

## **Draft Advice on the National Suicide Prevention Strategy – Submission to Public Consultation**

The National Suicide Prevention Office (NSPO) sought submissions on the draft Advice on the National Suicide Prevention Strategy. The draft Strategy builds on the significant work already being done in suicide prevention, including under the National Mental Health and Suicide Prevention Agreement. The Strategy draws on numerous other existing agreements, plans, strategies, reports, submissions and inquiries, as well as specifically commissioned research. The work has been informed and guided by the insights of people with lived and living experience of suicide and the people who support them, provided during targeted consultations with groups disproportionately impacted by suicide. For further information see [Public Consultation - Advice on the National Suicide Prevention Strategy Consultation draft](#)

### ***About Research Australia***

Research Australia is the peak body for the Australian health and medical research and innovation sector. Our membership is drawn from the whole pipeline of health and medical research and innovation, from universities and medical research institutes to charities and patient groups, and health care providers and companies commercialising new health technologies.

This submission has been informed by our members and the previous work of Research Australia, including discussions held with Research Australia's expert Mental Health Working Group.

Research Australia looks forward to the opportunity to work with the NSPO in designing and implementing the range of activities recommended below, across the health and mental health research pipeline.

### ***Recommendations***

*Research Australia recommends the following:*

- A stronger narrative throughout the Strategy including Key Objectives and Enablers focussing on evidence informed and evidence based practice, increasing research and data, including the implementation and translation of existing and emerging evidence, across the entire Strategy.
- An increased narrative throughout the Strategy on addressing the impact of social determinants including but not only in relation to health outcomes, and includes the impact of discrimination and intersectional discrimination, on prevention and supports.
- Increased focus on priority groups, with dedicated actions throughout Key Objectives and Enablers.
- A targeted focus on lived experience researchers, including the development of a dedicated strategy that addresses the role of lived experience researchers across leadership, governance and policies (such as across ethics frameworks and committees), and workforce.

- A range of dedicated actions aimed at increasing a research aware and research active workforce across all health, human, education and community services relevant to the work of suicide prevention. Specifically, the Suicide Prevention Strategy should include:
  - Mechanisms for informing and upskilling professionals so they can rapidly translate evidence into practice
  - Incentives to promote partnership between research institutes and service systems to enable research to be done in community with support for the workforce to undertake education and training.
  - Better pathways for those working in suicide prevention to upskill in research, from championing translation to leading investigation
  
- Increased actions to addressing data, data linkages and data infrastructure, supported by a dedicated data-aware workforce, including at local levels.
  
- Commitment to the sustainable implementation, including resourcing of successful pilots, with options for upscaling using implementation science.
  
- Specific actions dedicated to evidence, research and data in relation to capable and integrated workforce, as well as increase a focus on the role of clinician researcher type roles to support a research aware and active workforce. Specifically, workforce development should be informed by:
  - Evidence based learning outcomes, approaches and processes
  - Evaluations to determine outcomes of education processes
  - Capability development that enhances person-centred, culturally safe, inclusion of people with disability, gender sensitive, child and youth centred, trauma led and healing informed, and rights informed.
  
- The development of a structured mechanism to fund the research and data activities across the Strategy.

**How well does the Advice on the Strategy articulate what is required for long-term change in suicide prevention?**

The Advice articulates a range of Key Objectives and Enablers well. We agree with both a focus on prevention and on supports. However, there is a need to have a stronger narrative across all the Key Objectives and Enablers.

We note a strong focus on data and research, and the call for better coordination of data collection, research and dedicated efforts of funding bodies and the need for a coordinating mechanism. We agree that the Strategy requires great engagement with States and Territories and the health system. However, this could be strengthened with specific actions and recommendations under each Key Objective and Enabler that focusses on increasing research and data, including the implementation and translation of evidence.

We specifically acknowledge the focus on social determinants, and the specific disparities and the way they manifest differs between communities, including recurring themes include experiences of discrimination, economic insecurity, stigma, poor health outcomes, and reduced access to supports capable of responding to their needs (p7). Given this strong acknowledgement, there seems to be a lack of linking of these determinants in Figure 2, particularly in addressing prevention. A stronger narrative throughout on the impact of social determinants could be strengthened, including but not only in relation to health outcomes.

We acknowledge that throughout the Strategy there is mention of other frameworks and strategies which is positive, however, this can be strengthened. For example, the Key Objectives focussed on Social Inclusion and Exclusion could be strengthened to understand the impact of discrimination in community participation, as well as access to both preventative services as well as supports. For example, with regards to people with disabilities, 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 (AIHW Monitoring Data). Further to this example, recommendations focussed on neurodiversity as well as disability could be aligned with specific Roadmaps such as the National Roadmap to Improve Health and Mental Health of Autistic People or the National Roadmap for Improving the Health of People with Intellectual Disability, as well as implementing the recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of people with disability.

