Suicide Prevention Australia

Queensland Inquiry into social isolation and loneliness

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Suicide Prevention Australia

Recommendations

Whole of government approach	• Queensland Government to allocate responsibility for coordinating a whole-of-government state-wide strategy to address loneliness and social isolation to a senior Minister.
Financial distress	• Government to provide funding to expand Queensland Government Financial Literacy Program.
Reliable data	• Investment in data collection on social isolation at the community level. • Plan and deliver, in consultation with stakeholder organisations a bi-annual state-wide survey to capture the level of loneliness and social isolation experienced by Queensland residents. • QLD Treasury commission analysis on the economic impacts of loneliness.
Community-based programs and interventions	• Prevention strategies and programs should include targeted responses for at risk populations and age groups that are co-designed and culturally appropriate. • Deliver community-based programs and interventions in community spaces to address loneliness and social isolation (e.g. arts, community gardens, social cafes, community groups, phoneline services, sports, mentoring). Community-based peer-led organisations are well placed to target hard-to-reach at-risk priority populations. • Incorporate alternative measures (for example social prescribing) into Queensland primary healthcare and preventative health strategies, including funding to support the 'link worker' workforce.
Training & education	• To enable a community-wide approach to suicide prevention, deliver a staged approach to train all frontline workers in health and community sectors to identify and respond to people at risk of suicide, beginning with the mental health sector. • Undertake mapping exercise to identify existing community services, projects, and groups, to be able to provide support to strengthen local community driven efforts.

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Introduction

Suicide Prevention Australia welcomes the opportunity to contribute to this inquiry. We are the national peak body for the suicide prevention sector. We have over 300 members including the largest, and many of the smallest organisations working in suicide prevention. Suicide Prevention Australia supports and strengthens the services of our members, is an information channel connecting the sector and the voice of lived experience to government, as well as providing leadership, policy services, and research support to the suicide prevention sector.

The COVID-19 pandemic is a watershed event in the history of Australia and the world: challenging our public health systems and experts, and bringing unprecedented shifts in our global economy, society and how we live as families and individuals. Prior to the COVID-19 pandemic in Australia, 1 in 4 Australians report experiencing loneliness, and 1 in 10 aged 15 and over report lacking social support[1,2].

Response measures to the COVID-19 pandemic to protect community health have subsequently heightened risk factors for suicide such as social isolation, financial distress, and unemployment.

Leading up to the COVID-19 pandemic, Queensland experienced a series of natural disasters such as floods over 2010-2011, cyclone Yasi in 2011, and the devastating Townsville flood in 2019. The 2020 release of the Productivity Commission's Report into Mental Health brought to the forefront the impact of loneliness and social isolation on mental health and suicide[3].

Disasters and pandemics can have short and long term psychological impacts and make people vulnerable to suicide, now more than ever, Australia needs suicide prevention strategies and interventions to address risk factors that can lead to suicide.

The body of research outlined in this submission suggests a link between social isolation and loneliness and the tragic loss of life from suicide. Suicide is a complicated, multi-factorial human behaviour and more than an expression of mental ill-health. It has many and varied risk factors, but it is clear social isolation and loneliness are among them.

Conversely, addressing social isolation and loneliness, through building connections and relationships, also build protective factors that can reduce the risk of suicide. For this reason, Suicide Prevention Australia strongly supports work to address social isolation loneliness and the role effective action will play in delivering our ambition of a world without suicide.

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[1] Australian Psychological Society 2018. Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing. Melbourne: APS.
[2] Relationships Australia 2018. Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey. Canberra: Relationships Australia.
[3] Productivity Commission. 2020. Mental Health, Report no. 95, Canberra.

Structure

We have structured our responses according to the Terms of Reference as follows:

1. Nature and extent of the impact
2. Causes and drivers
3. Protective factors known to mitigate
4. Benefits of addressing social isolation and loneliness
5. Recommendations
6. Priorities for a state-wide strategy

1. Nature and extent of the impact

Social isolation and loneliness can have significant impacts and pose harms to both mental and physical health of Australians.[4] Research has shown social isolation to pose more significant health risk than 'smoking, poor diet and lack of exercise'[5], and loneliness has been found to increase the risk of premature death by approx. 30%[6]. The estimated prevalence of problematic levels of loneliness among Australians is around 5 million[7]. Loneliness has also been attributed to increasing the risk of health problems such as myocardial infarction and stroke[8], and increases the likelihood of experiencing depression by 15.2%[9].

International evidence demonstrates clear associations between loneliness, social isolation and suicidality. For example, a UK longitudinal study of the link between loneliness and suicide found for men living along and living with non-partners were associated with death by suicide[10]. For both men and women, loneliness was associated with hospital admissions for self-harm[11]. The study determined overall loneliness is an important risk factor for self-harm[12].

Another study addressing the addressing the association between loneliness and suicide in older adults in rural China found loneliness, hopelessness and depressive symptoms to be

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[4] AIHW. (2019). Social isolation and loneliness, *Australian Institute of Health and Welfare*, September 2019, available online: https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness.
[5] Ibid..
[6] Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T. & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A Meta-Analytic Review, *Association for Psychological Science, Sage Journals,* 10(2).
[7] Ending Loneliness Together. (2021). A National Strategy to Address Loneliness and Social Isolation, *R U OK, Australian Psychological Society,* available online: https://treasury.gov.au/sites/default/files/2021-05/171663_ending_loneliness_together.pdf.
[8] Hakulinen, C., Pulkki-Raback, L., Virtanen, M., Jokela, M., Kivimaki, M., & Elovainio, M. (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK biobank cohort study of 479 054 men and women, *Heart,* 104(18), 1536-1542.
[9] Abbott, J., Lim, M., Eres, R., Long, K. & Matthews R. (2018). The impact of loneliness on the health and wellbeing of Australians, *InPsych*, 40(6).
[10] Shawa, R.J., Cullena, B., Grahama, N., Lyalla, D.M., Mackaya, D., Okolieb, C., Pearsalla, R., Warda, J., Johnb, A. & Smitha, D.J. (2021). Living alone, loneliness and lack of emotional support as predictors of suicide and self-harm: A nine-year follow up of the UK Biobank cohort, *Journal of Affective Disorders,* 279 pg 316-323.
[11] Ibid.
[12] Ibid.

associated with death by suicide[13]. An elevated risk of suicide in older people in rural China was found among people who were unemployed, living alone, had less social support, experienced symptoms of depression, and showed higher levels of hopelessness and loneliness – highlighting the critical need for strategies and interventions to address social isolation and loneliness to be targeted to at-risk population and age demographics[14].

