Evidence Brief

# Enabler 4: Workforce and community capability

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## Definition and scope of this enabler

The aim of this enabler is to lay the groundwork for the National Suicide Prevention Workforce Strategy by outlining priority actions that are needed now to build the capability of workforces in suicide prevention. The Workforce Strategy will adopt a broad definition of the suicide prevention workforce that reflects the importance of a whole-of-community approach to suicide prevention and is inclusive of people who are likely to interact with, or make decisions that affect, someone who might be vulnerable to suicide.

## What are the key issues?

Key workforce challenges in suicide prevention are:

- The Australian suicide prevention sector is experiencing pervasive workforce shortages, across clinical, non-clinical, and peer workforces (reported by 83% of sector agencies) which are exacerbated by increased service demand and driven up through pandemic and economic (housing affordability, cost of living) pressures, as well as associated social and employment-related drivers of distress (1, 2, 3).

- The traditional sector reliance on the clinical workforce at the point of acute crisis (in emergency, primary care, and mental health service settings) is insufficient to address the magnitude of this problem and the nature of its underpinning drivers (4, 5). Simultaneously, moving beyond traditional perceptions of suicide prevention as the remit of health and crisis services requires recognising and articulating the broader roles and responsibilities across a broader understanding of the suicide prevention workforce.

- A whole-of-community and public health approach to suicide prevention (6), which increasingly addresses the social and upstream determinants of suicide, therefore requires strengthening workforce capacity both within and beyond the sector to develop the capability of wider community and societal stakeholders across different roles and settings (including peers, community members, gatekeepers, frontline workers, and government staff) in effective suicide prevention.

## What is currently happening (in Australia)?

- Suicide prevention workforce issues have been recognised in key national policy documents and reports and there is considerable momentum to build workforce capacity (2, 3, 5, 7).

- Current Australian approaches to workforce planning and capacity building in suicide prevention are disjointed and not concerted, involving varied frameworks and stakeholders at agency, sector, regional, state/territory, and national levels.

- Workplace-based approaches to suicide prevention capacity building at individual agency-level or within specific industry settings are important and well established in Australia (8, 9) but not a substitute for overarching sectoral workforce strategy, frameworks, and planning.

- There is a plethora of relevant existing training courses and providers available that can be leveraged to build capacity but very little systematic data to ascertain the profile, capability, levels, as well as training and support needs of the diverse suicide prevention workforce.

- Variable progress has been made in developing and implementing core competency and qualification frameworks for specific workforce groups and settings.

- There is wide recognition of the important role of people with lived experience in service design and delivery, along with considerable momentum to foster lived experience peer workforce roles, yet also some way to go in fully developing and effectively integrating required peer workforce capacity across a wider range of sector settings.

## What are the critical gaps and where should efforts be focused (in Australia)?

- A designated National Suicide Prevention Workforce Strategy will advance concerted and strategic workforce planning and development across jurisdictions, sectors, and settings, in alignment with presenting community needs, to ensure required future workforce supply and capability to effectively prevent suicide in Australia.

- National and jurisdictional workforce planning requires current and systematic workforce data. To facilitate effective future workforce planning and development, it will therefore be important to profile the diverse suicide prevention workforce across relevant sectors to better understand its size, capabilities, diverse experiences, work roles and settings, as well as associated training, development, and support needs.

- The National Mental Health Service Planning Framework (10) already informs national and jurisdictional modelling of mental health workforce supply and demand; and is currently being expanded to inform suicide prevention workforce and service planning.

- To underpin concerted workforce capacity building and development, it will be essential to implement core competency standards for the suicide prevention workforce in key roles and settings, including competencies for understanding and addressing social determinants.

- Existing key workforce challenges and expert consultation feedback (EC) highlight the need for increased investment and training to build the capacity of a diverse suicide prevention workforce across clinical, non-clinical and community settings.

- In line with this, it is essential to ensure appropriate diversity and make-up of the workforce so that it is equipped to better engage with groups disproportionately impacted by suicide, whilst expanding participation into relevant broader sectors and domains beyond health.

# ENABLER 4 ACTIONS

## Action 1
**Develop a National Suicide Prevention Workforce Strategy**

### Define action

Building on the National Suicide Prevention Strategy and related workforce strategies, the NSPO will lead the development of the National Suicide Prevention Workforce Strategy. The Workforce Strategy will identify priorities to build and sustain a capable suicide prevention workforce by: i) identifying the broad range of workforces that have a role in suicide prevention; ii) identifying mechanisms and priorities for resourcing the work required to attract, train, maximise, support and sustain an effective suicide prevention workforce; iii) progressing consistent approaches to developing the suicide prevention capability of workforces through competency frameworks, resourcing for training and implementation support for organisations; iv) supporting the expansion and integration of the suicide prevention peer workforce; v) making recommendations to enhance organisational and workforce capacity for culturally safe and inclusive suicide prevention; and vi) identifying opportunities to address system issues that limit the ability of services to provide best-practice care, inclusive of factors such as resourcing and workforce culture.

### Evidence for the action and possible sub-actions

At present, there are no existing international examples of standalone national suicide prevention workforce strategies. Notwithstanding this lack of benchmarks, the Australian Suicide Prevention Workforce Strategy is therefore bound to be the first national strategy of its kind in the world.

