after discharge. In addition, approximately 10 per cent of people only attend one week of treatment.¹³*

Given that some people do not or are unable to actively engage with follow-up treatment, care and support following a suicide attempt, there is an important need for mental health services to provide assertive and intensive outreach to support people in this period of crisis.¹⁴

An assertive outreach model in this capacity refers to mental health services:

- actively supporting a person and their family and carers to develop safety plans
- facilitating connections to community-based supports that meet the person's needs
- helping a person to develop coping strategies and self-assessments when they are feeling vulnerable or in distress.

Follow-up care services typically involve some clinical and psychosocial support and non-clinical assertive outreach, focusing on connecting the person with immediate treatment and support but also helping to identify and resolve what contributed to the suicide attempt or crisis.

Assertive follow-up usually involves more frequent contact with people after they are discharged from hospital and may include home visits, intensive case management and support during care transitions, safety planning, and tailored psychosocial support in the community.¹⁵

15.2.2 Effectiveness of after-care and assertive outreach

Providing coordinated and assertive after-care to someone who has attempted suicide is likely to bring about the strongest reduction in suicide attempts and deaths by suicide.¹⁶

Multiple methods of engagement have been shown to reduce the risk of suicide following discharge from an emergency department. This includes personalised written and telephone contact over an extended period, case management, phone-based consultations and other modes of assertive psychosocial and emotional support.¹⁷

Friends, loved ones and parents often have an integral role in a person's recovery. Assertive outreach and follow-up care also provides a high degree of support for families and carers of people who have attempted suicide through deploying strategies for identifying and building on factors that protect against suicide. They can also provide psychological support for families seeking to manage their own mental health needs after an attempted suicide. The availability of workers to directly assist families, friends and loved ones, enables these groups to experience lower levels of stress and receive the help they need to support their loved one.¹⁸

Social support is also an identified protective factor against suicide. Social support reduces the risk of suicide associated with depression and may assist in developing psychological resilience for people at risk of reattempting suicide.¹⁹

Despite the evidence to support the need for follow-up care, the Commission understands that in Victoria there is no universal access to follow-up services for this greatly at-risk cohort, and their families and carers. Many people are unable to get support close to home and their community. The situation is exacerbated in regional areas, where, compared with metropolitan areas, people often have to travel longer distances to obtain help and there are fewer mental health services available. Where follow-up services do exist, they vary in their level of resourcing, referral pathways and models of care.²⁰

The Commission recommends that, as a minimum, access to high-quality mental health assessment and assertive after-care support is available to all Victorians who need it, regardless of where they live.

15.2.3 Models of after-care in Victoria

In the 2016–17 State Budget, the Victorian Government committed \$27 million over four years for two pilot suicide initiatives: the HOPE program and the place-based suicide prevention trials.²¹

Hospital Outreach Post-suicidal Engagement program

The HOPE program is a core component of Victoria's Suicide Prevention Framework 2016–2025, which aims to halve Victoria's suicide rate by 2025.²²

In Victoria, six sites have been funded for three years and a further six receive recurrent funding. An additional four sites will be established through funding under a bilateral agreement with the Commonwealth Government. Table 15.1 shows where each HOPE site is located and the nature of its funding arrangements (excluding the Commonwealth-funded sites).

Overview of the HOPE program

The HOPE program is a core component of Victoria's Suicide Prevention Framework 2016–2025, which aims to halve Victoria's suicide rate by 2025.²⁵ The program targets adults (aged 18 years or older) who are at significant risk of suicide following discharge from hospital after presenting for a suicide attempt or serious planning or intent.²⁶

HOPE teams support individuals and their personal support networks—family, friends and other carers—for up to three months after discharge, helping them to identify and build protective factors against suicide.²⁷ Participants are contacted within 24 hours of hospital discharge and receive face-to-face contact within 72 hours. Following initial contact, the HOPE team provide clinical and/or community-based support that is flexible to individual needs (Figure 15.1). Core components of the support model include:

- team members—often key workers—providing regular contact and encouragement to participants via SMS, phone and face-to-face
- engaging peer support networks for participants
- developing safety plans that help participants to stabilise their mental health, identify and respond to mood changes, and implement coping strategies (safety planning also helps their supporters to understand the participant's risk factors, the supports required to make them feel safe, and how and where to access support)²⁸
- facilitating links to community-based supports to meet the specific needs of the individual and their supporters, including links to alcohol and other drug services, specialist accommodation services, family violence support services and longer term mental health services.²⁹

(further HOPE program details are not provided here , please refer to the Inquiry report for further details)

15.4 Expanding support in rural and regional areas

The Commission has heard compelling evidence that people living in rural and regional Victoria experience significantly higher rates of suicide and self-harm⁴⁹ and that the demand pressure challenges for mental health services are hugely amplified in these areas.⁵⁰ Evidence before the Commission highlighted the ‘tyranny of distance’ and the numerous inequities people living in rural and regional communities are confronted with when trying to gain access to mental health services, including:

- having to travel considerable distances to obtain care and the isolation that can result from being away from family, friends and support networks
- mental health stigma, which can be acute in rural and regional communities and can affect help-seeking behaviour
- services and supports often being out of reach—for example, because farmers cannot be away from their land for an extended time.⁵¹

There is much strength and resilience in rural and regional populations, often demonstrated in a common commitment to community participation and leadership. At community consultations, people impressed upon the Commission the many instances of people banding together to support one another.⁵² This community strength was demonstrated in the aftermath of the 2009 Black Saturday bushfires: research shows that close friends and family, social networks and community groups were important influences on resilience and recovery.⁵³

Although the evidence suggests similar levels of psychological distress for city and country people in Victoria,⁵⁴ the suicide rate is around 50 per cent higher in regional Victoria than metropolitan Melbourne.⁵⁵ For males aged between 35 and 54 years, the suicide rate in regional Victoria is 60 per cent higher than in Melbourne.⁵⁶ Similarly, rates of presentation to emergency departments and hospital admissions for intentional self-harm are higher in rural and regional areas than in metropolitan areas (see Figure 15.2).

Rural and regional communities have poorer access to and lower levels of use of mental health services.⁵⁷ In addition, a series of stressors and risk factors can be seen more often in rural environments:

- social isolation and prolonged separation from family⁵⁸
- acclimatisation to risk as a result of increased familiarity with injury, accident and pain⁵⁹
- higher rates of alcohol and drug misuse⁶⁰
- the impacts of prolonged drought and extreme weather events⁶¹
- higher rates of socioeconomic disadvantage.⁶²

There is an immediate need to provide more support for people living in rural and regional Victoria.

The Commission recommends that a complementary and connected clinical outreach service in each sub-regional health service be established as part of the HOPE expansion to all regional area mental health services (see Box 15.3 for the definition of sub-regional health services).

As part of the regional partnership model, each sub-regional outreach service should be networked to its regional health service’s HOPE program. This will enable people living in rural and regional areas to receive support after a suicide attempt, as well as providing assertive outreach mental health services more broadly.

This could include facilitating strong collaboration and pathways between GPs, psychiatrists, psychologists and outpatient services. Regional HOPE services should provide clinical and psychosocial support as required (for example, advisory and consultative support).

Psychosocial assessment followed up by tailored psychosocial support should also be provided. Evidence suggests that, compared with medical admission, psychiatric admission and referral for specialist mental health follow-up is associated with a lower risk of repeated self-harm.⁶⁴

Regional outreach services should have a focus on working with other health and social service providers to respond to local community needs. It is vital that, as part of their recruitment and training, the outreach workers gain the ability to meaningfully interact with and support people in these areas. Services should be culturally sensitive and workers should possess an understanding of rural and farming life.

Where services are available, they’re not always appropriate services [...] there may be service providers who don’t have an understanding of work and life within a rural farming community, and that’s often very important to build rapport with a client [...] to have that understanding of the situation that they’re in.⁶⁵

15.5 Expanding support to children and young people

Despite the fact that Victoria’s children and young people experience higher rates of suicide and self-harm compared to adults, and that these rates continue to rise, the Commission found that there are significant service gaps to support this cohort following a suicide attempt or self-harm. Chapter 11 established the size of this problem. The Commission concludes that appropriate and specific services are needed for children and young people at risk of suicide. ⁶⁶

Between 2009 and 2018 in Victoria the annual growth in the rate of suicides among people aged 10–24 years was 3.3 per cent (1.1 per cent higher than for people aged 25 years or older). In the past five years, the average growth in the rate for suicides for people aged 10–24 years was 6.5 per cent, significantly higher (3.4 per cent) than for people aged 25 years or older (see Figure 15.3).

On average, two to three Victorians aged 10–14 years take their own lives each year.⁶⁷ Across Australia between 2015 and 2017, suicide was the number one underlying cause of death for people aged 15–24 years.⁶⁸

Particular groups of young people are at greater risk of suicide, including young men, young people with an experience of mental illness, Aboriginal and Torres Strait Islander children and young people, young people recently in contact with the justice system, young people in out-of-home care, young people in rural and regional areas, young people who are trans⁶⁹ and young people who have been exposed to suicide or suicidal behaviour.⁷⁰

Several reports and submissions have highlighted that Victoria's suicide prevention policies and programs have identifiable gaps in evidence-based, appropriate and accessible programs and services for children and young people. In particular, young people who present to emergency departments or hospitals with self-harm or suicidal behaviour are often discharged without follow-up care, despite the elevated risk of suicide after discharge.⁷¹

headspace and the Orygen Centre for Excellence in Youth Mental Health have identified an urgent need for assertive outreach and follow-up care following presentations of children and young people to an emergency department for attempted suicide, suicidal ideation or self-harm.

Orygen's 2016 report *Raising the Bar for Youth Suicide Prevention* found that, in Australia, including Victoria, young people who are unable to access timely care are falling through the cracks, with tragic consequences. This was most evident in the period following discharge from an emergency department or hospital after a suicide attempt or self-harm.⁷²

The Commission has considered the proposal that a youth-focused assertive outreach and follow-up service like the HOPE model could be introduced to support children and young people.⁷³

The Commission accepts evidence from child and youth mental health experts that developing mentally and culturally appropriate approaches that address this cohort's individual help-seeking needs and behaviours should be central to any service model. Without this, evidence indicates that children and young people may not be able to effectively engage with services, or may not have their needs met.⁷⁴

Therefore, the Commission wants to ensure that not only can children and young people access follow-up care and support, but that it provides effective and evidence-based treatments specific to their needs.

The Commission recommends that the Victorian Government, through the proposed Mental Health Implementation Office, funds the Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen in partnership to create, deliver and evaluate the first phase of a new youth assertive outreach and follow-up care service (for children and young people who have attempted suicide, have suicidal ideation or have intentionally self-harmed) in their catchment areas.

The design of the service should be informed by the program guidelines and expanded referral pathways the Commission has recommended for the adult HOPE sites. Respecting the need for a youth-specific model of care, the Commission recommends that the four service providers work in partnership to develop an assertive outreach and follow-up service for children and young people that all providers can implement with fidelity. This should include an evidence-based multidisciplinary approach to care and the design of evaluation and screening tools.

The service should be delivered by a child and youth-friendly workforce and be connected and integrated into other mental health service offerings to ensure children and young people using the service are supported to transition into continuing care as required. Service design should also include connections to broader health, social and community services, including housing, youth justice, child and family support and education to ensure each person's holistic recovery needs are met.

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences⁷⁵

The Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen should also ensure that appropriate referral pathways are established into the new service from emergency departments and clinical community-based teams within the area mental health services.

The Mental Health Implementation Office, in partnership with the service providers, should ensure a robust evaluation methodology and program is established to assess the efficacy of the service. Subject to the findings of the phase 1 evaluation, the model of care should be considered for statewide expansion in the medium term. The voices of children and young people, as well as their families and carers, should inform the design of the new service and the evaluation methodology.

Any expansion should not pre-empt the final governance arrangements or models of care for children and young people that the Commission will recommend in 2020. The Commission is continuing to examine the necessary broader reforms to child and youth mental health services that will improve responsiveness, early intervention and quality, including alternative spaces for children and young people to seek and receive care. The Commission will consider the progress of this particular initiative, and the timing for its expansion, within that wider context. (p445-461)

SECTION FOUR

SOUTH WESTERN SYDNEY LOCAL HEALTH DISTRICT (SWSLHD), PART OF THE NSW GOVERNMENT

Overview

Mental Health services in south western Sydney are provided by the public sector, third schedule facilities, the private sector (including General Practitioners, private psychiatry, psychology and counselling services and private hospitals) and the community managed sector. Other government departments and coordinating organisations such as the South Western Sydney PHN are also significant within the District.

The reference to suicide prevention is as follows:

“7.19 People who Self-Harm or are at Risk of Suicide

Prevention of suicide is a priority area for government and communities, due to the devastation it causes for individuals, families, friends and communities. Suicide and suicidal behaviours (such as suicide ideation and self-harm) are potentially preventable.” p46-47

SWSLHD have a mental health plan “ The Mental Health Strategic Plan 2015-2024”. It says is aligned with Living Well: A Strategic Plan for Mental Health in NSW 2015-2024, which was developed by the NSW Mental Health Commission of NSW, and adopted by the NSW Government. Living Well provides a ten-year roadmap for reform of the NSW mental health system. The Mental Health Strategic Plan 2015-2024 will drive the reform process in SWSLHD and enable the District’s vision of Leading care, healthier communities “

In the Foreword of the document “South Western Sydney Local Health District noted the following mental health services.”

- Health Promotion
- Aboriginal Mental Health
- Care Coordination - Adults
- Community Emergency Care
- Early Intervention for Psychosis
- Rehabilitation/Recovery
- Perinatal and Infant Mental Health Service (including Karitane at Carramar and Camden)
- Child and Adolescent Mental Health Service
- Specialist Mental Health Service for Older People

INPATIENT SERVICES (available beds at July 2015)at Campbelltown as an example unless otherwise stated

- Adult - High Dependency 10
- Adult - Acute 40
- Adult Rehabilitation - Subacute
- Adolescent - Acute 10
- Young People - Acute 20
- Older People - Non-Acute 16 (At Braeside Hospital)
- Psychiatric Emergency Care Centre - Adults

The plan notes (in part) success in:

Greater support for young people in relation to prevention, early intervention and treatment, through collaborating with headspace, school-based programs and the establishment of a Youth Mental Health Team at Campbelltown

New services delivered in partnership with the community managed sector including the Housing and Accommodation Support Initiative, headspace and Partners in Recovery However, the report notes “SWSLHD is under-resourced to provide community based mental health services when compared to existing benchmarks”^{p13}

The South Western Sydney Local Health District Mental Health Strategic Plan 2015-2024 is consistent with the District’s vision of Leading care, healthier communities and with the NSW government’s vision of “the people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.”^{p15}

Mental health services and clinicians have a key role in preventing suicide by undertaking comprehensive clinical assessments and implementing effective management strategies. Opportunities exist to further improve the identification, assessment and management of at risk consumers across all health services and settings. In recognition of this need, the NSW Mental Health Drug and Alcohol Office have drafted a Policy Directive Suicidal People-Clinical Assessment and Management by Mental Health Services due for release in 2015.^{p46}

The impact of a suicide on family, friends, social and cultural networks and community can be immense and heightens the risk of suicide contagion and possible suicide clusters. Providing timely and appropriate support to individuals and communities after a

suicide (postvention) can assist in identifying and responding to those who may be at risk. Enhanced co-ordination across the spectrum of suicide prevention activity will contribute

Strategies for people who self-harm or are at risk of suicide include:

19.3 Develop a community based model of care, which includes education and training, to support consumers who self-harm and/or are at risk of suicide and their families, at all points of contact with the Health service: Completion 2017. p47

SWSLHD District Operational Plan 2018 – 2020

“In February 2018, the SWSLHD Strategic Plan 2018-2021 to guide the future directions of South Western Sydney Local Health District (SWSLHD) was released. The Strategic Plan includes six priority strategies which will be implemented between 2018 and 2021 to support the District to achieve its vision, Leading care, healthier communities.”

“The Operational Plan provides the basis for the implementation of the strategies related to mental health and is aligned with the SWSLHD Strategic Plan 2018-2021. It has also incorporated issues identified by consumers, carers, staff and partner service providers through the consultation process established for the development of the SWSLHD strategic and clinical services plans.”

The document contains no specific reference to Suicide prevention.

Staffing levels: LEVEL 5 FOR CAMPBELLTOWN (INPATIENT) P25 medical officer^ appointed under the NSW Mental Health Act 2007, medical officers in psychiatry and mental health clinicians (may include telehealth and/or on call arrangements).

Refer to Appendix IV: Nursing and Midwifery Workforce. Allied health professionals available (e. g. social worker, psychologist, dietitian, occupational therapist).

Aboriginal hospital liaison roles available, preferably both male and female.

Level 3: In addition, psychiatrist consultation available 24 hours (may include telehealth and/or on call arrangements).

Medical officer in mental health available 24 hours (may be on call).

Registered nurses with relevant skills and experience in mental health available 24 hours

Level 4: In addition, medical officer in psychiatry with two or more postgraduate years of experience on call 24 hours (may include telehealth); may be in training with the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Allied health professionals with relevant skills and experience in mental health available, commensurate with case mix and clinical load. Peer mental health workforce available.

For Laura

This is the point where I'd like to have the documents separated into the 2 parts .

It can be called "volume 1 and volume 2 " if you like.

I have seen this in another report , the second part has only the face page as at the front, and then the complete contents page/s .

The next item is simply page 167 and continues on

Can yo please delete the contents entry ""WHAT SOME ORGANISATIONS ARE SAYING ABOUT SUICIDE PREVENTION"

It's in section seven

PART 2

DRAFT

SECTION FIVE

THE VULNERABLE MEMBERS OF OUR COMMUNITY: A RESERVED PLACE TO ACKNOWLEDGE PAST AND PRESENT NEGLECT

OUR INDIGENOUS COMMUNITY AND THE IMPACT OF SUICIDE: OVERVIEW

As the author of this report, it is important to note I'm not indigenous, and yet I see and feel the catastrophic loss of life in the community. I do want to help, but my observations are meaningless. If it's one thing I have learned, it's that our indigenous community know what to do to start the pathway to reducing the suicide toll.

I'm concerned my cut and paste of documents on indigenous mental health are inadequate, and of no real value, as I really don't have a true comprehension as a non-indigenous person of the real needs. I do know that the people who have the power to help are NOT indigenous. They have the power over money. And they aren't about to hand that power to any community.

I looked at the available documents such as the 5th Plan and the NSPIS, as well as the other Mental Health/Suicide Prevention documents and I really can't see who wrote these. I don't know their family of origin. I do note, however, the significant reference in the *Monitoring Mental Health and Suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2018* of the concern expressed about the level of indigenous suicide, and a special reference to indigenous mental health. Being a priority,

with constant reference to actions (WHAT ACTIONS HAVE HAPPENED??), strategies and monitoring. I did find this interesting piece on page 36 of *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*:

“Australian governments must start thinking about Aboriginal and Torres Strait Islander peoples’ mental health in different ways. The evidence shows a strong support for investing in culture and communities to support social and emotional wellbeing. Supporting self-determination and working in partnership should be part of any overall response. A shift away from top-down policies and programs to those led by communities is vital.”

I also found indigenous statements such as the *Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* . So, I am offering to initially place the references to the documents I have found in the list below. I don’t know if that helps or not, so please accept my apologies if it is offensive for me to select the following information. I ask if someone from our indigenous community may wish to provide a more valuable appropriate selection of material at some time in the future. I will happily amend as required .

I have not referenced Federal, State or ATSiC committees at all, to pay respect to those who really know who the correct bodies are involved in the impact of Suicide in the indigenous community.

(Note: This is simply a cut and paste of the contents page if the reader wishes to refer to any particular document from this section.)

- *Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* as per Action 12.3 of the Fifth National Mental Health and Suicide Prevention Plan Outcomes of the 12 December 2017 NATSiLMH Workshop
- 2010 Wharerátá Declaration (available on the NATSiLMH website)

INDEPENDENT ATSiC SUICIDE PREVENTION REPORTS

- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSiSPEP) REPORT OF THE CRITICAL RESPONSE PILOT PROJECT Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project – 74 pages
- ATSiSPEP final report ‘Solutions that work – What the evidence and our people tell us- 55 pages

NATIONAL MENTAL HEALTH PLANS - ATSiC SUICIDE PREVENTION

- The 5th National mental Health and Suicide prevention plan 2017

PRIORITY AREA 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention (pages 30-34)

- Monitoring Mental Health and Suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan, 2018 Progress Report

“Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention “ p25-29

- National Review of Mental Health Programmes and Services – 30 November 2014 – Summary

“6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people” p20

- The Senate Community Affairs References Committee: The Hidden Toll: Suicide in Australia 2010 Chapter 6 :Targeted Programs and Universal Interventions: "Indigenous communities" p89

- Australian Institute of Family Studies :National Strategic Framework for Aboriginal and Torres Strait Islander peoples mental health and social wellbeing 2017-2023

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The strategy was published May 2013, produced under the Australian Government's Dept. of Health and Ageing

It was noted on the last page :Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group.

Dr Tom Calma AO, Northern Territory (Chair): Dr Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group. Dr Calma is a former Aboriginal and Torres Strait Islander Social Justice Commissioner, and the current National Coordinator for Tackling Indigenous Smoking. Dr Calma was recently appointed as the new chancellor of the University of Canberra.

