NSW GOVERNMENT

NSW Suicide Prevention Legislation

Discussion Paper

June 2024

Acknowledgement of Country

NSW Ministry of Health acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this discussion paper.

Acknowledgement of Lived Experience

NSW Ministry of Health acknowledges the individual and collective contributions of those with a lived and living experience of mental ill-health and suicide. Your shared experiences and narratives are vital in shaping our understanding and advancing the conversation on mental health and suicide prevention.

NSW Suicide Prevention Legislation

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Foreword

A message from the Minister for Mental Health, Minister for Housing, Minister for Homelessness, Minister for Youth and Minister for Water

In confronting the urgent challenge of suicide prevention, we recognise that it is not just a health issue but a societal one, requiring our collective attention and action. The complexity of suicide, a multi-faceted human behaviour, calls for an approach that goes beyond the boundaries of traditional health responses, necessitating a comprehensive whole-of-government approach.

Our objective is clear: to drive down suicide rates in NSW. Every life lost to suicide is a preventable tragedy, a stark reminder that behind every statistic lies a person, a family, a community torn by loss. We want NSW to be at the forefront of ambitious and determined reform efforts to reduce lives lost to suicide in this state.

Our belief is firm: through comprehensive and collaborative actions, we can not only address the underlying factors contributing to suicide but also create a resilient and supportive environment for all. Our strategy is one of collaboration and understanding, focusing on the broader social determinants of health such as financial insecurity, unstable housing, and social isolation – key factors that exacerbate suicidal distress.

Grounded in inclusivity and evidence, we hope to draw upon the lived experiences of individuals affected by suicide and centre the voices of priority populations. We aim to integrate these perspectives with international models and local experiences to develop a response that meets the diverse needs of our communities. This approach encompasses insights from both metropolitan and regional areas of NSW, ensuring diverse experiences, especially those directly impacted by suicide, informs and shapes our whole-of-government response.

Acknowledging our collective role in suicide prevention and understanding suicide as a complex issue that requires a whole-of-government approach, our united goal is to significantly reduce, and ultimately aim for zero suicides in NSW. This commitment requires the collective effort of every government agency and community member to move ever closer to a future where suicide is a rare and preventable outcome.

I encourage you to engage with this consultation process with openness and honesty. We want our suicide prevention legislation to be more than a piece of paper. We want it to be an active document guiding our work and for that to happen we need to hear your voices loudly and clearly.

Rose Jackson MLC
Minister for Mental Health

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Introduction, approach & the case for change

1.1 Introduction

Every suicide is a tragedy that deeply affects individuals, families, and communities, leaving a lasting impact on those left behind. Each life lost is not just a statistic, but someone's child, parent, partner, friend, or colleague. This loss extends beyond personal grief, affecting workplaces, social connections, productivity, and the fabric of society. It is important that the approach of the NSW Government to suicide prevention not only meets the needs of those at immediate risk, but also fosters a supportive, inclusive, community environment aimed at mitigating the underlying causes of distress to prevent people from reaching a state of suicidal crisis.

The NSW Government has made a commitment to introduce a Suicide Prevention Act. This paper outlines what we are currently doing for suicide prevention in NSW, how other jurisdictions have used legislation to implement a whole of government response to suicide, the role legislation can play in strengthening our response, and key functions we may like to see in a Suicide Prevention Act for NSW for your consideration.

1.2 Role of government in suicide prevention

Suicide is a multi-factorial human behaviour. No single agency, organisation, or person can reduce suicide rates on their own. A whole of government approach to suicide prevention is needed to address not only health related issues, but the broader social determinants of health that can lead to suicide.

Approximately half (49%) of people who die by suicide do not have contact with health services in their last year of life.[i] We know that people interact with a range of government services and systems as part of their day to day lives and that government plays a central role in preventing suicide.

The NSW Bilateral Mental Health and Suicide Prevention Schedule recognises that the drivers of suicide prevention system reform extend beyond the confines of the health sector, encompassing all aspects of individuals' lives, including their living environments, workplaces, educational settings, and social interactions (Article 23).[ii]

According to the World Health Organisation, governments are crucial in suicide prevention due to their capacity for strategic leadership, facilitation of collaboration across multiple sectors including public and private, and in providing adequate funding to enhance wellbeing support services.[iii]

The National Suicide Prevention Taskforce (2020) sees the pivotal role that government can play in suicide prevention to include:[iv]

- Utilising policy levers to enhance population wellbeing and to mitigate the social and economic factors contributing to distress.
- Employing legislation to increase community safety.
- Ensuring effective collaboration among service systems under its purview, facilitating linkages and providing responsive support to individuals experiencing suicidal distress.

1.3 What we are seeking to accomplish

While NSW is embracing a whole of government approach to suicide prevention, there is a gap in the governmental structure for stronger cross-portfolio delivery of suicide prevention programs and initiatives. Historically, suicide prevention has fallen predominately under the responsibility of the health portfolio. This legislation aims to instigate a cultural shift within the government where suicide prevention becomes a collective responsibility, with established mechanisms for ensuring accountability.

Notably, suicide prevention legislation has garnered widespread support from the suicide prevention sector. According to Suicide Prevention Australia, 78% of the sector support suicide prevention

legislation as a pivotal facilitator of success, while 92% underscore the necessity of a whole of government approach to suicide prevention.[v]

Suicide prevention legislation would serve to clearly articulate the roles and responsibilities of government agencies and hold them accountable for delivering suicide prevention initiatives. This accountability framework will foster a cultural transformation within government agencies, necessitating all agencies to assess, consider, and implement suicide prevention initiatives, both internally and externally for their service users.[vi]

Early stakeholder advice has highlighted the need for a suite of mechanisms to enable whole of government efforts in the legislation for it to be an effective policy lever. If legislation passes with only minor functions, it is unlikely to result in systemic reform. This is why we have presented a range of potential inclusions for the legislation in this paper in section 4 for consideration and discussion.

