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CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

SUICIDE PREVENTION

2025-2027 Needs Assessment

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples or people that identify as from the First Nations community. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region where this Needs Assessment will be used. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

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Content warning: The following chapter contains information about suicide that may be distressing. Please consider your wellbeing and reach out to services and supports as required.

Overview

Over 3000 suicides occur in Australia each year (1) and in 2022, there were 132 deaths by suicide within the central and eastern Sydney region. According to the Australian Institute of Health and Welfare, suicide is the leading cause of death for young people (1).

Key issues

- Individuals in the 0-24 year age group had the highest proportion of self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%)
- High rates per 100,000 of suicide in older people aged 80+

Key gaps

- Primary care professionals identify a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide
- Primary care professionals face challenges in identifying individuals at risk of attempting suicide

Social determinants and risk factors

A multitude of social determinants and individual risk factors contribute to how suicidal thoughts and behaviours and ultimately, suicide might arise as outlined below:

Social determinants include:

- Macroeconomic policies (e.g., taxation policies and austerity measures)
- Public policies (e.g., policies that limit the consumption of alcohol)
- Social policies (e.g., active labour market policies and housing policies)
- Legislative or regulatory frameworks (e.g., firearm ownership laws and online regulatory frameworks)
- Healthcare coverage and health system capacity and responsiveness (e.g., workforce constraints and waiting lists)
- Local environment (e.g., rural or remote location, neighbourhood deprivation and availability of means of suicide)
- Cultural and societal values (e.g., colonisation, racism, discrimination and views of, attitudes towards, and communication and suicide and self-harm)
- Social cohesion and social capital

Commercial determinants include:

- Firearm, pesticide, alcohol and gambling industries

Individual risk factors include:

- Demographic factors (e.g., age, sex, gender identity, sexual orientation, ethnicity and cultural heritage)
- Socioeconomic factors (e.g., education, employment, occupation and income)

Other risk factors include:

- Contextual factors (e.g., stressful life events; job insecurity; homelessness; housing; bereavement by suicide; lack of family support; adverse early life experiences; trauma

including intergenerational trauma; exposure to conflict, violence, and war; involvement with the criminal justice system; and access to means used for suicide)
- Clinical factors (e.g., mental illness drug and alcohol use, previous episodes of self-harm and chronic physical illness)
- Personality-based factors (e.g., impulsivity, impressionability, and coping style)
- Genetic or familial factors (e.g., family history of suicide)
- Neurobiological factors (e.g., DNA methylation)

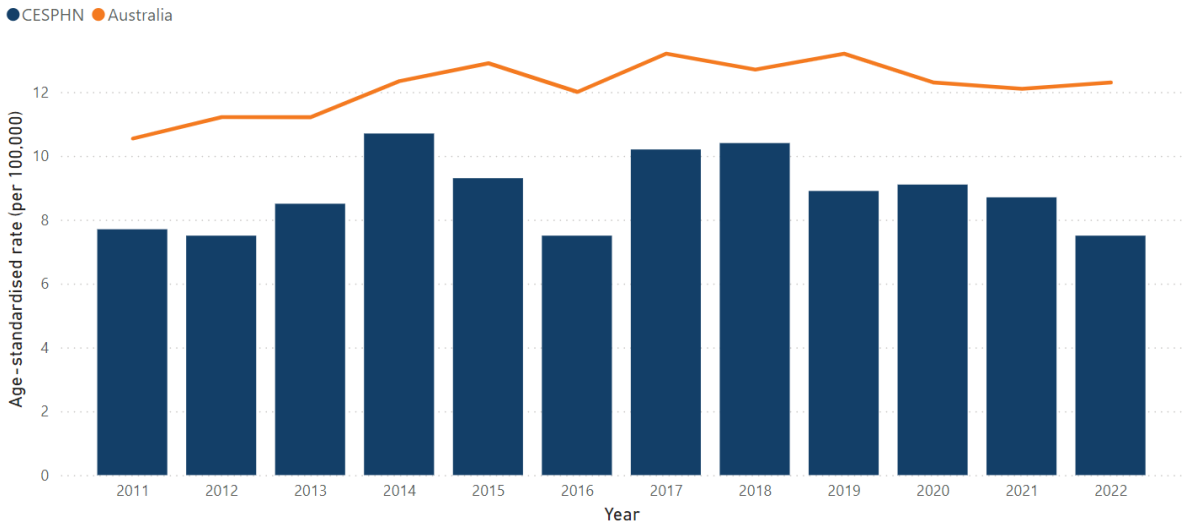
For those bereaved by suicide, the health impacts can be significant and can include further suicidality, complicated grief, PTSD, depression, and substance use disorders (2).

Prevalence of suicide and intentional self-harm

Suicide

Suicide rates in the CESPHN region fluctuate across time with no overt upwards or downwards trend.

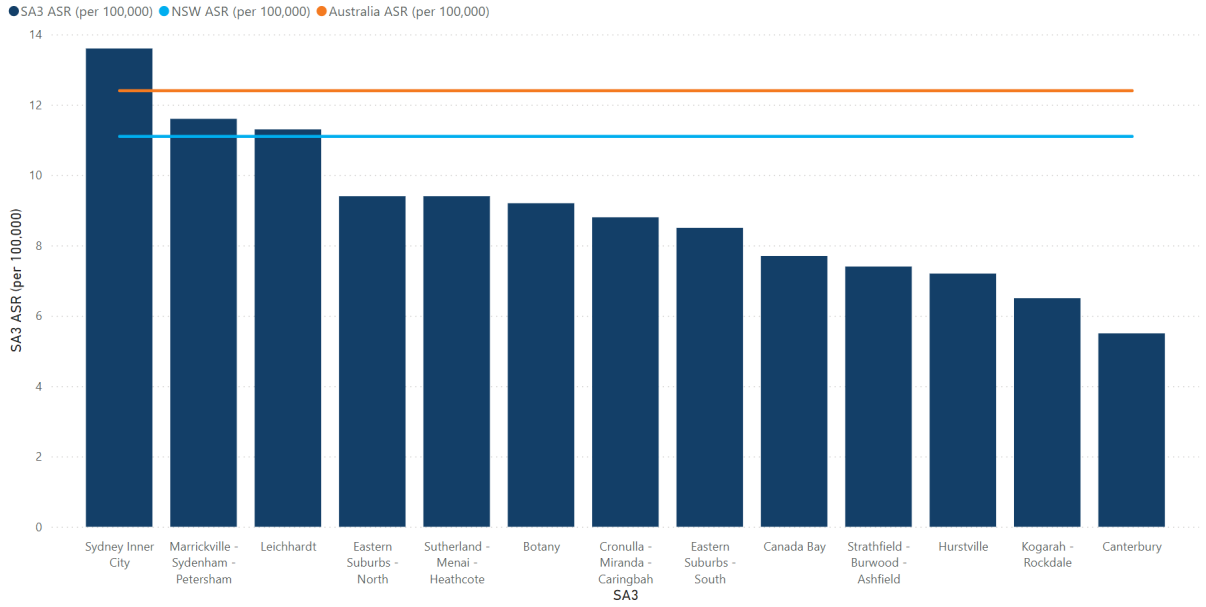
Figure 1: Suicide rate per 100,000 population, CESPHN region, 2011 – 2022



Source: AIHW, 2024

Suicide data for 2018-2022 shows that Sydney Inner City SA3 had the highest rate of suicide within the CESPHN region (13.6 per 100,000 population) with rates higher than both NSW (11.1 per 100,000 population) and Australia (12.4 per 100,000 population), followed by Marrickville -Sydenham-Petersham SA3 (11.6 per 100,000 population) and Leichhardt SA3 (11.3 per 100,000 population) (3).