Ms Adele Cox, Western Australia: Adele Cox is a Bunuba & Kija (Gija) woman from the Kimberley region of Western Australia. Adele is a current member of Australian Suicide Prevention Advisory Council (ASPAC) and past member of National Advisory Council on Mental Health (NACMH).

Prof. Ernest Hunter, Queensland: Ernest Hunter is an Australian medical graduate trained in adult, child, cross cultural psychiatry and public health. He is Regional Psychiatrist with Queensland Health and Adjunct Professor with the University of Queensland based in Cairns.

Mr Tom Brideson, New South Wales: Tom Brideson is a Kamilaroi man. Tom is a Visiting Fellow with NSW Centre for Rural and Remote Mental Health at Newcastle University; past Program Leader for the CRC for Aboriginal Health; consultant on Social and Emotional Wellbeing for Indigenous HealthInfoNet.

Dr Pat Dudgeon, Western Australia: Pat Dudgeon is from Bardi people of the Kimberley. She is a psychologist and is known for her role in Indigenous higher education. Pat is the current Chair of Australian Indigenous Psychologists Association (AIPA); first convener of the Australian Psychological Society Interest Group, Aboriginal issues and Aboriginal People and Psychology and current Chair of the Aboriginal and Torres Strait Islander Mental Health Advisory Group (ATSIMHAG). Professor Dudgeon was also appointed as a Commissioner to the National Mental Health Commission in 2011.

Mary Victor O'Reeri, Western Australia: WA Local Hero 2011. Mary Victor O'Reeri lives in the Billard and Beagle Bay Aboriginal communities in the remote north-west Kimberley region of Western Australia. Mary convened the inaugural Blank Page Summit in her remote community at Billard in the north west Kimberley in 2009.

Ashley Couzens, South Australia: Ashley is from the Riverlands District of South Australia and has been a senior Aboriginal Health Worker and a community worker for a number of years. He was instrumental in forming the Riverland Aboriginal Men's Support Group, and currently works as a Team Leader for the Life Without Barriers.

Contents

It is noted that the strategy is worded and structured in an identical fashion as all other strategies and reports produced by the Dept. of Health and Ageing .

An extract is provided here, however , readers are referred to the 48 page document for further details .

"Suicide prevention necessarily involves, in different ways, all sectors and levels of government, the non-government and community sectors, communities themselves and research and training institutions. The action areas identify key outcomes of the Strategy. Some actions entail multi-agency collaboration and multiple lines of responsibility, while others are more specialised. Over a 10 year period, the Strategy will aim to achieve measurable improvements in each of the identified target areas and within this timeframe it is possible and appropriate to set targets in consultation with the Aboriginal and Torres Strait Islander Mental Health Advisory Group which can be related to the National Mental Health Commission's National Report Card and the Roadmap for National Mental Health Reform 2012-2022. Longer-term capacity building (e.g. data development, building the community sector,

building the evidence base, Aboriginal and Torres Strait Islander workforce participation, evaluation of outcomes of specific initiatives and of the overall strategy) will yield reportable outcomes over the 5 and 10 year periods of the Strategy. “

Observations about the report

An invitation is extended to our indigenous community, to provide the most relevant observations . It is not appropriate for this report to do so . It is however noted , that the Strategy is now 7 years old, and there has been no improvement in the rate of suicides in our indigenous community.

8. Implementing Integrated Suicide Prevention in ATSI's: A Guide for Primary Health Networks August 2018

Professor Pat Dudgeon, Leilani Darwin, Rob McPhee and Christopher Holland with input from Steffanie von Helle and Lyndal Halliday

A joint project between the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute. The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention is funded by the Australian Government through the Department of Health's National Suicide Prevention Leadership and Support Program.

The document is a companion guide to the Centre for Evidence and Implementation and Black Dog Institute's LifeSpan Implementation Framework – Implementing Integrated Suicide Prevention. It is intended to support Primary Health Networks (PHNs) as they work to implement integrated approaches to suicide prevention in Aboriginal and Torres Strait Islander (Indigenous) communities.”(p2)

- Closing the Gap: National Partnership Agreements on Indigenous Health and the NSW Aboriginal Affairs Plan
- Living Well: Putting People at the Centre of Mental Health Reform in NSW : A Report

Pages 33 to 44

- NSW Parliament, Joint Committee on Children and Young People Report 5/56, October 2018, Prevention of Youth Suicide in NSW “Aboriginal and Torres Strait Islander Status” p20

OTHER ATSI SUICIDE PREVENTION REPORTS

One World Connected: An assessment of Australia's progress in suicide prevention “Aboriginal and Torres Strait Islander suicide PREVENTION” p12

No funding has been released to support the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The disappointment and disillusionment as a result of the now sixteen month wait for funds acts to reinforce historical trauma and may inadvertently add to suicide risk among our Aboriginal and Torres Strait Islander peoples. A powerful call for urgent understanding and action to improve Aboriginal and Torres Strait Islander wellbeing in Australia as documented in The Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide²³, has gone unanswered. (p12) (NB this report was released in 2014, so funds were probably since released, however, it is only 5 years ago, and It highlights the reluctance to fund essential resources.

- Two Ways Together, 2003-2012
- SWSLHD Mental Health Strategic Plan 2015 – 2024 “7.11 Aboriginal People and Communities” p36
- Suicide Prevention in Australia :Breaking the Silence “Indigenous Australians and Suicide” p76
- Taking the next steps in Indigenous suicide prevention, by Leilani Darwin, Advisor to Black Dog Institute, 26 May 2017

Productivity Commission Mental Health Inquiry , October 2019

In consideration of the most current reflection on Mental Health and Suicide Prevention in the ATSIC community, the following observations from unknown and noted sources are (in part) , provided as follows:

“Suicide prevention programs for Aboriginal and Torres Strait Islander people should have Indigenous-controlled organisations as the preferred providers, to increase the likelihood that program provision is sensitive to the experiences, culture and specific social issues faced within particular communities. Stronger connection of individuals with their culture and control over services have reduced suicide risk and improved social and emotional wellbeing in some communities.”

DRAFT FINDING 20.2 — SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

There is no notation about any contribution of the indigenous community of the following words, it is provided as a reference of an indication of the most up to date attitude of the bureaucratic (Federal) perspective on indigenous mental health and suicide prevention . It is understood , that this is not necessarily a reflection of the indigenous community.

“The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is profoundly influenced by their connection to land, culture, spirituality, family and community, in addition to the broader social determinants of health and wellbeing. The accumulated effects of traumatic experiences over many generations, and racism and discrimination that are endemic in many communities, can impede efforts to improve wellbeing.

Improvements in mental health of Aboriginal and Torres Strait Islander people require improvements in the conditions of daily life as well as actions to promote healing of past traumas and address discrimination.

Government actions that support inclusion and empowerment of Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing both for Aboriginal and Torres Strait Islander people and the broader community”.(p96)

DRAFT RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

- The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities.
- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.(p97)

Improving social participation for Aboriginal and Torres Strait Islander people

Many Aboriginal and Torres Strait Islander people experience high levels of distress — for example, one in three adults report having experienced high or very high distress in a recent four week period (figure 20.7).

Psychological distress is measured using a set of questions about negative emotional states experienced in the past 30 days. This measure is a 5-item subset of the Kessler 10 Psychological Distress Scale known as the K5. It is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may indicate a need for professional help.

Source: Tablebuilder, using National Aboriginal and Torres Strait Islander Social Survey 2014/15, ABS Cat no. 4720.0.55.002.

Social determinants of health — the ‘conditions of daily life’ and the broader structures of society that influence these conditions — play an important role in the health outcomes of Aboriginal and Torres Strait Islander people (WHO 2014b). Disadvantage and psychosocial stress often go hand in hand, and pose a concurrent risk to people’s health. Among other things, inadequate housing, a lack of employment, high rates of incarceration or insufficient education opportunities are sources of disadvantage for Aboriginal and Torres Strait Islander people that may lead to psychological distress (Zubrick et al. 2014). Entrenched poverty amongst Aboriginal and Torres Strait Islander people is recognised as a ‘significant underlying factor’ that contributes to self-destructive behaviour, intentional self-harm and suicide (Milroy et al. 2017) (chapter 1).

The past 250 years of Australia’s history is replete with actions that have reduced social inclusion and wellbeing among Aboriginal and Torres Strait Islander people and undermined progress in early intervention and treatment for those who have mental illness. Experiences of racism are consistently associated with poor mental health (Paradies 2006; Paradies, Harris and Anderson 2008), something reflected in the submissions to this inquiry (AAL, sub. 151; AMSANT, sub. 434; The Healing Foundation, sub. 193). Ongoing grief, loss and intergenerational trauma also contribute to the psychological distress of many Aboriginal and Torres Strait Islander people (Atkinson et al. 2014; HREOC 1997; Walker et al. 2014; Zubrick et al. 2014).

While individuals may be resilient to some of these factors in isolation, when combined and experienced over time they can have a substantial and negative effect on social and emotional wellbeing. Aboriginal and Torres Strait Islander people have been confronted with some of these risk factors over multiple generations, meaning that their health and wellbeing has been profoundly shaped by the circumstances of the past and is a ‘product of a history of dispossession, exclusion, discrimination, marginalisation and inequality’ (AH&MRC, sub. 206, p. 2).

The Royal Australian College of Physicians (sub. 488, p. 6) concludes that the combined effects of these social risk factors are ‘particularly stark’ for Aboriginal and Torres Strait Islander people, and ‘have caused the higher rates of disease, mental ill health, suicide and incarceration they face’.

Social and emotional wellbeing of Aboriginal and Torres Strait Islander people

Ideas of mental health and wellbeing are, to some extent, dependent on cultural perspectives, experiences and aspirations. This means that policy intended to support the mental health of Aboriginal and Torres Strait Islander people must align with their concepts of wellbeing. But this does not always happen in practice. As Yap and Yu (2016b) point out, the ABS definition of wellbeing — a ‘state of health and sufficiency in all aspects of life’ — does not recognise that different aspects of life matter for different groups of people (box 20.8).

The Yawuru Wellbeing Survey

Yawuru people are the traditional owners of the lands and waters in and around the town known as Broome, in the Kimberley region of Western Australia. *Mabu liyan* is a Yawuru concept that encompasses and extends on the Western idea of subjective wellbeing.

Mabu liyan reflects Yawuru’s sense of belonging and being, emotional strength, dignity and pride. Expressions of *liyan* are articulated based on collective structures: it is a model of living well in connection with country, culture, others and with oneself. Starting with *liyan* as the phenomenology of how Yawuru relate to, understand and define wellbeing provides a first step towards understanding and framing questions around wellbeing from Yawuru’s own way of knowing, being and living. (Yap and Yu 2016b)

In order to make well-informed decisions on matters affecting their community, country and wellbeing, Yawuru recognised that they needed to invest in data and knowledge development. This resulted in the development of the 2015 Yawuru Wellbeing Survey, a process that included:

- face to face semistructured interviews to conceptualise Yawuru ideas of a good life and mabu liyan
- focus group activities to select the relevant indicators of wellbeing
- a final consultation process to present lists of indicators back to the community for discussion, refinement and validation.

For Yawuru, the purpose of developing indicators of wellbeing is to measure aspects of Yawuru culture, identity and life from a Yawuru perspective, alongside other information about people's circumstances such as employment, health and education. This provides a baseline set of wellbeing information for Yawuru to use in making informed decisions about strengthening their wellbeing.

The survey development process identified a number of dimensions considered important to achieving and maintaining mabu liyan — family; community; country, culture and identity; selfdetermination, rights and autonomy; health and material wellbeing — and constructed a range of indicators to measure Yawuru wellbeing in these areas. For example, one indicator of connection to country was the frequency with which people were able to go fishing or hunting in the last twelve months.

Source: Yap and Yu (2016a, 2016b).

Reflecting this, the individual social and emotional wellbeing of Aboriginal and Torres Strait Islander people is affected by overlapping connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community (Gee et al. 2014) (figure 20.8).

To us health is so much more than simply not being sick. It's about getting a balance between physical, mental, emotional, cultural and spiritual health. Health and healing are interwoven, which means that one can't be separated from the other. (Dr. Tamara Mackean in RACP, sub. 488, p. 6)

For Indigenous peoples ... social and emotional wellbeing ... carries a culturally distinct meaning: it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep rooted, more collective and holistic concept of health than that used in Western medicine. (Dudgeon et al. 2016 in Thirili Ltd, sub. 549, p. 2)

The concept of the individual in this model is viewed as being part of, and inseparable from, family and community (Gee et al. 2014).

Source: Australian Government (2017a); Gee et al. (2014).

The nature and importance of these connections and the way in which people engage with each domain can vary at a point in time and throughout their lives — people may experience health connections and resilience in some domains while encountering difficulties and a need for healing in others (Gee et al. 2014). Loss of cultural connection has been identified as an important factor in youth selfharm and suicide in Aboriginal and Torres Strait Islander communities (Silburn et al. 2014).

The importance of culture and empowerment

Culture and cultural identity — including spirituality, connections to country and language, and relationships with family and kin — are recognised as fundamental to social and emotional wellbeing (Beyond Blue, sub. 275). Ongoing cultural engagements, such as living on or returning to country, learning or speaking an Aboriginal language and participating in cultural activities are positively associated with subjective emotional wellbeing (Biddle and Swee 2012). For example:

When I'm on Country, or with my community, it reminds me of a time where colonisation didn't impact our culture and we weren't influenced by Western society. Being on Country is for me a form of self preservation. It protects my mental health and puts things back into perspective ... It's because of my Country, my culture and my community, that I am able to be the proud Yuin/Kamilaroi woman I am today. (Jash 2019)

The importance of connections to culture and land is supported by a number of submissions:

A critical element of healing programs is an emphasis on restoring, reaffirming and renewing a sense of pride in cultural identity, connection to country, and participation in and contribution to community. (The Healing Foundation, sub. 193, p. 16)

Aboriginal and Torres Strait Islander peoples with strong attachment to culture have better self assessed health, and among those who speak an Indigenous language and participate in cultural activities, mental health is significantly better. (Beyond Blue, sub. 275, p. 28)

[P]ractising culture (including art, law and ceremony, caring for country, and hunting/food sources) builds empowerment and strengthens spirituality among Aboriginal and Torres Strait Islander people in remote Australia. These outcomes in turn improve wellbeing. (Department of Communications and the Arts, sub. 82, p. 5)

The positive contribution that cultural identification and connection to land can make to social and emotional wellbeing may be tempered for those Aboriginal and Torres Strait Islander people who live in urban areas, where people tend to experience higher levels of psychological distress due to actual or perceived discrimination (Dockery 2011).

Traditional healers

One aspect of connection to culture is the role of traditional healers, who protect and heal the physical, emotional and social wellbeing of Aboriginal and Torres Strait Islander individuals and communities (Oliver 2013; Panzironi 2013). Long held traditional healing practices remain most prevalent in more remote parts of Australia, including Central Australia (home to the Ngangkari), and the Kimberley region of Western Australia (home to the Maparn) (box 20.9).

Qualitative research suggests that access to traditional healers is a mental health service that is prioritised by Aboriginal and Torres Strait Islander people (Lowitja Institute 2018a). The potential benefits are recognised in the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Wellbeing (discussed further in chapter 22) (Australian Government 2017a).

The Ngangkari of Central Australia

The Ngangkari are the traditional healers in the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in Central Australia. The Ngangkari have nurtured the physical, emotional and social wellbeing of their people for thousands of years, helping them to cope and be resilient against life's problems. The basis for traditional healing is an understanding that the spirit is inextricably linked to the body and emotions, with a pathway to healing provided through cultural activity and connectedness to country. Some methods of healing and treatment used by Ngangkari healers include the blowing breath method, spiritual healing, the suction method, massage and wound healing, and bone manipulation (Panzironi 2013, p. 171). There are many parallels between traditional healing and methods employed in counselling such as developing trust, being held in mind (spirit), developing shared understanding, meaning and use of metaphors (Australian Indigenous HealthInfoNet 2019).

Ngangkari healers sometimes work alongside western medicine practitioners in a complementary role. This has helped to encourage Aboriginal people to visit doctors when they otherwise would not have. Ngangkari and western medical care are often provided in parallel and positive outcomes for patients reaffirms the importance of 'providing a holistic and culturally appropriate health care to Aboriginal patients' (Panzironi 2013, p. 134).

However, there is a need to develop further evidence about how traditional healing practices work best in partnership with mainstream mental health services to support the recovery of Aboriginal and Torres Strait Islander people with mental illness in their community (McKendrick et al. 2014). Assessment of the way in which traditional healing approaches work with mainstream services needs to not only consider conventional outcomes but also incorporate the knowledge and views of Aboriginal and Torres Strait Islander people as to what are important outcomes. The Australian Government has asked the Productivity Commission to develop a strategy for evaluating policies affecting Indigenous Australians (PC 2019b), and this strategy should be used as a basis for the assessment.

DRAFT RECOMMENDATION 20.3 — TRADITIONAL HEALERS

Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

In the medium term (over 2 – 5 years)

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people.
- This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

The ability to continue to engage with culture is recognised as having protective effects for the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, as is the ability to influence and control their daily lives (Chandler and Lalonde 1998; Marmot 2011), and 'live lives they would choose to live' (Marmot 2011, p. 3). Evidence from First Nations communities in British Columbia indicate that suicide rates are strongly correlated with measures of cultural continuity and local control (Chandler and Lalonde 1998). Self-determination and local leadership was one of five priorities identified from a series of suicide prevention roundtables held in six Aboriginal and Torres Strait Islander communities around the country (Milroy et al. 2017). The need for local solutions to address suicide among Aboriginal and Torres Strait Islander people is discussed in chapter 21.

This is further emphasised in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing:

Individual and community control over their physical environment, dignity and self-esteem, respect for Aboriginal and Torres Strait Islander peoples' rights and a perception of just and fair treatment is ... important to social and emotional wellbeing. (Australian Government 2017a, pp. 3, 6)

['This is the torment of our powerlessness'](#)

[The limited control that Aboriginal and Torres Strait Islander people have, and feel that they have, over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their own ability to do anything about it. In outlining their objectives for reform in the 2017 Uluru Statement from the Heart, Aboriginal and Torres Strait Islander leaders described this situation as 'the torment of our powerlessness':](#)

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness. (Referendum Council 2017)

A truth and reconciliation process is one element considered likely to contribute to the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, while also facilitating their broader social participation and inclusion (Lowitja Institute 2018b; RACP 2018). The Truth and Reconciliation Commission of Canada described this process, for their people, as:

establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples In order for that to happen, there has to be awareness of the past Without truth, justice, and healing, there can be no genuine reconciliation. (Sinclair, Truth and Reconciliation Commission (Canada), 2015, p. 10)

In Australia, such reconciliation is an ongoing process that is hindered by a lack of trust (AH&MHRC, sub. 206, p. 2). For some, constitutional recognition is considered:

a vital step towards making Aboriginal and Torres Strait Islander people feel historically and integrally part of the Australian nation, ... for the nation to connect with its past ... [and assisting] people to improve their chances for full participation in all Australia has to offer. (Lowitja Institute 2018b)

The Uluru Statement of the Heart outlines a path towards constitutional recognition and truth telling that is acceptable to many Aboriginal and Torres Strait Islander people (Referendum Council 2017). A number of submissions to this inquiry provide support for the changes proposed in the Uluru Statement from the Heart, recognising that these changes are likely to improve the social inclusion of Aboriginal and Torres Strait Islander people, and allow them to positively shape their own future:

The RACP urges the government to reduce the intergenerational effects of trauma, loss, racism and social disadvantage. Central to this is recognising self-determination and that the Indigenous concept of mental health encompasses social and emotional wellbeing and putting this at the core of Indigenous led, evidence based policy and program development (RACP, sub. 488, p. 6)

Giving full effect to [the United Nations Declaration on the Rights of Indigenous Peoples] will necessitate an accommodation of Indigenous self-determination within the political system, and a space for truth telling and healing, the need for which are expressed in the Uluru Statement from the Heart. (AHRC, sub. 491, p. 23)

Using the Uluru Statement from the Heart as guidance, there is an opportunity to promote truth telling and healing as part of a national process on the establishment of a Voice to Parliament. As noted by community leaders this process can support healing and improve mental health outcomes for Aboriginal and Torres Strait Islander communities across Australia. (Victorian Government, sub. 483, p. 16)

DRAFT FINDING 20.2 — SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is profoundly influenced by their connection to land, culture, spirituality, family and community, in addition to the broader social determinants of health and wellbeing. The accumulated effects of traumatic experiences over many generations, and racism and discrimination that are endemic in many communities, can impede efforts to improve wellbeing.

Improvements in mental health of Aboriginal and Torres Strait Islander people require improvements in the conditions of daily life as well as actions to promote healing of past traumas and address discrimination.

Government actions that support inclusion and empowerment of Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing both for Aboriginal and Torres Strait Islander people and the broader community.

21.4 Empowering Aboriginal and Torres Strait Islander people to prevent suicides

Aboriginal and Torres Strait Islander people are significantly more likely to die by suicide than non-Indigenous people and face unique factors that can increase their risk of suicide (box 21.5). For example, Aboriginal and Torres Strait Islander youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth (Dickson et al. 2019).

Box 21.5 Risk factors for suicide in Aboriginal and Torres Strait Islander communities

Suicide is believed to have been rare among Aboriginal and Torres Strait Islander people in precolonial times but has become increasingly prevalent over recent decades. Research identifies a number of risk factors which are disproportionately or exclusively experienced by Aboriginal and Torres Strait Islander people.

