phn SOUTH WESTERN SYDNEY

An Australian Government Initiative

SWSPHN Co-design Report

Suicide Prevention

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Introduction

Purpose

This co-design was undertaken by South Western Sydney Primary Health Network (SWSPHN) in response to funding granted to each PHN in the 2022-2023 Federal budget allocated for targeted regional initiatives in suicide prevention (TRISP). The findings and recommendations will inform SWSPHNs development of an action plan and commissioning decisions in relation to the program area.

The South Western Sydney Regional Mental Health and Suicide Prevention Plan for 2025 represents a regional strategy for addressing mental health and suicide prevention in SWS. This co-design supports the plan by building on the body of research on suicidality in priority populations. It achieves this through stakeholder consultation, data and literature review to understand suicide prevention, aftercare and postvention needs within the region, as well as utilising a systems-based approach to review current commissioned services and commissioning new activities if necessary.

This commitment to guide service procurement through co-design showcases SWSPHN's leadership in actively contributing to a comprehensive, evidence-based, and system-oriented strategy for preventing suicide across the region. Currently, SWSPHN is responsible for funding various services aimed at lowering the risk of suicide within the community. These services not only assist individuals who have survived suicide attempts but also offer support to those who have lost a loved one to suicide[1].

Aims and Objectives

This project is to commission and coordinate a systems-based approach to suicide prevention locally in SWS.

Aims

1. Enhance access to comprehensive suicide prevention and aftercare services and remove barriers for individuals within vulnerable populations *(Systems based approach 4,6,7,8)*
2. Strengthen community capacity to implement appropriate interventions in response to crises. *(Systems based approach 7,8)*
3. Increase public awareness and understanding of suicide prevention, emphasising the preventability of suicides, and promoting the use of mental health services to reduce stigma. *(Systems based approach, 9,10)*
4. Inform regional planning and develop targeted initiatives regarding suicide prevention and aftercare for vulnerable populations within the SWSPHN region, utilising a systems-based approach to improve current commissioned services, and commission new activities if necessary. *(Systems based approach 6,8)*
5. Ensure gatekeepers are supported through providing appropriate suicide prevention, aftercare and postvention training and education. (*Systems based approach 5,7,8,11)*

These aims focus on improving data quality, enhancing access to services, strengthening community response, and raising awareness to address suicidal behaviours effectively.

[1] Refer to appendix E for more information of current SWSPHN services

Objectives

1. Collate and interpret existing data and literature to understand the health issues and service needs for priority populations.
2. Understand barriers to accessing suicide prevention and aftercare services as well as gaps within these services for people with lived experience of suicide and/or suicidal bereavement and priority populations related to this.
3. Identify opportunities and priorities to improve suicide prevention, aftercare and postvention activities within the region such as:
    - Training and education need of gatekeepers.
    - Postvention communication and response protocols
    - Initiatives to reduce stigma and increase awareness of services.
    - Public awareness campaigns
    - Means restriction

A Systems based approach

A systems-based approach to suicide prevention, a World Health Organisation framework, has been used to guide this co-design. This approach suggests the causes of suicide are multifactorial and correlate with social determinants of health and wellbeing. It suggests a tailored regional and community specific approach is necessary to effectively manage this health issue. The framework includes 11 elements to guide the design and development of suicide prevention activities and services.

1. Surveillance—increase the quality and timeliness of data on suicide and suicide attempts.
2. Means restriction—reduce the availability, accessibility and attractiveness of the means to suicide.
3. Media—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. Access to services—promote increased access to comprehensive services for those disproportionately affected by suicidal behaviours and remove barriers to care.
5. Training and education—maintain comprehensive training programs for identified gatekeepers.
6. Treatment—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. Crisis intervention—ensure communities have the capacity to respond to crises with appropriate interventions.
8. Postvention—improve response to and caring for those affected by suicide and suicide attempts.
9. Awareness—establish public information campaigns to support the understanding Suicide is preventable.
10. Stigma reduction—promote the use of mental health services.
11. Oversight and coordination—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

The systems-based approach suggests strategically employing a combination of elements to ensure a comprehensive strategy to reduce suicidal risk in the community.

Co-design methodology

The Suicide Prevention Co-design project used a structured approach involving multiple consultation methods (surveys, structured interviews, and workshops). This approach was selected due to:

- The range of stakeholders to be engaged (community members, health professional, and community service providers)
- The time limitations placed on the co-design to ensure the procurement and contracting phases could be achieved for the commissioned service to commence at the end of 2023.

The systems-based approach suggests to strategically employ a combination of elements, including improving quality of treatment, enhancing crisis intervention, improving postvention services, and providing training and education, implementing means restriction, and enhancing oversight and coordination. This holistic approach ensures a comprehensive strategy to reduce suicidal risk in the community.

