Suicide Prevention Australia

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

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Introduction

Suicide Prevention Australia is the peak body for the suicide prevention sector in Australia. Suicide is complex, multifactorial human behaviour and is not simply an expression of mental ill-health. There are many, varied risk factors including those related to physical or mental health, financial and job insecurity, social isolation, and relationship breakdown.

Only half of those whose lives are lost to suicide in Australia each year are accessing mental health services at the time[1] and around half of those who die by suicide each year have a diagnosed mental health condition.[2] Many individuals who attempt or die by suicide may not have a mental health condition and most individuals who have a mental health condition may never experience suicide ideation or a suicide attempt.

Suicide prevention and mental health systems, services and policies are distinct but interrelated. There are unique issues facing both sectors yet also shared priorities around workforce, lived experience and awareness. There is also an overlap between many researchers, government agencies and service providers.

Given the interconnection between these two issues, policy reform offers mutually beneficial outcomes for both mental health and suicide prevention. As the national peak body for suicide prevention, we strongly advocate the Committee to consider the shared and distinct challenges, opportunities, and priorities for suicide prevention in Queensland. Consistent with your terms of reference, it is appropriate there are clear recommendations in respect of both mental health and suicide prevention reform.

This submission will address the following areas of the terms of reference:

a) the economic and societal impact of mental illness in Queensland
b) the current needs of and impacts on the mental health service system in Queensland
c) opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health
d) the experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers
e) the mental health needs of people at greater risk of poor mental health
g) service safety and quality, workforce improvement and digital capability
h) mental health funding models in Australia

Together, we can achieve a world without suicide.

[1] National Suicide Prevention Adviser. (2020). Final Advice, *Australian Government*, available online: https://www.health.gov.au/resources/publications/national-suicide-prevention-adviser-final-advice.
[2] Centres for Disease Control and Prevention. (2018). Suicide rising across the US, available online: https://www.cdc.gov/vitalsigns/suicide/index.html.

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Summary of recommendations

Recommendation: Expand and appropriately resource specialist mental health clinicians in both police districts and within ambulance call out teams across all Hospital and Health Services (HHS) in Queensland to ensure equity, build prevention capability, and aligned with Queensland Suicide Prevention Plan action for a state-wide co-responder model linking Queensland Police Service, Queensland Ambulance Service and Queensland Health.

Recommendation: Enhance and strengthen follow up procedures for people discharged into the community after a mental health and/or suicidality related presentation to ensure vulnerable Queenslanders are connected and engaged with community-based supports in line with Action Area 3 in Queensland's Suicide Prevention Plan.

Recommendation: Strengthen the mental health and suicide prevention workforces by not only increasing availability of staff, but ensuring appropriate infrastructure is in place to enable integration of both clinical and non-clinical workforces to enhance continuity of care between professionals and treating teams.

Recommendation: The Queensland Government to expand Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking to ensure equity across Hospital and Health Services (HSS) with priority focus on creating Safe Spaces in regional and rural areas where services are limited. Establishing Safe Spaces is identified in Action Area 3 in Queensland's Suicide Prevention Plan.

Recommendation: The network of Safe Spaces includes different tiers of services to support individuals at different times and with different needs.

Recommendation: Strengthen investment in support services to treat people living with an eating disorder and their carers, and ensure treatment and support services are available in every HHS.

Recommendation: The Queensland Parliament should pass a *Suicide Prevention Act.*

Recommendation: Where COVID-19 protective supports, including housing, financial and welfare assistance are being withdrawn, they should be transitioned out in a careful, staged way. This will ensure communities are supported in the medium-term when suicide rates are at risk of increasing.

Recommendation: Increase long term funding for key disaster recovery supports such as crisis helpline services and community case-workers post-disaster to support community recovery.

Recommendation: Implement a state-wide trial of the social prescription model.

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), and adopt all recommendations

made by the Community Support and Services Committee's Report[3] on the Queensland Inquiry into social isolation and loneliness

Recommendation: Deliver a Stigma Reduction Strategy that actively targets the stigma and discrimination directed towards people with mental illness, and that builds upon Queensland's Suicide Prevention Strategy and Queensland's Mental Health, Alcohol and Other Drugs Strategic Plan. The Strategy should be targeted and measurable.

Recommendation: Queensland Government should fully and meaningfully integrate lived experience knowledge, insights, and leadership in all aspects of suicide prevention. In alignment with Queensland's Suicide Prevention Plan.

Recommendation: Queensland Government should fund supporting structures to grow and sustain the lived experience workforce, including the peer workforce and integrating the newly established Mental Health Lived Experience Peak Queensland and organisations representing those with lived experience of suicide to drive policy development across the State.

Recommendation: Invest in targeted population and age specific suicide prevention supports and programs for people at greater risk of poor mental health and suicide.

Recommendation: Queensland Government to invest in Aboriginal-led and culturally appropriate models ensuring the access to culturally appropriate healing models in mental health and suicide prevention services.

Recommendation: Embed accreditation into the commissioning process for suicide prevention programs in Queensland to ensure Government funds are allocated towards safe, quality and effective programs.

Recommendation: To support efforts to build capacity on responding to suicide risk, Government should fund the development of industry-specific competency frameworks in high-risk sectors.

Recommendation: Increase supports available to frontline healthcare workers at risk of psychological harm from the impact of working through the COVID-19 pandemic.

Recommendation: Adopt the Western Australian Exemption law against mandatory reporting to remove barriers to help-seeking and treatment among clinicians with mental health concerns.

Recommendation: Increase funding cycles for PHN & NGO mental health and suicide prevention to 5 year contracts which includes strengthening outcome reporting requirements for continuous service evaluation.

Recommendation: Queensland Government to appoint a Minister for Suicide Prevention to lead an all of government approach to suicide prevention across the State as an extension to *Every Life: The Queensland Suicide Prevention Plan 2019-2029.*

[3] Parliament Community Support and Services Committee. (2021). Inquiry into social isolation and loneliness in Queensland, Report No. 14, 57th Parliament, available online: https://documents.parliament.qld.gov.au/TableOffice/TabledPapers/2021/5721T2070.pdf.

