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Dear Jane

Thank you for contacting the Australian Psychological Society (APS) regarding the consultation on the National Suicide Prevention Implementation Strategy. As promised following our telephone discussion, the APS provides further details to you now via email.

I can confirm that the majority of the 21 Priority Actions seem reasonable and appropriate and are largely consistent with current best practice frameworks in Australia and internationally.

Below I outline the APS concerns in relation to one of the Priority Actions, areas that we consider are worthy of further development, and also identify some gaps for further consideration.

1. Concern re: Action 19.2 Publicly reporting suicide attempts

We acknowledge the benefit of collecting a wide range of data in relation to suicide deaths and attempts. Collecting timely data in relation to suicide attempts can be useful to identify risks of contagion and identify potential emerging risk factors within communities and/or population groups. It is important to note, however, that the collection of data in relation to suicide attempts often occurs through hospital data (although not consistently across Australian jurisdictions) and is already reported upon through the Australian Institute of Health and Welfare. This data is likely to be an underestimate of actual suicide attempts and may be conflated with non-suicidal self-injury, depending upon how data is collected and which definitions are used. Not all suicide attempts are reported to hospitals or other authorities for recording. There may also be differences in reporting patterns by individuals (for example, women may report suicide attempts more than men). Release of suicide attempt data to the public can therefore be misleading. If there are increases in suicide attempts in particular communities, this may risk alarm and distress with the potential to increase contagion effects.

Efforts to better understand self-harm and non-suicidal self-injury are important as it is closely associated with suicide and further work is required to reduce its occurrence. In the event that suicide attempts data is to be released publicly, it is recommended that cautions are taken based upon the *Mindframe* media guidelines to reduce any possible unintended consequences which may follow. It is important to note that there is research from the United States exploring whether expressions of suicide acceptability under different circumstances are

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predictive of subsequent death by suicide. The research found differences across age and different circumstances (https://academic.oup.com/psychsocgerontology/advance-article/doi/10.1093/geronb/gbx153/4825820). The researchers note that:

> *special attention should be directed toward understand how rising rates of suicide may produce changing attitudes toward the act. Greater exposure to suicide at both the personal and societal levels not only raises the possibility of the act in the minds of others but likely also changes perceptions of and attitudes toward the behaviour* (2018, p. 11).

This could be the case in relation to public reporting of suicide attempts as well as reporting of deaths.

Given our concerns about possible unknown consequences of sharing data, the APS recommend that:

> *Action 19.2: "Publicly reporting suicide attempts" be amended to "Publicly reporting suicide attempts with careful consideration of to whom and how this information is shared".*

For example, consideration could be given to recommending that any new data on suicide attempts is gathered consistently across states/territories and becomes available through application rather than publically. What data is provided publically could be managed by Mindframe who currently manage the data on suicide-related deaths.

2. Areas of importance for strengthening

The focus on better data collection and usage and evaluation is critical. Consistency across data collection in jurisdictions is essential to make the most use of data and accurately make comparisons. Having access to data quickly will enable better responsiveness to trends and identify increased risk factors in locations and population groups. Being realistic about what data will be able to be accessed needs to be acknowledged. For example, accurate data which picks up on factors such as cultural background, LGBTI+, previous mental health issues and service access are all important but in reality quite difficult to gain access to quickly as it may only come through psychological autopsies or inquests. In fact, some of this information will not be known for some time and may never actually be found out. Over-emphasising data that is available or assuming that data is completely accurate will be unhelpful. It will also be useful to consider how data reports are made, particularly when increases in deaths occur over the course of a year. As indicated above, careful and sensitive reporting of suicide deaths is necessary given the uncertainties of the impacts of this information for individuals.

Finding ways to be innovative yet accountable and evidence-informed is quite a challenge, particularly when regional responses are being developed. Some guidelines and frameworks for evaluation would be useful to build some consistency and a culture of learning which includes awareness or acknowledgement of those activities which are found not to work or may be potentially harmful. This may take a culture shift as typically researchers have been reluctant to share research which has been found to have no effect or risks associated with it. This is critical to know about however when funding projects or creating new plans.