While the legislation will be state based, aligned with the powers and responsibilities of the NSW Government, it is important that it complements Australian Government policies and initiatives in suicide prevention. The aim is to construct a robust framework that effectively addresses the multifaceted nature of suicide prevention within NSW, fostering a collaborative relationship between state and federal efforts to maximise impact and efficacy.

1.4 Approach

A cross-portfolio whole of government Working Group has been established to bring NSW Government agencies and portfolios together to inform the development of the legislation. This Working Group will contribute to shaping the legislation, in addition to engaging people with lived and living experience of suicide, groups at greater risk of suicide, stakeholders, and peak bodies. The Working Group and targeted consultation will play a pivotal role in informing the legislation.

The voices of peak bodies in mental health and suicide prevention, representing populations disproportionately impacted or at risk of suicide, have been instrumental in shaping this discussion paper. They emphasised the imperative for greater government accountability in suicide prevention. This paper has been informed by existing work in whole of government reform for suicide prevention, including publications by Suicide Prevention Australia and Roses in the Ocean, as well as insights from the National Suicide Prevention Taskforce.

We know that consulting with people with lived and living experience of suicide is a cornerstone of successful systemic reform, empowering people by ensuring their voices are heard throughout the development process for legislation. It allows for testing of key functions of the legislation with the those who will be directly impacted by the reform.[vii,viii]

We also know that it is crucial that consultation is well planned, with adequate time, support, and transparent communication of outcomes, as the absence of this can hinder the implementation of reform.[ix]

Comprehensive consultation with people with lived and living experience of suicide and the suicide prevention sector will occur through multiple channels, both informal and formal, to develop the legislation. Plans are underway to undertake a series of consultations with communities disproportionately at-risk or impacted by suicide and other key stakeholders.

In recognition of the potential for discussion surrounding suicide to evoke distress or discomfort among consultation participants with lived or living experience, an organisation with the requisite expertise will be engaged to provide support to participants during and after consultations as a wellbeing safety measure.

The inclusion of Aboriginal people who have both lived and living experiences of suicide is vital. It is crucial in steering the development of suicide prevention solutions that are culturally sensitive and, importantly, led and informed by the communities they are designed to support.[x,xi] The Gayaa Dhuwi (Proud Spirit) Declaration, along with our commitment to Closing the Gap for Aboriginal people and other key strategies and policies (as outlined in Appendix 2), will guide our approach to engaging and consulting with Aboriginal communities and in shaping the legislation. This ensures outcomes that are not only culturally appropriate but also safe for Aboriginal people.

1.5 Current state of suicide distress

Behind each statistic is a person, family, and community.

In 2022, 911 people died by suicide in NSW equating to more than 2 people dying by suicide each day in our State.[xii] Aboriginal people die by suicide at more than twice the rate of non-Aboriginal people.[xiii] Each life lost to suicide is one too many and for every life lost, more than 100 people can be impacted.[xiv] In NSW, 14.8% of people (930,300) have had any suicidal thoughts and behaviours in their lifetime, and 3.3% (207,200) have experienced suicidal thoughts and behaviours in the last 12 months.[xv]

Suicide rates have not significantly decreased in NSW over the past decade (9.8 per 100,000 population in 2012 and 10.8 per 100,000 population in 2022).[xvi] More needs to be done to drive down the rate of suicide in NSW.

In addition to the emotional cost of suicide on families and the community, the economic cost in NSW has been calculated at more than $451 million each year.[xvii]

In addition to Aboriginal people, other population groups are disproportionately impacted by suicide:

- People with a personal history of self-harm – A history of self-harm is the most commonly identified suicide risk factor for males and females in all age groups.[xviii]
- Men – More than three quarters (78%) of suspected or confirmed deaths by suicide were men in NSW in 2023.[xix]
- People bereaved by suicide – Suicide bereavement is identified as a risk factor for suicide.[xx] It is estimated that five immediate family members and up to 135 individuals can be exposed to the impact of an individual's suicide.[xxi]
- LGBTQ+ communities – In NSW, 28% of LGBTIQ+ adults have attempted suicide in their lifetime, and 4.1% in the last 12 months.[xxii]
- Young people – Suicide is the leading cause of death among Australians aged 15-24.[xxiii]
- Veterans – Ex-serving males and females are more likely to die by suicide than the general Australian population.[xxiv]
- People living in regional, rural or remote areas – Experience higher rates of suicide than those living in major cities.[xxv]
- People with disability – Die by suicide at a rate three times greater than the general population.[xxvi]
- Older people – Males aged of 85 years had the highest age-specific suicide rate in 2022 (32.7 per 100,000 population).[xxvii]
- Culturally and linguistically diverse communities - Face unique and compounding factors that can expose them to risk of suicide and poorer mental health outcomes.[xxviii]

