National Suicide Prevention Strategy 2025–2035

Australian Government

National Suicide Prevention Office

Acknowledgements

Acknowledgement of Country

The National Suicide Prevention Office (NSPO) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters on which we live, work and learn.

Recognition of lived experience

The NSPO recognises the individual and collective contributions of those with lived and living experience of suicide. People who experience suicidal thoughts, have survived suicide attempts, cared for a person in suicidal crisis or have lost a loved one to suicide demonstrate tremendous generosity through providing their expertise and insights. Every person's journey is unique and a valued contribution to Australia's commitment to suicide prevention reform.

Contributors to the National Suicide Prevention Strategy

The NSPO has worked closely with a large range of people to develop this Strategy. This includes members of the Lived Experience Partnership Group, NSPO Advisory Board, Jurisdictional Collaborative Forum and Working Groups, as well as many Australian and international academics, service providers, people with lived and living experience and other members of the public. This Strategy benefits from the whole-of-community approaches Aboriginal and Torres Strait Islander peoples have used for many years. We would like to offer our thanks to the Aboriginal and Torres Strait Islander people who contributed to the development of this Strategy; we are grateful for the leadership, generosity and wisdom that have characterised their contributions. Finally, we would like to thank all of those who gave so generously of their time and expertise to this work.

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A note on language

The way we speak about suicide and self-harm has a major influence on how the community understands and responds to people who are experiencing suicidal thoughts and behaviours. It also impacts on the existence and degree of stigma and shame around suicide.

While there is ongoing debate on the words used in suicide prevention, this Strategy has drawn on the insights of people with lived and living experience of suicide, evidence-informed resources including the Mindframe guidelines,[1] research, and the knowledge of sector experts to guide the language used to describe aspects of suicide. A list of terms and definitions used throughout this Strategy is provided at Appendix A: Glossary.

Sources of support

Please be aware this Strategy contains information about suicide that may be distressing. Please take care of yourself as you read it and ask for help if needed. Support is always available. Below are options for online and telephone information and support in Australia.

Lifeline
13 11 14
lifeline.org.au

ReachOut
au.reachout.com

headspace
1800 650 890
headspace.org.au

Suicide Call Back Service
1300 659 467
suicidecallbackservice.org.au

QLife
1800 184 527
qlife.org.au

Open Arms
1800 011 046
openarms.gov.au

Defence Member and Family Helpline
1800 624 608

Kids Helpline
1800 551 800
kidshelpline.com.au

13YARN
13 YARN (13 92 76)
healthinfonet.ecu.edu.au

MensLine Australia
1300 789 978
mensline.org.au

Head to Health
headtohealth.gov.au

Beyond Blue
1300 224 636
beyondblue.org.au

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Ministerial Foreword

The persistent, devastating impact of suicide in the Australian community is a tragedy we must all face up to.

Despite our advances, as a community we have not been able to reduce the stubborn prevalence of suicide among Australians and the trauma it brings to families and loved ones.

Every day in Australia, some nine people die by suicide and more than 150 people attempt to take their own life. We recognise the immeasurable pain felt by those who experience suicidal distress and those who have lost someone to suicide.

This Strategy calls on us all to better understand the factors which cause suicidal distress in Australia, and to redouble our efforts in addressing them. Since the election of the Albanese Government in 2022, addressing these drivers of distress has been a priority across government – reducing financial distress, tackling domestic violence, making secure housing easier to find and extending free mental healthcare to those who need it.

The Australian Government is taking a comprehensive approach to preventing suicide. This includes working closely with our state and territory counterparts, service providers, community advocates, civil society and across the whole-of-government to ensure national consistency while also meeting the unique needs of those who are disproportionately impacted.

It's clear that the vision of this Strategy can only be achieved with significant and sustained reductions in Aboriginal and Torres Strait Islander people lost to suicide. It has been developed to align closely with the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, which was released by the Australian Government in partnership with the First Nations sector in December 2024.

We acknowledge everyone who has contributed to the development of this Strategy and the evidence that has informed it. We especially thank those with a lived and living experience of suicide who have so openly shared their stories and experiences.

Members of the Lived Experience Partnership Group and Advisory Board provided their time and expertise throughout the development of the Strategy. The National Suicide Prevention Office has provided coordination and advocacy across government since this project was first initiated. We thank you all for your tireless work and dedication.

The Hon Mark Butler MP
Minister for Health and Aged Care

The Hon Emma McBride MP
Assistant Minister for Mental Health and Suicide Prevention

Head NSPO

No one in Australia is immune to the impacts of suicide and those impacts are broad, deep and long-lasting. But it does not have to be this way.

The National Suicide Prevention Office team is proud to deliver the National Suicide Prevention Strategy. This Strategy provides a compelling rationale for actions that will achieve a more comprehensive and effective approach to suicide prevention in Australia. These actions will both ensure a high-quality support system and help to prevent people experiencing suicidal distress in the first place.

This Strategy marks a significant moment in suicide prevention in Australia, building on the efforts of many. In particular, it has been informed by the deep insights of thousands of people with lived experience, advancements in data collection and research, and the expertise of those across the suicide prevention sector.

For people with a lived and living experience of suicide, this is the culmination of many years of advocacy and consultation, which often involves revisiting some of the toughest moments in their lives. The team and I are very grateful to all those who have contributed from a lived experience perspective – thank you for your generosity and wisdom. We have worked to honour your contributions in the way this Strategy outlines a coordinated, holistic and evidence-based approach to suicide prevention.

The National Suicide Prevention Office has been skilfully supported by the Lived Experience Partnership Group and the Advisory Board. We thank our Chairs, Susan Edgar and Alan Woodward for their thoughtful leadership and guidance. We also acknowledge our Scientific Advisor, Professor Jane Pirkis who has made a significant contribution to this Strategy and to the broader understanding of suicide and suicidal distress over many years. To the service providers, policy writers, and others who participated in our working groups or met with us regularly, we are enormously grateful. We hope you feel very proud of this Strategy.

We would also like to acknowledge the suicide prevention leaders from around the country who have collaborated so willingly. In particular, the active support of each state and territory government has helped us develop a National Suicide Prevention Strategy that can facilitate a nationally consistent approach. Anyone, anywhere in Australia should benefit from a consistently high-quality suicide prevention system.

It is our hope that this Strategy is utilised, not just by governments, but by service providers, communities and individuals. We invite you all to reflect on what you are doing now and what you could do even better. It is only by working together to continually improve that we will see improved outcomes and reduced rates of suicidal distress.

Dr Alex Hains
Head NSPO

Chairs

It is with a sense of hope, optimism and conviction that the two advisory groups to the National Suicide Prevention Office welcome the release of this Strategy.

Throughout the development of the Strategy, we have been mindful of the impact that suicide has on so many Australians not only for those who have tragically lost loved ones, but for those who have suffered suicidal distress including those who have attempted to end their lives. Suicide is pervasive and lasting in its impact. It is not surprising that there is widespread support in local communities, workplaces and businesses, social and cultural groups, and our parliamentary representatives to do more and do better to prevent deaths by suicide and to reach people and provide their carers with meaningful support.

The factors that surround the emergence of despair, distress and mental ill health that in turn fuel thoughts of suicide are known and can be addressed. We are fortunate to have the knowledge gained over many decades of academic research, service and program delivery alongside the voices of those with lived experience of suicide, to guide the future direction of suicide prevention. It is only through harnessing all these insights that we will be able to prevent suicide. This is possible.

This Strategy turns a page in the Australian efforts to prevent suicides and better care for those who experience suicidal distress. It is broader and deeper in its outlook. It shifts the emphasis from that of crisis response alone to one of awareness and earlier responsiveness to reach a person with compassion and understanding to present alternative pathways and hope.

The involvement of all areas of government and the public service is required. Improved mental health services must be matched with building the capacity of social services, education, employment, human rights, and community/cultural development. For the objective is to enable every Australian to achieve the best possible state of health and wellbeing and to be assisted when life's challenges or health issues have the potential to undermine this.

Our involvement in the Strategy has been a privilege and we have taken seriously the importance of this work. Now is the time for commitment, action and enthusiasm in applying the Strategy to achieve results.

Susan Edgar
Chair
Lived Experience
Partnership Group

Dr Alan Woodward
Chair
Advisory Board

Introduction

Why this Strategy is important

Suicide rates in Australia remain unacceptably high.

Every year in Australia, more than 3,000 people die by suicide—nearly nine people a day.[2] Suicide remains the leading cause of death for people aged 15-44,[2] and the second leading cause of years of life lost, with over 159,000 years of potential life lost to suicide in Australia each year.[3]

But suicide deaths are only the tip of the iceberg. In 2020–2022, 1 in 6 people aged 16-85 in Australia (around 3.3 million people) had experienced suicidal thoughts or behaviour at some point in their lives.[4] Further, more than 1.7 million people aged 16-85 had self-harmed in their lifetime.[4] The same research shows that around 55,000 people in Australia attempt to take their own life each year—approximately 150 people each day.[4]

Suicide, suicide attempts or suicidal distress will impact most Australians at some point in their lives. It is estimated that around 135 people are affected by each suicide death.[5] The effects are devastating for families, kin and communities. People who are bereaved by suicide are also at greater risk of dying by suicide themselves,[6] with children of a parent who dies by suicide being three times more likely to take their own lives than children whose parents die by other causes.[7] Those who care for people who have attempted suicide can experience high levels of distress and their own risk is increased.[8] The impact on emergency and health service personnel who care for people who have attempted suicide is also long-lasting.[9,10] Beyond the human impacts, the economic cost of suicide and suicide attempts is estimated to be $30.5 billion each year.[11]

It does not have to be this way. Most suicides are preventable.

Over the past few decades, the economic, health and technological factors contributing to suicide and suicidal distress have shifted. At the same time, our understanding of suicide has increased greatly. A national strategy is critical to ensure suicide prevention efforts reflect up-to-date knowledge and our suicide prevention efforts continue to improve into the future.

The National Suicide Prevention Strategy (the Strategy) has been developed by the National Suicide Prevention Office to guide long-term, coordinated suicide prevention activity in Australia. It outlines a broadening of current suicide prevention efforts to encompass a truly preventative approach and to strengthen the current support system. It describes clear actions that must be taken to reduce the number of people who experience suicidal distress as well as ensure that people who are distressed (and those who care for them) can access high-quality, effective supports that facilitate long-term wellbeing.

Understanding suicide

Suicidal distress is a human response to overwhelming suffering. It is complex—typically, there are many factors at play rather than a single isolated cause. These factors include social determinants (such as income, education, employment, housing, early childhood development, social inclusion and access to health care) and individual factors, including contextual factors (such as stressful life events, trauma, abuse and discrimination), clinical factors (for example, mental illness, drug and alcohol use, chronic physical illness), personality factors, genetic factors and demographic factors (such as age, gender, sexual orientation, ethnicity, cultural heritage).[12] It is often the impact of social determinants interacting with a person's individual risk factors that lead to a person experiencing suicidal distress, as depicted in Figure 1.

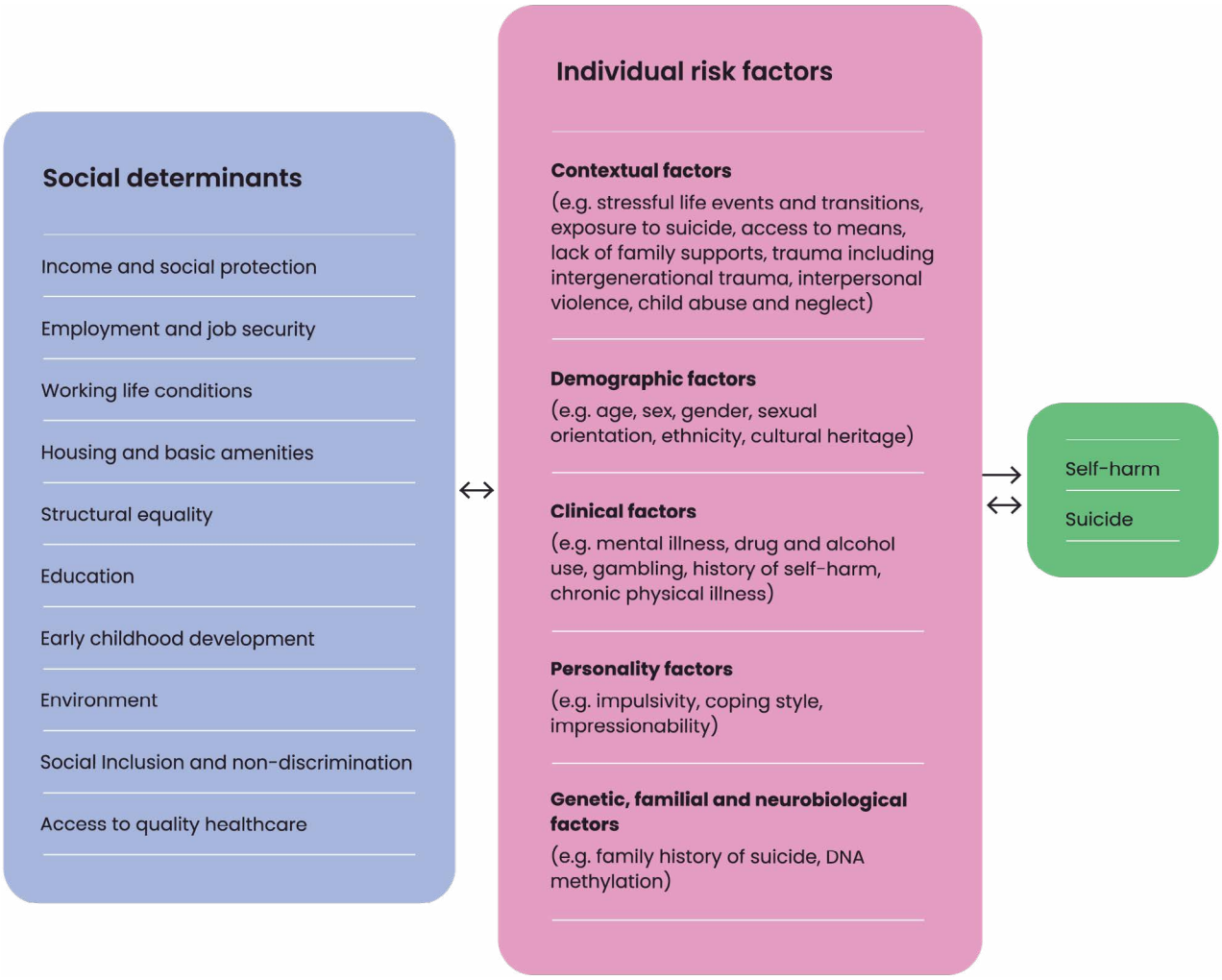
This understanding of suicide is consistent with the fact that psychosocial risk factors were the most commonly reported risk factor in Australia (present in 67.4% of suicide deaths).[2] It also aligns with the key themes that emerged from interviews with approximately 3,000 people with lived and living experience of suicide. These themes included suicidal thoughts and behaviours tracing back to early life experiences of abuse, violence, trauma, family conflict or bereavement, as well as experiences with alcohol and other drug problems, discrimination and concurrent and complex life stressors closer in time to a suicide attempt.[13]

A broader understanding of suicide prevention is also consistent with the concept of social and emotional wellbeing, which is foundational to Aboriginal and Torres Strait Islander understandings of physical and mental health.[14] Social and emotional wellbeing includes but extends beyond conventional concepts of mental health to encompass connection to Country—the interconnection between people, family, kin and community and the importance of connection to land, culture, spirituality and ancestry— as well as the role social of determinants in influencing people's lives.

Recognising that suicidal distress arises from the interaction of social determinants and individual factors makes it very apparent that approaches that only address individual factors or treat suicide solely from a mental health perspective are likely to be inadequate. While effective mental health care must remain a cornerstone of suicide prevention, particularly given the strong links between mental illness and suicide,[2] there is also a clear need for efforts to be broadened to encompass contributory socio-economic factors.

Australia's experience during the COVID-19 pandemic may provide a glimpse of the value of this approach. Despite increased psychological distress and adverse economic outcomes, rates of death by suicide in Australia did not significantly increase during the first year of the pandemic.[2,15] Although the reasons behind fluctuations in suicide rates are complex and the long-term impacts of the pandemic are still unclear, the experience suggests that government interventions that aim to reduce measures of insecurity (including economic, housing and health), and improve access to timely support services, should be prioritised to reduce suicide.[15-17]

Figure 1: Social determinants and individual risk factors for suicide and self-harm



The importance of an effective mental health system

This Strategy focuses on aspects of the mental health system that are particularly critical to improving suicide prevention outcomes, such as the promotion of mental wellbeing, access to preventive mental health supports, and ensuring mental health services are able to provide effective support for people experiencing suicidal distress. In these ways, a well-functioning mental health system plays a critical role in suicide prevention.

This Strategy does not seek to define the broader areas of reform required across the mental health system, but to work in concert with existing reform roadmaps; for example, the *Productivity Commission, Mental Health, Inquiry Report*, the *Royal Commission into Victoria's Mental Health System, Final Report* and the *National Mental Health and Suicide Prevention Agreement*.[11,18,19]

The disproportionate impacts of suicide

While suicide impacts the whole population, it does not impact all groups of people equally. Information about the known disproportionate impacts on some specific population groups is summarised in Table 1.

Importantly, data on groups disproportionately affected should not mask the strengths and resilience within these communities. It does not reflect inherent vulnerabilities within specific groups, but rather the fact that the root cause of the disproportionate rates of suicide lies in the disparities and inequities in social and economic circumstances that impact them. While the specific disparities and the way they manifest differs between communities, recurring themes include experiences of discrimination, economic insecurity, stigma, poor health outcomes and reduced access to supports capable of responding to their needs.

Given this, a shift to a broader approach to suicide prevention—one that not only provides comprehensive supports that respond to diverse health and socio-economic needs, but also addresses the socio-economic drivers of distress in the first place—will directly target the underlying causes of the disproportionate rates of suicide in these communities. This approach will also ensure that the system is inherently designed to be more flexible and is better able to respond to intersectionality—the reality that many people may identify with multiple groups and that these identity markers do not exist independently but, rather, influence each other with compounding effects.

> **Suicide can affect anyone. However, suicide does not affect everyone in the same way. My experiences with suicide intersect with my disability, cultural diversity, gender, sexuality, homelessness, and more. To understand and support me, intersectionality is not just an option—it's a necessity. My identities and experiences cannot be separated into silos or checkboxes. By embracing intersectionality, we recognise that a one-size-fits-all approach is inappropriate and dismissive of our identities. We need to see young people as whole people and co-produce suicide prevention supports that are truly holistic and inclusive."**
>
> **– Emily Unity**
> Participant, consultation with young people, July 2023

How the Strategy actions reflect the needs of disproportionately impacted groups

This Strategy identifies population groups based on non-modifiable factors. It emphasises that disproportionate rates of suicide are driven by disparities and inequities in social and economic circumstances, not inherent vulnerabilities.

This Strategy is structured around these social and economic issues, rather than by population groups. This helps ensure a focus on addressing the key social and economic factors that give rise to disparities in the impacts of suicide, and that the Strategy supports an intersectional approach.

In addition, the Strategy points out cases in which particular considerations are important to ensuring the needs of specific groups are met.

Table 1: The disproportionate impacts of suicide across population groups in Australia

Group	Impact
Males	In 2023 in Australia, just over three-quarters of all suicide deaths were among males. There were 2,419 male deaths at a rate of 18.0 per 100,000.[2] Suicide is the leading cause of death for males aged 15-55.[2]
Females	In 2022–23, females made up almost two-thirds (66%) of intentional self-harm hospitalisations.[20] Reporting of ambulance attendance data indicates higher rates of suicide attempt and self-injury (without suicidal intent) among young females compared to young males.[21]
Younger and older Australians	Suicide is the main cause of death for younger Australians. In 2023, nearly one-third of deaths among Australians aged 15-24 years were due to suicide.[2] More than half of all suicide deaths in 2023 (55.3%) occurred in people aged 25-54 (1,778 deaths).[2] However, some of the highest rates of suicides in a single age group occur among Australians aged 85 and older.[2]
Aboriginal and Torres Strait Islander peoples	Aboriginal and Torres Strait Islander peoples are more than twice as likely to die by suicide than the non-Indigenous population.[2] In 2023, the age-standardised suicide rate for Aboriginal and Torres Strait Islander peoples was 30.8 deaths per 100,000, which is 2.6 times higher than the non-Indigenous population.[2]
Lesbian, gay, bisexual, transgender, intersex, queer or questioning, and/or other sexuality and gender diverse (LGBTIQ+)	LGBTQ+ communities experience higher levels of suicidal thoughts and self-harm, compared to non-LGBTQ+ people.[22] Within the LGBTQ+ community, transgender and gender diverse people experience more suicidal thoughts and engage in more suicidal behaviours than cisgender people.[23] For people with innate variations of sex characteristics (intersex) there is inadequate data on suicide rates but evidence of significant distress.[24]
Culturally and linguistically diverse Australians	Just over 7 million Australians were born overseas, and 5.8 million people use a language other than English at home.[25] People who enter Australia as humanitarian entrants have nearly twice the rate of suicide as other permanent migrants to Australia.[26] Research shows that suicide rates of Australian-born people and migrants from English-speaking countries are similar, but migrants from Oceania countries and African countries have some of the highest suicide rates and these are increasing.[27]
People with disability	People with disability are three times more likely to die by suicide than people without disability.[28] Between 2013 and 2018, the suicide rate for people who used disability services was 33.5 per 100,000 compared to 11.4 per 100,000 for people without disability.[28]
Ex-serving Australian Defence Force members	Ex-serving Australian Defence Force members are at a higher risk of death by suicide than non-veterans.[29] Ex-serving males and ex-serving females are, respectively, 26% and 100% more likely to take their own life than Australian males and females.[29] Veterans who leave the Australian Defence Force for involuntary medical reasons are two to three times (females and males respectively) as likely to take their own life than those who leave voluntarily.[29]
People with mental illness	In 2023, Australian Bureau of Statistics (ABS) data indicated that 64% of people who died by suicide had a mental and/or behavioural disorder present.[2] Some studies suggest this may be higher at 80%[30] or even 90%.[31] Research also shows that people with severe and complex mental illnesses have a significantly higher risk of dying by suicide than those without.[31] However, most people with a mental illness do not die by suicide, and a person does not have to have a mental illness to be at risk of suicide.[4]
Families, carers and kin	Families, carers and kin often provide informal care following a suicide attempt. This has been found to contribute in some cases to caregiver burden; that is, the caregiver experiences higher levels of distress and increased risk of suicide.[8,32] Family history of suicide is recognised as a risk factor for suicide, through exposure to suicide, bereavement by suicide and heritability of suicidal behaviour.[33,34]

How this Strategy was developed

The Strategy builds on the significant work already being done in suicide prevention, including under the *National Mental Health and Suicide Prevention Agreement*.[19] It operationalises three seminal documents: the *Productivity Commission, Mental Health, Inquiry Report,*[11] the *Royal Commission into Victoria's Mental Health System, Final Report*,[18] and the *National Suicide Prevention Final Advice* reports.[35] The Strategy also draws on numerous other existing agreements, plans, strategies, reports, submissions and inquiries, as well as specifically commissioned research.