The focus on joining up areas of government is critical given that suicide prevention requires whole of community and whole of government responses. Having proactive and regular briefings and events is important to avoid reactive responses from leaders which can be potentially unhelpful.

Community-driven Aboriginal and Torres Strait Islander Suicide Prevention initiatives and plans are important, noting that there have been many inquiries and research that should be built upon (or indeed recommendations reviewed and implemented as appropriate). It is concerning to note in the recent Kimberley Coronial Inquest that most of the children and young people did not have any mental health assessment, despite having experienced considerable difficulties which were obvious to others. Having services which are culturally appropriate and work in a preventative and early interventionist framework are as important to responses at the point of suicide crisis. The Australian Psychological Society in a letter to the Premier of Western Australia dated 2nd April, 2019 sought to:

> *add our voice to those calling for Australian governments to make addressing the issue of Aboriginal and Torres Strait Islander youth suicides a matter of national health priority [and further] supports the recommendations made by State Coroner, Rosalinda Vincenza Clorinda Fogliani, and recognises the importance and urgency in taking action to prevent similar deaths from occurring in the future. The APS strongly encourages the Government to implement the Coroner's recommendations; including recommendations on increasing the cultural competency of service providers, increasing the Aboriginal healthcare workforce, and providing trauma informed, culturally appropriate prevention, mental health and social and emotional wellbeing services, as well as, taking action on Foetal Alcohol Spectrum Disorders (FASD).*

The APS also strongly supports calls for a dedicated National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and fully-funded Implementation Plan, including a focus on prevention child and youth suicides. It is suggested that the findings from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project and the work of the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention offer a strong evidence-base for medium term interventions to be built upon, especially in empowering communities to co-design and control suicide prevention services and responses.

Training and ongoing professional development is essential and core to supporting a wide range of people who are engaging at times of suicide risk. Looking broadly at who should be trained is essential (e.g. a community project in the US identified that some people intending to suicide took their pets to the lost dogs home/pound beforehand. Training of veterinarians and other staff in relation to asking questions related to suicide was found to be beneficial - https://www.oregonlive.com/business/2018/12/washington-county-discovers-unlikely-allies-in-suicide-fight-animal-shelters.html).

Given the ongoing learnings associated with best practice related to suicide prevention it is necessary that regular updates are made to training and people regularly provided with up-to-date information. Looking at ways to build consistency in relation to current best practice would also be useful. Training will need to be tailored to the role and expectations of the person and their professional background and experience. A focus on ongoing support and supervision is also key in this area. Setting realistic expectations of and providing sufficient support to community gatekeepers will be important as will be continuing to develop models that are evidence-based (noting that gatekeeper training while promising and helping learners to feel more confident and equipped in the short term may or may not actually lead to reduced suicide [see the Orygen literature review: https://www.orygen.org.au/Research/Research-Areas/Suicide-Prevention/Orygen_Suicide_prevention_research_bulletin?ext].

The suggested priority actions will need some significant further development to be more tailored and specific. Similarly, the evidence written in the discussion paper will need further development and explanations:

- The section on risk assessment needs further elaboration to explain the actual concerns with risk categorisation - see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4998936/pdf/bjporcpsych002071.pdf)
- Ways to appropriately support the lived experience workforce to ensure their own safety and wellbeing as well as clinical governance around their work role (noting that there are guidelines currently under development for peer workforces) need to be expanded.
- Digital technology approaches need to be further explored with appropriate caution, for example:

