



# **Select Committee Inquiry into Mental Health and Suicide Prevention**

## **Beyond Blue Submission**

24 March 2021

## 1. Introduction

Beyond Blue welcomes the opportunity to provide this submission to the House of Representatives' Select Committee Inquiry into Mental Health and Suicide Prevention.

**Reforming the mental health and suicide prevention systems is a big and complex task that will take time to complete, but it must be prioritised and action needs to start now.**

**The many landmark reviews of the mental health and suicide prevention systems over the last five years alone contain all the information and independent analysis needed for reform, and they are all pushing in the same direction.**

The findings of these reviews are unequivocal:

- the system is underfunded, confusing, fragmented, unbalanced and needs to be rebuilt;
- the people who most need an effective system need to be at the forefront of change, not passengers on the journey;
- reform is long overdue and now is the time for substantial investment and effective implementation.

Beyond Blue – along with many others in the sector – has provided extensive submissions, witness evidence and advocacy to the major reviews being analysed under the Committee's Terms of Reference. Our response to the Terms of Reference draws on and repeats several of these previous submissions and provides **six recommendations critical for re-building the mental health and suicide prevention systems Australians need. These recommendations are under two themes: *what the reform agenda should prioritise, and how the reform agenda should be achieved.*** For each recommendation, we refer the Committee to our previous submissions for greater detail and elaboration (attached for [reference](#)):

- the Department of Health's Consultation on the Productivity Commission Final Report (Attachment A)
- the National Children's Mental Health and Wellbeing consultation question responses (Attachment B)
- the Vision 2030 consultation response (Attachment C)
- the National Suicide Prevention Adviser's Interim Advice consultation (Attachment D)
- the renewal of the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Attachment E)

### Recommendations

#### What the reform agenda should prioritise

Beyond Blue recommends that the Australian Government, in partnership with State and Territory governments, should prioritise the following proposals from the major reviews:

1. Implement the Productivity Commission's recommendations on the digital mental health, children's screening, and universal aftercare.
2. Follow the National Suicide Prevention Taskforce's blueprint for the suicide prevention system and embrace digital solutions.
3. Undertake the comprehensive reform of the children's mental health system (0-12 years) proposed by the National Children's Mental Wellbeing Strategy, and go further.

#### How the reform agenda should be achieved

Beyond Blue recommends governments approach the task of undertaking the reform agenda by:

4. Embedding lived experience at the forefront of change through structure, policy and practice.
5. Creating a whole-of-government approach that positions mental health and suicide prevention as everyone's responsibility.

6. Taking a long term, iterative approach to the transformational change, and planning for and ringfencing the investment required.

## Recommendations – What the reform agenda should prioritise

### 1. Implement the Productivity Commission’s recommendations on a) digital mental health, b) children’s screening, and c) universal aftercare

#### A. Implement the national digital mental health platform, starting immediately by leveraging existing sector capability (refer to recommendations 10, 11, and 15 of the Productivity Commission’s Final Report)

- A plan to adopt and scale digital mental health solutions, alongside and integrated with telehealth and face to face services, is long overdue. The proposed national digital mental health platform – starting by leveraging existing sector capability and proving up solutions in a test and learn approach – will immediately improve access to support, integration and service navigation and will start to fill the low intensity gap in mental health care.
- The sector is already leading and innovating in digital mental health support, as seen by Beyond Blue, Lifeline and ReachOut coming together during the COVID-19 pandemic to augment the Coronavirus Mental Wellbeing Support Service. Leveraging established expertise and the capability of organisations the community knows and trusts will deliver immediate improvements in access to effective support options and lay the foundations of the national digital mental health ecosystem.
- **This is subject to a critical gap: In implementing the digital mental health supports, digital equity must be considered and addressed.** An estimated 2.5 million Australians, approximately 10 per cent of the population, are digitally excluded, meaning they cannot access, afford, or can connect and use online technologies effectively (Australian Digital Inclusion Index, 2020). People more likely to be digitally excluded are also more likely to experience poor mental health.

#### B. Implement universal screening and more education programs in family and children’s health services (Recommendation 5 of the Productivity Commission’s Final Report)

- Beyond Blue welcomed the Productivity Commission’s proposal for universal screening of children and parents, and more education programs in family and children’s health services.
- No area of policy offers greater potential to change Australia’s mental health trajectory than preventing mental health conditions occurring early in life. Around 50 per cent of mental health conditions arise before the age of 14. There are evidence-based approaches that work and deliver very high rates of return on investment, yet a comprehensive and embedded system of prevention and early intervention is yet to be built.
- **This is subject to a critical gap:** much more comprehensive reform is needed to create a well-resourced and integrated system so that children and families identified at risk through screening are supported swiftly and with a multidisciplinary approach (see our Recommendation 5 below).

#### C. Implement universal aftercare for all Australians and strategies to empower community-led Aboriginal and Torres Strait Islander suicide prevention (see Recommendation 9 of the Productivity Commission’s Final Report)

- The Productivity Commission’s recommendations for suicide prevention (recommendation 9) should be implemented as a priority. Suicide aftercare should be available to anyone who needs it.

Australia needs to prioritise evidence-based aftercare, both in hospital and community settings, urgently. This is a 'quick win' reform that should be prioritised due to the models and sector capability already available in Australia and the ability to reach one of the highest risk groups of people for suicide death.

- The Australian Government must prioritise the work of Gaaya Dhuwi on renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and provide an implementation plan to support the Strategy as soon as possible. It continues to be deeply concerning that Aboriginal and Torres Strait Islander peoples are around three times as likely to report high or very high levels of psychological distress and are twice as likely to die by suicide as the rest of the population. Improving social and emotional wellbeing is intrinsically connected to the social determinants of health and is critical to achieving the Closing the Gap targets and other important Australian Government policy commitments, including implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.
- In particular, Government must proactively ensure that services and supports for Indigenous communities are co-designed by Indigenous people, leaders and organisations. Indigenous leadership must be embedded across the mental health system, and specific funding must be dedicated to developing Indigenous identified positions, particularly in leadership positions, in mainstream organisations. As the Final Report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project 'Solutions that work' found, *'a common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and 'lived experience' elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time.'*
- For further information, see our [response](#) to Gaaya Dhuwi's consultation on renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

## 2. Follow the National Suicide Prevention Taskforce's blueprint for the suicide prevention system and embrace digital solutions.

- **After implementing the Productivity Commission's proposal for universal aftercare and Aboriginal and Torres Strait Islander suicide prevention, the rest of the suicide prevention system should follow the blueprint proposed by the National Suicide Prevention Taskforce.** Countries such as Scotland and Japan have achieved meaningful reductions in their national suicide rates through employing whole of government, integrated systems and mobilising the whole community in the effort. Change has occurred over the long term, often decades. The Taskforce's interim advice provides a comprehensive roadmap for reform over the long term that prioritises the need for compassionate and person-centred supports. It also establishes a dedicated workforce, research and evaluation strategies, targeted approaches to meet the needs of priority populations, and establishes the machinery to bring about that reform.
- **Digital options must be part of the solution** – see our [response](#) to the Taskforce's interim report. Missing from the Taskforce's proposal is consideration of how to use digital solutions to improve the suicide prevention system in a way that ensures everyone experiencing suicidality has a doorway to help. The population-level solution should include a digital first approach that provides people in crisis with warm pathways into care when they need it, guiding them through a range of support options that meet their needs, follow up, and linkage into specialist supports.
- These platforms – including moderated online peer to peer forums, apps and text-based support and website concierge – can create connections for people in suicidal crisis, their carers and family members, and help guide them through available options. Digital solutions can complement and

augment face to face engagement, through affordable, reliable and accessible telehealth delivery. A digital first approach could integrate with the national digital mental health platform.

- **Leverage (rather than replace) existing investments and capabilities in the sector and build on these efforts over time.** Over the last five years in Australia, considerable investment has been dedicated to developing programs and services that can support people before and after suicidal crisis. This has led to fragmentation and duplication in the suicide prevention sector - system integration is now required. **There are numerous proven and scalable models of care that can be integrated over time and adapted to local populations.** For example:
  - The Way Back Support Service and the HOPE initiative: Evidence-based models such as The Way Back Support Service – which will operate in around 40 locations by mid 2021 – can be leveraged in partnership with states and territories to make universal aftercare possible. The Service is integrating with the Victorian Government’s Hospital Outreach Post-suicide Engagement (‘HOPE’) initiative to deliver blended clinical/non-clinical aftercare support. These models also have the flexibility to include peer workforces, family support and referral pathways for priority population groups including Aboriginal and Torres Strait Islanders and LGBTIQ people.
  - The Government’s National Suicide Prevention Trial (which concludes this year) implements a systems approach to suicide prevention, adopting Black Dog Institute’s *Lifespan* model, in 12 locations across all states and territories. The Trial sites are tailored to local populations and several sites were dedicated to specific local demographics such as Aboriginal and Torres Strait People (Western NSW), ex-serviceman (Townville), and LGBTIQ (North West Melbourne).
  - The National Safe Spaces study provides a ready-made blueprint for a tiered network of spaces to appropriately divert people away from emergency departments and scale up the availability of safe alternatives for people experiencing suicidality. These models can deliver impact at scale and be tailored to local populations.

### **3. Undertake the comprehensive reform of the children’s mental health system (0-12 years) proposed by the National Children’s Mental Wellbeing Strategy, and go further.**

- **Comprehensive reform of the children’s mental health system is required to create a well-resourced and integrated system.** Significant integrated reform across community, education and service settings is needed to enable identification of children in need of support and to ensure appropriate services are readily available to them and their families and caregivers. There are several elements to the success of this comprehensive reform.
- **As indicated in Beyond Blue’s [response](#), the Strategy’s proposed model of integrated child and family care (Action 2.1c) is a critical first step to reforming the current services system and addressing the significant gaps in the system.**
- **However, the proposed model requires a greater focus on prevention.** The model must better recognise the ‘healthy’ end of the continuum and enable bolder action on prevention, with clear strategies that focus on functioning and supporting positive mental health and wellbeing, not just treatment. For example, targeted prevention would include identifying children and families at greater risk of severe mental health conditions and expanding the integrated model to include more holistic psychosocial and family supports for these children. These supports could include peer activities for children, family-focused interventions, supports addressing violence, and supports that address trauma and other adverse childhood events.

- **The critical role of educators in supporting children’s mental health and wellbeing in early childhood settings and classrooms also needs to be recognised.** There is a great opportunity to fully leverage early childhood and education settings to nurture social and emotional development, help prevent mental illness, and assist with identifying children and young people who may be experiencing mental ill health. Educators are a source of support for the children they educate, have connections to children’s families, actively demonstrate inclusive practices in their education setting and both identify and support children experiencing mental health or wellbeing challenges. Independent market research by IPSOS commissioned by Beyond Blue (2020) found that 94% of participating educators agreed that supporting the mental health and wellbeing of learners is part of their job (up from 86% in 2018).
- Identified gaps with the Strategy and areas where Beyond Blue believes focus should be on, are outlined in our response.

## Recommendations – How the reform agenda should be achieved

### 4. Embedding lived experience at the forefront of change through structure, policy and practice.

- **Sustainable, large-scale reform of the mental health and suicide prevention systems will only be achieved if people with lived experience are positioned, alongside clinicians, researchers, NGOs and governments, at the forefront of change.** As the Productivity Commission states, impact on people is the factor by which all other elements of reform are judged – if the system doesn’t work for the people who need the system most, it doesn’t work.
- **This transformational re-centring of lived experience requires a concerted shift and must bring everyone along the journey.** It must be done in partnership, not only with consumers and carers, but also the sector organisations, mental health services, peak bodies, clinicians and the non-clinical workforce. The delivery of joined up care involves everyone and an informed and balanced system must embrace all voices and expertise.
- **There are several tangible way Government can make the shift required, including:**
  - **Ensuring there are clear mechanisms for embedding the lived experience voice** within the instruments designed to set up the governance and funding architecture of a reformed mental health system – including the new National Mental Health and Suicide Prevention Agreement and National Mental Health Strategy – see our [submission](#) to the Productivity Commission.
  - **Embedding the outcomes that matter most to consumers and carers** in the whole of government approach to reform, including the National Mental Health and Suicide Prevention Agreement, and ensuring these outcomes are monitored and adapted in response to changing community needs – see our [submission](#) to the Productivity Commission.
  - **Dedicating sufficient time and investment** to ensuring consumers and carers are at the centre of design, implementation and monitoring. An allowance for both time and funding for co-design with consumers, carers, and sector organisations, to embed lived experience representatives at every level is needed. This should include embedding lived experience in governance arrangements and development of the foundational architecture and instruments, as mentioned above.
- **Importantly, the Select Committee must acknowledge that the time has passed for more consultation with people with lived experience.** Comprehensive feedback has informed all the landmark reviews. People with lived experience do not need another process to express their feedback – they need a redesigned system that meets their needs now and into the future.