To assess which elements of the systems-based approach would be most effective to achieve overarching aims and are priorities within the region for priority populations, this consultation was designed to gather data on barriers and enablers to suicide prevention, aftercare and postvention and opportunities to improve services in SWS.

Data Gathering phase

The data gathering phase involved a review of population health data, external literature, and SWSPHN commissioned service provider activity. Some of the data sources used to help guide this co-design included:

- South Western Sydney Primary Health Network Needs Assessment 2022-2025
- South Western Sydney Primary Health Network Proactive Approaches to Men's Suicide Prevention Western Sydney University Full Evaluation Report
- South Western Sydney Regional Mental Health and Suicide Prevention Plan to 2025
- Roses in the Ocean: Lived Experience of Suicide Engagement, Partnership and Integration Implementation Toolkit
- Mindframe – Our words matter: Guidelines for language use

Discovery phase

The discovery phase included a survey, focus groups and structured interviews.

GP Survey

A brief online survey was administered during SWSPHN GP Initial Assessment and Referral Decision Support Tool (IAR) training. The survey was completed by 11 GPs (eight female, three male), with a median age category of 55-64 years old.

Focus Groups

Nine focus groups involving 112 participants (27 male, 83 female) were held using face to face, virtual and hybrid formats. Two of the focus groups were held in-language using Arabic and Vietnamese interpreters and co-facilitators. The co-design team engaged with key community leaders and organisations to assist with promotion of the focus groups and encouraging participation within their community or network.

The focus group were able to engage with many people who were born overseas (30%), spoke languages other than English (26%) and identified as a migrant or refugee (18%). The highest level of participation occurred in Fairfield LGA (54% of participants)[2].

The communities targeted for focus groups were based on information from the SWSPHN Needs Assessment and informed by a literature review of priority populations. Young people and CALD communities, specifically Arabic, Vietnamese and Chinese communities, were identified as the priority consumer target groups. Mental health providers were also included as a target group due to their experience in supporting individuals with suicidal ideation and crisis presentations and those in aftercare who are longer in crisis but require follow up within SWS.

LGBTQIA+ individuals, older people, men, Veterans, First Nations communities, and individuals living in semi-rural and rural areas were also identified as priority populations. Insights of these populations were prioritised into the co-design via literature review and data analysis.

Structured Interviews

Structured interviews were held with 13 accredited healthcare professionals working in the SWS region in either face-to-face or virtual meetings. Participants were recruited via an expression of Interest distributed via SWSPHN's communications channels.

[2] SWSPHN. Needs Assessment (2022). Needs assessment reporting template (swsphn.com.au)

Co-design findings

Findings from data gathering phase

Prevalence

The wider literature review showed suicide and mental ill health are significant health issues in SWS. In 2021, there were 874 suicide deaths of NSW residents, with 7% occurring within the SWSPHN[3]. SWS residents experience higher levels of psychological distress, with 18.5% of adults self-reporting high, or very high psychological distress compared to NSW average (16.9%)[8].

The data indicates high levels of psychological distress among disadvantaged groups such as young people, Culturally and Linguistically Diverse (CALD) and First Nations communities [4]. Furthermore, these groups tend to experience greater barriers to accessing mental health care.

Certain population groups face an elevated risk of suicide and have reduced access to relevant healthcare services. These groups include men, LGBTQIA+, older people, veterans, Aboriginal and Torres Strait people, people living in rural and semi-rural areas and young people. These groups are more likely to die by suicide when compared to the average population[5]. CALD groups also face an elevated risk of mental ill health and suicide; however, this is not reflected in suicide outcomes as CALD groups heavily represented in SWS have relatively low age standardised suicide rates. However, they face unique challenges in accessing mental health care and receiving mental health diagnosis due to cultural stigma and shame.

Service utilisation

Commissioned service provider data shows a consistent rise in the use of mental health services. There has been a 26.9% increase in the number of referrals processed by the SWSPHN Mental Health Intake Team and a 11.6% increase in the number of clients who receive services[6]. Furthermore, it's important to highlight, women and young people are more likely to use clinical and psychological services.

In SWS, some residents within specific Local Government Areas (LGAs) experience a disproportionate impact from mental health issues. Campbelltown has the highest number of overnight hospitalisations related to mental health, followed by Wollondilly, Wingecarribee and Liverpool.

Wollondilly and Wingecarribee , report double the rate of suicides compared to Fairfield and Liverpool. This dual challenge of high suicide rates and a significant number of overnight hospitalisations for mental health issues in LGAs like Campbelltown, Wingecarribee, Wollondilly, and Liverpool highlights the immediate need to review suicide prevention strategies and improved aftercare and postvention services in this area.

The priority population groups mentioned previously face barriers to accessing mental health care. The key barriers identified across all groups were lack of awareness of mental health services as well as priority population specific services, difficulty navigating the healthcare system, personal shame, stigma, discrimination based on priority population status, and financial issues.

