The Willow Project: Suicide Prevention in Children and Young People

Naomi Watkins-Ligudzinska

Churchill Fellow 2019

"It is no use saying, 'We are doing our best.' You have got to succeed in doing what is necessary."

Winston Churchill

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About the Author

Naomi Watkins-Ligudzinska - CF, BSc, PGCert, PGDip MBACP, AccNCS

Naomi is one of the UK's leading Domestic Abuse consultants, as featured by the BBC and commissioned by Lincolnshire County Council, Bristol City Council and University of Lincoln.

Naomi has worked in the field of Emotional Wellbeing, Healthy Relationships and Domestic Abuse for 12 years. She is a CAADA trained IDVA (Independent Domestic Violence Advisor), YPVA (Young Persons Violence Advisor) and ISVA (Independent Sexual Violence Advisor), working with high-risk cases, at risk of homicide. She has chaired MARAC (Multi Agency Risk Assessment Conferences) and worked closely with the CPS (Crown Prosecution Services). She has been trained in Emotional Wellbeing by the NSPCC and ChildLine and worked with them for eight years.

She has worked with young people from the ages of 0-25 years and adults in varying capacities. She has been a nursery worker, deputy manager in a nursery, project worker, support worker, housing officer, drug and alcohol worker, counsellor, domestic abuse worker, ChildLine counsellor and supervisor. She has strong expertise in working with young people and adults, she has had specialist training in Emotional Wellbeing and Healthy Relationships from the NSPCC.

She is a qualified psychotherapist of 15 years and has worked with those affected by suicide, self-harm, domestic abuse, sexual abuse, low emotional wellbeing, stress, anxiety, depression, trauma, low self-esteem and confidence.

Having delivered various training to volunteers, staff members, professionals, children and young people, she has become a highly experienced trainer. She has written workshops for all levels and delivered to large and small groups alike.

Naomi was awarded an Angels in Business Award in 2016 for her work in the Community. She has a Dedication to Service Award for her commitment to Domestic Abuse from EDAN Lincs – 2021

Naomi is an Institute of Directors (IoD) 2019 award winner and 2020 finalist. She was awarded Director of the Year 2019 in the start-up category for NWCH, the Community Interest Company (CIC) she set-up in 2017. NWCH provides counselling for all ages, and training to become a counsellor. Naomi is the CEO of NWCH which has supported over 2000 people with access to quality therapy.

Naomi has a keen interest in Suicide Prevention in young people, having seen an increase in NWCH of young people needing help and feeling passionately that more needs to be done, by everyone. Naomi was awarded a Churchill Fellowship in 2019. She travelled to Australia and New Zealand to research Suicide Prevention in 4 years-30 years. To learn from other passionate organisations making a difference, she hopes to bring those teachings to the UK, to educate people and provide accessible services for young people.

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Why Australia and New Zealand

I knew Australia and New Zealand had excellent suicide prevention and support projects we could learn from and implement here in Lincolnshire and the UK as a whole.

I applied to the Winston Churchill Memorial Trust for a Fellowship after hearing Bronwen Edwards speak at the NSPA conference in 2018. Listening to Bronwen from Roses in the Ocean, I was amazed by her resilience, strength and passion for suicide prevention through working with people with lived experience. At this time this was something relatively new and had not really been approached within the UK.

I started to look to Australia and New Zealand, as I had heard good things about their approaches to mental health and suicide prevention in young people. I noticed a few organisations that really caught my eye, such as the Black Dog Institute and Headspace. Then I started to find more and more as I started to look, and I really felt that I needed to go and speak with these organisations to learn from them and to see what they had implemented with a view to seeing if we could recreate anything similar in the UK.

I travelled to Australia (Brisbane and Sydney) and to New Zealand (Auckland and Christchurch). I knew we could learn a lot from suicide prevention organisations in Australia and New Zealand which will enable us to implement projects and support systems that already work and create lasting change here in Lincolnshire.

The services we have in the UK are limited, mainly by funds but also by policies, procedures, criteria to access public sector services and waiting lists. We know young people are turned away by services due to not meeting the criteria of the service, therefore not even making the waiting list. We need to remember waiting times for young people feel much longer than they do for adults, a month in a young person's life can feel like the equivalent of a year in an adult's life. Young people have also told us that once in services they have not had consistency with the support they have received, there have been many changes in who their therapist is, and chances are the support has been too short at only 6-12 weeks. The support has also mainly been CBT (Cognitive Behavioural Therapy), which does not suit all young people. They enjoy the variety of art psychotherapy, group therapy with peers with lived experience, pet therapy and other innovative therapies. It can feel a little too much like school with 'homework' tasks. We can see some great work from Third Sector organisations supporting young people, but they are not recognised, valued or funded fairly.

Australia and New Zealand seem to have some similar concerns in terms of funding. However, they have access to a lot more funding than we do here in the UK. Which is referenced more fully in my conclusion.

In the UK we have challenges with how we address suicide prevention in schools, we have a lot to learn from Australia and New Zealand in this area. They work with young people in schools, and it has a great impact on suicide awareness.

Executive Summary

The Willow Project is a new project, started due to the findings of this research, The Willow Project aims to address suicidal ideation in young people and young adults aged 4 years - 30 years.

I wanted to address this and start a project in Lincolnshire because currently, there is nowhere to refer young people to. We are a counselling hub in Lincoln that receives an overwhelming number of referrals for young people and young adults who are suicidal, who have little or no support. I knew Australia and New Zealand had excellent suicide prevention and support projects we could learn from and implement here in Lincolnshire.

I wanted our service to feel confident in addressing suicide ideation, preventing suicide in young people and supporting their families to spot the signs and support accordingly. We want to run group therapy, workshops and more 1-2-1 counselling for young people aged 4 years - 30 years who have suicide ideation. I want the research to help develop a mental health toolkit for postvention for young people accessing our service which can be rolled out nationally. I would like to encourage policy makers to take the findings seriously and increase the funding nationally for suicide prevention, intervention and postvention.

I travelled to Australia (Brisbane and Sydney) and to New Zealand (Auckland and Christchurch). I knew we could learn a lot from suicide prevention organisations in Australia and New Zealand which will enable us to implement projects and support systems that already work and create lasting change here in Lincolnshire. I would like schools in our area to take suicide prevention more seriously and to invest in services to help teachers recognise the signs and symptoms of suicide ideation.

The main impact of this research will be a reduction in suicide attempts and suicide completions in Lincolnshire of people aged 4 years - 30 years. I wanted to identify good practice that the UK can learn from, which can be applied nationally.

I have made five key recommendations across a range of key areas, including commissioning and funding, peer support projects, quality therapy and support programmes and support for organisations and families and research.

The Fellowship taught me about my own personal practice and the practice of NWCH. The trip enabled me to reflect on good practice in the UK, for example access to some services and the strength of some of our policies and procedures.

However, it also highlighted to me areas that central government and local statutory services could improve on and how they should incorporate the Third Sector, community and private sector more, along with people with lived experience, to shape services and provision that are young person centred and accessible with quality outcomes. It is everyone’s responsibility to change the statistics and the reality is that more young people are ending their lives by suicide. Which given the current situation with the global pandemic, will sadly only rise in numbers.

Recommendations

1. **Funding and Commissioning**
   Central and local government, along with statutory agencies, need to commit to funding and commissioning Third Sector organisations to develop and deliver more prevention support for young people and make this their priority.

2. **Involving Young People**
   There needs to be a commitment to involve young people with lived experience to feed into support programmes. These programmes need to be available in schools and education establishments, along with workplaces being flexible to allow young working people to access these programmes.

3. **Joined-Up Services**
   Statutory and voluntary community sector organisations should provide access to therapeutic support in young people friendly spaces. In those spaces there should be access to all the support a young person may need, a ‘one-stop shop’. The criteria needs to be inclusive and not discriminatory.

4. **Supporting Families**
   There needs to be appropriate support and psychoeducation for organisations and families affected by suicide, which is timely, accessible and empathic in its overall approach.

5. **Outcomes and Evaluation**
   All new and existing services working with young people should establish appropriate suicide prevention services, to have an additional focus on outcomes and evaluation to ensure they are delivering effective and empathic treatment and support. Services should incorporate research into their processes.

Aims and Objectives

I applied to the Winston Churchill Memorial Trust for a Fellowship after hearing Bronwen Edwards speak at the NSPA conference in 2018. Listening to Bronwen from Roses in the Ocean, I was amazed by her resilience, strength and passion for suicide prevention through working with people with lived experience. At this time this was something relatively new and had not really been approached within the UK. I understand that many organisations were too scared to work with people with lived experience because they may become unwell, or they may not be able to give them the support that they need. We can learn so much from people with lived experience, they are the ones who have accessed services, who have had experience of services, positive and negative. We need to listen to the people who have survived suicidal ideations and intention. They can give us so much, in terms of how to shape our services going forward and these are the voices that need to be heard and not silenced.

I started to look to Australia and New Zealand, as I had heard good things about their approaches to mental health and suicide prevention in young people. I noticed a few organisations that really caught my eye, such as the Black Dog Institute and Headspace. Then I started to find more and more as I started to look, and I really felt that I needed to go and speak with these organisations to learn from them and to see what they had implemented with a view to seeing if we could recreate anything similar in the UK.

I have been a Psychotherapist for over 15 years now and have worked for organisations such as the NSPCC and ChildLine. In that time, I have seen an alarming number of children approaching services, or their parents and families approaching services, because of concerns around their children and young people's mental health. It has also been portrayed in the media that there is a rise in suicide ideation and intention and sadly completion in young people. These ages are young, starting from 10 years old. (England ONS, 2018). We are failing our young people and we need to look at why, what is it that we are missing and what we are not doing to support our young people. There tends to be a focus, and rightly so, on males aged 25 to 55 because we know that this is a high-risk group for death by suicide, (England ONS, 2018) but the rate for suicide in young people has steadily been increasing in the last 10 years. This is something that alarms me greatly and I want to do something about it. We know that prevention is the best way to help reduce suicide rates. I wanted to find out how and what we can do better.