## 5. Create a whole-of-government approach that positions mental health and suicide prevention as everyone's responsibility

(See recommendations 22 – 24 and action 23.3 – Productivity Commission's Final Report; National Suicide Prevention Taskforce Interim Report, recommendation 1; National Children's Wellbeing Strategy, section 4.1; Vision 2030 Roadmap, 'Working Together' priority).

- **The foundation for reform is a long-term, bipartisan, whole of government approach to mental health and suicide prevention that includes clear roles and responsibilities, an implementation plan and adequate funding architecture.** This is a unified vision from all the landmark reviews and must be implemented for both the adult and children's mental health systems. The whole of government approach needs to be cross portfolio and cross jurisdictional, and not confined to health. It needs to be led by First Ministers and incorporate clear roles and responsibilities across all levels of bureaucracy.
- **The whole of government approach needs to be implemented through a single roadmap that guides and unites mental health reform, which plans and directs action and investments, and monitors progress.** The single roadmap should constitute the twin, whole-of-government, strategies: the National Mental Health Strategy recommended by the Productivity Commission, and the National Suicide Prevention Strategy, recommended by the National Suicide Prevention Taskforce.
- **This whole of government approach must be enabled through long-term (rather than seed or pilot) funding commitments and the adoption of shared outcomes across Commonwealth and State/Territory governments.** The roadmap must be underpinned by associated instruments, such as the National Mental Health and Suicide Prevention Agreement (the Agreement) recommended by the Productivity Commission, which establishes the governance and funding architecture required for intergovernmental cooperation. The Agreement should contain funding for outcomes rather than activities, and embed long term priorities that support service continuity, incentivise sector innovation, appropriately ringfence new investment, and ensures funding is allocated where it is most effective.
- **Guided by a single roadmap and Agreement, a whole of government approach will provide:**
  - **Alignment between jurisdictions and strong leadership to drive change.** It will enable clear roles and responsibilities within governments and across them.
  - **The ability to measure the impact and effectiveness of cross-jurisdictional and cross-departmental actions.** We recommend that a national monitoring system is linked to the National Mental Health and Suicide Prevention Agreement so that investment is guided by evaluation.
  - **Collaboration and support across all levels of government, the mental health sector, and the community,** to deliver an integrated, person-centred system. It must be recognised that developing partnerships with consumers, carers, and sector organisations will take time and require an ongoing commitment to resourcing to sustain them for the long term. This should be supported by additional funding to organisations in recognition that these demands exist above and beyond normal service delivery. For example, the mental health system needs a digital transformation to deliver the services the community needs. This will require cross-sector collaboration and co-design with consumers and carers and will take time, investment and resources and commitment to iterative design and implementation.

## 6. Take a long term, iterative approach to the transformational change required and plan for and ringfence the investment that will be required.

- **Achieving reform of this scale requires a new approach to implementation.** The reform agenda proposed is complicated and will take time but is not an excuse for inertia. Government should move beyond the traditional implementation methodology (ie., 'waterfall' approaches) to an agile framework that embraces iterative design and a 'try, test and learn' approach, where it makes

sense to do so. Under this approach, initiatives can be incubated then proven in stages, rather than being delayed by over-investment in design phases that are not informed by user feedback and analysis.

- **This will necessitate a different mindset and instruments for funding.** Existing funding strategies, such as the ‘let a thousand flowers bloom’ approach of short term, time limited investment without security of tenure and piecemeal projects that are not interconnected, is no longer fit for purpose. For example, the National Mental Health and Suicide Prevention Agreement should contain funding for *outcomes* rather than activities and outputs, and embed long term priorities that support service continuity, incentivise sector innovation, appropriately ringfence new investment, and ensures funding is allocated where it’s most effective. These instruments must be long term enough to create funding certainty but have in-built flexibility for internal review of targets and outcomes, so the structures of the system evolve alongside emerging community needs.
- **It also calls for a whole of sector effort and cooperation, supported by Government.** The transformational change required by the landmark reviews (which Beyond Blue supports) will not be sustainable if organisations continue to be funded and work in siloes. This will be a huge change for the sector and it will need Government’s support to work better together, through partnerships, shared platforms and insights, and open learning and innovation.



## Attachment A

# Productivity Commission Final Report Response to Department of Health's Consultation Questions

### 1. *Of the recommendations made, which do you see as critical for the Government to address in the short term and why?*

Achieving reform of the scale outlined by the Productivity Commission requires striking the balance between investing in 'quick win' recommendations that deliver immediate value for the community, and in the structural components of a well-functioning sustainable mental health and suicide prevention system. Some will require incremental development over the long term, but are necessary for sustainable change and should not be delayed. In getting the balance right, Government must ensure that the priorities, preferences and experiences of consumers and carers are embedded across all recommendations, and for the voice of lived experience to be at the centre of a reformed system.

With this in mind, there are several immediate implementation priorities that will be critical for Government to address now:

- 1. Implementation priority 1 – whole of government approach (recommendation 22) that includes clear roles and responsibilities (action 23.3)** – because a bipartisan, whole of government approach is critical to guide investment for people who need it most, particularly the development of a new whole-of-government National Mental Health Strategy and National Mental Health and Suicide Prevention Agreement. Australia needs one roadmap that unites efforts, can be used to guide and track progress, and provides clear roles and responsibilities within governments and across them. The outcomes that matter the most to consumers and carers (**recommendation 24**) must be embedded in the instruments supporting the whole of government approach.
- 2. Implementation priority 2 – children's mental health (recommendation 5)** – due to the importance of preventing conditions for long term gains and impacts, and the ability to leverage existing capacity and capability, like Beyond Blue's 'Be You' initiative. We welcome the proposal for universal screening of children and parents, and more education programs in family and children health services. However, as described in the National Children's Mental health and Wellbeing Strategy, much more comprehensive reform is required to create a well-resourced and integrated system so that children and families identified through screening are supported swiftly and with multidisciplinary input.
- 3. Implementation priority 3 – suicide prevention (recommendation 9)** – due to the capability already available in Australia and the ability to reach one of the highest risk groups of people. Considerable investment has been dedicated to developing programs and services that can support people before and after suicidal crisis. Evidence-based models such as The Way Back Support Service – which will operate in 33 locations by March 2021 – can be leveraged in partnership with states and territories to make universal aftercare possible. The National Safe Spaces study provides a ready-made blueprint for a tiered network of spaces that takes the pressure off the emergency departments and provides safe alternatives for people experiencing suicidality. These programs can deliver impact at scale and be tailored to local populations.
- 4. Implementation priority 4 – national digital mental health platform (recommendations 10, 11, and 15)** – as there is existing capability within the sector to deliver the transformation required, it will immediately improve access to care and service navigation, and will help fill the

low intensity gap. The sector is already leading and innovating in the area of digital mental health support, for example, Beyond Blue, Lifeline and ReachOut coming together during the COVID-19 pandemic to augment the Coronavirus Mental Wellbeing Support Service. Leveraging established expertise and capability of sector organisations will deliver immediate improvements in access to effective support options and lay the foundations of the national digital mental health ecosystem. Any approach to building an entirely new platform must be agile. It could focus initially on interoperability of existing well known platforms and build out from there.

## **2. *Of the recommendations made, which do you see as critical for the Government to address in the longer term and why?***

The below actions are identified as longer term investment priorities, because they require sustained investment and concerted attention over time in order for the benefits to be fully realised:

- 1. Investment priority 1 – Build out the structural components** – because increasing investment in the structural components will be critical for continuing to evolve the mental health and suicide prevention system according to community needs and emerging evidence. This will, and must, be an iterative process of incubating systems and structures, and building them out over time, as the system develops in response to evolving community needs. These structural reforms must be started now, but will only be successful with dedicated and consistent investment over the longer term:
  - **Recommendation 23** – creating the instruments that will guide government’s investment strategy over time, particularly as new evidence based programs emerge. They will need to address the current service fragmentation not just between federal and state/territory services but also their delivery mechanisms through the NDIS, PHNs and LHNs.
  - **Recommendation 24** – ensuring that the outcomes that matter most to consumers and carers are embedded into the whole of government approach and are monitored and adapted in response to changing community needs. The national monitoring system should be linked to the National Mental Health and Suicide Prevention Agreement so that investment is guided by these outcomes.
  - **Recommendation 16** – building a new interdisciplinary workforce with the capacity to work differently and deliver a system where the consumer is at the centre. Drawing on work already being led by the National Mental Health Commission, professionalising the peer workforce will be a vital link in ensuring the system of supports is person- not clinician-led.
  
- 2. Investment priority 2 – Position lived experience at the forefront of change** – because, as the Productivity Commission acknowledges, consumer impact is the factor by which all other elements of reform are judged – if the system doesn’t work for the people who need the system most, it doesn’t work. A person-centred approach requires a cultural shift and will require concerted, long term attention to be properly fulfilled. Government should fund the formalisation of national peak bodies for consumers and for carers, to ensure there is continuity in the lived experience voice as the reform agenda is implemented over time. There should be clear mechanisms for embedding the lived experience voice within the instruments under **recommendation 23**.
  
- 3. Investment priority 3 – stop people falling through the cracks:** Government should fill service gaps and improve quality of care for everyone to ensure the system contains an in-built safety net, including by:
  - creating universal access to psychosocial support (**recommendation 17**),

- addressing service linkages, care coordination and system navigation (**recommendations 14 and 15**)
- improving community mental health options, such as reviewing Medicare Benefits Schedule rebatable services and access to low intensity supports (**recommendation 12**)
- reducing stigma and social exclusion, with a particular emphasis on improving community attitudes towards those with low prevalence mental health conditions and reducing self-stigma for those with higher prevalence mental health conditions. (**recommendation 8**).

**4. Investment priority 4 – address the social determinants of mental health** – because generational transformation in the mental health of Australians is only possible if we address the social determinants of mental health. Government should create dedicated long term funding streams to support the actions identified under **recommendations 19, 20 and 21**.

**3. *Of the critical recommendations identified in the previous questions, are there any significant implementation issues or costs you believe would need to be considered and addressed?***

**Taking an iterative approach to the structural components of the system:**

1. For the system to meet the needs of the people who need it most, it must be sustainable and responsive to emerging community needs. Government should not attempt to build everything at once, nor create new bureaucratic machinery that slows the pace of innovation.
2. Rather, it should address the longer term components of the Productivity Commission’s vision in an iterative way that enables a ‘try, test and learn’ approach, prioritising the incubation of services that can be proven, expanded and scaled.
3. The National Mental Health and Suicide Prevention Agreement is an opportunity to get this approach right. The Agreement should be approached as a ‘living document’ that first establishes clearly defined roles and responsibilities for governments and an agreed funding architecture, that can then be built out over time as the service system evolves. It should not opt for a highly prescriptive set of arrangements that fail to achieve consensus and risk delaying the pace of reform.

**Partnering with the sector for transformational system redesign:**

1. Some parts of the system will require wholesale re-design. This must be done in partnership with consumers and carers, and sector organisations who have the capability and experience to deliver parts of the reform agenda. Securing agreement on the high-level governance and funding architecture quickly will create the conditions for this to occur.
2. For example, the mental health system needs a digital transformation in order to deliver the services the community needs. This will take time, investment and resources, and a commitment to iterative design.
3. As mentioned in question 1, Beyond Blue, Lifeline and ReachOut have capability and experience to lay the foundations of the digital mental health platform, which could inform the Government’s broader digital transformation efforts.

**A new flexible and adaptive approach to funding that ensures:**

1. Services reach people where they are, rather than expecting people to go to services.
2. Service availability matches demand, including that it is equitable and reaches people in rural and remote locations.
3. That services and commissioning bodies are adequately funded.
4. That there are mechanisms to ensure cultural safety and appropriateness in service delivery, such as ensuring that Aboriginal Community Controlled Health Organisations are not simply

tasked with delivering and designing services, but empowered with long term funding to be strong advocates and leaders for their communities.

5. Allowing time and funding for co-design with consumers and to embed lived experience representatives in governance arrangements at every level, including the foundational instruments mentioned above.