Figure 2: Suicide rate by SA3, 2018-2022



Source: AIHW, 2024

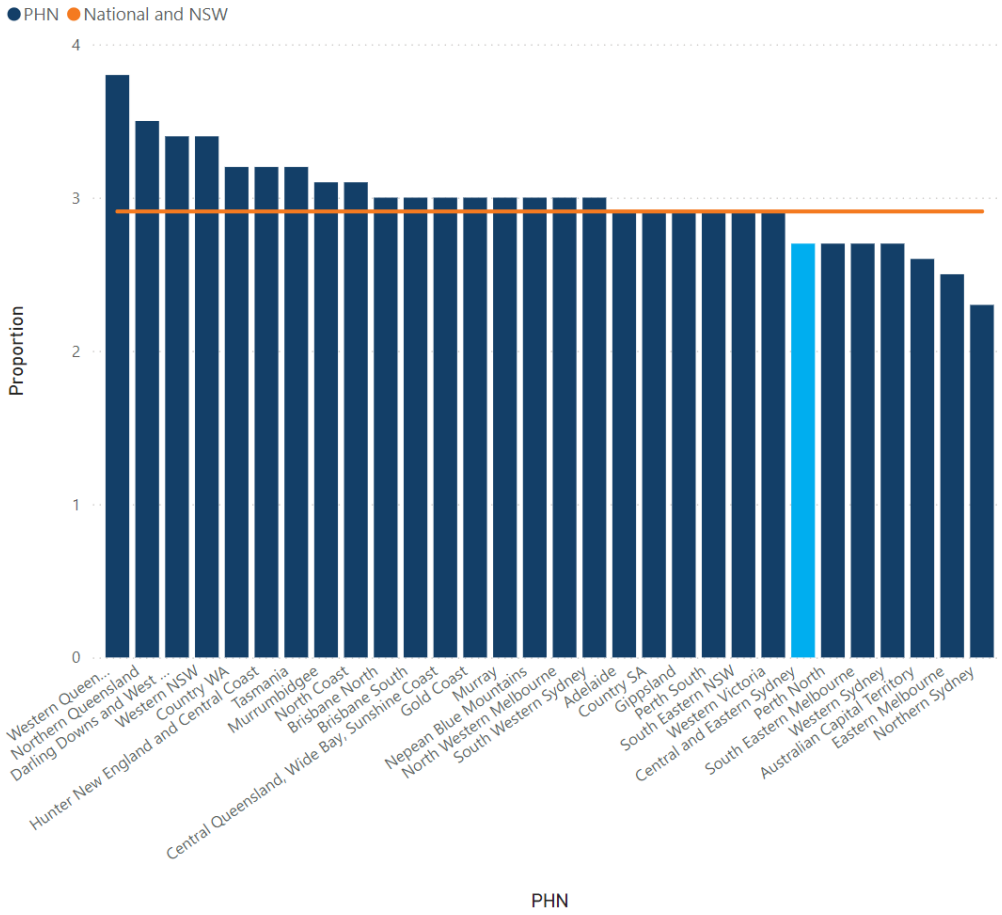
The NSW Suicide Monitoring System reported 940 suspected or confirmed deaths by suicide in NSW in 2023 (4). Monthly frequency data ranges from 92 suspected or confirmed deaths in July to 66 suspected or confirmed deaths in February.

Suicidal thoughts and self-harm behaviours

The National Study of Mental Health and Wellbeing (NSMHW) report provides modelled estimates for both suicidal thoughts and self-harm behaviours. Suicidal thoughts and behaviours in the NSMHW report refer to whether a person had ever seriously thought about taking their own life, made a plan to take their own life, or attempted to take their own life, and whether they had done so in the last 12 months. A person must have said they had seriously thought about taking their own life to be asked if they had made a plan and/or attempt (5).

In 2020-2022, 2.2% of people aged between 16-85 years in the CESPHN region had experienced suicidal thoughts and behaviours in the previous 12 months. This is below the state and national rates of 2.9% and 3.3% respectively. At a national level, 74.9% of people who had reported any suicidal thoughts or behaviours in the last 12 months also had reported having a mental health disorder in the last 12 months.

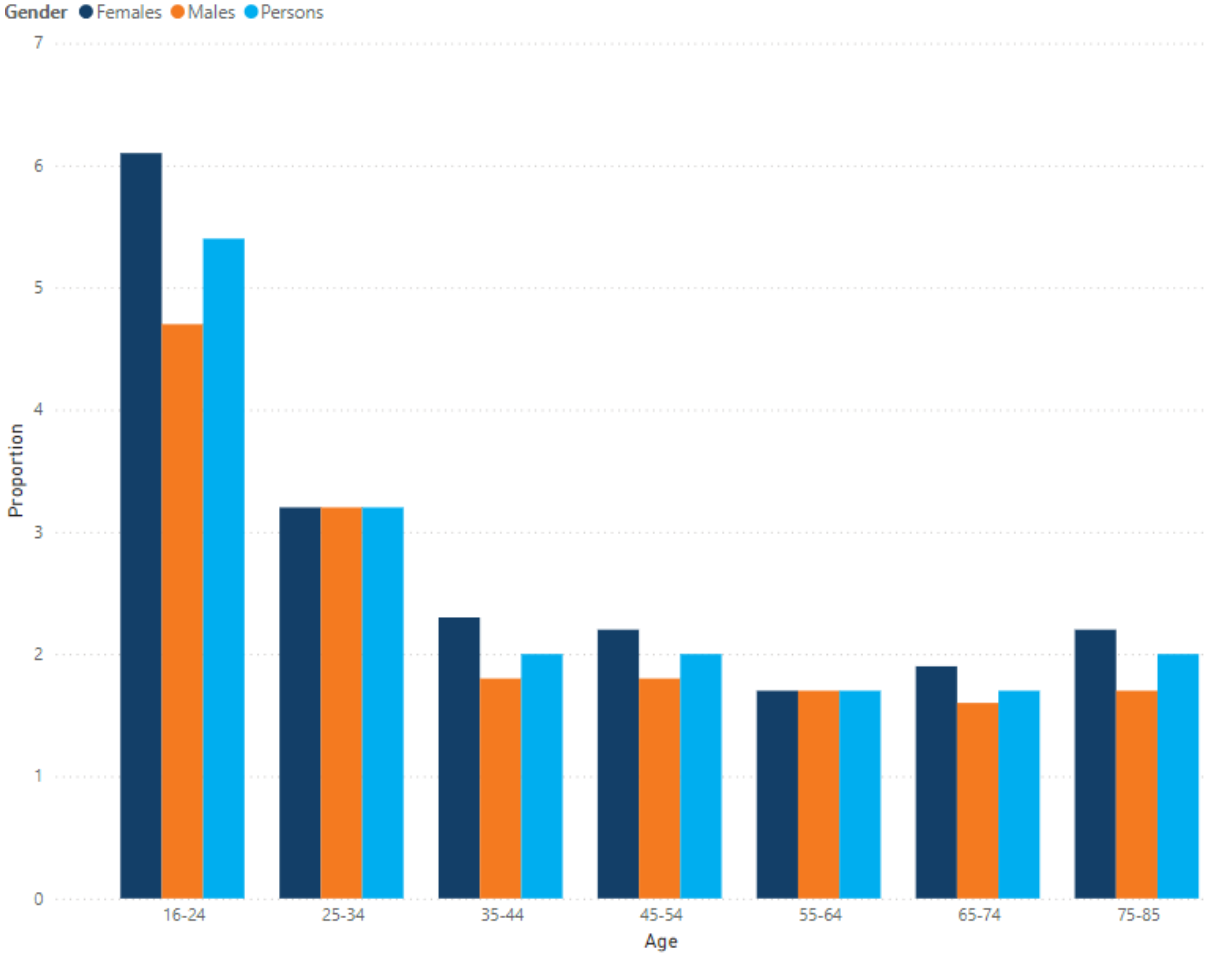
Figure 3. Suicidal thoughts and behaviours in the last 12 month by PHN, 2020-2022