While broader national suicide prevention strategies typically incorporate training and education components (11), the mere inclusion of these capacity building components in national strategies has so far not been linked to changes in suicide rates (12).
Current suicide prevention strategies in Australian jurisdictions also incorporate priority actions for workforce development and support (13). In Tasmania, this included a designated suicide prevention workforce development and training plan, which set out key actions to support priority workforces and groups to provide effective and compassionate care and support to people experiencing suicidal thoughts and behaviours (14). However,

while jurisdictional strategies and plans include indicators and are subject to regular review, evidence regarding their implementation and impacts is currently lacking.

Broader national and jurisdictional workforce strategies and policies of relevance to mental health provide useful models to inform national workforce strategy development in suicide prevention (1, 15). Yet, despite the overlap in workforces considered, specific suicide prevention workforce components are largely absent in mental health strategies, further underscoring the benefits of a designated national suicide prevention workforce strategy.

## Things we can build upon

Development and implementation of the National Suicide Prevention Workforce Strategy should actively build on and integrate with other existing national and jurisdictional workforce strategies of relevance to suicide prevention. Specifically, linkages between national mental health and suicide prevention workforce strategies should be clearly articulated (in terms of workforce overlaps, competency frameworks, workforce planning, development, and support mechanisms) to ensure that these can optimally integrate, complement, and reinforce each other. Monitoring and evaluation are further key to demonstrating ongoing implementation progress and impacts.

# Action 2

**Develop a competency framework, training and implementation guidance to build the suicide prevention capability of government staff**

## Define action

Develop a competency framework for government staff involved in development of policy and making funding decisions related to suicide prevention to build core knowledge about how:

i) policy and funding can support suicide prevention and avoid contributing to suicide risk.
ii) to effectively partner with people with lived experience of suicide to inform policy and funding.
iii) to incorporate cultural safety and inclusivity into suicide prevention policy and funding.
iv) to improve monitoring and evaluation of suicide prevention programs to measure outcomes and support continuous improvement.
v) to improve data collection to build understanding of community needs and inform policy and funding decisions.
vi) to support coordination and prioritisation of research to build the suicide prevention evidence base.

Amend available or develop new suicide prevention training for the government workforce aligned with the competency framework that incorporates (or builds on) the Shifting the Focus tool.

## Evidence for the action and possible sub-actions

A scan of the literature indicates that designated competency frameworks or training programs for this specific target group (government staff in policy and funding roles) are unlikely to exist already. Nevertheless, several generic competency frameworks of relevance to suicide prevention outline broadly applicable core competencies and basic knowledge

and skill requirements for diverse roles, which can be used as a starting point and further tailored or expanded as needed:

- The Shifting the Focus report (7) outlines workforce categories and competencies required for government and public sector agencies, which are primarily aimed at direct service staff (in clinical, frontline, and community settings), while basic competencies (e.g., general awareness and knowledge) also apply to policy and funding roles.

- The Suicide Prevention Competency Framework (8) outlines non-clinical suicide prevention competencies across four key domains (induction and continuous development, knowledge, safe communication, and collaborative support). These useful foundational competencies have broad workplace applications but are not directly aimed at policy/funding roles.

- England's Self-harm and Suicide Prevention Competence Framework (16) outlines three parallel frameworks of professional self-harm and suicide prevention competencies for working with children/young people, adults/older adults, and the wider public/community. While these have implications for training curricula, organisations, clinical governance, supervision, and research, they are primarily aimed at guiding service delivery.

- Scotland's Knowledge and Skills Framework for Mental Health Improvement, Self-Harm and Suicide Prevention (17) provides an example of an integrated national knowledge and skills framework that caters for both mental health and suicide prevention workforces. It sets out four graded knowledge and skills levels specific to a person's role in relation to mental health improvement and the prevention of self-harm or suicide (informed, skilled, enhanced, and specialist). Beyond the informed level, the specialist level is arguably the most relevant to articulating competencies of government staff in policy and funding roles.

- The Australian Public Service Mental Health Capability Framework (18) provides a systems-based approach to building mental health and suicide prevention capability within public service agencies underpinned by six evidence-informed domains (prevent harm, promote mental health, support recovery pathways, build literacy and develop capability, leadership and governance, and evaluate and improve). These competencies are broadly compatible with (albeit not specific to) government policy/funding roles and supported by a suite of e-learning modules of primary relevance for direct service staff and workplace peer workers.

- The U.S. Core Competencies for Suicide Prevention Program Managers (19) outline eleven competency areas (including specific knowledge, practices, and skills) that underpin successful suicide prevention programs and which can help maximize program impact. Directly informed through the ongoing implementation of a large national program of community-based suicide prevention initiatives, these core competencies provide key parameters to guide program commissioning, management, and quality improvement.

Evidence regarding the application of suicide prevention competency frameworks is scant, requiring further evaluative efforts in developing and implementing core competencies for this target group.

