Every life – Phase Two

Consultation report

Informing the next phase of Queensland's suicide prevention plan

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Feedback

We value the views of our readers and invite your feedback on this report.

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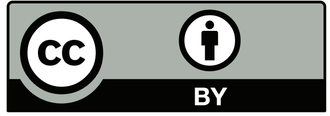
Translation

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you require an interpreter, please contact us on **1300 855 945** and we will arrange one for you.



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Acknowledgements

We respectfully acknowledge the First Nations Traditional Owners and Elders of the lands and seas on which we meet, live, learn and work. We acknowledge those of the past, who have passed on their wisdom and whose strength has nurtured this land. We acknowledge those of the present for their leadership and ongoing efforts to protect and promote First Nations people and cultures.

We recognise that it is our collective effort and responsibility as individuals, communities and governments to ensure equality, recognition and advancement of First Nations Queenslanders across all aspects of society and everyday life. We walk together in our shared journey of reconciliation.

We also acknowledge those people who have died by suicide and their loved ones, as well as other people impacted by suicide.

Many people, including people with lived experience of suicide, as well as service providers, organisational, sector, and peak representatives participated in consultations to inform Phase Two of *Every life*. We thank everyone for the generosity of their time and for the important contributions they have made.

It was not possible to include all the commentary received during the consultation process due to the volume of responses and feedback. Please know you were heard and your feedback was recorded and considered in the development of Phase Two.

The Commission's role

The Queensland Mental Health Commission (the Commission) is an independent statutory body established to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and alcohol and other drug system.

One of our primary functions is to develop a whole-of-government strategic plan to improve the mental health and wellbeing of all Queenslanders. The strategic plan supports coordinated action by relevant government agencies.

Commissioner's message

Developing Phase Two of *Every life: The Queensland Suicide Prevention Plan 2019–2029* has provided an opportunity to reflect on the first three years of the plan and look at the next steps required to reduce suicide and its impacts.

To develop Phase Two, the Commission engaged with a broad cross-section of Queenslanders, including people with lived experience and those who support them, peak bodies, non-government and sector organisations and government agencies, as well as members of the community to review the whole-of-government strategic directions and priorities for suicide prevention in Queensland.

Consultations included people with a lived experience of suicide, First Nations people, people in rural and remote communities, people from culturally diverse backgrounds, and LGBTIQA+ people.

This report provides an important overview of what we heard from the community and stakeholders. We acknowledge and are grateful for the honesty, bravery and generosity of the people who shared their personal stories and provided insight into what changes and next steps are needed for suicide prevention reform.

There was considerable consistency in the issues, concerns and solutions that we heard across the consultation. The strong desire for collaboration across all sectors and communities came through as a clear priority, along with the need to strengthen lived experience of suicide leadership; a stronger focus on governance and accountability; greater emphasis on research, data and evaluation; and strengthening of the workforce.

I look forward to putting Phase Two of *Every life* into action, and working together across the sector, all levels of government, and the broader community toward the shared goal of reducing suicide in Queensland.

Ivan Frkovic
Queensland Mental Health Commissioner

Introduction

Under the *Queensland Mental Health Commission Act 2013*, the Queensland Mental Health Commission (the Commission) is tasked with driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

The Commission has responsibility for developing and supporting implementation of *Every life: The Queensland Suicide Prevention Plan 2019–2029* (*Every life*) on behalf of the Queensland Government.

This report describes the consultation and engagement approach the Commission used to inform the development of *Every life* Phase Two. The report also summarises the key themes, issues and ideas presented by participants to help inform the future of suicide prevention in Queensland. The consultation findings, along with supporting evidence, have helped inform the priorities and actions identified in Phase Two of *Every life*.

Background

The Queensland Government has adopted and championed a whole-of-government and whole-of-community approach to suicide prevention since the late 1990s.

Every life was released in 2019 and is a sub-plan of *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023* (*Shifting minds 2018–2023*) and now *Shifting minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023–2028* (*Shifting minds 2023–2028*). *Every life* outlines Queensland's whole-of-government and whole-of-community approach to reducing suicide.

Every life was designed to be implemented over three phases across 10 years. Phase One consisted of 60 actions implemented across 15 Queensland Government agencies between 2019 and 2022. Phase Two will be implemented from 2023 to 2027 and builds on achievements and actions from Phase One. Phase Three, in turn, will build on both earlier phases.

Phase One of *Every life* was successful in embedding a whole-of-government approach to suicide prevention and creating a shared sense of ownership across government and beyond the health system. Annual progress reporting against the actions from Phase One has confirmed that many actions have been embedded into business-as-usual for agencies, creating a solid foundation to build upon.

At the time of the development of *Every life* Phase Two, *Shifting minds 2018–2023* was also in the process of renewal. As the overarching whole-of-government plan, *Shifting minds* provides the strategic framework to improve whole-of-population mental health and wellbeing, and to reduce the prevalence and impact of mental illness, problematic alcohol and other drug use, and suicide in Queensland. The development of *Every life* Phase Two has also drawn on the consultation process that took place to develop the renewed *Shifting minds*.

Consultation

To develop Phase Two of *Every life*, the Commission has worked with people with lived experience of suicide, their families and carers, Queensland Government agencies, non-government organisations and other key stakeholders to review the whole-of-government strategic directions and priorities for suicide prevention in Queensland.