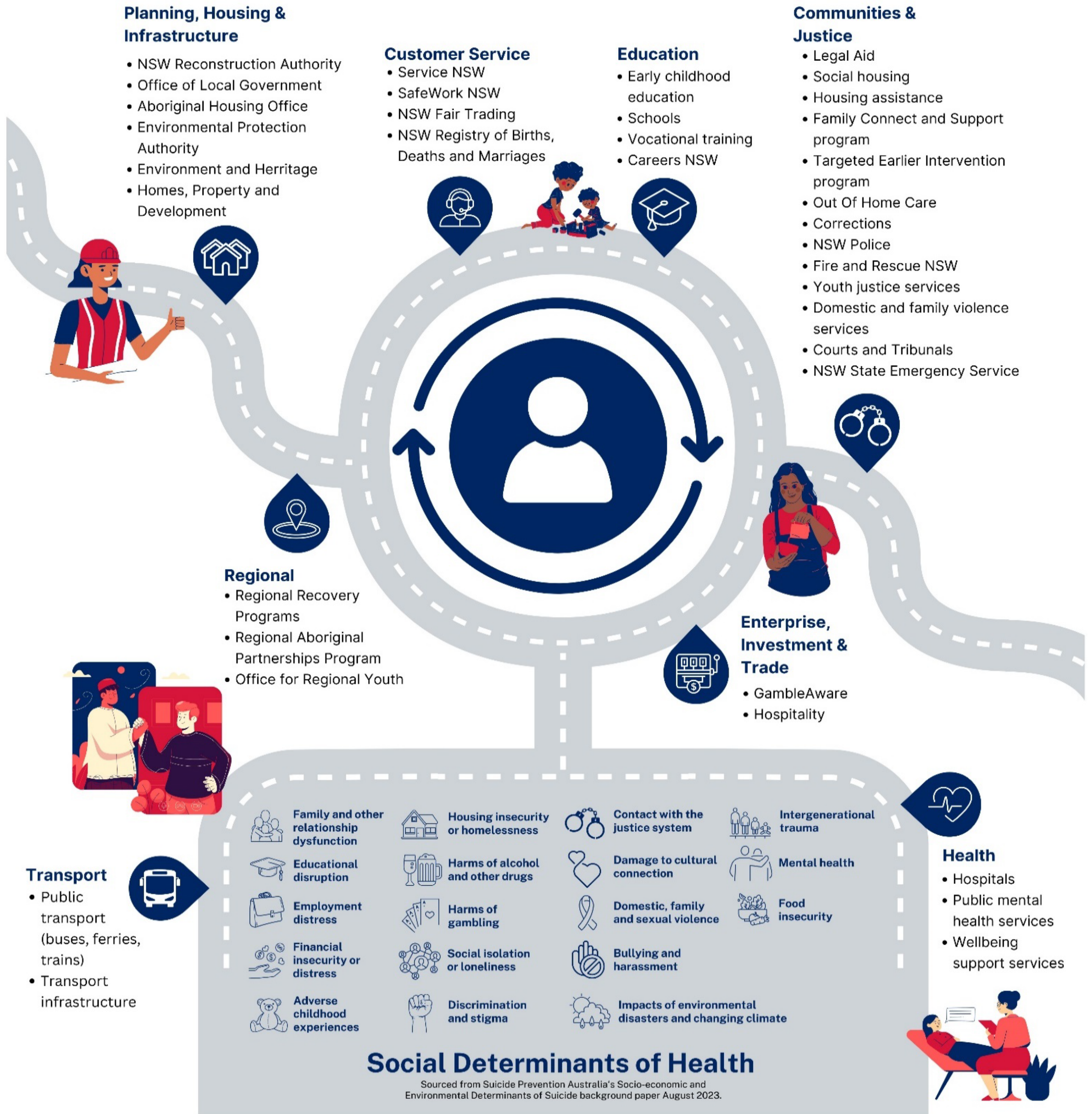
It is not always the case that mental ill-health is the primary driver of distress leading to suicide. Addressing the social determinants of health that can lead to suicide is crucial in intervention and prevention to reduce the likelihood of the person reaching suicidal crisis. These drivers can be related to social, economic, or environmental factors. Risk factors for suicide can compound and intersect, as such many people in distress may require a range of supports and engage with several government services on their journey to reduce their distress. See appendix 1 for more information on the key drivers of distress and their connection to suicide.

Multiple sources of distress can converge simultaneously, amplifying an individual's level of distress, and impairing their ability to effectively manage life stressors. This compounded distress can be further exacerbated by intersecting identities, leading to experiences of discrimination or disadvantage based on factors such as race, ethnicity, gender, disability, nationality, sexual orientation, and geographic location. Consequently, certain population groups may face a higher risk of suicide due to differential impacts of these factors.

It is intended that embracing a whole of government approach to suicide prevention will enable NSW Government to address inequities, recognising them as underlying drivers of suicidality.

We have mapped an example of key touchpoints in the community where people in distress may interact with government services. This infographic is not prescriptive and is intended to be viewed as an example.

Figure 1 Example of key touchpoints in the community.



2 What are we already doing in NSW?

2.1 Exisiting suicide prevention efforts in NSW

NSW's *Strategic Framework for Suicide Prevention 2022-27 (the Strategic Framework)*, developed by the Mental Health Commission of NSW adopts a whole-of-government and whole-of-community framework, focusing on prevention, early intervention, aftercare support for people after suicide attempt, and post-suicide support for people bereaved or impacted by suicide. NSW Government agencies are required to regularly report on their activities that aim to reduce suicidal distress and lives lost to suicide as part of the Strategic Framework.

NSW Health delivers a comprehensive range of mental health and suicide prevention services across the lifespan, encompassing both community and inpatient settings. These services are primarily dedicated to the assessment, treatment, and management of mental illnesses however increasing efforts are being dedicated to prevention of mental ill health, an area with primary responsibility belonging to the Australian Government. By providing a full spectrum of services and programs, from inpatient care to community-based supports, these not only aim to address individuals' mental health concerns but also play a crucial role in preventing and alleviating risk factors associated with suicide.

NSW has maintained a comprehensive approach to reducing the rate of suicide since 2019-20 primarily centred on health-related initiatives. A cornerstone of these efforts is the "Towards Zero Suicides" initiatives which focus on best practice crisis care, building on local community resilience, and effecting systemic enhancements in suicide prevention. Despite concerted efforts, a significant reduction in the rate of suicide has not yet been realised.

NSW's Suicide Data Monitoring System, a collaboration between the NSW Ministry of Health, Department of Communities and Justice, the State Coroner, and NSW Police, serves as a crucial tool for collating and analysing suicide-related data to inform responses and prevention measures.