We note the call for discrete research on priority populations who are more likely at risk, however, we note there is little focus throughout the strategy specifically targeting men. Further to the call for discrete research, this call could additionally be strengthened with a specific focus more explicitly acknowledging intersectional experiences and the need to address multiple forms of discrimination in some priority groups across the recommendations.

We note with the five essential components of the effective support system, of

- A culture of compassion – increase engagement with supports through reduced suicide stigma, reduced knowledge of and access to means, and increased capability of community and services
- Accessibility – affordable, timely and acceptable supports are available
- System-level coordination – supports are seamlessly linked and easy to navigate
- Holistic approaches – address drivers of distress and sustain engagement
- Increased connection – restore and build wellbeing through increased social connection and community engagement

However, underpinning all of these components should be specific focus on the evidence to ensure the essential components are person-centred, culturally safe and responsive, inclusive for people with disability, gender sensitive, child and youth centred, healing led and trauma informed, and rights informed.

We agree with the strong focus on prevention and social determinants that impact on prevention, however, some of the recommendations take a very individual responsibility approach to addressing social determinants rather than a systems change approach. Given Key Objective 8: system-level coordination, this could be further strengthened by focussing on specific recommendations on the implementation, uptake and success on system's level coordination. There is a key role for health services research and health systems research to help improve the existing system.

We specifically acknowledge the important focus on economic disadvantage including unemployment, low income, income uncertainty. However, a specific focus on poverty, including its impact on children and young people (see Bessell and Sullivan 2024) could strengthen this narrative as well as mentioning of the implementation of the recommendations of the [Senate Inquiry into the extent and nature of poverty in Australia](#) (noting other senate inquiries and Select Committees' reports are included in the strategy).

### **Is there anything critical to preventing suicide in Australia, that the Advice on the Strategy does not address?**

Research Australia recommends the inclusion of a stronger narrative that focusses on evidence informed and evidence based practice across the entire Strategy, including Key Objectives and Enablers. We acknowledge Critical Enabler 3 goes some ways to addressing this, however, having evidence informed and evidence-based approaches as a Key Objective, supported by data infrastructure, would elevate the importance of research and data to suicide prevention. This will ensure that all focus areas would be designed, implemented, evaluated, and where it doesn't yet exist, would build our understanding of what

works, and what doesn't; this would include identifying appropriate evaluation frameworks of prevention and support programs, as well as systems change. This principle should be underpinned by a framework that is designed by people with lived experience and could build on the principles of similar existing data and research frameworks or guidelines.

The following provides specific responses to each of the four enablers.

#### Enabler 1: Improved Governance

Research Australia strongly agrees with the need for dedicated leadership, governance structures and capability development across the Australian Public Service and jurisdictions in understanding each portfolio's role and responsibility in contributing to suicide prevention. Examples on what has worked and what hasn't worked for taking cross-portfolio approaches in frameworks such as Closing the Gap and Australia's Disability Strategy should be identified. Without a dedicated approach, an everyone's responsible approach can lead to no one being responsible. Further work could be undertaken to identify pooled funding given the cross-portfolio responsibilities.

As part of the embedding cross-portfolio approach, consideration to what opportunities and gaps may exist in government enabled research and data infrastructure should also be given, including what is available in Person Level Integrated Data Asset (PLIDA).

Within this Enabler, the focus on regional responses require stronger articulation of actions related to research and data. This includes specific consideration of capacity at local levels to collect, maintain, interpret and apply local level data, and goes to the need for research active workforce. See Critical Enabler 3 with regards to further information regarding regional approaches.

#### Critical enabler 2: Embedded lived experience

Research Australia strongly supports and acknowledges the clear call for greater engagement of people with lived experience. In a move from engagement of people with lived experience, to genuine partnership with lived experience, this should be the cornerstone of improvement in all aspects of the health system and other service support systems, including research. However, we feel that there is a gap and opportunity to further develop the role of researchers with lived experience. Implementing best practice in lived experience research ensures that the voices of those with lived and living experience are not only heard but also respected, valued and amplified in the research process.

#### The role of lived experience researchers

Lived experience researchers are not research participants but rather those who use their personal knowledge and expertise to inform the strategic direction, governance, design and delivery of research. They are most prominent in mental health research, in addressing research questions related to the delivery of care and service design. They have research expertise and may have formal qualifications, particularly in social sciences, but not necessarily a higher degree research qualification.

Those working in lived experience research roles consistently report challenges in being recognised within the research community. While their work is often referenced and utilised in policy, grey literature, service design and intangible knowledge sharing, there is little recognition or support of lived experience researchers in traditional funding or publishing methods. Often lived experience researchers are not able to be identified as a chief or principal investigator and may not even be acknowledged as a formal author or contributor to their work. There needs to be a recognition that expert lived experience researchers may not have a traditional research career pathway.