**4. What do you believe is required for practical implementation of these recommendations? What do you feel are the key barriers and enablers?**

1. **Enabler 1 – leverage existing capabilities and partnerships:** harnessing successful and proven offerings, rather than building new initiatives from scratch, will maximise the value of investment and prevent additional system fragmentation. Government should work with the sector through strategic partnerships and take an iterative approach, by incubating services based on what already works, proving and extending, then scaling rapidly.
  2. **Enabler 2 - intergovernmental cooperation:** The whole of government approach envisaged in **recommendations 23 and 24** must be enabled through long-term (rather than seed or pilot) funding commitments and the adoption of shared outcomes across Commonwealth and State/Territory governments.
  3. **Enabler 3 – system architecture:** there are actions that, if implemented right, are themselves enablers of the rest of the reform agenda, such as:
    - Having a genuine mechanism for placing consumers and carers at the centre of design, delivery and evaluation will – in the spirit of “nothing about us, without us” – ensure that a system designed *for* the people who need it, is also designed *by* them.
    - Having a system that is informed by meaningful data, insights and outcomes will allow for innovation and adaptation based on emerging community needs. How data and the linkages between datasets are used will be critical for ensuring that actions are effective and can inform future policy development and reform. The Government’s mental health response to COVID-19, including the funding and delivery of the Coronavirus Mental Wellbeing Support Service has demonstrated that there are good opportunities for regularly sharing data and insights to inform service innovation, monitoring and evaluation. This can and should be led by the sector and the community, with the support of Government.
    - As addressed in question 2, the new multidisciplinary mental health workforce itself, particularly the development of a professional peer workforce.
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1. **Barrier 1 – persisting with traditional implementation approaches:** To achieve the transformational change envisaged by the Productivity Commission, Government needs to move beyond a ‘waterfall’ implementation methodology to an agile framework that embraces iterative design and a ‘try, test and learn’ approach. Initiatives can be incubated then proven in stages, rather than being delayed by over-investment in design phases that are not informed by consumer feedback. This will require a different mindset and instruments for funding.
  2. **Barrier 2 – maintaining existing funding strategies:** the ‘let a thousand flowers bloom’ approach of short term pilots and piecemeal investment is no longer fit for purpose. The National Mental Health and Suicide Prevention Agreement should contain funding for outcomes rather than activities, and embed long term priorities that support service continuity, incentivise sector innovation, appropriately ringfence new investment, and ensures funding is allocated where it’s most effective.
  3. **Barrier 3 – sector cooperation:** the scale of proposed reform will not be sustainable if organisations continue to be funded in siloes. The sector needs Government’s support to work better together. This requires the sector to come together through incentivised partnerships, shared platforms and insights, and open learning and innovation. Government should

incentivise the sector to collaborate more effectively, by leveraging existing capabilities and harnessing partnerships that have proven success in responding to community needs.

**5. Are there clear steps you believe need to be taken to ensure the recommendations are successfully implemented?**

- 1. A single plan to guide and track progress:** This would logically be the new National Mental Health Strategy, underpinned by associated instruments such as the National Mental Health and Suicide Prevention Agreement. To be effective, sufficient time and investment must be dedicated to ensuring consumers and carers are at the centre of design and monitoring, so that the whole of government approach is guided by lived experience and adaptive to emerging community needs. As mentioned in Question 3, these instruments should be approached as a 'living documents' that can then be built out over time as the service system evolves. They should prioritise the broad architecture of reform, rather than highly prescriptive, contentious arrangements that risk delaying the pace of implementation.
- 2. Formalising the National Mental Health Commission in statute:** The new monitoring and oversight function role for the NMHC should be formalised in legislation, not just through the National Mental Health and Suicide Prevention Agreement. The NMHC should be enacted as an independent statutory authority with permanent funding, clear objectives and regulatory powers. Enshrining its role in statute will help refine and clarify the scope of the Commission's responsibilities, and empower the Commission to acquit its functions over the long term. It will also provide the regulatory stability and accountability that will sustain the new whole of government approach.
- 3. Re-designing the Medicare Benefits Schedule ('MBS'):** Beyond Blue affirms the Productivity Commission's recommendation to review the MBS for psychological services. The Better Access initiative has significantly increased utilisation of psychological services and treatment over its 15 years of implementation. However, numerous studies and national data have shown, it is also expensive, outcomes blind, undermined by issues of equity and distribution of access (e.g., the majority of private practitioners work in major cities and treat people who can pay out of pocket costs), and is provider- rather than person-led. Government should transform the MBS into a mechanism for stepped care involving multi-disciplinary workforces, that integrates with a digital platform, has robust, mandatory outcomes reporting, and is capable of allocating funding to where it's most needed.
- 4. Develop a best practice approach to reviewing the evidence and providing knowledge translation of innovations that work:** Government should develop best practice approach to research and innovation, by first commissioning a review of the current evidence in the mental health sector and providing guidance how to continually identify new innovations, test their effectiveness and scale up what works. There is great possibility and capability for innovation in the sector, but at present the evidence base for what works in mental health is still emerging, is piecemeal rather than comparative, and needs knowledge translation. It will be important to assess why actions already on agreed government agendas, such as the Fifth Plan for Mental Health and Suicide Prevention, are either working or are failing to have impact, in order to leverage successes and avoid repeating mistakes. Only by continually reviewing, translating and embedding understandings of what works (and does not work) can we improve the system in line with emerging community needs, and be genuinely responsive to consumers and carers.

**6. Do you believe there are any critical gaps or areas of concern in what is recommended by the PC?**

- 1. A comprehensive system for children's mental health:** Support for children 0-12 years should incorporate universal screening within a broader system of care. As described in the National Children's Mental Health and Wellbeing Strategy, for children under 12, there is no real 'system' of affordable, integrated care, delivered on the basis of need. Specialist children's mental health services are under-resourced to meet demand, meaning children miss out or have to wait until they age into youth services. Significant integrated reform across community, education and service settings is needed to enable identification of children in need of support and to ensure appropriate services are readily available.
- 2. A greater focus on prevention:** Beyond the recommendations relating to stigma reduction and early help for new parents and children, much of the reform agenda targets existing mental health conditions and the crisis end of care. A holistic mental health system needs to reach back further into wellbeing, to prevent early distress from becoming a mental health condition. Government should apply a prevention lens to all key areas of reform, including to workplace, suicide prevention, low intensity digital supports, and education.
- 3. Digital exclusion:** While simultaneously creating more digital mental health solutions, Government must address how they can be made available to everyone. People more likely to be digitally excluded are also more likely to experience poor mental health. An estimated 2.5 million Australians, approximately 10 per cent of the population, are digitally excluded, meaning they cannot access, afford, or possess the ability to connect and use online technologies effectively (Australian Digital Inclusion Index, 2020). Australians with low levels of income, education, and employment are significantly more digitally excluded.
- 4. Uptake of low intensity digital supports:** For a stepped care model of mental health to be successful in Australia, Government should do more to ensure consumers and clinicians are willing and able to use low intensity digital interventions. Clinical integration is a clear impediment to the development of a stepped care framework and uptake of low intensity treatment generally. Some doctors lack awareness of low intensity services, or are slow to recognise their utility, so do not refer patients to the most appropriate service for their needs. Government should conduct research to understand the barriers to community and clinical acceptance of low intensity digital treatment, and deploy consumer and clinician awareness campaigns focussed on the national digital mental health platform. Addressing digital exclusion must be part of the solution.
- 5. Creating mentally healthy workplaces:** Strengthening workplace regulation to reduce psychological injury, as outlined by the Productivity Commission, is commendable. However, the enormous costs of absenteeism and presenteeism due to mental ill health (estimated as between \$13 to \$17 billion annually) cannot be solved purely through a risk reduction approach or legal compliance. Government should continue to support the National Workplace Initiative, under the leadership of the Mentally Healthy Workplace Alliance, and in particular invest in implementation support for employers. As part of this initiative, workplaces need to be assisted and incentivised to employ best practice approaches that support inclusion and positive mental health and take into account business size and capacity, with a focus on small business.

## Attachment B

# National Children's Mental Health and Wellbeing Strategy

## Response to Consultation Questions

### Q1 Wellbeing continuum

***To what extent does the language used in the wellbeing continuum resonate with your experiences of mental health and wellbeing?***

We strongly support the adoption of a continuum-based model of children's mental health and wellbeing in the Strategy and the Commission's consultation on appropriate language use. To this end we make the following two recommendations:

- 1. Ensure language used in the continuum is non-stigmatising, non-medical and appropriate across all relevant settings for children and families.** Drawing on our experience working with early years services and in education settings through Be You, we recommend modifying the proposed language to ensure the model can be applied across all settings where children live, learn and play, including early years services, schools and community settings. For example, the use of the term 'unwell' is most relevant in clinical settings, but may be stigmatising for children and families, when applied in community-based settings. As an alternative example, our Be You Continuum Model uses the terms 'flourishing', 'going ok' and 'severely impacting everyday activities'. This model was developed in collaboration with educators and clinicians and uses language that resonated in both health and education settings.
- 2. Undertake broader consultation with families, communities, services, and educators, to determine the most appropriate language to be used in the continuum.** We took this approach to the development of anchor points for our own mental health continuum model. This process involved three rounds of co-design with community members reflecting the diversity in the Australian community. While this continuum was not specifically designed for children and families, this feedback helped us create a continuum model using language that resonates with the communities we support. This has resulted in widespread use of the model across a range of settings that we work in. We would be happy to share this co-design approach with the Commission to help in developing the right language and anchor points for the continuum.

### Q1 Wellbeing continuum

***Q. The Strategy acknowledges that the specific words used to describe the anchor points of the wellbeing continuum are not firmly established. What words would you suggest best describe the key anchor points on the wellbeing continuum?***

See response to Q1 above.

### Q2 Parenting programs

***The Strategy proposes that parenting programs be routinely offered to all parents/carers. What might help encourage parents and carers to engage with (parenting) programs? See also pages 36 -7.***

We commend the recommendation to routinely offer parenting programs to all parents/carers and make the following six recommendations to drive engagement and uptake:

- 1. Proactively address barriers to parent engagement through inclusion of explicit actions in the Strategy.** The Strategy highlights barriers to accessibility of parenting programs, including cost, access to childcare, inconvenient times and locations, however, there are no actions outlined to

address these barriers. As such we recommend the Strategy includes an action to address the range of barriers to accessing parenting programs.

2. **Promote the programs through existing parenting and family services.** The promotion of parenting programs should be integrated into existing mechanisms where parents are currently engaged, such as antenatal classes, maternal child health nurse visits (and the associated 'book'), early learning services, schools and health services, as well as existing government initiatives such as Be You and the [National Workforce Centre for Child Mental Health](#). This would ensure educators and health and community service providers promote programs using consistent concepts, language and approaches.
3. **Ensure that the method used to deliver parenting programs reflects the preferences and needs of parents/carers.** Much of our community engagement work across our programs and initiatives has confirmed consistent preference for a mix of face to face and online delivery. Ensuring parent/carer choice of, and preference for, different modes of program delivery will increase engagement and uptake.
4. **Use non-stigmatising, strength-based language.** We agree with the Commission, and the evidence from the [FrameWorks Institute in partnership with the Parenting Research Institute](#), that the language used to describe parenting programs is critical in engaging parents and carers. The language must set a positive, strength-based tone and focus on empowering parents and carers to support the development needs of the child. If programs are promoted as addressing 'problems' there is significant risk that parents will feel stigmatised and will be less likely to engage with them.
5. **Promote the opportunity for ongoing connection between parents and carers.** The Strategy should emphasise that parenting programs can provide the opportunity for connection, both face-to-face and online, with other parents and carers. We know that this opportunity for peer support and sharing of common experiences can be a particularly powerful way of encouraging engagement of parents and carers.
6. **Ensure programs are adapted for the local community and offer culturally safe and accessible material relevant to the local community.** Program content should be made available in several formats, with engagement approaches, conceptual translations, and modifications where required to support localised delivery that is compatible with culture, language and customs. Local, community organisations such as Primary Health Networks and local councils are well positioned to provide insights about the needs of their communities and ways of engaging local community groups. In addition, digital approaches can support wider distribution and engagement with options to customise content and connect families at the local level.

## Q2 Integrated care model

***Would the integrated model (Box 3) help to achieve the objectives outlined in Focus Area 2? What do you consider critical to this model working?***

We welcome the proposed model of integrated child and family care and strongly believe this is a critical first step to reforming the current services system and addressing the significant gaps in the system.

We believe the following elements are critical to the model working:

1. **Inclusion of mental health support across the continuum of care, from prevention and early intervention support, through to treatment for severe and complex mental health conditions.** This will enable it to achieve its intended objectives and help ensure that every child and family can consistently access practical, evidence-based information and support.
2. **Clear governance arrangements must be in place.** This includes additional, ring-fenced funding; clear roles and responsibilities; integration with other services across health, education, and social services; collection and reporting on outcomes; and community co-design and involvement in local governance structures to ensure the model meets community needs.
3. **Integration of the model with other community-based and social services for families and children and ensuring strong linkage and referral pathways exist.** This will enable greater



accessibility to clinical support for families and children and could allow for referrals into the integrated care model from community-based organisations and early years and education settings.

## Q2 Integrated care model

### ***What changes would you suggest to the model to make sure it achieved the stated objectives?***

We recommend the following changes to ensure the integrated model achieves the stated objectives:

- 1. Embedding a prevention focus within the integrated model.** This will ensure the model recognises the 'healthy' end of the continuum, and enable bolder action on prevention, with clear strategies that focus on functioning and supporting positive mental health and wellbeing, not just treatment. For example, targeted prevention would include identifying children and families at greater risk of severe mental health conditions and expanding the integrated model to include more holistic psychosocial and family supports for these children. These supports could include peer activities for children, family-focused interventions, supports addressing violence, and supports that address other adverse childhood events.
- 2. Ensuring low-intensity, early intervention support is a critical part of the model.** This is fundamental to creating a child-centred mental healthcare system, where children and families can access effective services that match their support needs and preferences. Getting help early in the mental health continuum, when children are experiencing some challenges to their mental health, can help to prevent deterioration to the point where children are struggling or unwell. We suggest families should have accessible, available, and affordable low intensity supports, including online, telehealth and face-to-face options, to ensure access to a service that best meets their needs. For children, this could include options such as [BRAVE-Online](#). For adults, it could build on the success of our low intensity cognitive behavioural therapy program, [NewAccess, and other](#) evidence-based low intensity models, such as MindSpot. Low-intensity support for children and families has also been successfully trialled in the UK, where families can access a programme of low-intensity CBT interventions, starting from the perinatal period.
- 3. Expanding the proposed workforce to include peer workers.** This will enable the model to provide a more holistic service including psychosocial and family supports. Please refer to Q3 Skilled Workforce below for further information to support this recommendation.