Through my organisation NWCH, we have seen that children and young people are repeatedly not having their needs met by statutory services. The feedback that we have had is that there is a lack of consistency with support, or therapy changing regularly, with the people delivering the therapy changing regularly too. The duration of the sessions is not long enough, usually 6-12 sessions maximum and they are too structured or too much about completing worksheets. Young people and children are telling us they are not feeling heard and not involved in their own therapy. The way we work incorporates a whole array of therapy such as, Jungian sand play therapy, art therapy, walking therapy and pet therapy. With young people and children, we need to be creative, and we need to listen to what they feel they need and want, to fully aide their recovery.

Introduction

Background to the project – completed in conjunction with LORIC (See Appendix 2)

The UK has full suicide statistics published for the period 1981-2017, although the latest update to the suicide prevention profile occurred as early as February 2019. (All data in this section is referenced fully in the LORIC report in Appendix 2).

Data from NOMIS puts suicide (and injury/poisoning of undetermined intent) 19th among the 20 most common causes of death. Although it represented 0.9% of all deaths that year (2017) it was also the fifth among the causes of death that could be considered even remotely preventable (after cancer, accidents, cirrhosis, and diabetes).

It is without doubt that suicide is a topic that is frequently discussed in the UK. In 2017, the "Third Progress report of the Cross-Government Outcomes Strategy to Save Lives" stated that each suicide is estimated to cost £1.67 million to the economy. It outlines the government commitment to spend an addition £1 billion by 2020 on mental health and suicide prevention. The National Strategy has identified many of the same high-risk groups that have already been mentioned in this report: young and middle-aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups (doctors, nurses, vets, farmers and agricultural workers) and people with a history of self-harm.

The ONS 2018 tells us 6,507 people died by suicide in the UK. It is thought to be much higher in 2019, though this could be due to how coroners report on suicide and how this has changed. England's Suicide Prevention Strategy tells us 135 people are affected by each suicide. Suicide is the leading cause of death in men under the age of 50 years in the UK and one in five people consider suicide during their lifetime. In my County of Lincolnshire, one person a week ends their life by suicide.

Many people think suicide mainly affects older adults, but there has been a rise in the number of younger people driven to end their own lives by suicide for various reasons. Suicide is the leading cause of death for 10- to 19-year-olds in the UK across all genders and this is the same for people under 35 years (England ONS, 2018). In people under 35 years, there were 1,866 deaths by suicide in the UK in 2018 in this age category. 263 of those were school-age children, this equates to four school age children a week, ending their lives by suicide in the UK. 2018 showed us a 20% increase from the year before. There was a rise in female suicide and self-harm.

The question I had was whether the same groups had been identified as high risk in New Zealand and Australia, and if so, to what extent are they also being targeted by suicide-prevention initiatives?

A dataset published on the 16th of April 2018 showed the registered deaths in New Zealand in 2015. Of those, 525 were attributed to intentional self-harm (around 1.7% of all deaths); in other words, an estimated 11 in every 100,000 of the population* had died by suicide in 2015.

Of the deaths ruled to be the result of intentional self-harm, 73% were males. The rates varied by both gender and ethnicity – for every 100,000 Maori men, approximately 25 had

been estimated to have taken their lives in 2015, compared to 14 per 100,000 non-Maori men. Among women, 11 in every 100,000 Maori females were estimated to have taken their lives, compared to 4 in every 100,000 non-Maori females.

(*Rates per 100,000 population, age standardised to WHO World Standard Population.)

The data on mortality in Australia shows that suicide is a serious issue. According to a governmental statistical release, 12.6 in every 100,000 of the population died of suicide in 2017, compared to 11.7 per 100,000 in 2016. To cite from the release:

"Suicide remains the leading cause of death for Australians aged between 15 and 44. In 2017, the overall age-standardised suicide rate was 12.6 per 100,000 in Australia.

The Australian Bureau of Statistics, Causes of Death, Australia, 2017 reports the preliminary figure for death due to suicide in 2017 at 3,128."

The statistics are dramatically different from those in New Zealand, where only 1.7% of all deaths were deemed to be from intentional self-harm.

From the data that I looked at with LORIC it was clear to see that suicide was an issue for the UK, Australia and New Zealand. However, it appeared there were many more suicide support organisations in Australia and New Zealand than there were in the UK. Therefore, I wanted to find out what these organisations were doing, was it working, what was good practice and what could be improved. Does having support make a difference and if so, what support is making the overall difference?

It seemed the me that the ages for Australia and New Zealand did not see a rise in young people, but more young adults, 30 years and above.

Therefore, it begs the question, are the support services for young people better in these countries than in the UK and can we implement similar here? When I heard about the rise in suicide rates in young people in the UK, I knew I needed to do something about it.

Purpose of the Report

This trip and report were to learn from other countries and bring that learning back to the UK. What can we be doing better, how can we be involving people with lived experience more?

This report will outline the interviews I had with the phenomenal organisations in Australia and New Zealand who are really making a difference. It will make recommendations on how to translate that to the UK. I will also be discussing what funding we need to make this a reality and which organisations to fund.

This report should promote discussion on suicide prevention and how we can provide meaningful support to young people. It should inform policy makers on the rationale for more funding for suicide prevention, intervention and postvention support. As a direct result of this report, I would hope to see more initiatives created to support young people and young adults with suicidal ideation and intention.

Method

I approached organisations before I planned my trip to see if they would be willing to be interviewed and for me to spend some time with their organisation. All interviewees signed a consent form and were given the questions beforehand.

I then met with them face to face or via zoom and conducted the interviews, which were recorded with Otter. The transcripts were provided to the interviewees to gain their consent to be used in this report. Consent was gained for photography and mention by name and title.

I then collated the interviews to base this final report on the findings.

Findings – Interviews

Roses in the Ocean – Bronwen Edwards – Brisbane

Funding & Commissioning / Involving Young People / Joined-up Services / Supporting families / Outcomes & Evaluation

Pictured (L-R)

Bronwen Edwards - CEO Roses in the Ocean and Naomi Watkins-Ligudzinska - CEO NWCH

"We are a lived experience of suicide organisation. We exist to save lives and reduce emotional pain. And we do that through our mission, as such as that we do that through empowering people with experience to inform and influence and enhance suicide prevention activity. A big purpose of what we do is creating a lived experience workforce, right around the country, so that we do have people who are skilled, can align their other skills with that experience, but they really understand the lived experience and how to meaningfully use it appropriately and safely. And then, the other main purpose of what we do is because of all of that, the privilege of hearing all those stories all the time, we then now are able to feed that up. And we have a very high profile in terms of consulting, advisory, advocacy, for lived experience. So, we have become the leading national experience organisation. In fact, we are the only organization that does what we do well in the country and have not yet found anyone around the world that does what we do, either."

Meeting Bronwen was inspirational, her story is very moving, and the work Roses in the Ocean does, is remarkable. It started with the untimely death of her brother Mark in 2008. Bronwen was invited to sit on a lived experience committee with just six other people, she was brave enough to speak out and to share her opinion far and wide to anyone that would listen. Which was that people with lived experience needed a voice and needed to be able to shape our services.

"*We've literally gone from, "Let's get let people to share their story, to having a speaker's bureau. That's such a tiny part of what we do, it's incredibly important and we train people to do it. It's gone so far beyond that now, people are involved in all aspects of suicide*

prevention, from policy to research, to co design to service delivery to peers in services you name it. You have got to have the experience involved. It's just been such a monumental shift.

"For example, 18 months or so ago, the Federal Minister asked us for our investment priorities and a lot of that was based around non-clinical alternatives, and aftercare and all of that sort of thing. The other thing that's been significant in Australia, and this was the Suicide Prevention sector, in a coalition, and we were part of that. It's getting recognition that mental health and suicide needed to be separated and acknowledging the overlap, but so that we have a fifth mental health and suicide prevention plan. We know that there are so many people that become suicidal, take their lives that have never had a mental illness in their life, and will not go to a mental health facility. Because the stigma is still a significant issue here."

Bronwen and her team have been able to get policy makers to listen to their recommendations, she also speaks above of a coalition, a collaborative approach to suicide prevention. I feel she makes valid points about there being many people not known to services who sadly end their lives by suicide and how do we get to those people? We also discussed there was a lack of places to go if you are feeling suicidal in the moment. Attending emergency departments is not the right place and the lack of care and empathy is detrimental to people. We do need a service that people can access 24/7 if they feel they want to end their lives, which is not the A&E department.

Bronwen's thoughts were to have a lived experience mentor in A&E to support people and for organisations to display a sticker saying people who feel suicidal can attend for support. We have started a similar approach with night cafes here in the UK, but they need more funding and evaluation to see if they are having the desired impact. We also discussed safe houses, again we do have some of these in the UK but not many. Respite houses could be a really great way for people to get a break when things are feeling tough, supported by peer mentors and qualified practitioners. We also need to be making sure those people who are dealing with the disclosures know what to say and to handle the situation properly:

"But to us, it's all about every single person needs to have not only the knowledge of what they should do, but the confidence to have those conversations and we believe it's a lived experience person that actually helps people build the confidence. So, when you can have a suicidal person stand up in front of you and say "if you ask me this, I won't tell you the truth. If you say it this way, well then will open up". I think that's what will help build confidence. It's not a short list."