Source ABS, 2024

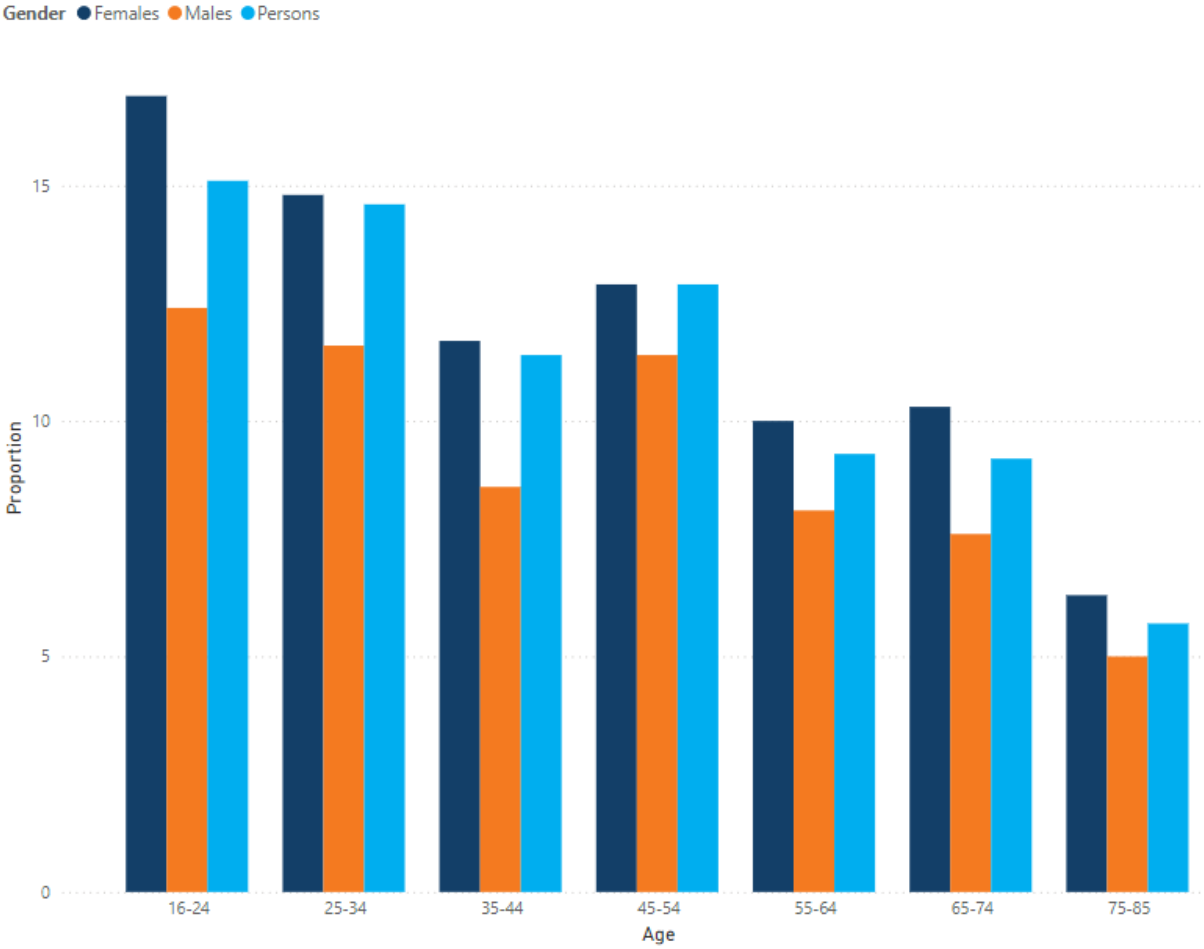
Within the CESPHN region, the modelled rate of suicidal thoughts and behaviours in the last 12 months is higher in females than males. Modelled rate of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) with a decline in every age range until 74-85 years where there is an increase (2.0 per 100 population) from 1.7 per 100 population in the 65-74 years.

Figure 4: Suicidal thoughts and behaviours in the last 12 month by age and sex, 2020-2022



Source: ABS, 2024

Figure 5: Suicidal thoughts and behaviours by lifetime, by age and sex, 2020-2022