Phase Two of *Every life* considers the evolved suicide prevention landscape since Phase One. It draws on thematic analysis of numerous inquiries, reviews and reforms that have taken place both within Queensland and nationally.

These include:

- *National Suicide Prevention Adviser – Final Advice*
- Queensland Parliamentary *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*
- Royal Commission into Victoria's Mental Health System
- Australian Government Productivity Commission Inquiry, Mental Health
- Royal Commission into Defence and Veteran Suicide

In May 2022, the Commission engaged an external consultant to undertake an independent evaluation of *Shifting minds* with a focus on its impacts and progress, as well as a targeted review of the systemic influence and impacts of Phase One of *Every life*.

The process was not intended to examine individual activities or initiatives. Instead, it looked at how effectively the plan was implemented across government and opportunities to strengthen the governance and implementation of future phases of the plan. Findings from the review have informed the priorities for Phase Two of *Every life*.

The review found that there is solid and positive engagement and support for *Every life* across government, non-government, community and industry sectors.

The review identified the value of increased collaboration and enhanced support for community-based and peer support activities. The review also highlighted the need to improve the collection, use and sharing of data to drive reform, monitor changes over time, and inform prevention activities. This has been used to inform the development of priorities and actions as part of Phase Two of *Every life*.

Consultation approach

Extensive consultation was crucial for developing Phase Two. Consultations included people with lived experience of suicide and their families and carers, First Nations people, people in rural and remote communities, people from culturally diverse backgrounds, and people of diverse sexual orientation and gender identity, including lesbian, gay, bisexual, transgender, intersex, queer/questioning and asexual (LGBTIQA+) people.

The consultation phase commenced in October 2022 and activities included a series of workshops throughout Queensland. Targeted consultations also occurred with specific groups of people. A separate consultation process to support the renewal of *Shifting minds* was also drawn upon to inform the development of Phase Two.

Targeted consultations

A consultation was held with the Queensland Suicide Prevention Network (QSPN) in October 2022. The QSPN consists of Queensland Government agencies and key suicide prevention sector stakeholders, including non-government organisations, Primary Health Networks and other state and national stakeholders. Consultations also occurred with:

- People with lived experience of suicide: nine people with lived experience of suicide took part in a consultation facilitated by Roses in the Ocean, the national peak for people who have lived experience of suicide.
- Young people: over 50 representatives from organisations supporting children and young people participated in a consultation that focused on the unique needs of young people.
- LGBTIQA+ people: 20 members of the LGBTIQA+ community participated in a consultation hosted by the Queensland Council for LGBTI Health.
- First Nations people: three consultations occurred with over 30 First Nations people and organisations, and were conducted in collaboration with the former Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships.

Shifting minds consultations

Shifting minds consultation activities included a series of workshops in various locations throughout Queensland and included broad invitations to cross-sector service providers and representative organisations. In addition to general consultation workshops, a series of targeted workshops were held with sector stakeholders on the needs of regional, rural and remote, older adults, infants and children, people with a disability, LGBTIQA+ and First Nations communities.

In addition to the in-person events, an *Every life*-specific consultation paper was published through the Commission's website and accompanied by an online survey and a call for written submissions. This occurred concurrently with a separate survey and submission process for *Shifting minds*. The survey was open from 11 January until 3 February 2023.

A total of 44 people responded to the survey. Forty per cent of people who responded to the survey identified that they worked in a mental health organisation, 35 per cent reported working in a suicide prevention organisation, and 20 per cent of participants worked in private sector organisations. Of those who worked in the mental health, alcohol and other drugs sector, 80 per cent worked in the adult mental health sector.

All consultations were supported by a discussion 'snapshot' that identified an ideal future state of our suicide prevention system (Appendix 1). The snapshot was developed using evidence, information and recommendations drawn from recent inquiries, reports and processes that have involved significant community and stakeholder engagement.

The final phase of the consultations involved a series of community forums where the draft *Every life* priorities were presented to members of the community and local service providers for feedback across six locations, and an online webinar. There were a total of 170 participants at the community forums and the webinar.

Table 1: Community forums for the development of *Every life* Phase Two and the renewal of *Shifting minds*

Consultation session	Number of participants
Community forum (Cairns)	30
Community forum (Ipswich)	25
Community forum (Longreach)	14
Community forum (Mackay)	20
Community forum (Rockhampton)	11
Community forum (Toowoomba)	19
Community forum (webinar)	51
Total	**170**

What has changed?

Through the consultation and development process, the vision and principles of *Every life* were tested to ensure they remain contemporary and relevant to the needs of Queenslanders. *Every life* Phase Two reiterates the vision articulated in Phase One, for:

A healthy and inclusive Queensland where all people can access appropriate support, achieve positive mental health and wellbeing and live their lives with meaning and purpose.

The principles for *Every life* Phase Two were adapted based on feedback from consultations, and the changes between the Phase One and Phase Two principles are outlined in Table 2.

Action areas

***Every life* Phase One had four broad action areas:**

- Building resilience
- Reducing vulnerability
- Enhancing responsiveness
- Working together

The only identified need for change between Phase One and Phase Two was to the final focus area 'Working together'. Originally, this area was intended to encourage different sectors and communities to work together to shift and challenge the status quo. The consensus going into Phase Two was that the appetite for collaboration was high, but more work was needed on strengthening the systemic enablers for reform.