We discussed how to involve young people safely and that children perhaps need more support in schools to understand their emotions, to talk about feelings and to know when something is not right, what to do, where to go for support.

I feel Bronwen's summary says it all:

"I think if we could get into every region of Australia, safe haven cafes, safe houses, people sitting in an ED (Emergency Department – equivalent to A&E in the UK) like if someone has to go to an ED, there needs to be a very low sensory safe place for them to be ideally not even getting to ED but have lived experience people there. We've got to have aftercare, literally meeting them at the hospital when they walk out, we need all of that infrastructure to wrap around. I think that's if that was overlaid in this country straight away, I wouldn't need to save thousands of people in the preventative side of things, and I think it's about that real capacity building. So that people are a lot more aware of what they are looking for and where to get help. And it's impossible to find where to get help still here. You know, I can have a friend ring, and it'll take me two days to ring around all my networks to find the right people for them. That's ridiculous."

How to translate this to the UK:

We need more lived experience people shaping our policies and services, with access to services being expanded out of A&E departments. We know people are more at risk once they are discharged from A&E and/or the crisis team and then not having any support.

An evaluation needs to be completed of Peer mentoring support and night light cafes, which have started already in the UK, to see the full impact and outcomes they are having.

Policy makers need to listen to grassroots organisations and lived experience people, through advocacy and committees. Lived experience people can train us to respond appropriately and informatively to those at risk, making sure children and young people have empathy and information on how to support themselves emotionally and how to ask for help with the services being there to help them.

Orygen – Michelle Lamblin – Melbourne (Online Interview)

Funding & Commissioning / Involving Young People / Joined-up Services / Outcomes & Evaluation

"There are now three components of the clinical service, the research and academic and the National Centre.

Our national kind of projects, we do a lot of policy and advocacy work, lobbying the government for various funding changes etc. We do a lot of communications and awareness raising.

We also have a large translational education as well. So, it's not just about doing research, or it's not just about working clinically it's about translating those findings back into the community, providing education programs, and training for healthcare professionals, universities or community services. And as part of that we obviously run our clinical service, which caters for young people under age 25, which includes specialised clinics for mood disorders, psychosis, and borderline personality disorder. And we have an early ultra-high-risk clinic, which I think is currently going undergoing some changes to the structure of it, but that's kind of still there. And as part of that we also have an inpatient unit base of the hospital, which caters to those really high risk, young people, that need to be hospitalized. We also have an outreach, access team, who can do home visits and triage people while they're waiting to come into service.

As well as that we also run a few headspace centres here in the Northwest. We have four which sit within our region. We are the lead agency for those four sites."

It was recommended I speak with Michelle Lamblin, Project Manager at the Suicide Prevention Research Unit at Orygen, due to my focus on young people. It was clear from the onset this organisation is pivotal in supporting young people with mental health needs and how they value young people's opinions.

I Skyped Michelle Lamblin as Orygen is a National Centre of Excellence in Youth Mental Health and the world's leading research and knowledge translation organisation, focusing on mental ill-health in young people. Orygen delivers cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure continuous improvements in the treatment and care for young people experiencing mental ill-health.

I could not believe their growth in such a short time; from three members of staff to 50 in the last three years, thanks to investment from funding bodies and government funding. Like ReachOut Australia, Orygen also involved young people in the design of their new building, again a great example of youth participation. I was also impressed that their suicide prevention model is a community-based approach, where everyone is accountable. Training is provided in communities, and schools have programmes to support young people. This is excellent forward thinking and cutting-edge research from Orygen.

"We're now in a beautiful new building. And even in designing the building, we did a lot of consultation with young people about how does it feel coming into Orygen? And what do you

want to see, and so they said things like, 'We don't want it to feel like a medical waiting room', and so a lot of the space's downstairs are really open and communal. And it's really a space where young people can come and enjoy or while they're waiting to see someone they can sit down, and we've got puzzles and books and things like that all over the place. It's a very chilled space. You certainly wouldn't feel like you're walking into a mental health service when you come in."

We soon realised the similarities in that some young people fall through the gaps. The high risk was being referred to hospitals and mental health residential units, but those deemed not complex enough - where do they get referred to, if they do not meet the criteria for CAMHs for example, here in the UK?

"It's the way that we talk about suicide risk assessment, it should be no different to a heart risk assessment, or diabetes risk assessment, or things like that, it should be part of standard practice. We shouldn't shy away from it or we shouldn't be reacting in a way that gives the client a reason not to speak up about it."

We both agreed we need consistency, empathy and better systems in place to risk assess and support young people with mental health issues and/or suicidal ideation. Michelle told me suicide is the leading cause of death for young people in Australia, the same as it is in the UK.

"But the issue is that once you do speak up, you might not have the right or appropriate care. Or if they're even available for you. It's one thing to say open up and speak to a friend, but what if that friend doesn't know what to say, or doesn't know what to do, or when to be really concerned about safety? I think that there still needs to be those awareness campaigns, and they are great, but they need to be matched by the availability of services and that people need to receive really efficient support, and they need to receive empathic support, and they need to have that feeling of, you know, okay, I've asked for help now what? Oh, now there's a six-week waiting period to get in."

Support needs to be timely and, alongside awareness campaigns, there must be training on how people respond and services to refer to, with little to no waiting list.

I was excited to hear of Orygen's new project with schools:

"Training community members, we're doing a piece of work on that at the moment. We're about to start in secondary schools for year 10 students, and we'll be providing year 10 students with training. But as part of that, every student does fill in some surveys, which include a risk detection screener, as well. And those young people who are identified as being at risk, they are referred on to outside support or with the school counsellor, or this specialised online modules that will be developed as part of this trial."

Peer support and support to schools is essential and this idea has merit along with a resources kit, group support for parents/caregivers, so that young people's support networks are fully on board with the process and feel as equipped as they can be to handle suicidal ideation or intention on their children and young people.

Two resounding strategies that are helping young people in Australia were:

"I think the provision of something like Headspace, which is a dedicated Youth Mental Health Service, which you can get into, is something to be proud of. But there are also alternative methods as well. I think that's really something that we can hang our hat on, in terms of doing something right for young people.

And also, I think the other thing in suicide prevention world as well, is that in the last few years, there's been a really, really big investment from the Federal Government in suicide prevention and various operations strategies and projects and things like that. I think the rollout of some of those projects and the evaluation of ours could be a little bit better."

How to translate this to the UK:

The salient points Michelle makes are about involving young people in the design of buildings, encouraging them to have training to become peer supporters, especially if they have lived experience.

Campaigns are useful and help to reduce stigma, but an expensive campaign is useless without support services having funding alongside it. We can encourage young people to speak up but where are we referring them to? We also need clear risk assessments and guidance as to how to support young people with suicidal ideation and intention.

A clear point here is the volume of investment from the federal government and that being filtered down to the right organisations. I was also extremely impressed with Headspace and their provision for young people – and they will be my first case study later in this report.

Standby - Kelly Playford-Veal and Monique Broadbent – Brisbane

Joined-up Services / Supporting Families/ Outcomes & Evaluation

Pictured (L-R)

Kelly Playford-Veal - Brisbane South Team Leader Standby, Naomi Watkins-Ligudzinska - CEO NWCH and Monique Broadbent – Head of Research and Strategy Standby

"Standby support after suicide is a postvention service. We support people who've been impacted by suicide in any way at any time. So regardless of when the suicide occurred, it could have been today, last week, 50 years ago, we are able to support people. And when people have been impacted that maybe because they have family and friends with the person who's died, or it could just be that they have heard about it and felt impacted. For some reason, they might have witnessed a stranger suicide, they may have found the body. They may be first responders, so police, ambulance, whoever it may be.

We work with both community members and professionals. We go out to psychologists' offices, to whoever needs the support really. We do short term support, which means that we may go out and see a group. So that may be a school or a football club or a workplace company, Kelly went out and did a workplace session last week. We may meet up with a large group or small group, we might even do follow up sessions with individuals or with groups. But then once we've done that initial short-term support, we then refer people into ongoing support. So, we're not able to do ongoing work, unfortunately. The support that we're doing may look like bereavement and grief support, or it may be more trauma focus, just depending on the circumstances and their relationship to the deceased. We offer holistic care and training."

Standby receive referrals from the police and the community. They then co-ordinate the counselling team to support the people who have been referred. This will include community development and community training.

"For example, last week, we had a referral to someone who attended our training as they were concerned about the suicidal behaviour of their colleague, and just wanted to get some

support. Even though we are suicide support, we are not prevention. However, postvention is prevention. Even though our focus is more on training, we are always in that space of preventing."

Standby also facilitate postvention suicide bereavement groups, for anyone that has been impacted by suicide; child, brother, sister, parent or friend/colleague.

This is vital in reducing the 'ripple effect' that suicide can have on the people who were around the person who has died by suicide. This approach is hugely helpful in the preventive space of suicide. Research tells us that people who are bereaved by suicide are at a much higher risk of feeling suicidal themselves. Postvention is prevention, this is something we could learn a lot about in the UK. The support is implemented quickly and can be one session within a week and then three follow-up sessions within 12 months. The counsellors work in pairs and go out to people's homes to provide the support. This is a very rare type of co-therapy model. The therapy can be a mixture of 1-2-1, family therapy or one or two family members together.

"The research showed us that there was there was a massive reduction in suicide risk, if they had access to standby services, with increased social engagement and less withdrawal from their community groups and everything if they had access to Standby service."

Standby's clients also show post-traumatic growth, by wanting to become community champions, wanting to hold fundraising events and help to break the stigma around suicide. People with lived experience have done videos for new people joining the groups, this has been a huge source of comfort and hope for those starting their support journey after suicide has rocked their family. Our support needs to be focused on the individual and tailored to their needs.