## Things we can build upon

In addition to the above competency frameworks, existing Australian suicide prevention policy and guidance documents can inform the development of specific core competencies for government staff in pivotal positions to foster effective lived experience partnerships (Enabler 2) (5, 20); cultural safety and inclusivity (21, 22, 23); as well as program evaluation, data collection, and research (Enabler 3) (7, 24) in the wider sector. Policymaking and service commissioning decisions should generally be guided by the current evidence base in suicide prevention (6), best-practice service quality standards (25) and accreditation programs (26), whilst harnessing innovation.

### Action 3

**Conduct an evaluation of existing suicide prevention training options and their suitability for use in upskilling frontline government and community service staff.**

## Define action

Evaluate existing suicide prevention training options and their suitability for use in upskilling frontline government and community service staff across key sectors and priority settings (including financial, employment, relationship, legal, disability support and aged care services) to:

i) identify suicide prevention competencies required of frontline staff in different roles and settings.
ii) assess existing suicide prevention training against identified competencies.
iii) recommend which suicide prevention training is best suited for different settings.
iv) identify gaps where current training does not address required competencies.
v) provide recommendations to efficiently address identified gaps (i.e., developing additional modules or tailoring training).

## Evidence for the action and possible sub-actions

National suicide prevention program directories reveal a plethora of relevant existing training options for frontline government and community services staff in key touchpoint roles, both in Australia (27) and internationally (28). These training programs incorporate varied training contents, formats, and modalities aimed at specific target workforces and audiences. The extent to which training programs are aligned with existing competency frameworks varies. A growing number of training programs seek accreditation and meet national quality standards (26).

Systematic literature reviews of non-randomised studies indicate that gatekeeper training can positively affect the knowledge, skills, and attitudes of trainees regarding suicide prevention (29), while the evidence from randomised controlled studies regarding trainee knowledge, appraisal, and self-efficacy remains equivocal (30). Longer term training outcomes which exhibit the strongest endurance effect include trainee knowledge and self-efficacy, while gatekeeper attitude, behavioural intentions, and behaviours indicate only a weak training effect with poor translation into practice (31). More narrowly focused literature reviews of gatekeeper training aimed at teachers and parents supporting adolescents (32, 33) have shown similar gains in terms of gatekeepers' knowledge, self-efficacy, skills, and likelihood to intervene, while evidence of improvement in attitudes and behaviours remains

mixed. A suicide prevention training review focused on pharmacists equally indicated a lack of evidence on long-term effectiveness (34).

Part of the challenge in demonstrating consistent training outcomes relates to varied study designs and outcomes assessed, as well as underpinning differences in target workforces, audiences, format, and content of training. This highlights the benefits of a greater standardisation of training core components (35) and the adoption of minimum competency standards (36) in suicide prevention training for different roles and settings. Suitable training formats and the creation of supportive organisational environments are key to effective translation of learning outcomes into practice.

## Things we can build upon

While systematic evidence on suicide prevention training for specific frontline government and community services staff in key touchpoint roles and settings is lacking, existing training programs can be tailored to articulate core competencies for such roles and settings, in alignment with generic suicide prevention competency frameworks for non-clinical direct service staff (see Action 2).

Workplace-based suicide prevention competency frameworks and training programs for high risk industries are well established in Australia (8, 9), highlighting ideal settings in which training can be implemented among a suite of measures to create supportive work environments (37) and facilitate effective training transfer into practice (38).

Building on current policy directions (7) and evidence regarding the critical role of social determinants and upstream factors for suicide and its prevention (39, 40, 41), it will be essential to consolidate the evidence in this area and develop related competencies for understanding and addressing social determinants.

**Expert consultations** further indicated that relevant existing suicide prevention training programs could be leveraged and made available widely (and ideally freely) for community members, peer workers, teachers, students and parents, allied health workers, and high-risk workplaces.

# Action 4

**Support the growth, development and integration of the suicide prevention Lived Experience (peer) workforce.**

## Define action

In advance of the national suicide prevention workforce strategy, progress work to support the growth, development and integration of the suicide prevention Lived Experience (peer) workforce through:

i) defining training requirements and ongoing professional development options;
ii) improving accessibility of training options;
iii) articulating scope of practice and career pathways; and
iv) developing resources to support organisational change to build and maintain a safe and inclusive organisational culture for the Lived Experience (peer) workforce.

## Evidence for the action and possible sub-actions

There is widespread recognition of the important roles that people with lived experience play in designing (42) and delivering (43) suicide prevention support services along with considerable sector and policy momentum to foster the growth, development, and integration of the lived experience workforce in Australia (5, 20) (Enabler 2). Accordingly, seminal frameworks and national guidance are now available to support lived experience workforce development (20, 44, 45), while training and capacity building initiatives are delivered through national lead agency Roses in the Ocean (46) and other providers (26, 47, 48). Despite these important strides over recent years, critical challenges remain in terms of building required lived experience workforce capacity across the wider sector and effectively integrating and supporting such roles within varied organisational and practice settings beyond clinical and acute mental health services (49).

Current literature reviews indicate that peer-based support programs (43, 50) and coproduced community interventions (51) show some promise in addressing suicide risk, facilitating support access, engagement and satisfaction, and giving voice to lived experience. Simultaneously, a distinct evidence gap remains regarding their ultimate effectiveness in changing suicidality outcomes, which requires further research to underpin future program rollout and delivery.