A longitudinal study of the Spanish general population (n=2,392) found feelings of loneliness to be related to suicide ideation among people aged 60 and over, and higher prevalence of suicide attempts in the previous 12 months compared to the younger and middle-aged participants [15].

In 2018, Queensland experienced suicide rates higher than the national average (16.3 deaths per 100,000 people compared to the national average of 12.6 deaths per 100,000)[16]. Queensland recorded 784 deaths by suicide in 2019[17]. The Queensland hospital system has experienced increases in service demand witnessing a 28% increase in people seeking care from an emergency department in April-June 2021 compared to the same period in 2020[18].

While we don't know the economic impact loneliness has on the Australian economy, in the US it is estimated that a lack of social connection among older adults can cost the government approx. $6.7 billion per year[19,20].

2. Causes and drivers

The COVID-19 pandemic has seen the introduction of physical distancing as a public health response measure. Social distancing includes self-isolating at home, curbing travel modes and opportunities, closure of non-essential business and schools and restrictions on social gatherings, such as funerals and weddings, to limit spreading the disease[21].

Specific groups such as older people, young people, women, people living with a mental illness, people with substance use issues, people experiencing homelessness, migrant workers, and people from culturally and linguistically diverse communities, can be

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[13] Niu, L., Jia, C., Ma, Z., Wang, G., Sun, B., Zhang, D. & Zhou, L. (2020). Loneliness, hopelessness and suicide in later life: a case– control psychological autopsy study in rural China, *Epidemiology and Psychiatric Sciences*, 29, e119, 1–7.
[14] Ibid.
[15] Bennardi, M., Caballero, F.F., Miret, M., Ayuso-Mateos, J.L., Haro, J.M., Lara, E., Arensman, E. & Cabello, M. (2019). Longitudinal Relationships Between Positive Affect, Loneliness, and Suicide Ideation: Age Specific Factors in a General Population, *Suicide and Life-Threatening Behaviour*, 49(1).
[16] Queensland Mental Health Commission. (2019). Every Life, The Queensland Suicide Prevention Plan 2019-2029, Phase One.
[17] Australian Bureau of Statistics. (2020). Causes of Death, Australia, available online: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release.
[18] The Queensland Cabinet and Ministerial Directory. (2021). Surges in Queensland public hospitals, Media release, *Queensland Government*, available online: https://statements.qld.gov.au/statements/92836.
[19] Flowers, L., Houser, A., Noel-Miller, C., Shaw, J., Bhattacharya, J., Schoemaker, L. & Farid, M. (2017). Medicare Spends More on Socially Isolated Older Adults, *AARP Public Policy Institute*, Insight on the Issues 125.
[20] Friends for Good. (2020). Submission to the Productivity Commission, Loneliness and Social Isolation, available online: https://www.pc.gov.au/__data/assets/pdf_file/0011/240221/sub115-mental-health.pdf.
[21] Douglas Margaret, Katikireddi Srinivasa Vittal, Taulbut Martin, McKee Martin, McCartney Gerry. Mitigating the wider health effects of covid-19 pandemic response BMJ 2020; 369 :m1557.

disproportionately impacted by social distancing measures as it exacerbates pre-existing feelings of loneliness and experiences of social isolation[22].

Links exist between social isolation and the experience of psychological harm[23]. For example, post-traumatic stress symptoms are heightened by extended periods of isolation, financial distress, and worry of contracting infection[24]. Heightened anxieties due to pandemic fears can intensify existing mental health problems[25].

Recent research into the psychological impacts of COVID-19 highlight the damaging impacts of social isolation and loneliness on mental health and wellbeing[26]. The authors stated, "a major adverse consequence of the COVID-19 pandemic is likely to be increased social isolation and loneliness, which are strongly associated with anxiety, depression, self-harm and suicide attempts across the lifespan[27]."

In June 2020 Suicide Prevention Australia and Wesley Mission released a joint white paper on reducing distress in the community following the COVID-19 pandemic. The report outlines existing evidence of the link between major events such as COVID-19 and suicidality, and insights gained through interviews with Wesley Mission's specialist services.

Operators from Wesley Mission's Mental Health and Resilience program informed during interviews that loneliness and isolation among older people is being exacerbated by the COVID-19 response. As older people are less likely to have access to social media or possess digital literacy, their access to social connection can be severely limited.

The Wesley Retirement Living villages Residents' Wellbeing Prospective Research Survey received a response rate of 82 per cent of the random sample of 265 residents[28]. 44.44% of Wesley Mission survey respondents felt mental health and wellbeing in their community has been negatively impacted, while one-third believed there has been a strong negative impact. Respondents stated that this is a difficult time for individuals with existing mental health illness, and mental health issues such anxiety and depression can stem from social isolation.

The negative impact of COVID-19 on isolating individuals within their own communities and from family interstate and abroad, has resulted in a surge of increase to crisis service access[29].

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[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Druss BG. Addressing the COVID-19 Pandemic in Populations With Serious Mental Illness. JAMA Psychiatry. Published online April 03, 2020. doi:10.1001/jamapsychiatry.2020.0894.
[26] Holmes, Emily & O'Connor, Rory & Perry, V & Tracey, Irene & Wessely, Simon & Arseneault, Louise & Ballard, Clive & Christensen, Helen & Silver, Roxane & Everall, Ian & Ford, Tamsin & John, Ann & Kabir, Thomas & King, Kate & Madan, Ira & Michie, Susan & Przybylski, Andrew & Shafran, Roz & Sweeney, Angela & Bullmore, Ed. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 10.1016/S2215-0366(20)30168-1.
[27] Ibid.
[28] Sussman, T., Hall, N. & Hanna, A. M. (2020). Suicide prevention: Collaborating with older people in independent living units, *Wesley Mission, Western Sydney University*.
[29] Lifeline. (2021). More Australians than ever seeking crisis support, Media Release, available online: https://www.lifeline.org.au/resources/news-and-media-releases/media-releases/.