"I think if the focus is more on that person, on their resilience. As there's still people way too often treated as their diagnosis and not as a person, and if you treat someone as their diagnosis, that's going to reinforce the symptoms."

We discussed how campaigns need to be carefully tailored to everyone, as we can all be at risk of suicide. Also, campaigns need to be able to reach rural areas and all communities, regardless of age, sexuality, gender and race.

"*We need to go back to the drawing board in terms of our campaigns, how Australia campaigns around suicide, and I think that there needs to be a message that, you know, suicide is not necessarily connected to mental health. And if you're experiencing these things, contact us, because that can turn people away thinking "I don't have a health or a mental health issue."*

We need to work towards breaking the stigma and fear in talking to young people about suicide. If we do not have these conversations, we cannot help to prevent suicides in young people.

"There's a new program at Headspace and schools are rolling out called BeYou, which is a very early intervention, but it's within the schools, most of the schools are very open to mental health support discussions generally. But as soon as the word suicide gets mentioned, they are backing away."

How to translate this to the UK:

Standby experience similar challenges in terms of not enough staff. They have three full time workers and have three million people in their region; 85% of Australians are impacted by suicide, it is not enough provision. They need more staff and more funding. Their short-term support model is effective, but they do realise some people need more than six sessions and there is not provision for that in Australia. There are some free services, but the wait times are very long, so signposting is as challenging there as it is in the UK.

More research is needed and more training so that professionals can respond appropriately. Suicide-specific bereavement groups are important, to have shared experiences with people who understand the challenges. Standby support young people affected by suicide too and suggest young people suicide bereavement groups as needed. Young people need MHFA and ASIST training in schools, with mental health champions. As more young people and adults are trained, the more the responses and prevention will be successful.

A reminder about self-care for professionals:

“Dealing with grief and death all the time, sometimes we forget about the living. I'm quite intentional of my weekends of living.”

YourTown – John Dalgleish - Brisbane

Funding & Commissioning / Involving Young People / Joined-up Services / Supporting Families / Outcomes & Evaluation

Pictured (L-R) – John Dalgleish – Head of Strategy and Research YourTown and Naomi Watkins-Ligudzinska - CEO NWCH and YourTown Team Members

YourTown helps to create brighter futures for young people and families. It is a values-based, national, Not for Profit organisation. They believe every young person has the right to a brighter future and aim to be part of the solution by delivering services that get results. Their services include Kids Helpline, training and employment for young people, parent education, and specialist accommodation for families. They are one of the largest not-for-profit service providers for young people in Australia, with sites across Queensland, New South Wales, South Australia, and Tasmania. I met with the Milton branch.

At YourTown, I met John Dalgleish, Head of Strategy and Research, and Laura Clarke, Advocacy and Policy Lead. I was also fortunate to meet CEO, Tracy Adams, along with counsellors, supervisors and YourTown volunteers.

My time with YourTown began with me doing a 40-minute presentation on Domestic Abuse in the UK, which I delivered as a 'lunchbox session' – in other words during their lunch break. Over 30 people attended, and I was live streamed to their other bases across Australia. There were so many questions and people queued to talk with me afterwards, which was heart-warming. Domestic Abuse prevention is another of my passions, so it was great to be so well received by an enthusiastic audience.

I then met with the Head of Service for KidsLine. KidsLine was inspired by ChildLine UK, where I used to work for eight years. They also run ParentLine. It was so interesting for me to hear that they are doing a fantastic job, answering calls to young people and parents seven days a week. Lastly, I held a focus group with 12 members of staff to discuss suicide prevention, domestic abuse, support services and so much more.

LifeLine – Jamie Gray, Fiona Leon, Rachel Bowes and Amy Webster - Sydney

Funding & Commissioning / Involving Young People / Outcomes & Evaluation

Pictured (L-R) Jamie Gray – Practice and Operations Lead LifeLine, Naomi Watkins-Ligudzinska – CEO NWCH and Rachel Bowes – Acting Director LifeLine

"Our tagline is 'Australia free of Suicide'. So, in terms of mission, that's where LifeLine sees itself or certainly a component of what they do. The other part of the work of LifeLine is a crisis support more generally. So not necessarily just people who are having thoughts of suicide but also people who for whatever reason, their life is out of control or a struggle in some way."

I spent the day with Lifeline Australia at their office in central Sydney. They are a helpline that has operated for nearly 60 years, with the tagline, *'Australia free of Suicide'*.

Since they have offices across Australia, my meetings with five staff members were held in person and via Skype. I learned that more people contact LifeLine than any other helpline, with over one million people per year calling for a phone chat, and some for an online chat. They already offer SMS services, but are currently looking into increasing their digital offering with more online chat and email services.

Rachel Bowes, Acting Executive Director for Operations, hosted me for the day and introduced me to the rest of the very friendly team, who are all passionate about making a difference to suicide prevention in Australia. One area I was really impressed with was their research into Artificial Intelligence (AI) to help reach out to people online who express suicidal ideation or intention.

LifeLine is an Australian nationwide service, with direct access to 2500+ volunteers.

LifeLine have seen lots of changes in their 60-year presence and are now seeing people are more likely to want online or text support services rather than telephone calls. They are funded by Federal government but need more funding to be able to extend their services and have employed staff. The volunteers are fantastic but, as with all volunteers, you cannot expect the same passion and drive as an employed person. It is a non-clinical support service, where you are talking to people who are just like the people on the other end of the phone, who have had LifeLine training. It is very similar to how ChildLine is run in the UK. They have around 20-25% of callers with suicidal ideation.

When thinking about what makes young people potentially have suicidal ideation:

"There's a whole bunch of stuff, there's this stuff with the younger people, like school aged high school age, people where there really is a lot around the pressure that comes from social media, from body image, from a real general lack of confidence in themselves and uncertainty about their place in the world and in their group. And that comes across very strongly, for the ones that make contact with us."

There are a lot of issues in Australia that relate to where people live. So rural, isolated farming communities, they are very heavily represented. And I think part of that is because a lot of those people live in places where there are no face-to-face services. And they do tend to use a whole range of telephony-based services, including ours. But isolation, the financial issues that come with living in very isolated and remote communities. And then of course, we know that there's a huge issue with indigenous people who don't call us."

"Increasingly lack of a secure home base and a support network, and unhelpful social influences are exacerbating the situation."

"High risk ages are 16-23. It's when young people are pushing limits, trying to discover who they are, while also going through a developmental transitional period where they increasingly rely less on their parents and more on themselves or others. They are also experimenting with drugs and alcohol and are usually experiencing multiple stressors of school, part-time employment, rent and lack of money."

LifeLine have some excellent new initiatives in the pipeline such as establishing and piloting the Lifeline Text service. This was developed using user centred design principles with help seekers and lived experience advisory groups. The service was evaluated as resulting in significant improvements in the distress levels and safety of users. This project is a finalist in the Suicide Prevention Australia Life Awards.

They are also developing and receiving a NHMRC partnership grant to look at artificial intelligence for detection of suicidality in calls.

LifeLine faces similar challenges to large organisations over here; how to monitor quality, consistency, and service delivery, particularly with volunteers and how to work together with other organisations. Like in the UK, there are so many organisations working in silo and doing similar things.

How to Translate this to the UK:

Young people need a lot of different options around how they can contact services, not having a one size fits all. Young children quite like the anonymity of being able to do something without necessarily feeling that their parents or anybody else are going to know, similarly to how ChildLine works here in the UK. We need to give some level of assurance around anonymity and confidentiality within the boundaries of what is safe to do so, young people are inherently quite suspicious, they know the system.

In some schools everyone completes mental health first aid training and it is mandatory for the whole school. There is a wellbeing champion in the teacher population and one in each year group of the pupil population. Students know who they would go to if they needed support. A lot of external experts are brought in to give talks in school time, and for parents, to raise awareness and provide support. Some primary schools' offer a similar service, where they frame it around the bullying component; how to look after your friends and how to spot when your friends are struggling. They have safe benches and safe spaces where you can go and sit, if you feel like you want to speak about something. There is also a peer leader initiative where each break time one or two of them are in with the younger children and the junior part of the school. If anyone sees the children are upset or worried or had a falling out with someone, then they have one of the older children that they can talk to. These are all excellent initiatives.

The LifeLine team had some excellent ideas about how to progress their suicide prevention work. Their ideas were around having a safety planning app that people could access when they were feeling at risk, having robust support after leaving hospital, similar to what Roses in the Ocean has set up, having a joined up working approach with other organisations instead of competing, working together to have joined up campaigns. The ideas around technology were just astounding and I love the idea of having technology that helps to improve health seeking behaviours an access to mental health services. I am sure we will see more of this develop across the whole country, particularly considering recent events in 2020 with the pandemic.

We need to have varied approaches so that all our services appeal to everybody, so nobody feels left out and people do not fall through the gaps of services. A text-based service is a really good idea and one that we really need to work on, particularly in recent times, but having accessibility to that 24 hours would be an exceptional service to help people. We come back to the idea of having a counsellor in every school which we did have, but of course due to funding that was pulled and one counsellor is not enough. We know with young people in a class of 30 there is going to be at least three young people that need therapeutic support for their mental health. We also cannot ignore that even in Australia they need more political focus on suicide prevention and not just to win an election. We have the very same in the UK in terms of our political stance. Words are great, papers and research are important, but it is action that we need and funding to back up that action.

"I'm here listening, I think is the key message to them. And when I say listening, I genuinely mean you know, being in that moment with that person without any ulterior motives at all. I think sometimes, and I guess this is one of the good things about LifeLine, is that really the aim of LifeLine is to listen, when that becomes a little bit less clear is when there is risk identified, and then the aim becomes to make that person safe. And I think that sometimes that can be the moment that we lose, some young people."