Crucially, the work has been informed and guided by the insights of people with lived and living experience of suicide, and the people who support them, provided during targeted consultations with groups disproportionately impacted by suicide.

The Strategy also seeks to humbly learn from and reinforce Aboriginal and Torres Strait Islander knowledge, cultures and ways of doing, embodied in social and emotional wellbeing approaches. It draws on the final report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project[36] and aligns with the National Agreement on Closing the Gap,[37] which acknowledges the ongoing strength and resilience of Aboriginal and Torres Strait Islander peoples.

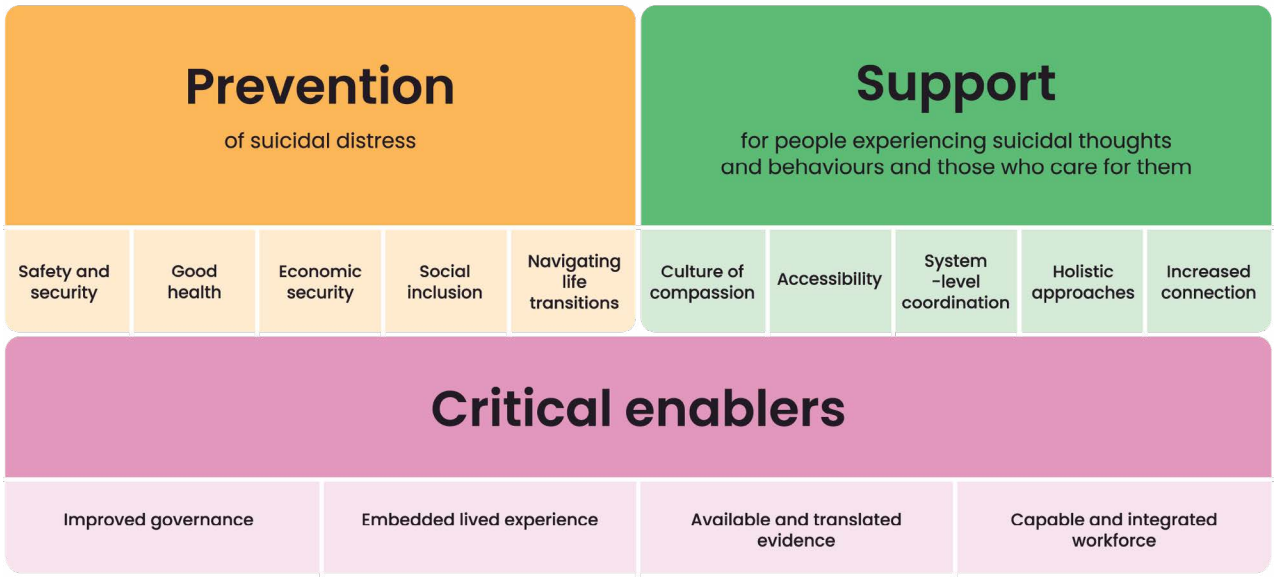
The drafting of the Strategy has been guided by the NSPO Lived Experience Partnership Group, the NSPO Advisory Board, the NSPO Scientific Adviser, two working groups and a Jurisdictional Collaborative Forum. Further information on the development of the Strategy and membership of groups involved is outlined in Appendix B: Development of the Strategy.

The complex development of the Strategy reflects the deep commitment of all parts of the Australian community to work together to achieve a significant and sustained reduction in suicide deaths, suicide attempts and suicidal distress.

Overview of the National Suicide Prevention Strategy

This Strategy outlines the actions required to realise a comprehensive approach to suicide prevention, aligning national efforts with the latest evidence and insights about what works. This includes adopting a genuinely preventive approach that reduces the likelihood of suicidal distress occurring in the first place, broadening support options to provide a more holistic response for people experiencing suicidal distress, and establishing the systems-level structures and processes required to sustain progress towards an effective suicide prevention system.

Figure 2: The National Suicide Prevention Strategy model



This Strategy identifies two domains of suicide prevention.

Prevention of suicidal distress describes what is required to reduce the likelihood of suicidal distress arising. This involves strengthening the baseline wellbeing of communities and better supporting those who are struggling with factors we know can lead to suicidal distress.

Support for people experiencing suicidal thoughts and behaviours and those who care for them describes what is required to have an effective support system: compassion, accessibility, coordination, connection, and a holistic approach to reducing suicidal distress. To provide high-quality support, these components must operate in each part of the support system and across the system as a whole.

Each domain has a set of key objectives and corresponding actions to achieve them. These are underpinned by four **critical enablers**, which must be present for the key objectives to be fully realised. The domains and objectives are not designed to be acted on in isolation, but as a collective package, with each being of equal importance.

These elements are represented in the model depicted in Figure 2, which is intended to provide a common understanding of the components required to realise an effective suicide prevention system and, consequently, be a blueprint for future suicide prevention efforts.

The Strategy operationalises this model by identifying the specific actions required to make progress in ensuring these elements are in place nationally. The model should also serve as the common basis for other work such as a National Suicide Prevention Outcomes Framework that will enable meaningful tracking of progress in suicide prevention efforts.

This Strategy is designed to operate in concert with existing strategies that address social determinants of suicide, such as those for housing (the National Housing and Homelessness Plan, which is in development[38]) and personal safety (the *National Plan to End Violence against Women and Children*[39]). It is also intended to work alongside and complement the recommendations of the *Final Report of the Royal Commission into Defence and Veteran Suicide*,[40] which provides a vital roadmap for addressing suicides and improving the lives of Defence personnel, veterans and their families. Together, these strategies and reports should be seen as vital components that provide national direction for suicide prevention efforts.

Significant work is underway in states and territories to develop and implement jurisdictional suicide prevention plans. The NSPO worked closely with suicide prevention leads from each state and territory and engaged in consultation with relevant departments within the jurisdictions to ensure alignment between these efforts and the coordinated national approach described in this Strategy. This means that this Strategy provides a genuinely national approach, representing a plan for coordinated effort between Commonwealth and state and territory governments.

The following are crucial pieces of work in suicide prevention that are currently under development and have not yet been released.

The **National Aboriginal and Torres Strait Islander Suicide Prevention Strategy**[41] and this Strategy sit side by side as mutually reinforcing scaffolding. The vision set out in this Strategy cannot be achieved without significant and sustained reductions in Aboriginal and Torres Strait Islander suicides. Such reductions can only be achieved through Aboriginal and Torres Strait Islander community and cultural leadership. But accountability for improved social and emotional wellbeing outcomes cannot rest solely with agencies and services run by Aboriginal and Torres Strait Islander communities.

The **Gayaa Dhuwi (Proud Spirit) Declaration Implementation Framework and Plan** commits all governments to work in genuine partnership with Aboriginal and Torres Strait Islander peoples, organisations and communities to drive culturally safe and responsive mental health, social and emotional wellbeing, and suicide prevention solutions. This Strategy seeks to emphasise Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing as a key source of leadership and guidance for holistic approaches to suicide prevention across the Australian population. It describes approaches aligned with the goals of the Plan.

Activities to build on

Throughout the Strategy, examples of initiatives and programs are highlighted as activities to build on in suicide prevention. These examples have evidence of being effective and are aligned with the aims of the sections of the Strategy where they appear.

The NSPO acknowledges that the programs presented are not the only relevant and effective programs that exist. The intent of providing examples of initiatives and programs in this Strategy is to highlight some of the effective work occurring in suicide prevention.

Inclusion in this Strategy is not an endorsement of the program or a suggestion that these programs should be funded, or should be funded in exclusion of others, to achieve the aims of the Strategy.

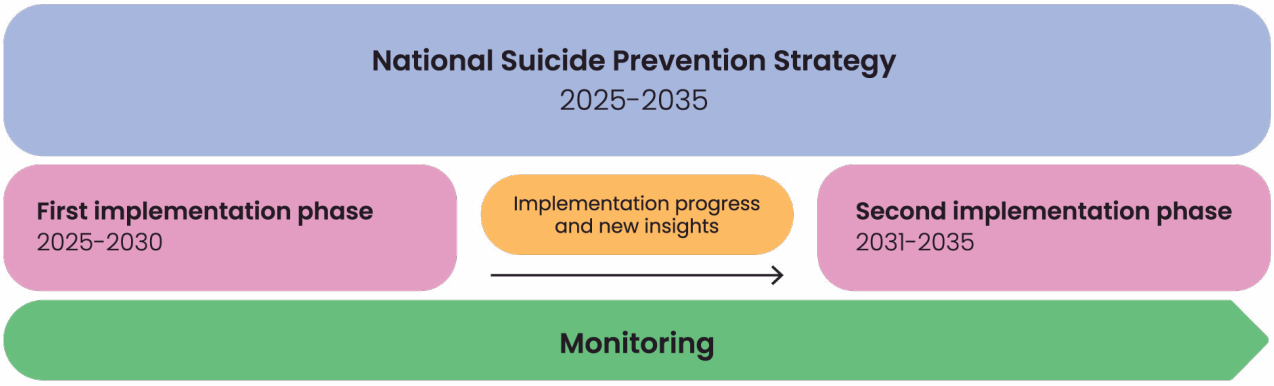
Implementation and monitoring

The Strategy has been designed for implementation to occur over a 10-year period. Implementation will be adjusted in line with new insights and activity tracking. Additionally, there will be a formal reflection point midway between two 5-year implementation phases to allow for review and adjustment in line with progress and new evidence (Figure 3).

Implementation will require collaboration across governments and portfolios, given their shared roles in preventing suicide. It should involve close engagement with sectors, services and communities, as well as people with lived and living experience of suicide, to maximise buy-in and mobilise efforts from everyone with a role to play in suicide prevention.

The National Suicide Prevention Office (NSPO) will undertake regular, timely monitoring of implementation of the Strategy to track progress and inform planning. In addition, it will be necessary to monitor the impact of national efforts. This will occur through the NSPO's development of the National Suicide Prevention Outcomes Framework, which will include an agreed set of suicide prevention outcomes and indicators. Regular reporting of both implementation activity and impacts will provide regular insights that will guide implementation of the Strategy over the next 10 years.

Figure 3: Implementation and progress reporting of the National Suicide Prevention Strategy



Prevention

of suicidal distress

A comprehensive approach to suicide prevention must do more than support people who are experiencing suicidal distress—it must also reduce the likelihood of people experiencing suicidal distress in the first place.

Suicidal distress is often related to the impact of the social, cultural, economic, legal and physical environments in which people live, work, learn and play (outlined in Figure 1). This Strategy focuses on five of these key social determinants: safety; good health; economic security; social inclusion; and the ability to navigate key life transitions. These warrant particular attention because of their potential to both positively influence wellbeing and negatively impact on a person and contribute to suicidal distress.[42] This Strategy approaches these factors from both perspectives.

1. Strengthening protective wellbeing

Communities in which people feel safe, healthy, economically secure and connected to others are associated with higher levels of wellbeing, lower levels of distress and lower suicide rates.[43-47] Improving the community's baseline wellbeing enhances opportunities to thrive and has a protective effect by 'buffering' the impact of suicidal risk factors.[42] Given this, suicide prevention should include efforts to strengthen the positive impacts of these factors.[48-50]

Wellbeing is more than simply the absence of illness. It encompasses quality of life and the ability of people and communities to contribute to the world with a sense of meaning and purpose.[51] Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing also incorporate the importance of connection to Country inclusive of culture, language, spirituality and ancestry,[52] noting the role of culture as a foundation for Aboriginal and Torres Strait Islander peoples.[53]

Building wellbeing requires policies developed from a human rights perspective that help to establish safety and security, promote inclusive societies, and recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[54] It also requires a focus on equity—an emphasis on directly addressing disadvantage and differences in opportunities to thrive that account for much of the disproportionate impact of suicide across society.

2. Reducing the prevalence and impact of key drivers of distress

There will inevitably be some people who experience stress associated with socio-economic factors and these stressors are known to elevate suicide risk. Experiences of childhood abuse and neglect, alcohol- and drug-related harm, and intimate partner violence (against females) were associated with almost half (48%) of suicide deaths and self-inflicted injuries in 2019.[55] Similarly, economic uncertainty,[2,56] social exclusion and loneliness,[57,58] chronic pain,[59] and family separation or bereavement[60-62] were associated with increased suicide risk. Reducing the impact of such stressors can prevent people from experiencing suicidal distress by reducing their sense of being trapped by circumstances.

Suicide prevention efforts must therefore also address the negative impact of socio-economic stressors—either by directly addressing the socio-economic factor or by providing proactive support for people negatively impacted.

This combined approach to prevention of suicidal distress draws on a maturing understanding of suicide prevention internationally,[63,64] and aligns with the socio-economic targets outlined in the National Agreement on Closing the Gap.[65] Being proactive, it is more efficient and offers more sustained protection from suicidal distress than a reactive approach that focuses on treating people when they are experiencing a suicidal crisis.[12]

1. Key objective

Safety and Security

A sense of safety and security, and the factors that enhance or diminish it, is closely linked to individual wellbeing and suicide risk. Addressing safety and security is therefore a foundational requirement in suicide prevention.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People experience enhanced wellbeing through increased sense of safety and security. The prevalence and impacts of risks to personal safety and security are diminished.

1.1 Improve safety and security

Enhancing wellbeing from a safety and security perspective seeks to foster a safe, stable and equitable society to prevent exposure to risk, discrimination and abuse. From a suicide prevention perspective, this should particularly involve strengthening structures and initiatives that ensure that people are afforded human rights in all aspects of life (action 1.1a) and experience positive and respectful interpersonal and intimate partner relationships (action 1.1b).

The recommended actions to improve safety and security are described in Table 2. Development of human rights and anti-discrimination reforms should also consider the need for protections for people experiencing suicidal distress and psychosocial disability.

Table 2: Recommended actions for Prevention objective 1.1: Improve safety and security

Action	Description
1.1a	Ensure a human rights-informed approach to suicide prevention, including through engaging with the Australian Human Rights Commission when reviewing and advising on reform.
1.1b	Implement Action 1 of the First Action Plan 2023-2027 under the *National Plan to End Violence against Women and Children 2022–2032*[39] to: "Advance gender equality and address the drivers of all forms of gender-based violence, including through initiatives aimed to improve community attitudes and norms toward family, domestic, and sexual violence."

1.2 Address risks to personal safety

A significant proportion of Australians encounter risks to personal safety that can lead to suicidal distress. Some of the risks and the impacts of these experiences are described in Table 3.

Table 3: Risks to personal safety

Risk	Impact
Child abuse and neglect	Child abuse and neglect is the leading risk factor contributing to the number of years of life lost to suicide and self-inflicted injuries. Childhood maltreatment has been found to account for 41% of suicide attempts.[66] It is associated with 24% of years lost in males and 33% of years lost in females.[55] People who have experienced a form of childhood maltreatment are 4.6 times more likely to have attempted suicide in the past 12 months.[67] More than 6 in 10 Australians have experienced childhood maltreatment, such as physical, sexual or emotional abuse, exposure to family violence, or neglect.[67]
Out-of-home care	Children and young people in out-of-home care (foster and residential care) are more likely to be exposed to risk factors for suicidal thoughts and behaviours. These children and young people typically experience complex trauma associated with their experiences of abuse and neglect prior to entering care and may be at risk of further harm while in care.[68,69]
Family, domestic and sexual violence	People hospitalised due to family and domestic violence are twice as likely to die by suicide compared with people hospitalised for other reasons.[70] One in four women has experienced violence, emotional abuse or economic abuse by a cohabiting partner since the age of 15, and 1 in 5 women has experienced sexual violence since the age of 15.[71] In Victoria, 17.5% of females who died by suicide between 2009-2016 had experienced family and domestic violence.[72]
Discrimination, racism and abuse	More than 1 in 10 Australians (13%) have experienced a form of discrimination in the past 12 months.[73] People who described themselves as gay, lesbian or bisexual were more likely to report experiencing discrimination than people who described themselves as heterosexual (30% compared with 13%).[73] Transgender, gender diverse and non-binary people report higher levels of discrimination and abuse than cisgender people and experience higher rates of self-harm and suicide attempts.[74] Racial discrimination has a significant association with suicidal thoughts and suicide attempts and people who experience racial discrimination experience increased risk of suicide.[57]
School-age bullying	Bullying behaviour and cyberbullying at school and among school-age children are associated with an increased risk of suicidal ideation and/or suicide attempts.[75,76]
Workplace bullying	Bullying and harassment at work has been associated with an increased risk of suicidal thoughts—some research suggesting 1.5 - 2.0 times the risk, usually within the context of other psychologically stressful employment conditions.[77] One-third of workers compensation claims due to mental stress are related to bullying and harassment.[78]
Disasters and climate change	People exposed to multiple disasters are at a significantly higher risk of attempting suicide.[79] Exposure to disasters can have long-term impacts, including on physical and mental health, financial circumstances and disruptions to housing.[80-82] Exposure to disasters will become more common due to climate change, and Aboriginal and Torres Strait Islander and regional communities will be disproportionately impacted.[83,84]
Impacts of disability	People with disability are three times more likely to die by suicide than people without disability. Experiencing limitations in activities due to disability is frequently identified as a psychosocial risk factor for people who have died by suicide.[2] People with disability are more likely to experience violence, abuse, neglect and exploitation.[85]

While the trauma associated with these experiences is unique for each person, there is clear evidence that these risks can significantly increase suicidal distress. Many of these risks intersect with other socio-economic factors, adding to the severity of suicidal distress and increasing the likelihood of suicidal behaviour. For example, factors that can increase the risk of experiencing violence include remoteness and socio-economic area of residence, disability, sexual orientation, gender identity and cultural influences, which themselves are associated with suicidal distress.[86]

Appropriate assistance for people who are experiencing these risks requires trauma-informed and culturally sensitive practices. These practices involve an understanding of the consequences of a history of trauma, prioritise trust and safety, facilitate choice and agency, highlight the person's strengths, and are informed by a person's culture, ethnicity and social identity.[87]

It is important that any action is tailored to suit the unique needs of specific cohorts and led by the experts in the relevant social policy areas (actions 1.2a to g).

The recommended actions to address risks to personal safety are described in Table 4.

Table 4: Recommended actions for Prevention objective 1.2: Address risks to personal safety

Action	Description
1.2a	Reduce the prevalence and impact of child abuse and neglect and family, domestic and sexual violence. • Implement the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*[89] and *Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031*.[90] • Implement the *National Plan to End Violence against Women and Children 2022–2032*,[39] including action 4 of the First Action Plan 2023-2027[91] to "Build the capacity of services and systems that support victim-survivors to provide trauma-informed, connected and coordinated responses that support long-term recovery, health and wellbeing".
1.2b	Ensure mental health services and other relevant supports, particularly those provided to children and young people, work in a trauma-informed and culturally safe way.
1.2c	Design and deliver nationally consistent wraparound services to support children and young people impacted by adversity (for example, experiences of trauma, abuse and neglect, residing in out-of-home care, or significant conflict with primary caregivers).
1.2d	Provide assistance and guidance for primary and secondary schools to implement evidence-based bullying prevention programs.
1.2e	Consistent with the *Australian Work Health and Safety Strategy 2023–2033*,[92] build the capability of employers to comply with their duty to manage psychosocial hazards at work, with a particular focus on industries that have higher rates of exposure to distressing and traumatic incidents.
1.2f	Continue to implement the *National Disaster Mental Health and Wellbeing Framework*[93] and incorporate suicide prevention capacity-building and processes as part of standard recovery responses for disasters spanning both immediate and long-term recovery efforts.
1.2g	Improve the safety and security of people with disability. • Implement *Australia's Disability Strategy 2021–2031*.[85] • Implement actions aligned with the joint *Australian, State and Territory Response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*.[94,95]

> **As a child who had experienced several adversities and traumas, there was a push in the 1990s and early 2000s to overcome, ignore and hide the truth. Admitting I was in foster care was not only ostracising from my peers, but teachers as well. I am now a foster carer, using my lived experience to inform, progress and influence not only the children in my care, but the systems created to support them. We need to move away from the idea that adversities only affect the child while they are a child—the trauma will always be there, but with support, the trauma may 'inform' areas in their life, rather than 'dictate'."**
>
> **– Chaya Rainbird**
> Lived Experience Partnership Group member

Activity to build on

The New South Wales Department of Communities and Justice funds the Staying Home Leaving Violence program, which aims to keep survivors of family, domestic and sexual violence connected to their existing support systems (such as friends and community). It provides help with safety planning, home security, managing finances and caring for children, as well as legal assistance to ensure the long-term safety and housing stability of every woman and child who has left violent and abusive relationships.[87]

2. Key objective

Good Health

Good physical and mental health are basic human rights.[96] People who have good mental and physical health are better able to participate in employment, education, recreation and social activities and are better protected against suicide.[12,97] Equipping people with the knowledge, skills and resources to maintain their optimal mental and physical health is a powerful way to protect against suicide.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People experience enhanced wellbeing through improved health outcomes. The prevalence and impact of major preventable health risks associated with suicide are reduced.