As a result of this feedback, Phase Two replaces 'Working together' with 'Enabling reform'. The actions under this area are targeted towards strengthening the enabling functions such as governance and accountability, embedding lived experience leadership, data, research and evaluation, and building workforce and community capability.

The themes that emerged from consultations under each of the four broad action areas were used to develop new priorities for Phase Two.

Table 3 provides a comparison of Phase One and Phase Two priorities, which were informed by the outcomes of consultation.

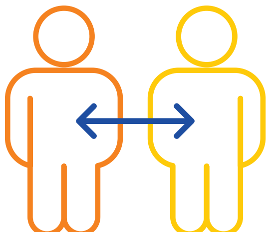
Table 2: Comparison of principles in *Every life* Phase One and Phase Two

Phase One principles		
We value culture.	We believe in recovery and hope.	We support equity.
We value the lived experience of people, families and carers.	We respect human rights and dignity.	We are person-centred.
We adopt a social determinants approach to mental health and wellbeing.	We adopt a joined-up planning approach that reflects population need and evidence.	We believe collective responsibility is vital to reform.

Phase Two principles		
We are led by people with lived experience of suicide and their families and carers.	We uphold the social and emotional wellbeing of First Nations people, acknowledge cultural rights and that culture is protective.	We uphold and promote the human rights and dignity of all people.
We are committed to social justice, equity and addressing the social determinants of health inequity.	Our approach is focused on prevention and providing supports as early as possible.	We support community-led initiatives that build on their inherent strengths, abilities and knowledge.
We value early responses in a community-based context.	We support people in a way that respects and responds to their individual and diverse needs.	We address all forms of stigma and discrimination against people who have lived experience of suicide.
We prioritise partnerships, coordination, collective responsibility and accountability for reducing suicide in Queensland.	We build upon and learn from cross-sector knowledge and experience.	

Table 3: Phase One and Phase Two action areas and priorities

Action area	Priorities: Phase One	Priorities: Phase Two
Building resilience: *Improve wellbeing in people and communities*		
	• Enable Queensland families and children to thrive • Strengthen school-based mental health supports • Build mentally healthy workplaces • Public sector to lead by example in workplace mental health and suicide prevention • Build inclusive, resilient and mentally healthy communities	• Enable Queensland children and families to thrive • Strengthen evidence-based suicide prevention strategies in places of learning • Build supportive workplace environments that are equipped to respond to distress • Build inclusive, resilient, socially connected and mentally healthy communities • Contribute to reduced distress and suicide risk by supporting Queenslanders to achieve economic, employment and housing security
Reducing vulnerability: *Strengthen support to people disproportionately impacted by suicide*		
	• Making men's suicide prevention a priority • Working collaboratively to support the most vulnerable Queenslanders • Targeted interventions for community members at greater risk	• Prioritise men's suicide prevention • Tailor responses and supports for populations disproportionately impacted by suicide • Improve the system-wide response to people who have experienced adversity and trauma • Create targeted responses and supports that consider key stressors, life stages and transition points

Action area	Priorities: Phase One	Priorities: Phase Two
Enhancing responsiveness: *Enhance responses to suicidality*		
	• Making every contact with a government agency an opportunity for intervention • Expanding options for the care of suicidal people, including non-medical and peer support options • Pursuing excellence in care of suicidal people across the health system • Timely and accessible support to people following a suicide	• Enhance government and community capability to provide timely and appropriate support at the point of distress • Expand alternative entry points to support and emergency department diversion services, including after-hours support, non-medical and peer support options • Improve service accessibility, responsiveness and appropriateness by expanding existing initiatives and developing new practice models
Enabling reform: (Phase One: Working together) *Strengthen the systemic enablers for reform*		
	• Creating a more coordinated approach to suicide prevention • Strengthening First Nations leadership in mental health and suicide prevention • Improve the way data, evidence and evaluation is used to drive suicide prevention • Reduce access to lethal means and creating safer public spaces	• Strengthen lived experience of suicide leadership in suicide prevention • Strengthen First Nations leadership in suicide prevention • Create a more coordinated and integrated approach to suicide prevention • Improve the way data, evidence and evaluation is collected, used and shared to drive and improve suicide prevention • Strengthen governance and accountability mechanisms • Develop the capacity and capability of the suicide prevention system workforce

Community and stakeholder feedback

Stakeholders were presented with an overview of the current system in Queensland and the key achievements under Phase One. Stakeholders were asked to consider the current challenges in the suicide prevention system in Queensland, what an ideal future suicide prevention system in Queensland would look like, and what action would need to occur over the next three years to arrive at the ideal future state.

Building resilience

Enable Queensland children and families to thrive

The current challenges

Stakeholders were clear that the early years are a critical period for children and families, and that reducing suicide risk starts in infancy. If families are well supported from the first days of a child's life, this can reduce the likelihood that a child will be exposed to adverse childhood experiences. This in turn can reduce vulnerability to suicide later in life.

Not all families are aware of or provided with universal access to early infancy parenting supports, and a lack of support for new parents can lead to many adverse outcomes, including longer term disengagement from services. Supporting parents' wellbeing and reducing family vulnerabilities is especially important.

Participants also identified that families are often not provided with the support they need to identify when children are experiencing mental health or other life difficulties, and do not have the skills needed to support their children at those times of need.