The table below summarises existing suicide prevention efforts in NSW. It is not intended to be an exhaustive list. For more information on current cross government suicide prevention activities in NSW visit the Mental Health Commission of NSW's website: https://www.nswmentalhealthcommission.com.au/shifting-the-landscape

Table 1: Summary of existing suicide prevention efforts in NSW

Initiative / Program	Details
Towards Zero Suicides	$143.4 million over FY2022-26 in services and supports that focus on best practice crisis care, community resilience, and system improvements. For more information visit https://www.health.nsw.gov.au/towardszerosuicides.
Policy and plan development	Psychological and Specialist Services, Child Protection and Permanency, District and Youth Justice Services, Department of Communities and Justice delivered agency-wide guidelines for addressing suicide and self-harm on the ground. SafeWork, Department of Customer Service delivered harm reduction within the workforce including a code of practice to explore psychosocial hazards in the workplace. Department of Education deliver evidence-based suicide prevention programs in schools. NSW Health and the Department of Communities and Justice delivered and continue to implement the Housing and Mental Health Agreement 2022 to help homeless and those at risk of homelessness with mental ill health. Department of Regional NSW have implemented the Riverina-Murray Youth Suicide Framework.
Cross-jurisdictional Policy Alignment and Investment in	Joint investment with the Commonwealth Government of $383 million FY2021-26 under the National Mental Health and Suicide Prevention Agreement which aims to

Initiative / Program	Details
Mental Health and Suicide Prevention	improve mental health and suicide prevention outcomes by addressing gaps in the mental health and suicide prevention system.
Closing the Gap	Work towards Closing the Gap Target 14 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing' led by NSW Health and the NSW Aboriginal Health and Medical Research Council. This includes expansion of the Building on Aboriginal Communities' Resilience program to 12 additional Aboriginal Community Controlled Health Organisations to deliver reliable, responsive, and sustainable programs for Aboriginal communities[xxix].
Training and Education	Extensive suicide prevention training in various settings, targeted at frontline staff, construction workers, teachers, and priority groups. Department of Communities and Justice have incorporated suicide prevention into training programs. Workers Compensation, Safety and Wellbeing, Department of Communities and Justice have provided suicide awareness training to peer support officers. Department of Regional NSW have provided mental health workshops for small businesses. Department of Customer Service Behavioural Insights Unit developed a guide – Taking action to help customers in distress: A Best Practice Guide for NSW Government which includes information and practices to support customers who are in distress when contacting agencies.
Identification and Support for Priority Populations	Programs targeted towards children and young people, older people, LGBTIQ+ individuals, Aboriginal people, and culturally and linguistically diverse communities; making mainstream services more accessible. Revenue NSW's approach to hardship includes mechanisms such as the Hardship Review Board and 50% Reduced Penalty Amount in the Fines space.
Suicide Data Monitoring System	Near real-time reporting on suspected and confirmed deaths by suicide, with the data being utilised by Local Health Districts for purposes such as reviewing critical incidents. Transport NSW reported use of suicide dataset.
Governance	The NSW Mental Health Taskforce provides governance over suicide prevention efforts in NSW. The Taskforce monitors implementation of the Strategic Framework for Suicide Prevention in NSW 2022-27.

2.2 Current systemic challenges and learnings

Shifting the Landscape

Findings from the initial monitoring and evaluation reports conducted by the Mental Health Commission of NSW on *Shifting the Landscape for Suicide Prevention in NSW 2022-2027* (the Strategic Framework) have illuminated several challenges. These include[xxx]:

- Challenges in effectively communicating and disseminating the Framework across a large governmental system
- Difficulties in sourcing information on suicide prevention activities from some agencies
- Absence of clear accountability mechanisms

The monitoring and evaluation reports have also highlighted the need for some government agencies to receive support and guidance in implementing the key priorities of the Strategic Framework and to better delineate the specific roles of each agency in suicide prevention.[xxxi]

Suicide Prevention Training

During the period spanning 2019 to 2021, NSW embarked on a whole of government initiative aimed at standardising suicide prevention training across public-facing government services.[xxxii] This initiative encountered obstacles in implementation, such as[xxxiii]:

- Lack of synergy with existing strategic activities
- Inconsistent communication across departments
- Utilisation of outdated approaches to suicide prevention
- Lack of accountability.

3 What other jurisdictions are doing

3.1 What can we learn from other jurisdictions

Suicide prevention legislation exists in five countries and one Australian state, namely South Australia, Japan, Canada, the Republic of Korea, Argentina and the United States of America. The South Australian legislation is the most comparable to the approach being taken in NSW, it is also the most recently introduced legislation having come into effect in 2021. A summary of comparable legislation is detailed below, with legislation from the United States excluded as it is not comparable.

South Australia

Table 2 South Australian Legislation: Key Features

Suicide Prevention Act (2021)
State-wide objectives, including best practice suicide prevention policies across the state, providing training and education in suicide prevention, identifying priority populations and implementing suitable initiatives to reduce suicide.
Establishment of a Suicide Prevention Council comprised of senior public sector officials, members of parliament and suicide prevention leaders in the community including lived and living experience across priority cohorts. The role of the Suicide Prevention Council is to prepare and maintain the South Australian Suicide Prevention Pan, make recommendations on policies and programs for suicide prevention and postvention and ensure that training in preventing suicide is available to the community and professionals in the state. The Council advises and reports to the Minister for Health and Wellbeing. Administrative support for the Council is provided by Preventative Health SA.
Development of a state suicide prevention plan mandated to include policies and measures that are to be implemented across the state to further the objects of the Act. It includes performance indicators, addresses the needs of priority population groups, includes provisions relating to education and training, and contains specific policies and measures for suicide prevention for Aboriginal and Torres Strait Islander people. Annual reporting is required for the state plan.
State authorities to have suicide prevention action plans to set out the strategies and measures they intend to put in place for suicide prevention for their staff and members of the community that engage with their services. Prescribed State authority action plans must give effect to the State Suicide Prevention Plan and explain how suicide prevention strategies will be incorporated into the primary functions and programs of the authority, and how they will be adapted to suit service level delivery. Action plans are reported on annually.
Data management protocols on sharing of information between specified persons and bodies on people at risk of suicide or a class of persons at risk of suicide to perform functions relating to health, safety, welfare and wellbeing, or to manage any risk of suicide persons who engage with or benefit from the services provided.
Impact: As the first Australian state with such legislation and a short period of implementation, specific impacts are yet to be determined.

Argentina

Table 3 Argentinian Legislation: Key Features

National Suicide Prevention Act (2015)
Recognition of suicide as a public health issue.
Emphasis on a coordinated, interdisciplinary, and inter-agency approach.
Training for various sectors in identifying at-risk individuals and prevention.
Establishment of a crisis helpline and suicide data registration system.
Impact: No significant decline in suicide rates since the enactment of the legislation.