2.1 Improve health outcomes

To improve health outcomes, greater emphasis on health promotion, health literacy and preventive health is needed. Equitable access to initiatives that promote good health through sleep hygiene,[98,99] healthy eating,[100] improved mental health,[101] and physical activity[102,103] can help enhance wellbeing, while initiatives that take a preventive approach to health problems, such as reducing drug use, including reducing alcohol and tobacco use,[104,105] can also be protective against suicide.

There are opportunities to leverage existing work—such as Australia's *National Preventive Health Strategy*[106] (action 2.1a) and the Senate Inquiry into Sleep Health Awareness in Australia[107] (action 2.1b)—to advance reform in this area.

The recommended actions to improve health outcomes as they relate to suicide prevention are described in Table 5.

Table 5: Recommended actions for Prevention objective 2.1: Improve health outcomes

Action	Description
2.1a	Implement the *National Preventive Health Strategy*[106] to promote a healthy diet, regular physical activity and adequate sleep; reduce tobacco use and alcohol and other drug harm; promote and protect mental health; and create an effective and equitable prevention system.
2.1b	Implement the Australian Government response to the Senate Inquiry into Sleep Health Awareness in Australia.[107] Improve health and wellbeing by: • promoting the importance of sleep health, in conjunction with a healthy diet and regular physical activity • educating and facilitating behaviour change to improve sleep health • incorporating sleep recommendations for all age groups into national guidelines and policies.

2.2 Mitigate health risks

In addition to a preventative approach, action can be taken to mitigate the main health risks associated with suicide.

In Australia, mental and behavioural disorders are reported in around 64% of suicides.[2] This highlights the importance of a well-functioning mental health system, particularly support for people with severe and enduring mental illness, as a fundamental part of effective suicide prevention. The *National Mental Health and Suicide Prevention Agreement*[19] provides a foundation for mental health system reform, including improving accessibility of mental health services (action 2.2a) and the expansion of initiatives specific to suicide prevention (action 2.2b).

In addition, more than half of all people who die by suicide have a physical health condition or disease separate from any mental health condition.[2] This strong relationship between physical illness and suicide means it is imperative to support people with significant physical illness, including life-changing injuries, chronic diseases, illnesses and pain, as well as their families, carers and kin, in relation to suicide prevention (actions 2.2b to c).[108,109]

Some population groups have distinct needs that require dedicated support and, in some cases, specialised care. Transgender and gender diverse people in Australia have reported substantial barriers when seeking gender-affirming care.[110] Additionally a significant proportion of people with neurodivergence face challenges accessing diagnosis, treatment and support.[111,112] These experiences have been found to be extremely distressing and may contribute to the disproportionate suicide risks experienced by these groups (actions 2.2d and e).[74,113,114]

Harm related to alcohol and other drugs is one of the most common risk factors identified in suicide deaths in Australia. The areas of connection between alcohol- and other drug-related harm and suicide highlight the critical role a well-functioning alcohol and other drug system plays in effective suicide prevention efforts. In 2023, about 1 in 6 people who died by suicide were intoxicated from acute alcohol use, and 1 in 7 had lived with a chronic alcohol dependence disorder.[2] In relation to other drugs, in 2023, about 1 in 6 people who died by suicide were intoxicated from acute psychoactive substance use or had lived with a psychoactive substance use disorder.[2] Experiencing a substance use disorder alongside a major depressive disorder significantly increases the likelihood of experiencing suicidal thoughts.[115] People who experience both mental illness and substance use disorders often face additional barriers to accessing care due to mutually exclusive service criteria between some mental health services and alcohol and other drug services (actions 2.2f to i).[17]

There is growing evidence of a link between gambling and suicidal distress. Problem gambling behaviour and gambling harm have strong implications for other suicide risk factors, such as financial distress, the functioning of family and intimate relationships, and intimate partner violence.[116] As access to gambling activities increases rapidly due to the rise in online gambling platforms and the normalisation of gambling culture in Australia, it is important to recognise the significant public health impacts and respond accordingly (action 2.2j).

The recommended actions to mitigate these health risks are described in Table 6.

Table 6: Recommended actions for Prevention objective 2.2: Mitigate health risks

Action	Description
2.2a	Continue to expand and enhance services for people experiencing mental ill health, particularly severe and enduring mental illness.
2.2b	Improve capability of all healthcare services to identify and respond to suicidal distress.
2.2c	Provide support services for families, carers and kin to better recognise and respond to any suicidal distress being experienced by families, carers and kin while acting in a support role.
2.2d	Conduct research into the connection between neurodiversity and suicide, and review experiences of people with neurodivergence in receiving care from key health services, to identify priorities for improvement.
2.2e	Work with people from LGBTIQ+ communities to co-design and implement mechanisms that ensure health services deliver safe and inclusive care that is responsive to individual needs for LGBTIQ+ people. This includes addressing barriers to access, training, and building connections with LGBTIQ+ service providers. • Improve access to safe and affirming care for transgender and gender diverse people accessing mainstream services. • Improve knowledge and service provision to improve care and decrease stigma towards people with variations in innate sex characteristics (intersex).
2.2f	Prevent and minimise alcohol-related harms among individuals, families and communities through nationally coordinated and evidence-informed action. • Support place-based primary prevention approaches to prevent and minimise alcohol-related harms and shared risk factors for suicidality. • Improve community and individual safety, and reduce injury and violence associated with alcohol consumption. Adjust the pricing, and reduce the availability, and promotion of alcohol that contributes to risky consumption. • Improve access to effective treatment, information and support services.
2.2g	Prevent and minimise drug-related health, social, cultural and economic harm among individuals, families and communities through nationally coordinated and evidence-informed action, including: • enhancing evidence-informed harm reduction approaches • enhancing access to evidence-informed, effective and affordable treatment and support services.
2.2h	Improve support for people experiencing both a mental illness and a substance use disorder to ensure a coordinated and seamless approach.
2.2i	Increase access to peer and support programs for families, carers and kin of people who are experiencing difficulties due to alcohol- and other drug-related harm.
2.2j	Respond to the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into online gambling and its impacts on those experiencing gambling harm.[117]

3. Key objective

Economic security

Historically, suicide rates in Australia and other usually prosperous countries[118] have increased following periods of major economic downturn and recession.[119] This highlights the need to include consideration of economic security in suicide prevention efforts.

Proactive work can be undertaken to enhance economic security and buffer communities against the impact of economic changes. This can operate in tandem with efforts to reduce suicidal distress among communities most severely impacted by economic insecurity.

What do we need to achieve?

People experience enhanced wellbeing through increased economic security. The prevalence and impacts of economic insecurity are reduced.

3.1 Provide economic security

Economic security provides people the means to purchase necessities, gives a sense of purpose, facilitates social engagement, and affords choice and control over important aspects of life. Better economic security is associated with improved mental and physical health.[120,121]

Economic security requires equitable access to meaningful and stable employment (action 3.1a) and access to education (action 3.1b). In addition, equipping people with financial literacy skills to better manage the money they do have and understand how to maximise their opportunities to grow wealth will enhance their economic security and lead to greater life satisfaction (action 3.1c).[122]

The recommended actions to prevent suicidal distress by providing economic security are described in Table 7.

Table 7: Recommended actions for Prevention objective 3.1: Provide economic security

Action	Description
3.1a	Building on current approaches, develop programs that strengthen equitable access to safe, meaningful and secure work. These should focus on ensuring workplaces are psychologically safe, inclusive and affirming, especially for people from LGBTIQ+ communities, people with disability, people from culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander people.
3.1b	Continue to develop programs that strengthen equitable access to vocational and tertiary education. These programs should be informed by the Australian Government's response to *Improving Outcomes for All: The Report of the Independent Expert Panel's Review to Inform a Better and Fairer Education System*.[123] This should include meaningful engagement with education for people at all ages.
3.1c	Develop programs to strengthen population-wide financial literacy skills.

3.2 Reduce economic insecurity

Changes in the economy can have devastating impacts. This is particularly true for people who move from economic stability to uncertainty, given that they can experience an almost immediate—but short-term—increase in their suicide risk.[124] It is also the case for economically disadvantaged populations, as people living in lower socio-economic areas consistently face higher rates of suicide, and adverse changes in the economy further increases this risk.[125]

Several key social and economic factors have been shown to increase suicide risk in Australia. These are described in Table 8.

Table 8: Risk to economic security

Risk	Impact
Unemployment	People who are unemployed are about twice as likely to die by suicide compared with people who are employed.[60] As the period of unemployment increases, so does the risk of suicide. Research published in 2023 found a causal relationship between unemployment and suicide.[125] Modelling of Australian suicides over a 13-year period indicates that nearly 20% of suicide deaths resulted directly from unemployment and underemployment.[126]
Economic disadvantage	The indicators of lower socio-economic status, such as low income, lower education and dependence on welfare benefits, increase with remoteness.[127] Financial hardship due to disasters or climate change may also disproportionately affect remote communities.[128]
Low income	People who are 'low' and 'medium-low' income earners have, respectively, 8 times and 2 times the risk of suicide compared with people in the highest income bracket.[60]
Income uncertainty	People who experience income uncertainty are at greater risk of suicide compared with people who have the most stable income.[129] The main category used to indicate economic issues as a relevant factor in suicide deaths is "other and unspecified problems related to economic circumstances". This is one of the most frequently occurring psychosocial risk factors, having been identified in 7.3% of suicide deaths.[130]
Housing	Housing is important for safety and is associated with economic security. There is evidence that having a choice about housing can deliver positive mental health outcomes through feelings of empowerment and belonging, both of which are associated with greater resilience and ability to cope with stressors.[131]

Effective policies and programs across government portfolios can help prevent socio-economic hardship from escalating into suicidal distress and suicide deaths.[42] These include regular consideration of the appropriate rates of social support payments, as well as the mutual obligation requirements. Government action also includes structural changes that prevent the emergence of the most salient socio-economic stressors.

Increasing economic security is vital to preventing suicide; however, it is important that any action taken is tailored to suit the different causes of insecurity and done in collaboration with experts in the relevant social policy areas (actions 3.2a to f).

The recommended actions to prevent suicidal distress by reducing economic insecurity are described in Table 9.

> “When I first arrived in Australia, I was moved to a community housing unit by a refugee settlement program where I did not feel safe.
>
> After my son and I were provided the opportunity to move to quality government subsidised rental housing, I felt safe and that made a significant difference in our life, my mental health started improving. The residents were considerate of others, they did not make loud noises to create disruption and interference in our neighbourhood. The apartment was well maintained and tidy under the supervision of a lovely lady. Being a single mother, having a child and coming from a war zone country, I feel that access to a safe and secure home is as necessary as access to food.
>
> From my own experience, I feel it is crucial to access safe, secure, quality, and affordable housing. It improves mental health and gives people a sense of control and security.”
>
> **– Refugee (not named for cultural reasons),** Lived Experience Partnership Group member

Table 9: Recommended actions for Prevention objective 3.2: Reduce economic insecurity

Action	Description
3.2a	Enhance programs that provide equitable access to employment opportunities. • Implement reforms outlined in *Working Future: The Australian Government's White Paper on Jobs and Opportunities*.[134] • Provide incentives to employers to employ groups of people who are chronically unemployed or underemployed. • Help people who receive income support payments to gain secure employment. • Ensure people's specific needs in finding employment at different ages are met. • Provide employment opportunities for people who are experiencing barriers to accessible workplaces, such as people living and working in regional, rural and remote communities and people with disability.
3.2b	Enhance access to vocational and tertiary education, including by providing: • enrolment for people who cannot otherwise afford to study • enrolment and access for people who are experiencing physical or geographic barriers to further education, including making reasonable adjustments to support engagement.
3.2c	Maintain the social security safety net, including regular consideration of payment rates.
3.2d	Continue to work to strengthen connections between financial counselling, mental health and suicide prevention supports to meet the holistic and complex needs of people experiencing financial distress.
3.2e	Provide equitable and inclusive access to safe, secure and affordable housing across the spectrum of housing and housing services, including homelessness services, social housing, private rental housing and home ownership.
3.2f	Develop a systematic process that ensures people retiring or leaving the workforce, and people requesting early access to superannuation, are proactively offered financial, physical health and mental health supports.

Activity to build on

The COVID-19 pandemic provides a useful demonstration of the role of public policy in protecting people from the potential negative impacts of socio-economic factors. Despite adverse economic effects and increased unemployment in 2020 and 2021 associated with the pandemic, there was not an increase in deaths by suicide in Australia.[132] Research has demonstrated that the COVID-19 economic response, such as the JobKeeper Payment and the Coronavirus supplement for income support recipients, helped to reduce levels of poverty and housing stress compared with pre-pandemic levels, and this may have had a protective effect against suicide.[133] This finding is consistent with international evidence that government support provided to alleviate financial hardship had a protective effect against suicide.[16,17]

4. Key objective

Social inclusion

Populations that have greater social capital—that is, those with stable families and closely knit communities that nurture and reinforce social connections—have lower suicide rates.[46] People thrive when they feel included in communities, are connected with others and have a sense of belonging, and this in turn builds wellbeing and reduces the prevalence of suicidal thoughts and behaviours.[72,135]

Suicide prevention efforts must therefore seek to nurture more inclusive communities, build stronger connections between communities, and reduce the prevalence and impact of factors that lessen social connection and inclusion.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People experience enhanced wellbeing through greater community inclusion and social connection. The prevalence and impact of loneliness and social exclusion are reduced.

4.1 Connect communities

People can be connected to others through their contributions to society; shared culture, identity and interests; working and volunteering relationships; and family and kinship networks. Each of these connections fosters a sense of belonging for the individual and community. Aboriginal and Torres Strait Islander concepts of connection include links to community, Country, culture, spirituality and ancestry.

Initiatives that build affirming and inclusive communities and provide opportunities for people to engage socially and culturally in a safe and secure way are therefore a fundamental part of preventing suicide (action 4.1a). A sense of community can be especially important for groups who may not typically have strong social networks, for people who face intersecting discrimination or disadvantage, and for people who may not feel included as part of broader communities, such as men,[136,137] Aboriginal and Torres Strait Islander people,[138] people from culturally and linguistically diverse backgrounds, older people, people from LGBTIQ+ communities and people with disability.[139]

As an example, volunteering can build social capital and contribute to wellbeing by providing social interaction and a sense of purpose[140] the National Strategy for Volunteering 2023-33 provides a strategic framework for enabling safe, supported and sustainable volunteering.[141]

The recommended actions to improve community connection are described in Table 10.

Table 10: Recommended actions for Prevention objective 4.1: Connect communities

Action	Description
4.1a	Work with communities to guide, coordinate and create initiatives that build cultural connection, sense of belonging, positive cultural identity, and engagement with cultural practices in communities. These programs should be focused on inclusion of all age groups, and actively reach out to people who would benefit most from strengthened community connections. • Build capacity for marginalised groups to grow community leadership for greater representation in the community. • Build the capability of individuals to participate fully in the community, including through digital and online engagement. • Reinforce efforts to promote healing and reconciliation between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. • Increase the number of sporting and other interest groups available to communities, and help community clubs to ensure diverse representation among participants. • Facilitate uptake and diversity of volunteering, including increased support to connect with volunteering options across settings such as schools, hospitals, aged care support, community programs and sporting clubs.

4.2 Address loneliness and social exclusion

Loneliness and social exclusion are risk factors for suicide.[142] Loneliness is the subjective feeling of a lack of connection with others and can be experienced regardless of whether a person is alone or surrounded by others. Social exclusion describes an experience of being rejected or ostracised by others and can be the result of experiences such as racism, ageism, homophobia or transphobia, stigma, ableism or economic circumstances that prevent inclusion or participation in the community. Loneliness and social exclusion are related to a desire for more, or more satisfying, social relationships (action 4.2a).[143,144]

Racism and racial discrimination are experienced by many people and are frequently experienced by Aboriginal and Torres Strait Islander people. Such experiences have negative impacts on mental health and on social and emotional wellbeing.[145] Prejudice against transgender people is also prevalent and has a similarly detrimental impact (action 4.2b).[146]

People who experience severe loneliness are 3.5 times more likely to attempt suicide in their lifetime and 17.4 times more likely to have attempted suicide in the past 12 months.[58] Approximately 1 in 3 Australians report that they feel lonely and 1 in 6 feel severely lonely.[147] For men, loneliness is associated with twice the likelihood of experiencing suicidal thoughts and making suicidal plans, and for some, an increased likelihood of a suicide attempt.[148] Young lonely men are particularly at risk for experiencing suicidal thoughts.[149]

The recommended actions to reduce loneliness and isolation are described in Table 11.

Activity to build on

Neighbours Every Day is a campaign that encourages individuals and communities to hold events to build connections with neighbours. Social identification — that is, feeling connection and a sense of belonging with your neighbours — contributes to community health and wellbeing and decreases loneliness and social fragmentation. Involvement in a Neighbour Day event led to a significant increase in social identification.[150]

Table 11: Recommended actions for Prevention objective 4.2: Address loneliness and social exclusion

Action	Description
4.2a	Address loneliness and social exclusion in Australia. • Conduct a review of relevant programs in Australia and the latest evidence to guide investment on initiatives that effectively address loneliness and social exclusion. • Improve community understanding of loneliness and social exclusion and relevant resources and programs through community awareness campaigns. • Implement and evaluate programs to build social connectedness and a sense of belonging, and improve relationships, including through funding community-based programs that focus on reducing loneliness among groups that experience high rates of social disconnection and exclusion, particularly men, older Australians, young people, people with disability, and people living and working in regional, rural and remote communities.
4.2b	Co-design, deliver and evaluate culturally appropriate programs for communities who experience stigma, discrimination and internalised shame. This includes initiatives that focus on combating homophobia, transphobia, ageism, racism and disability discrimination.

5. Key objective

Navigating life transitions

Life transitions—such as becoming a parent, retirement, bereavement, transitioning out of the Australian Defence Force and leaving places of detention—are an important focus for suicide prevention. Regardless of whether transitions are anticipated or unexpected, or whether they represent a fundamentally positive or negative change, they often involve significant disruption and may require substantial adjustment. Life transitions can bring about increased loneliness, financial distress or instability, and sometimes trauma.

As a result, life transitions are an important focus for suicide prevention. A comprehensive approach includes equipping people with the skills and wellbeing to navigate the challenges of life transitions and providing support when they occur.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12		13		14			

What do we need to achieve?

People experience enhanced wellbeing because they are equipped to navigate key stages of life and can work through disruptive transitions.

5.1 Assist people to thrive in key life stages

Protection against suicide can be built by positive experiences at key life stages, from childhood through to older age. This involves making sure people are proactively supported when transitioning into and out of these life stages so they can thrive.

With a safe and secure foundation, children can make a healthy start to life that is protective against suicide as they grow. Enabling healthy mental and physical development within the first 2,000 days of a child's life by equipping parents with the necessary resources can have lifelong positive impacts.[151] Building on the existing directions outlined in the *National Children's Mental Health and Wellbeing Strategy*[151] and *The Early Years Strategy*[152] (action 5.1a), and in alignment with the *National Agreement on Closing the Gap*[37] and the *National Preventive Health Strategy 2021–2030*,[106] programs focused on children's wellbeing should:

- empower parents, caregivers and families with the skills, resources and capabilities to ensure all children in Australia are able to thrive
- connect parents, caregivers and families with high-quality, affordable and integrated support and services when and where they need it
- deliver early childhood and primary education services that foster healthy mental and physical development
- ensure that educators are equipped with the knowledge, skills and resources to meet each child's physical, neurodevelopmental and cultural needs.

As young people move from childhood into young adulthood, it is important that they have the knowledge and skills to build and maintain their own wellbeing. This formative period can involve leaving school, starting employment and higher education, beginning to form intimate relationships, and becoming a parent or carer. Instilling good health practices in young people as they grow into adults builds resilient societies and improves mental and physical health outcomes that protect against suicide (action 5.1b).[153]

Schools play an important role in the lives of children and young people and act as a hub for a range of community events. Ensuring that schools and the school curriculum are designed to build wellbeing is an investment in lifelong community suicide prevention. Over recent years, educators have increased their emphasis on student wellbeing in response to growing community expectations for schools to address mental ill health, bullying, self-harm and suicide. These efforts should include:

- modelling inclusive and affirming cultures
- hosting activities that build a sense of community within the school—for example, home rooms, sporting and special interest clubs, extracurricular activities and social events
- establishing links with the surrounding community
- ensuring access to parenting advice and education, and providing regular communication about school and community events.