Some participants noted that there needs to be more research and evaluation of early childhood programs to build our understanding of what does and does not work from a suicide prevention perspective.

Opportunities

- Recognition that reducing exposure to adverse childhood experiences has an important role to play in suicide prevention
- Early interventions with proactive, accessible and coordinated support for children and families
- Investment in building the evidence that demonstrates the value of early childhood interventions
- Families are linked early to supports that they trust
- Increased investment in perinatal services and supports to build parents' resilience and reduce children's exposure to adverse experiences
- Services that proactively engage families and provide education and support to build the suicide prevention literacy of the whole family

Strengthen evidence-based suicide prevention strategies in places of learning

The current challenges

Although stakeholders agreed that the education system remains an important setting to provide suicide prevention and early intervention, there were many different views about what suicide prevention efforts should look like within those settings.

Some participants suggested that there should be universal and standardised mental health and wellbeing education and suicide prevention programs across all schools and at all levels of education (primary, secondary, tertiary). Other participants highlighted that different students have different needs, and education and support programs should be tailored accordingly as well as evaluated to determine what types of interventions have the most impact.

There was general recognition that standardised programs can be difficult to implement as each school is operationally independent and reliant on school leadership.

Opportunities

- School settings better recognised as an opportunity for suicide prevention programs
- Children and young people taught about positive mental health and wellbeing at schools
- Structural changes to education programs to reduce anxiety and stress for young people, and better support transitions
- Increased understanding of suicide and its impacts across the education workforce
- An active, evidence-based postvention program at all places of learning

Build supportive workplace environments that are equipped to respond to distress

The current challenges

Participants agreed that workplaces play an important role in supporting wellbeing and responding to distress. Some stakeholders emphasised that small businesses may be under economic and other pressures, while at the same time are not well-equipped to respond to employee distress.

In terms of public sector workplaces, there was a view that greater accountability is required for policies and activities designed to respond to distress across the public service.

Opportunities

- Strengthen workplace policies and practices that support positive mental health and wellbeing
- Support small businesses to better respond to employee distress and support overall wellbeing
- Public sector workplace environments should include progress reporting against key actions and targets

Build inclusive, resilient, socially connected and mentally healthy communities

The current challenges

Consultation participants placed a strong focus on the importance of community resilience, fostering community connection, community-led approaches and community responsibility.

Participants highlighted that social and community connection is key to individual and community resilience. They expressed concerns that a lack of social connectedness has been amplified through COVID-19, and said that programs that increase social and community connection need to be prioritised, funded and considered an important element of broader suicide prevention efforts. The clinical workforce, and general practitioners (GPs) in particular, need a deeper understanding of the role and value of programs that support social connection as part of a person's care.

During the consultations, participants expressed their view that communities understand their needs best. To develop and implement sustainable responses and solutions, community-led approaches need to be valued, supported and adequately resourced. It was emphasised that communities need to have the capacity and capability to support community connections and community responses, rather than relying on paid, formal services.

Opportunities

- Shift from a focus on building individual resilience to community resilience
- People should feel connected and included in their communities
- Greater investment in community connection programs
- Grassroots and community-led responses require funding and resources
- Increased 'social prescribing' to support social and community connection, and greater education among primary care systems about the value of social supports and available options
- Communities are a network of safety and support for people in distress
- Suicide prevention is seen as the responsibility of the whole community

Contribute to reduced distress and suicide risk by supporting Queenslanders to achieve economic, employment and housing security

The current challenges

Stakeholders repeatedly expressed that people are experiencing numerous life pressures, including financial pressure, the cost of living, unemployment and underemployment. The housing crisis, including the affordability and availability of housing, is a key stressor for Queenslanders. These social and economic factors can contribute to suicide, not only by increasing the stress that people are exposed to but also by acting as a barrier to accessing support services.

There was consensus that addressing the social determinants of wellbeing—meaning the conditions in which people are born, grow, work, live and age, and the wider ecosystem shaping daily life—is a crucial part of suicide prevention.

Opportunities

- Greater focus on social determinants as key stressors and drivers of suicide
- Greater support for Queenslanders to achieve economic, employment and housing security

Reducing vulnerability

Prioritise men's suicide prevention, and tailor responses and supports for populations disproportionately impacted by suicide

The current challenges

A key message across all consultations was the need for suicide prevention activities to be targeted and tailored to groups who may disproportionately experience psychosocial stressors that elevate their risk of suicide.

These priority groups include men, First Nations people, people from culturally and linguistically diverse backgrounds, young people, older people, LGBTIQA+ people, people experiencing domestic and family violence, people who have experienced adversity and trauma, and people in occupations that have disproportionately high suicide rates (for example, farmers, construction workers, veterans, first responders).

There was a general view by participants that current system responses do not reflect the individual needs of people who may be at elevated suicide risk, and that responses tend to be 'siloed' rather than considering the holistic needs of the person. A lack of system coordination was also identified. Issues such as stigma and discrimination as barriers to both help-seeking and effective help provision were raised, as was the possibility of unskilled service providers causing harm.

Participants noted that the evidence base used to drive suicide prevention responses for disproportionately impacted groups is often limited and needs to be improved.