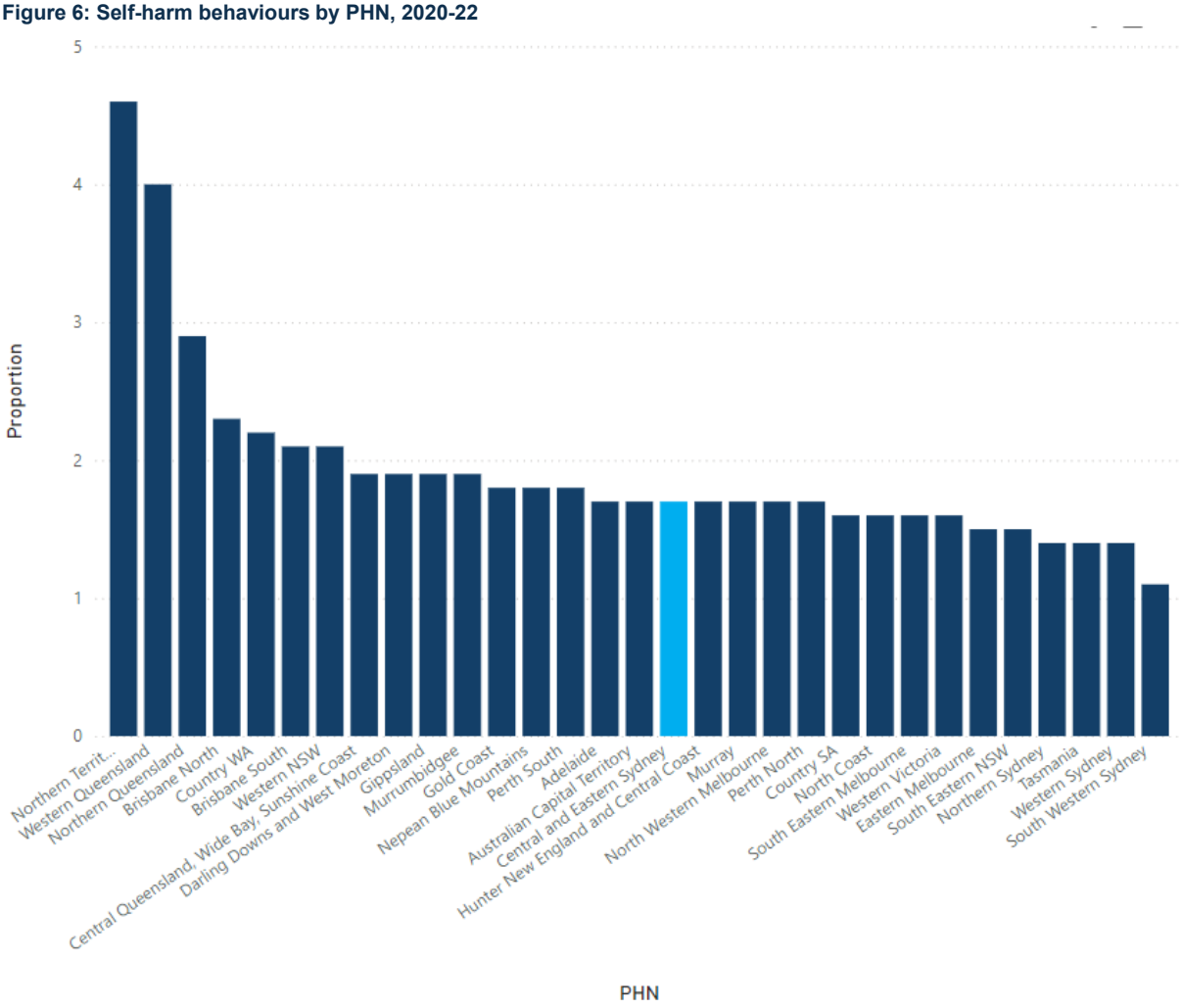


Source: ABS, 2024

Intentional self-harm behaviours

In 2020-22, modelling indicated that 1.7% of the CESPHN population aged 16-85 years displayed self- harm behaviours, which is defined as intentionally causing pain or damage to their own body (5). This behaviour may be motivated as a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although people who self-harm are at an increased risk of suicide (6). Due to the way the data is categorised and collected, there is no distinction in the data between intentional self-harm and suicide attempts. It is therefore impossible to accurately quantify suicide attempts. An awareness of this challenge should apply when interpreting the data. In the previous 12 months CESPHN had the 17th highest rate of self-harm behaviours across PHNs nationally.

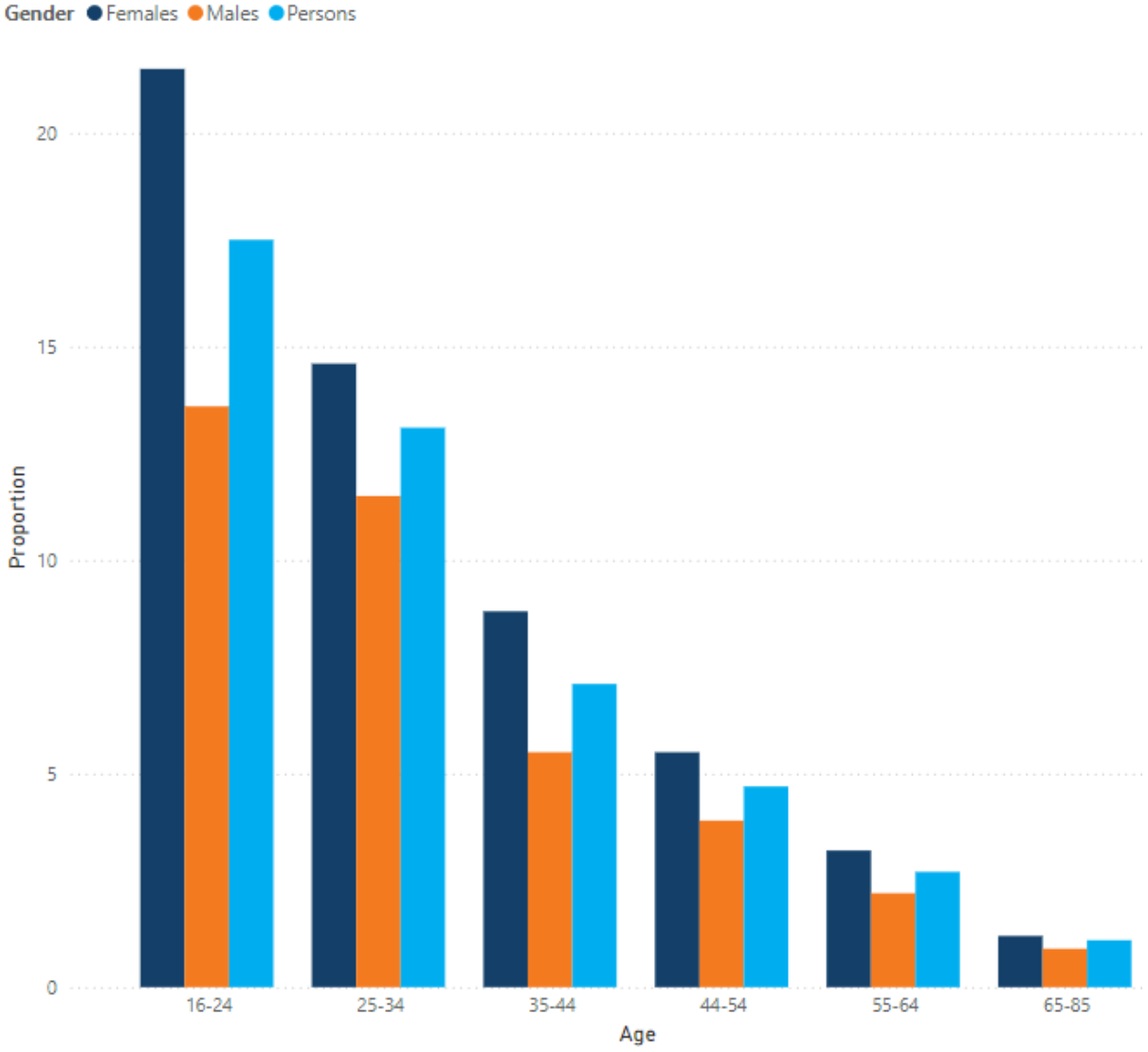
Figure 6: Self-harm behaviours by PHN, 2020-22



Source: AIHW, 2024

Within the CESPHN region, the modelled rate of self-harm behaviours (including both intentional self-harm and suicide attempts) in the last 12 months is higher in females than males. This is also consistent across the self-harm behaviours over a lifetime. Modelled rates of self-harm behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population, compared to the total population (1.7 per 100 population). Over a lifetime, 17.5% young people aged 16-24 years have displayed self-harm behaviours, compared to 8.1% of the CESPHN population aged 25-85 years.