> **"There needs to be a good transition plan for kids who go back to school after a suicide attempt. It can be a massive shift getting back into education. Many students don't re-engage with education, particularly if the attempt is in the final years. It makes a huge difference to their experience if there is coordinated care at home, at school and with the care team. This can make it possible for them to graduate."**
>
> **–Jordan Frith**
> Lived Experience Partnership Group member

Promoting good health across the lifespan contributes to wellbeing in older age. Social participation of older people is facilitated by fostering positive social attitudes towards older people, and creating physical and social environments that are accessible and inclusive (action 5.1c).[154] Environments and experiences that engage and stimulate each person can build cognitive functioning and help establish and maintain social connections. Later life should be appreciated as a time for living, and older people should be provided with opportunities to live in a way that provides agency, purpose and meaning.[155] Aged care, when needed, should ensure people live a satisfying and fulfilling life as much as possible (action 5.1d).

The recommended actions to ensure that people thrive in key life stages are described in Table 12.

Activity to build on

Mental health literacy programs can help young people understand concepts of mental health and wellbeing, learn strategies to maintain good mental health, decrease stigma about mental illness and increase help-seeking and resilience. Youth Aware of Mental Health is an evidence-based program provided through schools for young people to learn about and explore the topic of mental health.[154]

Table 12: Recommended actions for Prevention objective 5.1: Thrive in key life stages

Action	Description
5.1a	Continue to implement the *National Children's Mental Health and Wellbeing Strategy*.[151]
5.1b	Review the effectiveness of existing programs, including in schools, that build life skills and foster the wellbeing of children and young people, with a view to implementing and evaluating a coordinated, accessible and nationally consistent approach. The program should be co-designed with children and young people, but could include: • adaptive coping and problem-solving, and improving self-esteem and self-efficacy • financial literacy • self-help and peer support skills • safe and effective interaction with technology and digital media • tailored components to build the social and emotional wellbeing of Aboriginal and Torres Strait Islander children and young people.
5.1c	Develop a considered approach to build the wellbeing of older Australians, including to foster positive social attitudes, create physical and social environments that are accessible and inclusive, and encourage participation.
5.1d	Implement measures aligned with the *Australian Government response to the Royal Commission into Aged Care Quality and Safety*[157] to promote the health and wellbeing of aged care residents, including through connecting and integrating aged care services with the broader community to enhance community engagement.

5.2 Assist people with challenging life transitions

As people navigate new life circumstances, feelings of stress can escalate to distress which, without support, can escalate into suicidal distress. Some prominent life transitions and events have been identified as risk factors for suicide in Australia, and these are described in Table 13.

Table 13: Life transitions and events identified as risk factors for suicide

Life transition or event	Description
Perinatal period	Suicidal thoughts are common during the perinatal period. Estimates suggest 5–14% of expectant and new parents experience suicidal thoughts and behaviours.[61]
Key LGBTIQ+ milestones	There is evidence of increased risk of suicidal behaviour in LGBTIQ+ people close to coming out milestones; of all suicide attempts among LGBTIQ+ people, 61% occur within 5 years of realising their LGBTIQ+ identity.[158] For transgender, gender diverse and non-binary people, coming out as transgender or affirming one's gender and being unable to access gender-affirming treatment are stressful life events. Studies show these experiences may increase the likelihood of suicide attempt.[159,160]
Family and relationship breakdown	Disruption of family by separation and divorce has been identified in around 1 in 6 male and 1 in 10 female suicide deaths.[62] Intimate partner relationship problems such as romantic break-ups, arguments and conflict are also common factors in adult suicide.[161,162]
Legal problems	Problems related to legal circumstances have been identified in 13.8% of suicide deaths.[2]
Work changes	People exiting the labour force, especially people who retire involuntarily[163] or leave the labour force due to injury,[164] can be at greater risk of suicidal thoughts and behaviours.
Leaving Australian Defence Force service	Research has found that ex-serving males and ex-serving females were more likely than the Australian population to die by suicide, with suicide rates being 26% higher for ex-serving males and 100% higher for ex-serving females. The rates of suicide for involuntarily medically separated ex-serving males and females were 62.7 and 36.3 per 100,000 population, respectively—much higher than the rate among voluntarily separated males and the general population.[29]
Entering or leaving detention	People transitioning out of prison are at greater risk of suicide. A study on Queensland prisons found that released women and men were, respectively, 14.2 times and 4.8 times more likely to die by suicide than the wider Queensland population.[165] Self-harm rates for asylum seekers in all types of onshore closed immigration detention are many times higher than rates found in the Australian population.[166]
Ageing	For older people, risk factors for suicide include declining health, loss of independence, neurocognitive impairment and difficulty adjusting after moving into aged care.[167,168] Moving into aged care may involve additional stress for Aboriginal and Torres Strait Islander people due to trauma associated with institutional settings, especially for Stolen Generations survivors.[155] Stress about anticipated discrimination and mistreatment in residential aged care settings is common for LGBTIQ+ people.[169]
Bereavement	People recently bereaved are at a higher risk of suicide and that risk is higher again for people bereaved by a sudden death.[170,171] People bereaved by suicide have 1.65 times the likelihood of suicide attempt compared with those bereaved by sudden natural causes.[33]

> **The change that's happened across the sector is phenomenal. When we lost a family member to suicide over 10 years ago, we battled with nothing, we had no specific support services to turn to and no help in navigating next steps. The immediate support is there now where it wasn't before. Services can step in, in those early days after the loss of a loved one. Ideally, referrals to supports would happen automatically for those whose life has been impacted by suicide. It makes such a difference to set people up with wraparound support and walk beside them on their challenging journey ahead."**
>
> **– Susan Edgar**
> Lived Experience Partnership Group Chair

Supports need to be put in place to address the risk of escalated distress during life transitions and events. One means of doing so is by leveraging the related services that many people who are going through life transitions are likely to use; for example, couples going through a separation or divorce may be in contact with legal or family services and/or the Federal Circuit and Family Court of Australia.

These service contacts are well-positioned to identify those who might need additional support and facilitate their engagement with the appropriate services, including culturally sensitive support for Aboriginal and Torres Strait Islander people. Doing so is pivotal to preventing suicide; however, it is important that any action being taken is tailored to suit the circumstances of the transitions and the specific cohorts, and is done in collaboration with the experts in the relevant social policy areas (actions 5.2a to i).

The recommended actions to assist people during life transitions are described in Table 14.

Table 14: Recommended actions for Prevention objective 5.2: Assist people with challenging life transitions

Action	Description
5.2a	Increase access to and promotion of support programs for people transitioning into parenthood to help those experiencing parenting-related difficulties and distress.
5.2b	Through the Family and Magistrate Court systems, for people involved in family law and domestic violence matters, continue to provide information on and referrals to suicide prevention and other support programs, including peer support, counselling services, legal advice and parental assistance.
5.2c	Continue to provide subsidised access to counselling for people going through separation and divorce, promoted through family law services and other key touchpoints in the family law system.
5.2d	Provide timely and effective support for people in prison or youth detention settings. • Provide effective mental health and suicide prevention supports. • Provide transition support programs that facilitate access to stable housing; develop psychosocial, employment and job seeking capabilities; maintain ongoing transitional support after release; and—for Aboriginal and Torres Strait Islander people leaving prison—provide cultural support.
5.2e	Fund assistance for people transitioning into aged care environments, including culturally appropriate, trauma-informed and healing-informed approaches for Aboriginal and Torres Strait Islander peoples that acknowledge the heightened trauma associated with moving into institutional settings for members of the Stolen Generations.
5.2f	Provide universal access to: • postvention services to support people bereaved by suicide, including dedicated tailored supports for groups disproportionately impacted by suicide • bereavement support for all, including grief counselling, financial and legal advice and other care.
5.2g	Draw on existing reviews of workers compensation processes in Australia to develop best practices to improve: • the timeliness and fairness of procedures • the quality and duration of psychological support provided • the overall worker experience of claims processes • return to work outcomes.
5.2h	Implement measures aligned with the *Australian Government response to the Final Report of the Royal Commission into Defence and Veteran Suicide*.[40]
5.2i	Increase support for LGBTIQ+ young people and their families, carers and kin, to facilitate good mental health and supportive relationships, with a focus on the intersections between key coming out milestones and increased suicide risk.

Activity to build on

Feel the Magic provides evidence-based grief education programs for children and young people who are experiencing pain and isolation due to the death of a parent, guardian or sibling.[172] The program aims to support children, young people and their families to develop strategies to cope with a loss. A program for young people bereaved by suicide, called the Let's Talk Suicide virtual camp, helps them heal from the guilt, shame and blame often associated with suicidal grief.[173]

Support

for people experiencing suicidal thoughts
and behaviours and those who care for them

Compassionate, timely, appropriate and coordinated support that addresses the drivers of a person's distress is central to preventing suicidal distress from continuing or escalating. Support relates not only to responses from formal health and mental health services, but broader settings inclusive of community and other service touchpoints. This Strategy recognises that managing socio-economic factors is not just important in preventing suicidal distress, but in supporting those who experience suicidality.

In Australia there is widespread stigma associated with suicide, which can limit people's engagement with supports and lead to increased isolation and distress. In addition, the support that is currently available for people experiencing suicidal thoughts and behaviours largely relies on a mental health system that is born out of a physical health model. This contributes to experiences of care that can be inflexible, difficult to navigate and often limited to clinical or medical treatment options. These experiences can, again, diminish engagement and exacerbate distress for people experiencing suicidal thoughts and behaviours, and their families, carers and kin. In addition, Australia's mental health system is not sufficiently integrated with broader support services that help address the full range of drivers of suicidal distress discussed in key objectives 1–5.

Many encouraging mental health and suicide prevention reforms are underway, aimed at addressing these limitations. Achieving the change required involves progressing these reforms, expanding initiatives that deliver positive outcomes and building the evidence for promising support models. These reforms include procedural improvements to crisis responses involving emergency services and mental health workers, in-person after-hours crisis services for people in suicide distress, expanded community-based supports, and improved competency in risk formulation.

This Strategy proposes further strengthening our approach so that it is better designed to support people experiencing suicidal thoughts and behaviours, and their families, carers and kin, and reflects a contemporary understanding of suicide—that is, one that recognises the diverse and concurrent drivers of distress and is grounded in an understanding of suicidal distress not as a phenomenon to be managed, shut down or stopped, but as a human response to overwhelming suffering, which deserves to be met with a compassionate and holistic response.

To achieve this, the Strategy outlines five essential components of an effective support system and the actions required to establish them:

- a culture of compassion. Increase engagement with supports through reduced suicide stigma and increased capability of community and services
- accessibility. Ensure affordable, timely and acceptable supports are available
- system-level coordination. Ensure supports are seamlessly linked and easy to navigate
- holistic approaches. Address drivers of distress and sustain engagement
- increased connection. Restore and build wellbeing through increased social connection and community engagement.

Each of these components is framed as a key objective, and specific actions are outlined to deliver them. To achieve an effective support system, all components must be reflected in each service that provides support to people who experience suicidal thoughts and behaviours, and their families, carers and kin, as well as across the suicide prevention support system as a whole. This includes mental health, suicide prevention, primary care and emergency department services, as well as related supports; for example, in services for alcohol and other drugs, victim support, family and relationships, and child protection. The objectives and actions are relevant across all services and the diverse workforces employed within them, including nurses, doctors, psychologists, psychiatrists, social workers and peer workers.

6. Key objective

Culture of compassion

Connecting people who experience suicidal distress with supports is vitally important in preventing suicide.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

Maximising opportunities to provide the best possible support requires a shift to a culture of compassion. This is one where people with suicidal thoughts and behaviours, and their families, carers and kin, are met not with damaging attitudes and behaviours that limit engagement with support, but with understanding and respect for their strength, autonomy and agency.

This shift requires:

- concerted efforts to reduce stigma associated with suicide
- upskilling of service providers (outside of mental health and suicide prevention) and members of the general community to understand suicide and to be able to identify, reach out and compassionately respond to people in suicidal distress. Expanding the range of touchpoints available in this way means that people do not always have to reach out—but rather that these informal supports reach in to help
- providing training and support for staff to deliver best-practice, trauma-informed support.

What do we need to achieve?

People impacted by suicidal thoughts and behaviours experience a compassionate response that helps them feel understood and empowered by the support system and society.

6.1 Reduce suicide stigma

Stigma occurs in different forms, including structural stigma (when laws, policies and practices enable unfair treatment), public stigma (when negative opinions are held towards people with lived and living experience of suicide), cultural stigma (when norms and taboos are present in a culture) and self-stigma (when a person with lived or living experience of suicide comes to believe negative stereotypes about themselves; for example, that they are weak or selfish or not deserving of support).

There is significant and continuing stigma specific to suicide.[174,175] Many people regard suicide as morally wrong, a selfish act, or a sign of weakness or attention seeking.[174] Suicide stigma can limit the extent to which people with suicidal thoughts and behaviours engage with supports.[176] It can also lead to ostracism when it is vitally important that they be socially connected. In addition, self-stigma can add to social withdrawal and loneliness.[174] Suicide stigma can also be experienced by people who support someone who is suicidal and by people who are bereaved by suicide.[174] This can exacerbate distress and lead to isolation at a time when connection is critical.

Stigmatising beliefs about suicide in service settings are likely to lead to unsafe and unhelpful interactions with people who are experiencing suicidal thoughts and behaviours, or with their families, carers and kin.[177,178] When efforts to reach out for help do not go well, people may be discouraged from seeking help in future.

Education programs and campaigns have been found to be effective in addressing public suicide stigma (action 6.1a).[179,180] A reduction in suicide stigma has also been found through accurate and balanced media representation of people who experience suicidal thoughts and behaviours (action 6.1b).[181]

The Mindframe guidelines assist media professionals to communicate about suicide safely and accurately in a way that both reduces stigma around suicide and reduces the knowledge of means of suicide within the community.[1] Online services and platforms also have an important role to play in minimising exposure to stigmatising or harmful content, through effective moderation as well as enhancing user choice and control over the content they receive. Maintaining a focus on responsible media reporting guidelines and the removal of harmful suicide-related content from online platforms can reduce stigma as well as knowledge of means of suicide within the community (action 6.1c).[182]

Reducing suicide-related stigma among service providers can be achieved through education[179,180] during pre-service and ongoing professional development (action 6.1d). Ideally the content is co-designed and co-facilitated by people with lived or living experience so it is effective and challenges stereotypes.

The most effective way to reduce self-stigma related to suicide is to reduce structural and public stigma. Nevertheless, emerging evidence related to self-stigma about mental ill health could be drawn on to inform pilot programs for individuals, groups, and families, carers and kin (action 6.1e).[183] There are promising peer support group-based approaches about changing attitudes and promoting acceptance for people with severe mental illness symptoms,[184] as well as one-on-one interventions such as acceptance commitment therapy[185] and cognitive behaviour therapy.[186]

The recommended actions to reduce suicide-related stigma are described in Table 15.

Activity to build on

Alive and Kicking Goals! is a program from the Mens Outreach Service Aboriginal Corporation based in the Kimberley, Western Australia. It aims to reduce the high suicide rate among Aboriginal and Torres Strait Islander youth in and around Broome by reducing stigma and increasing help-seeking. The initiative trains youth leaders to deliver peer education workshops and provide one-on-one mentoring.[185,186]

Table 15: Recommended actions for Support objective 6.1: Reduce suicide stigma

Action	Description
6.1a	Invest in communication campaigns to reduce stigma about suicide, informed by the best available evidence.
6.1b	Build on work already being done in relation to mental ill health by co-designing updated guidance and accountability mechanisms to encourage non-stigmatising representations of suicide in traditional and online media.
6.1c	Continue to invest in and evaluate efforts to reduce the publication of material that promotes or encourages suicide in traditional and online media, and on online services and platforms.
6.1d	To reduce suicide stigma among health and non-health support service providers: • strengthen professional undergraduate and postgraduate curricula and ongoing professional development programs by integrating stigma-specific content • expand training programs that have been shown to be effective in reducing stigma and discrimination.
6.1e	Fund development and evaluation of individual and group programs that help to build self-compassion, hope and stigma-resistance with a view to developing guidelines for best-practice approaches for reducing self-stigma as the evidence base grows.

6.2 Build suicide prevention capability

An approach that can overcome barriers and increase opportunities to connect people with support is to broaden suicide prevention capability beyond traditional health services and into community settings. This enables community members and non-health services to be able to identify people who might be struggling and reach in to provide immediate and compassionate responses as well as connect them with relevant supports.[189,190]

Many people who experience suicidal distress are likely to talk to family members or friends before reaching out for more formal support. Building the capability of community members, especially people who are part of populations disproportionately impacted by suicide, to identify people who are experiencing suicidal distress, respond compassionately and offer connection to formal supports can overcome barriers to service access faced by these populations (action 6.2a).[191,192]

Suicide prevention capability should also be developed in service settings that provide support around social determinants of health, including legal, financial, employment, relationship and social support services, and aged care providers. Staff in education settings, such as schools and universities, can be upskilled to reach young people (action 6.2b).[193,194]

Promising results have been achieved internationally using short-term support models that build the suicide prevention capability of non-health support services and establish a direct referral pathway to a short-term support service.[195] This model is being trialled through Distress Brief Support[196] services under some of the bilateral agreements of the *National Mental Health and Suicide Prevention Agreement*.[19]

The recommended actions to build suicide prevention capability are described in Table 16.

Activity to build on

Suicide Story is a suicide prevention education and training program developed by Aboriginal people for Aboriginal people.[197] It delivers culturally safe workshops to equip community members with the skills, knowledge and confidence to respond compassionately and effectively to the risk signs of suicide. Evaluation of the program found that it decreases suicide stigma, improves awareness of the signs of suicidal thoughts, and improves skills and confidence to respond to grief, trauma, and the needs of those who may be contemplating suicide.[198]

Table 16: Recommended actions for Support objective 6.2: Build suicide prevention capability

Action	Description
6.2a	Promote uptake of suicide prevention training in the community, with tailored training and peer facilitators for populations disproportionately impacted by suicide.
6.2b	Build upon the existing Distress Brief Support trials to improve the capability of services that are frequently in contact with people negatively impacted by social determinants to recognise and respond compassionately to signs of suicidal distress. Relevant service contexts include sports clubs; Men's Sheds; education settings; social support services; aged care providers; and migrant and refugee settlement services. • Upskill staff through a core training package, with tailored modules for different service contexts, and processes for the maintenance of these skills. • Provide guidance on the development and implementation of organisation-specific processes for making referrals to additional supports. • Create a dedicated function within services to provide connections to ongoing supports. • Evaluate the effectiveness of these activities for groups disproportionately impacted by suicide.

6.3 Trauma-informed and empathetic responses

People who experience suicidal thoughts and behaviours and engage with formal support may have previous traumatic experiences, including stigma, disempowerment, or forced or failed treatment from health services.[11,13,197] Trauma-informed approaches are therefore essential.

Trauma-informed practice aims to recognise and understand trauma, and create a psychologically, emotionally and physically safe environment in which survivors of trauma can feel empowered and in control.[200] Trauma-informed practice can be achieved through a strengths-based approach that focuses on individual abilities, shows compassion for a person's pain, aims to build trust, and works collaboratively to meet a person's needs.[201]

There are promising service models and frameworks that can create an organisational culture of compassionate care for people experiencing suicidal thoughts and behaviours. Service models such as the Zero Suicide Framework help to create a systematic approach to suicide prevention and quality improvement in the healthcare system.[202] A key element is the introduction of a restorative just and learning culture that focuses on learning from critical incidents to improve outcomes (action 6.3a).

A restorative just and learning culture creates organisational environments with high psychological safety and trust, and more flexibility in responding to people presenting with suicidal thoughts and behaviours. This leads to capable and motivated staff–for example, mental health nurses, social workers, psychologists and psychiatrists–who are supported to deliver high-quality care.[203]

Restrictive practices, such as involuntary treatment, seclusion or restraint, are sometimes used in the care of people with suicidal thoughts and behaviours. There is mixed evidence about the harms versus the benefits of involuntary treatment for people experiencing suicidal thoughts and behaviours, and this warrants further investigation.[204-206] As current publicly available reporting does not include details about whether involuntary treatment orders are used in relation to expressed suicidal intent, there is a need to improve data collection to better understand current practice and in turn ensure people experiencing suicidal thoughts and behaviours receive compassionate care that is least restrictive (action 6.3b).

The recommended actions to ensure trauma-informed and empathetic responses are described in Table 17.

Activity to build on

Gold Coast Mental Health and Specialist Services implemented the principles of restorative just and learning culture alongside the Zero Suicide Framework[207] in response to critical events. This led to the culture change required to support learning and improved safety, and more compassionate interactions through increased empathy and trust between service users, their families and staff.[208]

Table 17: Recommended actions for Support objective 6.3: Trauma-informed and empathetic responses

Action	Description
6.3a	Require services that provide support to people experiencing suicidal thoughts and behaviours to work to implement a restorative just and learning culture.
6.3b	Review and improve data collection on involuntary treatment orders to include details about when these orders are used due to concerns about suicidal intent, with a view to improving understanding of current practice.

7. Key objective

Accessibility

Accessibility of services and supports across the continuum of care is crucial to suicide prevention—it facilitates early engagement, ensures timely crisis response and supports sustained wellbeing.

To achieve accessibility, required services should be easily found and readily available regardless of where a person lives, their support needs or their disability status or type. Services should be affordable, which may mean costs need to be reduced for some people. In addition, supports should be delivered in a way that is appropriate and acceptable, considering the intersectionality of people's culture, beliefs, identity, ability and care needs.[209]

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People impacted by suicidal thoughts and behaviours can access timely and appropriate support to suit their needs.