Suicide Prevention Australia

A) The economic and societal impact of mental illness in Queensland

The Productivity Commission estimates the cost of mental ill-health and suicide to the Australian economy is approx. $200 to $220 billion per year.[4] This figure includes quantifiable economic costs of approx. $43 to $70 billion per year.[5] The cost of lost productivity due to lower employment, absenteeism and presenteeism was estimated from $12 to $39 billion.[6] The cost of diminished health and reduced life expectancy was estimated at $150.8 billion per year.[7]

Specific to Queensland, per capita expenditure on specialized mental health services is $241 per person, which is lower than the national average of $257 per person during 2018-19.[8] Queensland further has the lowest average spending across jurisdictions for public sector specialized mental health hospital services during 2018-19 at $1080 per patient day.[9]

In 2017-18 more than one in five (23%) Queenslanders reported a long term mental or behavioural problem, this figure has more than doubled since 2001.[10] In 2020, 759 Queenslanders died by suicide.[11] For the period 2019-20, mental health-related presentations to public Australian emergency departments (ED) made up 3.8% of all presentations.[12] In Queensland, 4.1% of ED presentations in public hospitals were mental health-related.[13]

The National Hospital Cost Data Collection reports for the period 2018-19 in Queensland, the average cost per ED presentation is $728 per person, and the average cost of admitted ED presentation in Queensland as $1067 per person.[14] Nationally, the cost of mental health care patient activity on the Australian hospital system for the period 2018-19 was $3.23 billion.[15] This figure includes both admitted mental health and community mental health care. The Royal Australian and New Zealand College of

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[4] King, Stephen. (2021). A brief overview of the Mental Health Inquiry Report, Speech, available online: https://www.pc.gov.au/news-media/speeches/mental-health.
[5] Productivity Commission. (2021). Mental Health, Report no. 95, Canberra.
[6] Ibid.
[7] Ibid.
[8] AIHW. (2021). Mental health services in Australia, *Australian Institute of Health and Welfare,* available online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services.
[9] Ibid.
[10] Queensland Health. (2020). The health of Queenslanders, Report of the Chief Health Officer Queensland, available online: https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1011286/cho-report-2020-full.pdf.
[11] 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#intentional-self-harm-deaths-suicide-in-australia.
[12] Ibid.
[13] Ibid.
[14] NHCDC. (2021). Round 23 National Hospital Cost Data Collection, *IHPA,* available online: https://www.ihpa.gov.au/sites/default/files/publications/round_23_nhcdc_infographics_overview.pdf
[15] Ibid.

Psychiatrists (RANZCP) Queensland Branch report Queensland is Australia's lowest funded jurisdiction per capita for mental health care, and that the State has experienced a 90% increase in emergency department presentations.[16]

We commissioned a YouGov poll of over 1000 Australians to understand broader community perspectives on suicide prevention. Respondents identified social isolation and loneliness plus unemployment and job security as the key factors driving distress over the next 12 months, particularly amongst women.[17] Of key concern, one in four Australians surveyed reported to know someone who died by or attempted suicide in the past 12 months.[18] Research has found on average between 5 family members and 135 individuals may be impacted when a single suicide occurs.[19,20,21]

Research has demonstrated that people bereaved or impacted by suicide are at an increased risk for suicide.[22,23] Between 15 and 25% of people who make a non-fatal attempt at suicide will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[24] The relative risk for suicide after attempted suicide is between 20 to 40 times higher than in the general population,[25] and the most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'. [26]

A meta-analysis of exposure to suicide found 1 in 5 people have been impacted by suicide in their lifetime, and 1 in 20 in the past year.[27] Bereavement by suicide has been evidenced as a risk factor for

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[16] The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Queensland Branch. (2021). Psychiatrists welcome timely terms of reference for Queensland inquiry, Media Release.
[17] Suicide Prevention Australia. (2021). State of the Nation in Suicide Prevention, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2021/09/State-of-the-Nation-in-Suicide-Prevention-2021-report.pdf.
[18] Suicide Prevention Australia. (2021). One in four Australians touched by suicide, available online: https://www.suicidepreventionaust.org/one-in-four-australians-touched-by-suicide/.
[19] Andriessen, K., Krysinska, K., Kolves, K. & Reavley, N. (2019). Suicide postvention services: an Evidence Check rapid review brokered by the Sax Institute, *NSW Ministry of Health, Sax Institute.* Retrieved from https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Postvention-Report.pdf.
[20] National Suicide Prevention Taskforce. (2020). Interim Advice Report: Towards a national whole-of-government approach to suicide prevention in Australia. Canberra.
[21] Cerel, J., Brown, M.M, Maple, M., Singlton, M., Van De Venne, J., Moore, M. & Flaherty, C. (2019). How many people are exposed to suicide? Not six, *The American Association of Suicidology,* 49(2).
[22] Jordan, J.R. (2017). Postvention is prevention – The case for suicide postvention, *Death Studies,* 41:10.
[23] Pitman, A.L., Osborn, D.P.J, Rantell, K. & King, M.B. (2016). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults, *BMJ Open*, 6.
[24] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf.
[25] Sax Institute. (2019). Suicide aftercare services, Evidence Check, available online: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf.
[26] AIHW. (2021). Psychosocial risk factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide.
[27] Andriessen, K., Rahman, B., Draper, B. & Dudley, M. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies, *Journal of Psychiatric Research*, 88.

subsequent suicide, regardless of whether the relationship to the person who died by suicide is a blood-relative or not.[28]

A UK study of over 7,000 people bereaved by suicide found that 82% of participants reported a major or moderate impact on their lives, including relationship breakdown, unemployment, and financial distress – all of which are key risk factors for suicide.[29]

B) The current needs of and impacts on the mental health service system in Queensland

Strengthen systems to better capture at risk people in the community

1. Recommendation: Expand and appropriately resource specialist mental health clinicians in both police districts and within ambulance call out teams across all Hospital and Health Services (HHS) in Queensland to ensure equity, build prevention capability, and align with Queensland Suicide Prevention Plan action for a state-wide co-responder model linking Queensland Police Service, Queensland Ambulance Service and Queensland Health.

2. Recommendation: Enhance and strengthen follow up procedures for people discharged into the community after a mental health and/or suicidality related presentation to ensure vulnerable Queenslanders are connected and engaged with community-based supports.

3. Recommendation: Strengthen the mental health and suicide prevention workforces by not only increasing availability of staff, but ensuring appropriate infrastructure is in place to enable integration of both clinical and non-clinical workforces to enhance continuity of care between professionals and treating teams.

Suicide is complicated, multi-factorial human behaviour with many varied and complex risk factors. As noted by 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".

759 Queenslanders died by suicide in 2020.[30] On average, there were 209 suicide related calls to Queensland Police Service or the Queensland Ambulance Service every day for the period 2014-17, and 96% of individuals who had a suicide related contact with police or paramedics had contact with an ED.[31] 36% of people who died by suicide and had prior suicide-related contact with police or paramedics

[28] Pitman, A.L., Osborn, D.P.J, Rantell, K. & King, M.B. (2016). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults, *BMJ Open*, 6.
[29] McDonnell, S., Hunt, I.M., Flynn, S., Smith, S., McGale, B. & Shaw, J. (2020). From grief to hope, *The University of Manchester*. Retrieved from https://suicidebereavementuk.com/wp-content/uploads/2020/11/From-Grief-to-Hope-Report.pdf.
[30] Ibid.
[31] Queensland Forensic Mental Health Service, Metro North Hospital and Health Service, & Queensland Centre for Mental Health Research. (2020). Partners in Prevention: Understanding and Enhancing First Responses to Suicide

had been alive in the month following their contact with police or paramedics[32], indicating significant risk for suicide re-attempt and death.