Figure 7: Rate of Self Harm behaviours in the CESPHN region by lifetime by age and gender



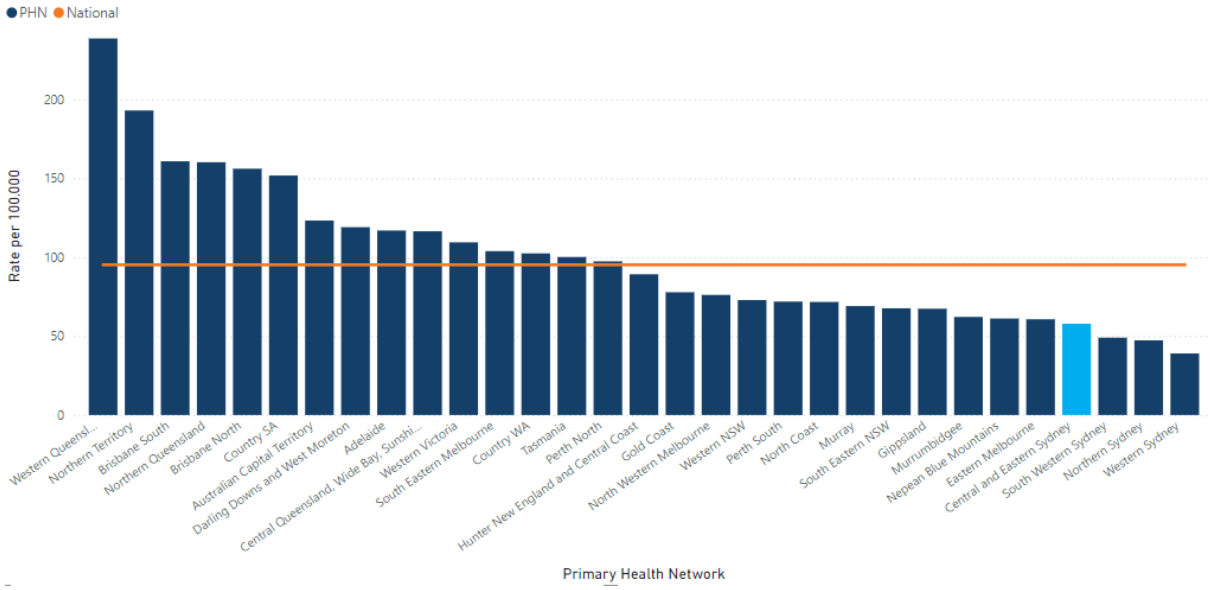
Source: ABS, 2024

Intentional self-harm hospitalisation

In 2022-23, there were 900 intentional self-harm hospitalisations (which include both intentional self-harm and suicide attempts) in the CESPHN region giving a rate of 57.9 per 100,000 population, down from 71.1 per 100,000 in 2019-20. This is lower than both the NSW and national rates (62.2 per 100,000 population and 95.2 per 100,000 population respectively).

Across CESPHN, 61% of self-harm hospitalisations in 2022-23 were for females (7).

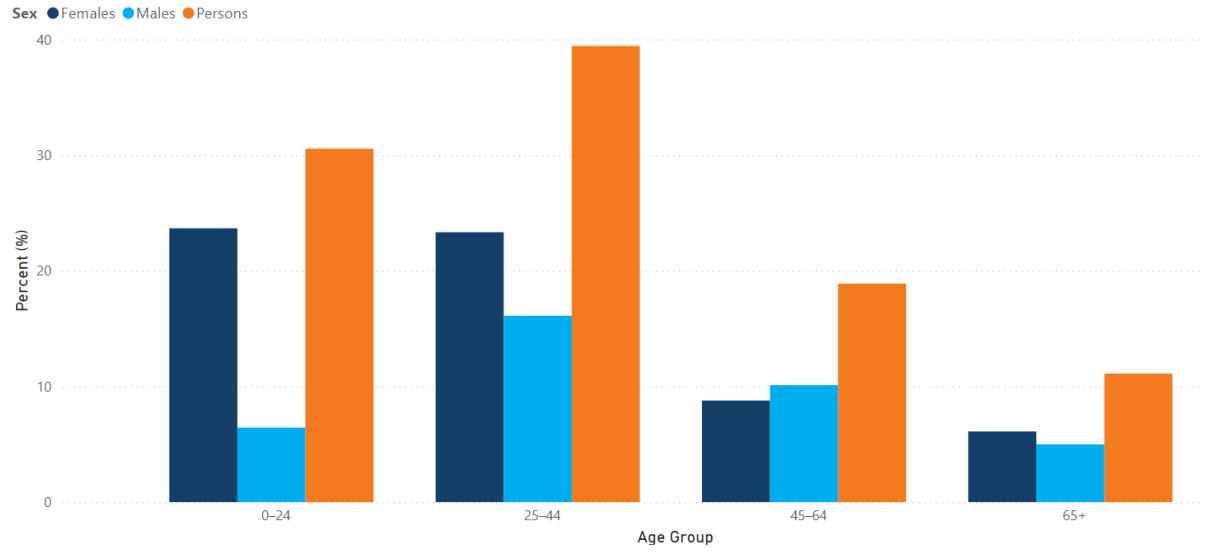
Figure 8: Self harm rate by PHN, 2022-23



Source: AIHW, 2024

Individuals in the 25-44 age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (39.4%), followed by 0–24-year-olds (30.6 %). This is a shift from 2021-22 where 0-24 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%) (7).

