29 August 2022

Bailey Nation-Ingle
State Suicide Prevention and Response Advisor
Department of Health, Victoria

Submission via **Engage Victoria**

Dear Ms Nation-Ingle

headspace submission: Suicide prevention and response strategy

headspace National welcomes the opportunity to provide input into Victoria's Suicide prevention and response strategy which will support a comprehensive and evidence-based approach to preventing and responding to suicide in the Victorian community. **Attachment 1** provides responses to the discussion questions outlined in the discussion paper.

About headspace

headspace is the National Youth Mental Health Foundation, providing early intervention mental health services to 12–25-year-olds across the country. The headspace platform provides multidisciplinary care for mental health, physical health (including sexual health), alcohol and other drugs, and work and study across a range of services.

The core of the headspace service offerings is the network of headspace centres contracted through Primary Health Networks (PHNs). Comprising the largest national network of youth mental health services, headspace has more than 150 centres embedded in local communities across metropolitan, regional and remote areas (including 37 in Victoria), online and phone support services through eheadspace, and also supports young people in school settings.

While the Australian Government is the majority funder through the federal Department of Health and Aged Care, with a brand recognised and trusted by young people headspace is also funded by a number of state governments through National Partnership agreements, and to deliver various programs supporting young people in their jurisdictions.

headspace supports suicide prevention work in Victoria's communities, schools and universities, and is currently participating in the International Students Wellbeing Taskforce – Victoria. Central to the headspace centre model is the concept of place-based collaboration. Each centre is run by a local agency, commissioned by the regional PHN in each location. A consortium of local service providers and community members come together to guide and nurture their local headspace centre, ensuring that the service is deeply embedded within the local system and community.

headspace offers a unique platform that can be leveraged to achieve integrated, holistic and responsive supports for young people experiencing mental illness. An integrated approach is necessary to improve the efficiency and effectiveness of services that can be hard for young people to access and navigate.

We would welcome the opportunity to continue supporting the Victorian Government in the development of the suicide prevention and response strategy.

Yours sincerely

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Attachment 1

headspace response to *Suicide prevention and response strategy: Discussion paper*

Vision

1a. The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate? (Yes/No)

1b. If not, what vision for suicide prevention and response would you like to see Victoria work towards?

headspace supports the Victorian Government's commitment to implement the recommendations of the Royal Commission, including the Commission's recommendation that a new suicide prevention and response strategy be established, which is guided by an overarching objective such as to work towards zero suicides.

This wording is deliberate, reflecting concerns in some quarters that zero suicides is unrealistic, unattainable and lacks meaning. Doubtless, significant reductions in suicides can only be achieved through widespread political, societal and cultural changes impacting determinants of mental health challenges that fall far beyond what reform of the Victorian Mental Health System can achieve.

Nevertheless, framing the vision in any other way could equally be viewed as unconscionable, and would dilute its strength as a 'call to action'. The Victorian Government should commit to the ongoing pursuit of a "towards zero" target, supported by delivery of contributory reforms that will make a meaningful contribution over time and as the 'new' system matures.

Priority populations

2a. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)

While supporting the series of groups that may need greater focus in the strategy, headspace also sees potential within this list for further nuance and/or granularity.

2b. If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

The groups identified in the strategy reflect, and go beyond, those identified by the Productivity Commission as groups of people who are more susceptible to mental ill-health including Aboriginal and Torres Strait Islander peoples, LGBTIQA+ people, rural and remote young people, Culturally and Linguistically Diverse (CALD) people, and young men.[1]

headspace is accessed by diverse young people (aged 12-25), many of whom are over-represented in mental health statistics and less likely to seek help. headspace is achieving higher engagement of a number of priority groups in headspace centres compared to the relative Australian population:

[1] Productivity Commission (2019). Mental Health, Draft Report Volume II. Commonwealth of Australia. Pg. 121.

- 38% of headspace clients lived in **regional or remote** areas (well above the national population proportion of 27% of all young people who live outside metropolitan areas) (ABS, 2016)
- 24% of headspace clients identified as **LGBTIQA+** (which compares to national estimates of 4% of males and 6% of females identifying as non-heterosexual)[2]
- 9% of headspace clients identified as **Aboriginal or Torres Strait Islander** (compared with 2016 census data which found that 4.5% of Australians aged 12–25 years identified as Aboriginal or Torres Strait Islander) (ABS, 2016).

Potential for further nuance and/or granularity

Age is a critical factor for prioritisation, whilst gender becomes a less significant differential

Three-quarters of all mental health issues emerge before the age of 25.[3] Suicide is the leading cause of death among young people – responsible for more than 40% of deaths among 15–24-year-olds.[4]

In terms of gender, recent data indicates that around three-quarters of young people accessing online supports for mental health concerns during 2021/22 were female.

It is particularly alarming that the rates of suicide have increased so dramatically in young women, a group who are known to present to mental health services in greater proportions than young men, and in much greater numbers to hospitals after an episode of self-harm.

Whilst suicide may cause more deaths amongst young men than young women, headspace would advocate that prioritisation based on age is as important, if not more so, than gender.

There is a need for strategies specifically targeted to young people. headspace supports the Royal Commission's recommendation that a youth mental health and wellbeing service stream be established. Mental illnesses often emerge at times of social and emotional development and the transition from adolescence through to the mid-20s is a time of significant change and brain development for young people. Turning 18, for example, coincides with major transitions such as finishing secondary school, being able to use tobacco and alcohol legally and living more independently.[5]

Children and young people are dynamic, as are their risk factors including impulsivity and vulnerability to suicide contagion behaviour. It is therefore necessary to apply age-appropriate approaches to suicide prevention rather than applying adult approaches to children and young people.

Educational stage

Due to the unpredictable and irregular occurrence of suicide events, a challenge remains around how to provide flexible and responsive support to school communities to prepare, respond to and recover from death by suicide of young people. Of particular concern is the increasing number of suicides and suicide attempts among primary school students. While there is a scarcity of evidence around the causes and appropriate responses to self-harm and suicide, there is growing evidence of a strong correlation between exposure to suicide/suicide attempts in young people and their own suicidal ideation and behaviour in subsequent years.

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[2] Wilson, T., & Shalley, F. (2018). Estimates of Australia's non-heterosexual population. Australian Population Studies 2(1): 26-38. https://doi.org/10.37970/ aps.v2i1.23

[3] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602. https://doi.org/0.1001/archpsyc.62.6.593

[4] Department of Health (2020). A report detailing key themes and early findings to support initial advice of the National Suicide Prevention Adviser.

[5] RCVMHS (2021) Final report, Vol. 2; p. 213.

International research indicates that young people are particularly susceptible to suicide contagion[6], and that schools are a common setting for youth suicide clusters.[7] This has reinforced the need for effective and quality-assured postvention services in schools. The shift has also been supported by research highlighting that student services' supports are a popular and easily accessible source of help for young people.[8] This is particularly important given the reluctance of young people to seek help from services, especially young people who are experiencing risk factors[9]. Postvention in a school setting also serves the best interests of young people by enhancing their traditional support networks and ensuring that disruptions to routines are minimised.

The headspace School Support Service has developed a national postvention service model in response to the growing evidence of suicide attempts and deaths by suicide among young people. The service model provides a comprehensive range of tools and services throughout the stages of response and recovery, delivered to schools at the front-line.

Another priority cohort is young people who are leaving secondary school and entering tertiary education. Statistics show that the risk of suicide increases significantly for young people following completion of compulsory schooling (**Table 1**). Effort should be put into providing children and young people with strategies and tools throughout their early childhood and schooling years so that they are equipped with, and can draw upon, these tools as they transition from adolescence.