[3] Health stats NSW (2021). Suicide statistics by PHN. Retrieved from HealthStats NSW
[4] *(Refer to Appendix B for more information from internal PHN documents)*
[5] *(Refer to Appendix A for specific information about suicide statistics and barriers to mental health care for these groups)*
[6] SWSPHN Qlik data

There is a need for the development of specialised services for young people with severe mental health issues and cultural sensitivity in mental health promotion, particularly for Arabic-speaking refugees, to address barriers to accessing suicide prevention, postvention and aftercare services.

Gaps were found in the quality of data relating to several priority populations, such as LGBTQIA+ and CALD, people. Some of the data is inconsistent and unreliable, resulting in limited or no data availability on suicide deaths and suicidality among these communities.

Findings from discovery phase

Thematic analysis[7] was used to categorise the information received via focus groups and structured interviews. Responses were grouped into four main categories with subcategories based on the content theme. The main categories were:

- **Barriers -** factors that decrease the chances of individuals using suicide prevention, aftercare and postvention services
- **Enablers (community consultations) -** elements that may increase patients accessing these services
- **Challenges to care provision (health service provider consultations)** - factors that make it difficult to deliver health services
- **Opportunities and priorities -** critical areas which require further investment to overcome challenges and improve access to suicide prevention, aftercare and postvention services in SWS.

Results from community consultations

The two main barriers to accessing suicide services identified were 'lack of awareness of services' and 'logistical/financial factors. Transport and cost made up most responses to 'logistical/financial factors' theme. The barriers identified were consistent across each service area (for accessing prevention, aftercare and postvention services).

CALD groups identified 'stigma/discrimination' (23%) as the main barrier to care. This included responses about cultural beliefs about suicide and mental ill-health, and shame associated with these health issues.

Overall, 'access to clinical support' provided by board-accredited healthcare professionals like psychologists and psychiatrists was identified as a factor which facilitates access to care. This includes receiving timely care and sufficient coverage in terms of duration of care. Alternatively, CALD groups identified peer support (24%) and access to helplines in language (19%) as enablers to accessing care.

Table 1: Thematic analysis of consumer focus group findings

Barriers	Enablers	Opportunity /priority areas
Lack of awareness of services (31%)	Access to clinical support (28%)	Improve public awareness of services (26%)
Logistical/financial factors (27%)	Helpline and Crisis Services (17%)	Enhance access to services (20%)

[7] *Refer to Appendix D for definitions of all themes*

Stigma/discrimination (17%)	Culturally appropriate care (13%)	Improve service coordination (16%)
Patient mental health factors - (7%)	Social support (13%)	Provide opportunities for social connection (16%)
Language barriers (7%)	Service coordination (11%)	Provide training and education for healthcare professionals (10%)
Lack of culturally safe care (6%)	Public awareness of services (10%)	Focus on culturally safe care (11%)
Poor quality of services (6%)	Access to non-clinical support (8%)	Build community capacity (2%)

There were also differences between responses from CALD and non-CALD groups regarding opportunities. 'Improve public awareness of services' was identified as the primary opportunity area for non-CALD populations. However, CALD groups overwhelmingly chose 'culturally tailored care' as their top opportunity area (46%). This includes cultural training for service providers, the availability of bilingual service providers, and enhanced translation services.

Results from service providers

Survey Findings:

GPs emphasised maintaining regular contact is the most effective approach when working with individuals who have experienced suicidal thoughts or attempted suicide (45%). Additionally, a significant 72% of respondents chose a lack of service coordination as the main barrier for patients seeking access to suicide prevention and aftercare.

Table 2: Thematic analysis of provider focus group findings.

Barriers	Challenges to care provision	Opportunity /priority areas
Lack of awareness of services (28%)	Inappropriate availability of services (39%)	Improve awareness of services (32%)
Individual's mental health factors (22%)	Lack of awareness of services (18%)	Improve service coordination (22%)
Logistical/financial barriers (17%)	Lack of funding for services (15%)	Provide training and education for healthcare professionals (19%)
Inappropriate availability of services (15%)	Patient psychological barriers (14%)	Enhance access to services (17%)
Inappropriate type of services (10%)	Ineffective service coordination (14%)	Focus on delivering culturally safe care (10%)
Inefficient service coordination (10%)		

Service providers identified 'lack of awareness of services' (28%) as the primary barrier to accessing suicide prevention, aftercare and postvention services. This refers to a service provider's understanding of available services and the referral process which can act as a barrier for patients seeking services.

When it comes to challenges in providing care, the 'inappropriate availability of services' (39%) was identified as a significant barrier. This includes long waitlists, limited opening hours, short durations of funded care, and patient eligibility for services. These issues often result in individuals not receiving timely or adequate support, exacerbating their vulnerability.

Opportunity areas and priorities involve 'improving awareness of services' among healthcare professionals (32%). This refers to ensuring healthcare providers are well-informed about the available suicide prevention, postvention and aftercare services and how to access them.