## Q3 Skilled workforce

### ***What additional actions may be required to ensure there is a sufficient skilled workforce (proficient) in child and family mental health?***

We welcome the actions to support a skilled workforce in child and family mental health, including incentivising training opportunities for mental health professionals to work in regional and remote areas; developing the cultural competency of health professionals; and incentivising existing service providers (such as GPs) to complete training in children and family mental health.

There is potential to expand the workforce that supports child mental health beyond the clinical workforce, as described in [The Lancet Commission on global mental health and sustainable development](#) (2018). **We recommend including an action on expanding the child and family mental health workforces, to include non-clinical, peer and lived experience roles.**

We have developed and expanded the non-clinical workforce through [The Way Back Support Service](#) and [New Access](#). Both services have had success in supporting people experiencing distress through trained and clinically supervised support coordinators (for The Way Back) and coaches (for NewAccess). In addition to expanding the workforce available to support people experiencing distress and crisis, this approach supports a stepped care model that facilitates access to low intensity care before calling on more intensive

clinical support. This model enables the recruitment of local community members to provide support, which can improve the accessibility of care, particularly for people living in rural and remote areas. It has also utilised digital technologies including phone and video appointments, which have successfully engaged people who may have difficulties accessing face-to-face support.

The role of the **peer workforce** has been emphasised in action 16.5 of the [Productivity Commission Mental Health Inquiry](#) which noted the importance of alternative workforces. The Commission recommended a focussed effort to increase provisions for the peer workforce including the creation of a professional association for peer workers and a program to educate health professionals about the role and value of peer workers (Action 16.5). Likewise, the interim report from the [Royal Commission into Victoria's Mental Health System](#) also emphasises the importance of **lived experience roles**. The informal role families play in supporting each other, and the potential to formalise some of this support through specified roles, could strengthen the Strategy. The Victorian Royal Commission has suggested earmarked lived experience roles could span service design and delivery, service and system leadership, research and evaluation, and system accountability and oversight. This also applies to child and family mental health.

### Q3 Skilled workforce

***What could be done to facilitate a skilled child and family mental health workforce that is equitably distributed, including across rural and remote areas?***

We recommend the Commission refers to the Productivity Commission recommendations on facilitating an equitably distributed workforce across rural and remote areas. This is comprehensively addressed by the Commission and recommendations are compiled in [Finding 16.1 – Supporting the rural, regional and remote mental health workforce](#).

We believe the following recommendations made by the Productivity Commission would greatly assist with facilitating an equitably distributed workforce to support the mental health of children and families:

- increased scope for GPs in regional Australia to consult psychiatrists in other parts of Australia about how best to help individual consumers (**Action 10.3** in the Productivity Commission Final Report).
- increased use of videoconference and telephone for people to interact with, and receive therapy from, their psychologist or psychiatrist. (**Action 12.2** in the Productivity Commission Final Report).

Expanding the child and family mental health workforce – as outlined above – will also facilitate a more equitable distribution of the workforce.

### Q4 Supporting educators

***Do the actions outlined in Focus Area 3 capture the role educators should play in supporting children's mental health and wellbeing?***

**Educators play a critical role in supporting children's mental health and wellbeing in early childhood settings and classrooms, and the actions in Focus Area 3 do capture part of this role.**

Educators are a source of support for the children they educate, have connections to children's families, actively demonstrate inclusive practices in their education setting and both identify and support children experiencing mental health or wellbeing challenges. Independent market research by IPSOS commissioned by Beyond Blue (2020) found that 94% of participating educators agreed that supporting the mental health and wellbeing of learners is part of their job (up from 86% in 2018). The COVID-19 pandemic has reinforced this, through their role working with both children and their families over 2020. Educators also need to maintain their own mental health and wellbeing.

**We recommend four additional actions to better support educators in their role supporting children's mental health and wellbeing:**

1. **Strengthening the mental health and wellbeing pre-service curriculum for pre-service educators.**

Educators have emphasised time as the single biggest barrier to them to undertaking professional development and further training. Beyond Blue supports Action 3.3e to have paid protected time for educators to participate in professional development on mental health skills and knowledge. However, to help set up future educators with a strong knowledge base in mental health and wellbeing prior to entering education settings, pre-service curriculum should include mental health and wellbeing. This would enable educators to have the time to build knowledge and skills in their initial study and training, preparing them for placements and future roles. Action 2.5 in the Strategy to increase requirements for early career training in child and family mental health should consider the inclusion of relevant training for pre-service educators. Accreditation of initial teacher education programs, including early childhood education were included in the Productivity Commission recommendations (Action 5.4).

## **2. Recognising the important role of early childhood leaders and principals in creating a wellbeing culture**

Early childhood leaders and principals have an important role in creating and leading a wellbeing culture. The importance of leaders of early learning services and schools continues to be emphasised in research on effective and comprehensive health promotion, including influencing ethos and relationships within the learning community, supporting professional learning, and leading whole school planning focused on mental health (Be You Evidence Summary, 2018). This research suggests the need to specifically include content targeted at leaders, and implementation processes which link to routine planning and accountability requirements. The need to pay attention to the wellbeing of leaders and staff has also been highlighted and needs to be considered in the content and implementation of any whole school or whole-setting approach.

## **3. Supporting inclusive practices in education settings**

Inclusive practices are vital for ensuring that everyone, including children, families and colleagues, feels valued and respected and have access to opportunities and resources. A role of educators is to demonstrate inclusive practices in their education setting. Action 3.1a, should be expanded to more explicitly capture inclusive practices that schools are using, and ensure that policies and processes are proactively developed and implemented, not just reactive to a situation (for example, bullying).

## **4. Building and maintaining constructive relationships with families before a concern arises**

While connection to family is a strong focus across the Strategy, this is a part of an educator's role through a whole learning community approach. Educators in early learning services or schools need to know how to work effectively, sensitively, and confidentially with families (who can have a diversity of circumstances) to foster the mental health of children and young people. To enable action 3.2c, teachers can proactively build relationships with families, so that if a concern arises, discussions can be based on an existing trusting relationship.

## **Q4 Supporting educators**

### ***Does the Strategy sufficiently outline the additional support, training and/or system amendments educators would need to facilitate change?***

The Strategy includes actions that can support educators to facilitate change. However, as noted above, there are additional actions that we believe should be considered to increase the overall impact of the Strategy. Recommendations from [The Lancet Commission \(2018\)](#) outline that the most effective mental health interventions use a **whole-school approach** in which social and emotional learning is at the forefront of the school ethos. To deliver on the Strategy's intent of creating an optimal mental health system for children, a critical focus for change should be on *both* educators and whole of learning communities. This focus underpins the design and purpose of Be You - to create mentally healthy learning communities across Australia.

**Be You is an evidence-based, fit for purpose, highly scalable framework that is available now to guide the implementation of Focus Area 3 of the Strategy.** Be You was designed with educators and other experts as Australia's national mental health in education initiative and includes an online platform of content, implementation and monitoring tools and professional development supported by a national network of

skilled consultants. Be You is funded by the Commonwealth Government and delivered by Beyond Blue in collaboration with service delivery partners Early Childhood Australia (ECA) and headspace.

Be You:

- Provides early learning services and schools with end-to-end support and capacity building from promotion and prevention to early intervention and postvention.
- Includes a continuous improvement philosophy and alignment with national and State/Territory quality standards and teaching requirements.
- Brought together and integrated five separate programs to create clarity, consistency and continuity to educators and their students and families.
- Provides a framework to ensure that time poor educators know where to turn for guidance in supporting mental health, rather than being confused by a plethora of competing and disintegrated options.

Be You includes a flexible and accessible online platform – backed by a trained workforce– that assists schools and learning services to:

- Develop or upgrade their mental health strategies.
- Empower educators to support the mental health of their students.
- Create links to services and supports through the Be You Programs Directory – a searchable database of mental health and wellbeing programs for children and young people from a wide range of providers.
- Involve parents and carers in supporting the mental health of their children and young people. Respond when a critical incidence occurs.
- Support educator self-care.
- Support anyone studying education to prosper in the workplace through developing their mental health literacy before they enter the workforce.

**Be You has already had immediate impact and achieved deep reach:** over 10,000 early learning services and schools and nearly 130,000 individual educators across Australia are participating. In a recent evaluation of the first nine months of implementation found that Be You had:

- (a) increased awareness among educators and education settings about children’s mental health;
- (b) increased insight into child behaviour and how to respond to it;
- (c) supported development of a common mental health language among educators; and
- (d) created confidence in discussing mental health with colleagues, children, young people, and families.

(Deloitte Access Economics (2020), Implementation evaluation report. Unpublished)

**We strongly recommend that the existing framework, infrastructure, capability and expertise of Be You is leveraged to implement Focus Area 3 of the Strategy. It is purpose-built and ready to use. Utilising Be You in this way will maximise the value and impact of the government investment in Be You, prevent further system duplication, and drive the growth of Be You to ensure it achieves its vision: *That every learning community is positive, inclusive and resilient – a place where every child, young person, educator and family can achieve their best possible mental health.***

## **Q5 Children and families who are struggling**

***How would you recommend we reach children and families who are struggling, systematically across the country?***

We support the Strategy’s strong focus on supporting children and families who are struggling and the systematic approaches to reaching these children and families outlined in the Strategy. For example,

through the provision of universal supports such as the promotion of parent helplines and antenatal courses, and by taking a broad approach to consider all settings in which children should be supported.

We recommend the following actions to systematically reach children and families who are struggling:

- 1. Better alignment between education and health sectors.** This will help to reach children and families who are struggling by ensuring referral pathways that are focused on connecting children and families with services that best meet their needs. Strong links with local agencies already implementing stepped care, such as Primary Health Networks and Local Health Districts, should be included in the Strategy.
- 2. Include actions to support children in severe crisis, including those experiencing suicidality or recovering from a suicide attempt.** Suicide is [the leading cause of death](#) in Australia for children aged 5-17 years. The Royal Commission into Victoria's Mental Health System found that there are significant service gaps to support children in this age group, following a suicide attempt or self-harm. The Commission concluded that appropriate and specific services are needed for children and young people at risk of suicide. These gaps are a key motivation to include suicide prevention and self-harm as part of the national Strategy to address child mental health and wellbeing.
- 3. Whole of community response for hard to reach, high-risk groups.** We support the Commission's suggestion of more enhanced responses to those high-risk groups who are hard to reach, using alternative touch points such as Centrelink and specialist support services that may interact with these groups (as outlined in Box 2 in the Strategy). We also agree with the Commission that a whole of community response is necessary to reach everyone in need; a suggestion that aligns with both the Productivity Commission and the Vision 2030 framework. This requires a well-connected network of services working in an integrated and seamless way.
- 4. Adopt place-based models to reach children and families with increased risk due to social conditions such as poverty, poor housing or domestic violence.** For example, the Centre for Research Excellence (CRE) in Childhood Adversity and Mental Health is undertaking research to design systems-based approaches that identify and respond to childhood adversity from before birth to the early childhood and primary school years. The approaches are being co-developed with families and professionals that will use the services in their local community and will be piloted in two communities: Wyndham in Victoria; and Marrickville in New South Wales. The design will encompass two hub sites in each community: a community health centre for families of children 0-5 years and a primary school for families of children 5-8 years. The [model](#) is a scalable solution where the hub sites will include a range of co-located health services and social services that will work together and in partnership with the community to help families to address the issues they are facing as well as their child's mental health.

## Q5 Children and families who are struggling

***Are there any additional actions necessary to improve the mental health and wellbeing of children who may be struggling, such as those in the care of the State?***

Refer to our response and recommendations in Q5 above

## Q6. Measuring progress

***What additional indicators of change would you suggest should be included to measure progress against the Strategy's objectives?***

We welcome the Strategy's approach to measuring progress against its immediate objectives. It is well considered, robust and comprehensive. However, the indicators of change for each focus area will only measure *immediate* outcomes. The Strategy must include a **long-term impact evaluation, focused on behaviour change**, to ensure the broader long-term impacts of all program activities are being measured.

We recommend that a **program logic is developed for this Strategy**, before the commencement of implementation, to ensure that a long-term impact evaluation is embedded.