Lived experience peer work brings unique qualities to the support relationship, which require both courage in showing vulnerability, and a good balance of authenticity and disclosure with selfcare and boundaries (52). Thus, peer work can be emotionally challenging and draining and therefore requires ongoing peer network, system-level, and workplace support (53).

Training needs and requirements identified for the lived experience peer workforce in suicide prevention are both unique and overlapping with broader mental health peer work (20). These include four main areas related to (1) personal wellbeing and self-care, (2) supporting others, (3) systems knowledge and navigation, and (4) disclosing suicidality and telling one's story (53).

Ongoing training, professional development, and career pathways have been advocated for the broader lived experience workforce (20, 53, 54). A suite of lived experience peer workforce training programs and capacity building initiatives is now being provided by national lead agency, Roses in the Ocean (46), guided by a framework to foster lived experience engagement, partnership and integration (44). While the evidence on lived experience involvement in training in other sectors has been mixed (55), early evaluations of lived experience peer workforce training programs in suicide prevention have shown promise in increasing participant knowledge and confidence (56). Beyond available foundational and more advanced training programs, formal qualifications specific to suicide prevention lived experience work, such as the related Certificate IV in Mental Health Peer Work, are currently lacking, as are designated competency frameworks to guide training and development. The Suicide Prevention Peer Workforce Development Service provided by Roses in the Ocean offers a nationally available suite of resources and training to strengthen the capacity of the emerging suicide prevention peer workforce and facilitate its active integration and support across wider organisational and sector settings (46).

To facilitate effective future workforce planning and development, it will be important to profile the emerging lived experience peer workforce in Australia to better understand its size, varied lived experiences, capabilities, work roles and settings, as well as training,

development, and support needs. **Expert consultations** also highlight the need to strengthen the lived experience workforce and peer-led suicide prevention approaches, including through appropriate training and support structures that facilitate their roles, as guided by the research evidence.

## Things we can build upon

Australia has made significant strides in establishing lived experience peer work frameworks and capacity building initiatives, and key lead agencies in this space are doing fantastic work (46, 57, 58) that deserves to be further strengthened to help overcome presenting challenges to fully develop, support and effectively integrate lived experience capacity across a wider range of sector settings.
Building on existing review findings, robust future evaluations of peer support programs are needed to examine program effectiveness in terms of suicidality outcomes along with lived experience defined indicators of program acceptability and success (43, 50, 51).

# Action 5

**Develop national guidelines for assessment, management and prevention of self-harm.**

## Define action

Develop national guidelines for assessment, management and prevention of self-harm.

## Evidence for the action and possible sub-actions

In Australia, current national guidelines for the assessment, management, and prevention of self-harm are largely designed to govern clinical practice and service delivery. Evidence- and consensus-based practice guidelines for the management of deliberate self-harm were issued by the Royal Australian and New Zealand College of Psychiatrists in 2016 (59). National Safety and Quality Health Service (NSQHS) Standards specify expected standards of care for health service organisations relevant to predicting, preventing and managing self-harm and suicide (60). At state-level, clinical practice guidelines have been issued by the Victorian Department of Health for emergency departments and mental health services in 2010 (61), and by Queensland Health for clinical teams and leaders in mental health alcohol and other drugs services in 2021 (62). Additional guidelines for specific subpopulations exist to inform culturally appropriate psychosocial assessment of Indigenous Australians who are presenting to hospitals (63) and clinical and community service provision to LGBTQA+ young people (64).

Internationally, national guidelines also exist in other English-speaking countries, including the UK (65) and the USA (66). Arguably, the most current and comprehensive set of evidence-based national guidelines have been issued by the National Institute for Health and Care Excellence (NICE) in the UK in 2022 (65). Informed by systematic literature reviews, these guidelines cover a broad spectrum of self-harm assessment, management and recurrence prevention activities for children, young people and adults, and are applicable to all sectors that work with people who have self-harmed. RANZCP practice guidelines previously endorsed NICE guidelines for the clinical management of self-harm.

There is limited evidence on the implementation of national practice guidelines for self-harm prevention and management and outcomes are mixed to encouraging. One cross-sectional survey in the UK indicated widespread awareness of NICE guidelines (85.6%), lesser in-depth

understanding (24.3%), and fair adoption (43.9%) among health professionals (67), while other studies have highlighted considerable awareness gaps in specialty settings (68) and even examples of malpractice contrary to existing guidelines in primary care (69). One national study in the UK demonstrated that the implementation of national recommendations in mental health services reduced suicide rates (70). Other types of national suicide prevention guidelines relating to media reporting have also been shown to be both effective in reducing suicide as well as cost-effective (71).

International benchmarks, particularly UK NICE guidelines, highlight the currency of evidence-based guidance and broad scope of application (to clinical and non-clinical settings) as key considerations for national guideline development in Australia. National guideline development is a major undertaking that can be facilitated by building on existing guidelines and evidence syntheses and which should be complemented by ensuring widespread guideline dissemination and adoption.

### Things we can build upon

The blueprint paper (6) on suicide and self-harm advocates a consistent terminology and public health approach to suicide prevention that can underpin national guidance. Existing benchmark guidelines and evidence reviews can be harnessed to inform the scope and contents of national guidelines and be built upon to streamline development. Since guidelines are not ends in themselves these require active dissemination and implementation efforts as well as review and monitoring to ensure the adoption and improved quality and outcomes of suicide prevention practice (72, 73).