- Lack of 'cultural continuity' — Indigenous self-determination over aspects of culture and community.
- Poor physical health and access to health services, family and relationship difficulties, stress associated with the death of family members, unemployment, homelessness, financial stress, violence and racism.
- Exposure to traumatic stressors and intergenerational trauma associated with cultural dislocation, and loss of identity and practices resulting from colonisation and the effects of the Stolen Generation.
- Alcohol use and Foetal Alcohol Spectrum Disorder. For example, alcohol attributable suicides were estimated to be 30% higher for Aboriginal and Torres Strait Islander males than for non-Indigenous males.
- Suicide 'clustering' — a series of suicides or self harming acts that occur within a single community over a period of weeks or months.
- Living in regional or remote areas where there are greater levels of social isolation and poorer access to services.
- Comparatively high rates of incarceration, although typically for relatively short periods of time.

- There is a strong element of impulsivity to many Indigenous suicide deaths.

Source: ATSISEEP (2016b); Dickson et al. (2019); Fogliani (2019); Thirri Ltd, sub. 549; Pascal, Chikritzhs and Gray (2009).

Evidence indicates that suicide prevention interventions for Aboriginal and Torres Strait Islander people are most effective when the relevant Indigenous community is involved and has control over the intervention (ATSISEEP 2016a; Healing Foundation 2018; WHO 2014a). For example, the Yarrabah community came together to respond to high rates of suicide through programs that empowered the community (box 21.6). In another example, Chandler and Lalonde (2008) found that Indigenous communities in Canada that exhibited many key markers of community control, such as control over health or education services, experienced significantly lower suicide rates.

Suicide prevention in the Yarrabah community

In the 1980s and 1990s, the regional Aboriginal community of Yarrabah in North Queensland experienced several waves of suicide.

During the third wave in 1995, the community held a crisis meeting that included community Elders and service providers. The meeting recognised the historical and social determinants that lead to suicidal behaviour and identified a number of solutions to be implemented at the local level, such as closure of the alcohol canteen. A key outcome of the meeting was the development of a feasibility study in 1997, which proposed a community controlled primary healthcare service model as the best way forward to improve the health of the Yarrabah community. The feasibility study ultimately led to three important developments that were considered key to addressing the high number of suicides in the mid-1990s:

- Gurriny Yealamucka Health Service — one of the first community controlled primary healthcare services in Queensland
- Family Wellbeing Project Partnership — a personal development course (developed by Aboriginal and Torres Strait Islander people) focusing on problem solving, conflict resolution and other life skills
- Yaba Bimbie Men's Group — a men's group that focuses on men's healing and restoring cultural pride, connection and responsibility.

These programs led to several improved outcomes because they were led by, controlled by and empowered the local community, including:

- improved reflective skills, hope and confidence
- prevention and management of domestic conflict and more positive family relationships
- reduced levels of alcohol consumption and conflict.

Source: Healing Foundation (2018).

Over time, governments have recognised the need to develop a tailored approach to suicide prevention for Aboriginal and Torres Strait Islander people (box 21.7). In 2016, the Aboriginal and Torres Strait Islander Suicide Evaluation Project (ATSISEEP 2016a) evaluated what works for the prevention of suicide by Aboriginal and Torres Strait Islanders. The project made several recommendations to governments including:

- suicide prevention activity should be community led
- the Australian Government should require Primary Health Networks (PHNs) to demonstrate cultural capabilities and standards and include Indigenous representation
- a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded
- Aboriginal Community Controlled Health Organisations (ACCHOs) are the preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people.

Australia's evolving suicide prevention strategy for Aboriginal and Torres Strait Islander people

In 2010, the Senate Community Affairs References Committee (2010) undertook an inquiry into suicide in Australia. Given the significant impact of suicide on Indigenous communities, the inquiry recommended that the Australian Government develop a separate suicide prevention strategy for Indigenous communities.

In response, the Australian Government developed the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in 2013 to complement the LIFE Framework (discussed in section 21.5) in acknowledgement of the disproportionately high rates of suicide and suicidal behaviour among Aboriginal and Torres Strait Islander people (DoHA 2013).

In 2016, the Australian Government funded the Aboriginal and Torres Strait Islander Suicide Evaluation Project to expand the evidence base for what works in Indigenous community led suicide prevention and develop tools and resources to support suicide prevention activities (ATSISPEP 2016a).

In 2017, The Fifth National Mental Health and Suicide Prevention Plan, established an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee (COAG Health Council 2017a). This subcommittee is responsible for advising and supporting the inclusion of Aboriginal and Torres Strait Islander people in the National Suicide Prevention Implementation Strategy also under development (discussed in section 21.5).

In 2018, the 2nd National Aboriginal and Torres Strait Islander Suicide Prevention Conference (2018) recommended revising the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and developing a related Implementation Plan, as well as allocating funding to Indigenous organisations to deliver these programs.

Many submissions supported pursuing some or all of these recommendations (AHRC, sub. 491; AH&MRC, sub. 206; Healing Foundation, sub. 193; Jesuit Social Services, sub. 441; Mental Health Commission of New South Wales, sub. 486; Mission Australia, sub. 487; NACCHO, sub. 507; NT Mental Health Coalition, sub. 430; Orygen and headspace, sub. 204; Thirili Ltd, sub. 549; VACSAL, sub. 225; WAAMH, sub. 416; WHV, sub. 318).

But implementation of these recommendations appears slow or non-existent.

Australia is yet to revise its National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and develop an associated Implementation Plan (box 21.7). A revised strategy and dedicated implementation plan is warranted given relatively high rates of suicide in some Indigenous communities. The existing strategy was developed by the Australian Government. A new strategy and plan should extend beyond the Australian Government and secure agreement from State and Territory Governments who are responsible for delivering some suicide prevention activities. To do so, the Council of Australian Governments (COAG) should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan. This will mirror arrangements for the National Suicide Prevention Implementation Strategy under development (section 21.5).

Some participants expressed concern that PHNs are not adequately engaging with Indigenous communities.

The authors are also strongly concerned with the accountability of PHNs to the Aboriginal and Torres Strait Islander communities they serve ... There are 31 PHNs across the country. If the \$196 million allocated to them towards Aboriginal and Torres Strait Islander mental health and suicide prevention since 2015 (as discussed above) is averaged out, that means that each PHN has received \$6.32 million. But we are not clear how this money has been spent, on which organisations, by what processes and with what results. Further, PHN approaches to commissioning or otherwise establishing mental health services in rural and remote areas vary significantly throughout the networks. (NATSILMH, IAHA, AIPA, sub. 418, p. 10)

The national peak body for ACCHOs recommended that its agencies become the preferred providers of all mental health and social and emotional wellbeing programs for Aboriginal and Torres Strait Islander people, rather than PHNs, primarily because:

Some Primary Health Networks do not collaborate well with ACCHOs ... Funding of ACCHO mental health services through PHNs is unacceptable due to the imposition of inappropriate and unacceptable reporting requirements. PHNs also have discretion to

allocate Aboriginal and Torres Strait Islander specific funds to non community controlled providers that are not necessarily culturally competent. (NACCHO, sub. 507, pp. 4–6)

The specific needs of consumers from particular communities or backgrounds are likely to be better met with initiatives and services that are sensitive to their experiences, culture and specific issues they face (chapter 4). The Commission supports a greater role for Indigenous organisations in suicide prevention as they are likely better placed to meet the needs of Aboriginal and Torres Strait Islander people.

However, this may not be feasible in all cases, such as areas where there is no appropriate Indigenous organisation. In these cases, there would still be a need for culturally appropriate suicide prevention activities and health workers in available mental health services. One way to achieve this is to develop pathways for Aboriginal and Torres Strait Islander health workers to transition into mental health related professions (chapter 11). But in many cases, capable Indigenous organisations already exist and investing in their capabilities and capacity could give them the opportunity to take on this suicide prevention role.

Indigenous organisations should be the preferred providers of local suicide prevention activities for Indigenous communities. For these organisations — and other providers of programs or services for Aboriginal and Torres Strait Islander people — performance monitoring, reporting and evaluation requirements should be adapted to ensure they are appropriate and responsive to cultural needs.”

This space is reserved for contribution from representatives of the ATSIC community if it wishes.

DRAFT

2. POST TRAUMATIC STRESS DISORDER (PTSD) AND SUICIDE

Overview

On the 16th December 2019 , the ABC reported about the loss of a 45 year old former Sergeant in the Australian Army, a veteran of the Afghanistan War . Kevin Frost was reported missing , and reported that he was found on the 14th , 2 days earlier .The reporter noted that “hundreds” of former personnel had lost their lives over the past 2 decades , noting that at least 10times more veterans have died than were lost in the actual Afghanistan War.

There is overwhelming evidence that Suicide rates for those in military/ post military service , first responders including, but not exclusive to police , ambulance and fire services and other work places who maybe exposed to trauma leading to PTSD have a far higher rate of Suicide than the general population. The contribution to this part of the report will be passed to selected potential contributors who have a close association with PTSD in these areas of service .

There are some contributions placed here that may help in explaining the need to prioritise resources , indeed, to treat this as an emergency to respond to .

National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2018 update (Australian Institute of Health and Welfare)

“From 2001 to 2016, there were 373 suicides in serving, ex-serving and reserve Australian Defence Force (ADF) personnel. Compared with all Australian men, the age-adjusted rate of suicide over the period was 51% lower for men serving full time in the ADF, 47% lower for men in the reserves and 18% higher for ex-serving men. In 2014–2016, ex-serving men aged under 30 had a suicide rate 2.2 times that of Australian men the same age.”

Summary

“There is ongoing concern within the Australian Defence Force (ADF) and the wider Australian community about suicide in serving and ex-serving ADF personnel. In particular, ex-serving ADF personnel may face increased risk of suicide.

Recent government inquiries have highlighted the need to improve the integration of service responses to meet the health and wellbeing needs of serving and ex-serving ADF personnel (JSCFADT 2015). The need to invest in prevention and early intervention strategies to improve health and wellbeing outcomes for these groups has also been highlighted. The Government has introduced further suicide prevention and mental health support services for serving and ex-serving ADF personnel and their families.”

I note that 29 of the 31 pages of this report simply provided, charts, data, and statistics on suicides. There is not one explanation of what is being done to address the situation.

However, there were some significant variations regarding suicide as a cause of death among ADF personnel. These are mentioned in the report on causes of death, but explored more fully in National suicide monitoring of serving and ex-serving Australian Defence personnel: 2018 update.

“This report found that the age-adjusted rate of suicide was 51% lower for current serving men when compared to the general Australian population, but 18% higher for ex-serving men.

These results support concerns that the transition to civilian life is a vulnerable time for ADF personnel, one that may increase risk of suicide and other mental health problems.

In response to such concerns, the Federal Government recently increased accessibility to mental health cover for Australian veterans” (NEWSGP > Clinical, Amanda Lyons, 21 Sep 2018)

Operation Compass

TRIAL SITE PHN: Townsville (North Queensland PHN)

FRAMEWORK: Lifespan

WEBSITE: opcompass.org.au

PRESENTATION TO: National Suicide Symposium, 22, 23 May 2019

OVERVIEW: “Operation Compass continues to roll out a number of evidence based suicide prevention training programs including Mindframe Plus training, which Townsville is the only trial site to implement training in real time situations.” It noted individuals from an ADF background respond to the challenges of helping others. This program is under evaluation using James Cook University 1 June 2019-1 June 2020.

The essence of this program is based around connecting with ex ADF persons experiencing mental health difficulties, and providing an ongoing connection to other ADF people to assist in combatting isolation.

Recommendation

The reason for providing this outline is that there are some areas that appear to be potentially identifiable of assisting high risk groups. The program outlined their perception of success in connecting with at risk persons.

The other group that are proposed to be assisted in PTSD are serving and ex emergency health workers such as police, ambulance and fire. I offer no supporting information other than this notation:

“Each year, relevant government agencies will also be required to report on the rates of suicide in institutions and facilities including across the health system, schools, police, corrections, and amongst the emergency response or “first responder” workforce. NSW SP Strategy 2010-15” p23

I have attached this category purely on the logic of close association of this category of work. More relevant contributions are most welcome.

3. LGBTQI+ COMMUNITIES

Overview

National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A New Strategy for Inclusion and Action 2016

National LGBTI Health Alliance

The National LGBTI Health Alliance is the national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on lesbian, gay, bisexual, transgender, and intersex people (LGBTI) and other sexuality, gender, and bodily diverse people and communities.

This is a plan for strategic action to prevent mental ill-health and suicide, and promote good mental health and wellbeing for lesbian, gay, bisexual, transgender, and intersex (LGBTIQ+) people and communities across Australia.

Historically, LGBTIQ+ people and communities have been relatively invisible in mental health and suicide prevention strategies, policies and frameworks and thus excluded from program and project responses.

A turning point in increased recognition of LGBTIQ+ people and communities was *“The Hidden Toll: Suicide in Australia”* (refer to page..... in this report) which clearly recommended that LGBTIQ+ populations be recognised as a higher risk group in suicide prevention strategies, policies and programs. The report highlighted that LGBTIQ+ people and communities should be provided with culturally sensitive and appropriate information and services.

“Regardless of the lack of adequate inclusion of LGBTI populations in overarching strategies, other key mental health and suicide prevention policy documents have gone partway to identify the specific needs of LGBTI people and communities.

These include:

- *“Contributing Lives, Thriving Communities: National Mental Health Commission 2015 Review of Programmes and Services* (refer to page ... in this report) identifies that LGBTI people with mental health difficulties face compounding disadvantage”
- *Roadmap for National Mental Health Reform 2012-2022*
- *National Mental Health Commission Strategies and Action 2012-2015* identifies LGBTI communities as a vulnerable and at-risk group that needs particular focus
- *(13) NMHC. A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention*

“we cannot be complacent about... suicides in populations where vulnerabilities exist such as lesbian, gay, bisexual, transgender and intersex people”. p129

Suicide prevention goals included: “accurate recording of deaths by suicide”, “mental health and suicide prevention sector workforce will be knowledgeable regarding LGBTI people”, “Mental health promotion and suicide prevention programs, activities and campaigns will address the underlying factors that compound the mental health outcomes for LGBTI populations.”

The Strategy centres around mental health objectives, it is recommended reading.

A CONTRIBUTION ABOUT THE PLIGHT OF THE LGBTQI+ COMMUNITY AND SUICIDE RATES

A timely piece from The Age (THE AGE - By Miki Perkins, July 17, 2019) noting a submission to the Royal Commission into Victoria’s Mental Health System, ongoing, 2019.

There is nothing more needed to explain the plight, and the need to focus resources to bring down the toll.

“LGBTI people have the highest rate of suicidality - which includes suicidal thoughts, plans and attempts - among any population in Australia, but the number of deaths is likely to be even greater because data on sexuality or gender identity is not consistently captured, the commission heard.”

“Chairperson Penny Armytage told the commission that she was challenged by the suicide rate for members of this community and “trying to think how we respond better. . . that’s totally unacceptable and it’s part of our terms of reference around suicide prevention”.

“Current figures show that LGBTI young people between the ages of 16 and 27 are five times more likely to attempt suicide, transgender people

over 18 are nearly 11 times more likely and people with an intersex variation over 16 are nearly six times more likely.

Gender and sexuality commissioner, Ro Allen, told the hearing that suicide in the LGBTI community was often hidden, and not consistently collected in police or coronial data.

"We have very, very bad data collection around this," Commissioner Allen said. "I remember going to funerals of young LGBTI people and families didn't know they were queer; it certainly wasn't recorded."

Commissioner Allen said it was not a person's gender identity, sexuality or intersex identification that was the cause of mental health illness, but the compounded discrimination they faced in everyday life.

Allen described "minority stress"; the experience of anticipating harassment or assault in everyday situations, and the lasting effect it has on mental health.

"We don't wake up in the cot hating ourselves, it comes from somewhere," they said. "[It comes] from stigma about how we are labelled and identified, whether it's through the media or through the recent postal survey which was a tsunami of attacks on our mental health."

Suicide rates in the transgender and gender diverse community are higher than in any other group, the commission was told.

Dr Michelle Telfer, the Director of the Royal Children's Hospital's gender service said young transgender people faced two periods of highest suicide risk: when they come out, and the period between seeking medical care and actually being able to access it.

"In terms of social acceptance of trans identities, we're still quite a long way behind the acceptance of the lesbian, gay and bisexual communities," Dr Telfer said.

When the service was originally established at the Royal Children's Hospital, staff were concerned about the length of time patients were having to wait for access, and the hospital secured state government assistance.

The four-year funding agreement has just expired, but Dr Telfer said she was hopeful to get further funding. Patients are still triaged rapidly but do have to wait to see a clinician.

"The commission also heard there is a severe lack of expert LGBTI clinicians and counsellors in Victorian rural and outer suburban settings.

Dr Ruth McNair, a GP at Northside Clinic, said she had patients come to the specialist clinic in North Fitzroy from more than 100 kilometres away because they didn't have local services that understood their needs."

Enough said at this point, a further contribution

1. CALD COMMUNITIES

An almost invisible community in Suicide Prevention .

It is intended to seek contributions from the CALD community in order to receive a meaningful perspective . The release of this draft (at this point in time)is intended to set the background for potential contributors to advise within the constraints of this document.

2. RURAL AND REMOTE COMMUNITIES

As advised in our CALD communities (above),this report will attempt to receive input directly from the community in order to receive a meaningful perspective . Also noted above , the release of this draft (at this point in time) is intended to set the background for potential contributors to advise within the constraints of this document.

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SECTION SIX

NATIONAL STANDARDS AND REGIONAL APPROACH DELIVERY OF SUICIDE PREVENTION SERVICES

Everymind: Life in Mind, Living Is For Everyone

The website is: livingisforeveryone.com.au

That site transfers you to: lifeinmindAustralia.com.au

Everymind advises that it is the leading national Institute dedicated to reducing mental ill-health, reducing suicide and improving wellbeing. It says the Institute has a reputation for delivering world-leading prevention programs and high-quality translational research. Everymind has developed *Life in mind*. It is the preferred national standard of the agreed platform for all suicide prevention plans, strategies and methodology of dealing with suicide prevention.

What is Life in Mind?

“Life in Mind is a national gateway connecting Australian suicide prevention services to each other and the community and link policy to practice, communities to help seeking and practitioners to the evidence base through the online portal.”

National & State Governments have advised that Suicide Prevention is a Priority, and has advised that “the Living Is For Everyone (LIFE) Framework is Australia’s national framework for suicide prevention”.

The above document is produced and published as by “The Australian Government: Department of Health and Ageing”.

Observations

The Institute does not provide any advice on the overarching of ACTUAL SERVICES, their required structures, connectivity and service outcomes.

It does provide information on such things as findings on consultations and Everymind is working on providing an online portal to link information to Suicide Prevention organisations.

The 5th National Mental Health and Suicide Prevention Plan “A national approach would draw on existing strategic guidance, including the Living Is For Everyone Framework.”

That’s great, but the Framework and the Strategies need an IMPLEMENTATION OF RESOURCES WITH A SINGLE ROLL OUT TO INTERCONNECTED ORGANISATIONS, AND A STRICT ADHERENCE OF **A POLICY OF NO OVERLAPPING OR DUPLICATION OF VALUABLE RESOURCES** (funding of Suicide Prevention Programs are constantly referred to as being under funded)

For more detailed reading on Everymind, please refer to www.everymind.org.au

Lifespan (Black Dog Institute – Centre for Research Excellence in Suicide Prevention (CRESP))

The Black Dog Institute, and centre developed within the Institute, The Centre of Research Excellence in Suicide Prevention (CRESP) formulates outcomes aspiring to lowering suicide rates in Australia and brings together key researchers to work towards this aim. LifeSpan is a new, evidence-based approach to integrated suicide prevention. It combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community.

Based on scientific modelling, LifeSpan is predicted to prevent 21% of suicide deaths, and 30% of suicide attempts.

LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis.

In December 2015, Black Dog Institute received an independent philanthropic grant from the Paul Ramsay Foundation to deliver LifeSpan in four sites in NSW and scientifically assess the impact of LifeSpan.

LifeSpan involves the implementation of nine evidence-based strategies from population level to the individual, implemented simultaneously within a localised region. For successful delivery, all strategies require a thorough consultation and review process to ensure their relevance and tailoring to the local context and community.

The National Mental Health Service Planning Framework (NMHSPF)

The (NMHSPF) Framework provides a “comprehensive” model of the mental health services required to meet population needs, and is designed to help plan, coordinate and resource mental health services.

It is a document providing an agreed national language for mental health services, with a detailed taxonomy and definitions of service types accompanied by national average staffing profiles and salaries. The associated NMHSPF Planning Support Tool (NMHSPF-PST) allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population.

As a technical resource Framework document, its content is not relevant to the content of issues presented in this report. Please see www.nmhspf.org.au

Primary Health Networks (PHN's)

A key element of the 5th National Mental Health & Suicide Prevention Plan and The National Suicide Prevention Strategy was to put forward the completely new strategy of channelling the responsibility of delivery of Suicide Prevention Services to PHNs.

The policy was actually outlined in the NSPS and this new priority started in 2015. The policy stated that this would be “PHNs in partnership with Local Hospital Network's LHNs”.