Table 1: Increased suicide and risk in Australia from ages 18-24 years

Age group	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
14 and below	13	16	16	22	22	13	18	24	22	19	26
15–17	68	51	62	73	67	76	74	78	79	77	73
18–24	239	284	264	289	306	322	331	340	369	384	381
TOTAL	**320**	**351**	**342**	**384**	**395**	**411**	**423**	**442**	**470**	**480**	**480**

Source: AIHW (2020) Suicide by year of registration of death, children and young people, Australia

Equally important as building this toolkit, is then supporting young people while they are engaged in tertiary education. headspace, for example, has developed bespoke suicide postvention and mental health literacy workshops and materials with Universities Australia.

The Productivity Commission found that tertiary students experience poorer mental health than the general population. Being a student is associated with stressors that can affect mental health, including academic demands, living away from home and support networks, and financial stresses. International students may also face language and cultural challenges.

Over 1.4 million students study in Australia's universities each year. Between 2008-2018, universities saw huge growth in students from marginalised communities, including Indigenous students (over 100%), students from low socio-economic backgrounds (+66%), students with disability (+139%); and students from regional and remote areas (+48%). These groups are more likely to experience poor mental health and may require different approaches and supports.

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[6] Swanson SA, Colman I. *Association between exposure to suicide and suicidality outcomes in youth.* CMAJ. 2013;185(10):870-7; Cox GR, Robinson J, Williamson M, Lockley A, Cheung YT, Pirkis J. *Suicide clusters in youth people: evidence for the effectiveness of postvention strategies.* Crisis. 2012;33(4):208-14; Robinson J, Too LS, Pirkis J, Spittal MJ. *Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults.* BMC Psychiatry. 2016;16(1):417

[7] Haw C, Hawton K, Niedzwiedz C, Platt S. *Suicide clusters: a review of risk factors and mechanisms.* Suicide Life Threat Behav. 2013;43(1):97-108.

[8] Robinson J, Yuen HP, Martin C, Hughes A, Baksheev GN et al. *Does screening high school students for psychological distress, deliberate harm, or suicidal ideation cause distress – and is it acceptable?* Crisis. 2011;32(5):254-63.

[9] Rickwood DJ, Mazzer KR, Telford NR. *Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood.* BMC Psychiatry. 2015;15:40

Orygen[10] found that over half of tertiary students aged 16–25 years reported high or very high psychological distress while 35.4% had thoughts of self-harm or suicide - levels supported by other Australian studies[11] [12] [13].

In 2022 headspace received funding under the National Suicide Prevention Grants round to enable training to 30,000 staff in all 43 universities, and to establish a Critical Incident Response clinical workforce to assist universities responding to suicides.

Community-based prioritisation

A review of deaths from suicide among young people in Victoria (2006 to 2015) found that nearly half had had no contact with headspace or any other service for mental health issues within the year before death. This limits the capacity of services to identify risk and provide support, and indicates the importance of equipping communities to be able to do so.

Through delivering community postvention response services since 2014, headspace has been able to identify and track changes in trending risk data for school communities. This in turn allows headspace to identify regions and communities that are at high or emerging risk of suicide events, and would require intensive, targeted, rapid response community support (postvention).

In 2020/21, the NSW Government funded headspace, working in partnership with Lifeline, to establish 12 Community Wellbeing Collaboratives in communities at high risk of suicide, as one of the Government's Towards Zero Suicides initiatives.

Postvention planning will enable communities to: detect risk; prevent risk; identify and contain risk; reduce risk, increase resilience, knowledge, awareness, skills, and longer term healing and recovery; and guide the region from postvention to prevention.

There remains a need to continue to develop postvention service design by incorporating the experiences and perspectives of communities – particularly populations that are over-represented in self-harm and suicide statistics – in order to create appropriate and responsive services.

[10] Orygen (2017). Under the radar. The mental health of Australian university students. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health.

[11] National Union of Students, 2016.

[12] Renner, P., O'Dea, B., Sheehan, J. & Tebbutt, J. 2015. Days out of role in university students: The association of demographics, binge drinking, and psychological risk factors. Australian Journal of Psychology, 67, 157-165.

[13] Stallman, H. M. 2008. Prevalence of psychological distress in university students--implications for service delivery. Aust Fam Physician, 37, 673-7.

Priority areas

3. What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?

All of the example priority areas identified for the strategy warrant inclusion.

It is noted that these proposed areas are also reflected in the proposed principles (below); our responses to each section should be considered in conjunction with each other.

Lived experience and family and peer support

We note that the Strategy is specifically focussed on people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide. Whilst our observations below reflect headspace's experience of engaging people with lived experiences of mental ill health more broadly, we believe they are relevant–and in fact may be even more important–when specifically considering informed approaches and responses to suicide.

As the Royal Commission observed, lived experience and peer support is a critical element of service design and delivery. Reform of mental health systems and services will only work if undertaken with people with lived experience at its core.

headspace notes and commends the extensive commentary in the Royal Commission's final report in Chapter 18 about the arrangements and supports needed to embed lived experience in service planning and delivery, and in Chapter 19 about valuing and supporting families, carers and supporters.

headspace supports the observations of the Royal Commission[14] and the National Mental Health Commission[15] that:

- people with lived experience have significant and distinct skills, experience and expertise to bring to the design and delivery of services and the creation of policy
- like anyone else, they need capacity building, professional learning and organisational supports to equip them for new roles – and that employing organisations may need specialist readiness training to ensure they are able to provide these effectively, including confronting prejudice and stigmatising beliefs.

In particular, headspace welcomes the commentary by the Royal Commission in Chapter 33 about the importance of supporting lived experience workforces. People who have experienced mental illness and psychological distress need help to prepare for and operate in roles where they are called to draw upon these experiences as this can add to the pressures and challenges that are inherent in working in the mental health sector.

headspace strongly encourages the Victorian Government to prioritise the preparation, wellbeing and support of the lived experience workforce, and the readiness of organisations as safe and supportive working environments.

We endorse the initiatives outlined in Victoria's Mental Health and Wellbeing Workforce Strategy focussed on the lived experience workforce, and those published on the Lived Experience Workforce Initiatives webpage, but note that these do not currently include tailored lived experience professional practice supervision.[16]

[14] RCVMHS (2021) Final report, Vol. 3, Chapter 18; Vol. 5 section 33.10.

[15] National Mental Health Commission, Sit Beside Me, Not Above Me, 2019, p. 16.

[16] RCVMHS (2021) Final report, Vol. 4,, p.541.

headspace supports the Royal Commission's emphasis on building leadership and decision-making capability of people with lived experience so that they can lead and influence across all aspects of the mental health and wellbeing system.[17]

headspace's strong view is that youth mental health services, for example, should be youth-focused – designed with young people, for young people.

Through participation, headspace recognises that young people, their family and friends are the experts about their own lives and have the right to be actively engaged in the issues that affect them. headspace advocates for the prioritisation of active and continuous engagement of young people in service governance, design, development, delivery and evaluation, as well as in their own care. Participation of young people in decision making is critical in ensuring that services continue to be responsive to young people's needs and preferences. Such participation acknowledges the expertise young people have in relation to matters that impact their health and wellbeing, the fulfilment of their potential and their right to partake in decisions that affect them. Over time this builds trust and mutual respect, and ensures services remain credible, acceptable, appropriate and responsive to their needs. This in turn makes clients feel welcome, comfortable, safe, respected, valued and understood.

headspace is proactive in providing opportunities for young people to guide headspace direction and ensuring voices that have historically been overlooked are heard. Engagement starts at the headspace centre, with local reference groups advising services and supporting community engagement. At headspace National, engagement includes: the headspace Youth National Reference Group (hY NRG) guiding headspace policy, governance, services, campaigns, peer support, and program design; two youth advisors who sit on the headspace Board; and Centre Youth Reference Groups that engage on service design, delivery and evaluation across Australia.