Opportunities

- Implement a more systematic program of activities to create the cultural shifts necessary to support men and to ensure that services are appropriate for men's needs
- Develop frameworks that emphasise and support wellbeing for groups disproportionately impacted, and tailor responses to those groups
- A more flexible and coordinated approach to particular communities and service responses, including:
  - across state/federal funding
  - across government departments
- Upskill mainstream services to work with high-risk groups, to better understand and respond to their needs
- Recognition of non-traditional networks of support, including community and peer-based supports
- Improve data on drivers of vulnerability and risk, understanding of where these drivers exist, and implementation of targeted approaches for these populations
- Build the evidence base around what works best to prevent suicide in different groups

Improve the system-wide response to people who have experienced adversity and trauma

The current challenges

Consultation participants emphasised the role that experiences of adversity and trauma have in contributing to a higher risk of suicide. Adverse childhood experiences were highlighted as being a significant contributing factor to suicide risk.

Stakeholders expressed concern that there is still a lack of understanding of how trauma presents, in particular among ambulance, police, domestic violence services, workplaces and schools. Participants felt that the current system and responses are not trauma-informed and can re-traumatise people who are seeking help and at their most vulnerable.

There also remains a lack of awareness of the impacts of intergenerational trauma.

Opportunities

- Improved understanding of suicidality in the context of trauma and adversity
- A trauma-informed response adopted system-wide, including trauma-informed education, resources and policies developed across agencies
  - Be clear about what outcomes a trauma-informed response is meant to achieve
  - Development and implementation of the Queensland Government trauma strategy

Create targeted responses and supports that consider key stressors, life stages and transition points

The current challenges

Consultations highlighted that there is no one-size-fits-all response to suicidal behaviour, and the most effective responses are those that are matched with people's situations and needs across their different life stages.

Participants acknowledged that a wide range of psychosocial influences can contribute to suicide, and that different influences and risks emerge at different life stages and vary across different groups.

There was general recognition that responses need to be collaboratively designed with the groups they seek to assist. Participants also said work is needed to develop effective early interventions for psychosocial risks that are commonly associated with suicide in certain in certain high-risk groups (such as isolation and loneliness, or the end of a relationship).

Opportunities

- Better recognition of specific 'risk points' such as justice system contact, particularly for young people
- Better consideration of different life stages and transitions as times of vulnerability and provide additional supports, including transitions from:
  - out-of-home care
  - primary to high school
  - education to workforce
  - becoming a parent
  - workforce to retirement
  - entry into supported living/aged care
- Enhanced understanding of what types of early interventions are most likely to be effective

Enhancing responsiveness

Enhance government and community capability to provide timely and appropriate support at the point of distress

The current challenges

An overarching theme across consultations was that although government services are an important element of suicide prevention systems, those services are typically geared toward crisis intervention.

To reduce the likelihood of people reaching a point of suicidal crisis, it is necessary to identify and respond to distress at an early stage. To achieve this, a shift is required from reliance and focus on formal service responsiveness and intervention, to community capability and capacity.

Stakeholders suggested that communities know their members best and are often best placed to provide support earlier in distress, so community-developed and community-led initiatives should be prioritised and resourced. While communities may not currently be equipped to respond to people in distress, with the right investment and support they can provide a network of safety and support.

A strong message was that suicide prevention should be seen as the responsibility of an entire community, not just the responsibility of the government.

Opportunities

- Invest in building community capability to respond to people in distress
- Build the skills of the community, including community leaders, and establish a system that can respond to distress and enable support and response escalation at any point
- Make training available to community members that is well promoted to ensure awareness about its availability
- Reducing suicide should be seen as a whole-of-community responsibility rather than a whole-of-government responsibility
- Invest in community-led initiatives
- Build on resources that are already in communities to respond to people in distress

Expand alternative entry points to support and emergency department diversion services, including after-hours support, non-medical and peer support options

The current challenges

There was widespread stakeholder recognition and concern that emergency departments are not an ideal environment for someone in distress. While there has been recent investment in new models that are alternatives to emergency departments, scale up of supports that work and adaptation of models to meet the needs of different populations and communities is required.

Fear of police and ambulance can also impact a person's willingness to call 000 when in crisis and people may be reluctant to attend emergency departments or access clinical care. There is a need to improve the ability for people to find and access supports when they need those, including after-hours, peer support and psychosocial options. This may be especially important for people in areas where health services are limited and/or where emergency departments are currently the only after-hours option available.

Opportunities

- An accessible and inclusive service system that provides timely support to people in distress, including after-hours support
- Innovative models as alternatives to emergency departments that improve support and care for all people and include accessible, safe and trauma-informed waiting room spaces
- Expanded alternatives to emergency department

Suicide prevention should be seen as the responsibility of the entire community.

Improve service accessibility, responsiveness and appropriateness by expanding existing initiatives and developing new practice models

The current challenges

Stakeholders said that when people seek help, they are often in crisis and the service system is currently difficult to navigate for people who are in distress. Long wait times for support services, limited service options, exclusion criteria, limited operation times and lack of support provided in a convenient and safe place further impact a person's ability to access the right type of support at the time when they need or want it.

Participants highlighted that support for innovation at the process, program and systems level is needed to ensure we are not just funding 'more of the same'. They stated that service options should include mobile crisis responses, safe spaces, crisis stabilisation units, online services that are of high quality, out-of-hours service access, peer support and co-responder models.