The Productivity Commission reports 15-25% of people who attempt suicide will re-attempt.[33] Following discharge from hospital after an attempt, the person is at elevated risk for re-attempt within the first three months.[34] People with mental illness are ten times more likely to arrive to ED by police or correctional services, and nearly twice as likely to arrive by ambulance.[35] People with mental illness are further overrepresented among people waiting in ED for an inpatient bed, and even more so among those who are held up from leaving ED due to unavailability of beds.[36]

In August 2020, NSW provided $6.1M to employ 36 specialist mental health clinicians across 10 Police Area Commands and Districts to expand the Police Ambulance and Clinical Early Response (PACER) pilot program.[37] The trial outcomes included avoidance of ED presentations, early links to community and welfare services, provision of alternative pathways to care, significant reduction in demand on agencies including Police time on scene, and reductions in ED presentations via Police and Ambulance.[38] PACER teams have also recently been introduced in Southern Tasmania.

The Mental Health, Ambulance and Police Project (MHAPP) is another example in NSW where specialist mental health clinicians are provided during peak periods to work with ambulance and police services to support people experiencing a mental health crisis.[39] Support can be provided via phone or on-site. Program benefits include early access to specialist mental health assessment in the community, reduced exposure to EDs, and more timely access to services and support.

Queensland already provides specialist mental health clinicians based in police districts and ambulance call out teams in some Hospital and Health Services (HHS) locations. For example, a pilot program based in the Gold Coast reported the Mental Health Co-Responder Team prevented two thirds of potential ED presentations, with only 22% of call outs requiring transport to hospital EDs.[40] This program requires state-wide roll-out. The Queensland Government must ensure specialist mental health clinicians are based in police and ambulance services across every HHS area so that every Queenslander receives the appropriate support required.

Crisis Situations – Summary Report, *Queensland Health,* Brisbane, available online: https://qcmhr.org/wp-content/uploads/2021/01/PiP_Summary_online.pdf.

[32] Ibid.

[33] Ibid.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] NSW Health. (2020). Groundbreaking first responder and mental health collaboration boosted by $6 million investment, Media Release, available online: https://www.health.nsw.gov.au/news/Pages/20200610_01.aspx.

[38] NSW Health. (2029). PACER – Police, Ambulance, Clinical, Early, Response, Media Release, available online: https://www.health.nsw.gov.au/innovation/2019awards/Pages/pacer.aspx.

[39] NSW Health. (2020). Mental Health, Ambulance and Police Project (MHAPP) Fact Sheet, available online: https://www.coordinare.org.au/assets/MHAPP-fact-sheet.pdf.

[40] Gold Coast Health. (2018). Joint police and mental health program extended, Media Release, available online: https://www.goldcoast.health.qld.gov.au/about-us/news/joint-police-and-mental-health-program-extended.

Our Queensland members report a significant lack of staffing in the mental health and suicide prevention workforces. Reporting many Queenslanders in crisis are suffering due to long wait times to access necessary supports. It is critical that not only are more mental health workers available to keep up with surges in demand on the system, but that Queensland Government ensures appropriate infrastructure is in place to enable integration of both clinical and non-clinical workforces to enhance continuity of care between professionals and treating teams.

All deaths by suicide are preventable. It is critical to build prevention capability within key community touchpoints for entering the Queensland health service system to ensure vulnerable people are identified and connected with appropriate support. A person-centred approach that recognises EDs are not best suited for people at risk of suicide is required, and alternatives to EDs (such as Safe Spaces and connecting people with community-based supports) should be available.

Safe Spaces

4. Recommendation: The Queensland Government to expand Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking to ensure equity across Hospital and Health Services (HSS) with priority focus on creating Safe Spaces in regional and rural areas where services are limited.

5. Recommendation: The network of Safe Spaces includes different tiers of services to support individuals at different times and with different needs.

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environment are not the most appropriate point of care for people experience emotional distress and people with lived experience report distress can be exacerbated by this setting.[41]

Safe Spaces aim to provide an alternative and are an umbrella term referring to non-clinical, peer-led supports for people in suicidal distress and/or crisis. They are also known in some areas as safe havens or safe haven 'cafes'. Safe spaces are 'drop in' style spaces that offer a non-clinical alternative to acute, clinical services for people experiencing emotional distress or suicidal crisis. Safe spaces provide warm, welcoming environments in which to reduce distress and are staffed by suicide prevention peer workers with their own lived experience of crisis who can connect with others through the mutual understanding that comes with meaningful shared experience.They also connect guests of the service with other community supports including clinical support according to the guests wishes.

The original concept was trialed as the Safe Haven Café in 2014 in Aldershot, United Kingdom. Individuals experiencing a mental health problem were able to visit the centre and converse with

[41] Roses in the Ocean. (2021). A National Safe Spaces Network, Discussion Paper, available online: https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf.

mental health professionals and peer workers. An evaluation found a 33% reduction in the number of admissions to acute in-patient psychiatric beds within the Safe Haven's catchment areas.[42]

Safe Spaces have recently emerged in Australia, including a $10.8 million commitment in the Queensland Budget to establish eight safe spaces. Roses in the Ocean have been a leader in supporting the co-design of these spaces in Queensland and extensively throughout NSW. There are also Safe Spaces being delivered in other jurisdictions across Australia. This model is being adopted given the unsuitability of emergency department for people experiencing suicidal thinking as well as the opportunity for a peer-led alternative drive better individual, economic and community outcomes.

It is important to note there are different types of Safe Spaces that operate in different ways and support individuals at different times and with different needs. Roses in the Ocean proposed an extension of a tiered approach trialed by Wesley Mission Queensland which consisted of a three tier model for mental health Safe Safes. The extended model include additional tiers focused on suicide prevention:[43]

> Tier 5 – a non-clinical peer run resident safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience
>
> Tier 4 – a non-clinical peer run safe alternative to emergency departments with a suicide prevention focus, staffed by suicide prevention peers with lived experience
>
> Tier 3 – a Safe Space to access psychosocial support and safety planning primarily existing mental health services enhanced with peer workers
>
> Tier 2 – a Safe Space to talk to someone and access a referral (e.g. community centres/services/chemist) in settings that are already operation with staff who are trained to identify risks and connect people to supports
>
> Tier 1 – a safe 'refuge' to sit in (e.g. library, coffee shop, hairdresser, barber) that are community based non-clinical supports

There is a particular need for investment in Tier 4 and Tier 5 Safe Spaces that have high-fidelity to the concept and to the lived experience co-design process. The key components of this model are:[44]

- A trauma-informed 'no wrong' door approach
- Non-clinical support that meets the holistic needs of guests
- A compassionate and capable peer-led workforce
- A safe and accessible location

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[42] National Health Service UK. (2016). Case study: Safe Haven Café in Aldershot, available online: https://www.england.nhs.uk/mental-health/case-studies/aldershot/.
[43] Ibid.
[44] https://rosesintheocean.com.au/a-national-safe-spaces-network/

- A warm welcoming environment
- Warm connections to other appropriate and reliable supports
- Shared governance and management

The Queensland Government should expand Safe Spaces as alternatives to Emergency Departments for individuals experiencing suicidal thinking to ensure equity across Hospital and Health Services (HSS) with priority focus on creating Safe Spaces in regional and rural areas where services are limited. Phase 2 of the National safe Spaces Network proposal provided to the Commonwealth Government in 2018 by Roses in the Ocean as lead of a consortium of sector organisation, has been funded in the federal Budget 2021 – this phase will develop a set of national standards for the national Safe Spaces Network. This should ensure existing Safe Spaces under development are genuinely aligned to the Safe Space concept and have fidelity to the co-design process. It should also include the delivery of new Tier 4 and Tier 5 Safe Spaces that are non-clinical, peer-led alternatives with a suicide prevention focus.