Healthcare providers play a critical role in connecting at-risk individuals with suicide services. So, improving their knowledge about available resources plays a significant role in improving patients' access to suicide prevention, aftercare and postvention services.

Identified areas of need for people in South Western Sydney

The Suicide Prevention Co-Design Project identified several common priority areas to reduce the risk of suicide.

Identified area of need	Co-design Aim	Systems based approach element
Training, education, and awareness Improve awareness and education among both community and healthcare professionals about identifying and responding to suicide risk, and the available suicide prevention and aftercare services is critical to increase service utilisation.	Increase public awareness and understanding of suicide prevention, emphasising the preventability of suicides and promoting the use of mental health services to reduce stigma. Ensure gatekeepers are supported through providing appropriate suicide prevention and postvention training and education.	5, 9,10 5,7,8,11
Access to services Address cost barriers, extending service hours, reducing waitlists, and providing psychological support to help patients overcome barriers to accessing care.	Enhance access to comprehensive suicide prevention and aftercare services and remove barriers for individuals within vulnerable populations.	4,6,7,8
Coordination and postvention protocols Support healthcare professionals and community to ensure that patients/families/friends and community are connected to the right supports.	Strengthen community capacity to implement appropriate interventions in response to crises.	7,8
Service delivery and design Tailor suicide prevention, postvention and aftercare services to meet individual needs, including providing care in the patient's language, offering personalised treatment plans, and matching the intensity of services to the patient's risk level, ensures more effective and person-centred care.	Inform regional planning and develop targeted initiatives regarding suicide prevention and aftercare for vulnerable populations within the SWSPHN region, utilising a systems-based approach to improve current commissioned services, and commission new activities if necessary.	6,8
Improved data and research Improve data available about priority populations within SWS, their risk of suicide and use of Suicide prevention, postvention and aftercare services.	Inform regional planning and develop targeted initiatives regarding suicide prevention and aftercare for vulnerable populations within the SWSPHN region, utilising a systems-based approach to improve current commissioned services, and commission new activities if necessary.	6,8

Recommendations

Recommendation 1: Enhance awareness of suicide and local prevention and aftercare services.

This recommendation aims to improve awareness of suicide and suicide prevention, postvention and aftercare services, both among patients and healthcare professionals.

Patients and professionals reported that they were unaware of the suicide prevention, postvention and aftercare services available in SWS. This is a barrier for patients accessing suicide services and poses challenges for professionals when making referrals. Additionally, GPs should be able to communicate this information in a culturally safe way that recognises patient demographics. This recommendation aligns with element 4, enhancing access to services and improving quality of treatment (element 8).

	Action Item	Description
1.1	Support General Practitioners (GPs) to identify suicidality, best practice clinical care and the services they can refer patients to.	Provide training programs for General Practitioners (GPs) to improve their skills in identifying signs of suicidality and knowledge on available services in the SWS region and how to communicate this in a culturally safe way This training could also encourage GPs to use resources like Health Pathways and Health Directory provided to assist them.
1.2	Develop resources for community about suicide prevention and aftercare services.	Create informative materials about local suicide prevention and aftercare services for both patients and healthcare professionals. Prioritise collaboration with community input to ensure resources are tailored to community needs.
1.3	Invest in public awareness campaigns promoting community suicide prevention and aftercare services.	Fund public awareness campaigns to encourage help seeking behaviours by breaking down stigma and informing the public about the availability of community suicide prevention and aftercare services.
1.4	Commission suicide prevention and awareness training for non-clinical providers that are responsive and adaptive to community needs.	Fund training for non-clinical providers such as frontline workers and community leaders to enable them to understand community needs, learn strategies to break down suicide stigma and develop strong relationships with community members. This will promote help seeking behaviour in community members and build a network of informal support. This can include co-facilitation of sessions and training the trainer initiatives.
1.5	Provide resources to GP's about culturally safe service delivery.	Supply resources about culturally safe care to support the delivery of culturally safe healthcare services.
1.6	Provide culturally safe patient information	Design and deliver culturally safe resources to patients so they can learn about suicide services, suicide prevention, and mental health.

Recommendation 2: Improve access to suicide aftercare services

This recommendation aims to address several patient-related challenges, including cost, transportation issues and long waitlists.

Patients and healthcare professionals identified logistic and financial barriers as the top 2nd and 3rd barrier respectively. This recommendation responds to identified need 2 by addressing logistic and financial barriers to improve access to suicide services. This recommendation aligns with element 4, enhancing access to services, by removing barriers to care and improving quality of treatment.