For those of you unfamiliar of the workings of PHNs, I'll have to leave this for you to research on your own. What is important is that the 31 PHNs were only “morphed” into their current form in 2015. PHNs had NO direct Mental Health staffing until 2016.

The DoH posted information *to assist PHNs* in 2017.

“This information resource is to assist Primary Health Networks (PHNs) to understand and engage with the work of projects funded by the Australian Government under the National Suicide Prevention Leadership and Support Program (the Program). The Program commenced on 1 April 2017 after an extensive tender process. All successful applicants from the tender process are funded until 30 June 2019.

The Program supports the Australian Government’s approach to suicide prevention by providing funding for a range of national projects designed to reduce deaths by suicide across the Australian population, and among at risk groups and to reduce suicidal behaviour (i.e. ideation, planning, self-harm and suicide attempts).

One of the aims of Program is to support PHNs to lead a regional approach to service planning and integration for suicide prevention activities which meets the needs of individuals at the local level. This document aims to facilitate information sharing through building sector partnerships and networks, and to build the capacity of PHNs to take action in response to suicide and self-harm in their immediate region

It is targeted towards PHN suicide prevention project managers to improve their knowledge of what the national projects do and how their work can link with and support PHNs role in planning and commissioning community-based suicide prevention activities in their region.

As far as our local South West Sydney Primary Health Network (SWSPHN) is concerned, Mental Health activities were commented upon in 2016, and the SWSPHN Annual Report notes “ 2017/2018 saw both the completion of our first full review of all contracted services plus the addition of newly commissioned activities, most particularly across our stepped-care model for mental health”.

In regard to Suicide prevention, the following is noted in the report under Mental Health:

- Clinical Suicide Prevention Services
- Lifeline Macarthur Regional Suicide Prevention
- Clinical Suicide Prevention Services

“The Clinical Suicide Prevention Service is designed for people who have previously attempted suicide or have suicide ideation but are assessed as being of medium to low risk.

If a person is a high risk, please refer directly to your closest emergency department.

The Clinical Suicide Prevention Service is an intensive therapy of up to 10 hours over two months. If ongoing care is required, GPs can refer on to You in Mind or Better Access.

Suicide Aftercare Program Lifeline’s Suicide Aftercare Program is for patients experiencing crisis after a suicide attempt who would benefit from short-term telephone-based support. Referrals can be made by a doctor or other clinician or through self-referral.”

12 PHNs were funded in 2016 for a trial in Suicide Prevention services under the Everymind model. The trial has been extended from JULY 2019.

The South Western Sydney Primary Healthcare Network (SWSPHN) is delivering local suicide prevention policy and distribution of services and local MENTAL HEALTH services, as well as formulating a model of mental health service basically modelled on the South Eastern New South Wales Regional Mental Health and Suicide Prevention Plan 2018-2023, involving the South Eastern NSW PHN.

In 2017, a contract of Suicide prevention activities involving gatekeeper training, postvention, post discharge follow up support, means reduction and improved data collections as provided to Lifeline Macarthur and was extended in 2018.

OUR COMMUNITY

Suicide Prevention Networks in Australia (SPNs)

The second principle underpinning the Living is For Everyone (LIFE) framework, a project of Australian Government Department of Health, indicates that suicide prevention is a shared responsibility across the community including families and friends, professional groups, government and non-government agencies.

By bringing together key members of the community who are dedicated to suicide prevention, we help community members to take ownership of the issue and work towards real solutions to address the problem of suicide in their region.

Networks are coordinated nationally and align to best practice standards. Utilising the networks methodology endorsed by the Australian Institute of Suicide Research and Prevention (AISRAP), potential network locations are identified in areas where there is a high incidence of suicide or a need from the community.

Wesley Mission has been a key coordinator, however there seems to be a variety of facilitators including PHNs and others.

There are 110 listed SPNs logged in this report, many are formed with the assistance of Wesley Mission. (see Appendix). Only 8 SPNs are Associate Members of SPA.

There is no evidence of, or research about, the contribution of actions of SPNs that contribute the establishment of local Suicide Prevention services. Nor is there any evidence of resource capacity of SPNs towards assisting Suicide Prevention at a meaningful level in the demographic region of the Network. There is no evidence of the “requirement” of Suicide Prevention services in the region to attend or corroborate with the relevant SPN.

The Living for Everyone (Life) Framework does not articulate the role of the SPN, nor responsibilities or resources. SPNs are not administered by any overarching organisation, nor is there a central reference point of data collection.

Active SPNs such as Whyalla SPN, Illawarra and Shoalhaven SPN, and Care For Life SPN Gold Coast, appear to have external resources to assist in their high level of activity. However, there is NO capacity for these SPNs to affect or deliver a local Suicide Prevention service, nor to coordinate the Suicide Prevention services in the SPN region.

FINANCIAL CONTROL AND EXPENDITURE FOR SUICIDE PREVENTION PROGRAMS

National Financial Control of Suicide Prevention Expenditure

Our Westminster system of government determines the decision making of matters financial and policies. Suicide Prevention resources and decision making is formulated within the Ministerial structure of the Cabinet in the Australian Government. That’s where the purse strings dictate resources. In the Federal cabinet the following scenario exists:

- 1) There is no Federal Mental health bureaucratic department, only the Department of Health
- 2) There is no Federal Minister for Mental health, only a Minister for Health
- 3) The Coalition of Australian Governments (COAG) comprises all States and Territories, with only NSW and Victoria having a JUNIOR ministry
- 4) There are therefore, no Federal, State or Territories cabinet members who have direct responsibility for allocation or producing the budget for Mental Health).

Please refer to pages 21-23 for earlier observations on the “bureaucratic status” of the Federal Dept. of Health and status of Mental Health bureaucrats in decision making of such areas as funding and sustainability of services.

An indicative explanation of Mental Health Expenditure using 2013 figures (supplied with thanks from the NMHC: “Contributing lives, thriving communities”, Report of the National Review of Mental Health Programmes and Services Summary, 2014)(P1 Executive Summary).

“Based on information received by the Commission from 16 Commonwealth agencies, the Commonwealth spent almost \$10 billion on mental health and suicide prevention programmes in 2012–13.

As illustrated in Figure 2, in 2012–13, the 16 agencies spent:

1. \$8.4 billion (87.5 per cent) on benefits and activity-related payments in five programme areas:

- Disability Support Pension (DSP)\$4,700m*
- National Health Reform Agreement (Activity Based Funding—ABF)\$1,000m*
- Carer Payment and Allowance (CP)\$1,000m*
- Medicare Benefits Schedule (MBS)\$900m*
- Pharmaceutical Benefits Scheme (PBS)\$800m*

2. \$533.8 million (5.6 per cent) through programmes and services with Commonwealth agencies and payments to states and territories:

- DVA and Defence programmes (\$192.3m)*
- Private Health Insurance Rebate for mental health-related costs (\$105.0m)*
- Payments to states and territories for specific programmes (perinatal depression, suicide prevention, National Partnership Agreement Supporting Mental Health Reform) (\$169m)*
- National Mental Health and Medical Research Council (NHMRC) research funding (\$67.1m).*

3. \$606 million allocated by the Department of Health (DoH), the Department of Social Services (DSS) and the Department of the Prime Minister and Cabinet (DPMC) on programmes delivered by NGOs.

- DoH spent \$362 million on 55 grant programmes, including payments to 213 NGOs, representing 11 per cent of total mental health-related expenditure from this department.*
- DSS spent \$180 million on six grant programmes, including payments to 196 NGOs, representing three per cent of total mental health-related expenditure from this department.*
- DPMC spent \$64 million on three grant programmes including payments to 133 NGOs (the proportion of total mental health-related expenditure that this represented was not available).*

In 2012–13 these three departments ran 64 programmes with total funding of \$606 million allocated to 542 organisations. These grants ranged from the highest of \$69.4 million (headspace) and \$29.5 million (beyondblue) down to numerous much smaller amounts below \$1.0 million.

These figures show that 87.5 per cent of Commonwealth funding on mental health is through five major programmes. That equates to \$7 out of every \$8 spent by the Commonwealth on mental health.

Four of these are demand-driven programmes providing benefits to individuals. The fifth major area of expenditure is an estimated \$1 billion per year provided to the states and territories under the 2011 National Health Reform Agreement (NHRA) for treatment of patients with a mental health need in the public hospital system, including an estimated \$280 million for patients in standalone psychiatric institutions.” Sourced from page 107.

ESTIMATE OF ACTUAL EXPENDITURE ON SUICIDE PREVENTION SERVICES

The following may certainly come under scrutiny from those people who have access to a more accurate set of figures .

The Federal Governments Total budget on Mental Health expenditure last year was \$9.53 billion. However , on closer scrutiny, of that, \$8.4 billion (87.5 per cent) was spent on benefits and activity-related payments in five programme areas)

The following is an exercise in estimates on financial outlays of actual Suicide Prevention expenditure at the National level(based on 2012-13 outlays)

CATEGORY OF EXPENDITURE	AMOUNT SPENT OVERALL NATIONALLY (\$millions)	ESTIMATE OF AMOUNT SPENT SPECIFICALLY ON SUICIDE PREVENTION SERVICES (\$millions)
Payments to states and territories for specific programmes (perinatal depression, suicide prevention, National Partnership Agreement Supporting Mental Health Reform	\$169m	Estimate say 1/3 of the expenditure \$55m
Research	No figure given	Allow say \$5m
National Health Reform Agreement	No figure given	Allow say \$50m
DVA and Defence programmes	No figure given	Allow say \$15m
DoHealth funded 55 mental health grant programmes, including payments to 213 NGO's.	\$362 m	Estimate 11 of the 55 mental health programmes to Suicide Prevention Allow say \$72m
Department of Prime minister and Cabinet	\$64m	No details given
		TOTAL ESTIMATE SPENT ON SUICIDE PREVENTION PROGRAMS \$197m

OBSERVATIONS OF FEDERAL EXPENDITURE ON SUICIDE PREVENTION PROGRAMS

- Using an approximate figure of \$200 million, Suicide Prevention expenditure is estimated to be 2% of the Mental Health Budget
- Total expenditure on health was estimated at \$154.6 billion in 2013–14, so the expenditure on Suicide Prevention was zero point one three percent (0.13%)
- Aust Govt outlays in 2012-13 was \$367.2 billion, meaning the Governments outlay was zero point zero five percent (0.05%) of expenditure.

According to the ABS that was about the same as money spent on tourism **promotion** in 2012-13.

(Source of above financial expenditure :The Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services -2015)

National Programs

The “National Suicide Prevention Leadership and Support Program” (NSPL&SP), (as reported in the NMHC, National Report, 2018), funded the following:

1. “National Leadership in Suicide Prevention Research Project “(University of Melbourne)
2. Established the Community Radio Suicide Prevention Project
3. Established the LGBTI Mental Health and Suicide Prevention Project
4. A trial called “Better off with you campaign “ (no details)
5. National Suicide Prevention Trial (NSPT)

On 29th May 2017, the Department of Health under the NSPL&SP (I’m unable to assess who administers the National Suicide Prevention Leadership & Support PROGRAM), announced a \$47 million allocation of Suicide Prevention programs.

The funds were allocated under the proposed roll out using the PHNs as per the 5th Plan’s new direction. “A regional approach to service planning and integration for suicide prevention activities which meets the needs of individuals at the local level.”

The idea is to “fund SP sector partnerships to build the capacity of PHNS to take action in response to suicide prevention and self-harm in their immediate region.”

I note that the funding announcement is for \$47 million. However, the “Evaluation and Advisory” organisation charged with the work is Australian Healthcare Associates, their Project “National Suicide Prevention Leadership and Support Program (NSPL&SP) – evaluation framework and data collection” stated categorically that the program activities is **\$44.5 million** for the period 2017-2020.

There is no breakdown of the funding allocation to the 18 organisations.

The organisations will be noted later in the list of Suicide Prevention “service provider “ organisations (shown in green NSPL&SP and referred to on page 65)

NSW Financial Control of Suicide Prevention Expenditure

NSW Government Funding

Funds committed for 2018-19 were Advised as “\$2M for the projects under the Suicide Prevention Fund and \$1M for mental health awareness training and continuing suicide prevention training for NSW Health non-mental health clinicians and non-clinical staff.”

Much of the rest of the document is aspirational cut and paste of other documents on Suicide Prevention.

There are references to “What is the NSW Government doing?”

This is listed as follows :

- Part funding the Wesley Mission operating the Mums and Kids Matter Program
- NSW Health’s Youth Community Living Supports Service providing community-based psychosocial support services for young people. Delivered by community managed organisations in **five (5)** LHDs
- expanding the adult Community Living Supports program to refugees with mental health conditions (not defined to what extent)
- Youth Aware of Mental Health (YAM) is a schools-based mental health and suicide prevention program for 14-16 year old youths, delivered by the Black Dog Institute
- NSW Health is funding Bright Minds, Connected Communities through the NSW Suicide Prevention Fund
- Mental Health First Aid and Older Persons Mental Health First Aid training is being rolled out across NSW
- NSW Health’s Suicide Prevention Fund, funding the Kumpa Kiira Suicide Prevention Project (Indigenous mental health)
- Funding (or part funding?) The Rural Adversity Mental Health Program (RAMHP)
- Ensuring 24-hour access to mental health and crisis services. Lifeline is identified as being “Supported by NSW Health”.
- Suicide prevention gatekeeper training is being delivered for communities, local services and organisations throughout NSW
- NSW Health funds suicide prevention gatekeeper training for non-mental health workers in front line roles such as emergency department staff, first responders, drug and alcohol workers and maternal health nurses
- Aftercare projects are being rapidly expanded throughout NSW. **NSW Health is funding eight community managed organisations** to deliver community based suicide prevention activities across NSW under the four-year Suicide Prevention Fund. From 2016-17 to 2019-20, these projects are aimed at developing a local response to local need and include:
 1. Next Steps Suicide Attempt Response Team – delivering seven days per week aftercare services in the Illawarra Shoalhaven region
 2. HealthWISE Suicide Prevention Initiative – providing clinical mental health aftercare support for those at risk or affected by suicide in the New England North West region
 3. Clarence Coordinated Aftercare Service – supporting individuals, families and others, following a suicide attempt and presentation to Grafton and Maclean hospitals.
 4. Hunter Primary Care Way Back Support Service providing case management for up to three months for people who have had a recent suicide attempt and presented to Calvary Mater Newcastle Hospital
 5. ACON Suicide Prevention Initiative – targeting LGBTI communities in the Sydney and South Eastern Sydney LHD areas
- A range of programs coordinated by the NSW Department of Education
- Online training is being delivered to Corrective Services NSW staff in Suicide Awareness and Managing At-Risk Inmates

The community based programs are an indication of the commitment of the NSW government in my opinion, as they only cover 2 of the 15 LHDs with any aftercare program. The LGBTI program only looks an after a subset of the Suicide Prevention community, and only in 2 LHDs, and as for the 3 hospitals aftercare program, there are TWO HUNDRED AND TWENTY (220) HOSPITALS in NSW.

NSW Government Funding of Suicide prevention Services

In October 2018, the NSW Government announced a \$90m plan for suicide prevention

(higher figures in red sourced from a separate press release advised in March 2019)

- \$4.25 million into "Zero Suicides in Care" program, which will aim to reduce suicide attempts by people in care (\$10.2 m)
 - \$3 million for aftercare services to improve follow-up care for people after a suicide attempt (\$9m)
 - \$10 million for alternatives to emergency department, to create new and immediate support for people with suicidal ideation (\$25.1M)
 - \$650, 000 for data collection on suicide data in NSW (\$1.95)
 - \$3.25 million for resilience building in communities, with focus on Aboriginal and Torres Strait Islanders (\$8.175m)
 - \$1.8 million for new bereavement services to prevent "clusters" of suicides (\$4.56m)
 - \$2.25 million for a Rural Adversity Mental Health program (\$6.75 m)
 - \$8.5 million for new outreach team to increase intensive, complex care for people with severe mental illness (\$21.35m but changed wording on target from " people with severe mental illness" to "people who are experiencing a suicidal crisis")
 - Then there is an addition to gatekeeper training \$2.4 m (community network, organisations, services and workplaces funding to purchase training for gatekeepers supported by related activities health promo, social media, etc.)

This release adds up to \$90m.

In June 2016, the NSW Government announced it is investing \$8 million over four years in a new Suicide Prevention Fund.

It would be remiss of this report not to note the comparatives of vital funding in NSW by the government. The independent Ramsay Funding of \$14.7 million for a subset of work on Suicide Prevention is contrasted by a paltry WHOLE OF NEED funding of \$2 million a year on Suicide Prevention.

The NSW Government is investing a record \$2.1B in recurrent and capital funding for mental health in the 2018-19 budget, including over \$100M for mental health reform, \$3.5M to strengthen system responses for Aboriginal people, people from CALD backgrounds and people with complex needs including intellectual disability, \$3M for communities to develop local responses to suicide and mental health challenges, \$3M in continued support for Lifeline's crisis telephone service, \$2M for the projects under the Suicide Prevention Fund and \$1M for mental health awareness training and continuing suicide prevention training for NSW Health non-mental health clinicians and non-clinical staff. In addition, a record \$700M was announced in June 2018 for a program to expand and enhance mental health infrastructure in NSW, with \$20M committed in 2018–19. (Source: The Strategic Framework for Suicide Prevention in NSW 2018-2023)

SECTION SEVEN

WHAT INDIVIDUAL PEOPLE ARE SAYING ABOUT THE STATE OF SUICIDE PREVENTION IN AUSTRALIA IN 2019

The following document from the NSW Parliamentary Research Service, July 2017 (e-brief 3/2017), has a perspective from a bureaucratic source, and provided here in full :

A REPORT : SUICIDE PREVENTION

NSW Parliamentary Research Service

July 2017 e-brief 3/2017 by Lenny Roth

The National Suicide Prevention Strategy commenced in 2000 and developed into a strategy with four interrelated components:

- *LIFE Framework: sets an overarching evidence-based strategic policy framework for suicide prevention activities*
- *NSPS Action Framework: provides a work plan for national leadership in suicide prevention and policy*
- *National Suicide Prevention Program: the Australian Government funding program dedicated to suicide prevention activities*
- *Mechanisms to promote alignment with and enhance state and territory suicide prevention activities: includes progressing elements of relevant frameworks, such as the Fourth National Mental Health Plan 2009-14.*

*In 2010, the Senate Standing Committee on Community Affairs published a report *The Hidden Toll: Suicide in Australia*. It made 42 recommendations for reform across a range of areas. The Commonwealth Government's response included the *Mental health: Taking Action to Tackle Suicide (TATS)* package, which provided new funding of \$274 million over four years from 2010–11. ⁴³ The TATS package had four strategic actions:*

1. More frontline services and support for those at greatest risk of suicide – including people who have already attempted suicide or who have severe mental illness. This will mean more psychology and psychiatry services, as well as non-clinical support, to assist people with severe mental illness and their carers with their day-to-day needs (\$115 million);

2. More to stop suicide and support communities affected by suicide: providing increased funding for direct suicide prevention and crisis intervention including through boosting the capacity of counselling services such as Lifeline, supporting communities – including Indigenous and school communities – affected by suicide, and to improve safety at suicide 'hotspots' (\$74.5 million);

3. Targets men who are at greatest risk of suicide – but least likely to seek help. More targeted crisis support services, workplace programs and anti-stigma and help-seeking campaigns will better support men (\$23.2 million); and

4. Promotes good mental health and resilience in young people, to prevent suicide later in life: providing more services for children with mental health problems, as well as in promoting resilience and good mental health in young people – so the children of today are less likely to develop problems later in life (\$61.3 million).

In 2011, the House of Representatives Standing Committee on Health and Ageing published Before it's too late: Report on early intervention programs aimed at preventing youth suicide. 45 The report made ten recommendations including for "research and evaluation to inform best-practice strategies, collaboration, increasing mental health literacy and 'gatekeeper' training".

The Government's response stated (in part):

The Australian Government has embraced suicide prevention activities as a significant component of mental health reform. We are delivering a \$2.2 billion investment in new and expanded mental health reforms over the period 2011-12 to 2015-16, which includes \$696.2 million specifically to support young people through early intervention and prevention mechanisms.

A FURTHER EXTRACT OF THE FIGURES RELATED TO SUICIDE PREVENTION

Another response to the 2010 Senate inquiry report was the development of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. This strategy was released in May 2013 and was allocated funding of \$17.8 million over four years from 2012-13 to 2016-17. Three years later, it was reported that this funding had not been spent.

In January 2014, the Department of Health released an Evaluation of Suicide Prevention Activities. It examined activities funded under the National Suicide Prevention Program and selected elements of the TATS package, from 2006-07 to 2012-13. A key finding was that:

Assessing the effectiveness of NSPP activities was hampered by a general absence of quantifiable outcome measurement by NSPP-funded organisations, outcome measurement is not something that funded organisations have engaged into any great extent to date. This issue is not unique to the NSPP and has been a challenge for suicide prevention activities throughout Australia and internationally.

In December 2014, the National Mental Health Commission delivered its report Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services. One of the nine strategic directions for reform was to "reduce suicides and suicide attempts by 50 per cent over the next decade".