## Action 6

**Build capability and provide resourcing for general practitioners.**

### Define action

In advance of the national suicide prevention workforce strategy, build the capability and provide resourcing for general practitioners by:

i) subsidising access to CPD accredited suicide prevention training specific for GPs.
ii) adding a Medicare Benefits Scheme (MBS) item for the development and review of safety plans.

### Evidence for the action and possible sub-actions

Systematic literature reviews have established the effectiveness of suicide prevention education and training for general practitioners with regard to ultimate outcomes of lowering suicide rates and suicidal behaviours in the general adult and patient populations (74), including some indication of improved proximate training outcomes in increasing practitioner knowledge, confidence, attitudes, and skills (75). While GP training formats and contents vary widely, and there is no international consensus on effective GP training practices (76), broader clinical workforce training guidelines do exist (77). Moreover, several GP-focused or relevant suicide prevention training programs are available in Australia which meet national quality accreditation standards (26, 27).

GPs have an important role to play in suicide prevention (78), yet current evidence from controlled studies remains equivocal on the effectiveness of GP-delivered suicide prevention

interventions (79). Specifically, the evidence does not support the routine use of suicide risk screening instruments in general practice (80). RACGP guidance rather recommends that GPs should be alert for higher-risk individuals and the possibility of suicide in these patients (81), and complement suicide risk assessment with evidence-based safety planning and ongoing care considerations (82, 83).

International studies have identified GP training needs in suicide prevention (84, 85, 86, 87, 88, 89), however a lack of systematic data on the suicide prevention capacity of Australian GPs (90) makes it difficult to ascertain current practices, training needs and gaps. Australian GP mental health training standards strongly recommend completion of suicide prevention training as part of ongoing professional development (91), while GP mental health core curricula and competencies are more explicit about suicide risk assessment (92) rather than safety planning or management (93). RACGP accredited mental health training courses are accessible to members only (94) and were not reviewed for suicide prevention content. Further, little public information is available on GP suicide prevention training completion rates or the impact of training subsidies on GP training uptake.

A key driver to embed evidence-based practices in primary care is the ability for GPs to bill activities through Medicare Benefits Scheme (MBS) items. At present, the MBS includes no designated items focused on suicide prevention activity (beyond generic mental health care items such as the GP management plan, GP mental health treatment, psychological therapy services, or focussed psychological strategies) (95). As noted, safety planning is regarded an effective evidence-based suicide prevention intervention (83). Pending a pathway to incorporate suicide prevention activities within generic existing MBS mental health care items, the introduction of a designated MBS item for the development and review of safety plans would therefore be consistent with current evidence and could facilitate the broader uptake of this potentially life-saving practice among GPs and patients.

## Things we can build upon

In the absence of systematic data on the suicide prevention capacity and training needs of Australian GPs, GP training and capacity building initiatives should be guided by existing evidence on effective interventions (74), clinical practice guidelines (81, 82, 96, 97), and facilitate CPD accreditation. A systematic appraisal of GP suicide prevention practices and training needs (potentially conducted with relevant professional bodies) is key to informing the future direction of targeted GP training and capacity building in suicide prevention.

## References


1. Institute for Social Science Research. National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries. Brisbane, Queensland: The University of Queensland; 2020.
2. Suicide Prevention Australia. State of the nation in suicide prevention 2022: A survey of the suicide prevention sector. Sydney: SPA; 2022.
3. Productivity Commission. Mental Health, Report no. 95. Canberra: Australian Government; 2020.
4. KPMG. Enabler 4: Workforce. Rapid evidence review. Canberra, ACT: National Mental Health Commission; 2022.
5. National Suicide Prevention Adviser. Compassion First: Designing our National Approach from the Lived Experience of Suicidal Behaviour. Canberra: Australian Government; 2020.
6. Pirkis J, Robinson J, Gunnell D, Hawton K, Hetrick S, Niederkrotenthaler T, et al. Understanding suicide and self-harm. Melbourne: Centre for Mental Health, University of Melbourne; 2022.
7. National Suicide Prevention Adviser. Shifting the Focus: Implementing a national whole of governments approach to suicide prevention. Canberra: Australian Government; 2020.
8. Suicide Prevention Australia. Suicide prevention: A competency framework. Sydney: SPA; 2021.
9. Ross V, Mathieu S, Witt K, Kõlves K. Preventing Suicide in the Workplace. In: Wall T, Cooper C, Brough P, editors. The SAGE Handbook of Organizational Wellbeing: Sage Publications Ltd; 2021.
10. Diminic S, Sparti C, Woody C, Hull I, Page I, Gossip K, et al. Analysis of national mental health workforce demand and supply: Stage 1 report. Brisbane, QLD Australia: The University of Queensland; 2020.
11. Platt S, Arensman E, Rezaeian M. National suicide prevention strategies – progress and challenges. Crisis. 2019;40(2):75–82.
12. Schlichthorst M, Reifels L, Spittal M, Clapperton A, Scurrah K, Kolves K, et al. Evaluating the effectiveness of components of national suicide prevention strategies: An interrupted time series analysis. Crisis. 2022.
13. Mental Health Alcohol and Drug Directorate. Compassion and Connection: Tasmanian Suicide Prevention Strategy 2023-2027. Tasmania; 2022.
14. Department of Health and Human Services. Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020). Hobart, Tasmania: Department of Health and Human Services; 2016.
15. Department of Health. Victoria's mental health and wellbeing workforce strategy 2021–2024. Melbourne: Victorian Government; 2021.
16. Health Education England, National Collaborating Centre for Mental Health. Self-harm and Suicide Prevention Competence Framework. 2018.
17. NHS Education for Scotland. Scotland's Knowledge and Skills Framework for Mental Health Improvement, Self-Harm and Suicide Prevention. Edinburgh, Scotland: NES; 2019.
18. Australian Public Service Commission. APS Mental Health and Suicide Prevention Unit [Available from: https://www.apsc.gov.au/working-aps/diversity-and-inclusion/aps-mental-health-and-suicide-prevention-unit
19. Suicide Prevention Resource Centre. Core Competencies for Suicide Prevention Program Managers [Available from: https://sprc.org/core-competencies/.
20. Byrne L, Wang L, Roennfeldt H, Chapman M, Darwin L, Castles C, et al. National Lived Experience Workforce Guidelines. National Mental Health Commission; 2021.