	Action Item	Description
2.1	Improve access to online and telehealth services	Improve access to online and telehealth services, making mental health support readily available to those who may prefer remote or discreet options and can also serve as a gateway to connecting them with appropriate aftercare services.
2.2	Promote Online Self-Help Resources (app, website etc.)	Promote online self-help resources and tools for individuals who may prefer to manage their recovery independently. These resources can include educational materials, self-assessment tools, and coping strategies for individuals in crisis.
2.3	Provide transportation subsidisation:	Address transportation barriers by offering transportation assistance or arranging community transportation services to help individuals access aftercare services, particularly in areas with limited public transportation options.

Recommendation 3: Enhance care coordination, including community postvention protocols.

This recommendation aims to provide effective suicide prevention, postvention and aftercare services to patients by improving follow-up and referral pathways as poor service coordination often leads to a loss of follow-up and prevents patients from receiving timely care.

Service coordination is highlighted as a priority element within the systems-based approach and was further reinforced by the findings from the consultations. This recommendation addresses the third identified need by developing structures which facilitate effective service coordination. This recommendation links to systems-based approach by leveraging element 5, training and education and element 11 oversight and coordination to support service delivery for gatekeepers to promote access to services and improve quality of care and postvention service (element 4,6).

	Action Item	Description
3.1	Facilitate cross-referrals:	Facilitate the establishment of streamlined referral processes between mental health services, other healthcare providers, and other relevant stakeholders, including first responders. Including improving patient handover through strategies such as data sharing protocols and shared clinical records.
3.2	Facilitate multi-disciplinary case conferences:	Promote and incentivise regular multi-disciplinary case conferences involving mental healthcare professionals, primary care physicians, and specialists to discuss complex cases and coordinate comprehensive care plans for patients at risk of suicide. Leverage telehealth to facilitate interdisciplinary consultations between mental health specialists and primary care providers, especially in remote or underserved areas.
3.3	Commission activities that support individuals, families and communities after the loss of a loved one to suicide	Develop postvention response protocols to deal with situations where loved ones are at risk of losing touch with support after a suicide loss. These protocols should aim to assist families in obtaining the support they require based on their needs. Additionally, these efforts should promote a community-wide response to a suicide death that is both effective and compassionate, focusing on timely coordination.

Recommendation 4: Tailor services to meet the level of patients' mental health needs.

This recommendation aims to affirm a stepped care approach by improving access to a variety of services that match the level of the mental health needs of a person who has attempted suicide or is experiencing suicidal thoughts. This recommendation links to a Systems based approach by improving access to services by improving quality of treatment and improving postvention services (elements 4,6,8).

The results of the co-design process revealed patients are more likely to be aware of acute services and are unaware of aftercare services. This recommendation responds to identified need by identifying methods to ensure suicide prevention, postvention and aftercare services meet patient mental health need thus improving service utilisation.

	Action Item	Description
4.1	Provide responsive suicide aftercare support programs:	Supportive outreach programs should be expanded to include the following groups: People living in the Wollondilly, Wingecarribee, and Bankstown LGA's during the critical timeframe of 3 months post a suicide attempt or suicidal crisis. People who live with or support a person who has attempted suicide
4.2	Provide non-clinical peer-led and mentoring services to promote social connectedness	Establish non-clinical, peer-led support services for people to connect with others with similar experiences of suicidality or suicide bereavement. This creates a supportive and understanding environment to build an informal support system. Ensure peer workers have access to appropriate and ongoing training and career development. Create awareness of the peer worker role and promote the effectiveness of non-clinical support within a multi-disciplinary approach to care.

4.3	Incentivise strategies which accommodate people at a low to moderate risk of suicide.	Such as: • Reserving/holding clinician appointments so people can be seen at very short notice. Allowances should be made for any appointments that are not used or not attended. • Completing the extensive and time critical care coordination activities including follow-up check ins. • Continuing to uphold SWSPHN's high standard of contacting referred patients within 24hrs and booking first appointments within 3-5 business days. • Providing after-hours care.

Recommendation 5: Improve suicide specific data on priority populations through additional consultations

This recommendation aims to gather data to inform service provision.

The co-design results indicated a data gap exists in SWS about the barriers, enablers and opportunities within suicide prevention, postvention and aftercare services for priority populations within SWS. This is critical because this information is needed to develop appropriate and effective responses to reduce the overrepresentation of these groups in suicide statistics. This recommendation links to a Systems based approach by improving data surveillance on suicide and suicide attempts (element 1).

	Action Item	Description
5.1	Engage community stakeholders: Involve representatives from these priority populations when designing, delivering, and commissioning services as well as in the development of resources	Facilitate opportunities for input from priority populations about the suicide prevention, postvention and aftercare services, activities and resources being delivered to them. This can include community forums and community representatives on working groups to gather qualitative insights about barriers, enablers and opportunities related to suicide prevention, postvention and aftercare services Collaborate with community leaders and community organisations that represent priority populations to gain their insights and feedback on the effectiveness of suicide prevention, postvention and aftercare services services in SWS.
5.2	Invest in more research about suicide in SWS related to priority populations	Fund activities which allow quantitative and qualitative data collection about barriers, enablers and opportunities related to suicide prevention, postvention and aftercare services for priority populations.