The key short-term recommendation in relation to this strategic direction was for the Commonwealth Government to establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

The report proposed further reforms including:

- To work with state and territory governments and key stakeholders to develop a National Suicide Prevention Framework based on Australian and international evidence of what works
- Invite business cases consistent with the framework from regional partnerships, possibly based on Regional Development Australia regions, on co-created models of suicide prevention;
- Use Commonwealth funding models which demonstrate buy-in from local communities through inclusion of contributions from partners, including local councils, business, and community organisations
- Progressively roll the model out across Australia over five years
- Establish nationally consistent routine data collections for suicides and suicide attempts and what services people are accessing, to allow monitoring and evaluation of the outcomes of the investment
- Work with states and territories to establish a national protocol whereby when hospitals discharge a patient from an inpatient service or after a suicide attempt, they provide appropriate supports including intensive follow-up services for 30 days

- Promote as standard practice that all frontline staff likely to come into contact with vulnerable people undergo mandatory training on suicide identification and prevention, and that their organisations set as performance targets “zero suicides in our care”. 51

The Commonwealth Government’s November 2015 response to the Commission’s report stated that it was committed to moving towards a regional, systems based approach to preventing suicide and that it would:

...” move to immediately implement a new national suicide prevention strategy with four critical components”:

- national leadership and infrastructure including evidence based population level activity and crisis support services;
- a systematic and planned regional approach to community based suicide prevention, which recognises the take-up of local evidence based strategies. This approach will be led by PHNs [Primary Health Networks] who will commission regionally appropriate activities, in partnership with LHNs [Local Hospital Networks] and other local organisations;
- refocusing efforts to prevent Indigenous suicide; and
- working with state and territory governments to ensure effective post discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan. 52

This strategy is outlined on the Department of Health’s website. It notes that “PHNs have been tasked with commissioning regionally appropriate suicide prevention activities and services from 1 July 2016”. In the lead up to the July 2016 federal election, the Coalition announced a \$192 million plan for mental health care and suicide prevention. 53 As part of this, the Government is establishing 12 Suicide Prevention Trial sites through Australia. 54 Two of the sites are in NSW: one in Western NSW and another on the North Coast. Each trial site will run for three years and receive approximately \$3 million. The Government stated:

With key national partners – such as the Black Dog Institute, beyondblue, headspace and other stakeholders – these trials will bring the best evidence- based strategies, models and digital technologies together to better target people at risk of suicide and ensure a more integrated, regionally-based approach. 55

The plan also included \$12 million for a Suicide Prevention Research Fund.

In October 2016, Australian Health Ministers released the Fifth National Mental Health Plan: Draft for consultation. Suicide prevention is one of the priority areas in the plan. 56

There are five actions:

1. Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them.
2. Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level.
3. Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.
4. Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care.
5. Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention. 57

In March 2017, Australian Health Ministers agreed that this plan will re-emphasise its objective of Suicide Prevention and will therefore become the Fifth National Mental Health and Suicide Prevention Plan. ⁵⁸

In the Commonwealth Budget 2017-18, new funding for suicide prevention included \$9 million over three years for the States and Territories to prevent suicide at high risk locations through projects such as fencing and lighting;⁵⁹ \$2.1 million for Lifeline, and \$9.8 million to fund pilot programs to improve mental health services and suicide prevention for veterans. ⁶⁰

On 28 May 2017, the Commonwealth Government announced funding of \$43 million for 17 organisations under the National Suicide Prevention Leadership and Support Program (formerly the National Suicide Prevention Program). ⁶¹ Also announced was \$3 million for the Black Dog Institute to support the 12 Suicide Prevention Trials; and \$1 million to support mental health and reduce suicide in the health workforce.

Stakeholder views

In September 2014, the National Coalition for Suicide Prevention, a group including 29 member organisations, released One world connected: an assessment of Australia's progress in suicide prevention. The report rated Australia's performance across ten areas, using a traffic light rating system. The summary of Australia's performance is set out below

poor rating (red) was given in two areas: "strategy, oversight and coordination", and "crisis intervention". The report stated:

The strategic approach to suicide prevention in Australia is piecemeal, uncoordinated and overly biased on activities falling under the remit of the Department of Health, especially mental health. ⁶²

With respect to crisis intervention, the criticism included:

... no national protocols, or state/territory arrangements, exist to establish linkages between crisis lines and crisis support services with the mainstream hospital and health services, and with mental health professional services. ⁶³

Suicide Prevention Australia's 2016 Election Manifesto called on the incoming Commonwealth Government to take four steps:

1. Support the shared goal of halving suicide in ten years
2. Cement Australia's ongoing commitment to suicide prevention by passing a National Suicide Prevention Act
3. Establish the National Office for Suicide Prevention
4. Establish the National Suicide Prevention Research Fund

In February 2017, following a National Coalition for Suicide Prevention workshop, Suicide Prevention Australia released A strategic framework for suicide prevention: Consultation paper. The paper stated that this strategic framework would contribute to the Federal Government's development of a national suicide prevention plan. The paper asks, "where do we want to be in 2025" and, in brief, it sets out the following six outcomes:

1. A whole system approach to suicide prevention
2. A properly resourced and funded suicide prevention system
3. A whole of community support and engagement model
4. A 'Person centric' and integrated approach in service delivery
5. High quality services through standards and regulatory framework
6. A robust 'Knowledge to Practice' system

In December 2016, Orygen, the National Centre of Excellence in Youth Mental Health, released a report Raising the bar for youth suicide prevention, 2016. The report presents 17 recommendations across a range of areas for youth suicide prevention. In brief, these are:

1. National leadership and coordination are needed
2. A system of youth mental health care should be built that responds early and effectively to suicide risk among young people
3. Regional responses should be developed that meet the needs of young people
4. Government and service commissioners should prioritise a commitment to using technology in a proactive way
5. Responses in education settings need to reflect emerging evidence that suicide prevention programs can be delivered safely to students
6. Postvention programs are important and should be included in both community-based and school-based youth suicide prevention responses.
7. Gaps and barriers in youth suicide prevention research and data collection need to be addressed.

Conclusion

Suicide is a major public health issue; the rate of Indigenous youth suicide is particularly alarming. Despite the existence of State and national strategies, over the past decade the suicide rate has increased in NSW (by 2.2 per 100, 000) and nationally (by 2.4 per 100, 000).

In recent years, there have been several major reports and policy developments, including the NSW Government's Living Well: A Strategic Plan for Mental Health in NSW 2014-2024, and the Commonwealth Government's new National Suicide Prevention Strategy. A Fifth National Mental Health and Suicide Prevention Plan is being finalised. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report will assist in implementing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Perhaps the most interesting development is the trial of a "systems based" approach to suicide prevention in selected regions in NSW and Australia. Recently, a NSW Parliamentary Committee established an inquiry into youth suicide.

Various stakeholders have called for a range of policy reforms including adopting a goal of halving the number of suicides in ten years, improving national leadership and coordination, and building a system that responds early and effectively to suicide risk among young people. It remains to be seen whether these reforms will be adopted and what progress can be made in suicide prevention in the years to come."

Observations of the report

An excellent overview that basically concludes that we are caught in a limbo of a terrible delay in implementation of agreed suicide prevention ACTIONS. We are stuck in a "roll out and evaluation " stage limited to a few places, with no thought of taking agreed and easily understood ACTIONS that would at least start to address this National tragedy.

Words of crisis, urgency and other meaningless adjectives attached to Suicide Prevention are meaningless from the bureaucrats and responsible Ministers who control budgets. Their power affects who lives or, in our case, how many die.

Personal Observations

I propose, five years after losing Aaron to suicide, and after just over a year of reading thousands of pages of documents, that this document now consider listening to people affected by suicide.

This space is reserved for people with lived experience, and I propose that the document is now distributed to all SPNs and other interested parties for their thoughts.

This will allow a meaningful contribution in 2020 of affected people having "yet again" a say in what's happening.

Further, once collated, perhaps we could provide a meaningful conclusion and a series of recommendations and attached to this document.

I do wish to acknowledge that 2018, and 2019, was an important point in the delivery of Suicide Prevention trials and programs funded by Federal and State governments. It may seem too early or even impertinent to produce a document like this before the trials and programs are concluded. I do think that there is anecdotal evidence from a variety of eminently qualified sources at this point that there are things that could and should be done urgently to help reduce suicide numbers.

The concept of waiting doesn't work in the area of Suicide Prevention, as waiting only CONTINUES THE NEEDLESS TRAGEDY.

I do also welcome comments, observations, clarifications and contributions on things missed in the document, you are all most welcome.

Some articles are noted below, collected over the past 9 months, they are not meant to be presented as anything other than starting the dialogue, organisations responding, individuals are all welcome to contribute.

DRAFT

SECTION EIGHT

A CASE FOR CHANGE

AN EXAMPLE OF HOW WE ARE NOT PROVIDING THE CORRECT LEVEL OF MENTAL HEALTH SERVICES

The following document was prepared in July 2019 as an outcome of a series of problems that had been known to me for some time in our local area of South Western Sydney . The researching of Mental Health and Suicide Prevention documents provided me with the understanding that there are serious structural problems in the delivery of services to people at the point of post discharge care .

The submission is self-explanatory and is before the Minister for Mental Health as at November 2019.

It is most important that I reiterate that this submission is in no way critical of the hard work being carried out by our mental health staff . Indeed , it is a “pleading” document, asking that we raise the level of resources to compliment and strengthen the dedicated work in our mental health service.

DRAFT

A SUBMISSION TO FUND CORRECT STAFFING LEVELS IN MENTAL HOSPITALS (SOUTH WEST SYDNEY)

PROVIDING A TRIAL ONE YEAR ENGAGEMENT OF A SOCIAL WORKER AND WORKABLE POST-DISCHARGE SERVICE FOR CONSUMERS LEAVING THE MENTAL HEALTH HOSPITAL SYSTEM IN CAMPBELLTOWN

DRAFT

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FOREWORD

On the 28th May, 2019, there was a tragic news report about a young homeless woman bashed to death in Melbourne. From this report, it could be gleaned that this young woman suffered from various health issues. In an ideal world, she should have been under care — not sleeping in a park. The man who allegedly killed her was also allegedly suffering from multiple mental health issues.

On the 29th May, an article was published in the Macarthur Advertiser. In this article, a family expressed their concerns and the desperate need to have a full-time psychologist at Burunji not only to help their daughter but all of the residents in care.

On the 6th June, at a Community Mental Health meeting in Ingleburn, a rather sad email was tabled. This email was from one of our mental health hospitals, asking for assistance to buy items for the hospital, including a \$48 remote control and a \$123 Nintendo controller. There was no money for these items.

On the 12th June, whilst attending the SWSPHN mental Health stakeholder workshop, I noticed a common thread throughout the three hours that centred around staffing resources and discharge from mental hospitals. Please note, this is not only my personal reaction to these comments; this was validated by several participants after the workshop closed. The following were notes written during that workshop:

“So often people are discharged from a mental hospital without a discharge plan.”

“They are not referring as they should, to Lifeline to use ...Care.”

“Need of access to a case manager is a right.”

“We need to have a transitional plan for young people.”

On the 4th July, our community group listened to the story of family members about the failure to have psychologists on staff at a mental health hospital, which only changed when a dedicated local member of parliament lobbied for this change. There is currently only a psychologist on staff for 3 days a week. The real surprise for us was that there has not been a full-time psychologist employed at a major South West Sydney mental health hospital for at least 12 years.

These events, taking place over a short five week period, shine a light on some of the problems we may have in our mental health hospitals.

This is, however, not an unusual grouping of isolated incidents. It's a timely reminder of past requests for so many basic needs at our mental health hospitals. It is a confirmation that resources are far too sparse. Policy makers in mental health have placed post-discharge support at the forefront of virtually every plan, strategy, report and framework produced over the past 15 years. Critical observations of such plans and reports of the state of mental health service, in general, have also placed this subject at the forefront.

Over the past eight years, at the local level, I have been aware that there have been shortages of resources. Vast sums of monies have been spent by community mental health volunteers to fund essential maintenance, programs and items for consumers. There have been constant comments about unfilled vacancies at the three Mental Hospitals at Campbelltown and I have heard comments, such as “*well, we are not able to be social workers too*” in the context of provision of after care discharge .

In isolation, each of the above observations do not constitute cause for concern.

This document contends that the problems are far more serious than just a few local mental health hospital glitches. Looking at the bigger picture, it is a reasonable extrapolation that there are limited resources, a genuine tragedy of inability to fund the correct and essential staffing of front line mental health practitioners and, finally, the lack of capacity to provide follow up care for someone post- discharge, especially in Hospital Outreach Post -Suicidal care

The inability to provide essential staffing levels and basic services to our most vulnerable, over long periods at a time, is a violation of our charter of care. The reality directly contradicts the aspirational statements repeated in virtually every mental health plan and strategy as it applies to NSW.

The people in residence at these hospitals and their staff are trying to succeed despite the inadequate staffing and amenities. The families of all concerned must be suffering needless stress and mental anguish. The post-discharge process must surely be a daunting prospect for many in this situation as consumers navigate their return to the community. I'm sure that everyone agrees that we need to ensure that those who are not able to return to their family's care, or to that of a good friend, are given the highest possible level of assistance.

This document is a proposal to action in real terms to reform a part of our mental health system. True reform is not blaming or criticising people or organisations. True reform is providing assistance and support in a way that has not been provided before. If the reform is successful, our society will be much richer for it.

DRAFT

SUMMARY

This document seeks to address sizeable gaps of service in our mental health hospitals in NSW, specifically, in the areas of staffing levels and in the area of post-discharge care, especially in Hospital Outreach Post-suicidal care .

The Federal and NSW Governments have stated their aspirational record of the required care .

However, this submission provides sufficient information from a variety of expert and anecdotal sources that proves the duty of care is not being met in 2020.

The proposal is to fund an immediate trial at Burunji and Waratah House in South West Sydney for the engagement of a post-discharge case worker to provide the required level of care as per the relevant policies, plans and strategies of the Australian government and the state of New South Wales.

Secondly, this proposal seeks to require the immediate funding and appointment of (full-time) front line in-house psychologists and clinicians in all mental health hospitals in New South Wales. The methodology of this engagement and any necessary processes should be referred to the relevant Human Resources staff and department heads.

Lastly, this proposal seeks to provide a forensic financial audit of the budgeting provisions for the essential Mental Health Hospital staffing in New South Wales.

WHY?

“The likelihood of suicide can increase significantly after a person is discharged from care. For instance, the risk of suicide increases by around 200 times for patients (both men and women) after discharge from inpatient clinical care.” Life in Mind www.everymind.org.au

BACKGROUND

We lost our son, Aaron, to suicide on the 19th July 2014. Our shattered lives have taken time to adapt to our new life of bereaved parents. However, time has allowed me to recover enough to participate more effectively in mental health community volunteer work.

As I became emotionally strong enough to cope with our loss, I decided that I would be prepared to get involved in the Macarthur Suicide Prevention Network (SPN). First, however, I needed to know more about the myriad of plans, strategies, programs, reports, inquiries, frameworks, platforms, commissions, peak bodies, committees, sub committees, advisory groups, roadmaps, reforms, PHNs, Suicide Prevention Networks, research findings, community services, government services and interest groups (pew!) that currently exist in this area.

My journey commenced in November 2018, and an initial 9 months to try to “get a handle” on this often stated “complex” subject. About mid 2019, I decided to not only read up on the above mentioned plans etc. in relation to Suicide Prevention, but also cutting and pasting the relevant parts to place them in some semblance of order.

There are several areas of concern that are mentioned far more than other aspects of mental health. They are Indigenous suicide rates, youth, the LGBTI community, our CALD community, and PTSD (especially military personnel and first responders). Those areas of concern are the recognised places within Suicide Prevention that need special attention and resources.

However, I also noted a recurring reference to three (3) Mental Health Priorities that are UNADDRESSED ISSUES OF CONCERN . The concerns are located within the mental health policy statements of “aspiration” of what is needed or should be happening, and the observations of criticism of what is NOT happening. The concerns expressed are a common thread, woven throughout virtually any document quoted in this report.

Those Mental Health priorities are:

1. Sustainability of funding
2. Data
3. Post-discharge care , especially in Hospital Outreach Post – Suicidal care

I decided to provide a case to assist our local mental health hospitals. My own observations seem to match the national/NSW concerns located in the plans etc. which refer to a lack of post-discharge (suicidal)care.

FINDINGS AND RECOMMENDATIONS

This report has found that there has been a long held concern of policy makers in Mental Health about the inadequate funding of front line staffing and Post Discharge care. Further, criticisms within the very plans and policies and strategies, as well as reviews by Commissions and respected organisations in Mental Health make continued references to the need to have the correct level of Post Discharge service for the consumer, as well as staffing levels.

In 2019 , the Victorian Royal Commission findings on Mental Health Services (Draft) report and the Federal Governments Productivity Commission Draft Report on Mental Health were tabled .

Significant references of concern were reiterated on Hospital Outreach - post suicidal care . There leaves no doubt , that care at this vulnerable point in peoples lives are shown to be lacking, continuing in 2019 , validating past Mental Health reports.

Therefore , *the first part of the finding* provided here is :

That inadequate post discharge care is *endemic* in our Australian Mental Health services , and has been validated as continuing .

“consumers still do not receive the support they need” is the catchcry of eminently qualified people in Mental Health services.

The *second part of the finding* , is :

There is sufficient local knowledge within the Mental Health services and volunteer organisations in the Macarthur Region to know for sure that the Mental Health system is not working properly in post discharge care .

The *third part of the finding* is:

Anecdotal observations within past and current plans / reports on budgetary constraints within Mental Health have long prejudiced our most vulnerable. The inability to provide a psychologist over a period of more than several months is a violation of consumers rights in mental health care. There’s a lack of accountability in the budget process that prejudices priorities in the services of the “poor cousins” in health primary care. The poor cousins are: Mental Health services.

The 2019 reports from the Productivity Commission and the Victorian Royal Commission into Mental Health services underline the Australia wide findings of Primary Health services providing an overarching validation of specific concerns in the Macarthur local Mental Health services.

Inserted on the 4th July 2019: As an outcome of the commencement of work planning an awareness of the lack of mental health services at Burunji, I have been made aware that there has also not been a clinical psychologist at Waratah House, Campbelltown, for more than 10 years. It is unacceptable for NSW Department of Health budgets not to fund appropriate staffing levels in mental health services. It is now 2020, underfunding must *cease immediately* .

Therefore, the recommendations are to immediately fund the appropriate staffing level as noted above.

Further, it is recommended that a trial be established immediately for the provision of a Post Discharge Case Worker, the trial to commence at Campbelltown. This proposal will have additional resources available post discharge ensuring the welfare of every consumer. It is also intended to be a “transformational” trial for consumers, initially in the Macarthur region, designed to add to consumer wellbeing providing an optimal post discharge recovery service attending to the myriad of needs for a consumer walking out of their hospital care.

Further, the model is recommended to be centred around the Victorian Government Hospital Outreach Post-suicidal Engagement (HOPE) program. The HOPE program is a core component of Victoria’s Suicide Prevention Framework 2016–2022 which aims to halve Victoria’s suicide rate by 2025. Details of the program are provided later in this report.

I propose this report be forwarded to all relevant local (State and Federal) politicians, the NSW Minister for Mental Health, the two cabinet ministers of Health (State and Federal), all relevant bureau heads of health departments, the CEO of the National Mental Health Commission, Christine Morgan, in her recently appointed role of National Suicide Prevention Adviser to report directly to the Prime Minister, Scott Morrison. Further, to the National Mental Health Commissioner, and the NSW Mental Health Commissioner.

DRAFT

SOURCES OF INFORMATION

I have visited five local mental health hospitals in South West Sydney over the past eight or so years, personally or as a member of community mental health organisations.

I know the people working at these hospitals do a wonderful job in a difficult working environment and with a seemingly endless shortage of staff. I am also told that there is an endless number of unfilled vacancies.

I have concerns that when people are discharged, staff may or may not have the ability to do much more than make further appointments for that person. It has been implied that staff at the hospitals do not have the capacity to follow-up on whether the consumer has attended those appointments. It is vitally important to note here that I am not claiming that people aren't doing their jobs in any way. In the example of the Macarthur area of South West Sydney, a case worker role may well be embedded within the referral to the Macarthur Mental Health service. The issue, however, centres around the capacity to provide appropriate suicide prevention in the post discharge process. It is my impression, that it may be difficult to do the necessary follow-up of referrals due to a variety of factors beyond the control of the staff at mental health hospitals in NSW.

I know first-hand of the frugal physical resources provided to a person who may be discharged into their own care if friends or family are not available to provide care or support. It is this scenario that this report seeks to address. I ask the reader to consider whether it should be the responsibility of our community to provide a carefully monitored care process for a person at this very vulnerable time in their life.

I do hope people are not offended by the above statements. I wish to reiterate that the comments above, and this report, do not seek to criticise or demean the work of any person or process in our hospital discharge system. It is, unconditionally, a document of support.

As I reached the end point of looking at the (above mentioned) myriad of documents about Mental Health, I noted that there were many organisations prepared to articulate statements of concern /critical observations about Post Discharge care. It seemed to me there was the same thread of concern woven through policy statements and critical observations related to Mental Health.

I wondered if these (often aspirational) references had been triggered by those in the mental health system observing that there were ongoing unresolved structural problems in this area.

The report will of course, need to "make the case" for such a case worker proposal. I felt it was better to acknowledge a degree of awkwardness at the onset in relation to a reader asking, "Wouldn't it be the jurisdiction or role of mental health services to deliver a managed post discharge service?" This report will, I believe, show that this may not be the case.