## Measuring progress

***Are there other challenges to undertaking research on child and family mental health and wellbeing that are not broadly captured in the Strategy?***

We note five challenges to consider when undertaking research on child and family mental health and wellbeing:

1. **Properly fund and embed evaluation from the outset.** One of the biggest challenges to measuring progress is failure to properly fund and embed evaluation at the outset. Evaluation should be pivotal, not an optional extra, and it must be well funded. Funding may need to occur across grant and funding cycles. The Strategy should outline funding principles that allow for evidence and learning to be better shared, with support for genuine learning.
2. **Ensure meaningful monitoring and evaluation.** We recommend the meaningful monitoring and evaluation of all services and activities that aim to support children and families. This should include:
  - a. A formative, process and outcome evaluation.
  - b. Early development of evaluation frameworks that is embedded in program/service design.
  - c. A mechanism to capture and share learning and continuous improvement.
  - d. Knowledge of the enablers and barriers required for implementation of programs and services to achieve outcomes.
  - e. A consideration of implementation context wherever possible, for example, location and population groups, so we can understand for whom did it work and why.
  - f. A deep understanding of the voices of children and families – what do they think worked and why?
  - g. The outcomes that matter the most to children and families, rather than the outcome that matters most to clinicians or services.
3. **Ensure evaluation support for community-based organisations.** Community-based organisations without in-house expertise could benefit from additional support with monitoring and evaluation.
4. **Partner with services and settings that work with children and families.** The Strategy recognises ethics approval as a key challenge when undertaking research on child and family mental health. From our experience with Be You and through implementing the [Children's Resilience Research Project](#), we know this challenge can be overcome. We recommend partnering with services and settings that already work with children and families as one of the best strategies to undertaking ethical research.
5. **Ensure there is national cross-sectional data, not just longitudinal data relating to child mental health and wellbeing.** This will be a key enabler of future evaluations on child and family mental health. We support a national data strategy to measure child mental health and wellbeing.

## Measuring progress

***What further actions need to be taken to encourage more service evaluation in clinical work?***

No comment

## Q7 Diverse communities

***Which of the Strategy's objectives and actions do you consider most critical to improving the mental health and wellbeing of children and families from: Aboriginal and Torres Strait Islander communities?***

We support strong community and cross-sector engagement in the Strategy design, and ongoing representation on the proposed Inter-Departmental Committees, including Aboriginal and Torres Strait Islander people, parents, carers, children and young people.

We support the prioritisation of Aboriginal and Torres Strait Islander organisations as the preferred providers of activities to promote social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples, and acknowledge Aboriginal communities have the solutions for creating a culturally responsive, sustainable, self-determining mental health system.

We particularly support the following Strategy objectives and actions: 1.1b, 1.2a-c, 1.3a-b, 2.3 e-g, 2.4c, 2.4 e, 2.5 e.

### **Q7 Diverse communities**

***Are there any additional actions you think are necessary to improve the mental health and wellbeing of children and families (from the above group)?***

In addition to ACCHOs, mainstream services should also be equipped to provide culturally responsive support to all children and young people, and to overcome gaps where the current systems do not have capacity to support community.

### **Q7 Diverse communities**

***Which of the Strategy's objectives and actions do you consider most critical to improving the mental health and wellbeing of children and families with disability?***

The actions articulated in the Strategy that relate to promoting wellbeing and early intervention (1.1b, 1.1g, 1.2a, 1.3a, 2.3 a-g, 3.1 a-h) are critical for children and young people with a disability and their families and carers. In many cases, there is a need for these types of low intensity options for families and carers, as much as for the children and young people impacted by disability. However, the current service system provides few options for support, with most services focusing on higher intensity needs. Supporting growth in this area of the system can set families up to maintain good mental health and reduce the need for more costly supports at a later stage.

### **Q7 Diverse communities**

***Are there any additional actions you think are necessary to improve the mental health and wellbeing of children and families with disability?***

Clear and accessible supports for family and carers of children and young people with a disability is vital to improve mental health and wellbeing, particularly in the earlier years before, and shortly following, a diagnosis. Many families find themselves flailing due to the complex nature of the system and the need for literacy and financial support to navigate and access the appropriate services.

### **Q7 Diverse communities**

***Which of the Strategy's objectives and actions do you consider most critical to improving the mental health and wellbeing of children and families from rural and remote communities?***

The role of family and community, particularly for promoting wellbeing, is critical for improving the mental health and wellbeing of children and families in rural and remote Australia. As such, focus and priority should be given to community-driven solutions that can fill a void or leverage existing support options or social networks to assist children and families.

## Q7 Diverse communities

***Are there any additional actions you think are necessary to improve the mental health and wellbeing of children and families from rural and remote communities?***

Digital solutions are a critical system element for supporting children and young people living in rural and remote communities. While they should not replace face-to-face opportunities for connection or care, they should form part of an integrated system to enable equitable access to services and supports. In planning support for rural and remote communities, access to services should not be limited to clinical care provided through telehealth. Consideration should be given to access broader prevention and early intervention focused programs and peer support forums. Digital inclusion must also be considered – including access to technology, digital literacy and affordability.

## Q7 Diverse communities

***Which of the Strategy's objectives and actions do you consider most critical to improving the mental health and wellbeing of children and families from CALD communities?***

For culturally and linguistically diverse communities, the principle of universality in the Strategy will be most critical, particularly for newly arrived migrants and refugees who may not have strong knowledge of the health system or share western concepts and knowledge of health and wellness. It is important to leverage co-design opportunities to improve knowledge, literacy and navigation to ensure children and families can access the support they need.

## Q7 Diverse communities

***Are there any additional actions you think are necessary to improve the mental health and wellbeing of children and families from CALD communities?***

Stigma may be an issue to overcome to improve access to services. As such, taking the services and supports to where the communities are, will be critical to ensuring those who need care can access it. The model proposed in the Strategy of outreach could work well, provided development and implementation of such models are done in partnership with the communities it seeks to serve.

## General feedback

***What avenues should be used to promote the Strategy upon publication, to ensure it reaches as many people as possible?***

We recommend the following two key actions to ensure successful promotion of the Strategy:

- 1. Clear commitment from Government to implement the Strategy actions and to do the foundational work required to support implementation.** This must happen before determining avenues for Strategy promotion. A key element of successful promotion of the Strategy is ensuring clarity on which actions Government will commit to implement, how these actions will be funded, how the Strategy will be governed, identification of clear roles and responsibilities, and a commitment to evaluating the Strategy. We support the implementation approach for the Strategy outlined in section 4.1, including the establishment of a National Steering Committee to develop an implementation plan and Inter-Departmental Committees at the Commonwealth level to oversee implementation.
- 2. Collaborative approach to promotion.** We recommend that the promotion and implementation of the Strategy focuses on bringing together organisations and individuals that can collectively design and implement the systematic reform outlined in the Strategy. There must be strong alignment and integration with other mental health and suicide prevention reforms, such as the Commonwealth Government's response to the Productivity Commission inquiry, and the Victorian Royal Commission into Mental Health.



We recommend the following three actions to promote the Strategy to organisations and stakeholders:

- 1. For launch, undertake a national roadshow.** This should be accompanied by a clear plan for rollout that clearly articulates the benefits for each stakeholder and targeted support for collaboration amongst organisations. Access to the tools and resources necessary to fully adopt the Strategy should be provided at this time.
- 2. Devise an integrated (digital and traditional media) strategy targeting national and niche children, family, education and relevant professional workforce press.** This could be accompanied by a social media campaign.
- 3. Use existing social networks organically built through contact with maternal and child health, educational settings, sport and other community settings.** A systematic education program, inclusive of plain English tools and resources, to roll out the Strategy's scope and how it must be incorporated into the strategies, policies and procedures for all these settings would be required.

We recommend the following actions to promote the actions within the Strategy to organisations:

1. Promote evidence-based, locally available or online supports and services to children and families through intermediaries such as schools and early childhood learning services, maternal health nurses, and community networks.
2. Promote Be You as a vehicle to deliver key elements of the Strategy.
3. Openly communicate the evaluation results for child mental health and wellbeing programs that are being delivered, including both positive and negative outcomes.

We recommend the following actions to promote the actions within the Strategy to families:

1. Ensure that evidence-based resources, that provide practical suggestions on how families can support children's wellbeing, are made easily accessible and promoted widely. These must include specific resources for families where there are additional physical, neurodevelopmental, or cultural needs, developed via genuine co-design.
2. Implement a nation-wide campaign aimed at promoting the availability and value of parenting programs, with specific efforts to address stigmatising attitudes towards participation in such programs.
3. Promote parent helplines and hotlines (available in each state and territory) as the first 'port of call' for any parenting concerns.
4. Plan and implement a program of activities (e.g. campaigns) to increase parents' and carers' understanding of how to promote wellbeing and positive mental health at home and the signs that extra support may be needed. These activities should directly address any common myths or misconceptions about child mental health and wellbeing.

## General feedback

***Please provide any additional feedback you would like considered regarding the strategy.***

We welcome the Strategy as comprehensive reform is required to create a well-resourced and integrated system. Significant integrated reform across community, education and service settings is needed to enable identification of children in need of support and to ensure appropriate services are readily available.

Additional feedback not covered in previous questions is outlined below:

### **A whole of government approach is critical.**

A bipartisan, whole of government approach is critical to guide investment in children's mental health and ensure that there is a clear understanding of roles and responsibilities. System-level enablers that are needed to ensure the Strategy is effective include additional ring-fenced funding, clear roles and responsibilities, collection and tracking of outcomes and leveraging existing capabilities.

The Strategy's implementation will require work across multiple layers of government and delivery mechanisms. As such, successful implementation requires a joined-up approach. Implementation of the Strategy could be piloted as a demonstration of the approach recommended in the Productivity Commission Report.

The Strategy should also include an overarching framework to support a comprehensive, integrated national system which includes practical information, education programs and in-person support such as home visiting to support children during the critical early years and at key life-stage transitions. This could further outline a children's mental health system across the continuum of care, to enable every parent to consistently access practical, evidence-based information and support they need to raise thriving children.

### **The Strategy must align with other strategies**

It is critical that the opportunities included in the Strategy are aligned with the recommendations of other major mental health reviews and reports including the [Productivity Commission's Final Report](#), to ensure meaningful consolidation and appropriate resourcing.

### **Additional feedback on diverse communities**

#### **LGBTIQ+**

The lack of focus or consideration given to children and young people who identify as LGBTIQ+ is a major omission in the Strategy. The 0-12 years developmental period is a crucial time for LGBTIQ+ children and young people and their mental health is central to this. The system must be built to support these children, to enable them the same opportunity to experience good mental health and access support when required.

The intersectionality of children, young people and families' experiences should also be considered to ensure the system can meet people where they are, and where they need support, regardless of which 'box' they fit into.

#### **Addressing racism**

The impact of racism, including structural racism should be addressed to support thriving children and families, and mitigate the potentially detrimental effects of all forms of discrimination. Our [Invisible Discriminator campaign](#) is one example of a national campaign which aims to raise awareness of the impact of discrimination on mental health of Aboriginal and Torres Strait Islander people.

# Attachment C

## Vision 2030 Consultation Response

### Part II: Priorities



### Q10. Do you agree with the identified priorities?

Yes, we believe the six priorities are the right priorities to enable a successful, connected, and well-functioning mental health and suicide prevention system that can better meet the needs of all people in Australia.

In particular, we welcome the focus on wellbeing in Vision 2030. Elevating the promotion of mental wellbeing, creating a system that values wellness and recognises the influence of social determinants of mental health is long overdue. We also welcome the priority of delivering quality, personalised care. However, it is important that the proposed actions for this priority area are expanded, to ensure that lived experience is embedded across the entire mental health and suicide prevention systems, as per the 'Principles for Delivering Vision 2030'. There is a gap between the intent of Vision 2030 and the proposed priority actions in the Roadmap.

### Q11. How would you rank the priorities?

It is difficult to rank the priorities, as achieving comprehensive reform requires action on multiple fronts. Delaying or devaluing individual priorities risks not achieving system reform.

We strongly support the Commission's emphasis on 'improving wellbeing'. We know that many common mental health conditions can be prevented. Yet, prevention has not previously been prioritised in the mental health system. The recently released 'Consensus Statement' (Prevention United, 2020) succinctly outlines the advantages: 'enhancing our focus on prevention will strengthen individuals and communities, save money, and save lives'.

### Q 12. What do you see as the main challenge with implementing the vision 2030 priorities?

The mental health and suicide prevention policy landscape is complex. There are multiple national and state-based inquiries currently being completed, which have the potential to result in further policy and service fragmentation including: the Productivity Commission Inquiry into Mental Health, the Royal Commission into Victoria's Mental Health System, the Royal Commission into Aged Care Quality and Safety,

the National Children’s Mental Health and Wellbeing Strategy, the National Preventive Health Strategy, the Primary Healthcare 10-year plan, the MBS review, the National Suicide Prevention Plan, a National Natural Disaster Mental Health Framework, the National Mental Health Workforce Strategy and the renewal of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The main challenge with implementing the Vision 2030 priorities is the need to have one national plan and set of priorities, which guides all further actions and investments, and can be used to monitor our progress.