Eating Disorders

6. Recommendation: Strengthen investment in support services to treat people living with an eating disorder and their carers, and ensure treatment and support services are available in every HHS.

The COVID-19 pandemic has heightened many risk factors for suicide for many Australians. In particular, the number of people being treated for eating disorders across the public health system increased from 25% to 50%.[45,46] The Butterfly Foundation report suicide is 31 times more likely for people with an eating disorder.[47] Concerningly, of the 4 in 100 people in Australia living with an eating disorder – only approximately 5-15% of those receive treatment.[48] Data from 2019 reports increases in children in Queensland being referred to services for eating disorders, with some children as young as seven years of age.[49] Evidence estimates 80% of people with a diagnosed eating disorder have at least

[45] Elwyn, R. (2021). Addressing the Eating Disorder Crisis in Australia: Areas of Risk and Avenues for Support Pre- and Post-Pandemic.
[46] Edwards, J. (2021). As COVID lockdowns roll on, eating disorders are surging and wait times are blowing out, available online: https://www.abc.net.au/news/2021-08-31/eating-disorders-regional-teens-covid-19-pandemic-/100417812.
[47] Butterfly Foundation. (2017). Suicide up to 31 times more likely for people with an eating disorder, Media Release, available online: https://butterfly.org.au/news/suicide-up-to-31-times-more-likely-for-people-with-an-eating-disorder/.
[48] Butterfly Foundation. (2021). Community Insights Research, available online: https://butterfly.org.au/wp-content/uploads/2021/11/Butterfly-Foundation_Community-Insights-Report_January-2021_FINAL.pdf#msdynttrid=15IVthcE1ytJRQoTne_m5afmtVIU7ys6Z0hroohlafk.
[49] Children's Health Queensland Hospital and Health Service. (2019). Growing numbers of young Queenslanders seeking help for eating disorders, Media Release, available online: https://www.childrens.health.qld.gov.au/media-release-growing-numbers-of-young-queenslanders-seeking-help-for-eating-disorders/#:~:text=Between%205%20and%2020%20per,suicide%2C%E2%80%9D%20Dr%20Catania%20said.

one more psychiatric disorder (e.g. mood disorders, anxiety disorders, PTSD, substance misuse, non-suicidal self-injury).[50,51]

In order to respond to the increasing rates of people experiencing eating disorders and service demand, the Queensland Government must strengthen investment in support services to treat people living with an eating disorder and their carers, and ensure treatment and support services are available in every HHS.

Suicide Prevention Act

7. Recommendation: The Queensland Parliament should pass a *Suicide Prevention Act.*

46% of Queenslanders had at least one contact with an ED or public mental health service where suicidality was identified.[52] Half of those whose lives are lost to suicide each year are not interacting with mental health services at the time. Accordingly, a whole-of-government approach to suicide prevention is key to turning the trend towards zero suicides in Queensland. 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.

Suicide Prevention Acts have proven successful overseas in legislating whole-of-government prevention priorities. An Act is necessary to ensure decision-makers across Government are united in working to prevent suicides. Legislation can ensure clear shared and individual accountability and focus agencies on practical and measurable steps to reduce and prevent suicide.

In Japan, the 2006 Basic Act for Suicide Prevention set priorities for cross-government, whole-of-community suicide prevention. Between 2008-2011, hospital admissions almost halved and from 2009 suicide deaths declined dramatically and hit a 15 year low in 2012. Recent findings show the Act facilitated suicide prevention by supporting networking among relevant stakeholders and led to a comprehensive, multi-sector approach addressing the varied social factors contributing to suicide. Acts have also now emerged in Canada, South Korea and Argentina.

In November 2021, South Australia became the first Australian jurisdiction to pass a *Suicide Prevention Act.* The content of the legislation included a co-design process in drafting – placing lived experience in policy development at the core of the Act. The legislation will:

- Enshrine state-wide objectives to reduce suicide including promoting best practice suicide prevention, providing training and education and supporting priority population groups

[50] National Eating Disorders Collaboration. (2021). Eating disorders in Australia, available online: https://nedc.com.au/eating-disorders/eating-disorders-explained/the-facts/eating-disorders-in-australia/.
[51] Udo, T. & Grilo, CM. (2019). Psychiatric and medical correlates of DSM-5 eating disorders in a nationally representative sample of adults in the United States, *International Journal of Eating Disorders,* 52(1):42-50.
[52] Ibid.

- Legislate a Suicide Prevention Council comprised of senior public sector officials, Members of Parliament and suicide prevention leaders in the community including lived experience across a number of priority cohorts
- Require a State Suicide Prevention Plan including performance indicators, annual reporting, specific measures for priority populations and to progress the objectives of the Act
- Require every State authority to have regard to the State Suicide Prevention Plan
- Require prescribed state authorities to have suicide prevention action plans which set out how the authority will prevent suicide by employees and members of the community

We recommend implementing suicide prevention legislation which is co-designed with people with lived experience and models the SA Suicide Prevention Act. Commitment to develop a Suicide Prevention Act in Queensland can augment broader mental health and suicide prevention reforms in the State. It can enshrine the Government's commitment to suicide prevention and ensure all agencies are focused on opportunities to prevent suicide right across the community.

Social determinants matter

8. Recommendation: Where COVID-19 protective supports, including housing, financial and welfare assistance are being withdrawn, they should be transitioned out in a careful, staged way. This will ensure communities are supported in the medium-term when suicide rates are at risk of increasing.

9. Recommendation: Increase long term funding for key disaster recovery supports such as crisis helpline services and community case-workers post-disaster to support community recovery.

The social determinants of health and wellbeing, including social, economic and physical environments, play a critical role in suicide rates. Addressing the social determinants is key to meaningful reductions in suicide rates. This includes early life, whole-of-person opportunities across Queensland Government responsibilities ranging from early childhood development, education and child protection through to key areas family and domestic violence, alcohol and other drugs and housing.

A whole-of-government focus on the social determinants is critical at this time. While to date, suicide rates in Queensland during the pandemic have been contained, disasters such as pandemics have physical, social and emotional impacts on people and communities who experience them, and last for extended periods of time.[53] The link between suicide in the aftermath of disasters is highly evidenced.[54] Research based in on US data found rates of suicide to increase during the first 3 years post-disaster[55],

[53] World Health Organisation. (2016). Psychological First Aid For All: Supporting People in the Aftermath of Crisis Events, available online: https://www.who.int/mental_health/world-mental-health-day/ppt.pdf.
[54] Jafari, H., Heidari, M., Heidari, S. & Sayfouri, N. (2020). Risk factors for suicidal behaviours after natural disasters: A systematic review, *The Malaysian Journal of Medicine*, 27(3).
[55] Cartier, K. M. S. (2021), Suicide rates may rise after natural disasters, Eos, 102, https://doi.org/10.1029/2021EO153699.

and another study found increases in suicide rates were seen 2 years post-disaster.[56] Evidence is also found of increases in rates of post-traumatic stress disorder and depression following a disaster.[57]

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 impacts of disasters are long-lasting and vary depending on the type and nature of the disaster.