This proposal will seek to outline that need and provide sufficient information to satisfy the reader as to the benefit to consumers who may be at their most vulnerable. At discharge, a consumer has to navigate their way through mental health service appointments, ongoing medication and follow up treatment with psychologists/psychiatrists. There may also be a need for additional support. It would be difficult to understate the level of concern and angst that a consumer would feel at such a time.

The following is NOT a suicide prevention document. The origins, as noted above, came from researching suicide prevention and the relevant documentation. There is a substantial reference to suicide prevention, however, it is important to emphasise this is a mental health document, with significant reference to mental health plans, strategies, frameworks, etc.

WHO RUNS WHAT AND WHO ANSWERS TO WHOM?

Campbelltown's Mental Health hospitals, Waratah, Burundi, Gna Ka Lun, the Psychiatric Emergency Care Centres (PECC unit) and ED at Campbelltown Hospital are run by the SWS Local Health District (LHD). (SWSLHD)

The LHD's are run by NSW Health.

NSW Health are governed by the overarching NSW Government, and any agreements that the NSW Government sees fit to commit to.

The NSW Government has made commitments within the Coalition of Australian Governments (COAG) agreements, including mental health. Specifically, the 5th National Mental Health and Suicide Prevention Plan (The Fifth Plan), the major mental health plan for Australia, was endorsed by the NSW Government under COAG on 4th August 2017. (page 9, Fifth Plan)

The Australian Government has provided the major components of Mental Health and Suicide Prevention Plans and Strategies. *Most importantly, the Australian Government has accepted the responsibility for a national approach to mental health with a collaborative effort.* There are a myriad of documents that flow from this.

MENTAL HEALTH AND SUICIDE PREVENTION PLAN AND STRATEGY DOCUMENTS

Our Federal and State governments and their agencies have produced a huge array of plans and reports on Mental Health and Suicide Prevention .

They set out their responsibilities , and also relevant inquiries and internal scrutiny identify shortcomings .

These documents are voluminous, and are listed (in part) below:

1. The Fifth National Mental Health & Suicide Prevention Plan
2. Fifth National Mental Health and Suicide Prevention Plan, 2018 Progress Report (NMHC)
3. The National Suicide Prevention Strategy (NSPS) 2015
4. *The National Suicide Prevention Implementation Strategy" (NSPIS) draft 2020-2025*

5. Monitoring Mental Health & Suicide Prevention REFORM: NATIONAL REPORT 2018” (NMHC)
6. Monitoring Mental Health & Suicide Prevention REFORM: PROGRESS REPORT 2018”
7. Next steps to reduce Australia’s suicide rate” December 2018
8. The Roadmap for National Mental Health Reform 2012 – 2022”
9. *“Living is for everyone: a framework for prevention of suicide in Australia”*13 Dec 2007, Department of Health and Ageing (Australia)
10. *Before it’s too late: Report on early intervention programs aimed at preventing youth suicide. 2011*, the Aust. House of Representatives Standing Committee on Health and Ageing
11. *The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.*
12. *The Hidden Toll: Suicide in Australia.* 2010 Senate Standing Committee on Community Affairs
13. *Evaluation of Suicide Prevention Activities* 2014 Department of Health
14. NSW State Health Plan: Towards 2021
15. Mental Health Commission of NSW *“Living Well: A Strategic Plan for Mental Health NSW 2014-2024*
16. Mental Health Commission of NSW *“Living Well: A Strategic Plan for Mental Health NSW 2014-2024*
17. Review of the Mental Health Commission of NSW – over 5 years 2012 – 2017
18. The NSW Suicide Prevention Strategy 2010-2015
19. Mental Health Commission of NSW, *“The Strategic Framework for Suicide Prevention in NSW 2018-2023*
20. The National Mental Health Commission Report of the National Review of Mental Health Programmes and Services TITLE: *Contributing Lives, Thriving Communities.* 2014 (Summary, and volumes 1 to 4)
21. The National Coalition for Suicide Prevention (NCSP) *“Response to World Health Organisation: World Suicide Report One world connected: an assessment of Australia’s progress in suicide prevention.* 2014
22. National Mental Health Commission: *Next steps to reducing Australia’s Suicide Rate*
23. Suicide Prevention Australia: SPN National Policy Platform
24. SWSLHD Mental Health Strategic Plan 2015 – 2024
25. *SWSLHD HREC Operations Manual 2017*
26. *The National Mental Health Service Planning Framework (NMHSPF)*
27. PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES: National Mental Health Commission 08/17
28. South Eastern New South Wales Regional Mental Health and Suicide Prevention Plan 2018-2023
29. National Coalition for Suicide Prevention Response to World Health Organisation World Suicide Report ‘Preventing suicide: A global imperative’ 10 Sept 2014
30. NSW Parliament Joint Committee on Children and Young People Report 5/56 – October 2018
31. SWSLHD Mental Health Services
32. A Service of South Western Sydney Local Health District: Operational Plan 2018 – 2020
33. The National Mental Health Service Planning Framework (NMHSPF) Jan 2019
34. IMPLEMENTING INTEGRATED SUICIDE PREVENTION IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES
35. A Guide for Primary Health Networks
36. SWSLHD HREC Operations Manual August 2017
37. Outcomes Report: Summary of the Literature for Discussing Suicide July 2012: Developed by Everymind
38. Lifespan from the Black Dog Institute -Centre for Research Excellence in Suicide Prevention (CRESP)
39. Productivity Commission of Australia Mental Health Report 2019 (Draft)
40. Royal Commission into Victoria’s Mental Health System 2019 (Interim Report)

The purpose providing extracts of selected Reports , Plans etc. is to establish irrefutable evidence of the acceptance by all levels Governments of their duty of care in Mental Health services , and further , this report seeks to provide relevant material that corroborates the expressed concerns of systemic failure to provide a *working* Mental Hospital Outreach Post -Suicidal Engagement program .

The following extracts relate to establishing the requirement of the NSW government to provide such resources as the government is a signatory to the Coalition of Australian Governments (COAG) agreement on such plans , strategies and frameworks .

In order to explain the context of the following documents as it applies to Post Discharge care , the following is noted :

AGREED REQUIRED LEVEL OF POST DISCHARGE CARE OUTLINED BY GOVERNMENTS

- The most important Plan on Mental Health at the Federal level is the Fifth National Mental Health And Suicide prevention Plan (the Fifth Plan)
- The plan articulates certain strategies and obligations in relation to the post discharge care process and cooperation of the government services at different levels .
- There are agreed frameworks that articulate the requirements of such matters as post discharge care , that are agreed by Federal and State governments .
- The National Suicide Prevention Strategy (NSPS) articulates the case from purely a Suicide Prevention perspective
- The NSW Governments LIVING WELL, A STRATEGIC PLAN FOR MENTAL HEALTH NSW 2014-2024, notes the obligations , and ,
- The NSW Suicide Prevention Strategy 2010-2015 , also confirms the requirements and importance of appropriate care .
- the South Western Sydney Local Health District (SWSLHD) Mental Health Strategic Plan 2015-2024 endorses its own perspective , as it applies to the Mental Health hospitals in question .
- SWSLHD operational plans etc are noted.

REFERENCES TO IMPLIED LACK OF ACHIEVEMENT MEETING THOSE REQUIREMENTS

- Fifth Plan references to failures
- Orygen
- , Croakey, an independent social journal for health 2017
- The National Mental Health Commission (NMHC) report 2018
- report (COMHWA) in Nov 2017
- The National Mental Health Commission(NMHC) Review- November 2014
- CONSUMERS OF MENTAL HEALTH WESTERN AUSTRALIA (COMHWA) report Nov 2017
- The National Coalition for Suicide Prevention (NCSP)
- The SOUTH WEST SYDNEY LOCAL HEALTH DISTRICT (SWSLHD) produced a report called the SWSLHD Mental Health Strategic Plan 2015 – 2024. (MHSP)

THE FIFTH NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN (THE FIFTH PLAN)

The Fifth Plan is the overarching National plan for mental health in Australia. No other document supersedes it. Furthermore, all NSW mental health policies and plans refers to this Plan.

“The 5th National Mental Health and Suicide Prevention Plan (the Plan) is an integral part of the National Mental Health Strategy. Endorsed by the Australian Health Ministers’ Conference in 1992, the National Mental Health Strategy is formed by a suite of documents, each with a specific purpose. The Fifth Plan builds on the foundation established by previous reform efforts and sets out a national approach for collaborative government effort over the next five years. (The Plan commenced in 2017). The Fifth Plan is underpinned by several targeted priority areas, which were developed taking into account feedback from key stakeholders and includes supporting actions that enable change.

“The supporting actions are not intended to solve all problems within the five-year period of the Fifth Plan but are instead intended to set the direction for change and provide a foundation for longer-term system reform.” (the Plan, page1)

Furthermore, the launch of the plan was significant as it included an addition of the words “and Suicide Prevention”. This plan recognised the crisis represented by suicide levels in Australia, and so made suicide prevention a priority (number 2).

State and territory governments committed themselves to the plan, “this plan commits all governments to work together to achieve integration in planning and service delivery at a regional level” (The Plan page. v)

PHNs AND LHNS

“Activity at the local service delivery level is driven through PHNs and Local Hospital Networks (LHNS). PHNs were established by the Commonwealth Government. They plan and commission medical and health services within defined regional populations and are expected to support service integration at the regional level. LHNS were established by states and territories. They manage public hospital services; may manage other health services funded by states and territories, such as community-based health services; and support service integration at the regional level.” PHNs and LHNS have strong relationships with the community-managed sector. Collective action by both PHNs and LHNS is necessary to drive effective service integration within a local region.” (page 9)

It notes that there was “extensive consultation undertaken by the National Mental Health Commission in 2014”. Over the next five years, it has been stated, The Fifth Plan will establish a “national approach for collaborative government action to improve the provision of better integrated mental health and related services in Australia.”

The 5th Plan goes on to provide actions that need to be taken, including Action 5, which alleges that “Governments will support PHNs and LHNS to develop integrated, whole-of-community approaches to suicide prevention”. This will include engaging with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan.

In priority area 2, the plan comments on the factors that contribute to suicide. It states that “a previous suicide attempt is the most reliable predictor of a subsequent death by suicide.”(the Plan p29, 30)

It goes on to note that “providing intensive follow-up care during the days and weeks after a suicide attempt, or following discharge from inpatient psychiatric care, it is possible to reduce the risk of future suicide attempts.”

EXTRACTS OF MENTAL HEALTH POLICY, PLANS, STRATEGIES AND REPORTS RELATED TO THE RESOURCES AND POST DISCHARGE SERVICE AT MENTAL HEALTH HOSPITALS IN NSW

The quotations have been taken only from contemporary documents. As much as possible, the content has been restricted to highlight and support the requirement of State and Federal Governments to provide the correct level of services regarding staffing and post discharge services in Mental Health.

REVIEW OF THE FIFTH PLAN

The 5th Plan was reviewed in 2018 by the National Mental Health Commission (NMHC). It noted the following:

Priority Area 1: Achieving Integrated Regional Planning and Service Delivery

“Stakeholders responsible for contributing to actions under this Priority Area include the Australian Government Department of Health, (others), PHNs and the state and territory government health departments.” (NMHC:page15)

This refers to the desired measurement aspirations of the 5th Plan as follows:

“Systems will be developed to allow mental health indicators to be analysed and reported at a regional level. This will allow PHNs and LHNs to monitor local variation in health needs, care and outcomes, including differences in:

- health status and needs, such as the proportion of the local population with high levels of
- psychological distress (PI 7) and rates of suicide (PI 19)
- the quality of mental health care, including the proportion of consumers and carers reporting a positive experience of service (PI 13) and the effectiveness of services in changing clinical outcomes (PI 14) or increasing social participation (PI 9)
- the accessibility and integration of health care, including population access to care (PI 15) and rates of follow-up after hospital discharge (PI 16) or after suicide attempts (PI 21)”

PI 16, as mentioned above, addresses post discharge care and measures the “proportion of discharges from an acute admitted specialised mental health unit for which there was a follow-up by a community mental health service within 7 days.” (page 60 5th Plan)

Priority Area 3: Coordinating Treatment and Supports for People with Severe and Complex Mental Illness

“The needs of people with severe mental illness are not homogenous. Some people have episodic illness. Others have more persistent illness that can reduce their ability to function, experience full physical health or manage the day-to-day aspects of their lives. Some people can be supported through time-limited clinical services in the primary care setting, while others require hospital-

based services or some form of community support. Despite ongoing efforts by governments and service providers, many people with severe and complex mental illness still do not receive the support they need.

As per the plan, the stakeholders that are responsible for contributing to Priority Area 3 actions include “the Australian Government Department of Health, the PHNs, and the state and territory government health departments.” (5th Plan page 22)

Action 4

Action 4 requires the provision of “consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system.” (5th Plan, page 25)

Action 7

“Governments will require PHNs and LHNs to prioritise coordinated treatment and supports for people with severe and complex mental illness at the regional level and reflect this in regional planning and service delivery.” (5th Plan page 22)

THE NATIONAL FRAMEWORKS

There is a continued reference to a Nationally recognised *standard* of service delivery that is referred to as the basis of all required standards of mental health services.

FACT SHEET 10: LIFE, LIVING IS FOR EVERYONE

The principles for conducting suicide prevention activities should start with placing the health and wellbeing of the individual at the centre.

“This is essential to all suicide prevention planning and initiatives, and to creating appropriate pathways to care for suicide prevention. This includes provision of community-based safety nets and services to support people in their transition between care providers and back into the community. The likelihood of suicide can increase significantly after a person is discharged from care. For instance, the risk of suicide increases by around 200 times for patients (both men and women) after discharge from inpatient clinical care.”

*“Safety nets should be provided to support people moving between treatment options, and back into the community through community-based services to support and **foster recovery after discharge from clinical care**; effective client hand-over practices between services and back into the community; and cooperation and communication between health professionals, community support services, families, workplaces, and community groups.” (page 19)*

“Ongoing care and support involving professionals, workplaces, community organisations, friends and family to support people to adapt, cope, and build strength and resilience within an environment of self-help. This may be the opportunity to increase broader community education about the issues and build awareness of the strategies that may be needed to prevent recurrences.”

Action Area 4 addresses providing a coordinated approach to suicide prevention. Its outcomes include:

- Local services linking effectively so that people experience a seamless service
- Program and policy coordination and cooperation, through partnerships between governments, peak and professional bodies and non-government organisations

The report makes reference to “action based on the best available evidence to guide activities, and providing “a coordinated response, and provide smooth transitions to and between care”.

Please refer to “Life in Mind” for further details. It is pertinent to quote particular references to the required standard of service and care. This framework was signed off as part of the COAG agreement.

RESOLUTION OF THE NATIONAL SUICIDE PREVENTION STRATEGY (NSPS)

This review was conducted by the National Mental Health Commission (NMHC) in April 2015. It was the result of a joint commitment by the Australian Government and states and territories, in the context of the Fifth National Mental Health Plan, to “prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support”.

The NSPS (2015 model) involved four strategies. Two of these included:

- a systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool
- national leadership and support activity, including whole of population activity and crisis support services

The NSPS document goes on to explain the decision to appoint PHNs as the delivery point of suicide. It states that “PHNs have been tasked with commissioning regionally appropriate suicide prevention activities and services from 1 July 2016.” It goes on to say that “PHNs will also work with Local Hospital Networks and other local organisations to support better targeting of people at risk of suicide.”

NSW GOVERNMENT PARLIAMENT HOUSE REPORT, JULY 2017

Researcher Lenny Roff said, “Work with states and territories to establish a national protocol whereby when hospitals discharge a patient from an inpatient service or after a suicide attempt, they provide appropriate supports including intensive follow-up services for 30 days” referring to the NMHC Report (admittedly) in 2014.

In 2016, Mr Roth commented on an Australian health ministers meeting, emphasising the following one of five actions in total:

“Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.”

DRAFT

AT THE NSW GOVERNMENT LEVEL

LIVING WELL, A STRATEGIC PLAN FOR MENTAL HEALTH NSW 2014-2024

In this report, dated October 2014, the Mental Health Commission of NSW said:

“Responses to suicide and suicidal behaviour within the health system also need improvement. All front-line staff – emergency services, community and crisis support, mental health and emergency department staff, as well as general practitioners – need training to know what to do in a crisis and where to point people for further support. Whenever and wherever a person exhibiting suicidal behaviour encounters the health system, preventive action and follow-up must be systematic and assured.”

The commission pointed out the need to “assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital”.

THE NSW SUICIDE PREVENTION STRATEGY

The, admittedly outdated, 2010-2015 strategy document provides a comprehensive, whole-of-government approach to suicide prevention.

“The Health system has responsibility for a range of issues across society as a whole, and in particular for people at risk, including the promotion of mental health and wellbeing, the prevention of mental ill health and drug and alcohol ill health, identification and management of risk of suicide, and ongoing care and support.”

“In addition to prevention and recovery oriented community based mental health services and a range of cross agency preventative health initiatives, a range of protocols and initiatives are in place to identify people at risk of suicide and improve responses to suicide, including– a suicide risk assessment and management framework and training program for the Health system to enhance the capacity of health workers to assess and effectively manage people who may be at risk of suicide, including specific protocols and training for clinical staff working in mental health and other hospital and community health settings; a standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings and their families and carers.”

A NOTE FROM THE AUTHOR

This policy may well exist , The problem in the Macarthur Region Mental Health hospitals are – INSUFFICIENT HUMAN RESOURCES TO PROVIDE THE POLICY IN THE FRAMEWORK .

SWSLHD “MENTAL HEALTH STRATEGIC PLAN 2015 – 2024” (MHSP)

In reference to collaboration, “significant improvements have been made in the past decade. These improvements have included enhancements in the availability of community and inpatient mental health services, strengthened partnerships with the community managed sector, and models of care which focus on recovery.”

A new approach is required in SWSLHD to improve the mental health of the community; to promote resilience and wellbeing; to respond early and appropriately to signs of mental ill health; and to support people to recover from their experience. (MHSP page 1)

The shifting of the focus of all services to a recovery-oriented model, in which the consumer is central to all decision making, is required. The enhanced capacity and responsiveness of community mental health services should be a priority, to deliver care and treatment to consumers in a range of settings.

Transitional supported accommodation packages should be provided in conjunction with community managed organisations to support people being discharged from inpatient care. (from Amanda Larkin MHSP Foreword Page 3)

LIVING WELL: A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014 - 2024

The Living Well plan was developed, by the Mental Health Commission of NSW, to set the direction for the reform of the mental health system in NSW. It has been adopted by the NSW government.

Living Well articulates the vision of “the people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.” Living Well also promotes a “recovery-oriented approach to mental health in NSW, which recognises the diversity of consumers and consumer experiences before, during and after engagement with the mental health system.” (LW page 5)

Mental Health priorities in the plan include the need to expand the availability of services, increase community awareness of mental health (including prevention and early intervention), improve the physical health of people with a mental illness and collaborate with other stakeholders to focus on improved responsiveness to both emergency situations and long term recovery. (LW page 5)

THE SWSLHD

According to the SWSLHD, by 2024, the mental health service system in South Western Sydney will “be recovery-oriented, with each individual enabled to make informed choices about their health, be partners in their care and plan for their future”.

The SWSLHD aspire to “clearly articulate the roles and responsibilities of the public, private and community managed sector, with all agencies and organisations working in partnership to improve the mental health system and outcomes for people with a mental health issue and their carers” (MHSP page 15)

The success of implementation will be measured by a number of indicators, including “*Mental Health Acute post-discharge community care - follow up within seven days.*” (MHSP page 17)

Further Aspirations

One further aspiration includes the introduction of “Prevention First: A Prevention and Promotion Framework for Mental Health”. This framework identifies the need to “target mental health promotion and intervention initiatives at five groups - the whole community/community groups, groups in the community with a higher risk of mental ill-health, groups/individuals showing early signs of mental ill-health, individuals currently experiencing an episode of mental ill-health *and those recovering from a mental illness.*” (MHSP page 18)

As per the SWSLHD, in 2013, the commencement of the HealthPathways project and developing innovative, technology focussed integrated care models within new and existing community health facilities. In addition, “SWSLHD Mental Health services participate in system coordination and integration initiatives with primary care providers, particularly GPs, to improve discharge planning and care planning, implement shared-care models and enhance skill development and service capacity” (MHSP page 18)

Discharge Planning Processes

The SWSLHD also sought to review and improve discharge planning processes, including “the development and communication of electronic discharge summaries to all relevant service providers to enhance the continuity of care”. This was completed in 2016.

Mental Health Pathways

The SWSLHD also sought to develop pathways and other service responses for people who present with anxiety and other mental health issues in inpatient and ambulatory care service. This was completed in 2015 (MHSP page 22)

The SWSLHD Consumers as Partners in Clinical Care Policy (2015) describes the expectations for working collaboratively with mental health consumers and carers in relation to decision making regarding treatment and care planning. “The policy provides clear direction to staff on strengthening the involvement consumers have in managing their recovery.” (MHSP page 23)

Housing and Homelessness

People with a severe and persistent mental illness are at high risk of becoming homeless due to difficulties maintaining relationships with family and friends, difficulties maintaining steady employment, extensive periods of hospitalisation, the limited supply of affordable housing and difficulties performing activities of daily living which support the ongoing maintenance of tenancies. Homelessness is a significant barrier to recovery and can result in unnecessarily long lengths of stay in hospital when no suitable accommodation is available in the community. (MHSP page 30)

SWSLHD is implementing “Going Home Staying Home” and is committed to ensuring that no inpatient is discharged into homelessness, consistent with National and State policy.