This has taken place at the same time as evolving technology continues to affect the way people and communities interact with one another in an increasingly digital world.

3. Protective factors known to mitigate

An evidence check conducted by the Sax Institute found for Australian adults, mental wellbeing protective factors include "employment, physical activity, strong social relationships and networks, diet and alcohol reduction, and green space"[30]. Among young Australian adults, protective factors include "physical activity and strong social relationships"[31]. For teenagers and children, protective factors include "positive family functioning, supportive communities, social support and physical activity"[32].

It is important that interventions and programs aimed at reducing loneliness and social isolation should be evidence-based, target age demographics, and target strengthening protective factors, building self-worth, foster positive emotions, and enable engagement with activities particularly in social community environments to build social connection[33].

A person's social support networks can play a critical role in the level of loneliness or social isolation experienced. Social support networks can include biological family, chosen family, friends, carers, colleagues, and neighbours. Social support networks are not measured by the quantity of relationships, but rather the quality. For example, a person may have a smaller social support network but feel more supported than someone who has a larger network. Strong supportive relationships and quality contact with others can act as a protective factor for loneliness, and challenging relationships can increase experiences of loneliness[34,35,36]. People without families have been found to experience higher rates of loneliness[37,38].

Evidence that suggests marriage may act as a protective factor exists as a survey undertaken by the APS and Swinburne University of 1678 Australian adults about their wellbeing, found Australians who were married were the least lonely in comparison to people who were single, separated, or divorced[39].

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[30] Sax Institute. (2020). Mental wellbeing risk & protective factors, Evidence Check, available online: https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/General/VicHealth-Attachment-1---Evidence-review-of-risk--protective-factors.pdf?la=en&hash=4CFF1B8DDED1E3CE257289448655A136AB5B4C16.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] National Academies of Sciences, Engineering, and Medicine. (2020). Social isolation and loneliness in older adults, opportunities for the health care system, *National Academies Press (US)*, Washington.
[35] Chatters, L. M., Taylor, H. O., Nicklett, E. J. & Taylor, R. J. (2018). Correlates of objective social isolation from family and friends among older adults, *Healthcare*, 6(1).
[36] Teater, B., Chonody, J. & Davis, N. (2020). Risk and Protective Factors of Loneliness among Older Adults: The Significance of Social Isolation and Quality and Type of Contact, *Social Work in Public Health*, 36(2).
[37] Ibid.
[38] Verdery, A. M. & Margolis, R. (2017). Projections of white and black older adults without living kin in the United States, 2015 to 2060, *Proceedings of the National Academy of Sciences*, 114(42).
[39] Ibid.

4. Benefits of addressing social isolation and loneliness

Australia has a number of existing programs and interventions aimed at reducing loneliness and social isolation of Australians.

Groups 4 Health (G4H) is an evidence-based intervention developed by the University of Queensland which targets psychological distress resulting from loneliness and social isolation[40]. By providing people with knowledge and skills to increase social connectedness and group-based social interactions, the program has yielded positive results with 60-69% of participants demonstrating improvement in depression, social anxiety, and loneliness post program completion[41]. Program participation has further been associated with reducing visits to General Practitioners[42] – which evidence has suggested social isolation and loneliness can be contributing factors to increased visits to GPs[43]. The program is now run annually in Australia and internationally (UK, Germany and Switzerland)[44] and as a result is reducing health expenditure.

Ending Loneliness Together is a national network of organisations who work together to address the problem of loneliness experienced among Australians[45]. They aim to bring together government and community to prioritise connection and belonging to reduce loneliness by half by 2030 in Australia[46]. Ending Loneliness Together delivers series of tailored seminars, workshops and programs to address loneliness.

Friends for Good provide a national phoneline service 'FriendLine' available for anyone aged 18 and over who needs to connect and is located in 5 jurisdictions across Australia (VIC, NSW, SA, QLD and WA). The service is staffed by volunteers and is aimed at reducing loneliness and building social connections among Australians by providing someone to talk to and referring people to community organisations, social groups and clubs[47]. Friends For Good report many callers feel a sense of human connection when using the service because they are not healthcare professionals, and fills a gap where people want to 'get to know' who they are talking to on the line – an option not afforded when receiving professional help[48].

Successful Ageing for Growth & Enjoyment (SAGE) is a year-long community-based psychoeducation program targeted to positive ageing in Australia. An evaluation of the program found almost half of participants reported positive changes to their cognitions or behaviours[49].

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[40] UQ. (2021). A social cure for better health, *University of Queensland,* available online: https://stories.uq.edu.au/research/impact/2020/a-social-cure-for-better-health/index.html.
[41] Ibid.
[42] Ibid.
[43] Cruwys, T. & Dingle, G. (2018). Why do lonely people visit the GP more often?, *Relationships Australia*, available online: https://relationships.org.au/news/blog/why-do-lonely-people-visit-the-gp-more-often.
[44] Ibid.
[45] Ending Loneliness Together. (2021). About Us,, available online: https://endingloneliness.com.au/about-us/.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Thompson, C. L., Calafiore, D., Chochovski, J., Trawley, S. & Von Truer, K. (2021). An evaluation of a community-based psychoeducation program for successful ageing, *BOM Geriatrics,* 3(2).

More recently in June 2021, UnitingCare Lifeline Queensland have begun a pilot program to combat loneliness referred to as PRALA (Phoenix Rising's Alleviating Loneliness Adventure). PRALA has been developed in partnership with people who have a lived experience of loneliness. delivered by Lifeline counsellors and is an outbound call service where people are referred to them from their Seniors Inquiry Line. The Project involves a weekly minimum hour-long call with a counsellor or more if needed. The Project aim is to provide regular, consistent conversations with people who are isolated of lonely and to form connections with them.