Appendices

Appendix A: Priority population information

- **LGBTQIA**, LGBTIQ+ people have the highest rates of both suicidal thoughts and suicide attempts in Australia; with same sex attracted Australians having up to fourteen times higher rates of suicide attempts. Within this group males who identify as gay, bisexual, transgender or intersex are four times more likely to have attempted suicide[8]. Additionally, 41% of LGBTQIA+ people did not access support services and reported the reasons as anticipated discrimination and being unaware of crisis support or LGBTQIA+ specific services[9].
- **Older people**, People within the 85+ category are most likely to die by suicide, they have an age specific death rate of 36.4 per 100,000. Followed by the 80–84-year-old age category (31.2 per 100,000)[10]. Additionally, these groups face barriers to accessing mental health support. These barriers include: a lack of services specialising in mental health care for older adults, the prioritisation of physical health care and poor mental health literacy (Wuthrich & Frei, 2015). Furthermore, this group is of specific concern as the people aged 65 years and older is projected to increase by 50% by 2041 and will have associated mental health burden that will need to be addressed.
- **Men,** Males accounted for 75.9% of deaths by suicide (2,384 deaths) in 2021, this represents an age-standardised suicide death rate of 18.6 per 100,000 people (compared with a rate of 5.8 for females)[11]. Furthermore, men are at greater risk of suicide but less likely to seek help. The reasons for this include lower rates of mental health literacy, help-seeking behaviour and stigma.
- **Veterans,** ex-serving males and females were more likely to die by suicide than the general Australian population, 24% and 102% respectively. Veterans have reported encountering significant barriers when attempting to access care, including difficulty navigating the healthcare system, a lack of after-hours care, a shortage of veteran-specific services, and mainstream service providers being unfamiliar with the veteran experience[12]
- **Aboriginal and Torres Strait Islander people,** Suicide accounted for 5.3% of all fatalities among Aboriginal and Torres Strait Islander individuals compared to non-Indigenous Australians (1.8%). Moreover, in 2019, only 31% of Indigenous individuals experiencing psychological distress sought support services. The primary reasons for this low utilisation included a feeling of judgment from mainstream service providers, lack of culturally safe care, personal shame, and fear of being judged by staff or recognised by other Indigenous patients[13].
- **People living in semi-rural and rural area** as remoteness increases, so do suicide rates, with 'Very Remote' areas experiencing an increase from 22.2 to 30.2 deaths per 100,000 people.[14] Additionally,

[8] Skerret DM. Mental Health and Suicidal Behaviours in LGBTI Populations and Access to Care in Australia: A Literature Review, prepared for Queensland AIDS Council (2014)
[9] LGBTQIA+ Health Australia. (2021). Retrieved from The 2021 update - LGBTIQ+ Health Australia
[10] AIHW. Suicide and Intentional Self-harm. (2021). Retrieved from Suicide and intentional self-harm - Australian Institute of Health and Welfare (aihw.gov.au)
[11]Suicide Prevention Australia. Stats and Facts. (2021). Retrieved from Stats & Facts - Suicide Prevention Australia
[12] AIHW. Annual Defence suicide deaths reporting. (2021). Retrieved from Annual Defence suicide deaths reporting - Australian Institute of Health and Welfare (aihw.gov.au)
[13] AIHW. Suicide prevention. (2022). Retrieved from Suicide prevention - AIHW Indigenous MHSPC
[14] AIHW. Suicide by remoteness areas. (2021). Retrieved from Suicide by remoteness areas - Australian Institute of Health and Welfare (aihw.gov.au)

dense, remote areas face significant barriers to accessing mental health services such as limited help-seeking behaviors, confidentiality concerns, cultural stoicism, travel expense, social factors, workforce shortage and resource limitation[15]. disparities.

- **Young people** In 2021, suicide emerged as the leading cause of death among Australians aged 15-24. In this year 322 young people aged 18-24 died by suicide[16]. Among children and adolescents aged 17 and below, there were 112 reported suicides, with a significant majority occurring between the ages of 16 and 17, accounting for 71% of these deaths. Additionally, young individuals encounter several barriers when seeking help from adults, including feelings of embarrassment, uncertainty, concerns about breaking the trust of their friends, and a fear that the situation might worsen if an adult becomes involved in their struggles [17]
- **CALD** – People from Culturally and Linguistically Diverse (CALD) communities may experience higher levels of psychological distress compared to other Australians due to their exposure to traumatic events, such as war, separation from family and friends, or the migration process. While the data on exact statistics for this group is sparse. The key barriers to accessing care for this group are language difficulties, processes of acculturation, cultural stigma, low mental health literacy, discrimination, racism, social isolation, financial issues, and even academic pressure [18]

[15]NRHA. Mental Health Factsheet. (2021). Retrieved from nrha-mental-health-factsheet-july2021.pdf (ruralhealth.org.au)

[16] AIHW. Suicide among young people. (2021). Retrieved from Suicide among young people - Australian Institute of Health and Welfare (aihw.gov.au)

[17] Michelmore L, Hindley P. Help-seeking for suicidal thoughts and self-harm in young people: a systematic review. Suicide Life Threat Behav. 2012 Oct;42(5):507-24. doi: 10.1111/j.1943-278X.2012.00108.x. Epub 2012 Aug 13. PMID: 22889130.