"It's everyone's business, young people come into contact with every part of our community."

Suicide Prevention Australia (SPA) - Sydney

Funding & Commissioning / Joined-up Services / Outcomes & Evaluation

Pictured (L-R) Naomi Watkins-Ligudzinska – CEO NWCH and Alan Woodward, Advisor for SPA

"I'm an advisor here at Suicide Prevention Australia. I'm here on a part-time basis. I also provide advice on various other parts of mental health and suicide prevention. Up until last year, I worked permanently and full time for LifeLine which is a large telephone helpline and online chat service. And I upgraded their research function, having established a Research Fund foundation within the organisation. And I had responsibility for broadly external stakeholder relations, policy, advocacy, Media and Communication. During the time I worked there, for 10 years, I did quite a few roles, and I have quite a background in health plans. I'm a co-convener of the special interest group on health plans with International Association for suicide prevention. Later this year, I have appointment as a commissioner with the National Mental Health Commission. I am busy, but I am happy to be working in a range of part time roles rather than having one role occupying my life. I have broadly worked in the field of mental health and suicide prevention now for 20 years. So, I've gained a little bit of knowledge along the way."

More than 100 organisations are SPA members, comprised of organisations of all sizes, as well as individual and associate members. SPA has 10 office-based staff in Sydney, yet despite being a small NGO (non-government organisation), it represents members across Australia and supports them in their work. It is similar to the National Suicide Prevention Alliance (NSPA), here in the UK.

SPA have established the hub, which is an online tool, which includes a best practice register. There are a handful of services listed on that. They use that as a capacity building resource, link it to more professional development and activity around a framework for encouraging improved effectiveness through quality approach.

The other initiative is a Suicide Prevention Research Fund that has been operating for 12 months. This is an innovative fund, in that it is research money available outside the traditional research sources, with the idea that Suicide Prevention Australia can better align the priorities of those working in the field, with those who are undertaking research and

generating knowledge.

"The challenge, in this country, is that the suicide rate has remained around the same level, over around 11-1200 thousand for the last decade. And we don't fully understand why we haven't been able to reduce the rate, despite the effort and so much good work being done. We have some ideas, but it remains a quandary.

In terms of the suicide rates for young people, we are lower than the national average for under the age of 24. And that has frankly been something of an achievement in Australia and in the 1990s young people's suicide rate was very high and into the early 90s. From the mid-1990s, Australia adopted a national youth suicide prevention strategy, which I believe was the first of its kind worldwide. And it's made a significant impact in reducing youth suicide in this country, which has largely been maintained".

The youth suicide prevention strategy that was adopted in Australia was an integrated strategy. It included some broad promotional and prevention work, including looking at the access of young people to mental health supports and treatments, but also involved Crisis Intervention Services. The Kids helpline, run by YourTown, was an example of a service that came to the fore during that period.

There was some other specific promotion of services, the lifeline service, which was not oriented towards young people was actively promoted to young people and showed to pick up with usage by young people. The introduction of some smaller projects and services for young people, the examination of schools-based programs for raising awareness around mental health and well-being and some intensive support services for young people experiencing difficulties show it was a fully integrated strategy.

We discussed some of the amazing initiatives by Orygen, Beyond Blue, Black Dog Institute, Headspace and Batyr, all featured in this report. The living works safe talk program has been introduced into a school setting, which has seen a recent research project undertaken by Orygen and has had promising results in terms of a reduction in young people's self-stigma around seeking help and suicide, increased confidence to look out for peers and to offer help to access services relating to suicide.

Alan discussed with me the nation campaign: https://www.ruok.org.au

"RU OK program is an awareness raising, social marketing campaign, to encourage people from all walks of life to engage in positive helping conversations. In other words, to ask, "Are you okay?" if they're concerned about a friend or family member, and it's been going for 10 years. One of the things that's very interesting about the RU OK program, in my view, is that while at one level, it's this large national campaign, with advertisements and merchandise and a day of the year, in the last five years, it's picked up a stronger community development component, including literally going into communities driving in, with even their own bus. Going into the community gives the people in the community who came to promote the message of mutually looking at for each other positive helping conversations, it gives them an impetus to do something, barbecue, or in our meeting at the community hall, or just something a bit more attention."

This is similar to the UK's Time to Talk initiative, on the last Thursday of every month.

How to Translate this to the UK:

Alan tells me there was a cooperative research centre established, called the young unwell CSA, which brought together many researchers from around the country to concentrate on research relating to technology and young people. It included several trials of technology tools, online outreach, and undertook survey research of young people's outlooks and attitudes. It established that many young people are online, researching about something around their own mental health or for others, but interestingly, amongst the cohort of young males who also reported high levels of psychological distress, around two thirds of them said that they would look online for help.

We need to be there to put out the offer of health and positive messages around suicide prevention, but with a sense that those highly vulnerable young people who are in distress may will be online looking for help, and we need to be present for them. Instead of expecting communities and rural areas to come to us, we need to consider going to them. There is a real gap in service provision; we need to be helping the many, not just the lucky few. Everyone plays a role in suicide prevention, not just professionals, and we need to create a society dedicated to suicide prevention.

"Research was undertaken through the University of Melbourne, asking people about their attitudes and outlooks on suicide. One of the things that we discovered was that about half of the Australian population believed that only health professionals could help a suicidal person. In other words, the general public didn't think they could play a role. When we match that up with some other research work done through the Black Dog Institute, around the help seeking behaviours of suicidal people, people who had survived a suicide attempt, and were asked to seek help, over half of those people surveyed, referred to friends and family members, only a very small proportion, contacted health professionals. So straightaway, you've got this massive dichotomy."

Black Dog Institute - Sydney

Funding & Commissioning / Involving Young People / Joined-up Services / Outcomes & Evaluation

"We're a mental health organisation. We think of ourselves as a translational Medical Research Institute. We're first and foremost about research, and particularly towards that translational end of the spectrum. And in keeping with that, we also provide clinical services, and we have education and community activities as well."

When I visited the Black Dog Institute, I was invited to give a presentation to the team about myself, NW Counselling Hub CIC (NWCH), The Winston Churchill Fellowship and my research findings so far about suicide prevention initiatives in Australia. This led to a host of inciteful questions from the entire team.

I interviewed Fiona Shand, who is a senior research Fellow at the Black Dog Institute. She is also Director of the Lifespan Suicide Prevention Project, a large, multi-level suicide prevention model.

I found Fiona's description of the Lifespan model very interesting. She explained that the team researched existing evidence-based interventions in suicide prevention before developing a framework that includes universal intervention. In other words, the model considers things that affect the whole population, through to selective and indicated intervention for the more at-risk end of the spectrum – delivered via community health initiatives, education, and front-line media. This makes it a multi-sector, multi-strategy model of suicide prevention.

In total, the model identified nine interventions to be trialled.

"Digital dog - is a mental health intervention, particularly targeting young people. It involved a cohort of around 20,000 high school students and took a series of measures around mental health and well-being and then looked at the impact of various mental health interventions along the way. There's a bunch of apps and other interventions that have been developed by the Institute. I think that's one of the areas of work where we're having an impact. I think

suicide prevention is the other area of work. And that's probably largely through two things. One was a Centre for Research Excellence, which kicked off in about 2013 coming out of that was this lifespan model."

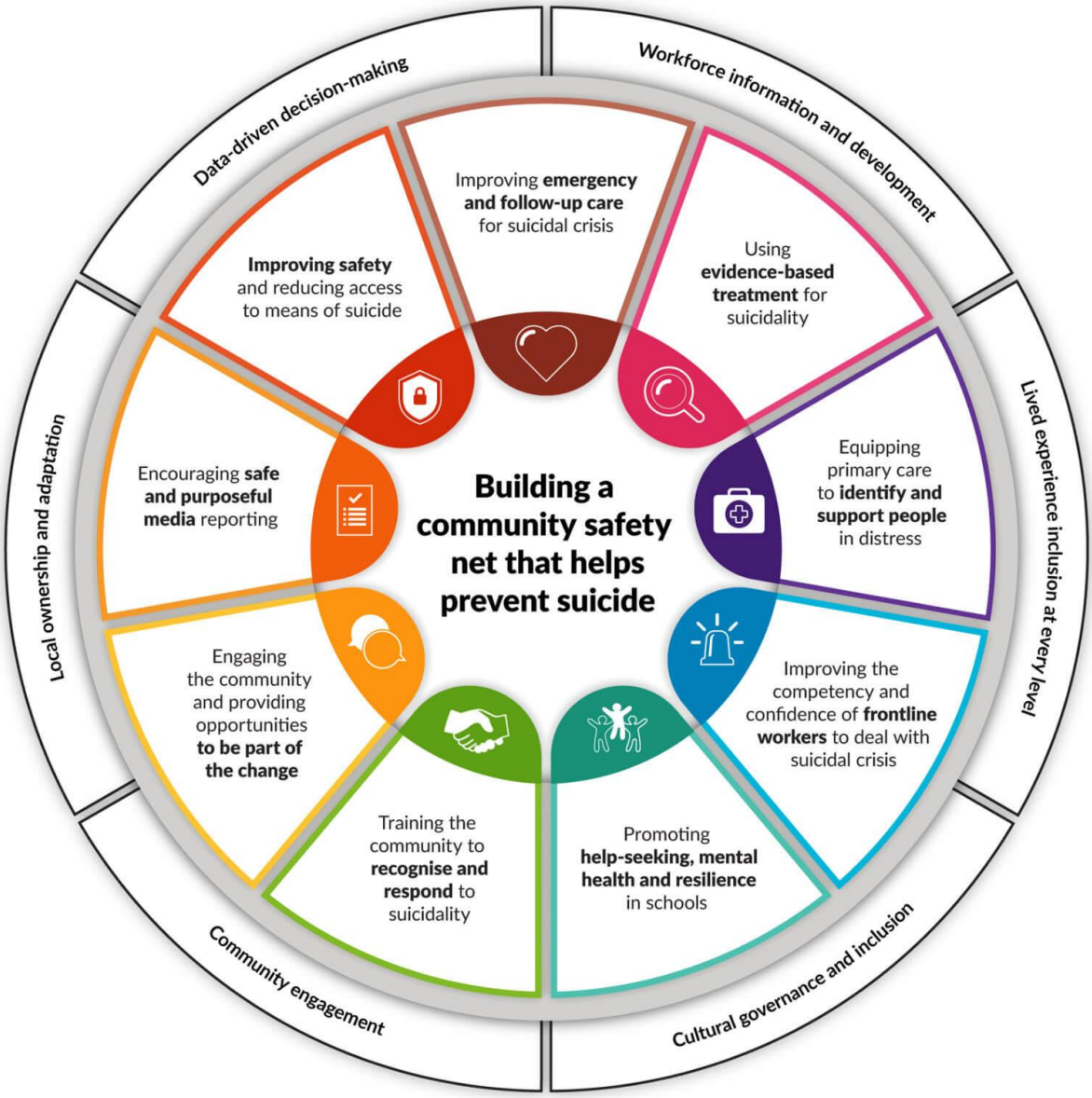
The first multi-level model of suicide prevention in the world was called European Alliance Against Depression. They were focused on community campaigns, primary care, getting GPs involved in treating depression and increasing access to treatment for depression etc. They tried that in a couple of countries in Europe and found reductions in suicide attempts and deaths compared to control regions where they did not have the intervention.