SWSLHD sought to develop transitional supported accommodation packages in conjunction with community managed organisations for people being discharged from inpatient care. This aim was completed in 2017. (MHSP page 26)

To secure a greater variety of accommodation options, a pilot partnership project, the Macarthur Real Estate Engagement Project, (MREEP) was established in 2012, under the Homelessness Action Plan, to improve access to housing and sustain tenancies for people with a mental illness. Outcomes from this project have been positive.

The SWSLHD has since supported the extension of the Macarthur Real Estate Engagement Project across the District to increase the accommodation options for people with a mental illness, in collaboration with the DIACC DAH. This was completed in 2017.

(A note from the author: The statements above are not necessarily correct. I was the Chairperson of MREEP from 2017 to 2019)

THE SWSLHD MENTAL HEALTH SERVICE OPERATIONAL PLAN 2018-2020

Priorities presented in this operational plan include improving the transfer of care and care pathways between inpatient and community services to provide community-based care and treatment wherever possible.

UNDER NSW HEALTH: MENTAL HEALTH CLINICAL DOCUMENTATION GUIDELINES

The following document is the only reference available that provides a policy in relation to: Transfer/Discharge Summary - GL2014_002, issue date January 2014. (Page 9 of 24.)

The purpose of the Transfer/Discharge Summary module is to document the current episode of care and its outcomes.

“It allows provision for documentation of issues requiring ongoing management, where care is being transferred to another mental health service unit or other service provider, such as a general practitioner. The module is intended for use in both inpatient and ambulatory settings and should be completed on or before the day of discharge (see PD2012_069, PD 2012_060). Ideally, discharge planning should be commenced at admission/opening of a service request.”

“In inpatient settings, the Transfer/Discharge Summary should be completed and signed by a medical officer. In ambulatory settings, the Summary should be completed and signed by a community medical officer or any appropriately qualified and experienced mental health professional in accordance with the relevant Local Health District policy.”

“Where care is being transferred, particularly to another mental health service, a copy of the current Care Plan should be attached to the Transfer/Discharge Summary module on discharge, to facilitate transfer of care and ongoing management. With the consumer’s consent, a copy of their completed Consumer Wellness Plan should be attached to the Transfer/Discharge Summary at the time of discharge and transfer of care. A copy of a completed Physical Examination module should also accompany the Summary at discharge from an inpatient setting.” (guideline page 9)

SUMMARY of REQUIREMENTS OF POST DISCHARGE CARE

CONSUMER NEEDS

- Consumers “still do not receive the support they need”.
- Mental Health Hospitals in NSW should be responsible for “a standardised discharge policy framework to promote continuity of treatment and ongoing support for people leaving adult mental health inpatient settings”.
- There needs to be a “recovery-oriented approach to mental health in NSW after engagement with the mental health system”. At the local level, there should be more collaboration. Services need to start “working as one team with patients, carers, the community and other service partners.”
- SWSLHD should fulfil its commitment to “be recovery-oriented” and to ensure that “no inpatient is discharged into homelessness, consistent with National and State policy”.
- We need to: “Place the health and wellbeing of the individual at the centre. This is essential to all suicide prevention planning and initiatives, and to creating appropriate pathways to care for suicide prevention.”

REQUIRED LEVEL OF CARE

The 5th Plan refers to:

- providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system
- providing timely follow-up support to people affected by suicide”

OTHER NOTES :

- “Providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system”
- Accountable for: “rates of follow-up after hospital discharge” (page 16)
- Services for consumers: “led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, are given effective follow-up support.”
- “follow-up must be systematic and assured.”
- “Assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital”
- Consumers should have “ongoing care and support.”
- Administration of Mental Health hospitals in NSW need to be held accountable and “Responsible for a Mental Health Acute post-discharge community care”
- Providing “a coordinated response, and provide smooth transitions to and between care”

SERVICE DELIVERY METHODS

- “LHNs to monitor local variation in health needs, care and outcomes.”
- “follow-up by a community mental health service within 7 days.”
- “provision of community-based safety nets and services to support people in their transition between care providers and back into the community.”
- “Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.”
- “follow up within seven days discharge planning processes” (repeated from a different source for emphasis)
- “transfer of care and care pathways between inpatient and community services completed on or before the day of discharge”
- “In inpatient settings, the Transfer/Discharge Summary should be completed and signed by a medical officer.”

REFERENCES TO IMPLIED LACK OF ACHIEVEMENT MEETING THOSE REQUIREMENTS

The following quote is from the opening paragraphs of the 5th Plan itself is located on page 18:

“The National Mental Health Commission’s 2014 National Review of Mental Health Programmes and Services concluded that mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and people having a poor experience of care and unmet need. Its highlighted service gaps, inefficiencies, duplication and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programs and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified opportunities to better integrate services.” (5th Plan page 21)

The 5th Plan then quotes from a NSW perspective:

“Similar problems and calls for action are echoed in plans released by state and territory governments. The strategic plan released by the Mental Health Commission of New South Wales identifies a number of problems in the mental health service system and concludes that service integration is a key priority of future reform.” (5th Plan page 22)

The National Mental Health Commission (NMHC) reported in 2018, reviewing the 5th Mental Health plan, addressed issues with priority area 2 – Suicide Prevention. It reported that “no significantly common achievements were identified across stakeholder groups at this point in time”. The MENTAL HEALTH SYSTEM requires a collaborative melding of state, federal, and community in

relation to discharge, however, it appears not to be the case as recently as 2018, as noted by the National Mental Health Commission/er.

From Orygen, The National Centre of Excellence in Youth Mental Health:

“Devolving responsibility for service system improvements (including follow-up care for high suicide risk following discharge from Emergency Departments and hospitals) to PHN/LHNs with little detail on how they will be supported to deliver this is a shortcoming of the Fifth Plan. While regional responsibility is seen to be a step forward in rectifying the issues of implementing integration in previous plans (p19), the expectation that the PHN/LHNs will regionally respond to gaps in service provision without addressing the higher level Commonwealth and state/territory responsibilities and the resourcing shortfalls across mental health services and systems is concerning.” (page 4)

“Concerning that the post-discharge care issue (which in the response to the National Mental Health Commission (NMHC) review was going to be addressed by COAG in this plan) is now a matter for the PHNs/LHNs, who will ‘seek to prioritise’ this (p34). The Fifth Plan should articulate how this will be done and when. The plan also needs to commit to ensuring what is done is evidence-based” (page 7)

“The actions are health-centric in their approach, whereas evidence suggests suicide prevention is best responded to through multiple systems and services outside of health. If the agreed scope for the plan is only mental health and health then this will be an issue.” (page 7)

“Need to include self-harm and suicide-related behaviours as a greater focus for actions and reporting within the Fifth Plan. The development of monitoring systems in hospitals across the country, linked to an aggregated national data set for presentations to Emergency Departments is one action that should be included.” (page 7)

In 2017, Croakey, an independent social journal for health, said:

“Of real concern is the fact that the 5th plan effectively exposes the rationale for this disintegration of our so-called mental health system. Never has it been clearer that PHNs manage primary care, funded by the Feds, while the states manage acute care and the hospitals.”

The NMHC in its report 2018 states:

“There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.”

Observations of the report (COMHWA) in Nov 2017 commented:

“PHNs commission just a subset of required mental health and suicide prevention services, and regional communities are reliant on LHNs, PHNs and local, state and other federal funding bodies to address overall mental health and suicide prevention needs.

The Consultation document outlines that monitoring of the NDIS, Contributing Life and PHNs will only occur “to the extent that the Commission is able to within allocated resources.” The NDIS has resulted in loss of recovery-focused community support services for thousands of consumers not eligible for NDIS who could previously access these services.

The National Mental Health Commission, in a review of ALL MENTAL HEALTH SERVICES in November 2014, asked the question, where are we now? The answer outlined a system that does not see the whole person. It referred to people being “discharged from hospital and treatment services into homelessness, or without adequate discharge planning”. It also addressed poor planning, coordination and operation between the Commonwealth and the states and territories, resulting in duplication, overlap and gaps in services.

It also asked the big question, where do we want to be? The NMHC recognised the aspiration to be a system that responds to whole-of-life needs. This would mean that no-one would be “discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services without an appropriate discharge plan which provides for necessary supports and includes regular follow-up.”

The NMHC provided its own statement on what needs to be done to change the problem, which included “managing the handover from hospital back into the community, step-down care and rehabilitation, aged care and palliative care” and the “clarification of roles and responsibilities between the Commonwealth and the states and territories”.

The National Coalition for Suicide Prevention (NCSP) measured Australia’s performance against this platform. The findings were:

Access to service: ORANGE LIGHT (meaning not acceptable) Promote increased access to comprehensive services for those vulnerable to suicidal behaviours. Remove barriers to care.

Treatment: ORANGE LIGHT Improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions.

The SOUTH WEST SYDNEY LOCAL HEALTH DISTRICT (SWSLHD) produced a report called the SWSLHD Mental Health Strategic Plan 2015 – 2024. (MHSP)

According to this report, in reference to community based mental health services, “SWSLHD is under-resourced to provide community based mental health services when compared to existing benchmarks”

The following working conditions are noted as issues/obstacles:

- Complex service environment
- Fragmented service system and conflicting advice
- Availability of information: Up to date information on mental health services and supports provided by the LHD and the community managed sector is difficult to obtain
- Variable approach to the implementation of recovery oriented practice

Carers experience “difficulty obtaining information regarding the status of their loved one”. There is a current “lack of engagement in care planning, monitoring and review”

ADDENDUM : 1st December 2019

The addition of the following content :

The Productivity Commission Inquiry MENTAL HEALTH DRAFT DOCUMENT delivered 31 October 2019, and a month later , the Royal Commission into Victoria’s MENTAL HEALTH SYSTEM– posted their INTERIM REPORT on the 28th November 2019.

REASON FOR ADDING THESE DOCUMENTS

These are arguably the most significant Mental Health FINDINGS documents produced for several years , their interim reports advise readers of significant problems at the Federal and State level in relation to Mental Health The observations and indeed , revelations in regards to Suicide Prevention at the state level are most revealing , and sadly disturbing .

I propose, the credibility of the reports are irrefutable. They are substantial in both content and findings . The contents have taken many hundreds of hours of work from eminently qualified people , thoroughly researched , and provided in concise documents. Indeed , in recognition of the validity of findings , the Premier of Victoria has announced that the Government will take up and implement all of the findings .

The two (2)-November 2019 reports are timely, and added (here), to the original September 2019 document “ [A PROPOSAL TO REFORM THE PROVISION OF ESSENTIAL STAFFING LEVELS ETC.](#)” that was presented to the NSW Government . The purpose is to support and validate the original findings .

THE PRODUCTIVITY COMMISSION REPORT (DRAFT) INTO MENTAL HEALTH 2019

The Productivity Commissions (draft) report was released after this submission was presented to the NSW Premiers office, and as this is being added , there are interviews with staff of the SWSLHD set for early 2020.

The importance of the substantial contribution by the PC on the subject of post discharge care cannot (I submit) be ignored. As mentioned earlier , the subject is presented as a concern within virtually every report and plan in the past 15 years , and not without good reason . Basically, to use a plain expression “we suck” in the delivery of effective care for post suicidal care of people leaving Mental Hospitals .

So , these extracts serve to put to bed any possibility of contradiction :

“Key factors driving poor outcomes in Australia’s mental health system include:

- a lack of clarity across the tiers of government about roles, responsibilities and funding, leads to both persistent wasteful overlaps and yawning gaps in service provision, with limited accountability for mental health outcomes. (p6)

Start. Now:

- Follow -up people after a suicide attempt
- Identify local priorities and responsibilities for Suicide prevention (p8)

IMPROVING GOVERNMENT COORDINATION

To deliver seamless care and support for an individual as their mental health circumstances change requires improved coordination over funding and service delivery by all levels of Government. *This includes greater clarity over who is taking responsibility for what.* While inevitably there will be ‘grey areas’, to minimise both service duplication and service gaps, pragmatic governance arrangements to enable the various parts of the mental health system to come together as envisaged under the Fifth National Mental Health and Suicide Prevention Plan are needed.

Broadly speaking, the Australian Government has generally taken responsibility for primary mental healthcare and *State and Territory Governments have taken responsibility for acute mental healthcare (public hospital mental healthcare). Fundamentally, this will not change under our proposed reforms. However, the ‘missing middle’ reflects the failure of clarity and coordination where primary and acute mental health care meet.*” (p42-3)

FUNDING AND INSTITUTIONAL REFORM

“Current funding arrangements in the mental health system contribute to poor consumer outcomes and a mix of services that is inefficient. For example, they provide few incentives at a local hospital level to minimise hospitalisations and avoid repeated presentations to emergency departments. *Beyond the healthcare system, funding for other supports such as psychosocial services is extremely fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people.*”(p45)

OBSERVATIONS ON INEFFICIENCY OF SERVICE DELIVERY

“Many of the reforms recommended in this inquiry draft report would involve governments spending more taxpayer funds on mental health. But even under current spending levels, governments are obligated to ensure taxpayer funds are used as efficiently and effectively as possible. Throughout this report, we report numerous instances in the mental healthcare system where this is not occurring.”(p47)

“Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).” (P222)

AFTERCARE FOR PEOPLE WHO HAVE ATTEMPTED SUICIDE

(A note from the author: This is a most relevant study that directly addresses the subject matter of the submission presented to the NSW Premiers Dep.)

The risk of suicide is greatest in the days immediately following discharge and remains elevated for weeks, months and even years (Chung et al. 2017; Meehan et al. 2006).

*Between 15 to 25 per cent of people who attempt suicide will reattempt, with the risk being highest during the first three months following discharge from hospital after an attempt. **Of these, 5 to 10 per cent will die by suicide.** Half of the people discharged from hospital after a suicide attempt do not attend followup treatment. Two thirds of people who do attend follow up treatment cease treatment after three months.* (Mental Health Australia, sub. 407, (p 24)

Adequate aftercare for people who have attempted suicide, including discharge planning and followup support, **can** prevent future suicide deaths and attempts (Luxton, June and Comtois 2013; Zalsman et al. 2016). For example, one study found that providing safety planning resources and follow up intervention for suicide patients in emergency departments approximately halved the odds of suicidal behaviour over six months (Stanley et al. 2018). Ideally, *aftercare should include support **prior to leaving a service**, as well as followup support within the first day, week and three months of discharge.*

Preventing deaths and attempts through aftercare reduces the associated social, emotional and economic costs of suicide. Krysinska et al. (2016) estimated that adequate aftercare could reduce the prevalence of suicide attempts that reach an emergency department by about 19.8% **and all suicide deaths by 1.1%. This could prevent about 5108 people from attempting suicide resulting in short incapacity, 1046 people from attempting suicide resulting in full incapacity, and about 34 people from dying by suicide.** Using the Commission’s estimated costs, aftercare could be expected to reduce the economic cost of suicide and suicide attempts by \$1.1

billion to \$2.3 billion each year. This is largely driven by preventing the loss of economic activity produced by people whose suicide attempt would be likely to result in full incapacity.

Currently in Australia not everyone who attempts to take their own life and seeks help receives aftercare. When it is provided, while some people with lived experience of suicide report positive experiences, *far too many report negative experiences*. They report that care was not always intuitive or easy to access, not offered consistently and that the quality, length and amount varies. *They report a lack of connection between services and clinicians*, meaning that people need to tell their story again and again. (NSPPRG 2019, p. 21)

The Commission heard about situations where people had been discharged from hospital following admission for mental illness and/or suicide attempt with no scheduled follow up, or where a follow up had been scheduled but the person had not been contacted if they did not attend. We were told that responsibility and accountability for follow up was unclear and inconsistent. (SA Mental Health Commission, sub. 477,(p31)

I was in a psychiatric ward for 5 days (for attempted suicide) ... I was not given the opportunity once to speak about why I was feeling the way I was, how they can help when I leave the ward and what we can do to prevent this from happening again. ... Once I had left the ward I was back to the beginning. I had no connections outside of the ward to help me on an ongoing basis, by changing this, people can feel like they are receiving the help they desire. (comment no. 21, consumers)

Many submissions identified the need for effective support for people who have attempted suicide (APS, sub. 543; Beyond Blue, sub. 275; CATSINaM, sub. 75; Jesuit Social Services, sub. 441; Laurence West, sub. 541; Mental Health Victoria, sub. 479; Private Mental Health Consumer Carer Network (Australia), sub. 49; Relationships Australia, sub. 103; Suicide Prevention Australia, sub. 523; your town, sub. 511).

There is a clear need to expand community based assertive outreach services to people who have attempted suicide. (Mental Health Australia, sub. 407, p. 24)

In addition to supporting people with suicide ideations, targeted after care and crisis care must be available to those who have previously attempted to end their life. (Mission Australia, sub. 487, p. 7)

There is a clear net benefit to providing universal aftercare for people who present at a hospital following a suicide attempt. Further, aftercare should extend to people presenting to any health or government service following a previous suicide attempt in order to reach and support as many people as possible.

Aftercare should include support **prior to discharge** or leaving the service , as well as IMMEDIATE and SUSTAINED follow-up support. (p15 Summary)

VICTORIAN ROYAL COMMISSION of INQUIRY INTO MENTAL HEALTH SERVICES

Another draft finding was delivered late in 2019, again , after this submission was presented to the NSW Premier's office .

Some may ask what is the relevance of what is happening in another state as this matter relates to Mental Health hospitals in South West Sydney NSW. The fact is , both states operate under the same financial and administrative models , and as noted above in the Productivity Commissions (draft) findings , there is a universal multi state concern about Post Discharge care from hospitals from people with suicidal ideation .

So, a brief observation may shed further light on the matter as a validation of earlier concerns . There are also two (2) opportunities to observe aspects of reasons why there is a post discharge care problem , and a recommendation from the Royal Commissions findings as a possible remedy .

Relevant Excerpts are :

15.2 THE VALUE of AFTER-CARE and ASSERTIVE OUTREACH

Evidence indicates that a suicide attempt is one of the strongest predictors of future suicide attempts. An individual that has had a non-fatal suicide attempt is at an increased risk of suicide, with the period after a first suicide attempt being the highest risk.⁵ Individuals that have undertaken intentional self-harm are at a significantly higher risk of suicide compared with the general population.⁶

Intervention following a suicide attempt is an important element to preventing subsequent suicide. Contact with a health service immediately after an attempt presents an opportunity to provide treatment to the individual, and support to family and carers.⁷

15.2.1 IMPORTANCE of after-care and assertive outreach

Rapid and proactive support following discharge from hospital is crucial for a person’s recovery⁸ and can decrease the risk of future suicide attempts during this particularly high risk period.⁹ Recent studies demonstrate that approximately half of suicides occur within the first month of discharge from a hospital.¹⁰ This risk for repeated self-harm or death by suicide remains high for the first 12 months following discharge.¹¹

One four-year cohort study found that, people who have been treated for or admitted to hospital following deliberate self-harm, have a 30 times greater risk of suicide in the year that follows compared with people who have not self-harmed.¹²

As discussed in Chapter 11, *capacity challenges in public specialist clinical mental health services* mean that many people are discharged from emergency departments or inpatient units too early after attempting suicide, *and without any form of follow-up care. Despite increased risk, approximately 50 per cent of people who attempt suicide do not engage with or attend any follow-up treatment after discharge. In addition, approximately 10 per cent of people only attend one week of treatment.¹³*

Given that some people do not or are unable to actively engage with follow-up treatment, care and support following a suicide attempt, there is an important need for mental health services to provide assertive and intensive outreach to support people in this period of crisis.¹⁴

15.2.2 Effectiveness of after-care and assertive outreach

Providing coordinated and assertive after-care to someone who has attempted suicide is likely to bring about the strongest reduction in suicide attempts and deaths by suicide.¹⁶

[From the author](#)

[This is the above mentioned remedy proposed by the Royal Commission](#)

15.2.3 Models of after-care in Victoria

In the 2016–17 State Budget, the Victorian Government committed \$27 million over four years for two pilot suicide initiatives: the HOPE program and the place-based suicide prevention trials.²¹

Hospital Outreach Post-suicidal Engagement program

The HOPE program is a core component of Victoria’s Suicide Prevention Framework 2016– 2025, which aims to halve Victoria’s suicide rate by 2025.²²

In Victoria, six sites have been funded for three years and a further six receive recurrent funding. An additional four sites will be established through funding under a bilateral agreement with the Commonwealth Government. Table 15.1 shows where each HOPE site is located and the nature of its funding arrangements (excluding the Commonwealth-funded sites).