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Appendix B: Internal document review

Needs assessment

Since 2011-12, mental health services in the SWS region have steadily increased, with notable growth in GP and Clinical/other Psychologist Mental Health Services. In 2018-19 and 2020-21, about 12% of the SWS population, roughly 13 out of every 100 people, used these services, although this figure is lower than the NSW average. Nonetheless, the consistent upward trend highlights the importance of this area.

Service use:

- GP mental health services in SWS rose from 10.8 per 100 people in 2013-14 to 13.2 per 100 people in 2020-21.
- Clinical psychologists and other psychologist services in SWS increased from 17.5 per 100 people in 2018-19 to 19.3 per 100 people in 2020-21, though these rates were slightly below the national averages.
- In 2020-21, other allied healthcare professionals' Medicare-subsidised mental health services in SWS lagged the national rate.
- Women were more frequent users of GP and clinical psychologist services compared to men, and young individuals aged 15-24 exhibited the highest service utilisation rates.
- There is high mental health related ED presentations and hospitalisations in Campbelltown and Liverpool LGAs. Indicating the need for prevention and aftercare services within South Western Sydney SWS
- Young people with severe mental health illnesses – surveys and consultations with young people and clinicians identified the specific service needs for this group and the need for a specialised, youth friendly and person-centred service.

In summary, mental health service usage has consistently grown in the SWS region, marked by variations in service types and preferences across different demographic groups.

Health need:

- Psychological distress was highest in the most disadvantaged groups (such as LGBTQI people) and young people.
- There is low mental health literacy in CALD population
- Increased burden of disease in Aboriginal population.
- CALD are a high-risk group" According to *2018 ABS Health Literacy Survey [*12], people who speak LOTE are less likely to feel understood and supported by health care providers. With on ly 26% of LOTE participants finding it easy to actively engage with health care providers. Furthermore, people from CALD background have considerably lower levels of health literacy compared with the general population. This means CALD population groups are less likely to access the services they need or understand issues related to their health

'Men's proactive approach to suicide prevention'

- A lack of peer-based initiatives with access to emotionally intelligent male role models resonated with men was reported in the 'Men's proactive approach to suicide prevention project'
- Mentoring and support groups have been identified as key strategies to reduce suicide rates in men.

- Many existing projects, initiatives and services don't resonate with men.

Regional mental health and suicide prevention plan

- Key priority area was 'strengthening suicide prevention and aftercare'.
- Improving mental wellbeing of Arabic speaking refugees and culturally sensitive mental health promotion program
- People from CALD backgrounds often have poorer mental health outcomes, higher risk of mental health problems than Australia born people. Additionally face stigma, language barriers which compound the issue.

Appendix C: Definitions of themes

Results from consumers

Barriers	Enablers	Opportunities /priority areas
Lack of public awareness of services - lack of knowledge and understanding of available healthcare or support services among the public, making it easier for individuals to access and benefit from these services when needed.	**Access to clinical support -** Access to psychologist, psychiatry and other accredited healthcare professionals in a timely manner	**Improve public awareness of services** enhance the knowledge and understanding of available healthcare or support services among the public, making it easier for individuals to access and benefit from these services when needed.
Logistica/Financial factors- Cost of service, transport to service	**Helpline and crisis services –** Access to non-face-to-face services.	**Enhance access to services** Address logistic and financial barriers to accessing suicide prevention, postvention and aftercare services
Stigma/discrimination - negative attitudes, stereotypes, prejudice, or discriminatory actions directed towards individuals who have mental health conditions,	**Culturally appropriate care –** Support that is sensitive to and respectful of an individual's cultural background, beliefs, and values, with the aim of providing care relevant and effective within their cultural context.	**Improve service coordination** - process of enhancing the organisation and management of various services and resources to ensure individuals receive seamless and well-coordinated care, reducing gaps and inefficiencies in their healthcare journey.
Patient mental health factors- patient motivation and difficulties in managing symptoms of ill health can prevent individuals from seeking care.	**Social support** - Assistance and encouragement provided by family, friends, and loved ones to promote emotional well-being, social connectedness, and overall mental health.	**Provide opportunities for social connection** - Initiatives and activities designed to create spaces and environments where individuals can interact, build relationships, and foster social bonds, promoting mental and emotional well-being
Language barriers - Communication obstacles arise when individuals and healthcare providers do not share a common language	**Service coordination** - The process of organising and facilitating access to various services, often involving referral pathways and follow-up to ensure individuals receive comprehensive care and support.	**Provide training and education for healthcare professionals - on**going learning opportunities and educational resources for healthcare practitioners to update their knowledge and skills, enabling them to deliver high-quality care
Lack of culturally safe care - The absence of healthcare practices and environments that respect and cater to the cultural beliefs, values, and needs of individuals from diverse backgrounds	**Public awareness of services** the knowledge and understanding of available healthcare or support services among the public, making it easier for individuals to access and benefit from these services when needed.	**Focus on cultural safety** - A healthcare approach that emphasises providing care in a way that is culturally respectful, aware, and sensitive to the unique needs, values, and beliefs of individuals from diverse cultural backgrounds
Poor quality of services – lack of long-term services, lack of support and empathy from healthcare professionals.	**Access to non-clinical support** - Peer Workers, lived experience support groups	**Build community capacity –** providing opportunities to improve community knowledge on suicide and the importance of accessing care