Most young people between 12–25 years of age either live with family or friends or maintain strong connections with them. Continued strong support from family and friends is pivotal to a young person's health and wellbeing[18] and young people are most likely to talk to family as the first step in help-seeking.[19] Therefore, family participation and support is an important component of the headspace model.

Family members are often the first to notice behavioural changes that may signal the onset of a mental health concern. More than 40% of young people who engage with headspace services access them via a referral or recommendation from family.[20] Australian young people are most likely to seek informal support, with 72% seeking help from parents or guardian/s or friends.[21]

Involving family in a young person's care acknowledges the important role they play in providing emotional and practical support for young people experiencing mental health (and any co-occurring) difficulties.

headspace has established mechanisms to support the central and continuous involvement of family in the governance, design, development, delivery, evaluation and continuous improvement of headspace services, including through a National Reference Group, and family and friends' participation groups at many headspace centres.

Intersectional and targeted approaches

As noted above, the Productivity Commission identified certain groups of people who are more susceptible to mental ill-health. headspace targets and reaches these often hard-to-reach groups as a priority.

Services must be culturally appropriate for priority populations that are disproportionately impacted by mental ill-health. Inherent in the headspace model is the requirement for headspace centres to

[17] RCVMHS (2021) Final report, Vol. 3; p. 16.
[18] Radovic A, Reynolds K, McCauley H L, Sucato GS, Stein BD, Miller E, *Parents' Role in Adolescent Depression Care: Primary Care Provider Perspectives.* Journal of Paediatrics. 2015;167 (4). 911-8
[19] https://growingupinaustralia.gov.au/research-findings/annual-statistical-report-2017/adolescent-help-seeking
[20] headspace centre client data 2013-2020 shows that almost half of young people are most influenced by their family or friends to attend headspace, primarily family.
[21] Mission Australia Youth Survey 2020

be using data and engagement to identify and respond to the needs of their local community and local priority populations.

Supporting the self-determination of First Nations people

For many decades Aboriginal and Torres Strait Islander people and communities have argued for accessible and appropriate mental health care to address the enduring mental health impacts of intergenerational trauma as the result of colonisation, racism, dispossession, discrimination, and marginalisation.[22]

First Nations young people are vulnerable to a lifetime of mental health concerns due to early and disproportionate exposure to risk factors.[23] Loss of cultural connection has been identified as an important factor in youth self-harm and suicide in First Nations communities.[24]

One in three Aboriginal people experience high or very high levels of psychological distress (about 2.5 times the non-Aboriginal rate), and a third have been diagnosed with a mental or behavioural condition.[25] Self-harm emergency department admissions are four times the rate of the general population. The national suicide rate for Aboriginal people is estimated to be twice the rate of the general population, and generally occurs at much younger ages.[26]

The proportion of Aboriginal and/or Torres Strait Islander young people with psychological distress rose from 28.4% in 2012 to 34% in 2020.[27] In a national survey, Aboriginal and Torres Strait Islander young people reported more and deeper challenges than their non-Indigenous peers, including being less likely to feel happy or very happy with their lives. A higher proportion (47.1%) reported having been treated unfairly in the past year compared with non-Indigenous young people (33.6%). Over half said the reason was race/cultural background.[28]

However, mental health services are accessed at low rates by Aboriginal and Torres Strait Islander young people, relative to their level of need.[29] 77% of Indigenous people aged 18-24 experiencing poor mental health have not seen a health professional.[30]

The principle of accessibility must be at the forefront of culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services.[31] However, First Nations young people are often disadvantaged in that they are not able to access appropriate services.[32] These young people are more likely to access – and will experience better outcomes from – services that are respectful and culturally safe places.[33]

Note: this is also relevant to the principles section below.

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[22] Productivity Commission Mental Health Report 2020, Vol.2; Swan and Raphael (1995) *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report*; Paradies, Harris and Anderson (2008), *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda*, Discussion Paper No.4; Herring and others (2013) *The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust*, Australian Social Work, 66.1; Victorian Aboriginal Community Controlled Health Organisation (2020) *Balit Durn Durn Report*

[23] Gee (2016) *Resilience and Recovery from Trauma among Aboriginal Help Seeking Clients in an Urban Aboriginal Community Controlled Health Organisation*

[24] Silburn et al, (2014) 'Preventing suicide among Aboriginal Australians', *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*

[25] RCVMHS (2021) Final report, Vol. 3; *Balit Durn Durn Report*, 2020

[26] https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-aboriginal-and-torres-strait-islander-people; Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*.; Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan: Victorian Suicide Prevention Framework* 2016–25.

[27] Brennan, N., Beames, J. R, Kos, A., Reily, N., Connell, C., Hall, S., Yip, D., Hudson, J., O'Dea, B., Di Nicola, K., and Christie, R. (2021) *Psychological Distress in Young People in Australia Fifth Biennial Youth Mental Health Report: 2012-2020*. Mission Australia: Sydney, NSW

[28] Tiller, E., Greenland, N., Christie, R., Kos, A., Brennan, N., & Di Nicola, K. (2021). *Youth Survey Report 2021*. Sydney, NSW: Mission Australia.

[29] Cox Inall Ridgeway (2020) *Internal Rapid Audit and Literature Review: embedding cultural safety into the headspace model integrity framework*.

[30] RCVMHS (2021) Final report, Vol. 3; *Balit Durn Durn Report*, 2020

[31] Australian Parliament Select Committee into Mental Health and Suicide Prevention 2021 Final Report, para.3.127

[32] Westerman and Vicary (2004). *"That's just the way he is": Some implications of Aboriginal mental health beliefs*. Australian e-journal for the Advancement of Mental Health, Vol 3, Issue 3; Hunter (1993) *Aboriginal Mental Health Awareness: An overview, Part II*. Aboriginal and Islander Health Worker Journal 17(1): 8-10.

[33] Cox Inall Ridgeway (2020)

Opportunities for more and better use of technology

Online services are increasingly being used by young people including those at risk of, or considering, suicide. As such, many mental health and suicide prevention services are now reaching more young people through: TeleWeb services (including crisis support such as Kids Helpline and Beyond Blue); web-based information; directed self-help through web programs or apps; online counselling; and through social media platforms, which are particularly relevant for young people.[34]

To date, limited evidence has been published on youth-specific technology-based suicide prevention interventions or the cost-effectiveness of online suicide prevention interventions. Some studies have shown effects on a range of outcome measures including an increase in help-seeking attitudes and intentions, and a decrease in suicidal ideation and stigma.[35] [36] Social media presents particular opportunities and challenges/risks when delivering suicide prevention interventions[37], yet young people regularly use these platforms. As such, there is an urgent need for more research on how social media can be safely utilised in suicide prevention interventions.

Technology shouldn't only be viewed in terms of how it can assist help-seekers, it should also be investigated as a tool to assist those helping young people, including to help them share information and referrals and manage young people's needs in a more coordinated and effective way. Where possible, access to services such as telehealth and face-to-face support should be provided conjunctly, particularly in rural, remote and high-risk settings.