The World Health Organisation notes that emergency situations such as natural disasters and other humanitarian crises exacerbate the risk of mental health condition, with one in five likely to have a mental disorder such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia. These risks are heightened in older people and marginalised groups.

Research also shows that serious mental illness, suicidal ideation and making plans for suicide increases as a result of natural disasters.[58] Queensland has over 350,000 cases of COVID-19 placing additional stress on health systems and crisis support workers resulting in delays for vulnerable people seeking support. The average calls to Lifeline have increased by 40% in 2 years[59], increases in calls to Beyond Blue by 42% nationally, and 8% increase in Queensland during 2020 compared to 2019.[60]

There is evidence that mental illness and suicide rates increase over time after a disaster, with suicide rates reaching the highest level up to two years after the initial disaster.[61] Recent events have demonstrated the need for resources to be available to respond, in real time, to multiple and compounding disasters.

C) Opportunities to improve economic and societal participation of people with mental illness

Improve social participation

10. Recommendation: Implement a state-wide trial of the social prescription model.

[56] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, *Journal of Crisis Intervention and Suicide Prevention,* 42(5).
[57] Beaglehole, B., Mulder, R.T., Frampton, C.M., Boden, J.M., Newton-Howes, G. & Bell, C.J. (2018). Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis, *Cambridge University Press.*
[58] Kessler, R. C., Galea, S., Gruber, M. J., Sampson, N. A., Ursano, R. J., & Wessely, S. (2008). Trends in mental illness and suicidality after Hurricane Katrina. Molecular psychiatry, 13(4), 374–384.
[59] Lifeline Australia. (2021). Australians reaching out for help in record numbers, Media release.
[60] O'Flaherty, A. & Levingston, R. (2021). Mental health need increases amid long waitlists for professional help, sharp rise in emergency presentations, available online: https://www.abc.net.au/news/2021-03-17/waitlist-for-mental-health-appointments-amid-sharp-rise-in-need/13253612.
[61] Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, The Journal of Crisis Intervention and Suicide Prevention.

11. 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), and adopt all recommendations made by the Community Support and Services Committee's Report[62] on the Queensland Inquiry into social isolation and loneliness.

12. Recommendation: Deliver a Stigma Reduction Strategy that actively targets the stigma and discrimination directed towards people with mental illness, and that builds upon Queensland's Suicide Prevention Strategy and Queensland's Mental Health, Alcohol and Other Drugs Strategic Plan. The Strategy should be targeted and measurable.

Social isolation and loneliness can have significant impacts and pose harms to both mental and physical health of Australians.[63] 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.[64] Loneliness is highlighted as a modifiable risk factor for suicide by the Royal Australian & New Zealand College of Psychiatrists.[65]

The estimated prevalence of problematic levels of loneliness among Australians is around 5 million.[66] Loneliness has also been attributed to increasing the risk of health problems such as myocardial infarction and stroke[67], and increases the likelihood of experiencing depression by 15.2%[68], and links exist between social isolation and the experience of psychological harm.[69]

Stigma and discrimination are harmful to mental health and can occur against people with mental illness, and high rates of people with mental ill health withdraw themselves from public spaces due to stigma and discrimination.[70,71] Mental illness is further associated with lower involvement in the labour

[62] Parliament Community Support and Services Committee. (2021). Inquiry into social isolation and loneliness in Queensland, Report No. 14, 57th Parliament, available online: https://documents.parliament.qld.gov.au/TableOffice/TabledPapers/2021/5721T2070.pdf.
[63] 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.
[64] 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.
[65] RANZCP. (2020). Suicide prevention – the role of psychiatry, *The Royal Australian & New Zealand College of Psychiatrists,* Position Statement 101.
[66] 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.
[67] 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.
[68] 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).
[69] Ibid.
[70] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report.
[71] SANE Australia. (2020). National Stigma Report Card, available online: https://nationalstigmareportcard.com.au/.

force and greater discrimination, both of which are risk factors for suicide.[72,73] It is crucial that active efforts should be made to reduce the stigma surrounding mental ill health and loneliness. Targeted stigma reduction efforts are required should be progressed complementary to any national stigma reduction efforts.

1 in 10 Australians aged 15 and over report lacking social support.[74,75] Among older Australians, rates of emotional loneliness are estimated to be 19% among those aged 75 and over.[76] During COVID-19 lockdown, staying connected to others was reported most difficult for Aboriginal and Torres Strait Islander Victorians (51%) and young Victorians aged 18-24 (39%).[77] 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.

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 alone and living with non-partners were associated with death by suicide.[78] For both men and women, loneliness was associated with hospital admissions for self-harm.[79] The study determined overall loneliness is an important risk factor for self-harm.[80]

Research from Indonesia during the COVID-19 pandemic showed that 98% of participants reported loneliness, and loneliness intensity were significantly and positively correlated with self-harm and suicide ideation intensity.[81] More than one third (39.3%) of participants reported self-harm and suicide ideation during the pandemic, a relationship that was higher in vulnerable groups, including participants with a disability (64.5%), those with HIV positive status (62.8%), and LGBTIQ+ people (56.8%).[82] Similarly, a study on loneliness, mental health, and social health indicators in LGBTIQ+

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[72] ABS. (2020). General Social Survey: Summary Results, Australia, available online: https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2020.
[73] Ibid.
[74] 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.
[75] 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.
[76] Ibid. & 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.
[77] VicHealth. (2020). VicHealth Coronavirus Victorian Wellbeing Impact Study, Victorian Health Promotion Foundation, available online: https://www.vichealth.vic.gov.au/-/media/ResearchandEvidence/VicHealthResearchFellows_2011/20200914_VicHealthVictorian_Coronavirus_Wellbeing_Impact_Study_Report.pdf?la=en&hash=27CB25E7BAAB7D673A81ED5CF46C5E75FB98B288.
[78] 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.
[79] Ibid.
[80] Ibid.
[81] Liem, A., Prawira, B., Magdalena, S., Siandita, M. J., & Hudiyana, J. (2021). Predicting self-harm and suicide ideation during the COVID-19 pandemic in Indonesia: A brief report of nationwide survey, available online: https://psyarxiv.com/f3c8w/download?format=pdf.
[82] Ibid.

Australians during the pandemic found that LGBTIQ+ Australians are at greater risk of loneliness and social isolation, highlighting the potential for heightened suicide risk for vulnerable groups that already have disproportional rates of suicide. [83]

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 programs. Lived experience expertise should be included in all levels of community-based programs (i.e. design, delivery, and evaluation).