The expectation of the service is that once a strong connection is formed, people will be more likely to access other services and supports. A key feature of the program is that it is time unlimited – the calls continue weekly for as long as the person wishes with the same counsellor each week. The model has been co-designed with lived experience and is grounded in trauma-informed practice and attachment theory. As the Project is new, evaluation at this stage is not available. We include this Project in our submission as a case study and recommend Government monitor the trial and evaluation and consider funding an expanded program subject to success of pilot.

As retirement is a major life event, an Australian study examined the experience of transition to retirement and connection to social groups in relation to quality of life and mortality over a period of 6 years[50]. The study found among retirees who had two group memberships prior to retirement they had a 2% risk of death in the first 6 years of retirement if they maintained these social connections, compared to a 12% risk of death if they lost connection to both groups in the first 6 years[51]. It was determined that the impact of social group memberships on mortality was comparable to the impact of physical exercise[52].

International evidence evaluating interventions aimed at reducing loneliness and social isolation is strong, however is commonly targeted to older people leaving gaps in knowledge around other priority population groups who may be particularly impacted by the COVID-19 pandemic such as young people. There is a need for further research to better understand the impact and depth of loneliness and social isolation experienced among Australians across the lifespan.

Evaluation of a peer-based intervention to reduce loneliness, social isolation, and improve psychosocial wellbeing among older Chinese immigrants in Canada found a significant decrease in loneliness and increase in resilience among participants compared to the control group[53].

Evidence demonstrates that interventions and programs to reduce loneliness and social isolation can result in improved health and wellbeing overall.

Alternative approaches

Alternative and innovative approaches to addressing loneliness are emerging overseas. For example, 'social prescribing', which involves the process of healthcare providers referring people in the community to existing community-based non-clinical supports. These supports

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[50] Steffens, N. K., Cruwys, T., Haslam, C., Jetten, J. & Haslam, S. A. (2015). Social group memberships in retirement are associated with reduced risk of premature death: evidence from a longitudinal cohort study, *BMJ Open,*

[51] Ibid.

[52] Ibid.

[53] Lai, D. W. L., Li, J., Ou, X. & Li, C. Y. P. (2020). Effectiveness of a peer-based intervention on loneliness and social isolation of older Chinese immigrants in Canada: a randomized controlled trial, *BMC Geriatrics,* 20 (356).

may include social support services, volunteering opportunities, arts activities, community gardens, or community groups. Research estimates that there is approx. 20% of people who consult their GP for social issues[54].

Social prescribing was incorporated into the UK Government's strategy to address loneliness in 2018 along with commitment and investment for 'link workers' who enable support to individuals with psychosocial solutions[55]. International evidence of social prescribing reports 74% of physicians in Germany and 65% in the UK reported connecting patients with social services or other community-based supports[56]. In Australia, our first pilot program for social prescribing targeting individuals living with mental illness was delivered over 2016/2017. Evaluation of the pilot program found participants experienced improved self-perceived quality of life, loneliness, social participation and economic participation among others[57]. Another example of social prescribing in Australia is the National Disability Insurance Scheme (NDIS) which links people to community supports to build social connections.

Wesley LifeForce Suicide Prevention Networks program is a national community-led network of people and organisations working together in local settings[58]. The program offers support and resources to communities, workshops, and delivers activities for prevention, intervention and postvention[59]. Evaluation of the program found clear evidence of positive internal impacts for Network members as well as some indication of positive community outcomes. Network activities resulted in perceived increases in community knowledge and awareness of, as well as stronger linkages between, local support services; and increased community confidence and capacity to assist those at risk of suicide.

Museums have been utilised in the UK as places to address community health and wellbeing[60]. The Bristol Museum and Art Gallery 'Art Shed' started in 2016 and involves prescribed art courses that take place in community wellbeing centres and surgeries. Course participants have a diagnosed mental health issue, most commonly depression or anxiety[61]. A case study of course participants reported improved confidence and sense of self-worth, with many appreciating the safe welcoming space provided by the activity[62]. Other case studies of Museums in the UK who provide health and wellbeing community-based activities have

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[54] Torjesen, I. (2016). Social prescribing could help alleviate pressure on GPs, *BMJ*, 352.
[55] Royal Australian College of General Practitioners & Consumers Health Forum of Australia. (2019) Social prescribing roundtable November 2019, Report, available online: https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Social-prescribing-report-and-recommendation.pdf.
[56] Ibid.
[57] Aggar, C., Thomas, T., Gordon, C., Bloomfield, J. & Baker, J. (2021). Social prescribing for individuals living with mental illness in an Australian Community Setting: A pilot study, *Journal of Community Mental Health*, 57(1).
[58] Wesley LifeForce. (2021). Wesley LifeForce Suicide Prevention Networks, evaluation summary, *Wesley LifeForce, Centre for Mental Health, The University of Melbourne*.
[59] Ibid.
[60] Dodd, J. & Jones, C. (2014). Mind. Body, spirit: How museums impact health and wellbeing, *Research Centre for Museums and Galleries (RCMG), School of Museum Studies, University of Leicester*.
[61] National Alliance for Museums, Health & Wellbeing. (2016). Case Study: Bristol Museum and Art Gallery – Art Shed.
[62] Ibid.

reported participants experienced significant increases in positive emotions after the programs[63].

We agree with the insights found in a roundtable on social prescribing by the Royal Australian College of General Practitioners & Consumers Health Forum of Australia that social prescribing has a range of benefits which include improvements to factors such as health, economic, social and productivity, resulting in improvements in overall health and wellbeing[64].

5. Recommendations

Research informs us that loneliness and social isolation are key risk factors for suicide and are associated with suicidal outcomes[65,66,67]. Suicide is a complicated, multi-factorial human behaviour and is more than an expression of mental ill health. As noted in the Interim Report of the National Suicide Prevention Advisor: "no single government portfolio can undertake the breadth of actions that are required to reduce suicides, reduce suicide attempts and respond effectively to distress"[68].

Preventing suicide therefore requires a holistic, cross-governmental approach that effectively coordinates funding and policy attention to address the social, economic, health, occupational, cultural, and environmental factors involved. This would include efforts across agencies to address social isolation and loneliness, and as a result, intervene early to address the risk of suicide for some individuals.