Opportunities for prevention and postvention support and reach through education settings (see also section 5d)

Young people's experiences of mental health are dynamic and unique, as is their susceptibility to risk of mental illness and psychological distress. Help-seeking behaviour by young people with mental health issues is extremely fragile. In a recent survey of young people, almost half said that if they were experiencing a personal or emotional problem, they would deal with it on their own.[38]

Suicide remains the leading cause of death among young people aged 15-24 years (and adults aged 25-44 years).[39] In addition, suicide attempts and self-harm are up to 20 times more common than suicide and are the primary risk factor for future suicide. The most recent Australian Child and Adolescent Health and Wellbeing Survey found that in the past 12 months 7.5% of young people aged 12-17 years reported having considered suicide and 2.4% (or approximately 41,000 Australian adolescents) had attempted suicide. A further 10% reported having self-harmed in their lifetime[40] and the last decade saw a significant spike in hospital admissions for self-harm among young women aged 15-19 years.[41]

Data captured through headspace Schools and Communities shows that:

- headspace school support service responds to 4-5 deaths a week (across Australia), with a notable increase in requests for support from primary schools
- the majority of suicide deaths that headspace School Support responded to in 2012-2018 were for students in year 10 (27%) and year 11 (28%) and incidents peaked in mid-late

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[34] yourtown. Preventing Suicide by Young People: Discussion Paper. Boystown; 2015.
[35] King CA, Eisenberg D, Zheng K, Czyz E, Kramer A, Horwitz A, et al. Online suicide risk screening and intervention with college students: A pilot randomized controlled trial. Journal of Consulting and Clinical Psychology. 2015;83(3):630-6.
[36] Robinson J, Hetrick S, Cox G, Bendall S, Yuen HP, Yung A, et al. Can an internet-based intervention reduce suicidal ideation, depression and hopelessness among secondary school students: Results from a pilot study. Early Intervention in Psychiatry. 2014:No Pagination Specified.
[37] Robinson J, Cox G, Bailey E, Hetrick S, Rodrigues M, Fisher S, et al. Social media and suicide prevention: a systematic review. Early Interv Psychiatry. 2016;10(2):103-21.
[38] Colmar Brunton (2018). Australian youth mental health & well-being survey 2018. Unpublished.
[39] ABS. 3303.0 Causes of Death, Australia, 2020: Table 1.4 Underlying cause of death, Leading causes by age at death, numbers and rates, Australia, 2020
[40] Lawrence D, Johnson S, Hafekost J. The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health; 2015.
[41] AIHW. Suicide and hospitalised self-harm in Australia: trends and analysis. Canberra: Australian Institute of Health and Welfare.; 2014.

October each year. Two per cent of suicide deaths were among primary school aged children.

The Royal Commission identified several factors that can increase the risk of suicide amongst young people, including personal stressors (e.g. sexuality, experience of abuse), interpersonal stressors (e.g. conflict), situational stressors (e.g. bullying) and exposure to suicide (e.g. a peer).

Schools and community groups play a critical role in identifying indicators of suicide risk, and in prevention and postvention support.

Key suicide prevention factors include availability of physical and mental health and wellbeing support, safe and supportive school and community environments and connectedness to family, community and social institutions.[42]

Schools are a key platform for the provision of mental health support that engage children, young people, and families along the continuum of intervention for health and wellbeing. Schools are well-accustomed to supporting students' learning and developmental needs and they also help students to develop resilience, social and emotional health, and confidence in seeking services and treatment. For these reasons, schools have long been regarded as suitable environments for implementing suicide prevention initiatives for vulnerable young people.[43] Over recent decades, schools have also become recognised as important sites for postvention[44], which involves responding to the mental and physical health and wellbeing of students and staff, both immediately following a suicide and in the longer term.

headspace supports schools Australia-wide with the Mental Health in Education Program and the Be You schools program (run in partnership with Beyond Blue). These programs equip young people, their parents and the broader school community with knowledge, skills and tools to support young peoples' mental health and build the support structures needed so they can seek help when they need it.

headspace School Support also provides evidence-based training, information and resources, and intensive support that assists secondary schools across Australia to prepare for and recover from suicide. This is achieved through delivery of evidence-based gatekeeper training using the Skills-based Training on Risk Management (STORM) approach and workshops that focus on: building staff capacity around issues of suicide; developing school policies and procedures around suicide; developing an Emergency Response Plan; and assembling and managing Emergency Response teams.

Tertiary education is another setting that presents a valuable opportunity for suicide prevention and postvention support. This is explored in the priority populations sections above, and referenced in section 5d below in relation to building the capacity of workplaces.

See also section 5b below in relation to broader training for gatekeepers in community organisations.

Mental health workforce supply and development

The acute workforce supply challenges across the mental health system are well understood and documented – including in the Royal Commission and Productivity Commission reports – but continue to escalate as service demand, complexity and acuity increase. Mental health services struggle to attract and retain staff as they compete with mainstream healthcare, as well as the broader social care sector.

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[42] RCVMHS (2021) Final report, Vol. 2; Victorian Government; p. 459.

[43] Robinson J, Cox G, Malone A, Williamson M, Baldwin G, Fletcher K, et al. *A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behaviour in young people*. Crisis. 2013;34(3):164-82.

[44] Robinson J, Cox G, Malone A, Williamson M, Baldwin G, Fletcher K, et al. *A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behaviour in young people.* Crisis. 2013;34(3):164-82; Hazell P, Lewin T. *An evaluation of postvention following adolescent suicide.* Suicide Life Threat Behav. 1993;23(2):101-9; Poijula S, Dyregrov A, Wahlberg K, Jokelainen J. *Reactions to adolescent suicide and crisis intervention in three secondary schools.* Int J Emerg Ment Health. 2001;3(2):97-106

The mental health workforce is characterised as being over-stretched, under-resourced, and experiencing high levels of burn-out and turnover – which in turn increases pressure on remaining staff members, causes reliance on inexperienced staff, and endangers the standard and quality of care that the workforce is able to provide.

Attracting people to new youth mental health services in Australia has had mixed success, with recruitment of youth workers and allied health staff, especially psychologists, being relatively more successful than recruitment of GPs and psychiatrists.[45] At present the headspace centre network is hamstrung by limited access to a workforce capable of delivering the evidence-based care that is required to ensure that young people are mentally healthy. The 2018 national survey of headspace centres showed that 87% of centres have difficulty attracting and retaining staff. Even in regions where a sufficient private practitioner workforce exists, the ability to increase the workforce to meet demand is often hampered by the physical size of the centre, which is unable to accommodate additional workers.