"Black Dog Institute revisited that and asked, "What are the evidence-based interventions in suicide prevention?" and came up with a framework which includes universal intervention. Things that affect the whole population through to selective and indicated intervention. The more at-risk end of the spectrum, across community health, education, front line media, so it's kind of multi-sector, multi-strategy and model of suicide prevention, there are nine interventions that we identified. And the trial we are running at the moment is in four regions, two years implementation of each region, which design and in that two years, the aim is to try and get all nine of those interventions implemented to some degree. And then we're using colonial and hospital data to see if we can pick up any changes in suicide attempts across each of those four regions."

The nine evidence-based strategies are implemented from whole-of-population level to the individual level, simultaneously within a localised region. For effective delivery, all strategies require a thorough consultation and review process to ensure their relevance and tailoring to the local context and community.

Multiple strategies = more lives saved.

Recognising that multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of its parts (i.e., due to synergistic effects), LifeSpan offers a data driven, evidence-based approach, setting it apart from current practise and raising the bar in suicide prevention.



Accessed from: 27/02/21

https://www.blackdoginstitute.org.au/research-centres/lifespan-trials

How does this help someone who is feeling suicidal? Fiona goes on to explain:

"We're trying to encourage help seeking. So, talking about suicide, making sure that media are reporting safely, but also, more importantly, reporting stories of recovery and help seeking. Lots of the voice of the lived experience. And within that there's a call to action. People will become interested in playing a role, they can then go and complete the online community training program, which helps them to talk to someone who they think might be feeling unwell, who might be at risk.

The first is directly to the person who might be feeling suicidal, is to encourage help seeking.

The second is to people who might be around them through the gatekeeper training programs, to encourage them to ask that person if they're okay, and if they're not, to use all of those skills that they develop.

And the third is to work with, the health system and strengthen their capacity and the response to people who are at risk, because we know that's not always ideal. And then the fourth is that in schools, we're rolling out the youth aware of Mental Health Program, which is

an evidence-based program from Sweden. That's being rolled out to all students in the region, so that it not only has an influence on those students, but also on the culture of the school."

How to Translate this to the UK:

Lifespan brings together all the amazing work that is happening across the whole of Australia, all the recommendations in my report, and how we should all be working together to prevent suicide with the aim to create a world that is free from suicide. We have some of these initiatives already in the UK, such as training membership organisations and support services, but we do not have a joined-up, holistic approach such as the one above. Lifespan puts the onus on everybody to make a difference. If we work together, people will not fall through the gaps.

The risk age for young people has been identified by Black Dog Institute as years 9-10. This is where we need to implement a universal programme, because it is impossible to pinpoint who is at risk. A psychoeducational, supportive programme targeted at all young people from before these crucial years and then tailored to age, from primary school and beyond would be effective in breaking the stigma around discussing suicide. I feel now that young people are scared to mention suicide, as then everything falls out of their control. Services and caregivers are informed, and they clam up. Young people reach out to other young people; imagine if that young person was trained and felt confident to respond? How many lives would we save, how many friendships would we strengthen? There also needs to be support for families; parents do not know how to support their children or how to have these conversations. Papyrus is an excellent organisation in the UK doing just that.

"When you're an adult, you have much more choice about whether you stay or leave a particular environment. Whereas a young person, you can't leave, for financial and other reasons. I think that's part of the reason why we see quite high levels of suicidal ideation among young people, they have so much less control over their environment."

ReachOut Australia - Sydney

Funding & Commissioning / Involving Young People / Joined-up Services / Supporting Families / Outcomes & Evaluation

Pictured (L-R) Mariesa Nicholas – Director of Research, ReachOut, Naomi Watkins-Ligudzinska – CEO NWCH and Kerrie Buhagiar – Director of Service Delivery

"Our vision is to help young people be happy and well, our mission is to use technology to empower young people to make the most of their mental health and well-being and help them thrive. We're very much about giving young people the tools to empower them and give them the autonomy to make choices, positive choices in terms of how they live their lives and manage their well-being.

"Our shift was really thinking about, let's try and purposefully go out and involve those people who might be suffering, who might be experiencing early signs and symptoms, or who are experiencing mental health issues, but don't really know it, or don't identify it, or don't want to do anything about it and understand what their lived experience is like.

I think that idea of like really thinking about what the lived experience is. And how do we change our service to make that lived experience heard. Rather than I think a lot of traditional clinician driven models tend to go with 'you need to fit in with us.'

I think that launching ReachOut service was a big achievement as well, I think that idea of really thinking about parents, a good parent or relationship means that you will likely get help. And I think the idea of really working with parents to support them to support their young people has been a really big achievement and something that needs to continue."

The research they have undertaken shows parents really want to help their young people, they just struggle to know how or to empathise, as they just do not understand the behaviours or challenges as it is so different to 'their day'. Also, there is a challenge around funding being outcome-based and how to evidence those outcomes. I have recommended that services should have evaluation tools to help with this.

"I think one of the challenges is that we adults and mental health professionals and policymakers put out a definition on the issues, which then make it really hard for young people to relate to them. I think there's a big gap in young people who are showing the early signs and symptoms of mental health issues, but who aren't necessarily resonating with the messaging that's coming out, because we're not talking to them in their language.

And I think there's a gap in really good prevention. Like everyone talks about prevention, government's love to talk about prevention, but really, when it comes down to it, they love funding the pointy end, because it's more tangible. And you can see the results, whereas I think it's all policy has shifted, it's like we can't really demonstrate the impact of a prevention campaign in two years or three years. I think it's just that we're not doing enough in prevention would be my take on it."

I found this organisation so inspiring, particularly their views on empowering young people to make their own decisions around their life and mental health. Understandably, young people love ReachOut Australia because they are an integral part of it. They work tirelessly to incorporate young people's views and feedback directly into their work. I was particularly interested in their programme to support parents, which incorporates a one-to-one coaching programme. They have found parents care and worry about their teenagers, but do not know how best to support them. Ultimately, the parents programme benefits both parents and young people tremendously.

"We've got a program for young people aged 14 to 25, a program for parents of young people aged 12 to 18. And a Schools Program, which is really about gearing up educators, mainly secondary school teachers, to be able to both educate students in mental health and well-being but also respond to anything that comes up in the school environment, which happens a lot. We also have a youth involvement program. ReachOut has been around now for 21 years. And from the very beginning, we've worked in partnership with young people to design develop and deliver all of the programs that we run."

"When we started, we were the world's first online mental health service, it was around 1997, there were about 30,000 Australians online, our founder at the time had a vision, he could see the potential of the internet in terms of connectivity and joining people together and sharing information. He really drew on that. I think the first thing was getting it off the ground way back then. We've always had a kind of mindset of innovation, and moving, doing things that are a little bit out of the box. We started back in 1997. And we now have over 2 million Australian visitors every year and globally something like 5 million."

I was very interested to learn about ReachOut NextStep, where they help a young person to work through a range of different symptoms to help figure out what is going on for them. The idea is it helps a young person to work out what is going on, as often young people do not know the answer to this. They are then asked to scale it, on a 5-point scale. Once they have additional information such as postcode and demographics, they would recommend the right service or intervention for that young person which could be anything from information or an app or a tool they could use in their life, to peer support or a telephone line that they could call, as well as face to face services. I like the idea of giving young people choice and options in terms of what support they wanted, which also helps to manage demand on waiting lists, and capacity on services. The capacity could be kept free for people who really need the higher intensity options.

"I think that the other thing for young people is not always to just move them into a headspace, a psychologist or to move them into a counselling service. I think sometimes there are a lot of other things that can happen early or as an adjunct. We have seen from peer support programmes, young people who are accessing clinical services, also get a lot of benefit from talking to other young people about what is going on for them and supporting each other and getting some of that social and emotional support. Because a lot of young people feel really isolated and do not want to talk about these things to people that know

them. But if you can do it in a space where your identity remains anonymous, and nobody knows who you are, then people disclose things that they otherwise would not."