Within the current research system, a lack of formal recognition or publication of work makes finding future funding, permanent roles and research partners more difficult. It also significantly impacts the ability for research to engage with lived experience experts at the conceptualisation, design and planning stages,

missing the opportunity for true co-design and resulting in often tokenistic engagement with lived experience.

There is a strong need for leading lived experience researchers to champion best practice in the health and medical research landscape, and a growing recognition of the importance of involving people with lived experience in leadership of research projects. There are few opportunities for lived experience researchers and experts to engage in the design of research and complete early exploratory activities to support future larger grant proposals or fellowship applications based on true co-design and lived experience leadership. Lived experience expertise and leadership can be embedded in research through roles such as lead or co-leading investigators, peer researchers, advisers and independent consultants.

To further embed the role of lived experience researchers, we recommend a dedicated strategy that addresses leadership, governance and policies (such as across ethics frameworks and committees), and workforce actions.

### Critical enabler 3: Available and translated evidence

Research Australia recommends a range of dedicated actions aimed at increasing a research aware and research active workforce across all health, human, education and community services relevant to the work of suicide prevention. We recommend the Suicide Prevention Strategy include:

- Mechanisms for informing and upskilling professionals so they can rapidly translate evidence into practice
- Incentives to promote partnership between research institutes and service systems to enable research to be done in community with support for the workforce to undertake education and training.
- Better pathways for those working in suicide prevention to upskill in research, from championing translation to leading investigation

We note that there are a number of pilots mentioned throughout the plan. Further commitment of the sustainable implementation, including resourcing of successful pilots and ongoing support for upscaling using implementation science needs to be included in the Strategy to prevent the impact on communities when programs are design, implementation and successful, but then fail due to the lack of ongoing support.

Further to research aware and active workforce, a dedicated focus on data needs further consideration and would include:

- Investment in data collection, linkage and dissemination through activating
  - Improved linked data systems
  - Improved data infrastructure, as noted in our [Submission](#) to the Consultation on the National Digital Research Infrastructure Strategy. This is not only a technical computing challenge, but requires infrastructure and workforce to support governance processes and the development of data sharing standards. It also requires integration with systems outside the Research Infrastructure system, for example with health system data infrastructure across jurisdictions as well as operating systems.
  - Invest in the creation of new workforce across the service system that may be employed specific for data analysis and application to service improvements
- As noted above in the focus on regional plans, there needs to be an increase in governments' dissemination of data back to organisations and the service system to enable localised decisions about the needs of the community. This would also require increased capacity and capabilities of organisations and the service system to apply data to service delivery in order to understand the needs of Autistic people within their services.

- For example, Priority Reform 4 of the National Agreement of Closing the Gap requires shared access to location specific data and information to support Aboriginal and Torres Strait Islander communities and organisations to be genuine partners, build the community controlled sector and measure transformation of mainstream organisations in addressing systemic racism. A similar reform agenda could and should be applied to the Strategy.

***Critical enabler 4: Capable and integrated workforce***

Research Australia recommends a specific action dedicated to evidence, research and data in relation to capable and integrated workforce, as well as increase a focus on the role of clinician researcher type roles to support a research aware and active workforce. Specifically, workforce development is informed by:

- Evidence based learning outcomes, approaches and processes
- Evaluations to determine outcomes of education processes
- Capability development that enhances person-centred, culturally safe, inclusion of people with disability, gender sensitive, child and youth centred, trauma led and healing informed, and rights informed.

Further to individual roles and capabilities, focus needs to be given to creating and maintaining environments that enable researcher capacity and capability. For example, the draft Good Institutional Practice Guide (the Guide), released by NHMRC identifies the importance of workplace environments ‘to promote open, honest, supportive and respectful institutional cultures conducive to the conduct of high-quality research’. Our response to the [Guide](#) provides further information.

**Which actions do you think are the highest priority?**

We reiterate that a focus on evidence, research and data including enabling infrastructure should be a priority across all activities and recommendations.

***Is there anything else you would like to tell us in response to the draft Advice on the Strategy?***

The Strategy would be strengthened through the development of a structured mechanism to fund the research and data priorities. One opportunity is through the Medical Research Futures Fund.

Thank you again for the opportunity to submit a response. For further information please contact our Head of Policy, Dr Talia Avrahamzon – [talia.avrahamzon@researchaustralia.org](mailto:talia.avrahamzon@researchaustralia.org)

Warmest



Nadia Levin

CEO & Managing Director

Research Australia

## ABOUT RESEARCH AUSTRALIA

Established with the assistance of the Federal Government in 2002, Research Australia is the national alliance representing the entire health and medical research (HMR) pipeline, from the laboratory to the patient and the marketplace. Research Australia works to position Australian HMR as a significant driver of a healthy population and a healthy economy.

**Our vision:** Research Australia envisions a world where Australia unlocks the full potential of its world-leading health and medical research sector to deliver the best possible healthcare and global leadership in health innovation.

**Our mission:** To use our unique convening power to position health and medical research as a significant driver of a healthy population and contributor to a healthy economy.