The one plan and set of priorities should enable:

- Alignment between jurisdictions and strong leadership to drive change. We support the development of a National Wellbeing Framework to inform the establishment of a new National Mental Health and Suicide Prevention Agreement. The Framework could also be used to provide consistency to other agreements, for instance, those connected to outcomes outside health portfolios.
- Collaboration and support across all levels of government and the community to deliver an integrated system that supports the delivery of person-centred care, at a local level. Strong stakeholder partnerships are a key principle of Vision 2030, but these relationships take time to develop and require an ongoing commitment to resourcing to sustain them for the long term. In addition, engagement with diverse groups including people at different life stages, carers and consumer groups, needs to occur regularly over time and requires ongoing investment and monitoring. This should be supported by additional funding to organisations in recognition that these demands exist above and beyond normal service delivery.
- The use of research, evaluation and ongoing quality improvement processes to measure the impact and effectiveness of cross-jurisdictional and cross-departmental actions. A deeper understanding of social determinants and their impact on mental health should be captured in the ‘National Wellbeing Framework’ and will require a commitment of funding and accountability by whole of government. Measuring the impact of this will be challenging but will be critical to judging the success of the priorities and adapting as necessary. This action and monitoring currently sits within the second phase of change (years 3-5) of the vision, however these activities should be resourced from earlier in the implementation stage to capture the journey of changes and reflective learnings.

Part III: Opportunities

### **Q 13. Does the Roadmap have the right opportunities to achieve Vision 2030?**

Beyond Blue broadly supports the opportunities identified in the Roadmap to achieve Vision 2030 – however it is critical that these directly align with the Productivity Commission’s recommendations, so that we have one set of reform priorities that are guiding investments and actions.

The most important opportunity to achieving Vision 2030 is the positioning of people with lived experience at the forefront of change. A person-centred approach requires a cultural shift which is acknowledged as a priority in all reform strategies in the current context (see response to Q12). The significance of this shift cannot be underestimated. While a person-centred approach is embedded throughout the Roadmap, it will require dedicated attention to be properly fulfilled. This should include either a dedicated stream of activity and indicators, or inclusion of lived experience across every priority area. According to the Productivity Commission, this is the factor by which all other elements of reform are judged – if it doesn’t work for the people who need the system most, it doesn’t work.

The opportunities outlined within the ‘improving wellbeing’ section are exciting new approaches to addressing and preventing many of the factors associated with poorer mental health. Recognition of the impact of social determinants and the need for better integration within the service system is well evidenced. Implementing funding transition strategies to better resource prevention and health promotion is also strongly supported. This should include setting specific targets for the proportion of the budget allocated to these areas to significantly reduce the incidence of mental ill health and the long-term costs associated with this. Opportunities for improved accountability for funding based on new data mechanisms and outcome measurements are critical to achieving the vision.

## Q14. Are there other opportunities you would like included?

The need for mental health reform in Australia is so strong that there will always be more to do. This has resulted in an abundance of reviews, inquiries, emerging strategies and plans that currently appear to lack any cohesive drive to bring them together. It is critical that the opportunities included in the Roadmap are aligned with the recommendations of the Productivity Commission and other major reviews, so that further fragmentation is avoided and a process of meaningful consolidation can commence.

Some examples of other opportunities, that should be included within a consolidated plan, include:

- **Developing mental health hubs for children and families.** The importance of children’s social and emotional development in the early years is well-established, however a comprehensive system of support for Australian children and families is still lacking. In addition to existing youth services and the proposed hubs for adults, mental health hubs for children and families should also be actioned. These hubs should be codesigned to meet local community needs, and informed by evidence-based practice, including the Centre for Research Excellence in Childhood Adversity and Mental Health (<https://www.childhoodadversity.org.au/>), co-funded by Beyond Blue and the National Health and Medical Research Council.
- **Developing a comprehensive range of low intensity support options.** Digital low-intensity supports are an integral component of a more comprehensive mental health system, and should be combined with telehealth and face-to-face options, to ensure that people can access a service that best meets their needs. This should build on the success of Beyond Blue’s low intensity cognitive behavioural therapy program, NewAccess.
- **Prioritising Aboriginal and Torres Strait Islander organisations** as the preferred providers for mental health and suicide prevention activities for Aboriginal and Torres Strait Islander peoples. Aboriginal communities have the solutions for creating a culturally-safe, sustainable, self-determining mental health and suicide prevention system – providing they are sufficiently resourced and enabled to do so. This cannot be a long-term action for reform – it must happen now. We need to ensure that long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing is prioritised from the outset.
- **Building on current programs, services and capabilities.** There is significant potential to achieve system reform by building on the mental health and suicide prevention sector’s current capabilities. For example, Beyond Blue’s Be You initiative (<https://beyou.edu.au/>) is in a unique position to inform the “strategic policy on social and emotional learning in the education system, including the development of national standards for teacher training”, given its significant reach to over 10,000 Australian education sites, and alignment with national and State/Territory quality standards and teaching requirements. Likewise, Beyond Blue’s Coronavirus Mental Wellbeing Support Service has demonstrated what an integrated digital and telehealth service looks like – through strong referral partnerships with Reach Out, Lifeline and Mind Australia – that could be extended to better meet community needs. These existing initiatives should be built on, to drive reform efforts.

## Q15. What impact will the proposed opportunities and priorities have on you or your organisation?

Many of the proposed opportunities and priorities are aligned with the strategic directions of Beyond Blue including:

- Promoting mental health and wellbeing
- Tackling stigma and discrimination
- Streamlining access to services
- Investing in knowledge through research, evaluation and innovation
- Using data insights to continually improve service responses and tailor these to individual needs
- Supporting schools and educators to improve student wellbeing
- Extending the availability of low-intensity services so that people get access to the support they need wherever they are in the spectrum of stepped care

- Supporting vulnerable populations
- Improved integration between services both within and beyond the mental health sector
- Sharing data and insights to inform service planning, monitoring and evaluation.

We look forward to working with government to deliver Vision 2030, and using our role as Australia's most well-known and visited mental health organisation, to ensure that more people get evidence-based information, support and referrals to help with depression, anxiety and suicide prevention.

## Q 16. What can be done immediately or must be done first?

The immediate priority is to get national agreement on a plan and set of reform priorities, which guides further actions and investments, and integrates the recommendations and proposed actions from the many reviews and strategies currently underway or recently completed. Once this is clear, the role and sequencing of the Vision 2030 actions should also become more apparent.

Foundational actions should include:

1. Recentring the system around lived experience This is a fundamental cultural shift that has implications for all other areas of reform. All planning should incorporate lived experience from the first points of design, through implementation, evaluation and service improvement. Embedding the peer workforce is an important part of this shift.
2. The development of a National Wellbeing Framework, which can inform the National Mental Health and Suicide Prevention Agreement. The Framework should lay out the indicators that point to improved wellbeing outcomes for individuals and the community across portfolios and jurisdictions. These indicators should then be translated into meaningful targets and the process for accountability established.
3. The establishment of a national statutory authority with responsibility for setting, monitoring and evaluating Australia's progress in mental health and suicide prevention. This is especially important given the number of reform proposals, inquiries, strategies and plans currently being developed that impact upon Australia's mental health.

## Part IV: General

### Q 17. How would you like to see the Roadmap integrated with ongoing policy and reform?

The challenge in integrating the multitude of reforms will be ensuring oversight and accountability that works. To be effective, we need a central organising mechanism for mental health and suicide prevention reform for the next decade. The Roadmap could play a vital role in informing this mechanism by pulling together the most significant developments from major reviews. This means drawing on the key levers of a whole of government approach:

1. **Clarity of roles and portfolio responsibilities** – accountability will be essential to achieving integration. Devolving too much responsibility to a multitude of autonomous regional structures (such as PHNs or LHNs) sacrifices national consistency and the benefits associated with scaling up successful evidence-based programs across the country. Key reforms, such as the introduction of a National Suicide Prevention Office, should be overseen by structures that report into first ministers.
2. **Funding** – it will be important that cross jurisdictional agencies are resourced with sufficient funding and have accountability for delivering on overarching reform priorities (perhaps through the National Wellbeing Framework), not only the discrete elements (such as the National Mental Health and Suicide Prevention Agreement, or the standalone National Suicide Prevention Strategy).
3. **Data** – how we use data and the linkages between datasets will be critical for ensuring that actions are effective and can inform future policy development and reform. There are good opportunities for sharing data and insights to inform service planning, monitoring and evaluation. There are also significant opportunities to introduce outcome-based funding arrangements.

## Attachment D

### National Suicide Prevention Taskforce's Interim Advice consultation

#### Are the key areas of focus to achieving a national whole-of-government approach to suicide prevention covered by the recommendations? What are the most critical recommendations to achieving this approach?

The recommendations directly reflect and address the key areas of focus. The urgent need to do more, differently, to prevent suicide in Australia has generated the authorising environment and readiness for comprehensive reform among stakeholders and the community. This is represented by the vision that we move towards zero suicides, an ambitious and uncompromising goal that sets expectations high, even at the most challenging times, such as in the midst of a global pandemic. For this reason, classifying recommendations as 'prioritised' or at various degrees of 'critical' is extremely difficult, though pragmatism may demand such measures.

The task is further complicated by the nature of the problem, which requires a comprehensive response, so delaying or removing individual recommendations could compromise the integrity of the larger system.

Nevertheless, there are two key areas on which future progress relies and which act as connecting points for all the recommendations: embedding lived experience throughout the system (recs 3, 4 – especially with regards to peer workforce) and having dedicated structures that promote accountability, ensure the system is adequately resourced and continuously improves (recs 1, 2, 5, 6).

In addition to prioritising the implementation of structural, governance and performance scaffolding, it will be important to move quickly to implement tangible actions to improve services and supports for people on the ground. Recommendation 12 is therefore a critical recommendation. New models that create alternatives to emergency departments, safe spaces in the community (noting a scoping study has been commissioned by the Commonwealth) and universal aftercare, are three examples.

#### Are the recommendations feasible and able to be implemented? Why or why not? What considerations, barriers and enablers need to be understood?

The recommendations are detailed, considered and feasible. Implementation will require setting targets, timeframes and allocating significant funding from portfolios across government. We strongly support the focus on agile coordination and alignment across government, recognising that this requires strong leadership at every level, not least to deal with the perception that suicide is a Health Department responsibility.

The current public and policy focus on mental health and suicidal distress, seen through engagement with major inquiries and heightened by COVID-19, can be seen as an enabler, allowing decision-makers to take bold steps in a supportive environment. Setting up long-term systems and structures that encourage bipartisan commitment and accountability is vital to ensure that reform survives the political 'winds of change' that will inevitably arise.

#### Are there any critical gaps in the recommendations that need to be addressed?

A gap in the recommendations is a vision for how to keep track of people who engage with services, online or in person, so that suicide prevention is not simply a system of transactional episodes of care. This is especially important for people with complex needs, who may require case management and who would benefit from longer term relational engagement. In our submission to the Initial Findings, Beyond Blue recommended an integrated service system with a highly accessible doorway into care, behind which

tailored and compassionate supports could be offered. The population-level solution is a digital first approach that provides people in crisis with warm pathways into care when they need it, guiding them through a range of support options that meet their needs, follow up, and linkage into specialist services as required. However, we recognise that digital inequity is a challenge that means some people will need different solutions – a digital approach is just one, but an important, reform.

Beyond the recommendations for integrating crisis response and support through helplines, there could be further consideration of how to provide the *system* of suicide prevention supports and services to better utilise the benefits of digital platforms. These platforms – including moderated online peer to peer forums, apps and text based support and website concierge – can create connections for people in suicidal crisis, their carers and family members, and help guide them through the range of options available. Consideration must be given to how to use digital solutions to improve referrals and service linkage in a way that reaches everyone: not just replacing face to face engagement, but augmenting it and enhancing it, as needed, through affordable, reliable and accessible telehealth delivery.

Digital solutions have been addressed by the Productivity Commission's Inquiry into Mental Health, but without specific focus on suicidality. For instance, the Distress Brief Intervention could be made available through telehealth and platformed in a way that enables integration with other services.

### **Please provide any specific comments on the recommendations related to 'A shift to a national whole-of-government leadership and governance' (recommendations 1, 2, 3 & 4)**

Beyond Blue strongly supports the recommendations for a whole-of-government approach, especially the recognition of the centrality of lived experience. While the systemic and structural changes proposed are critical, the cultural shift towards placing the people most impacted, and with their own lived experience, at the centre and in every stage is foundational to the genuine reform we need.

In respect of the data, evidence and knowledge translation enabler of a whole-of-government approach (para 2.3), we support the proposal to develop co-designed outcome measures, commencing in 2021, for use in all future funding agreements and for ongoing evaluations. However, we suggest consideration be given to how this is achieved. There is benefit to a standardised data collection approach, including outcome measurement. However, this should be done knowing clearly the complexity and breadth of suicide prevention programs implemented at a national level, and the need for services to be able to use outcome measures that are appropriate for that specific intervention.

As stated in this section, what matters is the *way* a shift toward a whole-of-government approach takes place – there should be a collaborative, representative and considered process for the development of shared outcome measures and an outcomes framework, so that evaluation efforts are improved rather than simply standardised.

When this is achieved, there needs to be transition funding for service providers to build capacity and infrastructure to collect and report outcome measures. This is often overlooked.