In particular, the headspace network has had difficulty with:

- attracting GPs: 27% of centres reported that they didn't have access to a GP, and for those centres that did, most had a GP presence for fewer than 15 hours per week
- attracting GP registrars – only a handful of GP registrars are currently placed in centres
- limited access to telepsychiatry outside of rural and remote locations
- the significant national dearth of appropriate workforce in healthcare roles from Aboriginal and/or Torres Strait Islander and refugee and migrant backgrounds to deliver culturally appropriate services for these population groups.
- accessing private practitioners in outer regional, rural and remote areas. In addition, there is a large body of literature about why people leave the mental health workforce. Commonly cited reasons for high staff turnover in the mental health sector include:
- remuneration issues in the sector and job insecurity resulting from short term contracts
- limited access to professional development, lack of career paths and professional recognition[46]
- excessive workload[47], burnout and high rates of absenteeism due to perceptions of system failure.[48]

> *"Youth Mental Health Practitioner roles are very difficult to recruit appropriately experienced staff with the right attitude/right fit for the service in regional remote area. Funding provided currently does not cater to the salary levels with additional benefits needed in our region. Increased resourcing to address need for more Aboriginal staff and build the capability of the Aboriginal workforce (through generous PD/training benefits) - including MH [mental health] trainees would be of high benefit"* - service provider

The key challenges outlined in the draft National Mental Health Workforce Strategy, released for consultation in 2021, are consistent with those faced by headspace. These include: workforce shortages; skills shortages; maldistribution geographically, between service settings and within occupations; and some occupations not operating to their full scope of practice. In its response to this draft strategy, headspace highlighted that the strategy's success would require adequate resourcing by, and coordination between, all Australian governments and use of strong data and evidence to underpin workforce planning and drive accountability and transparency. headspace also highlighted the need for structured early career programs, mental health being included in all pre-service training, providing support for all workplaces and upskilling the mental health

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[45] Carbone S, Rickwood D, Tanti C. Workforce shortages and their impact on Australian youth mental health service reform. Advances in Mental Health. 2011;10(1):92-7.
[46] ConNetica. Queensland NGO Mental Health Sector Workforce Profile & Analysis Report 2009. 2009.
[47] Workplace Research Centre. Identifying patterns to skills growth or skills recession: Decisions for workforce development in the community services and health industries. Surry Hills NSW: Community Services and Health Industry Skills Council; 2008.
[48] Andrews G, Titov N. Changing the face of mental health care through needs-based planning. Australian Health Review. 2007;31:S122-S8

workforce to ensure a social and emotional approach is provided, as mental ill-health is often exacerbated by social challenges that are outside the scope for mental health practitioners.

Similar issues are echoed in Victoria's Mental Health and Wellbeing Workforce Strategy 2021-2024.

Unless we can create a sustainable pipeline of new, appropriately skilled workers and provide them with the right professional experiences and supports, the sector will continue to experience high turnover rates, inexperienced workers, and a lack of relationship continuity for young people we are seeking to support.

The National Youth Mental Health Workforce Strategy (2016-2020) developed by Orygen outlines four key domains for an effective youth mental health workforce. These are:

1. A capable and skilled clinical and non-clinical youth mental health workforce which can provide young people who have emerging mental health problems with early detection, and evidence-based responses that are appropriate to their needs, circumstances and age group.
2. A sustainable, secure and ongoing supply of appropriately qualified youth mental health professionals and specialists to address the current and continuing shortage of specialist workers within the youth mental health workforce.
3. A culture of innovation and continuous improvement which is embedded across the youth mental health workforce. This includes building collaborative partnerships between researchers, evaluators and service deliverers to ensure effective and rapid knowledge transfer and translation.
4. A responsive, collaborative and flexible youth mental health workforce that is enabled to provide shared and integrated care for young people.

The National Mental Health and Suicide Prevention Plan released in 2021 also highlights the importance of investing in growing and upskilling the mental health workforce.

The **headspace Early Career program** is designed to develop clinician human resourcing in youth mental health, specifically in psychology, occupational therapy and social work. The program delivers both student and graduate placements in headspace Centres in Victoria, Tasmania, Western Australia and Queensland.

Alongside clinical placements, graduates benefit from 40 days of education, facilitated discipline communities, and supervision by a local or centralised Clinical Educator (0.4FTE) who provide the necessary support and clinical leadership to students and graduates during their placements.

Students undertake two-to-four-month clinical placements according to their discipline and course structure, and deliver services under local or Clinical Educator supervision. The combination of placement and professional supports aim to provide the most effective learning environment for emerging allied health professionals and seeks to address human resourcing challenges in the mental health sector.

As well as providing immediate capacity (in supervised occasions of service within their scope of practice) and growing the workforce, the program is intensely focused on providing allied health professionals with knowledge and skills specific to youth mental health. This is critical to providing the holistic, multidisciplinary model of care that young people require.

Data integration and communication

As mentioned above (see Priority Populations – Community-based prioritisation), headspace has been able to identify and track changes in trending risk data for school communities over time, and to identify regions and communities that are at high or emerging risk of suicide events.

As part of the Community Wellbeing Collaboratives outlined above, the NSW Government has facilitated access to separate datasets held across portfolios and agencies that capture different risk indicators. The capacity to undertake integrated data analysis has made it easier to identify at-risk communities, and at earlier stages. Data integration of this nature is particularly important for preventative interventions before a community reaches the point of requiring crisis response interventions.

Even where indicators of risk can be identified, there is often fragmented communication between schools, health services and the community, as well as among health services themselves. The Victorian Coroner has reported on instances where individually, a number of direct and indirect support services have responded to identified risks in isolation, but that a lack of communication between them meant that these were not recognised collectively.

The challenge of connecting communication and responses is likely to increase as online engagement with people at risk increases.

Prioritising the enhancement and resourcing of communication channels between stakeholders is required to identify and respond to serious mental health concerns and ensure an integrated care coordination approach.

For young people, there is an opportunity to establish a coordinating function that helps bring together the emergency departments, headspace centres, first-responders, schools, and other state-funded clinical care providers in a community to support young people to overcome suicide.

Principles

4. What principles should guide the development and implementation of the strategy?

headspace recommends the guiding principles established by the Royal Commission as the basis for informing the development and implementation of the strategy, noting that these were based on extensive community consultations in Victoria as well as relevant international documents such as the UN Convention on the Rights of Persons with Disabilities, the World Health Organisation's publications on mental health and legislation such as the Commonwealth's Carers Recognition Act 2010.[49]

The example principles identified in the draft strategy are all worthy. However, young people's experience of mental health and suicide risk factors is more diverse, variable and less predictable than in adults. Principles for suicide prevention and response must therefore reflect the unpredictability of suicidal ideation, and the need for holistic, community-embedded approaches to identification, early intervention, prevention and response.

These distinctions are explored in the commentary throughout this submission, but some particular principles and nuances are outlined below.

Access and early intervention

Greater investment in prevention and early intervention is critical in terms of making inroads into the incidence of mental ill-health in young people. This can help to address young people's mental health issues before they progress to more serious and longer-lasting conditions[50], given:

- many young people do not seek help
- young people's help-seeking behaviour and engagement in services can be fragile
- mental health issues in young people can persist into adulthood, resulting in chronic morbidity
- the nature of young people's mental health problems are not fixed - they may first present with sub threshold symptoms which then resolve, become threshold for diagnosis, change symptoms etc.

One of the most significant risk factors for suicide and suicide-related behaviour is an experience of mental ill-health, yet young people with complex and severe mental health conditions are often unable to access the expert and specialist mental health care they need. There also needs to be a 'no risk is too little' approach, just like the 'no wrong door' approach for those with more complex needs, who need help now.

It is critical to ensure this early and immediate access to mental health care for young people who are at risk of or are engaging in self-harming behaviours. However, as demonstrated through the data on waitlists at headspace and wait times for eheadspace, significant investment is needed to increase service capacity if we are to ensure no young people who could potentially be at risk fall through the cracks. The evidence shows that even a small amount of investment during this 'waiting period' can be hugely beneficial to reducing suicide attempts[51], as the individual still receives care in the form of support and monitoring, while waiting for ongoing clinical support.