"I think there's a good analogy, if you had a restaurant and no one visited, you wouldn't assume that the problem is with all your customers, you would assume maybe your restaurants food, staff, equipment. And it's like we as a mental health sector in that kind of clinician driven model. Maybe the problem is that our model is broken. Not that young people are broken."

How to Translate this to the UK:

ReachOut's pull to young people is that it has young people all over it, driven by them and sharing their own stories. It has peer support forums, monitored by staff, but it is peer-to-peer support. This is similar to ChildLine here in the UK.

They then created something similar for parents of young people aged 12-18 years which was a huge success. We know parents can feel isolated and stuck when they have a young person they struggle to relate to and struggle to see a way to help them. They can also access a 1-2-1 coaching programme which would be so beneficial here in the UK.

The challenges they face are keeping up with the ever-growing changes in technology and having funding to innovate with those changes.

"*There are a lot of gaps and people who are falling through the net, because we just aren't providing the right things at the right time to everybody that needs them."*

The Mental Health Foundation – Auckland – New Zealand

Funding & Commissioning /Joined-up Services / Outcomes & Evaluation

Pictured (L-R) Ellen Norman - Manager for Maori development Mental Health Foundation, Naomi Watkins-Ligudzinska – CEO NWCH and Virginia Brooks - Suicide Bereavement Service Coordinator Mental Health Foundation

"So, this picture is around suicide. It's an old Chief who went out fishing for his family. He went out and never came back, so was presumed drowned. His wife sat on that hill, waiting and waiting and waiting for him to come back. She waited until the day she died. So, thinking about it from their context, it was a form of suicide. She yearned so much for her loved one who didn't return, and her heart was so broken, that she passed away too."

In Auckland, I began with a visit to The Mental Health Foundation (MHF) where I met Virginia Brooks, and Ellen Norman.

The room that we met in had a very interesting picture with poignant message pictured above; Ellen tells the story below:

Ellen continued:

"There's all kinds of things that we see as different from today's thinking around suicide. We've had those kinds of stories throughout New Zealand, where death arose through yearning of lost loved ones, rather than anything else".

This is particularly apt in the Maori community. Both Ellen and Virginia educated me on Maori beliefs, their strong sense of family and being part of a collective, a community.

People feel lost and the MHF help build connection through their resources and support. They are an advocate for the Maori community and make sure their voices are heard and services are shaped to fit Maoris, instead of Maoris having to make themselves fit services.

"We create resources and information for the mental health landscape and do some advocacy and policy work behind the scenes. We're a mainstream organisation sitting in that

space doing that work. And we do a lot of work around the well-being space. There are some other organisations that come into different areas connected to that so we're not the only ones, but we do have a unique place where we sit in that, which is so valuable."

While I was in New Zealand, the government announced a new mental health strategy for about 10 years with over 30 points. It focused on four key areas for suicide prevention, Virginia helped explain it for me:

"It's going to look at health promotion and well-being, it's going to look at suicide prevention, and postvention. In this instance, meaning getting people before they are at the edge of the cliff. So, getting people while they are still in mental distress and vulnerable, and trying to support people when they're in that space before they get to the space where they're acutely suicidal. And then the third piece of suicide intervention addresses or speaks to people, when people are acutely suicidal. So that puts the focus on prevention as being early prevention. Because you need it to be early to be effective. And looking at those social determinants, and what is bringing people into that vulnerable space. Then the intervention will address people who are acutely suicidal or experiencing suicidal ideation or have attempted to take their life. And then the fourth piece will be postvention after suicide, supporting people after suicide loss."

In the past there has not been clear commissioning of mental health services, and services have had to compete for funding. Virginia hopes this was on the cusp of changing, with a mental health commissioning group being set up, as currently services do not work together and do not information share.

Virginia helped to set the context of suicide in New Zealand:

"So, we have around 600 people dying from suicide a year. We are only a small country; we are just under 5 million. And of course, we have a high rate of youth suicide, so when you break down the high rates of youth suicide, it is predominantly Māori, we are overrepresented Māori youth and Māori male so young Māori males are overrepresented in those suicide stats. In New Zealand we have our Māori populations that are indigenous people, and they are overrepresented over all our suicide stats. So same thing you find globally with the Aboriginal community who lead the world. And big overrepresented in stats and US, American Indian.

Some of the historical background around that is colonialization, disposition of land, culture being disrupted, people feeling unvalued, that discrimination. And then because of the systemic racism and oppression, people not necessarily having access to all those social determinants of health, those people do not necessarily have the education or the income or the housing. We have got Māori overrepresented in our prisons, overrepresented in homelessness, overrepresented in poor health outcomes. To address Māori suicide, you've really got to address those social determinants of health and racism and colonialism."

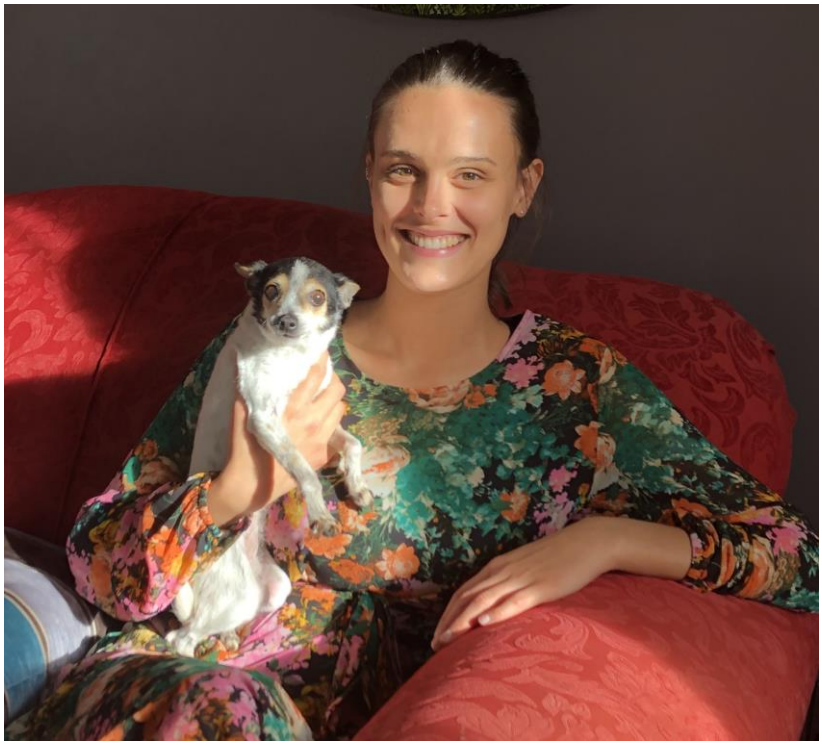
New Zealand also had some key events which have impacted on their suicide rates, the Canterbury earthquakes being one and the mosque shooting which had happened only a few months before I arrived in Christchurch. We also discussed the challenges for young people around employment and financial stability playing a part in suicidal ideation as well as a recent rise in homelessness. Virginia hoped there would be some funding for counselling as that was one of the barriers to people seeking therapy.

How to Translate this to the UK:

The resources that The Mental Health Foundation (MHF) provide to the people of New Zealand are simply amazing. They have consulted people of all ages to garner their help in designing resources that engage and help people in a meaningful way. I feel we can learn a lot from this, and I plan to engage with people in the UK, to consult them on their ideas of what they believe would work best to engage and help people in a meaningful way, so that NWCH CIC can build and disseminate similar resources.

Voices of Hope – Auckland – New Zealand

Involving Young People / Joined-up Services / Supporting Families



Pictured: Genevieve Mora - Co-Founder of Voices of Hope

"The idea behind Voices of Hope (VOH), is to promote mental well-being empowerment and recovery. Both Jazz Thornton and I (Co-founders of VOH) have lived experience with mental health, so we wanted to create a platform where we could share people's stories in an open, honest, and real format. We want to try to get rid of both the stigma and shame that is attached to mental ill health. I think the difference between the work we do, and a lot of other people's work is that we focus on hope.

That is a big thing for us. We focus on those of us who have overcome difficult mental ill health experiences, because we want others to visit our website and say, 'oh my gosh, they are all like me, where I was or where I am right now, and they're now well, so I can be too'. We're all about inspiring people to keep on fighting!"

Jazz and Genevieve are both 24 years old and they have hugely inspired me with what they have achieved in just two years. Neither takes a wage and both give their time tirelessly to help others survive their own mental health struggles. They provide videos and lots of support on social media to help break-down the stigma around mental health.

Voices of Hope exists to enable people with lived experience of mental ill health to help those who are currently struggling, which reminds me of Roses in the Ocean as discussed in my very first interview from Brisbane, Australia (page 14). They produce videos and materials to help others and now have a team of 13 writers. VOH was set-up in 2017 and everyone is a volunteer.

"We create hope filled content, we based a lot of our stuff on social media, to help individuals that are struggling with mental illness and give them the hope they need to keep on going. We were the first of its kind. In New Zealand, at least to start creating video

content around mental illness, there's a couple of organisations that do it for disabilities, we were the first to actually sit down and talk to people."

They are very clear they are not professionals, but they are a platform to provide hope through lived experience; I would call them experts by experience. Genevieve also feels that young people as young as primary age need mental health awareness through schools, just tailoring it to being about managing emotions and awareness and what to do if something does not feel right.