Whole of government approach

In 2018 the UK appointed Tracey Crouch, the world's first Minister for Loneliness supported by launching a cross-government strategy to address loneliness to respond to evidence that up to a fifth of UK adults feel lonely most or all of the time[69]. The Strategy includes reforms aimed to equip all GPs in England to refer patients experiencing loneliness to community activities and voluntary services by 2023, and the Government has invested £1.8m to increase and transform community spaces (e.g. new cafes, art spaces or gardens)[70]. The Minister overseas implementation of this strategy as well as awareness raising activities and a Local Connections Fund.

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[63] Ibid.
[64] Ibid.
[65] Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olie, E., Carvalho, A. F. & Courtet, P. (2019). Suicidal thoughts and behaviours and social isolation: A narrative review of the literature, *Journal of Affective Disorders*.
[66] U.S. Department of Veterans Affairs. (2019). Loneliness – A risk factor for suicide, *U.S. Department of Veterans Affairs, Veterans Health Administration*.
[67] McClelland, H., Evans, J. E., Nowland, R., Ferguson, E. & O'Connor, R. (2020). Loneliness as a predictor of suicidal ideation and behaviour: a systematic review and meta-analysis of prospective studies, *Journal of Affective Disorders*, 274.
[68] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention in Australia.
[69] UK Government. (2018). PM launches Government's first loneliness strategy, Media Release, available online: https://www.gov.uk/government/news/pm-launches-governments-first-loneliness-strategy.
[70] Ibid.

Recently, Japan has followed suite appointing its first Minister for Loneliness in 2021. Strong international evidence shows that a whole-of-government approach is essential to driving reform, coordinated action and a reduction in the suicide rate[71]. A whole-of-government approach aligns with Queensland's Suicide Prevention Plan[72].

Queensland is showing strong leadership in establishing a Parliamentary Inquiry into Social Isolation and Loneliness. There is an opportunity for Queensland to become a national leader in this area with the allocation of specific ministerial responsibility for loneliness. The Queensland Government could be a national first-mover and leader in this area and seek future discussion at the National Cabinet level about State, Territory and Commonwealth priorities to address social isolation and loneliness.

Recommendation: Queensland Government to allocate responsibility for coordinating a whole-of-government state-wide strategy to address loneliness and social isolation to a senior Minister.

Financial Distress

The COVID-19 pandemic is a unique health crisis and one that has touched the lives of thousands directly affected by the virus, as well as their loved ones. The impact of COVID-19 extends to all members of our community, many of whom are at risk of losing their businesses, their jobs, their livelihoods and – perhaps for the first time – are struggling with their wellbeing.

The Australian Bureau of Statistics (ABS) reported 45% of Australians aged 18 years and over have been financially impacted by COVID-19 over the period mid-March to mid-April 2020, and 31% of household finances have worsened[73]. The ABS further identified changes in mental health and wellbeing throughout COVID-19, in comparison to data from 2017-2018 National Health Survey, reporting almost twice as many Australians experienced anxiety during physical distancing measures[74].

The impacts of the COVID-19 pandemic have proven to be wide-reaching, with the effects on the Australian economy growing increasingly apparent. The number of Australians receiving main unemployment welfare support payments (JobSeeker & Youth Allowance) for the period December 2019 to May 2020 grew from approx. 820,000 to 1,640,000[75]. A significant increase among people estimated to be of working age receiving these payments was further witnessed[76].

In 2020 after a 3 month lockdown due to COVID-19, Queensland experienced a spike in gambling with almost $300 million put into gaming machines in a single month (31.5% increase

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[71] World Health Organisation. (2018). *National suicide prevention strategies Progress, examples and indicators*, Geneva, accessed online at <https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf>. See World Health Organisation recommendations 18 and 19.
[72] Ibid.
[73] Australian Bureau of Statistics. (2020). 4940.0 – Household impacts of COVID-19 Survey, 14-17 Apr 2020, *Australian Bureau of Statistics*, Canberra.
[74] Ibid.
[75] Klapdor, M. & Giuliano, C. (2020). The impact of COVID-19 on JobSeeker payment recipient numbers by electorate, *Parliament of Australia*, available online: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2021/COVID-19JobSeekerRecipientNumbersElectorate.
[76] Ibid.

on July 2019)[77]. This pattern has continued with the last 12 months witnessing $2.8 billion lost in Queensland's poker machines marking the biggest loss in a financial year since 2004[78].

There is evidence of a link between problem gambling and higher rates of loneliness.[79] Studies have also shown that gambling at venues is a way some individual may seek to alleviate their feelings of isolation.[80] While existing evidence between gambling and suicide is not comprehensive, we do know that gambling leads to financial distress, unemployment, and relationship breakdown: all established risk factors for distress and, sadly, suicide.

The 2015 HILDA Survey found that of the 6.8 million regular gamblers (39% of Australian adults) who lost an estimated $8.6 billion, people experiencing gambling-related problems accounted for almost half (42% or $3.63b) of the total expenditure that year[81].

Key risk factors for suicide such as financial distress and unemployment were found to be overrepresented sociodemographic characteristics among people who experience problems with their gambling i.e. had low incomes, unemployed, and live in low socioeconomic areas[82].

Protective factors for suicide such as social support and connectedness in stable relationships, physical health, and employment[83] are compromised by the financial harms associated with problem gambling (e.g. bankruptcy, inability to afford life essentials such as food, either losing or selling off assets to cover gambling debts or continue gambling, and job loss)[84] leaving people vulnerable to risk factors of suicide.

Research has further found almost 1 in 5 people presenting with suicidality also experience problems with their gambling[85].