Points of presentation and discharge at hospitals and emergency departments are also critical and it is now widely acknowledged that the period following discharge from psychiatric inpatient care or admission for a previous suicide attempt carries a very high risk for suicide or further attempts.[52]

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[49] RCVMHS (2021) Interim Report, p.13.
[50] Senate Committee on Mental Health (2006). A national approach to mental health – from crisis to community: First report. Commonwealth of Australia.
[51] Page A, Taylor R, Gunnell D, Carter G, Morrell S, Martin G. Effectiveness of Australian youth suicide prevention initiatives. Br J Psychiatry. 2011;199(5):423-9.
[52] Suicide Prevention Australia. Position Statement: Mental Illness and Suicide. 2009.

Emphasis needs to be placed on investing in programs and initiatives that assist people at these points. Modelling has been done on investment in suicide responses and initiatives, and evidence supports that the best return on investment occurs in the most high-risk areas (for example emergency departments and post-treatment).[53]

Integration

Major reviews of Australian mental health systems at the national and state levels report systems and services that are siloed, fragmented, and hard for clients and even providers to navigate.

There is both opportunity and need to reduce siloing and fragmentation of mental health and related social support systems, so that individuals can more readily access holistic, multi-disciplinary, wrap-around supports that meet their specific needs and circumstances across ages and stages of life – ensuring people can access the right support, when they need it and how they want it.

There are a range of domains where service integration can take place including:

- vertical integration: integration across primary, secondary and tertiary care, and including collaborative operating models across state-funded, private and community agencies.
- horizontal integration: integration across social support sectors, which may include health, education, social and justice services
- longitudinal integration: integration across the course of life, spanning paediatric care into adult services.

In parallel with stronger integration between child and adult state mental health services, this would enable us jointly to improve people's access to the appropriate level of care, and increase the efficiency of service delivery and client pathways within joined-up, individualised care and support.

Recent research by Orygen and the Centre for Youth Mental Health, The University of Melbourne [54] found that "Integrated care is conceptually and pragmatically complex", including approaches to organisational, functional, service and clinical integration that exist along a continuum of collaboration based on levels of communication, proximity and practice change.

The researchers identified from literature core values of integrated care: that it is collaborative, coordinated, comprehensive, continuous, holistic, flexible, reciprocal, there is shared responsibility and accountability, and is led by whole- systems thinking. They conclude "it is clear that there is no "one-size fits all" model".

Stronger integration is a priority for headspace. We are in the process of developing a working definition of integrated care that reflects important themes identified by young people, families and friends that access headspace services. Consultation with professionals is also informing what systems, services and providers can take away from our integrated care definition, reflecting what the workforce see as important themes of integrated care.

The headspace Strategy 2021-24 is particularly aiming to:

- ensure that support is available to young people across all four streams (mental health, general health including sexual health, alcohol and other drugs (AOD) and work and study) in headspace centres across the country, with AOD and vocational support being the most essential areas for further investment and effort

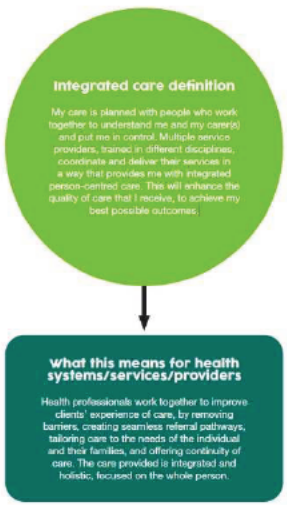

Figure 1 - headspace integrated care definition (based on World Health Organisation 'user-led' definition of integration)

[53] Cosgrave EM, Robinson J, Godfrey KA, Yuen HP, Killackey EJ, Baker KD, et al. Outcome of suicidal ideation and behavior in a young, help-seeking population over a 2-year period. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2007;28(1):4-10. 2018;27(10):1295-304.

[54] Bartholomeusz, C. & Randell, A. Evidence to practice: integrated care in youth mental health. headspace, The National Youth Mental Health Foundation. Melbourne, 2022. Publication pending.

- build ‘One headspace’. Rather than having to navigate various service offerings – sometimes explaining their needs multiple times and waiting too long for help – our goal is to ensure young people can access the right support, when they need it and how they want it.

Being adaptable – including consumer choice

headspace’s aim is to ensure young people can get timely access to the services they need through the medium of their choice – in-person (via over 150 headspace centres across Australia), or online by video, webchat, email or website (via programs run and coordinated nationally).

As highlighted in the Priorities section above, technology should be used as a tool to assist both help-seekers and those assisting them. It should be used to support more coordinated and effective management of young people’s needs. Digital therapies should be provided in conjunction with in-person supports where possible, particularly in rural, remote and high-risk settings.

Suicide prevention and response initiatives and actions

5a. In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?

headspace considers the Royal Commission's recommendations to be comprehensive, and informed by a deep understanding of the needs of the Victorian population, current issues and challenges impacting on prevention and postvention suicide supports, and leading practice initiatives nationally and internationally.

We also acknowledge that school-based initiatives highlighted early in this submission are supported by the Victorian Government and form part of the existing prevention and postvention activities that this strategy will build on.

Despite suicide being the leading cause of death amongst its young people, Australia lacks a consistent youth suicide prevention practice approach. The strategy could consider the development of an evidence-based practice framework to unite diverse youth serving agencies within communities in Victoria and beyond under a common, evidence-based approach and language.

headspace notes that several organisations in NSW, QLD and New Zealand are partnering with US organisation **SafeSide** to build youth suicide prevention and workforce capacity. Consistent with a holistic health systems approach to suicide prevention.[55] The SafeSide approach brings together a range of research-supported practices, including from leading Australian services. The program uses this research to present planning, assessment and response strategies and techniques that can be practically incorporated in everyday practice.

For example, Gold Coast Health has established a Suicide Prevention Pathway based on SafeSide's prevention-oriented risk formulation. The Pathway is a multi-level comprehensive system approach that integrates multiple best practices and risk formulation. We understand that evidence from Gold Coast indicates a reduction in repeated suicide attempts for those who received care on this Pathway.

[55] Brodsky et al 2018

5b. What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness, and prevent suicide?

Better support for parents and carers

Continued strong family support is pivotal to a young person's health and wellbeing[56] and young people are most likely to talk to family as the first step in help-seeking.[57] Family is often the first to notice behavioural changes that may signal the onset of a mental health concern. More than 40% of young people who engage with headspace services access them via a referral or recommendation from family.[58] Australian young people are most likely to seek informal support, with 72% seeking help from parents or guardian/s or friends.[59]

There is growing evidence that depression and anxiety disorders in young people can be prevented.[60] Research has also identified risk and protective factors for adolescent depression and anxiety problems[61], including some that are potentially modifiable by parents.[62] Importantly, preventative parenting interventions have demonstrated benefits that last up to 20 years after the intervention.[63]

Parents have an important influence on young people's risk for internalising problems.[64] They benefit from receiving support and resourcing for their caring roles.[65] However, there is a lack of accessible, cost-effective depression and anxiety prevention programs for parents of adolescents.[66] Most existing interventions designed for parents of adolescents target behavioural problems such as substance use and risky behaviours not directly related to internalising disorders like anxiety and depression.[67]

There is a growing body of evidence that shows a systemic approach to clinical care that includes the family will improve the mental health outcomes and overall wellbeing for young people.[68]

headspace currently offers 'Tuning into Teens', a group parenting program to help parents understand and respond to their teenager's emotions and teach their teenage children to express their emotions in healthy and positive ways. The program positively impacts parenting behaviours and anxiety and depressive symptoms in teens up to 9 months after program completion.[69]

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[56] Radovic A, Reynolds K, McCauley H L, Sucato GS, Stein BD, Miller E, *Parents' Role in Adolescent Depression Care: Primary Care Provider Perspectives.* Journal of Paediatrics. 2015;167 (4). 911-8

[57] https://growingupinaustralia.gov.au/research-findings/annual-statistical-report-2017/adolescent-help-seeking

[58] headspace centre client data 2013-2020 shows that almost half of young people are most influenced by their family or friends to attend headspace, primarily family.