Today's multitude of wireless devices may help us finally improve the bleak statistics and subjective clinical approaches we've utilized thus far in suicide prevention. Yet we must immerse ourselves in the population to see the nuances of suicidality. For instance, the most at-risk, or those at their riskiest moments of life, may never charge their phones nor motivate to check in with an online service, thus passive monitoring that doesn't require batteries must be a part of any solution. There has been an increase in research that focuses on predicting and understanding suicide using new technologies, yet there remains a considerable need for caution, given the severity of any potential oversight or error. Many of these preliminary results are positive and give us hope that these initiatives may end up being an important part of our suicide prevention armamentarium. Mental health clinicians will continue to play a central role in suicide prevention, and early use of these technologies will augment the work of human clinicians, not replace them. It is also imperative that people with psychiatric illness, including suicidal thoughts, are actively involved in the design and development of these technologies. This approach will ensure that the technology has a suitable user interface and results in high levels of user engagement, thus is acceptable in real-world situations and is effective. [From Vahabzadeh, Sahin, and Kalali, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5077254/]

3. <u>Areas that are not focused on explicitly in the Priority Actions but should be considered for inclusion in priority areas or built into actions:</u>

(i) Prevention and early intervention: A focus on the point of suicide risk/crisis will not address the underlying needs and issues facing people who may go on to become at risk of suicide. Having a framework that articulates this and values the role of prevention and early intervention in its many forms seems critical, and aligns with community awareness raising activities. This is a significant omission in the priorities.

Promoting help seeking is often talked about as a key element of suicide prevention, however, there is often little focus on the barriers to help seeking, including accessing culturally appropriate supports, having the confidence and skills to know where to go and what to say when asking for help (e.g. Black Dog research in relation to men accessing help: https://www.blackdoginstitute.org.au/news/news-detail/2017/09/09/study-reveals-barriers-for-men-at-risk-of-suicide).

(*ii) Stigma reduction:* Despite considerable efforts to reduce the stigma associated with suicide, it continues, including self-stigma, and actions are required to continue the work that has begun (in safe ways that do not lead to potential contagion). The complex association between stigma and suicide requires further research (e.g. https://www.frontiersin.org/articles/10.3389/fpsyt.2017.00035/full)

(iii) Means reduction: This is a core element of suicide prevention and will need to be built into actions. This does not necessarily mean actions such as gun control that are outside the scope

of the health sector, however, a focus on ensuring that assessments relating to any possibility of harm include exploration of possible or intended means and access and safety planning includes ways to remove or reduce access is essential.

(iv) Safety planning: Safety planning includes means reduction and other key elements. Safety planning is currently the practice with the best evidence behind it yet it is not explicitly spelt out in the document that this should occur at the point of assessment and prior to discharge (in the example of emergency departments). Supporting carers and support people is essential and an area that is not yet fully developed (e.g. a study in US with young people showed that naming up to four adults to provide support and training and supporting them was successful).

(v) *Evidence based treatments for suicidality (as opposed to more general treatment plans):* Although this may be included in several proposed priority areas it is not developed in the paper and there is an emerging evidence base in relation to treatments such as Dialectical Behavioural Therapy and Mentalisation Therapy which are shown to treat suicidality as well as addressing other issues facing the individual [Black Dog Institute are active in this area https://www.blackdoginstitute.org.au/docs/default-source/lifespan/lifespan-strategy-summaries-research-summaries/lifespan_evidence_based_treatment_research_summary.pdf?sfvrsn=6].

(vi) Focus on emerging needs of children and young people: The recently released Scotland Suicide Prevention Action Plan has an explicit section on this. We draw your attention again to the recent Western Australia Coroner's report into the 13 child and young people deaths in the Kimberley. Anecdotally, there are reports of young children in primary school with suicidal ideation and suicide plans. The Kids Helpline data would confirm this with 15% of calls from children and young people related to suicide, 1 in 6 counselling sessions related to suicide and a further 1 in 12 related to self-injury (see https://kidshelpline.com.au/insights/2018).

Thank you again for the opportunity to provide feedback on the Strategy. Please do not hesitate to contact the APS if you require further information.

Yours sincerely

Frances Mirabelli

CEO