Overview of the HOPE program

The HOPE program is a core component of Victoria’s Suicide Prevention Framework 2016–2025, which aims to halve Victoria’s suicide rate by 2025.²⁵ The program targets adults (aged 18 years or older) who are at significant risk of suicide following discharge from hospital after presenting for a suicide attempt or serious planning or intent.²⁶

HOPE teams support individuals and their personal support networks—family, friends and other carers—for up to three months after discharge, helping them to identify and build protective factors against suicide.²⁷ Participants are contacted within 24 hours

of hospital discharge and receive face-to-face contact within 72 hours. Following initial contact, the HOPE team provide clinical and/or community-based support that is flexible to individual needs (Figure 15.1). Core components of the support model include:

- team members—often key workers—providing regular contact and encouragement to participants via SMS, phone and face-to-face
- engaging peer support networks for participants
- developing safety plans that help participants to stabilise their mental health, identify and respond to mood changes, and implement coping strategies (safety planning also helps their supporters to understand the participant’s risk factors, the supports required to make them feel safe, and how and where to access support)²⁸
- facilitating links to community-based supports to meet the specific needs of the individual and their supporters, including links to alcohol and other drug services, specialist accommodation services, family violence support services and longer term mental health services.²⁹

(further HOPE program details are not provided here , please refer to the Inquiry report for further details)

From the Author

This is the second opportunity to observe possible remedies . In this case , it relates to evidence of the potential core problem in the post discharge process . That is , sufficient resources. The details are:

1. COORDINATION & LACK OF INTEGRATION

Achieving integrated regional planning and service delivery was a key priority of the Fifth National Mental Health and Suicide Prevention Plan.²⁸ It is difficult to achieve, however, in a context where there is limited statewide system planning.

Dispersed funding arrangements and unclear roles and responsibilities contribute to a poorly coordinated service system. In a submission to the Commission, a group of mental health experts said that a lack of coordination between the Commonwealth and Victorian governments has contributed to an increasingly fragmented system:

Commonwealth monies [are] being expended on mental health in a manner that is not integrated with extant state-funded services: this leads to major problems in terms of dislocated care, complex care systems and lack of knowing who has responsibility for what.²⁹

Further, siloed funding and governance arrangements can lead to disorganisation and inefficiencies across the sector.³⁰ For example, the National Mental Health Commission submitted that a lack of coordination between governments has led to an uncoordinated and fragmented set of programs and policies on suicide prevention. This has resulted in a patchwork of solutions and duplication of effort.³¹ (p109)

19.3.5 “CROSS SUBSIDISATION” (THE SMOKING GUN OF WHAT WE KNEW WAS HAPPENING)

Due to a lack of transparency inherent in the current funding model, the funding allocated to public mental health care in Victoria has not always found its way from health services’ budgets to services for people living with mental illness;¹⁰⁰ it has, at times, been co-opted for other purposes.¹⁰¹ Reflecting on his role as Minister for Health in the mid-to-late 1990s, Mr Knowles informed the Commission:

One of the suggestions which we (unfortunately) accepted was to roll funding for mental health into the overall funding of health generally. We ultimately found that this meant mental health services were starved of funding as the funding was swallowed up by physical health services.¹⁰²

The cross-subsidisation to inpatient services has contributed to the diminishing capacity of services in the community, which in turn has led to increased emergency presentations and a need for more inpatient treatment.¹⁰⁶ As Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, explained in relation to Mercy Mental Health:

There’s been a slow shift of resources within mental health services from the community to acute services which has left community services in a very difficult position of not having sufficient staff to provide or meet the case management needs of the people that we treat in our catchment area.¹⁰⁷

Similarly, Associate Professor Ruth Vine explained the position at NorthWestern Health:

Another driver of unmet need is that the under-funding of inpatient units is cross-subsidised by community teams. This means that community teams are much ‘skinnier’ than intended and that, for every clinician position that is lost from a community team to fund inpatient units, there is a loss of service availability to approximately 25 patients at any one time.¹⁰⁸ (p118)

(an additional comment : I BELIEVE that this is the core component of the problem of the post discharge care issue outlined in this submission, and, all other matters flow from this basic PROBLEM – STARVATION OF FINANCIAL RESOURCES)

CONCLUSION

There is a duty of care by the New South Wales government and its agencies of Post Discharge care , in hospital outreach , Post - Suicidal care .

From the Productivity Commission Inquiry on Mental Health (Draft) Report . October 2019

REQUIRED DISCHARGE CARE

“EVIDENCED BASED INTERVENTIONS “

“Indicated interventions target vulnerable individuals at risk, such as those displaying early signs of suicide thoughts or who have made a suicide attempt. Interventions might include follow-up support after a suicide attempt or management of mental disorders.

A systematic review of suicide prevention strategies around the world identified certain interventions that are likely to be effective at reducing suicide, particularly:

- support for people who have attempted suicide (‘aftercare’) can reduce further attempts or deaths” (p853)

AND

Aftercare for people who have attempted suicide

A previous suicide attempt is considered one of the most reliable indicators of future suicide or suicide attempts (NMHC 2014e; Owens, Horrocks and Allan House 2002; WHO 2014a; Yoshimasu, Kiyohara and Miyashita 2008). For example, a recent meta-analysis found that patients discharged from inpatient psychiatric care who were admitted with suicidal thoughts or behaviours were nearly 200 times more likely to die by suicide than the global average (Chung et al. 2017). The risk of suicide is greatest in the days immediately following discharge and remains elevated for weeks, months and even years (Chung et al. 2017; Meehan et al. 2006).

Between 15 to 25 per cent of people who attempt suicide will re-attempt, with the risk being highest during the first three months following discharge from hospital after an attempt. Of these, 5 to 10 per cent will die by suicide. Half of the people discharged from hospital after a suicide attempt do not attend follow-up treatment. Two thirds of people who do attend follow up treatment cease treatment after three months. (Mental Health Australia, sub. 407, p. 24)

Adequate aftercare for people who have attempted suicide, including discharge planning and follow-up support, can prevent future suicide deaths and attempts (Luxton, June and Comtois 2013; Zalsman et al. 2016). For example, one study found that providing safety planning resources and follow-up intervention for suicide patients in emergency departments approximately halved the odds of suicidal behaviour over six months (Stanley et al. 2018). Ideally, aftercare should include support prior to leaving a service, as well as follow-up support within the first day, week and three months of discharge. (p857-858)

A question may then be asked :

ARE THERE IDENTIFIABLE SYSTEMIC PROBLEMS RELATED TO MENTAL HEALTH SERVICES IN AUSTRALIA ?

Little doubt is left as the following quote from the National Mental Health Commission (NMHC) observes:

“The National Mental Health Commission’s 2014 National Review of Mental Health Programmes and Services concluded that mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and people having a poor experience of care and unmet need. It is highlighted service gaps, inefficiencies, duplication and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programs and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified opportunities to better integrate services.” (p21)

One may ask:

Is there is any relevance specifically to New South Wales ?

Selected findings and observations from the New South Wales Mental Health Commission (NSWMHC) located in LIVING WELL PUTTING PEOPLE AT THE CENTRE OF MENTAL HEALTH REFORM IN NSW: A REPORT provide the following :

“Still, most remain unwell at discharge, pointing to the need for continuing care in the community. And for 4%, their health worsens while 24% leave hospital with no significant change in their condition”. (p15)

And in LIVING WELL: A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014 - 2024

“At present, there are clear gaps in the co-ordination and integration of suicide prevention activities and programs across all levels of government. There is a need for better governance and more clearly delineated roles and accountabilities for suicide prevention.

Funding for suicide prevention is split between federal and state governments. As a consequence, efforts aimed at suicide prevention may be poorly co-ordinated and opportunities for more effective action are easily overlooked. More specifically, some parts of NSW have suicide prevention groups and bereavement support networks but others do not. This reflects a fragmented system made up of isolated programs 57”(p36)

“Responses to suicide and suicidal behaviour within the health system also need improvement. All front-line staff – emergency services, community and crisis support, mental health and emergency department staff, as well as general practitioners – need training to know what to do in a crisis and where to point people for further support. Whenever and wherever a person exhibiting suicidal behaviour encounters the health system, preventive action and follow-up must be systematic and assured.

Actions

3.4.8 Assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital”.(p38)

The next question may be asked :

ARE THERE INDEPENDENT FINDINGS OF PEOPLE BEING LOST TO FOLLOW UP CARE IN NSW?

Again , from the NSWMHC, LIVING WELL – A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014-2024

“The present situation often leads to people being ‘lost’ to follow-up care in the community after a hospital admission. This can result in tragedy as seen all too commonly in the stories of those who become forensic patients and those who complete suicide after discharge.

Another perversity is that for those who do need hospital care, the pressure on the system is so great that they receive *suboptimal care in quality and duration*.

The impact of this system is felt well beyond the individual and their family and carers, and beyond the health system. Failure to provide adequate mental health support in the community leads to crisis and difficulties maintaining continuity of services for those in need that directly impacts on other government agencies and the broader community.(p55)

Then , to look at the Macarthur Region and ask the question:

IS THERE EVIDENCE OF A LACK OF RESOURCES IN THE MENTAL HEALTH HOSPITALS OF THE REGION ?

The answer is yes , as evidenced in this document ., and examples such as :

From SWSLHD Strategic Mental Health Plan 2015-24 IN REGARD TO “Community based mental health services”:

- “SWSLHD is under-resourced to provide community based mental health services when compared to existing benchmarks: “Recovery”
- “Variable approach to the implementation of recovery oriented practice” (p 13)

AND “Carer’s experience”:

- “Difficulty obtaining information regarding the status of their loved one
- Lack of engagement in care planning, monitoring and review” (p 14)

WHAT ARE THE REQUIRED REMEDIES ?

Again , the NSW MHC report : LIVING WELL – A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014-2024 , advises the following (targeted for the Macarthur Region) conclusion :

“Planning and forecasting need”

- “LHDs received little guidance about how they should plan their mental health services and ensure their accountability. In the absence of this advice, some developed their own clinical service plans without external input regarding treatment goals or evidence-based models of care.
- Mental health service configuration is not contemporary. There are high levels of inpatient care with insufficient enhancement to community care over many years. The result is an inadequate response to more severe mental illness in the community, which frequently does not embody ideas of recovery and trauma-informed practice.
- The scope of services that the LHD is expected to provide with the funding it receives is unclear, and is further complicated by parallel Commonwealth and NSW funding streams without joint planning.
- Specialist state-wide mental health services hosted by a number of LHDs – including the Transcultural Mental Health Centre and the NSW Aboriginal Mental Health Workforce Program – HAS require support and attention from the Ministry and the LHD executive, if they are to adequately perform their state-wide role and not be vulnerable to the LHD budget pressures”.(p115)

There are references to the Health budgets being manipulated to target preferred outcomes in various areas, and it is not unreasonable to conclude that the Macarthur Region , Mental Health resources are potential victims of this process .

The conclusion ?

People of the Macarthur Region are potentially dying , because, in the area of post-discharge care , especially in Hospital Outreach Post – suicidal care ,staffing levels are INADEQUATE

A CONCLUDING CONCERN

I am sure that the matter may attempt to be refuted or just plain fobbed off .Responses could easily centre around :

- “these items are being fixed” and “we are building a brand new Mental Health Hospital , and all will be well “.
- “We have the matters in hand and are responding accordingly”

My response is : It is no longer acceptable to put off this matter , there have been many many months of patience , and the matter now *has to be addressed* , and I request that this now be dealt with as a matter of urgency , and with community consultation (not myself).

Respecting the hard work being done by staff in the SWSLHD mental health, under the most difficult levels, there need to be a complete change in funding and a monitoring of the provision correct budget of service levels.

[Suicide , it's time we talked LOUDER](#)

SECTION NINE

CONCLUSION

I wish to firstly , acknowledge our First Nation people , the Traditional Owners of country throughout Australia and recognise their continuing connection to land, waters and culture. We pay our respects to their Elders past, present and emerging. You have been invaded ,massacred, ignored, stolen and wronged in so many ways . I am so sorry for your pain , as it continues .

I have been humbled to meet with , proud people from so many places ,at Tharawal in Airds South West Sydney ,NSW . And I feel welcome attending 2 meetings about Suicide in the community. It has been devastating , and it made me cry for sure. In May , 2019 at the National Suicide Symposium In Canberra I met Rowena , a wonderful indigenous community Suicide prevention worker from the Kimberley in far away Western Australia , there were also many tears as we shared our stories about losing our sons to suicide , but it was good to share , it helps a little .

I implore every reader of this document , to do something, however small , to address the ongoing catastrophic loss of life in our indigenous community , I feel it is more imperative than anything we do to address our suicide tragedy . As I understand it, the indigenous community do not need non indigenous people to do the work , they know what is needed , they just need the financial resources to start the process . Please .

“Everybody you know and love is going to die . The scariest truth of our mortality : none of us matter. Nothing we say matters , nothing we do matters , in the grand scheme of things , we will all be invisible eventually. We inject as much meaning in our life as possible.Yet , our thoughts and creations will be invisible 10,000 years from now , and there’s no stopping that “

(Eli Roth, Introduction H.G.Wells : The Science Fiction Collection) .

All of the words written on Suicide Prevention, all of the work carried out by eminent researchers , panel members , committees, commissioners will be invisible in 10,000 years . The work done by politicians and bureaucrats, and their decisions will not matter in 10,000 years .

And yet, some strive for meaning in our lives , some leave a momentary legacy that is soon lost in time .

There is an invisible struggle happening in Suicide Prevention right now , ultimately nothing we say matters, nothing we do matters . People will die , taking their lives today , more will inevitably die tomorrow and into the future .

The National Mental Health Commissioner said “ The National Mental Health Commission’s 2014 National Review of Mental Health Programmes and Services concluded that mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and people having a poor experience of care and unmet need. It highlighted service gaps, inefficiencies, duplication and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programs and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified opportunities to better integrate services.²¹(p18)”

This was repeated in so many similar words in October 2019 in the Productivity Commission Inquiry DRAFT report into Mental Health . Sadly, inadvertently, more of the same .

We can continue on the present path of publicly exposing the inadequacies of Suicide Prevention efforts in Australia , and produce findings ad nauseam. Politicians WILL continue to produce grandiose statements of their latest gifts to us , predicting (unachievable) goals , and bureaucrats at the monetary decision making coal face , will dispense their valuable dollars as they see fit . And, yet, nothing we do matters .

Those who are dear to us , cherished , will take their lives, and cause our lives to be shattered. But , as Eli Roth says “our thoughts and creations will be invisible 10,000 years from now” ,so there maybe some solace for those of us left behind . In the end , we too will die , and nothing will matter .

Is that our future ? Lives lost to Suicide needlessly , changed only if people were held accountable?

A solution ?

I believe there is a *pathway* to finding that solution , true progress lies in the reform of financial resources and centralised decision making that produces accountable outcomes . The Suicide Prevention documents produced over the past 10 years do not ADEQUATELY FOCUS the need to address the structure of decision making in Australia , and ,how allocation of resources are made . These are exactly what they claim to be , strategy’s and plans ,and their contents are centred around aspirations . But that is not the subject . The subject is reform of a social problem that has not been addressed, *and is not being addressed*.

The basic tenet of the problem even comes down to reforming the wording of the subject “ Suicide Prevention Strategy ” . The subject should be a Suicide Alternative Strategy or Model.

What is so different between the use of the word Alternatives over Prevention?

Prevention is the action of stopping something from happening or arising, it is a active reaction of a negative issue , an Alternative is the availability of another possibility or choice, it also relates to activities that depart from or challenge traditional norms.

Reform is change , and change is a very uncomfortable thing to deal with .

If I can remember correctly my management studies, resistance to change is a common problem . People often don't want or like change, consequently, it is often opposed. Reasons vary, but in the area of Suicide Alternatives , I believe the primary reason would be change to power .

For example , the Hon Greg Hunt , Federal Minister for Health is, I'm sure, a nice man , and carries the burden of responsibility of the overall health and wellbeing of Australians on his shoulders . the budget is finite , and people are losing their lives as their health finally fail.

The problem is , *primary health* matters far more than *mental Health* .

Looking at the figures , its pretty simple :

In 2017, there were 160,909 deaths in Australia, and of that -

Intentional self-harm was 3, 128 the 14th level of cause (in 2008 there were 2341 and 2012 it was 2580 and now 3128. , can you see the increase?)

There were also Accidental falls of 2,782 . The rest were *primary health* related .

We can see that the Ministers for Health (Federal and States) have to be most mindful of the fact that 96.3% of deaths occur in the primary health sector versus suicide only being the 14th level of cause of death . Most people are aware that the rate of deaths from preventable diseases are falling (unless you are indigenous that is) . Many of the deaths are statistically attributed to people who are elderly , which distorts the "cause" description . We are all going to die .

Young people, are dying from a preventable cause .The reason for the inability to create a parallel set of statistics of all causes of deaths is *power* .

Those holding the power of decision making The outcome is resistance to change .

There are many reasons for Resistance to change and it manifests itself in many ways .

Change holds people accountable and requires responsibility . These are words that are missing from the aspirational strategies and plans in the world of Suicide Prevention

The latest draft Suicide Prevention Strategy seeks to rewrite the many previous attempts at delivering a better strategy, and viola , problem finally solved , and we will see the suicide rate begin to fall .

"Discomfort brings engagement and change."

— Seth Godin

There has to be a buy in to have effective change, the decision makers , the people allocating resources need to feel uncomfortable, and consider actions that will generate change .

There needs to be a driver , an advocate .

An Advocate who will it be ?

Hon Greg Hunt , Minister for Health would be a wonderful advocate for reform . He has the power , and as such , may not be inclined to reform his own Health portfolio due to competing interests from all of the primary health sectors .

Perhaps members of the National Suicide Prevention Project Referencer Group (NSPPRG.)whose Chairperson is Dr Margaret Grigg .(margaret.grigg@health.vic.gov.au) the Executive Director , Health Service Policy and Commissioning at DHHS. (Dept of Health and Human Services , State of Victoria) might be the advocate, however , at this point in time , the NSPPRG is charged with the responsibility of providing the draft of the very document that has raised my concern .

Those members do not have the power .They could of course , do something brave , and expose the real problem and present it to government and bureaucrats . But , perhaps the NSPIS 2020-2025 strategy will be the strategy of more of the same . Perhaps too, the NSPPRG will endorse the strategy , and agree to more of the same .

On the 20th July 2019 , there was the welcome appointment of National Mental Health Commissions CEO, Christine Morgan, to the new role of National Suicide Prevention Adviser to report directly to the Prime Minister, Scott Morrison.

However , new role has four key tasks:

- Report on the effectiveness of the design, coordination and delivery of suicide prevention activities in Australia, with a focus on people in crisis or increased risk, including young people and our first nations people;
- Develop options for a whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions;
- Work across government and departments to embed suicide prevention policy and culture across all relevant policy areas to ensure pathways to support are cleared, and people who are at an increased risk of suicide are able to access support; and
- Draw upon all current relevant work government and the sector is undertaking to address suicide, including the Fifth National Mental Health and Suicide Prevention Plan and Implementation Strategy, and the findings of the Productivity Commission and Royal Commission into Victoria's Mental Health System inquiries.

Now we have a defined "advocate " , a most welcome development . There is a caveat , of course . If the outcome of the advocacy is " more of the same " then there will be a continuation of the same level of needless deaths, the weight of this role is gratefully recognised , and desperately wishing success out of the continued lack of progress.

The problem still is power , and of course, the Prime Minister has it all. The scenario now is : *the advocate has the ear of the power of the Australian Government* .

The conclusion ? , *more of the same . Waiting for an advocate , who either has power , or can advocate directly to those in power , and achieve change.*

ABOUT THE AUTHOR

My name is Ken Barnard. I do not hold any Mental Health qualifications, nor have I worked in or studied Mental Health in any form.

I was approached in 2011 to act as Consortium Chairperson for Headspace Campbelltown following my involvement of working with other members of local Rotary Clubs. We had formed a group of likeminded people to provide local forums on mental health after meeting Professor Gordon Parker from the Black Dog Institute.

I have continued in my membership in Rotary and served as President of the Ingleburn club twice. I have a special interest in assisting in the building of cyclone proof school classrooms on a remote island (EMAE Island, Sheffa Provence), in Vanuatu.

In 2011, I joined Beautiful Minds, a Macarthur Area Community Mental health group. This group established places such as Harmony House in Campbelltown and has raised hundreds of thousands of dollars working on renovations to Waratah House, Burunji, Brown Street, and a myriad of resources to those places including Gna Ka Lun. I served as Vice President for 8 years and stepped down in 2019 to advocate in the area of Suicide Prevention reform.

I have had an interest in community service for some time serving as Board Member at Myrtle Cottage, Ingleburn Zone Director for the Salvation Army Red Shield Appeal, member of the Macarthur Homeless Steering Committee (9 years) and the Real Estate Engagement Project (REEP), for 9 years . I am an advisor to the newly formed "Home Help" Family and Community Services funded homelessness prevention initiative.

In 2014, we lost our son Aaron to suicide, a great shock as we were quite unaware there was any problem.

In 2016, I was asked to join the "Our Experience Matters" group at SWSPHN Mental Health department. At the same time, I have been able to speak at one forum and to advocate at the invitation of Lifeline Smeaton Grange for placement of information signs at bridges in the Southern Highlands, to address means reduction.

In 2018, after recovering sufficiently to be able to work on community projects, I retired from the board of Myrtle Cottage and Chairperson the local Salvation Army Red Shield Appeal . The Macarthur Real Estate Engagement Project had gone I to hibernation (happily, it has been resurrected and I have an ongoing advisory role) This has allowed me to have a greater role in Mental Health community service.

In 2019, I joined the Macarthur Suicide Prevention Network, and embarked on a learning process of researching the myriad of documents that relate to Suicide Prevention and Mental Health in Australia. This process has allowed me to extract the relevant material in this report.

I now feel emotionally strong enough to consider a role in advocacy in that area.

DRAFT