[59] Mission Australia Youth Survey 2020

[60] Fisak BJ, Richard D, Mann A. *The prevention of child and adolescent anxiety: a meta-analytic review.* Prev Sci. 2011 Sep;12(3):255–68; Merry SN, Hetrick SE, Cox GR, Brudevold-Iversen T, Bir JJ, McDowell H. *Psychological and educational interventions for preventing depression in children and adolescents.* Cochrane Database Syst Rev. 2011 Dec 07;(12):CD003380.; Yap MB, Morgan AJ, Cairns K, Jorm AF, Hetrick SE, Merry S. *Parents in prevention: a meta-analysis of randomized controlled trials of parenting interventions to prevent internalizing problems in children from birth to age 18.* Clin Psychol Rev. 2016 Oct 21;50:138–158.

[61] Cairns KE, Yap MB, Pilkington PD, Jorm AF. *Risk and protective factors for depression that adolescents can modify: a systematic review and meta-analysis of longitudinal studies.* J Affect Disord 2014 Dec;169:61-75; Beesdo K, Knappe S, Pine DS. *Anxiety and anxiety disorders in children and adolescents: developmental issues and implications for DSM-V.* Psychiatr Clin North Am 2009 Sep;32(3):483-524

[62] Yap MB, Pilkington PD, Ryan SM, Jorm AF. *Parental factors associated with depression and anxiety in young people: a systematic review and meta-analysis.* J Affect Disord 2014 Mar;156:8-23; Pinquart M. *Associations of parenting dimensions and styles with internalizing symptoms in children and adolescents: a meta-analysis.* Marriage Fam Rev 2016 Oct 14;53(7):613-640.; Schleider JL, Weisz JR. (2017) *Family process and youth internalizing problems: a triadic model of etiology and intervention.* Dev Psychopathol 2017 Feb;29(1):273-301

[63] Yap MB et al, 2016, op.cit.

[64] Yap MB et al, 2019 op.cit

[65] Baker D, Burgat L, Stavely H. *We're in this together. Family inclusive Practice in mental health services,* Orygen 2019

[66] Yap MB et al, 2019 op.cit

[67] Sandler IN, Schoenfelder EN, Wolchik SA, MacKinnon DP. (2015) *Long-term impact of prevention programs to promote effective parenting: lasting effects but uncertain processes*. Annu Rev Psychol 2011;62:299-329

[68] Productivity Commission, 2020 https://www.pc.gov.au/; State of Victoria, Royal Commission into Victoria's. Mental Health System, Interim Report, Parl Paper No. 87 (2018–19)

[69] Kehoe CE, Havighurst SS, Harley AE. (2013) *Tuning in to teens: improving parent emotion socialization to reduce youth internalizing difficulties.* Soc Dev 2013 Oct 15;23(2):413-431.

In addition, headspace is partnering with Monash University to jointly design and pilot an eheadspace-specific version of their 'Partners in Parenting' (PiP) [70] and Therapist-Assisted Online Parenting Strategies (TOPS) [71] programs. These have been developed as a stepped-care approach to prevention and early intervention of depression and anxiety in children and adolescents, by building the skills and confidence of parents.[72]

Coordination of responses within communities

Where services and referral pathways exist, there is often fragmented communication between schools, health services and the community, as well as among health services themselves. Notably, Commonwealth, state and local boundaries frequently confound coordination efforts. For young people, there is an opportunity to establish a coordinating function that helps bring together the emergency departments, headspace centres, first-responders, schools, and other state-funded clinical care providers in a community to support young people overcome suicide. Prioritising the enhancement of communication channels between key stakeholders is required in responding to serious mental health concerns to ensure an integrated care coordination approach occurs across education and health settings.

Investment is also needed in cross-sector service models and partnerships to ensure the diverse needs of Aboriginal and Torres Strait Islander young people are met in culturally safe ways. For headspace, as an example of a mainstream health service, sustainable and genuine partnerships between local headspace centres and Aboriginal community-controlled health organisations would work toward ensuring First Nations young people are supported in their communities. Investment in genuine partnerships would also support and strengthen, rather than compete with or duplicate, existing local services and programs.[73]

For Aboriginal and Torres Strait Islander young people, the Central Australian Aboriginal Congress provided headspace with this recommendation:

> *"Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services, healing programs, culturally secure SEWB programs and, where appropriate, Aboriginal families living on country."*

This recommendation is supported by research which demonstrates that improvements in mainstream service delivery for First Nations young people and communities occurs through ongoing community partnerships, including those with Aboriginal community-controlled organisations and Elders.[74]

Providing training for community members

While educational settings should be a key focus for suicide prevention and postvention strategies, there are many community settings that young people frequent outside of formal education that should also be a focus.

The Royal Commission identified community gatekeeper training as an approach that could be utilised within such settings. This involves community members such as sports coaches, youth workers and retail workers being provided with training to equip them with skills to discuss suicidal behaviour and encourage young people to seek help.[75] These community members often come

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[70] Yap MB et al, 2014, op.cit.
[71] Yap and others, 2019, op.cit.
[72] Sarah Pheik Hoon Khor, Catherine Margaret Fulgoni, Deborah Lewis, Glenn A Melvin, Anthony F Jorm, Katherine Lawrence, Bei Bei, Marie Bee Hui Yap (2021) *Short-term outcomes of the Therapist-assisted Online Parenting Strategies intervention for parents of adolescents treated for anxiety and/or depression: A single-arm double-baseline trial*. Aust N Z J Psychiatry. 2021 Jul 7;48674211025695.
[73] Department of Health. (2015). Implementation plan for the National Aboriginal and Torres Strait Islander health plan 2013–2023. *Commonwealth of Australia*.
[74] Wright, M., Getta, A. D., Green, A. O., Kickett, U. C., Kickett, A. H., McNamara, A. I., & O'Connell, M. (2021). Co-designing health service evaluation tools that foreground first nation worldviews for better mental health and wellbeing outcomes. *International journal of environmental research and public health*, *18*(16), 8555.
[75] RCVMHS (2021) Final report, Vol. 2; p. 479.

into contact with young people; therefore, opportunities to train and upskill these members should be considered as a key component in supporting young at-risk people.

5c. In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?

As discussed above in the context of the lived experience workforce, headspace commends the focus of the Royal Commission on supporting the wellbeing and development of the mental health workforce, and the initiatives that are already underway in Victoria to enact these recommendations.

By nature of their work, frontline workers experience an extremely high mental and emotional load as they support people experiencing crisis and high levels of psychological distress.

The workforce requires levels of resourcing to enable appropriate caseloads, and allocation of therapeutic, administrative and professional support time, to experience sustainable working conditions that allow them to offer clients the full scope of their capacity and expertise.

Professional supports include clinical and peer support – including time and resources for supervision, debriefing and reflective practice – to enable them to continue to function professionally and effectively and to maintain their own wellbeing.

5d. How can we better educate and build the capacity of workplaces to reduce the risk of suicide and better support staff? What capabilities or supports are required?