South Korea

Table 4 South Korean Legislation: Key Features

Act on the Prevention of Suicide and the Creation of Culture of Respect for Life (2011)
National priority on suicide prevention for all government bodies.
Establishment of a National Suicide Prevention Plan every five years.
Suicide monitoring system, education and training, and research assistance.
Suicide Prevention Centres and emergency helpline services.
Impact: Significant downward trend in suicide rates, especially from 2013 to 2017.

Canada

Table 5 Canadian Legislation: Key Features

Federal Framework for Suicide Prevention Act (2012) - Key Features
Development of a federal framework for suicide prevention.
Emphasis on public awareness, knowledge sharing, and collaboration across sectors.
Funded various suicide prevention activities from 2020-2022.
Impact: Fluctuating suicide rates, not a steady decline since the legislation.

Japan

Table 6 Japanese Legislation: Key Features

Basic Law on Suicide Countermeasures (2006) – Key Features
Shift of suicide prevention responsibility to the Cabinet Office from the Ministry of Health, Labour and Welfare.
Implementation of the general principles of suicide prevention policy (2007, revised in 2017) with a 30% reduction target.
Requirement for local suicide prevention plans in all prefectures and municipalities.
Revisions in 2016 included addressing suicide prevention in education and labour.
Establishment of the Japan support centre for suicide countermeasures (2016).
Impact: Japan has seen the greatest impact from its legislation including a 40% reduction in suicide deaths over 15 years, showing a steady decline from 2009-2019, with a slight increase in rates from 2020 onwards. It should be noted that the decrease coincided with the implementation of other laws and changes, making it difficult to attribute the reduction solely to the legislation.

4 Potential elements of the NSW Act

4.1 Potential elements of the NSW Act

It is evident that comparable legislation includes whole-of-government approaches that are enduring and adaptable, enhancements to data collection and sharing, and widespread suicide prevention capacity building across government. These elements, as well as some novel elements not included in other legislation have been considered in the NSW context and are presented below for discussion.

It is intended that the legislation functions as a guiding framework, equipped with mechanisms that foster cohesive action across government entities. Importantly, the legislation should not be used to mandate funding of any specific initiative or programs, and changes to the *Mental Health Act 2007* are outside of scope for this legislation.

4.1.1 State-based suicide prevention plan

The legislation could include a requirement for **a comprehensive whole of government state-based plan** with actions that include specific initiatives for priority groups at greater risk of suicide, clear accountability, and clear timeframes for renewal. This function was implemented in Japan, Canada, and South Australia.

Responsibility for developing the state-based plan would be clearly assigned, for example to the Mental Health Commission of NSW, and would include clear timeframes for delivery.

Benefits: A state-based suicide prevention plan will ensure ongoing commitment and action to suicide prevention for NSW that is responsive to community needs. While NSW currently has a Strategic Framework, it does not have specific actions for implementation. A state-based plan could seek to operationalise the Strategic Framework. Widespread consultation and engagement would occur and alignment with National strategies would be ensured.

Risks: Increased administrative burden of upgrading the Strategic Framework to a state-based plan out of session, given the Strategic Framework is current until 2027.

4.1.2 Agency-based action plans

The legislation could also include a requirement for **agency-based suicide prevention action plans** that align with the state-based suicide prevention plan and include clear reporting and accountability measures. Agency-based action plans could be reported on annually. This function was implemented in South Australia and Japan.

To support the development of agency-based action plans, an existing body could provide technical support and guidance to agencies. For example, the Mental Health Commission of NSW may be well placed to support agencies develop their plans given their role in delivering whole of government strategies and frameworks.

Benefits: All government agencies are committed to suicide prevention and have actions to implement in their remit to reduce distress in the communities they service and support. Agencies know their community best and are well suited to develop localised suicide prevention activities for their areas of expertise.

Risks: Agencies do not feel supported with resources or technical advice to develop suicide prevention action plans. Challenges in achieving culture change at an agency level.

4.1.3 Suicide Prevention Council

Legislation could also establish a **new suicide prevention council** which includes mechanisms to embed people with lived and living experience of suicide in governing the Act. This function was implemented in Japan, Canada, and South Australia.

The Office of Chief Psychiatrist in South Australia, who is responsible for oversight of the South Australian Suicide Prevention Act, informed us that their Suicide Prevention Council is working well in providing advice to Government.

The South Australian Suicide Prevention Council membership includes those with a lived and living experience of suicide, those working to prevent and respond to suicide in the community, population groups most affected by suicide, people in key leadership roles across government and a member of Parliament.

It is potential that the council hold similar functions to the Suicide Prevention Council outlined in the *South Australia Suicide Prevention Act 2021*:

- To support preparation and maintenance of the State Suicide Prevention Plan.
- Make recommendations on policies and programs intended to reduce deaths by suicide and attempted suicides and enhance postvention responses.
- To receive reports from prescribed State authorities in relation to their suicide prevention action plans, and to summarise and submit such reports to the Minister. In NSW legislation this function may sit with the Mental Health Commission of NSW.
- To provide opportunity and a platform for people with lived experience of suicide, and other members of the community working in the area of suicide prevention, to voice their opinions and concerns.
- To support collaboration between suicide prevention networks and local government.
- To identify opportunities in suicide prevention, treatment, crisis intervention and postvention.

Benefits: A suicide prevention council will embed voices of lived experience of suicide in government decision making, support functions of legislation, and support ongoing suicide prevention activity in NSW.

Risks: If the scope of the functions and responsibilities of the council are not clearly communicated, it could result in the desired outcomes not being achieved. Failure to value the voices of lived experience would result in under-utilisation of the group for its purpose.

4.1.4 Suicide prevention capacity building

The legislation could include mechanisms to ensure that the public facing public sector workforce has the **capability and capacity to interact with people in distress** who are accessing their service or under their care. Capacity building (through training) as a key function of legislation has been implemented in Japan, Canada, and South Australia.