On a related point, hard data is vital but so are qualitative insights.

### **Please provide any specific comments on the recommendations related to 'Improved data and evidence to inform decision-making' (recommendations 5 & 6)**

#### *Recommendation 5*

Beyond Blue supports the recommendations for governments to continue to work with the Australian Institute of Health and Welfare and remove the barriers to the routine sharing of relevant data with the National Suicide and Self Harm Monitoring System. We suggest there be an agreed activity timeline with



states and territories to enable the sharing of this data. We also recommend governments provide funding support for system improvement and capability building to enable this work.

We support the recommendation for governments to establish consistent definitions for suicide-related data and increase data capture for priority populations. This should be a core consideration of a national outcomes framework. That is, to draw a clear link between data being collected, system development and adaptation for that data capture, and, importantly, the purpose and benefit of collecting it: ensuring data and insights are shared and utilised to inform policy, programming and funding decisions. Capacity building on data literacy (including person-centred ways of collecting sensitive data), data management and reporting at the service level is important, especially for organisations managing multiple funding agreements and their corresponding, but often divergent, reporting requirements. It is important to strike the balance between the benefit of standardised data points and fit-for-purpose, tailored data points, including outcome measures. We want to ensure the move toward more consistent data and evaluation does not have the unintended effect of obstructing services in collecting the data they need to collect, or for innovative approaches to evaluation.

We strongly support the recommendation on improving data capture for priority populations. For LGBTIQ+ people, there is a lack of systematic data collection in population research and data collection in mental health services. As stated by the LGBTI Health Alliance, this exclusion has led to inaccuracy in reporting and significant underestimates (Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People, 2020). Collecting standardised demographic information on sexuality, gender and intersex status, as recommended by LGBTIQ+ recognised peak bodies, should be required for all suicide prevention activities (and ideally for all relevant cross-portfolio activities).

#### *Recommendation 6*

We support the recommendation for the development of an outcomes framework for suicide prevention programs and services. The way this is developed is critically important, allowing enough time for meaningful input from people with lived experience, Aboriginal and Torres Strait Islander peoples and other priority population representatives. Using a range of evidence-based indicators to measure the effectiveness of an intervention is important, particularly including the perspectives of people with lived experience.

An outcomes framework also needs to be sufficiently flexible to be relevant for a range of suicide prevention activities. It should articulate a review process and the mechanisms for how evidence is reported back. There should be a balance between optimising coordination and not stifling innovative approaches to evaluation.

An outcomes framework also needs to consider that evaluation is not just about measuring impact. There is great value and insight to be gained from formative/process evaluations, particularly for suicide prevention activities. It is critical that these kinds of evaluation approaches receive investment, alongside impact evaluations, to ensure we understand the detail of how and why programs work, not just their high-level effectiveness. This is particularly important for new and innovative suicide prevention activities.

Finally, there should be specific focus on opportunities for knowledge sharing and dissemination across both targeted suicide prevention activities and whole-of-government efforts while a knowledge brokerage function is being established. For instance, sharing findings from evaluations should be facilitated in real-time where possible, so the sector is able to learn from interventions as they are being implemented. Publishing evaluation findings can also assist in broader policy development.

There are a range of suicide prevention activities, including trial and pilot activities, across Australia that are adopting a localised approach. As the Productivity Commission's Inquiry into Mental Health has recommended, evaluating the effectiveness of these localised initiatives and publishing findings is integral to a broader understanding of what is effective in suicide prevention for different groups and in different parts of Australia.

## Please provide any specific comments on the recommendations related to ‘Policy and cross-portfolio approaches to reduce and respond to distress’ (recommendations 7, 8 & 9)

Beyond Blue supports all three recommendations for cross-portfolio and multijurisdictional initiatives to mitigate risk factors for suicide, to intervene early in the trajectory toward suicidal behaviour, and target early distress. We welcome the broadening of responsibility for suicide prevention across health and non-health departments, so that efforts are aligned and address the spectrum of suicidal experience.

### *Distress Brief Intervention*

We strongly support the Taskforce scoping options for a Distress Brief Intervention (‘DBI’) in Australia. We support piloting and scaling up a DBI that can support people in early distress before they escalate into crisis. We welcome the approach proposed by the Interim Report, and suggest the model could go broader than the Scottish DBI pilot to include referral pathways for people with exiting health or other government institutions at points of vulnerability (such as the justice system or out-of-home care). Such a model would align with the whole-of-government approach to early distress that underpins these recommendations.

### *Social connectedness*

We strongly support the proposed action for scoping a national approach to improving social connections and addressing loneliness, including the particular consideration of priority populations and regional implementation. We welcome the Taskforce’s focus on the UK model as a blueprint for coordination and suggest strategies under that model could be adopted here. Specific Australian enhancements could include the Australian Bureau of Statistics developing and implementing nationally recognised indicators of loneliness and for these indicators to be included in survey data used by government and non-government organisations. We also suggest piloting, evaluating and scaling up an integrated suite of projects that connect people who are lonely with meaningful opportunities for social interaction and participation.

### *Aftercare*

We support the proposed action to explore a community-based care model aligning with the principles of aftercare to support those transitioning from custodial settings to the community. This is a welcome advance and the focus on evaluation and research will provide much needed understanding of what works to prevent suicides associated with the justice system.

### *Homelessness*

We support the priority actions which address housing and homelessness reform. We recognise the shortfalls that exist in supported housing places and public housing and the challenge this presents to delivering on a ‘no exit to homelessness’ approach. In particular, we welcome the Taskforce’s priority action to align strategies for housing and homelessness with a whole-of-government approach to suicide prevention. While the recent announcements in Victoria and NSW of substantial funding to grow the supply of social housing in these states are a positive development, there needs to be a more nationally consistent approach to address insecure housing (including to prevent people from becoming homeless in the first place) and coordinated strategies to prevent suicidal distress associated with insecure housing and homelessness.

As part of the Taskforce’s recommendations on housing and homelessness - specifically the priority actions proposed regarding a whole-of-government approach and further government investments in both housing and suicide prevention strategies - Beyond Blue recommends governments invest in more proactive, aftercare follow up for people experiencing suicidality who have been discharged from hospitals and psychiatric inpatient units. This should include resourcing assertive follow up at 3, 6 and 12 months after discharge to check on housing status, provide proactive assistance where housing is at risk and assess for suicide risk.

## **Please provide any specific comments on the recommendations related to ‘Targeted approaches to meet the needs of priority populations’ (recommendations 10 & 11)**

Beyond Blue supports the recommendations for an equity approach to suicide prevention planning, including improved data capture and accountability for funded programs and services to demonstrate outcomes for identified priority populations. We suggest adding small business owners (including sole traders) to the group of people likely to be vulnerable to suicide as a result of COVID-19 measures because of the impact of financial insecurity on their mental health. The Australian Small Business and Family Enterprise Ombudsman (‘ASBFEO’) has called for additional support for small business owners experiencing stress as a result of business disputes and difficult trading conditions. In recent months, the ASBFEO has experienced a significant increase in calls to its assistance line from small business owners displaying signs of psychological distress. The ongoing impact of drought, floods and the 2019 summer bushfires exacerbate the effects of the pandemic on many small business owners. This has demonstrated a critical need for a tailored early-intervention support to help these small business owners cope with high levels of stress.

Beyond Blue also supports the recommendation and priority actions for Aboriginal and Torres Strait Islander suicide prevention. In particular, we welcome the focus on improving cultural safety within mainstream service providers. Beyond Blue supports enhanced roles and increased, long-term funding for Aboriginal Community Controlled Health Organisations in leading suicide prevention services and supports for First Nations peoples (for further details, see our submissions to the Productivity Commission’s Inquiry into Mental Health and our recent submission to Gaaya Dhuwi’s consultation for the renewal of the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy). We therefore welcome the Taskforce making it a priority action to ensure suicide prevention is Indigenous-designed, led and governed at the national, regional, and community levels.

## **Please provide any specific comments on the recommendations related to ‘Health and mental health reform as critical to suicide prevention’ (recommendations 12 & 13)**

Beyond Blue supports both of these recommendations for consolidating and expanding on existing suicide prevention work in health portfolios across all levels of government. Greater transparency and accountability in delivering on suicide prevention strategies and plans is welcomed. This is consistent with trends to include performance indicators and set targets in these guiding documents.

We have previously advocated for improving experiences of care in emergency departments and for crisis support to be provided in alternative community-based settings that are less likely to exacerbate distress, so it is good to see these actions raised as priorities.

The Productivity Commission’s Inquiry into Mental Health also recommends better connections between funded helplines noting that these services are often underfunded to meet demand. Increased collaboration can help to deliver the changes needed to ensure all people get the timely and targeted responses they need. The work required to develop and implement new cross-organisational and cross-platform processes should be co-designed with existing providers who have evolving digital and telephonic infrastructure and strong community visibility and trust, rather than an imposed new solution that further fragments and confuses people. Collaboration on interoperability and connecting up of national helplines and digital platforms is already underway. However, this needs to be supported by additional, dedicated funding outside of funding for service delivery.

Beyond Blue strongly supports actions for addressing alcohol and other drug (AOD) use as a contributing factor in suicide and self-harm. Our Beyond the Emergency research (2019), conducted with Turning Point and Monash University, showed that in more than 40 per cent of ambulance attendances involving men, the person was intoxicated with alcohol, 16 per cent involved illicit drug use and in nearly 12 per cent of cases, an overuse of pharmaceutical drugs had taken place. This research also showed that paramedics were witnessing much higher rates of suicidal behaviour than hospital records were showing.

While better and more accessible pathways to treatment for problematic AOD use are much needed, the cross portfolio approaches highlighted in the report are an important step towards identifying and supporting people who may not explicitly seek help for co-occurring AOD issues and suicidality.

## **Please provide any specific comments on Compassion First – designing our national approach from the lived experience of suicidal behaviour**

Putting the voices of those with lived experience of suicidal behaviour at the centre of the reform agenda is absolutely critical. This report draws on comprehensive research and extensive consultations with a diverse range of individuals and uses these first-hand accounts to illustrate the key message – Compassion First. The positioning of those with lived experience as experts at the forefront of driving change is to be applauded.

A ‘seismic shift’ to change the narrative and representation of suicide, and address the barriers to receiving help, is consistently emphasised by people’s accounts. The need to address the inadequacies of the current system is undisputable when presented with the countless examples of stigma and lack of empathy felt by so many people who have experienced suicidal behaviours. *Compassion First* emphasises cultural and attitudinal changes as necessary and paramount to reducing stigma and providing genuine support for people at their point of need.

The mapping of different journeys used to illustrate some of the common factors and stresses that might underpin the experiences of those who have survived a suicide attempt is useful for identifying the different touchpoints for intervening earlier, and ensuring better connections between different parts of the service system.

Valuable viewpoints were provided by research participants on what they thought would be most helpful in shifting trajectories of suicidal behaviours including helpful interactions (diagram p22) and systemic approaches such as: non-medical safe spaces, care coordination and long-term treatment along with lived experience leading change. Finally, the ‘*opportunities for change*’ section offers a number of clear and evidence-based suggestions to all of us working in this area, with a particular focus on those with lived experience expertise being highlighted as a priority. These align well with many of the key recommendations that are the focus of the *Interim Report*.

## **Please provide any specific comments on Shifting the Focus – a national whole-of-government approach to guide suicide prevention in Australia**

Shifting the Focus provides a viable framework and rationale for a national whole-of-government approach to suicide prevention. Both the ‘*shared understanding*’ and ‘*comprehensive approach*’ sections outline clear, evidence-based arguments that substantiate their purpose. As a stand-alone document, Shifting the Focus presents a thorough, if not quite comprehensive picture of risk and protective factors in relation to suicide. There are some areas that are either absent (e.g. the relationship between gambling, self-harm and suicide) and others that only warrant minor mention (e.g. involvement in child protection systems, Family Court), though the guiding questions included should point responsible authorities to these areas. For similar reasons, high level indicators, such as ‘financial hardship or distress’, which could be linked to many determinants (e.g. housing affordability, income support levels, unemployment or underemployment, cost of living, healthcare), do not need to be exhaustive to serve their point.

The section on ‘*equipping our workforces*’ appears to be aimed wholly at governments’ own workforces and those of the services they fund. While these should certainly be the major focus, there is a missed opportunity here to connect the whole-of-government work with the rest of the workforce, and indeed the wider community. For instance, in many workplaces, Human Resources staff may become aware of people who may be in distress or at suicidal risk. While these interactions may be raised through other concerns, such as disciplinary processes, they could still perform a helpful function in the system for identifying risk and connecting people to support. In a similar way, Employee Assistance Programs (EAP) and next

generation, lower intensity workplace mental health service models provide a second level of risk identification and the potential to engage protective supports.

Finally, the *Decision Making Tool* provides a helpful starting point and set of questions for planning. Consistent with the approach on data, insights and evaluation, this tool should also be the subject of evaluation to ensure that future rounds of planning benefit from the lessons learned now and future iterations of similar planning tools reflect emerging evidence and continually improve.