Cultural awareness

As discussed above, First Nations people continue to experience poor mental health and barriers to access at much more significant levels than the general population. Their experiences of marginalisation and intergenerational trauma necessitate investment in more accessible, culturally safe and appropriate services to support Aboriginal and Torres Strait Islander communities, particularly in regional and remote locations across Australia.

Actions could include:

- opportunities and incentives for peer-based workers to attain additional qualifications
- localised and relevant cultural awareness training for all workers
- support workers to introduce and practice cultural healing
- build a stronger outreach workforce for better engagement
- increase workforce understanding and capacity to bring together cultural and clinical approaches in the development of a care plan.

headspace, in partnership with Cox Inall Ridgeway, has recently undertaken a cultural safety and awareness review of our organisation and its operations and practices.

Our review strongly highlighted the need and desire to bring together clinical and cultural outcomes, develop cultural competencies, and incorporate cultural outcomes across the headspace network.

A range of opportunities were identified to enhance the headspace service delivery model to provide safe, engaging and culturally appropriate support, including:

- more visible employment of First Nations people in all areas of the organisation
- First Nations staff or young people greeting arrivals

- outreach, going to talk with young people where they are, and engaging with families and community
- flexibility in how to approach young people in centres including soft entry points like 'hang out' or 'grab a feed' timeslots, and casual engagement processes and spaces
- activity-based, artistic and cultural programs including learning about culture and language, traditional knowledge and craft, going on Country with Elders, and yarning circles
- capacity to offer flexible walk-in support and response to young people in crisis, single session therapy and narrative therapy, including single session therapy for families
- developing engaging promotional materials, with storytelling and representation of First Nations people and language
- cultural awareness training run with local Elders or First Nations organisations; specialised upskilling in practices such as narrative therapy, cultural healing, and culturally specific care planning.

headspace recognises that building trust with community takes time, dialogue and respect, and it is important not to rush relationship building with communities, or in processes for engaging young people. This is also important for building nuanced understanding and approaches to address the specific needs of each community. We will support our centre staff to develop relationship building skills and practices over time, and ensure they have the guiding frameworks, time and resources they need for proactive community involvement.

Schools

Continuing the expansion of mental health education and skill development in schools, such as through the Mental Health Education Program and Be You initiatives (outlined above), is one of the most cost effective and impactful investments that can be made.

While headspace continues to grow its service offering for young people aged 12-25, we note that 50% of mental health disorders arise before the age of 14[76], yet there is limited support available to support the mental wellbeing of young children. As the National Mental Health Commission reported: "There remains a critical gap for children aged from birth to 12 years, both for the child and for parents who need to be supported to maximise their child's development and wellbeing"[77]

Evidence is now emerging to suggest that suicide prevention programs can be delivered safely in schools if done so carefully.[78] Orygen's report Raising the Bar for Youth Suicide Prevention[79] highlighted a number of studies that show training students how to identify and respond to suicide risk in oneself and others has the potential to improve knowledge, confidence, attitudes, and help-seeking intentions. There also appears to be emerging evidence for the cost-benefits of these educational and training-based programs[80] and school-based suicide prevention programs when calculated against a willingness to pay.[81]

The headspace School Support service has developed a national postvention service model in response to the growing evidence of suicide attempts and deaths by suicide among young people. The service model provides a comprehensive range of tools and services throughout the stages of response and recovery, delivered to schools at the front-line.

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[76] Kessler et al., 2007

[77] National Mental Health Commission, 2014

[78] Robinson J, Bailey E, Spittal M, Pirkis J, Gould M. Universal Suicide Prevention in Young People: An Evaluation of the safeTALK Program in Alice Springs High Schools. Final Report to the Lifeline Research Foundation. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health.; 2016.

[79] Robinson J, Bailey E, Browne V, Cox G, Hooper C. Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2017.

[80] Ashwood J, Briscombe B, Ramchand R, May E, Burnam M. Analysis of the Benefits and Costs of CalMHSA's Investment in Applied Suicide Intervention Skills Training (ASIST). RAND Health Quarterly. 2015;5(2).

[81] Ahern S, Burke LA, McElroy B, Corcoran P, McMahon EM, Keeley H, et al. A cost-effectiveness analysis of school-based suicide prevention programmes. Eur Child Adolesc Psychiatry. 2018;27(10):1295-304.

Universities

There is a major opportunity for a more concerted focus and investment to deliver the components of the National University Mental Health Framework. There is also a need to develop tailored approaches to respond to the diverse range of private higher education providers and VET providers, including TAFEs.

In Australia, there has not been an economic cost-benefit study of investing in tertiary student mental health. However, a study in the United States found a social return of $6.49 on every $1 spent by the government on prevention and early intervention in college student mental health.[82] This was based on mitigating against course incompletion, loss of future workforce potential and downstream mental health system costs. The report highlighted that for the community college students (where we can draw the closest parallels with Australian TAFEs), the net benefits were estimated to increase to $11.39 for each dollar invested.

Universities are unique educational settings and play a key role in shaping and supporting students' mental health and wellbeing. There is generally a greater onus on students to take responsibility for remaining engaged in their studies compared to secondary school students. There are cohorts of international and domestic students with limited local family support. University studies can occur at a time of great transition and change for individuals, including leaving secondary school, leaving countries or familiar settings, or returning to study after years in the workforce or raising families.

Since 2008, universities have also seen a massive growth in undergraduate students coming from marginalised communities. Between 2008 and 2018, Aboriginal and Torres Strait Islander students more than doubled; enrolments of students from low socio-economic backgrounds increased by 66%; there was a 139% growth in students with disability; and enrolments of students from regional and remote areas increased by 48%. Statistically these groups are more likely to experience mental health difficulties and may also require different approaches in supporting their mental health[83]. According to "Under the radar: the mental health of Australian university students", more than half of tertiary students aged 16–25 years reported high or very high psychological distress while 35.4% had thoughts of self-harm or suicide[84].

In 2020, headspace partnered with peak body Universities Australia (UA) to design, deliver and implement the Universities Postvention Toolkit. This is an evidence-informed toolkit that is created specifically for universities to help keep their communities safe and supported following a death by suicide. It provides clear, practical guidance for universities in managing a traumatic event in the weeks and months following a death. headspace delivered workshops implementing the toolkit to 140 senior leaders in universities providing specialist advice on developing institutional suicide response plans, the appropriateness of language and how to communicate about a suicide. In 2021 headspace, in partnership with Universities Australia, designed a carefully tailored mental health literacy framework and is delivering 60 accompanying workshops for Australian university staff that help them notice changes in a person's mood or behaviours, start a conversation about mental health, and provide appropriate support.

In 2022 headspace received funding under the National Suicide Prevention Grants round to enable training to 30,000 staff in all 43 universities, and to establish a Critical Incident Response clinical workforce to assist universities responding to suicides.

5e. What higher risk industries/workplaces should we prioritise for immediate suicide prevention action and why?

Please see earlier responses relating to building the capacity of school and university staff to identify and respond to suicide risk amongst young people.

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[82] Ashwood J, Stein B, Briscombe B, Sontag-Padilla L, Woodbridge M, May E, et al. Payoffs for California College Students and Taxpayers from Investing in Student Mental Health. California: RAND Corporation; 2015.
[83] Universities Australia and headspace, 2021 *Real Talk.*
[84] Orygen, The National Centre of Excellence in Youth Mental Health. *Under the radar. The mental health of Australian university students*. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2017.

5f. For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

headspace acknowledges the informed commentary and leading practice examples provided in the Royal Commission's report.