The Queensland Government financial literacy program provides assistance to people who require knowledge, support, financial counselling, and education to manage financial distress. It's critical that the program continue to grow in line with increased financial distress and

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[77] Ruddick, B. (2021). Problem gambling spirals across Queensland after COVID lockdowns lift and poker machines turned back on, *ABC News*, available online: https://www.abc.net.au/news/2021-07-28/qld-covid-pokie-problem-gambling-spike/100324776.
[78] Ibid.
[79] Castrén, S, Basnet, S, Salonen, AH, Pankakoski, M, Ronkainen, JE, Alho, H & Lahti, T 2013, 'Factors associated with disordered gambling in Finland', Substance abuse treatment, prevention, and policy, vol. 8, no. 1, pp. 1–10
[80] Thomas, AC, Allen, FC & Phillips, J 2009, 'Electronic gaming machine gambling: measuring motivation', Journal of Gambling Studies, vol. 25, no. 3, pp. 343–55
[81] Armstrong, A., & Carroll, M. (2017). *Gambling activity in Australia: Findings from wave 15 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey*. Australian Government, Australian Institute of Family Studies, Australian Gambling Research Centre.
[82] Ibid.
[83] Life in Mind. (2020). Risk and protective factors for suicide, *Everymind*, available at: https://lifeinmind.org.au/about-suicide/suicide-across-the-lifespan/risk-and-protective-factors.
[84] Browne, M., Rockloff, M., Hing, N., Russell, A., Murray Boyle, C. & Rawat, V. (2019). NSW Gambling Survey 2019, *NSW Government, NSW Responsible Gambling Fund,* available at: https://www.responsiblegambling.nsw.gov.au/__data/assets/pdf_file/0007/280537/NSW-Gambling-Survey-2019-report-FINAL-AMENDED-Mar-2020.pdf.
[85] De Castella, A., Bolding, P., Lee, A., Cosic, S., & Kulkarni, J. (2011). *Problem gambling in people presenting to a public mental health service: Final report.* Melbourne: State Government of Victoria, Monash University.

gambling in Queensland and the risk of related social isolation. Improved financial literacy across the population has the potential to simultaneously address social isolation related to problem gambling and any consequential risk factors for suicide that result.

Recommendation: Government to provide funding to expand Queensland Government Financial Literacy Program.

Reliable data

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. This includes accurately recording suicide and suicidal behaviour; and linking data on agreed risk factors for suicidal behaviour, including social isolation and loneliness.[86]

It is estimated that for every death by suicide, there are 20 suicide attempts[87]. Access to consistent and accurate data enables Government and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions. We know that loneliness is linked to risk of suicide, yet we have limited Australian data on loneliness and social isolation.

We need quality, robust data on loneliness and social isolation to better understand who is at risk and how best to support a more connected community in Queensland. Additional data collected should be linked to Queensland's Suicide Deaths Register. Community-based organisations are bets placed to undertake community-level research of hard-to-reach populations due to existing on the ground local level community connections but require additional Government support to do so.

Recommendation: Investment in data collection on social isolation at the community level.

Recommendation: Plan and deliver, in consultation with stakeholder organisations a bi-annual state-wide survey to capture the level of loneliness and social isolation experienced by Queensland residents.

Recommendation: QLD Treasury commission analysis on the economic impacts of loneliness.

Community-based programs and interventions

Evidence presented in this submission demonstrates the necessity for interventions and community-based supports to reducing loneliness and social isolation, with many yielding positive results among participants. Community-based programs and interventions should be co-designed with target populations, be appropriately targeted to age demographics given protective factors can differ among age groups and be integrated into communities and existing

[86] Productivity Commission. (2019). Draft Report of the Productivity Commission Inquiry into the Mental Health System, available at <https://www.pc.gov.au/inquiries/completed/mental-health#report>.
[87] World Health Organisation. (2014). Preventing suicide: a global imperative, *Word Health Organisation*, Geneva.

programs. Many neighbourhood and community centres are often first responders to distress in the community and provide critical place-based infrastructure.

As part of a whole-of-government approach the following are recommended.

Recommendation: Prevention strategies and programs should include targeted responses for at risk populations and age groups that are co-designed and culturally appropriate.

Recommendation: Deliver community-based programs and interventions in community spaces to address loneliness and social isolation (e.g. arts, community gardens, social cafes, community groups, phoneline services, sports, mentoring). Community-based peer-led organisations are well placed to target hard-to-reach at-risk priority populations.

Recommendation: Incorporate alternative measures (for example social prescribing) into Queensland primary healthcare and preventative health strategies, including funding to support the 'link worker' workforce.

Training & education

The Australian Psychological Society reports approx. 1 in 4 Australians are experiencing an episode of loneliness, and 1 in 2 report they feel lonely for at least 1 day each week[88].

The negative impact of COVID-19 on isolating individuals within their own communities, while suicide rates have remained stable in the near-term as a result of additional protective and financial supports, crisis service access has increased[89] and there's evidence from disasters in Queensland (Cyclone Yasi)[90] and other countries[91] that the long-term impact of disasters may not be felt for several years. This means we must put in place systems and supports in the community now to intervene early.

Due to COVID-19, people providing face-to-face services are facing clients and customers in crisis. To adapt to the continually changing COVID-19 response measures all workers both in and outside of health need to be equipped with the knowledge and skills to identify people at risk and refer them onto appropriate support services. By equipping key touchpoints and gatekeepers in the community with the capacity to identify risk factors for suicide and to guide individuals towards appropriate supports, we can reduce suicide.

Recommendation: To enable a community-wide approach to suicide prevention, deliver a staged approach to train all frontline workers in health and community sectors to

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[88] Australian Psychological Society. (2018). Australian loneliness report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing, *APS,* Melbourne.
[89] Ibid.
[90] Woods, C., West, C., Buettner, P. & Usher, K. (2014). "Out of our control": Living through Cyclone Yasi, *International Journal of Qualitative Studies in Health and Wellbeing*.
[91] Beaglehole, B., Mulder, R.T., Boden, J. M. & Bell, C. J. (2019). A systematic review of the psychological impacts of Canterbury earthquakes on mental health, *Australian and New Zealand Journal of Public Health*.

identify and respond to people at risk of suicide, beginning with the mental health sector.

Recommendation: Undertake mapping exercise to identify existing community services, projects, and groups, to be able to provide support to strengthen local community driven efforts.