### **Please provide any additional comments for the National Suicide Prevention Adviser to consider for the Final Advice in December 2020**

Beyond Blue has appreciated the opportunities to engage in consultations, both written and verbal, to inform the development of this advice. We look forward to future collaborations, including with the proposed National Office of Suicide Prevention.

## Attachment E

# Beyond Blue response on renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

### Introduction

Beyond Blue welcomes the opportunity to respond to the renewal of the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (the 'Strategy').

We continue to be deeply concerned that Aboriginal and Torres Strait Islander peoples are around three times as likely to report high or very high levels of psychological distress and twice as likely to die by suicide as the rest of the population. Improving social and emotional wellbeing is deeply connected to the social determinants of health and is critical to achieving the Closing the Gap targets and other important Australian Government policy commitments, including implementation of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

We strongly support the positions outlined in the Discussion Paper and the directions and leadership being taken by Gaaya Dhuwi. Our response provides suggestions for expanding on some of these positions. Step 1: Establishing Indigenous control, governance and coordination of national and jurisdictional level suicide prevention activity relevant to Indigenous communities

The Discussion Paper asks:

- if there is a national mechanism for the implementation of the renewed NATSISPS, which organisations should be a part of it?
- what do you think about specific national initiatives that are proposed to be coordinated nationally under Indigenous governance? What/who is missing?

Beyond Blue agrees that the coordination mechanism should sit within The National Suicide Prevention Leadership & Support Program, to leverage the bodies already mandated to guide a national approach to suicide prevention. Some of the organisations that could be considered as contributors include:

- **National Aboriginal Community Controlled Health Organisation (NACCHO)** – to bring the local approaches of ACCHOs across the country aligned under a national agenda
- **Suicide Prevention Australia** – to establish links to SPA's national peak body agenda, especially on policy and advocacy support for greater funding for Indigenous led suicide prevention
- **WellMob** – to advise on the development of nationally consistent social, emotional and cultural wellbeing online resources for Aboriginal and Torres Strait Islander people
- **National Suicide Prevention Trials sites (Darwin and Kimberly)** – to provide insights and models from the Indigenous focussed sites to inform new models of service delivery and local adaptations to existing models of delivery
- **National Mental Health Commission** – to establish links to the Commission's national reporting role
- **National LGBTI Health Alliance and Tekwabi Giz (Aboriginal and Torres Strait Islander inclusion collaboration)** – to ensure the voices of Indigenous LGBTI people are included in design, delivery and evaluation of services and supports.

Beyond Blue supports the specific national initiatives proposed for national coordination, within a systems approach to Indigenous suicide prevention. Research shows that integrated, whole-of-community approaches to suicide prevention are effective in reducing suicide rates. Countries that have taken a coordinated whole of population approach to suicide prevention, such as Scotland, Ireland and Japan, have seen significant reductions in national suicide rates by adopting strategies that target prevention and provide entry points across the spectrum of suicidal experience.<sup>i,ii,iii</sup> In saying this, we know that First Nations people globally continue to experience greater suicide risk and deaths.

#### Step 2: Establishing Indigenous control and governance at the regional level

The Discussion Paper asks:

- if there is to be Indigenous governance of suicide prevention at the regional level, how could it best be supported?
- which organisations or groups should be involved?

- Indigenous governance is best supported when Indigenous voices are at the decision making table, and governance structures are framed around Indigenous beliefs and values
- Indigenous governance should be embedded in both mainstream commissioning organisations and ACCHOs. At the regional level, the mainstream organisations that should be involved include Primary Health Networks (PHNs), area mental health services and local hospital districts (LHDs), as well as other related and supportive non-health sectors that operate on a regional basis
- As PHNs and LHNs are funded to deliver programs that will likely service some (but not all) of the Aboriginal community, these bodies should ensure there are Indigenous representatives on governance committees, so that decisions impacting on the lives of Indigenous people are informed by Indigenous voices
- ACCHOs already have Indigenous values and beliefs embedded in their structures, but require appropriate levels and sustainability of funding to deliver services and representation for Indigenous people at risk of suicide

Where the regional level is the conduit for funding structures (e.g. through states or PHNs), Indigenous governance can be supported by linking sustainable channels of funding to collaborative governance mechanisms. We know that social and emotional wellbeing services delivered by Indigenous health organisations need urgent funding attention. Sixty percent of ACCHOs recently reported that mental health/social and emotional wellbeing services constitutes the top health services gap.<sup>iv</sup> ACCHOs must have long-term funding certainty to develop sustainable models of care to support their community. Internationally, the Organisation for Economic Co-operation and Development identifies short-term funding as a major risk for reforms in Indigenous self-governed sectors.<sup>v</sup>

The Royal Commission into Victoria's Mental Health System in its Interim Report illustrated how sustainable funding could be achieved, by:

- ensuring that ACCHOs have recurrent funding for social and emotional wellbeing teams across the state
- creating scholarships to develop the necessary qualifications and experience for Aboriginal leadership in clinical services
- recurrently funding an Aboriginal Social and Emotional Wellbeing Centre for the whole state that joins Indigenous leadership and governance with clinical research and expertise to provide practice guidance and build on the evidence for better outcomes.

The Royal Commission in Victoria also recommended a structured approach to expand the reach of social and emotional wellbeing teams across the state through training, long term indexed funding, and support for the Victorian Aboriginal Community Controlled Health Organisation to develop, lead and host an Aboriginal Social and Emotional Wellbeing Centre.

### Step 3: Establishing Indigenous control and governance at the community level

The Discussion Paper asks:

- How can Indigenous governance of suicide prevention activity be best supported at the community level?

Beyond Blue strongly agrees with Gaaya Dhuwi that communities should remain in control of how nationally integrated approaches to suicide prevention are implemented in place, and that they must be free to respond flexibly. Social and emotional wellbeing should be embedded into existing suicide prevention / mental health community stakeholder reference groups.

We have seen how self-determination can lead to better outcomes in the response to COVID-19 in Australia. Indigenous-led advocacy, planning, decision-making, community engagement and deployment of solutions – working alongside public health practice and research – has successfully protected elders and communities from infection. <https://pursuit.unimelb.edu.au/articles/doing-it-themselves>

Step 4: Identifying program elements to be considered for integrated approaches to Indigenous suicide prevention at the community level

The Discussion Paper asks:

- What else is important in suicide prevention?

- Services and supports for Indigenous communities must be co-designed by Indigenous people, leaders and organisations. Indigenous leadership must be embedded across the mental health system.
- Specific funding is required for Indigenous identified positions, particularly in leadership positions, in mainstream organisations. As the Final Report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project ‘Solutions that work’ found that *‘a common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and ‘live experience’ elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time.’*
- The Australian Indigenous Psychologists Association (AIPA) have identified a major gap in the absence of an Aboriginal and Torres Strait Islander phone helpline.<sup>vi</sup> A proposal like ‘Call a Cuz’ which was developed several years ago could be renewed and might consider leveraging the infrastructure already existing in major national helplines through partnerships with mainstream providers.
- Gatekeeper training provided to the mainstream community must include information on cultural safety, so that it is relevant and safe for Aboriginal and Torres Strait Islander communities. This includes providing compulsory cultural safety training to mainstream clinicians, and embedding culturally safe training at the pre-service / tertiary education level
- The development of professionalised peer workforce by the National Mental Health Commission should include a specific Indigenous peer workforce, including guidelines for recruitment, workforce training, and remuneration and professional development
- There should be Indigenous lived experience in needs assessment, project design, evaluation design and knowledge translation activities
- Improving the connections between mainstream services and supports for Indigenous clients should include telehealth options, which are particularly important for remote communities. It is important for commissioners and service providers to have good relationships with community-level supports, including gender-specific groups, elders and youth specific services, cultural healing and leadership.
- Digital mental health programs must be culturally safe and relevant to Indigenous people, and strategies should be included to improve digital inclusion (see Step 5)



- Evaluations of government programs should be principles-focussed with a guarantee that Aboriginal and Torres Strait Islander knowledges, priorities, perspectives and voices are central in all components: evaluation prioritisation setting, design, implementation, data management and sovereignty, data analysis, and knowledge translation activities.

Step 5: Identifying vulnerable groups within the Indigenous population challenged by suicide for selective prevention activity within an integrated approach

The Discussion Paper asks:

- Are there any other groups that should be included?

- The Strategy should address digital exclusion to ensure suicide prevention strategies, including the digital and telehealth solutions proposed in the Discussion Paper, reach Indigenous people equitably
- An intersectionality lens should be adopted to ensure people who may be at increased risk of suicide because they belong to more than one vulnerable group receive services and supports tailored to their needs
- Particular attention should be paid to targeting responses to young people, who can be at high risk and may experience issues accessing mainstream services.

#### *Digital inclusion*

- Indigenous communities have been early adopters of social media and use social media at higher rates than non-Indigenous Australians. In the past five years, more than 60 per cent of the remote Aboriginal population were on Facebook, which is 20 per cent more than the average Australian community<sup>vii</sup>
- However, levels of digital inclusion among Indigenous peoples are significantly lower than the national average.<sup>viii</sup> The Australian Digital Inclusion Index shows Indigenous people living in urban and regional areas have low digital inclusion. While this gap has improved steadily since the ADII was first published in 2016, there was no improvement in the 12 months to October 2020. Affordability is a key factor, driven by a disproportionately high use of mobile-only and prepaid connectivity, which carries higher costs than fixed connections.<sup>ix</sup>
- Research conducted in 2014-2015 show only 47.5 percent of Aboriginal and Torres Strait Islander peoples who reside remotely had accessed the internet in the past 12 months, compared to 88.8 percent of Aboriginal and Torres Strait Islander peoples living in metropolitan areas. This further diminishes with remoteness, due to both access and affordability<sup>x</sup>

#### *Intersectionality*

- It is critical to consider how intersections with other identities and experiences may impact on an individual's wellbeing and suicide risk. As identified in the Discussion Paper, Indigenous people who identify as LGBTI may experience greater levels of discrimination and disadvantage and be more vulnerable to suicidality. People living in rural and remote communities may also experience additional barriers compared with their urban counterparts particularly, as outlined above, in relation to digital inclusion.

#### *Young people*

- The Discussion Paper rightly acknowledges young Indigenous people as a high risk group and the importance of adapting existing 'mainstream' initiatives to be more culturally responsive and inclusive of social and emotional wellbeing principles
- For example, in partnership with Kimberly Aboriginal Medical Services and Punturkurnu Aboriginal Medical Services, Beyond Blue is collaboratively implementing a co-designed place-based adaptation of Be You, the National Mental Health in Education Initiative, in the Pilbara and Kimberly of Western Australia. The intent is to ensure Be You is culturally safe and responsive for schools and community members through adaptations being community led as to ensure sustainability throughout the community. The adaptations vary according to the community but have included adopting visual learning, languages, community engagement approaches, yarning, and embedding local ways of

knowing being and doing. This work has been undertaken through engaging existing local community members who understand the local needs, context and conventions.

Step 6: Developing and implementing Integrated service models for mental health and those at risk of suicide / after a suicide attempt/ postvention within an overall integrated approach

The Discussion Paper asks:

- How can ACCHSs and other relevant services work together better? Who else needs to be considered?
- Gaaya Dhuwi could undertake journey mapping of Indigenous people through community-level social services and government agencies - such as Centrelink, employment agencies, prisons, universities - to identify touchpoints of vulnerability for suicide risk and opportunities for intervention
- Consideration should be given to other organisations working in the Aboriginal and Torres Strait Islander space. For instance, First Nations Media play a critical role in ensuring messages reach a range of communities
- In developing aftercare approaches that are culturally safe and responsive to the needs of Indigenous people who have attempted suicide, the Strategy could leverage existing service models being implemented by PHNs and local hospital networks, such as The Way Back Support Service, as a baseline for embedding Indigenous-specific enhancements and referral pathways
- In taking a holistic approach to suicide prevention, the Strategy could mirror the Prime Minister's Suicide Prevention Advisor's approach in identifying opportunities for early intervention within existing systems that people interact with in daily life. In her interim recommendations, the Advisor recommended using government and community systems to meet and proactively respond to people at points of vulnerability, and developing a whole-of-government workforce with skills to respond to distress.<sup>xi</sup>

Step 7: Ensuring the cultural safety of mainstream services

The Discussion Paper asks:

- How can we make mainstream services more culturally safe?
- How can we rapidly increase Indigenous employment across mainstream health and suicide prevention services?
- Priority should be given to partnerships and relationships between Aboriginal organisations and mainstream organisations, as these offer ways to both build the cultural safety of mainstream services, as well as longer term avenues for Indigenous employment and workforce participation, including through secondments and placements
- Mainstream services should systemise their outbound referral pathways, so that Indigenous people can be consistently and safely referred to services, supports and networks with cultural expertise, such as those that are Indigenous led
- Mainstream health services should be expected to establish and evaluate Reconciliation Action Plans.
- Mainstream services should embed processes for collecting demographic level data and using relevant indicators to monitor, evaluate and improve service for Indigenous clients. Examples of appropriate indicators can be taken from the ATSIPEP 'Quality indicators in a suicide prevention activity'.

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