The Work Health and Safety Act 2011 includes in its objects “promoting the provision of advice, information, education and training in relation to work health and safety” (3.1.d). A similar inclusion could potentially feature in the legislation to ensure commitment to equipping public facing employees in the public sector with the skills to respond to people in distress. We do not intend to mandate training of any type to meet this objective, and know that many public facing public sector workforces, for example public sector teachers and support staff already undertake a wide range of mental health and suicide prevention training and activities that would likely meet the objective of this inclusion.

If included in NSW’s legislation, we propose an existing body could provide technical assistance to support agencies to equip the workforce with the skills and capabilities needed for suicide prevention. There is also an existing resource developed by the Department of Customer Service Behavioural Insights Unit titled *Taking action to help customers in distress: A Best Practice Guide for NSW Government*[xxxiv] which includes information and practices to support customers who are in distress.

Benefits: Public facing employees in government services are supported with the skills and knowledge to respond compassionately to people in distress and refer people to existing support services in NSW.

Risks: Potential administrative and financial concerns with providing widespread training to public sector employees.

4.1.5 Data collection and sharing

Legislation could include opportunities for **better sharing of data and strengthening data collection methods** related to suicide prevention for policymaking and strategy evaluation. Enhancements to data collection and sharing has been legislated in Japan, Canada, and South Australia.

The intention is to enhance cross government data accessibility and collection to enable robust data to be utilised in suicide prevention efforts and establish clearer authority for sharing of information between key agencies about people at risk of suicide, or who have died by suicide. Legislation could aim to leverage existing agency data for safe and considered sharing across agencies.

Consultation across government agencies is needed to understand the needs, purposes, scope, and current legal and privacy frameworks in place. Consultation across government would consider current legislative or policy barriers and enablers to sharing of individual information, and the scope to:

- develop or enhance protocols for sharing aggregated data to understand rates of suicide or suicide-related behaviours
- identify risk factors and populations at risk of suicide
- understand NSW government agency responses and identify opportunities for prevention and response
- support coordinated local and regional planning and response.

Any inclusions related to data sharing and collection would adhere to standards for Aboriginal and Torres Strait Islander suicide prevention evaluation and data sovereignty when working with Aboriginal data. This work will be progressed in consultation with the Information and Privacy Commission of NSW.

Benefits: Increased data sharing across agencies to inform suicide prevention efforts.

Risks: Privacy and confidentiality must be protected. There may be increased administrative duties for agencies.

4.1.6 Consideration of suicide impact in policy decisions

Legislation could include more opportunities for government to **consider suicide impact in policy and legislation decision-making** to reduce the risk of potential failures of public administration causing distress in the community.

The way that this could be practicably implemented in NSW legislation is uncertain. The potential for this to become a *tick box* activity is front of mind, as is the potential large administrative burden that could be imposed on government agencies if the right balance of scope and mechanism is not achieved.

A potential mechanism by which this could be implemented is to require that all significant policy decisions must be made *with regard to* or *be consistent with* the state-based suicide prevention plan (see section 4.1.1). The state-based suicide prevention plan would detail the considerations for policy makers to take into account.

Another potential mechanism could be to leverage the Statement of Public Interest, which is a statement that must accompany any government bill before proceeding in the Legislative Council. The Statement of Public Interest currently considers why the policy is needed based on evidence and stakeholder input, policy objectives, alternative options to consider, analysis of benefits and risks, pathway for implementation, and consultation undertaken to inform the policy. There is potential that this could be amended to consider the potential impact on suicide. Other alternative options could include addressing this aim via executive government processes, such as a Premier's Memorandum.

Benefits: A suicide prevention in all policies approach will mitigate risk of government agencies inadvertently increasing psychological distress in the community.

Risks: This could become a tick box exercise or result in a large administrative burden for agencies.

4.2 Discussion questions

The voices of peak bodies in mental health and suicide prevention, representing populations disproportionately impacted or at risk of suicide, have been instrumental in shaping this discussion paper. They emphasised the imperative for greater government accountability in suicide prevention. Our approach has been informed by existing work in whole of government reform for suicide prevention, including publications by Suicide Prevention Australia and Roses in the Ocean, as well as insights from the National Suicide Prevention Taskforce.

We highly regard the expertise, perspectives, and experiences of individuals with lived and living experience, recognising the invaluable contributions they offer to shaping this legislation.

We want to hear from you on the potential elements for inclusion. A whole of government approach to suicide prevention could not be possible without you.

The following discussion questions could be considered:

1. Which of the potential inclusions listed in section 4.1 do you think are required to enable a whole of government approach to suicide in NSW?
2. Are there any anticipated implementation barriers or unintended impacts you foresee for any of the potential elements?
3. What additional elements do you suggest for inclusion in a NSW Suicide Prevention Act?

5 Appendices

5.1 Appendix 1 - Drivers of distress

The drivers of distress that can be linked to suicide were briefly outlined in section 2.2. This appendix provides a detailed summary of the drivers of distress and key figures associated with those drivers which will be considered in future activities of the legislation such as the state and agency-based plans.