GPs are often a first contact point for people who are in distress, however, they are often ill-equipped to respond due to a range of systemic issues such as time pressures, alongside a lack of knowledge, skill and capability. The lack of access to bulk-billing GPs results in people waiting to be treated and seek help, which leads to people accessing support when they are already in crisis. GPs are also often reluctant to refer to psychosocial support services, even if they are more appropriate for responding to distress.

Participants acknowledged the recent investment in Distress Brief Intervention sites in Queensland through the *Bilateral Schedule on Mental Health and Suicide Prevention: Queensland* (the *Bilateral Agreement*) and in safe spaces. Continuing to build on these service models will be important moving forward, including ensuring the models are culturally appropriate, available at a sufficient scale to meet demand, and integrated into the larger service system.

A system shift from 'help-seeking' to 'help-offering' was important to consultation participants, whereby support services proactively engage participants as opposed to placing the responsibility on the individual to engage in support. By offering help, proactive support could be provided before a person reaches a crisis point.

Stakeholders also talked about the importance of providing intensive support to a person after a suicide attempt or suicidal crisis. Even though there has been significant recent investment in scaling up aftercare supports, not everybody has access to these supports. People from groups who are disproportionately impacted by suicide may find it particularly difficult to access aftercare that is appropriate for their needs.

Participants also highlighted the need to support regional, rural and remote communities with innovative models and responses to people who are in distress.

Opportunities

- Increased awareness of available service options, including widespread promotion of available services to the community
- Increased service navigation roles to help people access support when they need it
- Integrated digital support options that people can use when in crisis, and greater investment in and use of digital interventions
- Access to appropriate aftercare services for all people, including family-based planning and support
- Engagement of people in ongoing care, support and treatment following a suicide attempt
- Place-based initiatives that are co-designed with communities and people with lived experience of suicide
- Scale up of co-responder models
- Safe spaces that are developmentally and culturally appropriate and embedded into existing infrastructure (for example, pharmacies, libraries and other community places)
- Provision of holistic models of care that respond to the whole person, and include both clinical and psychosocial supports
  - A coordinated and collaborative service system, including models of co-location and integration of services
  - A culturally responsive service system
  - Increased knowledge and skill of GPs to respond to people in distress, including making referrals to community-based psychosocial supports ('social prescribing')
- Support the development of new service models in regional, rural and remote areas and communities, including flexible funding that allows for innovation
- Increase community capability in rural and remote areas to support people in distress within communities that lack access to health services

Enabling reform

Strengthen lived experience of suicide leadership in suicide prevention

The current challenges

In targeted consultations, participants with lived experience of suicide emphasised the importance of embedding that experience in all aspects of planning, implementation and service delivery. This was seen by stakeholders as a critical enabler for system reform as well as for the delivery of a compassionate, comprehensive and appropriate suicide prevention response.

Stakeholders indicated that people with lived experience need to be better supported to use their experience to drive system reform, and that the suicide prevention system needs to be more confident and skilled in engaging people with lived experience in its work.

Participants would like to see an expanded suicide prevention peer workforce and were concerned that this is currently underdeveloped in Queensland, with no systematic funding mechanism or strategy for engaging people with lived experience.

Opportunities

- Expand and resource the role of people with lived experience of suicide, including investing in skills development and leadership capacity
- Remove barriers to care and support of health workers with lived experience of suicide
- Create a robust and available suicide prevention peer workforce
- Collaborate with lived experience organisations
- Develop and implement new service models that engage and utilise lived experience
- Increase the acceptability and use of the peer and lived experience workforce across government departments

People with lived experience need to be better supported to use their experience to drive system reform.

Strengthen First Nations leadership in suicide prevention

The current challenges

In targeted consultations, First Nations representatives emphasised the importance of framing suicide within the context of social and emotional wellbeing, rather than illness, to better reflect First Nations culture.

The importance of supporting and building the First Nations workforce was repeatedly raised, as was the need to upskill workforces more generally to ensure culturally safe and culturally responsive practices.

The need for enhancing community capacity was frequently emphasised, as was the importance of models of care that are developed by and for First Nations people.

Many participants also identified broader themes, such as the importance of early intervention and whole-of-family supports, as well as building community connections and capability to respond early to people in distress through existing points of contact such as schools, GPs and community organisations.

Opportunities

- Give communities greater control over suicide prevention activities through localised decision-making, flexible funding models and community-led responses
- Increase the First Nations workforce
- Improve the capability of GPs to respond more appropriately to First Nations patients
- Recognise and address the social determinants of suicide
- Support greater First Nations representation in leadership, governance and program implementation roles
- Talk to communities on the ground and support local initiatives
- Service providers need to spend significant time with individuals to determine their needs and make appropriate referrals, and complex needs need to be recognised
- Recognise the interconnections between suicide and broader issues such as housing, foetal alcohol syndrome and justice system contact

Create a more coordinated and integrated approach to suicide prevention

The current challenges

Participants were concerned that there is a lack of responsibility for system coordination and a lack of connected policies, implementation and planning processes across government. In particular, it was noted that there is a lack of coordination across state and federal funding and across the community and health sectors.

Funding was often raised during consultations. There was a strong message that connectedness, coordination and collaboration amongst service providers on the ground is also needed; however, current funding arrangements often contribute to further disconnection and working in silos. Short-term funding cycles create numerous challenges for services, including workforce recruitment, inability to establish trust with the community, and significant time spent on negotiating funding arrangements. Lack of alignment of funding across various funding agencies leads to inefficiencies and a more coordinated and collaborative approach is needed. A lack of flexible funding models that enable communities to design initiatives that are innovative and meet their unique needs was raised.