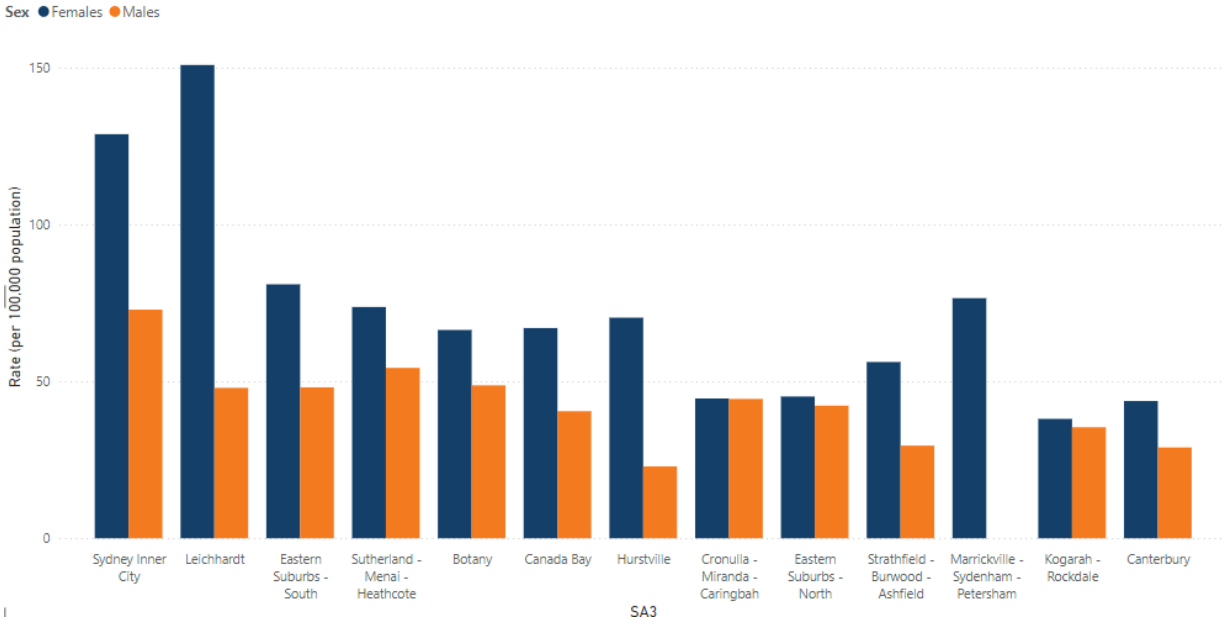
Figure 9: Intentional self-harm hospitalisations by age group and gender, CESPHN, 2022-23



Source: AIHW, 2024

Females in the Leichhardt SA3 had the highest intentional self-harm hospitalisation rates (150.9 per 100,000 population) within the CESPHN region, followed by Sydney Inner City SA3 (128.8 per 100,000 population). Across all SA3s, females had higher rates of intentional self-harm hospitalisations than males (7).

Figure 10: Intentional self-harm hospitalisations rate by sex, by SA3, 2022-23



Source: AIHW, 2024

Means restriction

Restriction of means of suicide plays an important role in reducing suicides. Whilst this is not the focus of suicide prevention activities for CESPHN, important data on suicide means is available at the Australian Institute of Health and Welfare website. Discussion of suicide means and methods has not been included in this Needs Assessment due to the documented risk of contagion.

Groups disproportionately affected

Aboriginal and Torres Strait Islander people

- Nationally in 2023, the rate of suicide in Aboriginal and Torres Strait Islander peoples has increased to 30.8 per 100,000 people from 23.6 per 100,000 people in 2018. This is the highest rate in the last five years and represents an increase of about 30% (8).
- By comparison, in 2023, the suicide rate across all Australians was 12.1 per 100,000 population.

Children and young people

Nationally, suicide is the leading cause of death in young people aged 15-24 years. In 2022:

- 304 Australian young people (aged 18–24 years) took their own lives
- 77 deaths by suicide occurred among children and adolescents (aged 17 and below) with the majority occurring in those aged 15–17 (83.1%)
- Deaths by suicide represented 30.9% of all deaths in young people aged 15–17 years and 32.4% of all deaths in those aged 18–24 years—up from 16.5% and 23.9% respectively of all deaths in these age groups in 2001.

Suicide among humanitarian entrants and other permanent migrants

Whilst multicultural communities who include refugee, humanitarian entrants and other permanent migrants have varied experiences, they may also have some shared experiences that contribute to suicide risk factors. These include difficulties adjusting to a new culture, experiences of stigma, and changes in social and family networks a result of migration (9). Australians from multicultural backgrounds who are refugees or humanitarian entrants may experience additional or more pronounced challenges due to past experiences of persecution or human rights abuses within their country of origin, or trauma associated with war or their refugee journey (9).

Amongst humanitarian entrants who arrived on or after 2000:

- Between 2007 and 2020, the Age-standardised rate (ASR) of death by suicide was 6.7 per 100,000.
- This was higher in males (11.0 per 100,000) than in females (3.0 per 100,000) (9)
- The ASR increased with increased time since arrival in Australia (4.2 deaths per 100,000 person-years for less than 5 years since arrival, 7.3 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person-years for more than 10 years since arrival.

Amongst other permanent migrants who arrived on or after 2000:

- Between 2007 and 2020, the ASR of death by suicide is 4.0 per 100,000
- This was higher in males (5.8 per 100,000) than in females (2.3 per 100,000)
- The ASR increase with increased time since arrival in Australia (2.6 deaths per 100,000 person-years) for less than 5 years since arrival, 2.6 per 100,000 person-years for 5–10 years since arrival, 11 per 100,000 person years for more than 10 years since arrival.

This data highlights the difference between the two migrant groups, with humanitarian entrants having higher rates. No specific data is available on refugee status within the National Mortality Database or the National Hospital Morbidity Database

LGBTIQ+ peoples

There is no local national dataset that captures suicide or intentional self-harm rates amongst the whole LGBTIQ+ community. However, research has been undertaken through two surveys which provide aggregated data by state/territory, age-group, gender and sexual orientation. These surveys, Private Lives 3 (PL3) and Writing Themselves In 4 (WTI4) were both undertaken in 2019 and target LGBTQ+ adults and LGBTQA+ young people. Both surveys form part of the 2024 Rainbow Realities report, commissioned by the Department of Health and Aged Care to inform the National LGBTIQ+ strategy. This report is discussed in more detail in the LGBTIQ+ chapter.