Table 1: Drivers of distress and key figures

Driver of Distress	Key Figures
Housing stress	• Problems related to housing and economic circumstances was identified as a contributing risk factor to death by suicide among 4.8% of females and 6.5% of males in 2022.[xxxv] • 29.2% of households in NSW are experiencing housing stress in 2021.[xxxvi] • 1 in 7 low-income households with poor mental health experience housing stress.[xxxvii] • In 2021-22 around 37.5% of all Specialist Homelessness Services (SPS) clients with a current mental health issue received support from specialist homelessness services in NSW.[xxxviii]
Financial distress and cost of living	• From 2001 to 2022, age-standardised suicide rates were highest for those who lived in the lowest socioeconomic areas (most disadvantaged areas).[xxxix] • One in four Australians (25.1%), are finding it difficult to get by on their current income.[xl] • In January 2022, 37.4% of Australians thought that price rises were a very big problem. This increased to 56.9 per cent in October 2022.[xli] • Life satisfaction in October 2022 was 10 per cent lower for those who thought that rising prices were a very big problem compared to those who did not (6.41 compared to 7.13).[xlii]
Relationship dysfunction or breakdown	• 15.6% of deaths by suicide among males and 10.1% among females in 2022 had disruption of family by separation and divorce identified as a contributing risk factor.[xliii] • Problems in relationship with spouse or partner was identified as a contributing risk factor to death by suicide among 13.6% of males and 12% of females who died by suicide in 2022.[xliv] This factor includes intimate partner violence and domestic violence.
Unemployment	• Estimated suicide risk is lower among those with a job.[xlv] • Research examining unemployment and underemployment figures and suicide rates in Australia has found both were significant drivers of suicide mortality between 2004-2016.[xlvi]
Education	• Suicide risk is higher among those with fewer years of education.[xlvii] • Over three quarters of people in NSW with moderate to good mental health achieved a high school qualification compared to just under three quarters of people with poor mental health.[xlviii]
Alcohol and other Drugs (AOD)	• AOD use has a complex and multidimensional role in the development of suicidal thoughts and behaviours, and there is robust evidence that demonstrates the link between AOD use and risk of suicidality.[xlix] • 26.5% of people with a mental health condition in NSW used any illicit drug in the past 12 months in 2019 compared to 14.9% of people without a mental health condition.[l] • 28.4% of people with a mental health condition in NSW are single occasion risky drinkers in the past 12 months compared to 23.3% of people without a mental health condition.[li]

Loneliness

- Loneliness is significantly associated with experiences of depression and suicidality among men, above and beyond area-level socioeconomic disadvantage and unemployment.[lii]
- Almost half of NSW residents reported experiencing feelings related to loneliness 'some of the time' or 'often'.[liii]
- About 1 in 2 people with poor mental health reported feeling lonely compared to 1 in 8 people with moderate to good mental health. The difference is consistent across all age groups and regions.[liv]

Intergenerational trauma

- Compounding impacts of colonisation and oppressive policies and practices (including massacres and forced removals from family and Country) have had a profound and enduring impact on Aboriginal peoples' health and social and emotional wellbeing.[lv]
- Aboriginal Elders identify trauma resulting from colonisation as a root cause for increase in suicide attempts and deaths.[lvi]

Stigma and discrimination

- On average, 59.3% of Australians said they had stopped themselves from accessing or using healthcare services because of stigma about mental health issues.[lvii]
- In 2018, one in five people with a psychosocial disability in NSW experienced discrimination due to their disability in the last 12 months.[lviii]
- Nearly half (48%) of carers in NSW reported avoiding telling people about their support role to avoid being judged and 40% reported being worried that people will view them unfavourably because of their support role.[lix]
- Research assessing sociodemographic characteristics and suicide stigma based on a large-scale suicide prevention trial in NSW found higher stigma scores among Aboriginal and Torres Strait Islanders, men and people living in regional areas.[lx]
- The proportion of people with recent personal lived experience reporting experience of unfair treatment in public life domains in NSW are occurring in the following:[lxi]
    - 35% by people in the workplace
    - 31% in finding a paid job
    - 28% in applying for and getting welfare benefits or disability pensions
    - 27% by the legal system
    - 26% in education or further training
    - 21% in housing (including renting and accessing public or community housing)
- Structural stigma and discrimination can occur in employment, justice and legal systems, insurance, education, housing, and the health system.[lxii]

Gambling

- Gambling is associated with death by suicide[lxiii] and has been found to be a contributing factor in deaths by suicide.[lxiv]
- 31% of people who gamble weekly or more were experiencing harms from their gambling according to the Problem Gambling Severity Index (PGSI).[lxv,lxvi]
- Of people who play the pokies between 2am-8am in NSW, 64.4% are experiencing the harms of gambling.[lxvii,lxviii]

Legal circumstances

- Problems related to legal circumstances is a common risk factor for suicide among males aged 25-54 years old (associated with more than 10% of deaths by suicide).[lxix] This factor includes domestic violence orders, child custody or support proceedings, litigation, restraining orders, potential or impeding legal circumstances or court appearances, charges and illegal activity.

Disasters

- Research demonstrates people exposed to multiple natural disasters and human-made disasters are at significantly greater risk of attempting suicide[lxx], and the link between suicide in the aftermath of disasters is highly evidenced.[lxxi,]
- NSW has recorded 30 natural disasters across the State from Jan 2023 to Jan 2024.[lxxiii]

	• More than half (51%) of Australians who experienced a climate change-fuelled disaster since 2019 feel their mental health has been somewhat impacted, of whom one in five (21%) claim that the disaster they went through has had a “major or moderate impact” on their mental health.[lxxiv] • People living NSW are the most likely to have experienced multiple disasters since 2019.[lxxv]
Violence	• 41.0% of adults in NSW have experienced either physical or sexual violence in the last twelve months and since the age of 15 in 2021-22.[lxxvi] • Research estimates between one and two in four children and young people grow up experiencing adult family violence in Australia.[lxxvii] • Intimate partner violence against females aged 15 years and over is one of the top four risk factors contributing to almost half the burden of suicide and self-inflicted injuries.[lxxviii]
Adverse childhood experiences	• Child maltreatment is associated with youth suicide.[lxxix] • People aged 5 to 25 who have experienced sexual abuse are 3 times more likely to attempt suicide than people of the same age cohort who did not experience child maltreatment.[lxxx] • Experiences of physical and emotional abuse can double the chances of a young person attempting suicide.[lxxxi] • One in two young people in Australia grow up with some form of domestic and family violence.[lxxxii] • Child abuse and neglect during childhood of persons aged 5 years and over is one of the top four risk factors contributing to almost half the burden of suicide and self-inflicted injuries.[lxxxiii]
Living in regional, rural, and remote areas	• The highest rates of burden from suicide and self-harm were among people living in remote and very remote areas, being 2.3 times higher than in major cities in 2019.[lxxxiv] • In 2021, the suicide rate in rural and regional NSW (16.4 per 100,000 population) was more than double that of the Greater Sydney area (7.6 per 100,000 population).[lxxxv] • In 2020-21 intentional self-harm hospitalisations were 1.5 times higher in very remote areas (176 per 100,000 population) compared to residents in major cities (107 per 100,000 population).[lxxxvi]
Living with disability	• People aged under 65 years, who used disability services between 1 July 2013 to 30 June 2018, died by suicide at a rate three times greater than the general population of the same age.[lxxxvii] • The rate of deaths by suicide for females aged 20–34 years who used disability services was over five times greater than the rate among females aged 20–34 in the general population.[lxxxviii] • The rate of deaths by suicide for males aged 20–34 years who used disability services was more than double the rate among the general population of the same age.[lxxxix] • The highest rate of death by suicide, across all gender and age groups, was among men who used disability services aged 35–49 years.[xc] • For females who used disability services, the highest rates of suicide were within the 35–49 years age group.[xci]
Personal history of self-harm including suicide attempt	• A previous suicide attempt is the largest single factor indicating future suicide risk and death by suicide.[xcii] • In 2022, 17.4% of males who died by suicide had a personal history of self-harm and/or suicide attempts, and 34% of females.[xciii] • For people who have experienced a suicide attempt, risk of re-attempting is particularly heightened in the initial year following an attempt.[xciv]