Stakeholders highlighted that collaboration is necessary for greater system efficiency and effectiveness. Bringing people together also creates empathy and understanding among people about the broader system and its different perspectives and challenges.

Opportunities

- Longer-term funding cycles to enable services to plan, recruit staff and build relationships and trust with the community
- Transparent and accountable funding arrangements
- Joint funding and co-commissioning, with greater coordination across state and federal funding initiatives and greater connectedness between the health and community sectors
- Flexible funding models focussed on outcomes rather than standardised approaches
- Invest in innovation rather than funding ‘more of the same’
- Invest in and scale up programs that work
- Joint project implementation teams across different government agencies
- Include wellbeing and suicide prevention statements into government policy development processes

Improve the way data, evidence and evaluation is collected, used and shared to drive and improve suicide prevention

The current challenges

A number of participants expressed concern about shortcomings in how data is collected, integrated, shared and reported on. Participants stated that there is a lack of data that demonstrates what programs and initiatives do and do not work, and that decision-making around the investment of resources is therefore not supported by robust data. The view was expressed that there is currently limited focus and investment in rigorously evaluating suicide prevention initiatives, and outcome measures often don't reflect the stated goals of the initiative.

Opportunities

- Use data more effectively to help improve services and supports, understand if services are making a difference, and identify effective service models
- Use data to understand what the risk factors for suicide are, and where they are occurring in the community, to target our responses
- Need to better understand the journey of a person at risk of suicide and opportunities for intervention
- Services need to be supported to undertake evaluations
- Improve data consistency, linkage and integration across government agencies and explore setting up a driving body/group across agencies to address barriers to data sharing and linkage
- Have locally developed outcome measures that are based on what that community defines as success
- Develop a comprehensive suicide prevention research agenda

Support for innovation at the process, program and systems level is needed to ensure we are not just funding 'more of the same'.

Strengthen governance and accountability mechanisms

The current challenges

Stakeholders expressed that governance and accountability mechanisms for strategic planning and implementation need strengthening to ensure that reform occurs.

Opportunities

- Joint ownership at a senior level of strategic plans and accountability mechanisms to drive plans forward
- Build suicide prevention impact statements into departments, including budget processes
- Accountability for *Every life* Phase Two implementation and alignment of local plans with *Every life* direction

Communities understand their needs best… community-led approaches need to be valued, supported and adequately resourced.

Develop the capacity and capability of the suicide prevention system workforce

The current challenges

Participants identified a wide range of issues with the suicide prevention system workforce, including significant workforce shortages that are being particularly felt in rural and remote and First Nations communities.

Stakeholders frequently expressed that there has been escalating distress among health workers since the onset of the COVID-19 pandemic and there is generally poor workforce morale. The workforce is currently not supported to disclose their own mental health difficulties and suicidal thinking and utilise services. Structural barriers including the mandatory reporting of health workers with mental health concerns continue to cause concern.

Negative experiences, vicarious trauma, burnout and the lack of support of the workforce, along with short-term funding and correspondingly uncertain employment contracts, impacts the ability to retain staff. Lack of training leads the workforce to be more vulnerable to traumatisation. Training and upskilling of the workforce is needed, including outside health.

Opportunities

- Develop a deeper understanding of workforce shortage issues and develop a whole-of-government workforce strategy that addresses these issues, including:
  - focus on workforce attraction and retention
  - increase the volunteer and peer support workforce
  - focus on strengthening the First Nations workforce
  - map growth of workforce needs
  - develop a pipeline for how people will enter the suicide prevention care workforce
- Nurture the workforce, improve working conditions and provide greater support to workers
- Provide safe spaces and processes that allow the workforce to disclose wellbeing challenges and use services and supports
- Focus on the ‘function’ of workers and services delivered to ensure consumer needs are met with the workforce available, rather than whether a worker is a clinician or otherwise
- Better educate the community about different roles and offerings within the care workforce, including in non-clinical areas
- Develop, promote and provide training programs and resources that are designed to upskill the workforce and particularly to strengthen the workforce who provide peer and psychosocial support
- Focus on building workforces who have diverse backgrounds and experiences, with attention given to matching the composition of the workforce to the needs of priority groups who are at greater risk of suicide

Appendix 1

Suicide prevention in Queensland – A future state

Pillar descriptors

Building resilience: This pillar is about ***building personal resilience, social connectedness, and positive wellbeing,*** which can be protective factors against a wide range of adverse issues including vulnerability and risk. The places where people ***live, work and learn*** have a significant role to play in building resilience. ***Community connectedness*** can strengthen resilience through fostering social cohesion, understanding and embracing diversity, reducing stigma and discrimination, and providing safe environments. Building resilience ***early in life*** sets a strong foundation for social and emotional wellbeing.

Reducing vulnerability: This pillar focuses on strengthening support to the ***people, groups and communities that are more vulnerable to suicidality*** because of their experience of ***adversity, trauma, intergenerational disadvantage or discrimination***, or through increased presence of ***social, economic and health factors***. This includes developing a greater understanding of the drivers of vulnerability and risk, enabling early interventions at key touchpoints and providing tailored approaches.