21. Suicide Prevention Australia. Culturally and Linguistically Diverse (CALD) populations: Policy position statement. Sydney: SPA; 2021.
22. National LGBTI Health Alliance. Cultural competency implementation framework: Achieving inclusive practice with Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) communities. Newtown NSW; 2013.
23. Dudgeon P, Milroy J, Calma T, Luxford Y, Ring I, Walker R, et al. Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. Crawley, WA: University of Western Australia,; 2016.
24. Suicide Prevention Australia, Centre for Mental Health University of Melbourne. Closing the loop: Suicide prevention research priorities. Sydney: Suicide Prevention Australia; 2023.
25. Suicide Prevention Australia. Suicide Prevention Standards for Quality Improvement Edition 2. SPA; 2022.
26. Suicide Prevention Australia. Best practice directory: SPA; [Available from: https://www.suicidepreventionaust.org/directory-of-programs/.
27. Life in Mind. Gatekeeper training [Available from: https://lifeinmind.org.au/gatekeeper-training-search.
28. Suicide Prevention Resource Center. Choosing a suicide prevention gatekeeper training program – A comparison table: SPRC; 2018 [Available from: https://sprc.org/wp-content/uploads/2022/12/GatekeeperMatrix6-21-18_0.pdf.
29. Isaac M, Elias B, Katz LY, Belik SL, Deane FP, Enns MW, et al. Gatekeeper Training as a Preventative Intervention for Suicide: A Systematic Review. Can J Psychiat. 2009;54(4):260-8.
30. Yonemoto N, Kawashimaa Y, Endoa K, Yamada M. Gatekeeper training for suicidal behaviors: A systematic review. Journal of Affective Disorders. 2019;246:506–14.
31. Holmes G, Clacy A, Hermens DF, Lagopoulos J. The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review. Arch Suicide Res. 2021;25(2):177-207.
32. Mo PKH, Ko TT, Xin MQ. School-based gatekeeper training programmes in enhancing gatekeepers' cognitions and behaviours for adolescent suicide prevention: a systematic review. Child Adol Psych Men. 2018;12.
33. Torok M, Calear A, Smart A, Nicolopoulos A, Wong Q. Preventing adolescent suicide: A systematic review of the effectiveness and change mechanisms of suicide prevention gatekeeping training programs for teachers and parents. Journal of Adolescence. 2019;73:100-12.
34. Carpenter DM, Lavigne JE, Roberts CA, Zacher J, Colmenares EW. A review of suicide prevention programs and training policies for pharmacists. J Am Pharm Assoc. 2018;58(5):522-9.
35. Osteen PJ, Frey JJ, Ko JY. Advancing Training to Identify, Intervene, and Follow Up with Individuals at Risk for Suicide Through Research. Am J Prev Med. 2014;47(3):S216-S21.
36. Hawgood J, Woodward A, Quinnett P, De Leo D. Gatekeeper Training and Minimum Standards of Competency. Crisis. 2022;43(6):516-22.
37. American Foundation for Suicide Prevention, United Suicide Survivors International. National Guidelines for Workplace Suicide Prevention [Available from: https://workplacesuicideprevention.com/.
38. Reifels L, Krishnamoorthy S, Kolves K, Francis J. Implementation Science in Suicide Prevention. Crisis. 2022;43(1):1-7.
39. Australian Institute of Health and Welfare. Social and economic factors and deaths by suicide: AIHW; 2023 [Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/social-factors-suicide.