The PL3 survey found that for suicidal thoughts

- 75% of people from the LGBTQ+ community in NSW reported having experienced suicidal thoughts in their lifetime
- 91% of trans men nationally reported having experienced suicidal thoughts in their lifetime
- 90% of non-binary people nationally reported having experienced suicidal thoughts in their lifetime
- 86% of trans women nationally reported having experienced suicidal thoughts in their lifetime

The PL3 survey also found that for suicide attempts:

- 28% of people from the LGBTQ+ community in NSW reported having attempted suicide
- 53% of trans men nationally reported having attempted suicide
- 46% of trans women nationally reported having attempted suicide
- 40% of non-binary people nationally reported having attempted suicide

The WTI4 survey of lesbian, gay, bisexual, trans and gender diverse, queer and Asexual (LGBTQA) young people, aged 14 to 21 years found that:

- 79.6% of participants in NSW had experience of suicidal thoughts
- 49.2% of participants in NSW had experience of a suicide plan
- 26.2% of participants in NSW had experience of suicide attempt
- 62.4% of participants in NSW had experience of self-harm
- 92.1% of trans men, 90.7% of trans women and 87.5% of non-binary people had experience of suicidal thoughts
- 73.2% of trans men, 61.3% of trans women and 58.4% of non-binary people had experience of suicide plan
- 46.9% of trans men, 40.0% of trans women and 34.8% of non-binary people had experience of suicide attempt
- 85.8 % of trans men, 68.0% of trans women and 76.1% of non-binary people had experience of self-harm
- Over 80% of pansexual (84.8%), Queer (83.1%), and lesbian (81.5%) peoples had experience of suicidal thoughts
- Over 50% of pansexual (57.2%), Queer (53.8%), and lesbian (50.1%) peoples had experience of suicide plan
- Over 30% of pansexual (35.1%), Queer (30.0%), and lesbian (30.0%) peoples had experience of suicide attempt
- Over 60% of pansexual (74.3%), Queer (70.8%), lesbian (68.4%), and bisexual (62.8%) peoples had experience of self-harm
- Cisgender men and cisgender women had lower rates across every measure (10).

Further groups disproportionately impacted by suicide

Additional priority population groups identified in the Department of Health and Aged Care's Program Guidance for Targeted Regional Initiatives for Suicide Prevention are:

- Aboriginal and Torres Strait Islander peoples
- LGBTQIA+SB people
- Culturally and linguistically diverse communities and refugees
- People experiencing homelessness or housing instability
- Children and young people, including those in out-of-home care
- Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)
- People living in regional, rural and remote areas of Australia
- People experiencing or at risk of abuse and violence, including sexual abuse, neglect and
- family and domestic violence
- People with a disability
- Australian Defence Force members and veterans
- People experiencing socioeconomic disadvantage
- People who are (or were previously) in contact with the criminal justice system
- People with complex mental health needs, including people with co-occurring mental health
- and cognitive disability and/or autism.
- People with harmful use of alcohol or other drugs, or people with substance use disorders

- People who have made a previous suicide attempt or who have been bereaved by suicide.

Suicide and self-harm prevention services

Within the CESPHN region, extensive work has been undertaken to map out suicide prevention services across the region. These include services that are commissioned by CESPHN as well as services funded by other organisations include state government and local health districts. Services in the region have been categorised into six different categories all of which have a distinct purpose.

1. Crisis support and aftercare services
2. Treatment and support services for people experiencing suicidality or distress
3. Community awareness, mental health literacy and resilience
4. Joint governance and system change
5. Health and other frontline services
6. Community capacity building.

Table 1: Suicide prevention services, CESPHN region

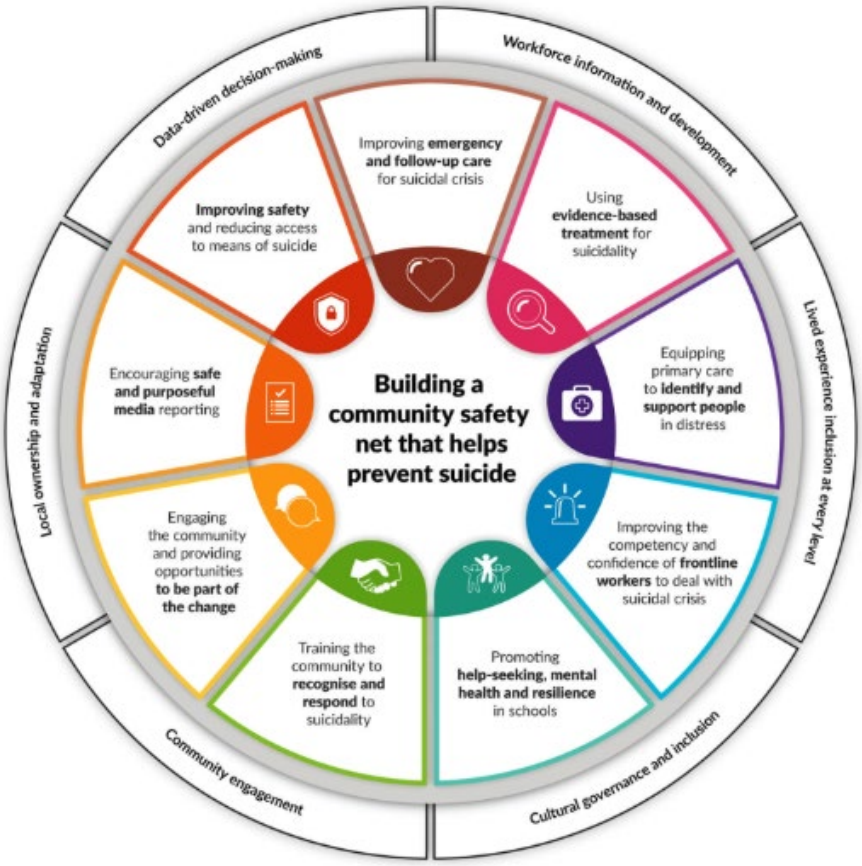
Crisis support and aftercare	Treatment and support services for people experiencing suicidality or distress	Community awareness, mental health literacy and resilience
Zero Suicides in Care initiative The Way Back NSW Crisis lines (Lifeline, Suicide Call Back, 13 YARN) Acute Care Teams in hospitals ACON SP Aftercare Support Service Support lines - Kidshelpline, Qlife, Mensline, eheadspace CAMHS [Child and Adolescent Mental Health Service] Canterbury Medicare Mental Health Centre NSW Mental Health Line SafeGuards team (0-17 years) Safe Havens StandBy Support After Suicide Suicide Prevention Outreach Teams PACER – Police, Ambulance, Clinical, Early, Response Thirrili Indigenous Suicide Postvention Service	Psychological Support Services (PSS) Suicide Prevention Services [CESPHN] Head to Health Centre (Canterbury) headspace centres Tribal Warrior Connector Service Support groups (e.g., Alternatives to Suicide; Gender Centre) Support Groups; local council social groups) Social Prescribing Models Your Coach Plus delivered by PCCS Babana Aboriginal Mens Group Digital tools and apps (e.g.,WellMob, Beyond Now)	Suicide Prevention Australia Doing It Tough website Babana community awareness days and yarning circles Heal Our Way campaign headspace centres and beyondblue Be You outreach programs into schools Community engagement programs run by local councils (e.g. youth groups, gardens, clubs, activities for older people) World Suicide Prevention Day, R U OK Day (Sep) and Mental health month activities (October) HERE, ACON's LGBTQ+ Suicide Prevention Digital Hub UrHere, social media campaign by Wellways STOP campaign for SESLHD Promotion of Mindframe guidelines
Joint governance and systems change	**Health and other frontline services**	**Community capacity-building**
Inner West Suicide Prevention Collaborative St George Suicide Prevention Collaborative Establishment of Eastern Suburbs Suicide Prevention Collaborative	Black Dog Institute Suicide Prevention Training for GPs HETI Mental Health Training for GPs Vicarious trauma training for youth mental health providers Mandatory training for PHN-contracted Suicide Prevention Services (SPS) providers Suicide Prevention Training in Systems Outside of Mental Health Anglicare older people gatekeeper QPR training	Suicide Prevention for Seniors training (Anglicare) Workplace Mental Health Coaching

Source: Adapted from Beacon Strategies Report: Targeted Regional initiatives in Suicide Prevention (TRISP) Consultation and Co-Design for CESPHN, October 2023

The system's approach to preventing suicide

To support the community at a local level, a systems approach should be used. Lifespan is an integrated framework for suicide prevention that combines nine strategies that have evidence for suicide prevention into one community-led approach.