7.1 Available and affordable support options

People can only connect with relevant support services if they are aware the services exist and know how to access them. User-friendly online platforms that host localised, up-to-date service information can help people find relevant services (action 7.1a).

Timely access to supports is critical for people who experience suicidal thoughts and behaviours, given that they are at increased risk of attempting or dying by suicide. These services need to be resourced to be readily available, and accessible during hours that meet the needs of the population they support. The *Productivity Commission, Mental Health, Inquiry Report*[11] highlighted the need to increase resourcing for community-based mental health supports to meet population needs (action 7.1b). Anxiety and stress can increase when people are placed on waiting lists for care because demand exceeds service capacity. Uncertain, unexpected and longer wait times further aggravate anxiety and stress.[210] Additional flexibility may be required, because suicidal distress may diminish the individual's capacity to avoid exclusion criteria, such as missing appointments. Health service capacity should be expanded to ensure demand can be met.

Services must not only be known and available but must be affordable. The risk of suicide is 2.3 times greater for people in the lowest socio-economic quintile, but this group has the lowest usage of mental health and suicide prevention services, largely due to affordability and geographical access barriers.[211,212] Improved affordability is required to address inequity in access to services for people with low incomes and for people who need long-term support including those with chronic suicidal thinking (actions 7.1c, d and e).

Increasing the use of digital technology to deliver support (for example, through videoconferencing) can overcome some access barriers, including travel, cost and availability (action 7.1f). Self-guided and therapist-supported digital interventions directly targeting suicidal thoughts and behaviours have been found to reduce suicidal thoughts significantly and are another promising way to use technology to improve access to support.[213]

The recommended actions to enhance availability and affordability of supports are described in Table 18.

Table 18: Recommended actions for Support objective 7.1: Available and affordable support options

Action	Description
7.1a	Provide comprehensive, accessible and localised information about suicide prevention support options, including via online health information portals, to improve service awareness and navigation for the community and service providers.
7.1b	Expand the capacity of community and hospital services to meet population needs and improve timely access to support for people who experience suicidal thoughts and behaviour.
7.1c	Improve affordability of community-based psychological therapy for people in the lowest socio-economic quintile.
7.1d	Improve affordability of ongoing support for people with chronic suicidal thinking, including evidence-based therapies and non-clinical, peer-led suicide prevention support services.
7.1e	Increase the number of Medicare Mental Health Centres to provide greater in-person access to mental health assessment and treatment for all ages.
7.1f	Use digital tools to improve access to timely care and support for people experiencing suicidal thoughts and behaviours, especially for people living and working in rural, regional and remote parts of Australia. • Expand the availability of therapist-supported and self-guided digital services and tools. • Expand the availability and improve the integration of videoconferencing with face-to-face service delivery.

7.2 Rapid support for people in suicidal crisis

Long wait times in emergency departments for people presenting in suicidal crisis are commonly cited as a barrier to accessing care and a disincentive to seeking support.[214] Service models designed to provide rapid, tailored responses to people in suicidal distress, such as co-responder models (that is, joint response to emergency service calls for suicidal crisis by police and/or ambulance with a clinician or suicide prevention peer support worker) and safe spaces, have shown promising benefits for individuals and the service system.[192,215-217] Expanding these supports will improve timely access to appropriate care for people in suicidal crisis (actions 7.2a and b).

Given people's engagement with digital technologies generally, the use of technology to identify signs of distress, provide psychoeducation and facilitate connection may improve access to and engagement with supports (action 7.2c).[218-220]

The recommended actions to ensure rapid support for people in suicidal crisis are described in Table 19.

> **"After my discharge from the psychiatric ward, I felt highly vulnerable and fragile. The fear of losing my support system and experiencing a relapse in my mental health weighed heavily on my mind. It was during this critical time that a peer worker introduced me to 'Safe Haven', a community café designed for individuals facing mental health challenges.**
>
> **During my first visit to the café, I was truly captivated by the atmosphere. It exuded a sense of safety and acceptance, surrounded by fellow peers. Here, we had the autonomy to engage in self-care through art, sensory modulation, music, or simply by interacting with others who shared similar lived experiences. This community experience proved to be incredibly rewarding for me, alleviating the sense of isolation I had been feeling. It facilitated connections with like-minded individuals and provided an opportunity to learn from the journeys of others; all of which significantly supported my own recovery."**
>
> **– Isha Garg**
> Lived Experience Partnership Group member

Table 19: Recommended actions for Support objective 7.2: Rapid support for people in suicidal crisis

Action	Description
7.2a	Review co-responder models (that is, joint response to emergency service calls for suicidal crisis by police and/or ambulance with a clinician or suicide prevention peer support worker) in Australia and use the findings to establish guidelines for a best-practice national approach, including culturally appropriate responses for Aboriginal and Torres Strait Islander people.
7.2b	Evaluate safe space services in Australia, to inform the development of best-practice guidelines for co-design of future safe space services. The guidelines should include advice on safe space services for young people.
7.2c	Investigate opportunities to use technologies, including artificial intelligence, to identify and respond to emerging distress, including suicidal thoughts, on online platforms via collaboration with technology companies and leveraging relevant international work.

7.3 Appropriate and acceptable delivery of support

To be truly accessible, supports also need to be appropriate for and acceptable to the people that use them.

Appropriate supports are those that align with the needs of the person experiencing suicidal thoughts and behaviours and their families, carers and kin and are provided in a way that suits the person receiving those supports.[209]

To be acceptable, supports need to be ethically and culturally safe, respectful of the wisdom held by communities and affirming of sexual and gender identity.[221] An acceptable support is one that a person is comfortable to access and the service provider is comfortable to provide.[209]

In Australia, some groups are reluctant to access support for suicidal thoughts and behaviours because of concerns about the appropriateness and acceptability of available services. Men are less likely to engage with services than women, because services are often not designed to meet men's needs. Men report valuing non-clinical interventions that promote social interaction (for example, sports-based activities or Men's Sheds), but the effectiveness of these approaches for suicide prevention is yet to be established.[222] Trialling service models that are tailored to men, building workforce knowledge of gender and masculinity constructs, and increasing capacity to apply this knowledge, is central to improving the effectiveness of suicide prevention supports available to men (action 7.3a).[223]

Despite high rates of suicidal thoughts and behaviour among LGBTIQ+ people, many are reluctant to access support services due to past experiences of stigma and discrimination and concerns about service appropriateness.[224] For example, there is evidence that one-third of young LGBTIQ+ people chose not to use a crisis support service during their most recent personal crisis because they anticipated discrimination.[225] There is a recognised need to provide tailored suicide prevention supports for LGBTIQ+ people to improve engagement and the appropriateness of services (action 7.3b).[18]

An Australian study of coronial data from 2006 to 2019 found that migrants from Oceania or African countries were disproportionately impacted by suicide compared with other migrant groups and the Australian-born population.[27] While further research is required to understand the reasons behind the higher suicide rates, there is an opportunity to increase early engagement with support by providing people experiencing suicidal distress with local, culturally competent services that are co-located with, or referred to by, trusted community supports (action 7.3c).

Culturally safe, accessible, targeted and coordinated care is needed for Aboriginal and Torres Strait Islander peoples. The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*[41] provides specific recommendations aimed at ensuring appropriate support is available whether through Aboriginal and Torres Strait Islander-led or non-Indigenous services. Acting upon these recommendations is essential to provide accessible and effective support.

The recommended actions to ensure appropriate delivery of support are described in Table 20.

> “I recently worked with a young trans person who felt particularly discriminated against in hospital, so they had many bad experiences over the years presenting to emergency departments. Eventually, they held back from presenting, so we stepped in to engage with them and work with them to build up their skills and knowledge around distress tolerance and regulating emotions.
>
> The team and I worked together with them for almost a year, connecting them to social and art-based activities within the community. Over time, we were able to help them move into permanent accommodation and enrol in TAFE, where they are now studying animation. There is no longer a requirement for ambulance interventions as the young person has stopped self-harming. Through engaging with a Lived Experience Peer Worker, this person was able to break the cycle of going to hospital, being retraumatised, leaving hospital and going back into crisis.”
>
> **– Chris Trupp**
> Lived Experience Partnership Group member

Table 20: Recommended actions for Support objective 7.3: Appropriate and acceptable delivery of support

Action	Description
7.3a	Comprehensively review men’s engagement with existing support options for people with suicidal thoughts and behaviours. Use the findings as the foundation for a co-design process to develop new models to better meet the needs of men.
7.3b	Increase the availability of safe and appropriate suicide prevention services for LGBTIQ+ people. • Embed designated LGBTIQ+ peer workers across suicide prevention services by resourcing dedicated positions. • Resource an LGBTIQ+ organisation or organisations to develop and implement a capacity-building program for suicide prevention services to provide a safe and affirming workplace for peer workers and service for LGBTIQ+ people. • Resource an LGBTIQ+ organisation or organisations to provide support to designated LGBTIQ+ peer workers in suicide prevention services through peer supervision, a community of practice and a resource hub.
7.3c	Increase the availability of tailored, culturally appropriate suicide prevention support services for migrants at higher risk of suicide (for example, people from Oceania or Africa).

8. Key objective

System-level coordination

When people connect with services, it is important that they encounter a system that has clear, coordinated responses and that assists them to engage with services that meet their needs.

Prevention					Support				
1	2	3	4	5	6	7	**8**	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People impacted by suicidal thoughts and behaviours experience a seamless support system that facilitates access to appropriate supports.

To achieve this and deliver an effective suicide prevention system in Australia, better coordination within the system is needed. Coordination involves deliberately configuring pathways of care and building service linkages, processes, staff capability and infrastructure to ensure that care is effective.[226] Coordination can improve experiences, engagement and outcomes of care.[227] For the service system, effective coordination can improve productivity and reduce hospital admissions related to suicidal thoughts and behaviours by providing timely and appropriate support ahead of a suicidal crisis.[227]

8.1 Consistent care pathways

A care pathway provides a standardised, evidence-based approach to determining what happens, when it happens, and who is responsible at different points in the provision of support.[228] Care pathways can reduce the complexity of coordinating a person's care and help to reduce the variation of processes in and between services.[229] Care pathways are associated with improved patient outcomes.[230]

Clinical care models for suicide prevention, such as the Zero Suicide Framework,[231] provide a structure to guide suicide prevention care pathways and have been widely adopted internationally. The implementation of care pathways using this approach has shown promising results in Australia—including reducing the risk of subsequent suicide attempts and increasing the time between subsequent attempts in comparison with treatment as usual (action 8.1a).[232]

There is also an opportunity to improve care pathways for people who contact telephone and online crisis services. This includes enabling crisis lines to deploy in-person crisis support and pairing this with a short-stay facility to support crisis stabilisation (action 8.1b).[215] Similar service models are recognised as best practice in the United States of America under the *National Guidelines for Behavioural Health Crisis Care Best Practice Toolkit*.[233] Establishing crisis stabilisation centres aligns with the recommendation of the *Nowhere Else To Go*[234] report to invest in alternatives to hospitals, such as short-stay units, to provide support options for people who need more support than can be provided in the community but do not require the level of care provided in a mental health inpatient facility.

Evaluations of mobile crisis teams have found they are effective at diverting people in suicidal crisis from psychiatric hospitalisation and linking them to appropriate community-based services.[235-238]

The recommended actions to improve consistency of care pathways are described in Table 21.

Table 21: Recommended actions for Support objective 8.1: Consistent care pathways

Action	Description
8.1a	Develop and implement suicide prevention care pathways in all regions of Australia, across health and other support service settings. Appropriate care pathways and dedicated roles should be developed for population groups who may require access to tailored services; for example, Aboriginal and Torres Strait Islander peoples.
8.1b	Adapt the *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* for the Australian context, and trial and evaluate a service model based on this resource.[233]

8.2 Dedicated care coordination

Care coordination involves helping people navigate support options, encouraging maximum engagement with supports, ensuring clear and consistent communication between services and facilitating the transition between services when necessary. Care coordination supports continuity of care and leads to improved health outcomes and reduced healthcare costs.[227]

Care coordination is an effective element of aftercare services. These services provide support to people who have been discharged from hospital after a suicidal crisis or suicide attempt. They involve providing a consistent ongoing contact point, short-term support and assistance with care coordination.[239] In addition, care coordinators often support families, carers and kin to be involved in care planning and connect support people with information and supports.

Given the increased risk of future suicide attempts or death for people who have self-harmed or attempted suicide,[240] and the promising outcomes of best-practice aftercare services,[11] there is a clear need to expand access to aftercare services beyond people admitted to hospital because of a suicide attempt (action 8.2a).

Expanded access needs to include people who present to hospital for a suicidal crisis, self-harm or suicide attempt but are not admitted, and people who do not present to hospital but may be referred from primary care settings and safe space services. There are early indications that continuing to integrate the suicide prevention peer workforce into aftercare services improves service engagement (action 8.2b).[241]

There are opportunities to leverage existing services and workforces to deliver tailored aftercare support to children and young people. A tailored approach is necessary to ensure supports are developmentally appropriate and include active involvement of primary caregivers (action 8.2c). Such services would help to alleviate distress, provide ongoing support to minimise disruptions to development, and decrease the likelihood of future suicidal behaviour.

Dedicated care coordination roles are required to support people who experience chronic suicidal thoughts and people with suicidal thoughts who have complex needs. This would respond to the increased risk of suicide for people who have suicidal thoughts,[240,242] the current limitations in affordable ongoing support options, and the current limited capacity of the system to provide holistic care for people with complex needs (action 8.2d). Dedicated care coordination roles need to be flexible, with options to engage and re-engage as needed, and be able to adapt as people's needs and suicidal thoughts change over time.[243] For people who experience suicidal thoughts and have complex needs—for example, comorbid physical, mental health or substance use issues, disability or multiple social stressors—connection with a diverse range of supports and a collaborative approach to care that offers continuity will be crucial.

Recommended actions to enhance care coordination are described in Table 22.

> **After the unravelling of our son and the revelation of the trauma he endured, there was a light and a service offered to us that made an extraordinary difference. A caring, diligent, and informed police officer rang every week to touch base, to check in and to offer assistance if needed. This approach was so appreciated and the relief of a service coming to us, rather than the stress of finding the appropriate service ourselves, was profound. Our family did not have to repeat our story again, to be retraumatised and we were captured in a system that could follow up and advocate for us when needed."**
>
> **– Imbi Pyman**
> Lived Experience Partnership Group member

Activity to build on

The Hospital Outreach Post-suicidal Engagement (HOPE) program is an aftercare service that contacts participants within 24 hours of hospital discharge and provides support for up to 3 months. An evaluation of the pilot found that engagement with HOPE significantly improved subjective wellbeing and connection with supports, and that a model integrating psychosocial and clinical care was required to meet the needs of participants with mental ill health.[244]

Engagement with a South Australian Aboriginal and Torres Strait Islander co-designed aftercare service that was part of the National Suicide Prevention Trial led to a decrease in re-presentations associated with a repeat suicide attempt. Service users also reported improvements in adherence to medication and better engagement with services.[245]

Table 22: Recommended actions for Support objective 8.2: Dedicated care coordination

Action	Description
8.2a	Expand the application of aftercare services to accommodate anyone who has recently self-harmed, attempted suicide or experienced a suicidal crisis.
8.2b	Integrate suicide prevention peer workers into all aftercare services by resourcing dedicated roles and support structures, such as peer supervision and communities of practice.
8.2c	Improve access to aftercare services and ongoing support for children and young people, and their families, carers and kin, following a suicide attempt by removing age exclusions from services and: • establishing specific care pathways for children and young people to enable warm referrals (to support a person to connect to services, such as by phoning services for the person, passing on information to the service with the person's consent and helping them to navigate the service system) to age-appropriate supports for aftercare where existing specialised aftercare services are not available • upskilling aftercare service staff in effective approaches for working with children and young people, and exploring the co-location of youth workers in universal aftercare services.
8.2d	Resource dedicated care coordination roles to support people with chronic suicidal thoughts and people with suicidal thoughts who have complex needs.

8.3 Collaboration across services

Collaboration across services can improve the efficiency and effectiveness of care by reducing waiting times, overcoming access barriers and supporting smooth transitions between services. Effective collaboration requires policy, processes and infrastructure that facilitate efficient sharing of information.[226]

The *Strengthening Medicare Taskforce Report* recommended better data infrastructure and processes across the health system to enable safe sharing of patient information to support better diagnosis and healthcare management, and empower people to participate in their own health care.[246] Making these changes would support improved collaboration across health services that support people with suicidal thoughts and behaviours (action 8.3a).

Improving collaboration across sectors, such as health, education, social services and justice, would enable more effective holistic support for people's health and other needs. Currently, collaboration across support services relies primarily on the relationships between individual workers at a local service level.

The *National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness* include recommendations to improve collaboration across services relevant to supporting people with suicidal thoughts and behaviours.[227] Leveraging these guidelines would identify and progress system changes to improve collaboration between services across sectors (action 8.3b).

The recommended actions to enhance collaboration across services are described in Table 23.

Table 23: Recommended actions for Support objective 8.3: Collaboration across services

Action	Description
8.3a	Facilitate timely sharing of clinical information across health services through improved use of technology to connect data across all parts of the health system. This work should be supported by robust national governance, legislative frameworks and regulation of clinical software.
8.3b	Implement the *National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness*[227] to address gaps and make changes required to improve collaboration between services across sectors in relation to suicide prevention.

9. Key objective

Holistic approaches

Approaches to supporting people with suicidal thoughts and behaviours need to be holistic—care should focus on understanding each person's specific situation and needs, and on addressing the underlying drivers of suicidal distress (for example, physical health, substance use, or financial, legal or interpersonal stressors). It also means that supports need to be available for as long as necessary, not just in times of crisis, particularly for people who experience chronic suicidal thoughts. All supports should seek to sustain long-term engagement and wellbeing.

Prevention					Support				
1	2	3	4	5	6	7	8	**9**	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People impacted by suicidal thoughts and behaviours receive holistic support that meets their needs, helping to reduce immediate distress and address the fundamental drivers of their distress.

9.1 Person-centred approach

Long wait times and negative experiences (for example, use of restrictive practices in emergency departments, feeling judged or not believed) are commonly cited as a disincentive to seek support in subsequent suicidal crises.[214]

Reviews of emergency department access, including the *Nowhere Else To Go* report,[234] have recommended that emergency departments be resourced to provide the same quality of care to people in suicidal distress as to those with physical health emergencies. Improved processes are needed to support emergency department staff to collaborate with mental health, suicide prevention and other staff to facilitate consistent high-quality person-centred care (action 9.1a).

While safety is already central to suicide prevention practices, there is a need for a shift in the way safety is understood. Instead of focusing on whether service providers deem a person to be safe from imminent suicidal behaviours, suicide prevention practices should focus on whether the person feels safe to work on understanding and addressing the drivers of their distress. Current practice involves risk assessments that stratify a person's experience (a process known to be flawed), which then determines treatment options.[247] A focus on the person's own feeling of safety involves a comprehensive understanding of their situation and needs, helping them to uncover what is driving their distress, drawing on their own expertise to alleviate this distress, and collaboratively developing a plan to support them beyond the current crisis (action 9.1b).

Promising approaches in Australia that are contributing to changing practice include capacity-building of emergency department staff to respond appropriately to people in suicidal distress; changes to triage processes to include support from staff in dedicated roles; the use of comprehensive psychosocial assessment; and the use of care

pathways to improve consistency and quality of care. For example, the Suicide Risk Assessment and Management in Emergency Department Settings[248] course is designed to enhance the knowledge and skills of emergency department clinicians; the SafeSide recovery-oriented framework pairs with training to guide best practice[249]; and the Zero Suicide Framework[250] presents seven principles for safe suicide care with resources and training[251] to guide implementation. There is also guidance that outlines best-practice approaches, such as the *Guidelines for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings*.[252]

The recommended actions to embed a person-centred approach are described in Table 24.

Table 24: Recommended actions for Support objective 9.1: Person-centred approach

Action	Description
9.1a	Develop national best-practice guidance for crisis support services, including emergency departments, to support people in suicidal crisis, with a view to resourcing nationally consistent implementation that includes: • mental health expertise being a core part of staff capability development • ongoing mental health and suicide prevention education, training and professional support for all service staff • applying accessible service design principles that create low-stimulus, reassuring environments • trialling new workforce models to improve quality of care, including integrating suicide prevention peer workers into service teams • inclusive practice that involves and supports families, carers and kin (with consent).
9.1b	Review approaches to risk assessment of people with suicidal thoughts and behaviours, with a view to creating an assessment approach based on collaborative care planning, rather than risk stratification or prediction.

9.2 Integrate support to address key drivers

Support for people who experience suicidal thoughts and behaviours must address any underlying socio-economic factors that may be contributing to suicidal distress (action 9.2a). This can be facilitated by:

- co-location of services. For example, health–justice partnerships that embed legal assistance within healthcare services, health–education partnerships that embed healthcare services within school settings, and co-locating mental health clinicians within primary care settings[253-255]
- agreements. For example, between health, education and social services to support coordination of service delivery to better meet the needs of children and young people
- establishing referral pathways. For example, between suicide prevention and housing support services.

The recommended action to integrate support for key drivers is described in Table 25.

Table 25: Recommended action for Support objective 9.2: Integrated support to address key drivers

Action	Description
9.2a	Trial and evaluate models that facilitate partnerships between health and non-health services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.