40. Mathieu S, Treloar A, Hawgood J, Ross V, Kolves K. The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviors and Interventions to Mitigate Their Impact: A Review. Front Public Health. 2022;10:907052.
41. Shand F, Yip D, Tye M, Darwin L. The impact of social determinants on suicide and how policy settings can help. Sydney, NSW: Black Dog Institute; 2020.
42. Watling D, Preece M, Hawgood J, Bloomfield S, Kolves K. Developing an Intervention for Suicide Prevention: A Rapid Review of Lived Experience Involvement. Arch Suicide Res. 2022;26(2):465-80.
43. Schlichthorst M, Ozols I, Reifels L, Morgan A. Lived experience peer support programs for suicide prevention: a systematic scoping review. Int J Ment Health Syst. 2020;14:65.
44. Roses in the Ocean. Lived Experience of Suicide Engagement, Partnership & Integration (LESEPI) Framework. Brisbane (Qld): RITO; 2022.
45. Suomi A, Freeman B, Banfield M. Framework for the engagement of people with a lived experience in program implementation and research. Canberra, ACT: Australian National University; 2017.
46. Roses in the Ocean. Suicide Prevention Peer Workforce [Available from: https://rosesintheocean.com.au/what-we-do/suicide-prevention-peer-workforce/.
47. Life in Mind. Gatekeeper training: Lived experience [Available from: https://lifeinmind.org.au/gatekeeper-courses?livedExperience=1&q=.
48. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Suicide Prevention Training [Available from: https://cbpatsisp.com.au/clearing-house/best-practice-programs-and-services/training/.
49. Roses in the Ocean. Expanding the suicide prevention peer workforce: an urgent and rapid solution to Australia's suicide challenge. Brisbane, Qld: RITO; 2022.
50. Bowersox NW, Jagusch J, Garlick J, Chen JI, Pfeiffer PN. Peer-based interventions targeting suicide prevention: A scoping review. Am J Community Psychol. 2021;68(1-2):232-48.
51. Hanlon CA, McIlroy D, Poole H, Chopra J, Saini P. Evaluating the role and effectiveness of co-produced community-based mental health interventions that aim to reduce suicide among adults: A systematic review. Health Expect. 2023;26(1):64-86.
52. Huisman A, van Bergen DD. Peer Specialists in Suicide Prevention: Possibilities and Pitfalls. Psychol Serv. 2019;16(3):372-80.
53. Hawgood J, Rimkeviciene J, Gibson M, McGrath M, Edwards B, Ross V, et al. Informing and Sustaining Participation of Lived Experience in the Suicide Prevention Workforce. Int J Environ Res Public Health. 2023;20(4).
54. Kaine C. Towards Professionalisation: Exploration of best practice models in mental health peer work to inform the establishment of a national professional organisation [Literature Review]. Private Mental Health Consumer Carer Network (Australia) Ltd, National Mental Health Commission; 2018.
55. Wiles LK, Kay D, Luker JA, Worley A, Austin J, Ball A, et al. Consumer engagement in health care policy, research and services: A systematic review and meta-analysis of methods and effects. PLoS One. 2022;17(1):e0261808.
56. Hawgood J, Gibson M, McGrath M, Riley J, Mok K. Preliminary Evaluation of Lived Experience of Suicide Training: Short-, Medium- and Longer-Term Impacts of Our Voices in Action Training. Community Ment Health J. 2022;58(5):875-86.
57. Aboriginal and Torres Strait Islander Lived Experience Centre [Available from: https://www.blackdoginstitute.org.au/education-services/aboriginal-and-torres-strait-islander-network/.
58. The ALIVE National Centre for Mental Health Research Translation [Available from: https://alivenetwork.com.au/.

59. Carter G, Page A, Large M, Hetrick S, Milner AJ, Bendit N, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. Aust N Z J Psychiatry. 2016;50(10):939-1000.
60. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service (NSQHS) Standards: Action 5.31 Predicting, preventing and managing self-harm and suicide. Sydney, NSW: ACSQHC.
61. Department of Health (DoH). Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services. Melbourne, Vic: DoH; 2010.
62. Queensland Health. Suicide Prevention Practice. Queensland Health Guideline QH-GDL-967:2021. Brisbane, Qld: Clinical Excellence Queensland, Mental Health Alcohol and Other Drugs Branch; 2021.
63. Leckning B, Ringbauer A, Robinson G, Carey T, Hirvonen T, Armstrong G. Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts. Darwin, NT: Menzies School of Health Research; 2019.
64. Strauss P, Hill N, Marion L, Gilbey D, Waters Z, Moore J, et al. Suicide prevention in LGBTQA+ young people: best practice guidelines for clinical and community service providers. Perth, Australia: Telethon Kids Institute; 2022.
65. National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence (NG225). London, UK: NICE; 2022.
66. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Am J Psychiatry. 2003;160(11 Suppl):1-60.
67. Leather JZ, O'Connor RC, Quinlivan L, Kapur N, Campbell S, Armitage CJ. Healthcare professionals' implementation of national guidelines with patients who self-harm. J Psychiatr Res. 2020;130:405-11.
68. Heyward-Chaplin J, Shepherd L, Arya R, O'Boyle CP. Audit of healthcare professionals' attitudes towards patients who self-harm and adherence to national guidance in a UK burns and plastic surgery department. Scars Burn Heal. 2018;4:2059513118764100.
69. Carr MJ, Ashcroft DM, Kontopantelis E, While D, Awenat Y, Cooper J, et al. Clinical management following self-harm in a UK-wide primary care cohort. J Affect Disord. 2016;197:182-8.
70. While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. Lancet. 2012;379(9820):1005-12.
71. Flego A, Reifels L, Mihalopoulos C, Bandara P, Page A, Fox T, et al. Cost-effectiveness of media reporting guidelines for the prevention of suicide. Suicide Life Threat Behav. 2022;52(5):1048-57.
72. Guidelines International Network [Available from: https://g-i-n.net/.
73. National Health and Medical Research Council. Guidelines for Guidelines Handbook: NHMRC; [Available from: https://www.nhmrc.gov.au/guidelinesforguidelines.
74. Mann JJ, Michel CA, Auerbach RP. Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. Am J Psychiat. 2021;178(7):611-24.
75. Dueweke AR, Bridges AJ. Suicide Interventions in Primary Care: A Selective Review of the Evidence. Fam Syst Health. 2018;36(3):289-302.
76. Audouard-Marzin Y, Kopp-Bigault C, Scouarnec P, Walter M. General practitioners training about suicide prevention and risk: A systematic review of literature. Presse Med. 2019;48(7-8):767-79.