Enhancing responsiveness: This pillar focuses on ***enhancing and improving responsiveness to people in crisis and distress, and those affected by suicide***. This includes all parts of the system, including the health system, housing, employment, social services, law enforcement and justice services, child protection services, other government agencies and the broader community.

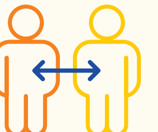
Enabling reform: This pillar is foundational and focuses on the systemic enablers needed to drive reform across the other three pillars of *Every life*: 'Building resilience', 'Reducing vulnerability' and 'Enhancing responsiveness'.

Building resilience

- **Mental health and wellbeing is prioritised** by all government and non-government agencies and within the private sector.
- All Queenslanders **are aware of, and have access to,** supports and programs that build resilience, reduce distress, build a sense of connection and strengthen hope.
- People feel **connected and included in communities** that drive social inclusion and foster diversity.
- All people are supported to achieve **economic, employment and housing security**.
- All people are provided with the **best start to life** and their families are supported in the first 2,000 days of life.
- **Regardless of their geographic location, Queenslanders can access support** if they are experiencing distress, including suicidality. This includes at workplaces, schools, community centres, sports and recreation facilities or in public spaces such as on transport.
- Mental health and wellbeing strategies are embedded in **workplaces, schools and community settings** so that they reach people where they are.

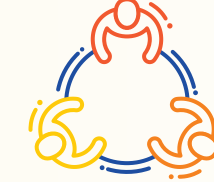
Reducing vulnerability

- Priority groups receive **targeted, culturally responsive and accessible supports** that are tailored to their needs.
- The **diversity within priority groups** is considered and addressed in initiatives that aim to prevent suicide.
- Priority groups receive service responses that are holistic, address social determinants and **consider the factors contributing to vulnerability and suicide risk.**
- People can seek support or services **without fear of discrimination or stigma.**
- **A skilled peer-workforce** that targets priority populations is available, utilised and valued.
- **Data is readily available on drivers of vulnerability and risk** to inform decisions around priority groups and approaches.
- **Key touchpoints are used as opportunities for early intervention** that proactively support people through life stages and at key transition points.
- **Genuine First Nations governance and leadership** guides the planning, implementation and evaluation of all suicide prevention strategies for Aboriginal and Torres Strait Islander people and communities.
- Workplaces and people in **occupations at high risk of suicide are targeted** with specific and tailored suicide prevention initiatives.
- An integrated approach to suicide is implemented that addresses the drivers of problematic **alcohol and other drug use.**



Enhancing responsiveness

- **All government agencies have the capability** to provide timely and appropriate intervention at the point of distress.
- All people receive a **compassionate, timely and evidence-based response** following a suicidal crisis at emergency departments and other health services.
- **Expanded and accessible service options** including alternatives to emergency departments that provide a warm, welcoming environment to reduce distress and respond to crisis.
- **Services and policy are co-produced in true partnership with people with a lived experience,** and lived experience is considered expert and essential input into the design and delivery of suicide prevention responses.
- A **skilled peer-led workforce** is available, utilised and valued.
- Services received by people experiencing suicidal distress are **safe and culturally appropriate.**
- An **integrated and coordinated service system** that addresses the multiple needs and social determinants of people who are in distress and enhances the continuity of care between services and treating teams.
- **The community has the capability** to respond to people in distress.
- A comprehensive response that addresses social determinants of health and wellbeing is delivered to people **earlier in distress.**
- **Caregivers** of people who have died by suicide or attempted suicide receive compassionate, timely and evidence-based response and support.



Enabling reform

Lived experience — Governance — Data and surveillance — Workforce — System coordination

Need help?

Thinking and reading about mental ill-health, problematic alcohol and other drug use, and suicide can be distressing.

If you need help, please ask for the support you need. No one needs to face their problems alone.

National 24/7 support services

Service	Phone	Website
Lifeline	13 11 14	www.lifeline.org.au/gethelp
Suicide Call Back Service	1300 659 467	www.suicidecallbackservice.org.au
MensLine Australia	1300 789 978	www.mensline.org.au
Beyond Blue Support Service	1300 224 636	www.beyondblue.org.au
13YARN	13 92 76	www.13yarn.org.au
SANE Australia Helpline	1800 187 263	www.sane.org
QLife (LGBTIQA+)	1800 184 527	www.qlife.org.au
Kids Helpline	1800 551 800	www.kidshelpline.com.au
Defence Family Helpline	1800 624 608	www.defence.gov.au/dco/defence-helpline.asp

Alcohol and other drugs support services

Service	Phone	Website
National Alcohol and Other Drugs Hotline	1800 250 015	www.health.gov.au/contacts/national-alcohol-and-other-drug-hotline
adis	1800 177 833	www.adis.health.qld.gov.au
Family Drug Support	1300 368 186	www.fds.org.au

Post suicide bereavement support services

Service	Phone	Website
StandBy Response Service	1300 727 247	www.standbysupport.com.au
National Indigenous Critical Response Service	1800 805 801	www.thirrili.com.au/nicrs

Telephone Interpreter Service

If you require translation support, please ask the telephone crisis service to use the Translating and Interpreting Service by phoning **131 450**.

Hearing impaired callers

Dial **106** by TTY or in an emergency use National Relay Services TTY number **133 677**.

Queensland
Government