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 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.[84]

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.[85] In Australia, the first pilot program for social prescribing targeting individuals living with mental illness was delivered over 2016/2017. Evaluation found participants experienced improved self-perceived quality of life, loneliness, social participation and economic participation among others.[86]

The Community Support and Services Committee (Committee) report to Queensland Parliament on the Inquiry into social isolation and loneliness in Queensland recommended the Queensland Government implement a state-wide trial of the social prescription model (Rec. 7). The Victorian Royal Commission into mental health also recommended in the final report (Rec. 15) to implement a social prescribing trial in each region in Victoria by the end of 2022. [87]

We further support the Committee recommendation for Queensland Government to 'advocate to city councils of major centres to ensure adequate provision of green space, parks, toilet access, infrastructure and planning, access to transport and meeting places such as libraries, and social infrastructure, to promote mitigating factors that alleviate social isolation and loneliness' (Rec. 10).[88] Queensland's Suicide Prevention Plan: Every Life identifies action (19) 'the Office of the Queensland Government Architect, where appropriate, will highlight the importance of lethal means mitigation

[83] Eres, R., Postolovski, N., Thielking, M., & Lim, M. H. (2021). Loneliness, mental health, and social health indicators in LGBTQIA+ Australians, *American Journal of Orthopsychiatry*, 91(3), 358–366. https://doi.org/10.1037/ort0000531.
[84] Torjesen, I. (2016). Social prescribing could help alleviate pressure on GPs, *BMJ,* 352.
[85] Ibid.
[86] 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).
[87] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report, Volume 1: A new approach to mental health and wellbeing in Victoria, Parl Paper No. 202, Session 2018–21 (document 2 of 6).
[88] Ibid.

measures to create safer public spaces as part of the office on major construction projects in Queensland.'[89]

D) The experiences and leadership of people with lived experience of mental illness

Lived Experience Leadership

13. Recommendation: Queensland Government should fully and meaningfully integrate lived experience knowledge, insights, and leadership in all aspects of suicide prevention.

14. Recommendation: Queensland Government should fund supporting structures to grow and sustain the lived experience workforce, including the peer workforce and integrating the newly established Mental Health Lived Experience Peak Queensland and organisations representing those with lived experience of suicide to drive policy development across the State.

Lived experience leadership, knowledge and insights must be integrated in all aspects of suicide prevention. Survivors of suicide attempts, carers and the bereaved are all are uniquely placed to inform suicide prevention and postvention and are essential to ensuring policies and practice meet the needs of those at-risk or impacted by suicide.

Lived experience is a significant priority and it is important that lived experience, including experience among particular priority cohorts, is integrated from policy design and development through to delivery, research and evaluation. There's an important role peer workers in suicide prevention service delivery. This is particularly important to high-risk cohorts and hard-to-reach groups. For example, workers in occupations with the highest rates of suicide.

While there is increasing awareness of the benefits that come from lived experience-led policy and services, the value that is brought from lived experience needs greater acknowledgement and respect. This unique and important role needs better recognition in clinical and non-clinical settings.

Given the critical important of lived experience in suicide prevention, additional efforts are needed to support the lived experience workforce. In conjunction with the Commonwealth, strategic investment is required to ensure a skilled, safe and sustainable lived experience workforce, including the peer workforce.

We welcome the establishment of the Mental Health Lived Experience Peak Queensland (the Peak) to provide policy advice and system advocacy across the State. This is a key mechanism to ensure that people with lived experience are involved in policy development in Queensland. We understand the Peak is still working towards becoming fully operational and encourage Queensland Government to

[89] Queensland Mental Health Commission. (2019). Every Life: The Queensland Suicide Prevention Plan 2019-2029.

fully integrate the Peak into policy decision making, development, implementation, and evaluation processes.

Suicide Prevention Australia's strongly supports the recommendations of the Final Advice of the National Suicide Prevention Advisor to integrate lived experience in all aspects of suicide prevention. This should extend to integrating lived experience leadership, knowledge and insights into the design, delivery and evaluation of any measures related to suicide prevention.

E) The mental health needs of people at greater risk of poor mental health

15. Recommendation: Invest in targeted population and age specific suicide prevention supports and programs for people at greater risk of poor mental health and suicide.

The risk of suicide is not uniform across the community. There are a range of risk factors that contribute to heightened risks of suicide attempts or death by suicide. For example, research finds almost half of suicides and self-inflicted injuries are linked to risk factors of child abuse and neglect, drug and alcohol use and partner violence.[90]

There are also groups of the community whose risk of suicide or self-harm are higher than others:

- A previous suicide attempt is one of highest risk factors for a future suicide attempt.
- Suicide is the leading cause of death among young Australians 15-24 years with over one third of deaths in this cohort due to suicide
- The rate of suicides for Indigenous Australians is more than double that of non-Indigenous Australians
- Males account for over 75% of deaths, men are three times more likely to die by suicide than females
- People from LGBTIQ+ communities have higher rates of mental ill-health and suicide than the general population in Australia
- The highest suicide rates are for those aged 85 or older
- Rates of suicide in veteran population have been found to be up 18% higher than for the general population

[90] Australian Institute of Health and Welfare. (2021). Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015, Cat. no. BOD 22. Canberra, DOI:10.25816/5ebca2a4fa7dc.

- Australians from culturally and linguistically diverse (CALD) backgrounds generally demonstrate reduced and variable rates of access to mental health services, despite potentially having higher needs due to migration stressors
- People in rural and remote NSW are more likely to die by suicide than those living in our major cities
- Carers of people living with mental illness and/or suicidality
- People living with complex mental illness
- People with disabilities

The groups and risks above are not an exhaustive list but demonstrate that certain parts of the community are at higher risk than others. In line with a public health approach, additional investments and supports are required to address these areas of risk. Suicide Prevention Australia's 2021 State of the Nation in Suicide Prevention report identified 71% of participants from the suicide prevention sector do not believe priority populations are appropriately funded.

The policy and service responses to each risk factor and cohort vary and in some areas is unique. For example, the rights of Aboriginal and Torres Strait Islander peoples to self-determination, justice and autonomy should underpin everything we do in suicide prevention. Service approaches that work for young people may differ to those that work best for seniors. It is also important to understand the complexity of the mental ill-health recovery journey and lifecycle which may vary for different populations at different stages of life.

Aboriginal and Torres Strait Islander people

16. Recommendation: Queensland Government to invest in Aboriginal-led and culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services.

According to the Queensland Suicide Register, Aboriginal and Torres Strait Islander people are more likely to be bereaved or impacted by suicide and are at higher risk of reporting multiple suicide exposures.[91]

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. The concept of suicide among Aboriginal and Torres Strait Islander communities can further differ from Western ideology which is why culturally appropriate suicide prevention strategies that are co-designed and

[91] Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University.

delivered by Aboriginal-controlled organisations or providers is critical. Involving Aboriginal and Torres Strait Islander elders in service and program design can enhance effectiveness[92].

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. We further support recommendation 4.3 made by the Select Committee on Mental Health and Suicide Prevention in the Final Report that all priority be given to funding 'Indigenous-led and culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services'.[93]

G) Service safety and quality, workforce improvement and digital capability

Accreditation programs

17. Recommendation: Embed accreditation into the commissioning process for suicide prevention programs in Queensland to ensure Government funds are allocated towards safe, quality and effective programs.

The Fifth Mental Health and Suicide Prevention Plan recognises the importance of standards to assuring services and programs are safe, quality and outcomes-focussed. There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability factored into their design. Communities need to have the assurance that Queensland's suicide prevention programs provide a consistent, high quality and safe standard of care.