77. National Action Alliance for Suicide Prevention Clinical Workforce Preparedness Task Force. Suicide prevention and the clinical workforce: Guidelines for training. Washington DC; 2014.
78. Mughal F, Troya MI, Dikomitis L, Chew-Graham CA, Corp N, Babatunde OO. Role of the GP in the management of patients with self-harm behaviour: a systematic review. Br J Gen Pract. 2020;70(694):e364-e73.
79. Milner A, Witt K, Pirkis J, Hetrick S, Robinson J, Currier D, et al. The effectiveness of suicide prevention delivered by GPs: A systematic review and meta-analysis. J Affect Disord. 2017;210:294-302.
80. Saab MM, Murphy M, Meehan E, Dillon CB, O'Connell S, Hegarty J, et al. Suicide and Self-Harm Risk Assessment: A Systematic Review of Prospective Research. Arch Suicide Res. 2022;26(4):1645-65.
81. Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice (Red Book), 9th edn. RACGP; 2021.
82. General Practice Mental Health Standards Collaboration (GPMHSC). Suicide prevention and first aid: A resource for GPs. East Melbourne, Vic: RACGP; 2016.
83. Nuij C, van Ballegooijen W, de Beurs D, Juniar D, Erlangsen A, Portzky G, et al. Safety planning-type interventions for suicide prevention: meta-analysis. Br J Psychiatry. 2021;219(2):419-26.
84. Michail M, Tait L, Churchill D. General practitioners' clinical expertise in managing suicidal young people: implications for continued education. Prim Health Care Res Dev. 2017;18(5):419-28.
85. Poma SZ, Grossi A, Toniolo E, Baldo V, Leo DD. Self-perceived Difficulties With Suicidal Patients in A Sample of Italian General Practitioners. J Clin Med Res. 2011;3(6):303-8.
86. Ritter K, Stompe T, Voracek M, Etzersdorfer E. Suicide risk-related knowledge and attitudes of general practitioners. Wien Klin Wochenschr. 2002;114(15-16):685-90.
87. Sudak D, Roy A, Sudak H, Lipschitz A, Maltsberger J, Hendin H. Deficiencies in suicide training in primary care specialties: a survey of training directors. Acad Psychiatry. 2007;31(5):345-9.
88. Leavey G, Mallon S, Rondon-Sulbaran J, Galway K, Rosato M, Hughes L. The failure of suicide prevention in primary care: family and GP perspectives - a qualitative study. BMC Psychiatry. 2017;17(1):369.
89. Boukouvalas E, El-Den S, Murphy AL, Salvador-Carulla L, O'Reilly CL. Exploring Health Care Professionals' Knowledge of, Attitudes Towards, and Confidence in Caring for People at Risk of Suicide: a Systematic Review. Arch Suicide Res. 2020;24:S1-S31.
90. Hawgood J, Krysinska K, Ide N, De Leo D. Is suicide prevention properly taught in medical schools? Medical Teacher. 2008;30(3):287-95.
91. General Practice Mental Health Standards Collaboration (GPMHSC). Mental health training standards 2023–25: A guide for general practitioners. East Melbourne, Vic: Royal Australian College of General Practitioners; 2022.
92. Royal Australian College of General Practitioners. 2022 RACGP curriculum and syllabus for Australian general practice: Mental health. East Melbourne, Vic: RACGP; 2022.
93. Australian College of Rural and Remote Medicine. Rural generalist curriculum. Brisbane, Qld: ACRRM; 2021.
94. General Practice Mental Health Standards Collaboration (GPMHSC). RACGP Courses [Available from: https://gpmhsc.org.au/find-a-course.
95. Australian Government Department of Health and Aged Care. MBS Online: DHAC; [Available from: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home.

96. Bernert RA, Hom MA, Roberts LW. A review of multidisciplinary clinical practice guidelines in suicide prevention: toward an emerging standard in suicide risk assessment and management, training and practice. Acad Psychiatry. 2014;38(5):585-92.
97. David Rudd M, Bryan CJ, Jobes DA, Feuerstein S, Conley D. A Standard Protocol for the Clinical Management of Suicidal Thoughts and Behavior: Implications for the Suicide Prevention Narrative. Front Psychiatry. 2022;13:929305.