Figure 11: Lifespan framework



Source: Black Dog Institute 2020

Implementing a systems-based approach is highly complex and requires strong local partnerships and community buy-in. Strategically planned, well-resourced stakeholder engagement, community consultation and genuine co-design with adequate timeframes to build and maintain relationships and community trust are essential to the successful implementation of systems-based suicide prevention (11).

Between 2016-17 and 2020-21 the Department of Health and Aged Care undertook the National Suicide Prevention Trial across 12 PHN sites. This trial was then evaluated with the findings implemented across all PHN regions across Australia by the Targeted Regional Initiatives for Suicide Prevention (TRISP) funding. In 2023, CESPHN commissioned Beacon Strategies to undertake a consultation and co-design project under TRISP.

The consultations and lived experience interviews identified the following areas of need:

1. Strengthen the **services that already exist** to make them more effective in responding to people's needs and preferences — particularly around being flexible, effective, compassionate and inclusive.
2. Increase **awareness** about what services and supports are available, what someone might expect when accessing them and who can help with navigating the system.
3. Easier **access** to the right type of services and supports, in the right place, at the right time — particularly pathways so people don't have to present to a hospital and can avoid barriers like eligibility criteria, travel and cost.
4. Acceptance and promotion of **non-clinical services** and approaches that focus on assisting people through the situations or difficulties that cause distress.
5. Increased engagement of people and groups in the community who have limited supports in place or experience **barriers to seeking help** based on their circumstances, identity or background — particularly making existing services more culturally appropriate for people from culturally diverse backgrounds and Aboriginal communities.
6. Increase effective **community engagement** to create support mechanisms outside of professional services (e.g. schools, workplaces), to reduce stigma in how people communicate about suicide, and train community gatekeepers to identify and respond to people in distress.
7. Effective mechanisms of **local collaboration, governance and networking** to plan and take collective action on suicide prevention.
8. Better engagement and involvement of people with **lived experience** centrally within the suicide prevention system, including more peer support.
9. Increase support to the suicide prevention **workforce to build the capacity, capability and confidence** to respond to people in distress, and to provide the training and professional support they need and have an increased tolerance of 'risk'.

In response to the identification of the above, CESPHN co-designed and commissioned a suite of initiatives and services throughout 2023-24 to address unmet needs with the aim of decreasing suicide in the region.

Further consultation with CESPHN staff in 2024 has identified additional areas of need. These needs are both systems-level and service delivery needs. System level needs include:

1. Increased recognition that systemic issues are causing suicidal distress and attempts and the roles that holistic support can play to reduce this. Examples of systemic issues include but are not limited to:
    - being under financial distress or instability
    - experiences of racism
    - experiences of domestic and family violence
    - homelessness
    - LGBTIQ+ discrimination
2. More research needs to be undertaken on female suicide attempts and intentional self-harm. The data we have shows higher levels of deaths by suicide in males due to the lethality of means males use on average in comparison to females. However, the data also show that females attempt suicide and engage in intentional self-harm at a higher rate than males.
3. Further work needs to be undertaken in the multicultural space that recognises individual disparate cultural needs, including the needs of refugees and the impact of trauma on these communities

4. Continual reviewing, improvement, availability and communication of information about available services and how to navigate them for service users, their carers and people working across the system
5. Increased service integration to improve interface between primary care (particularly GPs) and acute/crisis mental health services.

Service level needs include:

1. An increase in publicly funded Dialectical behaviour therapy (DBT) therapy to build skills that don't require a diagnosis or admission into a broader program, and ideally located in community locations
2. Increased affordable accessibility to general practitioners. A reduction in bulk billing at general practices has decreased access to GPs and has impacts on both the creation and maintenance of Mental Health Care Plans.
3. Continued co-location of CESPHN funded Psychological Support Services (PSS) within culturally safe and engaging environments
4. Recruiting clinicians working in PSS who are capable and comfortable working with a person who is suicidal and across a range of presentations (e.g. clinical, trauma, situational stressors).

Workforce

The clinical workforce that works to support people experiencing suicidality is the mental health workforce. A detailed analysis of the composition of this workforce can be found in the mental health chapter of the Needs Assessment.

The non-clinical suicide prevention workforce consists of non-clinical community or support workers and the suicide prevention lived experience workforce. There has been significant focus on the lived experience workforce in recent years, as emerging research has evidenced the benefits of interventions from lived experience or peer workers.

Relevant documents demonstrating the importance and relevance of suicide prevention lived experience workforce, and the need to support its development, include the following:

- Draft Advice on the National Suicide Prevention Strategy (12)
- The National Mental Health Commission National Lived Experience (Peer) Workforce Development Guidelines (13)
- LELAN Lived Experience Leadership for Organisation and System Change: A scoping review of concepts and evidence (14)
- Leading the Change, A Toolkit to Evaluate Lived Experience Inclusion and Development, Mental Health Commission of NSW (15)
- Roses in the Ocean's Suicide Prevention Peer Workforce paper (16)

CESPHN currently commissions the Suicide Prevention Lived Experience Workforce Development Initiative, enabling funding to be utilised for identified workforce development activities.

Opportunities to address health and service needs

Evidence-based service improvement opportunities:

- Enhance data and clinical document sharing between service providers
- Increase awareness of available services to reduce hospital emergency admissions
- Provide bilingual or culturally appropriate services to address diverse needs
- Build capacity, capability and confidence of the workforce to respond to people in distress and have a higher tolerance of suicide “risk”

Promote suicide prevention education:

- Increase the community’s awareness of suicide prevention and what resources are available

Partnerships and engagement including with people with lived experience:

- Continue to partner with people with lived experience to gain further suicide prevention insights, reduce stigma and improve services.
- Continue facilitating the CES Suicide Prevention Working Group, focusing on promotion, prevention, postvention, pathways, and aftercare and maintaining a strong connection with key agencies.
- Support regional oversight and coordination of regional, state, and federal suicide prevention strategies, including the NSW Ministry of Health’s Towards Zero Suicides initiatives and the Department of Health and Aged Care’s Targeted Regional Initiatives for Suicide Prevention.

Workforce:

- Continue to jointly review and update the Mental Health and Suicide Prevention Training and Professional Development resource with regional partners.

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