6. Priorities for a state-wide strategy

Targeted support for vulnerable groups

Our submission has highlighted the evidence behind targeting interventions to at-risk populations in reducing loneliness and isolation. The following section provides background to the suicide rates among at-risk populations which we believe a state-wide strategy should include actions to address. It is important the development and delivery of a state-wide strategy be informed by those with lived experience of social isolation and loneliness, in particular among these priority cohorts.

Males

Male suicide is an issue requiring targeted policy and funding attention. More than three-quarters of intentional self-harm deaths occur in males. Australia requires a concerted effort to address the underlying issues that might lead men to the point of crisis. Many men who are at risk of suicide or who take their own lives have no experience with mental ill health. We need to strategically identify opportunities to intervene with men who may be vulnerable to suicide, but not interacting with the formal mental health or suicide prevention systems. A whole-of-government approach to male suicide prevention is required to improve the coordination of services. Cross-agency collaboration is vital to reach men at risk both before, during and after a suicidal crisis.

In addition, support services are not always accessible and appropriate due to the fact that some males may not engage in help-seeking behaviour. Of concern, 72% of males do not seek help if they are experiencing issues with mental ill-health.[92] Research involving analysis of data from men in the Australian Longitudinal Study on Male Health has highlighted the potential connection between masculine behaviour norms, in particular self-reliance, and a reluctance to actively seek help particularly within a clinical setting.[93] However, tailoring and targeting clinical and non-clinical interventions may increase men's service uptake and the effectiveness of treatments.[94]

Aboriginal and Torres Strait Islanders

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[92] Seidler, Z.E., Dawes, A.J., Rice, S.M., Oliffe, J.L. & Dhillon, H.M. (2016). The role of masculinity in men's help seeking for depression: a systematic review, *Clinical Psychology Review,* 106-118.
[93] Pirkis, J., Spittal, M.J., Keogh, L., Mousaferiadis, T. & Currier, D. (2016) Masculinity and suicidal thinking, *Soc Psychiatry Psychiatric Epidemiol,* Vol 52, pp. 319–327.
[94] Ibid.

Given the extremely high rates of suicide in Aboriginal and Torres Strait Islander communities we recommend funding for Aboriginal and Torres Strait Islander- specific interventions, especially specialist programs and services tailored to remote and regional Aboriginal and Torres Strait Islander communities, as the majority of Aboriginal people (63%) live outside major urban areas.

In line with the National Suicide Prevention Adviser's view that Aboriginal and Torres Strait Islander Controlled Health Organisations are the best placed organisations to become preferred suicide prevention providers to their own communities, these interventions should be run by community-controlled organisations. This recognises the rights of Aboriginal and Torres Strait Islander peoples to self-determination; their rights as health consumers to access culturally safe and competent services, and continuity of care.

Involving Aboriginal and Torres Strait Islander elders in service and program design can enhance effectiveness[95].

Older people

Australian data on suicide deaths in 2018 reported males aged 85 and over accounted for 2.7% of total male deaths by suicide in 2018, (the highest age-specific rate of suicide at 32.9 per 100,000), and females aged 80-84 was 9.0 per 100,000[96]. Older people were further found to have other existing chronic health conditions at time of death, for example 11.5% of suicides in Australians over 85 had cancer[97].

Research undertaken by Relationships Australia found 19% of Australians aged 75 and over experience loneliness[98]. The COVID-19 pandemic is likely to have exacerbated loneliness among older Australians due to physical distancing measures, difficulties in adapting to technology resulting in social isolation (e.g. not going places to avoid using QR codes, difficulty connecting online with family and friends), fear and anxiety of contracting COVID-19 due to higher level risk of fatality from the disease, and avoid accessing necessary healthcare due to online modes of service delivery.

Young people

Suicide is the leading cause of death among young Australians[99] and requires targeted youth specific interventions, policy and program design that is appropriately funded to prevent youth from reaching crisis[100].

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[95] Warr, D., Cox, J. & Redshaw, S. (2020). A review of associations between social isolation, loneliness and poor mental health among five population groups, Evidence Summary, *PHN Murrumbidgee, Three Rivers UDRH, Charles Sturt University*.
[96] AIHW. (2020). Suicide and intentional self-harm, Snapshot, *Australian Institute of Health and Welfare*, available online: https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm.
[97] Ibid.
[98] Relationships Australia. (2018). Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey, available online: https://www.relationships.org.au/what-we-do/research/an-epidemic-of-loneliness-2001-2017.
[99] Australian Bureau of Statistics. (2018). *3303.0 - Causes of Death, Australia, 2017*, available online at <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.
[100] Relationships Australia. (2017). July 2017: Youth Suicide, available online at < https://www.relationships.org.au/what-we-do/research/online-survey/july-2017-youth-suicide>.

The Australian Bureau of Statistics (ABS) reports young people aged 15-24 years accounted for over one-third of deaths (38.4%) in 2018[101]. For Aboriginal and Torres Strait Islander youth, significantly higher rates of suicide are experienced compared to non-Indigenous youth[102,103]. High rates of suicide are further experienced by young people who are LGBTIQ, or who live in rural or remote areas.[104] Research reports approximately 100-200 suicide attempts for every one suicide occur among young people[105,106].

Research estimating lifetime prevalence of mental illness determined emergence by the age of 14 years, and 3 fourths by age 24[107]. The Mission Australia Youth Survey of Australians aged 15-19 years over the period 2012-2016 identifies a significant increase in young people who meet the criteria for probable serious mental illness from 18.7% in 2012 to 22.8% in 2016[108]. High rates of mental disorders within the previous 12 months among young people aged 16 to 24 are also evidenced within the ABS 2007 National Survey of Mental Health and Wellbeing[109].

By implementing early intervention and prevention programs we can build resilience early in life to enhance coping mechanisms when faced with adversity in later life, foster positive mental health and wellbeing and most importantly, prevent our youth from reaching crisis.

People from Culturally and Linguistically Diverse (CALD) Backgrounds

Australians from CALD backgrounds generally demonstrate reduced and variable rates of access to mental health services, despite potentially having higher needs due to migration stressors. The lower utilisation of mental health services are likely due to high stigma and poor understanding of mental health illnesses, language barriers, lack of health information, lack of understanding of appropriate healthcare pathways, Medicare ineligibility, healthcare costs, normalisation of distress, under-diagnosis, or mis-diagnosis.