9.3 Extend beyond crisis support

Currently, most service models focus on acute episodes of suicidal crisis. They are based on the premise that people will connect with supports when experiencing an increase in suicidal distress and their distress will be resolved in response to interventions. They often assume that when people disconnect from the service, the 'problem is solved' and suicidal distress will not occur again.

However, not everyone who experiences suicidal thoughts will experience suicidal crisis. In addition, while suicidal distress is a rare occurrence for some people, for others it is a recurring experience over a longer period.[256-258] This latter experience—sometimes referred to as being chronically suicidal —is often associated with a severe or complex mental illness. People who experience enduring suicidal distress require longer-term support options and flexible access that reflects the ebb and flow of suicidal thoughts and behaviours.[259,260] Given this, suicide prevention services should not be exclusively oriented towards crisis care. Strong primary care and community-based services that provide accessible long-term support to people with suicidal thoughts and behaviours should be mainstays of building and sustaining wellbeing.[261]

A range of care types and models specific to this population should be explored and evaluated to build the evidence base and inform service planning and funding (action 9.3a).[192] Many non-clinical and peer-led approaches have shown promising outcomes and their value is increasingly well-recognised.[262-264] Peer-led approaches can decrease stigma, reduce barriers to care and provide more holistic and strengths-based care.[265] These should be continued as part of a comprehensive suicide prevention system.[192,266]

The recommended action to strengthen long-term support is described in Table 26.

Table 26: Recommended action for Support objective 9.3: Extend beyond crisis support

Action	Description
9.3a	Co-design, implement and evaluate community-based long-term support models for people who experience chronic suicidal thoughts, and their family, carers and kin, to create, understand and continuously improve effective care.

Activity to build on

Peer support programs for people who experience suicidal thoughts or have attempted suicide are increasingly available in Australia.[265] For example, Alternatives to Suicide (Alt2Su)[267] is a peer support group providing the opportunity for adults to talk about suicidal experiences and other forms of emotional distress without fear of being put through a crisis management system. The Lifeline Eclipse aftercare program is a psychoeducational program providing the opportunity for adults to connect with peers who have survived a suicide attempt and learn skills that may help participants cope with feelings and thoughts of suicide, keeping them safe into the future.[268,269]

10. Key objective

Increased Connection

As discussed in **Prevention of suicidal distress**, feeling connected to other people and the community helps to build wellbeing and reduce distress.[46,47,224] Building wellbeing by improving social connection has a protective effect against suicide by cushioning the impact of risk factors.[42]

Equipping people to build greater self-efficacy and develop and sustain personal and community supports is therefore key to recovery following suicidal distress and crisis, and a necessary component of an effective approach to suicide prevention.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

What do we need to achieve?

People who have experienced suicidal thoughts and behaviours feel increased wellbeing through enhanced connection to supports, social networks, community and culture.

Families, carers and kin are empowered in their caring role and experience increased wellbeing by being supported through the impacts of their caring role.

10.1 Reconnect with and strengthen personal support networks

Personal support networks—that is, families, carers and kin, as well as other supports including chosen family, friends and colleagues—are critically important to people who experience suicidal thoughts and behaviours. Support from families, carers and kin can alleviate the distress and isolation associated with suicidal thoughts and behaviours, assist recovery following a suicidal crisis and facilitate future disclosures of suicidal distress, thereby reducing the risk of future suicide attempts.[270,271] It is important to note that not all families, carers and kin are safe and supportive; for example, in the context of family violence, where including families, carers and kin in assessment, care and support processes could increase risk to a victim survivor.

Including families, carers and kin in assessment, care planning and support for people with suicidal thoughts and behaviours may contribute to better outcomes, especially if interventions help to strengthen relationships or involve support people in the collaborative development and implementation of safety plans.[272,273] Families, carers and kin may also contribute vital information not recalled by the person experiencing suicidal distress (action 10.1a).[272]

However, families, carers and kin need to be supported in this role. Families, carers and kin may experience distress in relation to their loved one's suicidal thoughts and behaviours as well as their caring role. Carer stress is reduced when families, carers and

kin are confident and knowledgeable about how to support a loved one who experiences suicidal thoughts and behaviours, including following a suicide attempt; are confident their loved one is receiving good health care; and receive quality support themselves to address their own needs (action 10.1b).[8,274]

Support for families, carers and kin may include the provision of information and assistance to increase their confidence and effectiveness in their caring role and alleviate their own distress. Carer peer support, while relatively new in suicide prevention, has produced promising outcomes in the context of mental illness—both one-on-one and group formats have demonstrated improvements in carer wellbeing, reduced carer burden and improved empowerment, and should be explored further (action 10.1c).[275,276]

The recommended actions to reconnect with and strengthen personal support networks are described in Table 27.

> **“When it comes down to it, the only reason that I am still alive is because of my wife. She and my three children are the pillars of strength, love and support. For years, I silently battled my undiagnosed mental health challenges. My wife always stood by me during my darkest moments, like the time she found me in the shower and rushed me to hospital. For months, she drove for hours from our home to the hospital, with our young children, just to be by my side. She did it all alone.**
>
> **Once back home, her role changed over time. She transitioned from my partner to my primary caregiver, managing my medications, accompanying me to appointments, holding me when I was overwhelmed and taking me back to hospital whenever I felt threatened by my own thoughts. She even left her job to focus on my wellbeing and our children. She had no support. Though I’ve been blessed with tremendous support, my wife often felt isolated, confronting societal biases and difficult discussions, all to keep her husband alive and our family intact.**
>
> **She embodies the ‘invisible’ unsung heroes that we often overlook. They might not ask for help, but they need it. Such heroes, from families and caregivers, are invaluable to society. Like me, many owe their lives to them. Prioritising their wellbeing is not just gratitude, it’s a critical strategy for reducing our nation’s suicide rates.”**
>
> **– Ben Farinazzo**
> Lived Experience Partnership Group member

Table 27: Recommended actions for Support objective 10.1: Reconnect with and strengthen personal support networks

Action	Description
10.1a	Comprehensively review barriers to involving families, carers and kin in care planning and delivery for people who experience suicidal thoughts and behaviours. Use the findings of this review to develop, trial and evaluate solutions.
10.1b	Co-design, trial and evaluate face-to-face and online support programs for families, carers and kin of people who have experienced suicidal thoughts and behaviours. Use findings to inform service planning and improve accessibility of effective programs.
10.1c	Trial the integration of carer peer workers in services supporting people who experience suicidal thoughts and behaviours to aid the engagement and support of families, carers and kin.

10.2 Connect with community supports

People who experience suicidal thoughts and behaviours gain enormous benefit from reconnecting with informal community-based supports, including relationships with friends, neighbours and other members of the community.

The value of increased social participation is recognised through the emergence of 'social prescribing'—when primary care providers refer people to non-clinical care, including social supports, to prevent or mitigate the adverse effects of social determinants linked with poor health and wellbeing.[277,281] Social prescribing may include referrals to services to meet unmet material needs, such as food and housing, and connection with community services and activities to fill unmet social needs; for example, to reduce loneliness. This is especially important for those who do not have active personal support networks. For Aboriginal and Torres Strait Islander people, social prescribing can include connection to language, cultural and community activities (such as yarning) to improve social and emotional wellbeing.[282]

While evidence for social prescribing has not been developed specifically for suicide prevention, outcomes achieved through social prescribing are relevant for people who experience suicidal thoughts and behaviours. The available evidence indicates some positive impacts on suicide risk factors such as loneliness, belonging, social connectedness and sense of purpose.[280,283-287] Other potential benefits of social prescribing for people with suicidal thoughts and behaviours include improved self-reported health and wellbeing, self-management skills, physical activity, ability to carry out activities of daily living and enhanced quality of life, as well as reduced anxiety, social exclusion and demand for health professionals to address non-medical needs (action 10.2a).[284,285,288-290]

The recommended action to connect people with community supports is described in Table 28.

Table 28: Recommended action for Support objective 10.2: Connect with community supports

Action	Description
10.2a	Design, trial and evaluate a model of social prescribing for people with suicidal thoughts and behaviours, available through primary care settings, that includes a dedicated coordinator role and consideration of people's cultural needs. This model should promote uptake by people who are not well connected socially and people living in communities where formal services are less readily available.

Implementing this approach to support

The Support domain has outlined five essential components of an effective support system for people who experience suicidal distress and those who care for them. Implementing the actions related to the five components will facilitate higher-quality support. However, additional work is required to facilitate the model being used as a basis for service design, planning and delivery. Moving from current practices to the model outlined will require suicide prevention services to reflect on how they could improve the supports they offer and the way they offer them in the context of their role in the overall support system. It will involve some degree of change for many services.

There is therefore a need for guidance on how to operationalise system-level coordination and provide clarity for key service types about how best to apply the model outlined in this Strategy (action 10.3a). The guidance should, for example, illustrate how services focused on responding to people in crisis could maintain a focus on the fundamental drivers of distress and on increasing a person's connection with supports. It should also outline how they need to work with other service types to ensure a coordinated approach.

This guidance will assist in maturing our understanding of the system architecture, the roles and responsibilities of the different services that make up the service landscape, and how they are meant to operate in an integrated way. This in turn will facilitate more intentional system design going forward, leading to improved system efficiency and experiences of care.

The recommended action to implement the five components of the Support domain is described in Table 29.

Table 29: Recommended action for Support objective 10.3: Implementing this approach to support

Action	Description
10.3a	Develop clear guidance on how the key service types (for example, crisis lines) could realise each of the key objectives outlined in the Support domain: culture of compassion, accessibility, system-level coordination, holistic approaches and increased connection. Service delivery organisations would use this guidance for improved service planning, design and delivery.

Critical enablers

The critical enablers describe the governance, lived and living experience involvement, data and evidence shifts, and workforce that are needed to implement and sustain the more coordinated, better-quality and more effective suicide prevention system outlined in earlier sections. The critical enablers provide the mechanism for continuous improvement of the suicide prevention system, and therefore should not be considered short-term, but rather enduring activities. The critical enablers have been structured around four main areas of system reform, but in practice they are mutually reinforcing and have many crossovers. For this reason, the critical enablers should be read as a group of actions to be implemented together.

11. Critical enabler

Improved governance

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

Although suicide prevention activities have traditionally been funded and delivered through government health portfolios, many of the factors that contribute to or protect against suicide fall outside of the remit of health portfolios. In addition, responsibility for suicide prevention activities in Australia sits across different levels of government—the Australian Government, state and territory governments, and local government. This has led to a lack of clarity over responsibility and accountability for suicide prevention.[259,291]

A more comprehensive approach to suicide prevention requires clear accountability for agreed objectives.[292-294]

- To ensure appropriate authority for suicide prevention activities across the government, accountability for suicide prevention should rest with the highest level within a government.
- To prevent duplication and gaps in services, all levels and parts of government should agree on priorities, clarify roles and responsibilities, and collaborate where needed on delivering suicide prevention activities.
- To provide transparency and accountability, there should be joint reporting between all levels and parts of government on what has been done and how this has collectively influenced suicide.

To ensure clear accountability, several countries have formalised cross-portfolio commitment into partnership agreements (see the **International activity to draw upon**) or Suicide Prevention Acts (for example, Republic of Korea).[295]

What do we need to achieve?

Suicide prevention in Australia has clear accountability and coordination of efforts across portfolios and between levels of government.

Given the federal system of government in Australia, a whole-of-governments approach is needed to establish accountability across portfolios and across all levels of government—the Australian Government, state and territory governments, and local government.[296] Regardless of the mechanism, a whole-of-governments effort requires the formalisation of processes and structures to ensure the consideration of suicide prevention in all policies, provide clarity of roles and responsibilities across governments, and support the strengthening of regional efforts.

International activity to draw upon

England has a cross-sectoral suicide prevention strategy that commits portfolios to suicide prevention actions, including targets for monitoring progress.[297]

New Zealand has used a collective impact approach (a model that creates a network of stakeholders that collaborate and align their efforts to address a social problem[298]) to suicide prevention. This includes cross-government governance and portfolio-specific indicators and targets (evidence-based and measurable goals).[64]

Scotland is pursuing a whole-of-government approach to suicide prevention in which the Scottish Government and the Convention of Scottish Local Authorities have joint responsibility for delivering outcomes, which will be subject to regular evaluation, monitoring and review at both national and local levels.[63]

11.1 Implement 'suicide prevention in all policies'

Considering the wide range of factors that can influence suicide (see **Prevention of suicidal distress**), all government policies should be explicitly considered for their potential impact on suicide before they are endorsed.[12] This is called a 'suicide prevention in all policies' approach and is based on the 'health in all policies' approach.[299,300] It requires suicide prevention considerations to be embedded into policy development as routine practice across governments.[299] This will establish accountability for policymakers to, firstly, ensure their policies 'do no harm' and, secondly, build wellbeing as a protective factor for suicide. This may require capability building within government portfolios to ensure policymakers understand the relationship between suicide and their policy areas (action 11.1a).

The recommended action to implement 'suicide prevention in all policies' is described in Table 30.

Table 30: Recommended action for Critical enabler 11.1: Implement 'suicide prevention in all policies'

Action	Description
11.1a	Establish a 'suicide prevention in all policies' approach. • Create mechanisms that assess all new policies for their potential impact on suicide and provide guidance to policymakers on options for minimising risks. • Invest in building capability in all portfolios to ensure policymakers understand the relationship between their policy areas and suicide.

11.2 Clarify responsibilities for suicide prevention

A workable whole-of-governments approach to suicide prevention in Australia requires accountability across portfolios and between all levels of government.

Currently, responsibility for suicide prevention is outlined in suicide prevention strategies and frameworks in place across states and territories. These strategies and frameworks are broadly aligned in their priorities for suicide prevention, including references to shifting towards whole-of-governments arrangements and cross-portfolio governance structures.[301-307]

Additionally, the *National Mental Health and Suicide Prevention Agreement*[19] and associated bilateral agreements outline the roles and responsibilities of the Australian Government and the state and territory governments in delivering mental health and suicide prevention services. The *National Agreement on Closing the Gap*[37] also commits governments to several priority reforms to improve a range of outcomes, including a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.[37]

While the *National Mental Health and Suicide Prevention Agreement*[19] provides a robust foundation, it must be strengthened to formalise shared accountability for suicide prevention across portfolios and between all levels of government (action 11.2a). In addition, the roles and contributions of portfolios beyond health must be further clarified and emphasised given the breadth of work underway in non-health portfolios to address socio-economic factors that are associated with suicide. Governance structures within the *National Mental Health and Suicide Prevention Agreement*[19] must also be refreshed to ensure they align with the whole-of-governments scope of suicide prevention efforts.

A strengthened approach must also facilitate further partnership and shared decision-making between governments and Aboriginal and Torres Strait Islander organisations, communities and people in accordance with the commitments by all governments under the *National Agreement on Closing the Gap*.[37]

The recommended action to clarify responsibilities and accountability for suicide prevention is described in Table 31.

Table 31: Recommended action for Critical enabler 11.2: Clarify responsibilities for suicide prevention

Action	Description
11.2a	Build on the *National Mental Health and Suicide Prevention Agreement*[19] to progress a national approach to suicide prevention that enables cross-portfolio and whole-of-governments planning, sets priorities and targets, and outlines responsibilities and accountability for suicide prevention outcomes consistent with the suicide prevention model outlined in this Strategy. • Allocate sufficient funding and develop appropriate funding models to improve quality and outcomes, facilitate effective cross-portfolio collaboration, and reduce funding duplication and gaps. • Establish processes for data sharing between governments and portfolios to support evidence-informed decision-making, surveillance, monitoring and reporting, and continuous improvement. • Create a clear framework for coordinated cross-government action to address emerging means of suicide. • Develop an agreed set of suicide prevention outcomes at national and jurisdictional levels for all portfolios responsible for actions in this Strategy. • Collaborate meaningfully with people with lived and living experience of suicide in the planning, implementation and evaluation of national suicide prevention work. • Strengthen partnerships and shared decision-making arrangements and structures between Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations, governments, Aboriginal and Torres Strait Islander communities, to progress a national approach to suicide prevention.

11.3 Strengthen regional suicide prevention

Any effort to create greater collaboration and accountability for suicide prevention in Australia should consider and strengthen regional activity. Place-based and community-led suicide prevention approaches tailor activities to meet local needs and ensure local suicide prevention is effective. They have been shown to reduce local suicide rates by 7%,[308] and broader positive community impacts arise from the local planning, coordination and commissioning of suicide prevention services[309] (action 11.3a). The *National Agreement on Closing the Gap* emphasises the importance of community-specific, community-led and placed-based approaches in addressing Aboriginal and Torres Strait Islander suicide,[37] providing mechanisms for empowering self-determination of local Aboriginal and Torres Strait Islander communities. The importance of Aboriginal-led and Torres Strait Islander-led, community-specific and place-based responses are core principles of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.[41]

Activity to build on

The National Suicide Prevention Trial 2016–2021 funded 11 primary health networks, across 12 regional areas, to develop and implement a systems-based approach to suicide prevention at a local level for at-risk populations.[310] The evaluation report of the trial identified that strengthened regional suicide prevention requires the inclusion of local governments as partners, dedicated resources to develop partnerships and networks, and support to take a long-term perspective to suicide prevention, with regular monitoring and reporting to allow for continuous improvement of commissioned services.[309,311]

Culture Care Connect is a national, community-based program, coordinated by the National Aboriginal Community Controlled Health Organisation.[312] The program supports integrated suicide prevention planning and culturally safe response activity, while building a sustainable and supported workforce. The program aims to bring together community leaders, local organisations and services to plan and coordinate suicide prevention activity that meets the unique needs of communities in an integrated and holistic manner.

In many regional settings, the components required to implement a collaborative approach to suicide prevention are already in place, such as the joint planning between primary health networks and local hospital networks and Aboriginal Community Controlled Organisations. This could be enhanced through involvement of local government partners to increase links to communities and community organisations beyond those that are health-based. Funding arrangements should aim to provide greater continuity of services and include key performance indicators to allow for monitoring and improvement of services. More resources will be required for regional suicide prevention planning and coordination roles to successfully engage with regional stakeholders and people with lived and living experience of suicide, and to establish networks, coordinate planning and organise activity across the full range of suicide prevention activities identified in this Strategy.

The recommended action to strengthen regional suicide prevention is described in Table 32.

Table 32: Recommended action for Critical enabler 11.3: Strengthen regional suicide prevention

Action	Description
11.3a	Strengthen the ability for long-term regional planning and commissioning of suicide prevention. • Enhance the role of local government in suicide prevention, particularly with respect to informing regional suicide prevention activities in a whole-of-governments approach to suicide prevention. • Require primary health networks, local hospital networks, and local governments to partner with each other as well as local Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations in the planning and delivery of regional suicide prevention plans and responses. • Empower Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations to deliver social and emotional wellbeing, healing and community-based suicide prevention services through flexible funding models that ensure alignment with the needs of the local community. • Review funding models to support continuous improvement of services and provide greater continuity for regional services. • Review the resourcing and role requirements for regional suicide prevention planning and coordinating positions to ensure they have the capability, capacity and authorising environment to be effective in driving the full range of suicide prevention activities aligned with the model in this Strategy. • Require regional planning and service delivery organisations to demonstrate meaningful inclusion of a diversity of lived and living experience of suicide in their governance and decision-making, including regional planning; service design, delivery and evaluation; and tender processes. • Include reporting on regional planning and activity as part of the monitoring and reporting of the *National Mental Health and Suicide Prevention Agreement*.[19]

12. Critical enabler

Embedded lived experience

People with lived and living experience have the greatest insights into what works, what does not work, and what is missing in suicide prevention. For suicide prevention efforts to be of high quality and effective, it is vital that people with lived and living experience of suicide have a central role in designing, delivering, governing and evaluating suicide prevention activities.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

The participation of people with lived and living experience of suicide in public policy development can be understood using a scale from 'inform' to 'empower' (see Figure 4).[313] Engagement with people with lived and living experience should be as far to the right of this scale as circumstances allow.[314] Regardless of the level of the engagement, safe and beneficial engagement depends on skilful facilitation, support systems and organisational cultures of authentic curiosity and humility.

Figure 4: The International Association for Public Participation (IAP2) Public Participation Spectrum
Source: Adapted from © International Association for Public Participation www.iap2.org.[313]

Increasing impact on the situation →

	Inform	Consult	Involve	Collaborate	Empower
Public participation goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	To obtain public feedback on analysis, alternatives and/or decisions	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution	To place final decision-making into the hands of the public
Promise to the public	We will keep you informed	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide

What do we need to achieve?

Suicide prevention in Australia has consistent and meaningful involvement of people with a lived and living experience of suicide in the design and delivery of high-quality and effective suicide prevention activities.

Over half of the national, state and territory, and regional suicide prevention policy documents in Australia were developed with some degree of engagement with people with lived and living experiences of suicide.[259] However, more can be done to increase the level of engagement and increase its impact on the documents produced.

Current approaches do not always maximise engagement or match the method and the goals of the engagement. Some groups are underrepresented—typically those that are disproportionately impacted, largely due to the existing systemic barriers limiting their access to engagement opportunities. There has been less engagement with people with lived and living experience of suicide outside of health portfolios. Coupled with a lack of collaboration across portfolios and sectors, this can lead to the development of poor-quality policy. This enabler outlines the actions needed to create consistency in and familiarity with how people with lived and living experience of suicide are meaningfully engaged in suicide prevention.