Embedding accreditation and standards into commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason Suicide Prevention Australia partnered with people with lived experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

[92] 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.*

[93] Select Committee on Mental Health and Suicide Prevention. (2021). List of Recommendations, Final Report, available online: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Mental_Health_and_Suicide_Prevention/MHSP/Report/section?id=committees%2freportrep%2f024705%2f76791.

As outcome-oriented standards, the Standards are designed to support the suicide prevention sector and provide assurance to consumers that the suicide prevention programs developed by an organisation are safe, high-quality and effective. The Standards offer an opportunity for organisations to participate in an accreditation program that will provide consistency in delivery and quality improvement.

Over 70 programs and services are working towards accreditation, including major organisations including Beyond Blue, Roses in the Ocean and Standby – Support After Suicide and LivingWorks. More information about the standards can be found here: https://www.suicidepreventionaust.org/suicide-prevention-quality-improvement-program/. Accreditation standards should be embedded in commissioning processes for suicide prevention services in particular services commissioned by all levels of Government.

Competency Framework

18. Recommendation: To support efforts to build capacity on responding to suicide risk, Government should fund the development of industry-specific competency frameworks in high-risk sectors.

To support efforts to enhance and build capacity, and capability of the non-clinical suicide prevention workforce to respond to people experiencing suicidal thoughts and behaviours, Suicide Prevention Australia has developed a Competency Framework, which can be accessed here: https://www.suicidepreventionaust.org/competency-framework/. The Framework builds on the evidence of 'what works' regarding the knowledge and skills required for workforces in suicide prevention across diverse settings. It recommends the essential competencies for organisations and their staff to work safely and effectively to reduce suicidal behaviour.

Research highlights the criticality of compassionately offering of help to people in distress accessing appropriate and timely support. The pathway someone in distress follows is altered by the ability of others to respond appropriately to the first disclosure of distress or suicidal behaviour. Ensuring this is vital in preventing a future suicide attempt[94]. Everyone has a role in suicide prevention. With people spending so much of their lives at work, this framework is an important building block to help employers recognise suicidal behaviour and respond appropriately.

The Framework provides a starting point for employers and staff to consider what they need to know to promote wellbeing and intervene effectively to reduce distress and suicidal behaviour in their workplace. The Framework identifies the minimum standard of suicide prevention and postvention knowledge, skills, attitudes, attributes, and values necessary for staff in their workplace. The Framework can be used by employers as a gap analysis to identify areas for improvement in the induction, education and training, and support and wellbeing of their staff.

[94] KPMG. (2020). Leading with Empathy: Embedding the voice of lived experience in future service design, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2020/12/Leading-with-empathy-final-report.pdf.

To support efforts to build capacity on responding to suicide risk, Government should fund the development of industry-specific competency frameworks in high-risk sectors. Building on the Suicide Prevention Australia Framework this can provide a tailored approach to build on the evidence of 'what works' regarding the knowledge and skills required for workforces in suicide prevention across diverse settings.

Mental health of frontline workers

19. Recommendation: Increase supports available to frontline healthcare workers at risk of psychological harm from the impact of working through the COVID-19 pandemic.

20. Recommendation: Queensland adopt the Western Australian Exemption law against mandatory reporting in order to reduce risk for clinicians.

Frontline workers are at an increased risk of developing poor mental health during pandemics due to potential exposure to the virus, potential to transmit the virus to their loved ones, moral injury (e.g. 'not doing enough' narratives), having to work in environments where necessary equipment (whether medical or preventative e.g. masks) are under resourced, or being assigned to work in 'high risk' units.[95,96,97] A strong evidence base exists on the increase of emotional distress among healthcare workers during and post pandemic outbreaks.[6,7]

Australian research (n=3587) into the impact of COVID-19 on healthcare workers found poor work health and safety, PPE, and workplace culture resulted in a loss of psychological and physical safety at work associated with an occupational moral injury.[98]

Research which surveyed the psychological impact of SARS exposure on hospital workers in Beijing (n=549) and found 10% experienced high levels of posttraumatic stress (PTS) symptoms following the epidemic.[99,6] Employees who quarantined, worked in high-risk units (e.g. SARS units), or had loved ones who were infected were '2 to 3 times more likely to have high PTS symptom levels, than those without these exposures'.[21,6] These results are consistent with a survey of healthcare workers at three Toronto

[95] Pfefferbaum, B. & North, C.S. (2020). Mental health and the COVID-19 pandemic, *The New England Journal of Medicine*.
[96] Greenberg, N., Docherty, M., Gnanapragasam, S. & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic, *BMJ*, 368.
[97] Nobles, J., Martin, F., Dawson, S., Moran, P. & Savovic, J. (2020). The potential impact of COVID-19 on mental health outcomes and the implications for service solutions, *National Institute for Health Research, University of Bristol*.
[98] Ananda-Rajah, M., Veness, B., Berkovic, D., Parker, C., Kelly, G. & Ayton, D. (2021). Hearing the voices of Australian healthcare workers during the COVID-19 pandemic, *BMJ Leader,* available online: https://bmjleader.bmj.com/content/5/1/31.
[99] Wu, P., Fang, Y., Guan, Z., Fan, B., Kong, J., Yao, Z., Liu, X., Fuller, C.J., Susser, E., Lu, J.& Hoven, C.W. (2009). The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception, and altruistic acceptance of risk, *Canadian Journal of Psychiatry*, 54(5).

hospitals (n=1557) in which higher psychological stress scores were reported among nurses and healthcare workers who provided care to SARS patients.[100]

Similar results are found in a study of hospital practitioners (n=359) involved in responding to the MERS outbreak in Korea in 2015, where those directly involved in MERS-related care provision demonstrated the highest risk for PTSD symptoms.[101]

Frontline healthcare workers including mental health care workers are subject to The Australian National Regulation Law 2010 which requires reporting practitioners who may 'place public at risk of substantial harm due to impairment'.[102] This legislation poses significant concerns for clinicians who may fear mandatory reporting for impairment and as such avoid seeking necessary mental health care for themselves.

A national survey of more than 14,000 medical practitioners in Australia found one in ten doctors experienced suicidal thoughts, with almost 4% reporting high levels of psychological distress.[103] Doctors reported key barriers to help seeking as: lack of confidentiality or privacy, impact on registration and right to practice, and concerns about career development or progress.[104]

Western Australia currently has an exemption for practitioners to not have to mandatory report providing a health service to another practitioner/student.[105] This model is considered beneficial and recommended for national adoption in Australia.[106] In 2018 the Australian Medical Association Queensland, The Royal Australian College of General Practitioners, The Royal Australian and New Zealand and College of Psychiatrists Queensland Branch, Australian College of Rural and Remote Medicine and Australasian College for Emergency Medicine signed a joined statement calling on Queensland Government to improve mental health reporting laws to prevent doctor suicides.[107]