Psychological distress	• Of the total NSW population, 16.7% live with high or very high psychological distress, and 7% experience a severe mental health condition.[xcv] • In 2020–2022, of the 6.3 million people aged 16–85 years in New South Wales, 40.5% or 2.5 million people had a lifetime mental disorder.[xcvi] • Three in four Australians who experienced any suicidal thoughts or behaviours in the last 12 months had a mental disorder.[xcvii]
Bereavement by suicide	• People bereaved or impacted by suicide are at an increased risk for suicide.[xcviii,xcix,c] • It is estimated that five immediate family members and up to 135 individuals can be exposed to the impact of an individual's suicide.[ci] • More than one in three people aged 16–85 years had ever been close to someone who had taken or attempted to take their own life.[cii] • 4.7% of Australians reported they had been close to someone who had taken or attempted to take their own life in the last 12 months.[ciii]
Psychosocial hazards in the workplace	• Of the approx. 10,000 serious mental stress claims in 2021-22, more than half (52.2%) were due to work-related harassment or bullying, and work pressure.[civ] • In 2021-22, mental health conditions accounted for 9% (11,700) of all serious workers' compensation claims and 7% of all work-related injuries and illnesses. This represented a 36.9% increase in claims since 2017-18.[cv]

5.2 Appendix 2 - Alignment with national strategies

The last five years has witnessed significant movement towards mental health and suicide prevention reform by the Commonwealth Government. Table 8 outlines key national strategies, frameworks, policies, and reports that support a whole of government approach to suicide prevention. Table 9 refers to key strategies, policies and reports for Aboriginal people.

Table 8 National strategies, policies, and key reports

National Strategies, Policies, and Key Reports		
National Mental Health and Suicide Prevention Agreement 2022	Policy	The Parties will collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians (Overview, 3).
National Mental Health Policy 2008	Policy	The Policy embeds a whole of government approach to mental health and recognises the need for ongoing reform.
National suicide prevention strategy for Australia's health system: 2020–2023 We note the next Strategy is in development yet to be released.	Strategy	The Strategy states an underlying principle in a systems-based approach to suicide prevention is whole-of-government efforts that recognise that suicide prevention should occur across the life course and in the multiple settings where people live, work and play. Suicide is a whole-of-society issue, and a whole-of-government approach is needed to achieve real change.
National Preventative Health Strategy 2021-2030	Strategy	The Strategy recognises that a whole-of-government response is required at all levels. This Strategy will enhance the focus on prevention not only within the current health system, but also beyond, involving other sectors and industries that have a direct impact on the health and wellbeing of Australians.
Fifth National Mental Health and Suicide Prevention Plan	Strategy	The Strategy recognises the need to ensure that implementation of the Fifth Plan is supported by an inclusive, whole-of-government approach.
Vision 2030	Framework	The Framework identifies integrated and coordinated care within and beyond the health system as a priority and seeks to inform and drive cross-sector leadership, governance, and accountability.
National Suicide Prevention Advisor's Final Advice Report 2020	Report	Key enabler: Leadership and governance to drive a whole of government approach and that the Mental Health Expert Advisory Group will act an enabler for whole of government implementation.
Productivity Commission Inquiry Report: Mental Health 2020	Report	The Productivity Commission recommended governments should, in collaboration with consumers and carers, commit to a more strategic and cross-portfolio approach to mental health that promotes genuine accountability and that prioritises prevention, early intervention and recovery (Recommendation 22). Further reforms mentioned included identifying responsibilities for suicide prevention across different levels of governments and portfolios in order to create a whole-of-government approach to suicide prevention.

Table 9 Strategies for Aboriginal and Torres Strait Islander people

Key Strategies for Aboriginal and Torres Strait Islander people

Gayaa Dhuwi (Proud Spirit) Declaration[cvi]	Policy	The Declaration on First Nations leadership across all parts of the Australian health system to achieve the highest attainable standard of mental health and suicide prevention outcomes.
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023[cvii]	Strategy	The Strategy outlines government commitment to improving social and emotional wellbeing and health outcomes for Aboriginal people. Cultural considerations must be embedded in practice to ensure culturally safe, responsive, person-centred responses.
"We are Strong. We are Resilient. But we are Tired" – Voices from the Aboriginal and Torres Strait Islander Lived Experience Centre Yarning Circles Report[cviii]	Report	The Report captures insights of Aboriginal people's lived experience of suicide to inform recommendations to government and builds on existing work to further understand Aboriginal lived experience and how it is conceptualised across other populations.
Closing the Gap – Annual Report and Implementation Plan 2023[cix]	Report	Key outcome areas of Closing the Gap includes: everyone enjoys long and healthy lives (outcome 1), children are born healthy and strong (outcome 2), and people enjoy high levels of social and emotional wellbeing (outcome 14).

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