Continued efforts to build the skills, knowledge and capabilities of people with lived experience of suicide are necessary if we are to generate the cultural changes and systemic shifts needed for driving down the suicide rate. Key to the Strategy's success is the accountability of governments, and agencies across government, for implementation consistent with the Strategy's engagement of people with lived experience of suicide. Sadly, government agencies at all levels are mostly still in the earliest phases of developing meaningful lived experience participation in their suicide prevention activities, or even understanding why this is so critical."

– Bronwen Edwards
National Suicide Prevention Office Advisory Board member

12.1 Create supportive and safe environments

People with lived and living experience of suicide have highlighted that meaningful engagement depends on feeling accepted and valued by those who are seeking their participation. Those wishing to engage with people with lived and living experience of suicide must therefore create environments that are inclusive, supportive and safe, recognise the value of lived and living experience, and are open to incorporating the insights provided. In some instances, this will require guidance and training of senior leaders and the staff who will be working directly with people with lived and living experience of suicide. This should focus on the development of supportive structures, environments that recognise the value of lived experience in decision-making, and a commitment to engaging people with lived and living experience of suicide in a meaningful way (action 12.1a).[315]

The recommended action to achieve this is described in Table 33.

> **"It's essential to accept lived experience expertise as an important part of the system. It's important to have Lived Experience Advocates in government and service delivery decision-making positions to look at views through the lived experience lens and to remove the institutional stigma. The presence of lived experience in decision-making positions abolishes the idea that we impinge on the process; we are not a burden. Our involvement provides a safeguard against problems arising when policies are implemented and ensures the evidence being presented is supported through the lived experience, so we can be confident that the advice being provided is the best it can possibly be."**
>
> **– Graeme Holdsworth**
> National Suicide Prevention Office Advisory Board member

Table 33: Recommended action for Critical enabler 12.1: Create supportive and safe environments

Action	Description
12.1a	Build the capability of government departments and agencies to work with people with lived and living experience of suicide. • Ensure senior leaders have the knowledge and skills required to create organisational cultures that value and enable lived and living experience expertise in decision-making. • Equip managers with the knowledge and skills to provide direct support and line management for staff with lived and living experience of suicide.

12.2 Build capability to contribute

People with lived and living experience should be empowered to contribute in a way that achieves the maximum positive impact. This is true whether participation occurs through consultations, membership of advisory boards or employment in designated roles.[316]

Pre-engagement training for people with lived and living experience can help them enjoy greater meaning from their roles.[317] Appropriate remuneration should be offered along with options for mentoring and future development. People with lived and living experience should have access to formal and informal supports before, during and after their involvement, in recognition that contributing from a lived and living experience perspective can be difficult.[314] Where possible, consistency in this engagement approach across portfolios would help minimise the requirement for people with lived and living experience to complete different pre-engagement training or understand different systems.

Activity to build on

Roses in the Ocean offers a range of training workshops that prepare people with lived and living experience of suicide to share their stories, participate impactfully and be effective lived experience leaders.[318]

The Aboriginal and Torres Strait Islander Lived Experience Centre[319] brings together and elevates the voices of Aboriginal and Torres Strait Islander people and provides a culturally safe platform for shaping policies, programs and services of importance for Aboriginal and Torres Strait Islander communities.

It is important to note the broad diversity of people with lived and living experience of suicide. Designing suicide prevention policies, programs and services that are effective depends on having a representative diversity of people with lived and living experience engaged in the policy development process.[314] This may require proactive steps to engage people who are representative of those the policies are intended to help (action 12.2a).

The recommended action to build capability to contribute is described in Table 34.

Table 34: Recommended action for Critical enabler 12.2: Build capability to contribute

Action	Description
12.2a	Build equitable and inclusive processes that support the broadest range of people with lived and living experience to participate in government processes. • Provide pre-engagement training to build capability for people with lived and living experience to take up leadership roles in influencing government processes. • Provide appropriate remuneration for those whose participation is not part of a paid employment role. • Offer mentoring opportunities that support continuous skill development, including reflective practices, and help people manage the unique stressors they may experience in designated roles. • Proactively facilitate representation from groups that are disproportionately impacted by suicide.

12.3 Clear and structured methods of engagement

To establish the most effective and mutually reinforcing way of working together, people with lived and living experience of suicide have emphasised the importance of clearly defined roles, including an understanding of what is being expected of them, and how they can contribute, and transparency about the scope of their role in decision-making processes.[316]

Processes and structures that support engagement must be designed with a clear understanding of their purpose, aims and scope. Best-practice guidelines[314] indicate that government agencies should carefully consider key aspects of engagement to ensure transparent, diverse and meaningful engagement with lived and living experience.

Governments should also maximise opportunities to support cross-portfolio consistency, decision-making and continual improvement in engagement by creating central whole-of-government groups involving both staff and people with lived and living experience (action 12.3a).

Activity to build on

The Lived Experience of Suicide Engagement, Partnership and Integration Framework, developed by Roses in the Ocean, informs the mapping of engagement, employment and partnership with people with lived and living experience across all stages of a project.[320]

The LifeSpan Lived Experience Framework,[321] developed by the Lived Experience Resource Centre at the Black Dog Institute,[322] is another resource that helps to guide strategic and purposeful lived experience involvement in suicide prevention initiatives.

To ensure the approaches to embedding lived and living experience are effective, it will be crucial to develop outcomes-based measures. Outcomes-based measures would assess whether the engagement was meaningful, how the insights enhanced decision-making, and how improved decision-making impacted on the outcomes of the program and service (action 12.3b).

The recommended action to achieve clear and structured methods of engagement is described in Table 35.

Table 35: Recommended actions for Critical enabler 12.3: Clear and structured methods of engagement

Action	Description
12.3a	Establish dedicated lived and living experience roles and governance bodies centrally and/or within departments and agencies to ensure lived and living experience of suicide is integrated into decision-making processes for policies and programs with relevance to suicide prevention.
12.3b	Create and report on co-produced outcomes that demonstrate the activity and impact of embedding people with lived and living experience of suicide in government decision-making.

13. Critical enabler

Available and translated evidence

An effective approach to suicide prevention is underpinned by robust evidence and evaluation.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

This requires:

- a systematic and coordinated approach to data collection and research to improve our understanding of suicide
- translation of evidence into routine practice in a timely fashion, in collaboration with people with lived and living experience of suicide and the communities from which the data and information comes
- investment in high-quality evaluation to determine whether suicide prevention activities are achieving their intended outcomes and to inform any necessary improvements.

What do we need to achieve?

Suicide prevention in Australia uses fit-for-purpose evidence to guide timely, high-quality and effective suicide prevention activities.

13.1 Enhance data for suicide prevention

Evidence based data is essential for understanding the prevalence of suicide, suicidal behaviours, suicide risk factors and the social determinants of suicide, such as rates of long-term unemployment and homelessness.[11] Data, including from suicide registers and other sources, must be collected and monitored in a timely way to ensure early identification of emerging issues and early, appropriate responses.[323]

Activity to build on

The establishment of the National Suicide and Self-Harm Monitoring System,[216] led by the Australian Institute of Health and Welfare, has made Australia a world leader in the collation and reporting of suicide-related data.[323] The system collates data on suicide, self-harm and suicidal behaviours. It includes a public website to provide information and a restricted portal for vetted users to share content between governments and agencies. The National Suicide and Self-Harm Monitoring System[216] continues to build capability to collate and synthesise the relevant information at national, jurisdictional and regional levels. Further work is being done to improve understanding of the experiences of groups who are disproportionately impacted by suicide but not yet routinely identified in data, such as LGBTIQ+ people and people with disability.

There are jurisdictional differences in the approaches to issues such as data collection,[11] privacy, consent and reporting. These differences limit the ability to share, link and report data in a consistent way at a national level.

The information needed to inform suicide prevention efforts is broadening as the understanding of suicide matures. In addition to the conventional data on suicide deaths, attempts, thoughts and behaviours, more information is needed on groups disproportionately impacted by suicide, upstream drivers of suicide and socio-economic factors (such as employment, education and loneliness), the experiences of families, carers, and kin, and those bereaved by suicide.

New data will be needed to support evaluation and outcome measurement. Decision-makers and policy agencies will require more sophisticated analyses that not only provide insight into what has happened or is currently happening, but also into potential future needs. This requires better health data, high-quality data from other portfolios and the means to link relevant datasets (action 13.1a).

Progress is being made against these needs through the ongoing work of the National Suicide and Self-Harm Monitoring System[216] and the data improvement work occurring under the *National Mental Health and Suicide Prevention Agreement*.[19] There is also an opportunity to leverage the National Suicide and Self-Harm Monitoring System[216] to strengthen partnerships in data collection, sharing, linkage and reporting across governments and to commission work to broaden the data included in the system to meet future needs (actions 13.1b and c).

The recommended actions to enhance data for suicide prevention are described in Table 36.

> **"It has always amazed me that after my attempt, my name would not appear in any data system as a suicide attempt. In suicide prevention, data and statistics are important. They are essential to the evidence-based nature of our services. Evidence-based systems are derived from combining data and research, which then informs and initiates funding and services. The continued cycling of data, research and funding is how services develop and grow."**
>
> **– Graeme Holdsworth**
> National Suicide Prevention Office Advisory Board member

Table 36: Recommended actions for Critical enabler 13.1: Enhance data for suicide prevention

Action	Description
13.1a	Ensure alignment between suicide prevention data activities, including those under the National Mental Health and Suicide Prevention Agreement,[19] the National Suicide and Self-Harm Monitoring System,[214] and the monitoring and reporting function of the National Suicide Prevention Office.
13.1b	Expand the ability of the National Suicide and Self-Harm Monitoring System.[216] • Improve the timeliness of collection, sharing, linking and reporting of suicide-related data to inform timely responses to emerging trends. • Improve the linkage of national and state and territory datasets on suicide and suicide attempts with other relevant datasets to identify protective and risk factors for suicide, and social and health service usage of people who die by or attempt suicide. • Improve routine identification of groups disproportionately impacted by suicide. • Improve data consistency across jurisdictions to provide a clearer national picture of suicide.
13.1c	Resource the National Suicide and Self-Harm Monitoring System[214] to broaden the reporting of suicide-related data. • Include indicators of wellbeing and suicidal distress associated with the social determinants of suicide. • Include the experiences of families, carers and kin and those bereaved by suicide.

13.2 Strengthen suicide prevention research

Research is a powerful tool through which to improve understanding of suicide and suicidal distress and gain new knowledge on suicide prevention.[11] Thanks to the efforts of initiatives such as LIFEWAYS,[324] the Centre of Research Excellence in Suicide Prevention[325] and the National Suicide Prevention Research Fund,[326] Australian suicide prevention research is well regarded internationally.

Currently, most Australian suicide prevention research is funded through the National Suicide Prevention Research Fund, the National Health and Medical Research Council, and the Medical Research Future Fund, and each body has set its own research priorities in suicide prevention. There is an opportunity to make more effective use of these funds through better targeting and coordination of investments. This should entail greater collaboration to identify and address national suicide prevention research priorities (action 13.2a). The development of this Strategy has highlighted the need for research into protective factors, upstream preventive initiatives, the importance of embedding research evidence into practice, and the benefits of involving people with lived and living experience in research, policy and program design.

There is also a need to strengthen the suicide prevention research sector to address the identified research priorities. In part this can be done through increased and sustained investment in suicide prevention research. However, it also requires a stronger research workforce, an increase in the diversity of expertise and perspectives, and closer alignment of research and practice. These can be achieved by supporting early and midcareer suicide prevention researchers, the involvement of people with lived and living experience of suicide in suicide prevention research, and the participation of researchers from communities disproportionately impacted by suicide, service providers, and academics from disciplines not traditionally involved in suicide prevention research (action 13.2b).[11,296,327]

The recommended actions to strengthen suicide prevention research are described in Table 37.

Table 37: Recommended actions for Critical enabler 13.2: Strengthen suicide prevention research

Action	Description
13.2a	Ensure better targeting and coordination of suicide prevention research funding by establishing a mechanism that supports: • ongoing collaboration between funding bodies, philanthropic organisations and the sector • robust processes for the regular joint identification of national suicide prevention research priorities • coordinated delivery of targeted funding schemes to address identified national priorities.
13.2b	Strengthen the capacity and capability in the suicide prevention research sector through increased and sustained investment in suicide prevention research and by supporting the greater inclusion of: • early and midcareer researchers in suicide prevention research • people with lived and living experience of suicide in the leadership, design, delivery, interpretation and translation of research • researchers from communities, service delivery and other academic disciplines.

13.3 Promote evaluation of suicide prevention activities

Evaluation is necessary to understand whether current programs and services are effective, how to improve them, whether to continue to fund them, and whether they achieve the same outcomes for all communities.[296]

The Productivity Commission noted a lack of routine evaluation of suicide prevention efforts in Australia and that evaluations tended to look at project objectives rather than suicide outcomes.[11] There are many challenges to embedding routine evaluation including services being funded to deliver supports but not to evaluate their effectiveness; limited capability within the sector for evaluation; and lack of the necessary data. These issues can be addressed.

Specific resources are available to build evaluation capability, including the Zero Suicide evaluation framework[328] and advice from Suicide Prevention Australia on ensuring that a program is of sufficient quality[329] and is accredited.[330] In addition, more general guidelines are available about evaluation in the government environment.[331]

Bringing evaluation practice up to a level that would provide confidence about what works in suicide prevention requires investment in evaluations and development of an evaluation culture and capability more broadly. This includes support for high-quality qualitative and quantitative data collection, and development of the skills and knowledge to support evaluation design (action 13.3a).

Beyond specific programs, there is a need to understand whether the entire suicide prevention system is having the intended impact. To achieve this requires a shift from monitoring only suicide deaths to also monitoring upstream outcomes such as suicide attempts, suicidal thoughts and distress, and wellbeing. This will also be beneficial in enabling more proactive responses. To establish this approach, a National Suicide Prevention Outcomes Framework aligned with this Strategy should be developed (action 13.3b). This should be informed by progress in suicide prevention reform, including through regular monitoring and reporting on the implementation of this Strategy (action 13.3c). The recommended actions to promote evaluation of suicide prevention activities are described in Table 38.

Table 38: Recommended actions for Critical enabler 13.3: Promote evaluation of suicide prevention activities

Action	Description
13.3a	Enhance evaluation of government-funded suicide prevention activities. • Require government-funded programs to demonstrate evaluation practices to receive continued funding. This requirement should be introduced over a reasonable period to enable service provider organisations to prepare. • Build evaluation funding into the budgets, and evaluation requirements into new contracts for government-funded programs. • Require evaluations to consider effectiveness (including for groups disproportionately impacted by suicide) and cost-effectiveness. • Ensure data collection can support evaluation, outcome measurement and data analytics. • For services that do not have this capacity in-house, fund a suitably qualified and independent organisation to support service organisations to build their evaluation culture and capabilities in line with the above requirements.
13.3b	Develop and implement a National Suicide Prevention Outcomes Framework that identifies an agreed set of suicide prevention outcomes and indicators, extending beyond health measures.
13.3c	Develop and implement an approach to the regular monitoring of, and reporting on, the implementation of the National Suicide Prevention Strategy.

13.4 Improve the translation of evidence into practice

Evidence is most valuable when it can be rapidly translated into actions that improve the quality and effectiveness of what is being delivered. However, there are barriers to translation of evidence into practice, such as data, research and evaluation findings not being widely accessible. As a result, there is a typical evidence-to-practice gap—the time it takes for health research to be embedded in routine practice—of about 17 years.[332] This gap can be reduced, including by:

- building capability in translation practices
- ensuring evidence is shared with and able to be used by the people who are represented in the evidence; for example, ensuring data sovereignty for Aboriginal and Torres Strait Islander peoples so that improvements to services can be locally driven, as can reporting on specific targets under the National Agreement on Closing the Gap[37]
- improving access to evidence through central repositories and customisable reporting, so people can find evidence on what is most important for their organisation, as well as enhanced data analytics to support decision-making
- establishing networks and partnerships between those with the evidence and those who need to apply it to policy and programs
- bolstering the efforts of bodies that are engaged in translating evidence, such as the National Health and Medical Research Council, Suicide Prevention Australia and LIFEWAYS, so they can reach more people.

Addressing these challenges will see significant progress being made in the use of suicide data to improve outcomes (action 13.4a).

Translation goes beyond ensuring evidence-based care. Translation of population prevalence and demographics can assist with service planning by providing information about expected demand for services, alongside an understanding of the nature and capacity of the services in any particular location. For example, the *National Mental Health Service Planning Framework*[333] has begun to be applied to suicide prevention to understand current and needed services in different locations (action 13.4b). Another application includes the translation of emerging trends in suicide into timely and localised responses; for example, making sure the right people know about suicides clustered around a location or time, or increasing use of a specific method of suicide. The National Suicide and Self-Harm Monitoring System[216] is working towards providing such information, but there is also a need to establish translation processes to deliver responses at a regional or local level (action 13.4c).

The recommended actions to improve the translation of evidence into practice are described in Table 39.

Table 39: Recommended actions for Critical enabler 13.4: Improve the translation of evidence into practice

Action	Description
13.4a	Enhance the ability of government agencies, primary health networks and local hospital networks to use findings from the best available evidence to inform suicide prevention planning and funding decisions. • Strengthen their capability in data, statistics and continuous improvement. • Enhance the value of data from the National Suicide and Self-Harm Monitoring System[216] through improved access and tailored reporting for users. • Develop a central national repository of evaluation reports on suicide prevention programs, services and other activities. • Establish translation networks and governance systems to support the translation of evidence into the improvement and implementation of policies and programs. • Incentivise research bodies to facilitate the timely translation and communication of suicide prevention research.
13.4b	Continue to build on the *National Mental Health Service Planning Framework*[333] and accompanying tool to support the planning of regional suicide prevention services. • Ensure epidemiological estimates include the prevalence rates of the social determinants of suicide, consider groups that are disproportionately impacted by suicide, and cover suicidal thoughts, distress and behaviours. • Use a service taxonomy and workforce categories specific to suicide prevention.
13.4c	Expand the ability of the National Suicide and Self-Harm Monitoring System[216] to inform timely translation into policy, program and service responses. • Establish routine processes to review new data to identify emerging issues that should be prioritised for policy, funding and service responses (including trends in methods of suicide, demographics or lead indicators). • Introduce geospatial surveillance functionality to enable rapid identification of regional suicide and suicide attempt clusters to trigger timely local service responses.

14. Critical enabler

Capable and integrated workforce

The most foundational requirement for the delivery of the approach to suicide prevention described in this Strategy is a robust, capable and well-supported suicide prevention workforce.

Prevention					Support				
1	2	3	4	5	6	7	8	9	10
Critical enablers									
11		12			13			14	

This Strategy conceptualises the 'suicide prevention workforce' as the broadest possible network of people involved in providing compassionate and effective responses to people in suicidal distress and to those impacted by the social determinants that can lead to suicidal distress. This workforce includes:

- people working in emergency services and health care including, among others, general practitioners (GPs), doctors, nurses, pharmacists, psychologists, psychiatrists, social workers and peer workers
- frontline workers delivering income and psychosocial supports, such as financial, housing, unemployment and family support services in the community
- personal support networks, such as family, carers and kin, and social supports, and institutions, such as educational, religious and spiritual communities, media, interest groups, and workplaces
- policymakers who develop and implement population-level interventions related to suicide prevention, including policies that promote general wellbeing, reduce the impact of the social determinants of suicide, or aim to alleviate suicidal distress.

All members of the suicide prevention workforce must be empowered to understand their role in suicide prevention, have the capability to perform their role, and be sufficiently supported to operate effectively and compassionately in a sustainable way.

What do we need to achieve?

Suicide prevention in Australia is delivered by a capable, integrated and sustained workforce.

14.1 Develop a national suicide prevention workforce strategy

Given the central role of the mental health system in supporting people experiencing suicidal distress, challenges faced by the mental health workforce are of fundamental relevance to suicide prevention. The *National Mental Health Workforce Strategy 2022–2032*[334] highlights workforce shortages, poor geographical distribution of the workforce, underutilisation of skills and qualifications, out-of-date competencies that do not reflect contemporary approaches, and the lack of a long-term sustainability plan for the workforce.

The *Productivity Commission, Mental Health, Inquiry Report*[11] outlines recommendations aimed at strengthening the mental health workforce, including peer workers, mental health nurses, psychologists, psychiatrists and GPs. These recommendations are not restated in this Strategy, but their implementation is vitally important.

In addition to that ongoing work, several challenges specific to suicide prevention need to be addressed.

- The suicide prevention workforce does not yet have a cohesive approach to workforce planning and capability building. Qualification and training requirements and definitions of competencies are inconsistent across jurisdictions and disciplines.[335]
- The broader conceptualisation of the suicide prevention workforce includes people and roles outside those traditionally associated with suicide prevention. Effort is required to build their understanding of the important roles they play and develop their capabilities to be effective in those roles.

There is therefore a need to develop a national suicide prevention workforce strategy to guide planning across jurisdictions, disciplines and settings to help ensure Australia has a cohesive suicide prevention workforce that can meet future needs. This workforce strategy should outline a national approach to:

- clarifying the roles and core competencies of the suicide prevention workforce, aligning with existing jurisdiction- or discipline-specific role descriptions where possible
- building a diverse, compassionate and trauma-informed workforce that reflects the diversity of communities it serves and is equipped to deliver high-quality care that meets a diverse range of needs
- equipping suicide prevention workers to provide holistic support across roles and settings when needed and enabling the required level of integration
- recognising and responding to the impact of vicarious trauma and carer fatigue on key workforces, and its relationship to suicide prevention.

To succeed, the national suicide prevention workforce strategy will rely on collaboration across sectors and governments to inform its development and to monitor its implementation and impact (action 14.1a).