We recommend funding the co-design of culturally appropriate mental health services and suicide prevention programs and initiatives addressing social isolation, which would be jointly implemented by CALD community organisations to address stigma and increase utilisation of mental health and suicide prevention services in CALD communities.

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[101] Ibid.
[102] Department of Health. (2013). Aboriginal and Torres Strait Islander suicide: origins, trends and incidence, available online at <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-ab>.
[103] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R. & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, *Arch Gen Psychiatry*, 62(7).
[104] Robinson, J., Bailey, E., Browne, V., Cox, G. & Hooper, C. (2016). Raising the bar for youth suicide prevention, *Orygen, The National Centre of Excellence in Youth Mental Health,* Melbourne.
[105] Beyond Blue. (2020). Suicide, available online at < https://healthyfamilies.beyondblue.org.au/age-13/mental-health-conditions-in-young-people/suicide>.
[106] Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, editors. (2002). Reducing suicide: a national imperative. *Washington, DC: National Academy Press.*
[107] Ibid.
[108] Mission Australia & Black Dog Institute. (2017). Youth mental health report: Youth survey 2012-2016, available online at <https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/2017-youth-mental-health-report_mission-australia-and-black-dog-institute.pdf?sfvrsn=6>.
[109] Australian Bureau of Statistics. (2008). 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007, available online at < https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features32007?OpenDocument>.

People from Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) Communities

People from LGBTQI communities have higher rates of mental ill-health and suicide than the general population in Australia. In particular, LGBTQI young people aged 16 to 27 are five times more likely to attempt suicide in their lifetime, transgender people aged 18 and over nearly eleven times more likely, and people with a variation in sex characteristics (sometimes known as intersex) aged 16 and over are nearly six times more likely.[110]

Recent research into the mental health and wellbeing of LGBTQI Australians demonstrated we are not seeing parallel improvements in LGBTQI mental health. 41.9% of study participants reported considering attempting suicide in the previous 12 months, 74.8% had considered attempting suicide at some point in their lives, 5.2% reported having attempted suicide in the past 12 months, and 30.3% had attempted suicide at some point in their lives.[111]

The evidence shows the elevated risk of suicidality experienced by LGBTQI people links strongly with their continuing experience of discrimination and exclusion, and the subsequent trauma from these experiences.[112] We also know that LGBTQI people are less likely to access help when in crisis. Research undertaken by La Trobe University found 75.3% of LGBTQI participants did not use a crisis support service during a recent personal or mental health crisis.[113]

Invest in a Peer Workforce

Wherever possible, dedicated peer worker roles should be established in suicide prevention (distinct from the mental health lived experience workforce). Peer workers should also be available to families and carers who are either supporting someone experiencing suicidality or are bereaved by suicide. We support the recommendations made in the National Suicide Prevention Advisor's Interim Report to build the lived experience and peer workforce to help break down stigma and provide person-centred supports[114].

This rationale should extend to future services addressing social isolation and loneliness and supports consideration of incorporating lived experience in both program design and delivery.

We believe there is an opportunity for Government to fund industry-based peer support initiatives targeted toward workers in occupations with the highest rates of suicide. Workers in the construction industry have, for example, benefited from the peer-led, industry-based

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[110] National LGBTI Health Alliance, (2020). Snapshot Of Mental Health And Suicide Prevention Statistics For LGBTI People, accessed online at <https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/240/attachments/original/1595492235/2020-Snapshot_mental_health_%281%29.pdf?1595492235>.

[111] O. Hill, A., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, *Melbourne: LaTrobe University*, accessed online at <https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf>.

[112] Eckstrand, K.L. & Potter, J. (2017). Trauma, resilience, and health promotion in LGBT patients: What every healthcare provider should know, *Springer*.

[113] Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis, Bundoora, VIC & Canberra, ACT: *Australian Research Centre in Sex, Health & Society, La Trobe University & Lifeline Australia*.

[114] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention in Australia.

MATES in Construction program: the delivery of which coincided with a 10 percent reduction in the suicide rate for construction workers in Queensland[115].

This program involves training construction workers to notice behaviour changes or signs in conversations with their colleagues that might indicate they needed help; and then pointing them in the direction of support services such as psychologists and social workers. Drawing from the MATES in Construction model, industry-based, peer support initiatives for other high-risk occupations would involve providing regular connection and assertive support via mechanisms tailored to the industry involved. For a geographically dispersed sector, for example, this could involve online technology.

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. The most common form of suicide postvention support is peer support groups and receiving support from others bereaved by suicide[116]. There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[117] Postvention supports also mitigate adverse impacts including the risk of a bereaved person engaging in suicidal behaviour. People who are bereaved by suicide are themselves at elevated risk of suicide, particularly if they have a history of prior trauma, suicidal behaviour or depression.[118]

Quantifying and properly training the suicide prevention workforce will provide our society with the means to assist in the lives of people even before they reach crisis point. Peer workers with lived experience of suicide should be equipped to work in close partnership with clinicians and the 'formal' suicide prevention workforce.

Recommendation: Ensure that state-wide strategy and planning to address social isolation and loneliness includes a focus on integrating peer workers.

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[115] Doran, C., Ling, R., Gullestrup, J., Swannell, S. & Milner, A. (2015). The impact of a suicide prevention strategy on reducing the economic cost of suicide in the New South Wales construction industry, *Crisis*, 37, available online: https://doi.org/10.1027/0227-5910/a000362.
[116] Harrington-LaMorie, J., Jordan, J.R., Ruocco, K. & Cerel, J. (2018). Surviving families of military suicide loss: Exploring postvention peer support, *Death studies*, 42(1):1-12.
[117] Bartone, P., Bartone, J.V., Violanti, J.M. & Gileno, Z.M. (2017). Peer Support Services for Bereaved Survivors: A Systematic Review, *Journal of Death and Dying*, 80(4).
[118] Andriessen, K., Krysinska, K., Hill, N.T.M., Reifels, L., Robinson, J., Reavley, N. & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes, *BMC Psychiatry*, 19(49).