Results from providers

Barriers	Challenges to care provision	Opportunities /priority areas
Lack of awareness of services	**Inappropriate availability of services**	**Improve awareness of services**
Individual's mental health factors - patient motivation and difficulties in managing symptoms of ill health can prevent individuals from seeking care.	**Lack of funding for services** - Funding challenges encompass difficulties in accessing resources to expand the workforce, addressing salary concerns, and the lack of Medicare Benefits Schedule (MBS) items to support patients.	**Provide training and education for healthcare professionals** - ongoing learning opportunities and educational resources for healthcare practitioners to update their knowledge and skills, enabling them to deliver high-quality care
Logistical/financial barriers – Cost of service, transport to service	**Lack of awareness of services** - aims to ensure healthcare providers are well-informed about the available suicide prevention, postvention and aftercare services and how to access them	**Enhance access to services** - Reducing time to see specialist, cost of service and transport/distance barriers, Aswell as improving afterhours care
Inappropriate availability of services – Opening hours, waitlists,	**Patient psychological barriers** - patient motivation and difficulties in managing symptoms of ill health can prevent individuals from seeking care.	Focus on delivering culturally safe care A healthcare approach that emphasises providing care in a way that is culturally respectful, aware, and sensitive to the unique needs, values, and beliefs of individuals from diverse cultural backgrounds.
- services too acute **Inappropriate type of services** /not matching patient need	**Ineffective service coordination** - issues with referral pathways, lack of follow-up	**Improve service coordination** - process of enhancing the collaboration and communication among healthcare providers and support services to ensure that individuals receive comprehensive and seamless care, reducing gaps, redundancies, and inefficiencies in their healthcare journey.
Inefficient service coordination – issues with referral pathways, lack of follow-up		

Appendix D: Focus Group Breakdown

Focus group	Location	No. Participants
Young People	Community Links Tahmoor	8
Safe Haven Peer Workers + Service Users (community)	Safe Haven Campbelltown	15
CALD: Arabic Speaking Group	Core Services Fairfield	20
Regional Planning Implementation group (LHD TZS Staff, L.E advisor, Service Provider staff)	Hybrid Setting (SWSPHN)	7
CALD: Vietnamese Women's Group	Cabramatta Library	40
CALD: Mandean Women Union	Liverpool Women's Health Centre	8
CALD: Chinese & Vietnamese Speaking Group	Mounties	8
Campbelltown Youth Reference Group	Headspace Campbelltown	3
Liverpool Youth Reference Group	Headspace Liverpool	5

Appendix E: Current South Western Sydney services

Lifeline Macarthur and Western Sydney Suicide Aftercare Program – Provides short term telephone crisis support for adults who have survived a suicide attempt, providing much needed support in the crucial time following the attempt.

Eclipse Support Group - A support group for adults who have survived a suicide attempt, regardless of whether the attempt was recent or in the past. The group is a safe space where people can talk openly about their suicidal ideation and attempts with others with similar lived experiences.

Suicide Bereavement Support Groups - Provides a safe place to share thoughts, ideas and feelings with others who understand the enormity of the loss.

Suicide Prevention Networks - Brings together health, education, emergency services, community members and community organisations to help save lives by identifying and establishing collaborative community responses and prevention strategies to increase suicide education and reduce stigma.

Corporate and Community Training - Offers a wide range of training courses to corporate businesses and community groups, facilitated by accredited trainers who work with participants to promote an inclusive culture or workplace that de-stigmatises suicide and mental health issues and encourages help-seeking.

The Way Back Support Service – 12-week peer-led outreach support for people who have been discharged from an Emergency Department or referred by a SWSLHD Community Mental Health Team following a suicidal crisis or attempt.

Clinical Suicide Prevention Service – Priority access to clinical psychological therapy for people who have attempted suicide or have suicidal ideation of low to medium risk.