The recommended action to develop a national suicide prevention workforce strategy is described in Table 40.

> **During my inpatient stay at a psychiatric ward, I received invaluable support from a dedicated social worker. She took the initiative to deeply reflect on and understand how my unique background and cultural heritage intersected significantly, influencing my complex need for a sense of belonging. Recognising the importance of this, my social worker connected me with a psychologist from my own cultural community; this professional not only comprehended my intricate childhood experiences, but also provided a nurturing environment for growth and recovery. I firmly believe that such personalised support, tailored for individuals from diverse cultural backgrounds, is pivotal. It enables us to connect with like-minded individuals and professionals who can truly empathise with our core value systems and cultural origins."**
>
> **– Isha Garg**
> Lived Experience Partnership Group member

Table 40: Recommended action for Critical enabler 14.1: Develop a national suicide prevention workforce strategy

Action	Description
14.1a	Develop a national suicide prevention workforce strategy to guide a coordinated approach to workforce planning and development across governments and portfolios. • Define the scope of the suicide prevention workforce. • Raise awareness of the broad range of workforces that have a role in suicide prevention. • Clarify roles, competencies and required areas of capability development. • Identify priorities for attracting, training, maximising, supporting, retaining and sustaining key workforces that deliver culturally safe and inclusive suicide prevention services.

14.2 Build capacity and capability of key workforces

While a national suicide prevention workforce strategy will help broaden and strengthen suicide prevention in the medium to long term, there are immediate workforce needs to be addressed.

General practitioners

GPs have a pivotal role in suicide prevention because they are often the first (and sometimes only) contact that people experiencing suicidal thoughts and behaviours have with the healthcare system, and act as the lynchpin for the inclusion of families, carers and kin in support planning.[336-338] However, there are opportunities to improve the support provided by GPs to people experiencing suicidal thoughts and behaviours.

Suicide prevention education and training for GPs has been shown to decrease suicide rates and suicidal behaviours at the population level.[191] In Australia, however, there is currently no requirement for GPs to complete training in suicide prevention and there are practical barriers for many GPs to undertake such training. There is a need to increase the availability, accessibility and promotion of high-quality suicide prevention training tailored for GPs to encourage uptake and improve care delivered in general practice nationally. In addition, while best-practice guidelines for suicide prevention exist,[339,340] brief up-to-date evidence-based guidance on care for people with suicidal thoughts and behaviours should be readily available to all GPs, even if they have not completed training (action 14.2a).

GPs commonly report that people experiencing suicidal distress often require longer and more frequent sessions, which may not be sufficiently recognised by current funding models. There is a need to recognise the complexity of providing best-practice care and increase support for GPs to undertake this work. This may also extend to resourcing multidisciplinary team-based care to enable holistic support to be provided to individuals and their families, carers and kin.[341]

These actions to support general practice through strengthened funding models and a move towards multidisciplinary team-based care align with the recommendations of the *Strengthening Medicare Taskforce Report*,[246] and would help to improve access to primary care and strengthen continuity of person-centred care for people with suicidal thoughts and behaviour.

The recommended action to build capacity of GPs in suicide prevention is described in Table 41.

Activity to build on

A variety of suicide prevention training is available to build the capability of health workers to work with people experiencing suicidal thoughts and behaviours. For example:

- Advanced Training in Suicide Prevention[342,343] aims to increase the health professional's skill and confidence in taking a detailed history and developing a collaborative management plan to increase safety
- Collaborative Assessment and Management of Suicidality (CAMS)[344,345] is a therapeutic framework to guide collaborative assessment and care planning.

Table 41: Recommended action for Critical enabler 14.2 Build capacity and capability of key workforces (General Practitioners)

Action	Description
14.2a	Better equip GPs to provide and coordinate care for people experiencing suicidal thoughts and behaviours. • Support access to high-quality suicide prevention training tailored for GPs and disseminate evidence-based guidance on best-practice care to all GPs. • Establish a mechanism to recognise the complexity of presentations and length of time required by GPs to provide best-practice support for people with suicidal thoughts and behaviour (which includes, for example, developing and reviewing safety plans, care coordination with other service providers, and case conferencing). • Ensure GPs can facilitate access to support services for people experiencing suicidal thoughts and behaviour by enhancing multidisciplinary team-based care in primary care.

Suicide prevention peer workforce

In this Strategy, the suicide prevention peer workforce refers to people trained in peer work with a lived or living experience of suicide working in service settings. The important role that the peer workforce plays in suicide prevention has been widely recognised.[265] While the evidence base is still developing, early research shows promise in relation to suicide risk, access, engagement and participant satisfaction.[192,241,265] As a result, there has been some effort to integrate this workforce into suicide prevention supports across Australia.[346]

> **"The growth of a peer workforce that is distinctively for suicide prevention is critical. This means decentralising support services out of their concentration in mental health systems, making suicide prevention peer workers easily and directly accessible throughout communities. People in crisis are looking for benign points of entry to support that are outside of hospitals and emergency departments, where the rapport, compassion and lived understanding of suicide prevention peer workers is readily available."**
>
> **– Mark Ellis**
> Service Systems Working Group member

However, there are not enough peer workers to meet the current demand in suicide prevention services and there are challenges related to accessibility of training, a lack of consistency in training requirements and workplace supports.[347]

To continue to expand the suicide prevention peer workforce and integrate it into services in a way that supports high-quality service delivery and workforce retention, a nationally consistent approach to attracting, training and retaining peer workers is required. Such an approach would need to articulate training requirements and include mechanisms to improve accessibility of training. Attracting a diverse peer workforce, representative of the populations disproportionately impacted by suicide, also needs to be considered in growing this workforce.

Currently training opportunities are limited and expensive, especially for those who may themselves be experiencing ongoing impacts from the social determinants of suicide. Even with affordable training, the need to take leave from paid work to complete the training and participate in unpaid placements can be a further obstacle. There is an opportunity to reduce the financial burden for peer workers to ensure this workforce can grow.

To retain suicide prevention peer workers, employing organisations need to develop cultures, processes and structures that support the professional needs and value the role and expertise of this workforce. National guidance that outlines the scope of practice and professional needs of suicide prevention peer workers—for example, access to supervision, co-reflection and continuing professional development—would assist workplaces in providing this support consistently (action 14.2b).

There is also a need to continue to build the evidence of effectiveness of the suicide prevention peer workforce through evaluation of suicide prevention activities (as discussed in critical enabler 13).

The recommended action to build the capacity and capability of the suicide prevention peer workforce is described in Table 42.

Table 42: Recommended action for Critical enabler 14.2: Build capacity and capability of key workforces (suicide prevention peer workforce)

Action	Description
14.2b	Establish a nationally consistent approach to attract, train and retain the suicide prevention peer workforce. • Attract a diverse suicide prevention peer workforce through recruitment approaches and mechanisms to assist with accessibility of training including financial assistance. • Ensure training is of high quality and provides foundational knowledge in peer work and suicide prevention. • Develop guidance to support employing organisations to provide the suicide prevention peer workforce with a workplace that values and meets the professional needs of this workforce.

> **Being able to effectively use my lived experience in practice and share purposefully, along with the traditional training I've had, has meant I've seen a lot of success in suicide prevention. People feel more comfortable talking and being honest with peer workers because we have the identified lived experience."**
>
> **– Chris Trupp**
> Lived Experience Partnership Group member

14.3 Develop national guidelines for suicide prevention

Australia has guidelines for the assessment, management and prevention of 'self-harm' (suicide). These are principally designed to govern clinical practice and health service delivery. Numerous guidelines exist across jurisdictions,[348-350] for specific disciplines,[351] for health services,[352] and for specific groups, such as Aboriginal and Torres Strait Islander peoples[354] and LGBTIQ+ young people.[353] National guidelines for suicide prevention based on the approach outlined in this Strategy would provide a strong foundation for the national suicide prevention workforce strategy. These guidelines should be relevant to a workforce that operates across sectors and should focus on ensuring quality of services for suicide prevention (action 14.3a).

The recommended action to develop national guidelines for suicide prevention is described in Table 43.

Table 43: Recommended action for Critical enabler 14.3: Develop national guidelines for suicide prevention

Action	Description
14.3a	Develop national evidence-based guidelines based on the suicide prevention model described in this Strategy to guide best practice and serve as a foundation for consistent capability building for workforces that provide care and support to people who experience suicidal thoughts or behaviours.

Conclusion

The Strategy recognises the responsibility of governments, agencies, services, communities and all members of the community to work together to prevent suicide. Drawing on the latest evidence and insights about what works, it provides guidance for all levels of government about how to progress a coordinated and comprehensive approach to suicide prevention which extends to improving the baseline wellbeing of communities and minimising exposure to harm.

The Strategy also provides practical direction for services and those delivering them to promote reflection and progress towards high-quality compassionate supports that address the full range of challenges underlying a person's distress.

Finally, the Strategy provides impetus for individual reflection about what is required of the whole community to reduce suicidal distress and deaths—from senior levels of policy through to efforts to reduce stigma, foster connections and respond with compassion when someone is in emotional pain.

The changes described throughout the Strategy are substantial, but they are necessary to act on the clear imperative to realise a significant reduction in suicidal distress and suicide deaths.

Implementing this Strategy will require considerable long-term effort, sustained collaboration and mutual accountability across governments, and the humility to revise approaches in line with outcomes and new evidence.

At its heart, this Strategy asks governments, agencies, services, communities and all members of the community to recognise their role in suicide prevention and work together to achieve change. There is no more essential task.

Appendix A

Glossary

Key terms

Suicide is an action that a person takes to deliberately end their own life and that results in death.

A **suicide attempt** is an act in which a person harms themselves with the intention of ending their life and survives.

Suicidal thoughts and behaviours describe the range of experiences that a person who is suicidal may be having. This range spans from having thoughts of suicide to attempting suicide. Suicidal thoughts and behaviours describe a person's experience rather than risk.

Suicidal distress describes the experience of unbearable emotional and psychological pain, which can be associated with thoughts or plans to end one's life as a means of escaping that unbearable pain. This experience is also referred to as **suicidal crisis**, especially when this emotional and psychological pain intensifies for a period and the person considers themselves at imminent risk of taking action to end their life.

Stress can be defined as a state of worry or mental tension caused by a difficult situation. Stress is a natural human response that prompts us to address challenges and threats in our lives. Everyone experiences stress to some degree.[355]

Distress is broadly defined as a state of emotional suffering characterised by symptoms of depression (for example, loss of interest; unhappiness; desperateness) and anxiety (for example, restlessness; feeling tense). Distress is considered a transient (not long-lasting) state in response to specific stressors and it typically diminishes or vanishes when either the individual adapts to the stressor or the stressor is removed.[356,357] Challenging life circumstances, including psychosocial risk factors, can lead to feelings of stress, which can escalate to distress, which—without support—can escalate into suicidal distress.

Self-harm is an act in which a person harms themselves with a motive that may or may not involve the intention to end their life.[358] It is broader than, but includes, suicide attempts, due to intent—some people may self-harm with suicidal intent or for other reasons. Motives behind self-harm may be difficult to identify.

Lived and living experience of suicide refers to the experience of people who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, or been bereaved by suicide. For Aboriginal and Torres Strait Islander peoples, lived experience recognises the effects of ongoing negative historical impacts and/or specific events on the social and emotional wellbeing of First Nations peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.[359]

The importance of language

The way we speak about suicide and self-harm has a major influence on how the community understands and responds to people who are experiencing suicidal thoughts and behaviours. It also impacts on the existence and degree of stigma and shame around suicide.

'Died by suicide' is preferred over terms such as 'completed suicide' or 'successful suicide' that imply a fatal outcome was desirable. Similarly, 'suicide attempt' and 'non-fatal attempt' are preferred to terms such as 'failed suicide'. The term 'committed suicide' is not used because the word 'committed' is often associated with crime or sin, neither of which is a helpful association. It is also important to avoid terms such as 'suicide epidemic' or 'suicide crisis' as their use risks sensationalising suicide.[1]

Other terms

The Strategy uses different terminology at different times to reflect the specific research being cited. Extensive consultation was conducted with key stakeholders to ensure appropriate language and terminology has been used throughout the Strategy.

Male and **Female** refer to a person's sex. The concept of sex is based on the physical or biological aspects of a person's body. The concept of gender identity relates to the way a person feels, presents and is recognised within the general community. The Strategy generally uses terminology relating to gender (for example, man, woman, transgender); however, this may vary when needing to be consistent with cited research. For example, to accurately reflect ABS Causes of Death statistics, the Strategy uses the sex-based language of male and female.

Transgender and **gender diverse** describe people whose gender differs from the one assigned to them at birth.[360] There are many different experiences within gender diversity, for example:

- non-binary. Someone whose gender identity is more diverse than the binary of male or female. Someone who is non-binary may express genders besides male or female, along with male and female, and changing gender identity[361]
- sistergirl and brotherboy. Aboriginal and Torres Strait Islander descriptions of gender diverse people who have a female or male spirit and take on respective roles within the community
- genderfluid. Someone whose experience of gender changes and is fluid; for example, someone who is genderfluid may feel more like a man or a woman on certain days and like neither a man nor a woman on others.[361]

Mental health and behavioural disorders are characterised by a clinically significant disturbance in an individual's cognition, emotional regulation or behaviour. The term covers a range of disorders including (but not limited to) anxiety, affective and substance use disorders.[2]

Psychosocial risk factors are one categorisation of risk factors related to suicide deaths captured by the Australian Bureau of Statistics. The category includes the International Classification of Diseases (ICD-10)[362] codes Z00–Z99, which capture broad health, social and identity factors such as family history, sexual orientation, child abuse and neglect, and social exclusion.[2]

Families, carers and kin refers to anyone who provides active support (paid or unpaid) to people who experience suicidal thoughts and behaviours. This includes biological family, chosen family and broader kin networks as well as designated carers as defined by the *Carer Recognition Act 2010* (Cth).

Suicide prevention peer workforce refers to people trained in peer work with a lived or living experience of suicide who work in service settings to support people through purposeful sharing of lived experience and principles of reciprocity and equality.[363]

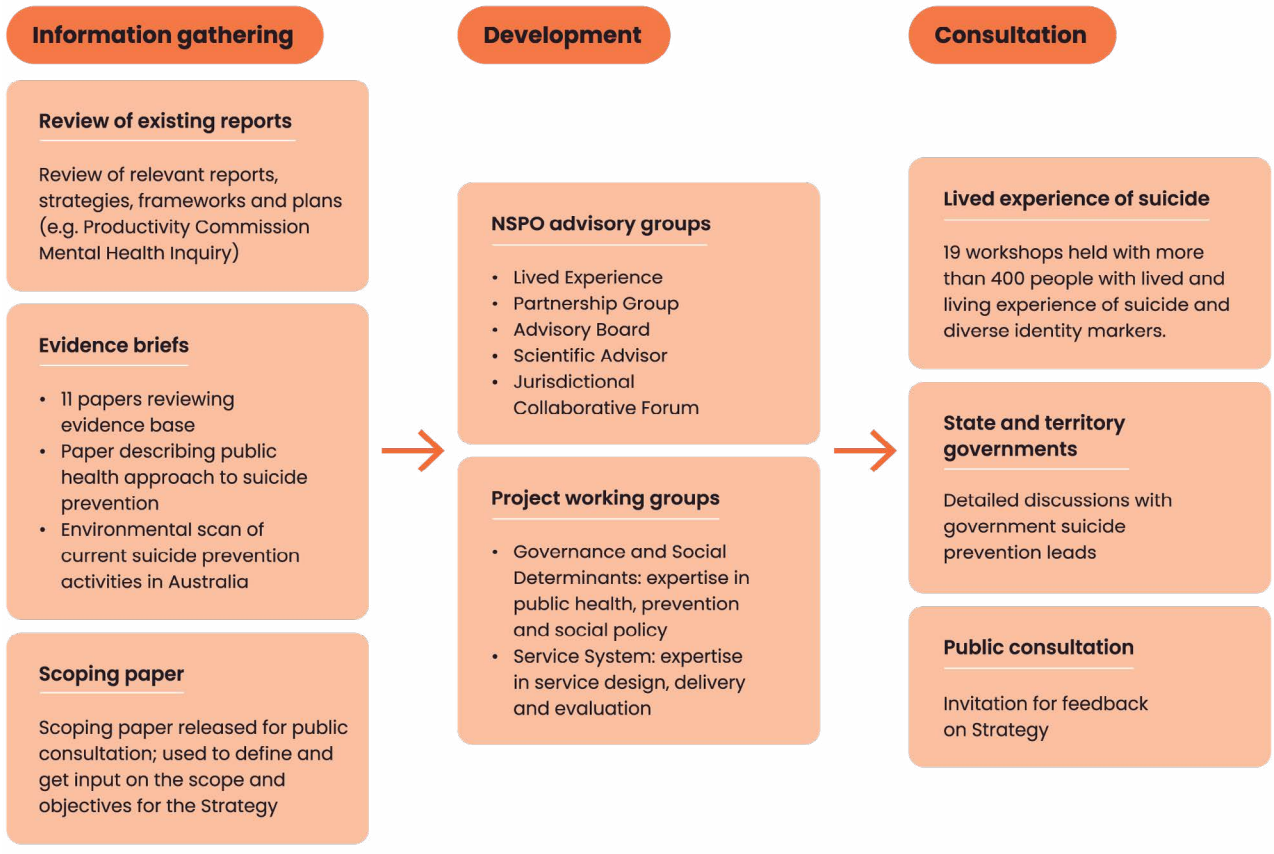
Whole-of-governments refers to work occurring between all levels of government—the Australian Government, state and territory governments, and local government—and across ministerial portfolios, government departments and agencies at each level.

Appendix B

Development of the Strategy

Figure 5 summarises the activities and participants involved in the information-gathering, development and consultation stages of the Strategy.

Figure 5: Development of the National Suicide Prevention Strategy



This Strategy draws on 32 existing agreements, plans, strategies, reports, submissions and inquiries, including the *Productivity Commission, Mental Health, Inquiry Report*,[11] *Royal Commission into Victoria's Mental Health System, Final Report*[18] and the *National Suicide Prevention Final Advice* reports.[35] In addition, the University of Melbourne was commissioned to produce a series of academic papers, literature reviews and evidence briefs to ensure that the actions are grounded in the latest available evidence.

Two working groups composed of people with lived and living experience of suicide, leading academics, and service providers contributed further input and advice, and a Jurisdictional Collaborative Forum was convened to ensure alignment with suicide prevention activity nationally. The work was also overseen by the NSPO Lived Experience Partnership Group, composed of a diverse range of people with lived and living experience of suicide, and the NSPO Advisory Board, composed of representatives of peak bodies, service providers and national and international experts in suicide, economic and social policy. The membership of these groups is detailed in Tables 44–46.

The development of the Strategy has been informed and guided by the insights of people with lived and living experience of suicide and the people who support them. Extensive consultation was undertaken, including through a workshop at the Roses in the Ocean Lived Experience Summit[316] and through 19 consultations with more than 400 people with lived and living experience of suicide from communities disproportionately impacted by suicide.

To ensure alignment with Aboriginal and Torres Straits Islander suicide prevention leadership, the NSPO worked closely with Gayaa Dhuwi (Proud Spirit) Australia. The Strategy draws on the final report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project[36] and aligns with the *National Agreement on Closing the Gap*,[37] which acknowledges the ongoing strength and resilience of Aboriginal and Torres Strait Islander peoples.

Table 44: Membership of the Lived Experience Partnership Group

Name	State or territory of residence
Susan Edgar (Chair)	Western Australia
Ken Barnard (Dec 2022 - Sep 2024)	New South Wales
Amy Bertakis	New South Wales
Benjamin Brien	New South Wales
Ben Farinazzo (Dec 2022 - Jun 2024)	Australian Capital Territory
Jordan Frith	Queensland
Isha Garg	Victoria
Charles Nasir	Northern Territory
Imbi Pyman	Victoria
Chaya Rainbird	Tasmania
Refugee*	South Australia
Jo Riley	New South Wales
Chris Trupp	Queensland
Luke Woods (Dec 2022 - Mar 2024)	Queensland

* not named for cultural reasons

Table 45: Membership of the National Suicide Prevention Office Advisory Board

Name	
Dr Alan Woodward (Chair)	Graeme Holdsworth
Professor Steve Allsop	Pino Migliorino
Gwen Cherne	Nicholas Parkhill
Professor Cutler	Kym Peake
Professor Patricia Dudgeon	Dr Wendy Southern
Professor Kathy Eagar	Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia
Bronwen Edwards	Chief Executive Officer, National Mental Health Commission
Professor Karen Fisher	Chief Executive Officer, Suicide Prevention Australia
Professor Sharon Friel	

Table 46: Membership of the National Suicide Prevention Strategy Working Groups

Governance and Social Determinants Working Group	Service Systems Working Group
Peter Anderson	Katrina Armstrong
Joe Ball	Monica Barolits-McCabe
Melinda Benson	Marion Byrne
Stephen Carbone	Maria Cassaniti
Gillian Clark	Joyce Chia
Zaccariah Cox	Sam Cruickshank
Nicole Falkiner	Mark Ellis
Thomas Jessup	Kate Finch
Anna Louise Kimpton	Kerry Gleeson
Tim Keane	Erin Halligan
Kathryn Mandla	Nikki Jamieson
Stephen Scott	Luke Lindsay
Fiona Shand	Dan Mobbs
Stephanie Trainor	Mike Nolan
Addie Wootten	Jay Pickard
	Nicolas Proctor
	Jo Robinson
	Hope Saba

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