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[100] Maunder, R.G., Lancee, W.J., Rouke, S., Hunter, J.J., Goldbloom, D., Balderson, K., Petryshen, P., Steinberg, R., Wasylenki, D., Koh, D. & Fones, C.S.L. (2004). Factors associated with the psychological impact of Severe Acute Respiratory Syndrome on nurses and other hospital workers in Toronto, *Psychosomatic Medicine,* 66(6).
[101] Lee, S.M., Kang, W.S., Cho, A-H.,Kim, T. & Park, J.K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients, *Comprehensive Psychiatry*, 87.
[102] Elwyn, R. (2021). Fear of the Impaired Practitioner, Mandatory Reporting, and Clinician Suicide: Can Lived Experience Professionals Heal a Sick Mental Health Field?, *ResearchGate*.
[103] Beyond Blue. (2013). National Mental Health Survey of Doctors and Medical Students, available online: https://www.beyondblue.org.au/about-us/our-work-in-improving-workplace-mental-health/health-services-program/national-mental-health-survey-of-doctors-and-medical-students.
[104] Ibid.
[105] Mony, S. (2020). Insights: Western Australia: What are the Mandatory Reporting Requirements for Registered Health Practitioners?, *Meridian Lawyers,* available online: https://www.meridianlawyers.com.au/insights/western-australia-what-are-the-mandatory-reporting-requirements-for-registered-health-practitioners/.
[106] Goiran, N., Kay, M., Nash, L. & Haysom, G. (2014). Mandatory reporting of health professionals: the case for a Western Australian style exemption for all Australian practitioners, *PubMed*, available online: https://pubmed.ncbi.nlm.nih.gov/25341329/.
[107] RACGP. (2018). Queensland doctors call on State Government to save lives, Media Release, available online: https://www.racgp.org.au/gp-news/media-releases/2018-media-releases/december-2018/queensland-doctors-call-on-state-government-to-sav.

H) Mental health funding models in Australia

21. Recommendation: Increase funding cycles for PHN & NGO mental health and suicide prevention to 5 year contracts which includes strengthening outcome reporting requirements for continuous service evaluation.

In 2021 we conducted the second iteration of our annual survey: The State of the Nation in Suicide Prevention. We designed the State of the Nation in Suicide Prevention survey to gather in-depth intelligence from our membership and the broader suicide prevention sector to ensure we provide a clear, collective voice for the sector. Key insights from our survey highlighted that the suicide prevention and mental health sectors are facing workforce shortages, for example a lack of available specialists, limited vacancies in health facilities, and long waiting lists. Respondents expressed the need for more referral pathways, greater funding, and improved integrated systems of care, and reported concerns around the uncertainty of funding for suicide prevention programs and services.

The continuing changing landscape of the COVID-19 pandemic and other natural disasters has increased demand for suicide prevention programs and services. The operating environment continues to shift with 59% of respondents reporting a change in the climate for funding security in the previous 12 months, and many reporting shorter contracts and uncertainty in funding and donations. Funding length remains inconsistent with the majority of respondents reporting core funding of two years or less (58%) while the remaining 42% report core funding of three or more years.[108] Our members have further reported complications in funding application processes and delays in funding distribution – funding of which is critical in enabling effective suicide prevention and reducing distress in the community.

Government funding needs to keep pace with rising levels of distress and ensure the sector is on a sustainable footing. We note the shortcomings of a regional only approach compared to a large public health approach to suicide prevention, and the need for consistency in strategy and programs nationally at a population level and local treatment level.

The Select Committee on Mental Health and Suicide Prevention Final Report recommended Governments fund PHNs for mental health and suicide prevention services on five year cycles, transition mental health and suicide prevention services provided by non-government organisations to five year funding contracts, require PHNs to commission mental health and suicide prevention services on five year contracts, and strengthen long and short term outcome reporting requirements to enable continuous service evaluation as part of increased length of contracts and funding cycles (Recommendation 28).[109]

[108] Suicide Prevention Australia. (2021). The State of the Nation in Suicide Prevention, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2021/09/State-of-the-Nation-in-Suicide-Prevention-2021-report-2.pdf.
[109] Ibid.

I) Relevant national and state policies, reports and recent inquiries

22. Recommendation: Queensland Government to appoint a Minister for Suicide Prevention to lead an all of government approach to suicide prevention across the State as an extension to *Every Life: The Queensland Suicide Prevention Plan 2019-2029.*

Strong international evidence shows that a whole-of-government approach is essential to driving reform, coordinated action and a reduction in the suicide rate[110].

Every Life: The Queensland Suicide Prevention Plan 2019-2029[111] outlines strong commitment to a whole of government and whole of community approach to suicide prevention in Queensland that extends beyond the health portfolio. Preventing suicide 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. Establishing the necessary machinery to enable a whole of government approach to suicide prevention is essential to lead reform and elevate suicide prevention on the State's agenda.

The National Suicide Prevention Adviser's Final Report recommends leadership and governance are key to driving a whole of government approach to suicide prevention.[112] Appointing a Minister for Suicide Prevention aligns with the State's Suicide Prevention Plan, national reform; and will enable the coordination of a cross-portfolio approach to reducing suicides in Queensland.

The Committee may also have regard to relevant recommendations from the Royal Commission into Victoria's Mental Health System. Recommendations 26 and 27 both regard suicide prevention and may provide useful examples.

The Royal Commission recommends that the Victorian Government (Recommendation 26):

1. establish in the Mental Health and Wellbeing Division, a Suicide Prevention and Response Office, led by a State Suicide Prevention and Response Adviser who reports to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).
2. enable the Suicide Prevention and Response Office to:
   a. establish a system-based approach to suicide prevention and response efforts;
   b. work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide to co-produce, implement and monitor a new suicide prevention and response strategy for Victoria;
   c. work closely with the Commonwealth Government to ensure suicide prevention and response efforts in Victoria are coordinated with, and complement, national

[110] 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.

[111] Ibid.

[112] National Suicide Prevention Adviser. (2021). National Suicide Prevention Adviser's Final Advice, Executive Summary, available online: https://www.health.gov.au/sites/default/files/documents/2021/04/national-suicide-prevention-adviser-final-advice-executive-summary.pdf.

approaches;
d. facilitate a community-wide and government-wide approach to suicide prevention and response efforts;
e. work within governance structures that encompass all government departments and relevant agencies, with Deputy Secretary and Secretary level membership; and
f. employ people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide.

The Royal Commission recommends that the Victorian Government (Recommendation 27):

1. build on the interim report's recommendation 3 on suicide prevention and response and develop initiatives to support people experiencing suicidal behaviour including:
a. providing training in appropriate responses for members of workforces likely to come into contact with people experiencing suicidal behaviour;
b. providing free, online evidence-informed 'community gatekeeper training' for Victorians to develop suicide awareness and prevention skills;
c. enabling Aboriginal people to design culturally safe 'community gatekeeper training' for Aboriginal people; and
d. facilitating Victorian industries and businesses to invest in evidence-informed workplace suicide prevention and response programs, with an initial focus on forming partnerships with high-risk industries.
2. develop initiatives to support people at risk of experiencing suicidal behaviour, by:
a. co-producing an aftercare service for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning people following a suicide attempt; and
b. in partnership with the Commonwealth Government, implementing statewide postvention bereavement support, so that every person bereaved by suicide is automatically referred to a postvention bereavement provider.
3. develop an intensive 14-day support program for adults who are experiencing psychological distress, modelled on Scotland's Distress Brief Intervention program.