We discussed the new pressures for young people now, with technology, instant messaging and social media and how relationships are different. Bullying is now 24/7, instead of just at school and this all plays a part in young people's self-esteem. Young people are filled with images of what they think is a healthy weight / diet / way to look / what success looks like / relationships, from social media platforms. We went on to discuss how we can help young people:

"Having someone to talk to and someone that would just listen was huge for me. Almost like creating community and support, for individuals that are struggling. And I think, if we have more awareness about it, and people are talking about it more openly, and it's becoming part of a normal conversation, then younger people are going to be able to feel more able to go to someone and ask for help."

New Zealand have some helplines and we discussed how funding was required for every school to have a Psychotherapist for young people be able to access funded therapy. We also know there needs to be more integrated care in the UK, instead of treating things in silo, accepting there is co-morbidity and that is the same in New Zealand. There are the same issues about being released from hospital with not enough support in place and the same complexities as we have in the UK with people being turned away form services for being 'too complex' and how damaging it is to hear those words.

I was pleased to hear VOH plan to do more video content, public speaking, raising awareness and giving hope where they can.

How this translates to the UK:

More evidence for using peer-lead, lived experience people and services to give hope, when there is none.

Christchurch Primary Health Organisation (PHO) – Christchurch – New Zealand

Funding & Commissioning / Joined-up Services / Outcomes & Evaluation

Pictured (L-R) Laila Cooper – CEO PHO, Naomi Watkins-Ligudzinska – CEO NWCH and Sandi Malcolm – Service Manager PHO

The PHO funds GP's. So, people pay to see the doctor in New Zealand, but it's a co-payment, and the PHO funds practices to provide subsidised services and other health services.

Interestingly, I learned that people living in Christchurch, particularly those who were young children during the earthquakes eight years ago, are showing a decline in their mental health. This presents as high levels of anxiety and trauma related symptoms. People have also been re-traumatised by the terrorist attacks in March 2019, which rocked the nation. The PHO heavily praised the work of '298 Youth Health Centre' headed by Susan Bagshaw, who I had the pleasure to meet (pg.44), and they feel that Christchurch really came together as a community in the wake of the traumatic events of recent years, especially after the terrorist attack.

There are high rates of self-medication with alcohol and drug use, and self-harm rates are also on the increase with young people who have been through the earthquakes. There has also been an increase in clinicians needing mental health support, I am aware there is also a rise in the UK and am fully expecting another rise due to the current pandemic in the UK.

There are some primary school initiatives around wellbeing which have started to be rolled out across New Zealand to try and build resilience and support. This is between health and education and is a first for New Zealand. Some of the schools have classrooms of 70 children with several teachers, but to me that still seems far too many.

There are some teachers also struggling with mental health and are seeing a lot more mental health concerns in the classroom. There have been some great online initiatives over the years. However, both Laila and Sandi were keen to mention the great work of 298 Youth Health Hub.

The positive is the health care available to young people:

"After visiting a GP, they can be referred to our Brief Intervention counsellors. And we have a psychologist so they can access them for free, they get up to five one-hour sessions. But if they do need some of the more specialised elements then we have a one service that has sort of an enhanced service, so they can go and visit them in the home, they can connect with the family."

Both were positive that with the announcement of the new budget there would be more mental health provision going forward that would be funded. We identified the same concerns; loneliness, social media, relationship and connection as being things young people need help with.

How does this translate to the UK?

We agreed that there needs to be more positive stories in the media, showing people who have survived and what helped them. They felt more resources are needed to meet the demand; this is a similar problem to what we have in the UK. I felt Christchurch and the UK had a lot of similarities. More funding is also needed for the youth hub, to enable young people to get the support they need.

Pegasus Health Care – Christchurch – New Zealand

Funding & Commissioning /Joined-up Services / Outcomes & Evaluation

I met with Pegasus Health Care, David Cairns, Suicide Prevention Co-Ordinator, John Robinson, Suicide Prevention and Postvention Co-Ordinator and Gythlian Loveday.

Pegasus Health supports many aspects of health and wellbeing in Canterbury and has created a network of organisations who work collectively on several issues. They provide services and support to general practices and community-based health providers to deliver quality health care to patients and they are committed to improving health outcomes of the people in their communities.

David has worked in this field for ten years. It was clear that there are high rates of suicide in Christchurch, but no higher than other parts of New Zealand, and there has not been an increase in suicide rates due to the earthquakes or terrorist attacks. Gythlian made a great point about how isolating and traumatising this line of work can be, with little support, and people can be dismissive of those in the field which is why having a network of like-minded individuals can really help.

We discussed young people needing their identity to be explored and how this can be challenging for young Maori people. We also talked about how this is different to how non-Maori young people identify and how those two sets of young people interact and fit together.

Their varied roles are about supporting communities to support themselves. It was clear that they have several organisations who are pulling together to form a suicide prevention alliance in New Zealand and Pegasus are helping to co-ordinate that, which is similar to our NSPA – National Suicide Prevention Alliance.

298 Youth Health Hub – Christchurch – New Zealand

Funding & Commissioning / Involving Young People / Joined-up Services / Supporting Families / Outcomes & Evaluation

Pictured: Dame Susan Bagshaw

Brilliant Bagshaws plug health gap

Sue and Phil Bagshaw have dedicated the majority of their lives to helping others.

Recently honoured Dame Susan Bagshaw invited me to a research meeting with a room full of passionate and motivated people.

Susan then took me to 298 Youth Health Hub that supports 10- to 24-year-olds, in their new facility that they moved to during the week I was visiting. They have been forced to move five times since the earthquakes, which has been a sad normality for the businesses and people of Christchurch.

This Youth Health Hub is similar to the Headspace centres in Australia, but it felt more homely, with lots of friendly faces around. Young people had clearly influenced the design and feel of the Hub and it has a range of in-house doctors, nurses, counsellors, and youth workers to support clients.

"298 is a youth health hub, one-stop-shop where you can get anything to help your health development. We provide health services, dentists, doctors and nurses but also counselling and youth work. Youth work is a really most important part in a way because they're the people who help young people get into training, get jobs, find housing, get benefits, help them with their income."

Susan is an amazing, down-to-earth and welcoming lady who clearly loves what she does. While we were there everyone wanted her attention, and she was signing things whilst attending to a patient too. Susan took it all in her stride and with a smile on her face.

"We got a building, and then we actually as one organisation, hired all the different workers to do the different jobs. We always worked well with other organisations. That was back in 1995. And then the idea caught on and some funding was given to about three little places in the lower part of the North Island. And then more been added on, now there is about 11 that are funded, but it's probably about three or four that are ready to go once they get funded."

What Susan has created is just astonishing, with little to no funding and that is the issue; the massive lack of funding and having to fight for it. Susan had an interesting view on New Zealand's suicide rates:

"We have one of the highest suicide rates in the world amongst young people, but actually, the highest rate is amongst middle aged men just like everywhere. I think a lot of the issues, is our identity. And, you know, it's always goes up after a period of unemployment. And in the Western culture, employment is so much part of identity. And I think, in young people, the worst thing is that they're not fully employed. So, they're not forming an identity in terms of the Western cultural values on identity."

The 298 Youth Health Hubs help to address this by giving young people connection, a safe base and a place to be themselves. Susan sums it up well:

"I think the fact that actually lot of youth organisations are trying are actually saying, look, let's get together. I think it's great sector to work in. Because loads of people are really committed, they really want to make a difference. And are now getting it right, much more in terms of working with young people. I think that's the change that is gradually happening. And that gives me a huge hope."

How this translates to the UK:

We need this initiative of a youth one-stop-shop that really helps young people to access services all under one roof. I have seen this work in Australia and now also in New Zealand.

It is the same in terms of funding being competitive which makes grassroots organisations non-collaborative, they do not share information and not do collaborative funding bids. I understand this to a certain extent, and you could argue that there is a space for everybody, but to really think about the young person and put them at the forefront, we do need to be working collaboratively.

If this one-stop-shop were to go ahead, organisations would have to put in a collaborative funding bid and then work out a way of working together all under one roof. Although challenging, it is a great way to support young people; to information share and to make sure that the right support is going in for young people.

The idea is to have one established organisation with others in their building and start to grow it from there.

Case Studies

Batyr

Funding & Commissioning / Involving Young People / Joined-up Services / Outcomes & Evaluation

Pictured (L-R) Nicholas Brown – General Manager, Batyr, Naomi Watkins-Ligudzinska – CEO NWCH and Sarah Scales – Speaker Development Co-Ordinator, Batyr

"Batyr was born essentially in 2011. And we're in the prevention space in the mental health sector. We engage, educate and empower young people, in schools and universities. We encourage positive conversations around mental health. And we do that through running a structured program, where a big part of that is having young people share their stories, in hope of them being able to connect with the audience of young people, and then encouraging them to reach out for support on that peer-to-peer model. If someone's sitting in the audience, they need help, but are too scared to ask for help, once they've heard another young person who have gone through something similar, and the positive experience they've had, the resilience, persistence, and the hope. It's not all like butterflies and rainbows, we need to keep it authentic as well. It's balancing that. The idea is that someone who's in that the audience leaves feeling empowered, and the speaker themselves leaves feeling empowered, and really triumphant around how far they've come as well."

When I met with Batyr, I presented in person to the team and via Zoom to other members around Australia. I gave the same presentation as I had to the Black Dog Institute and again, it sparked great questions and debate. What struck me was the relaxed, young, hip vibe in Batyr's office, where everyone was so warm and welcoming; I joked that it was like a Google office! It is so obvious to me why young people want to be involved with Batyr.

After my presentation, I met with Sarah Scales, Speaker Development Co-Ordinator and Nicholas Brown, General Manager; both were very accommodating and inspiring people.

I was impressed by Batyr's focus on giving a voice to young people with lived experience. The speaker programme allows young people to go into schools and share their experience of suicide and mental health, a fabulous and invaluable initiative. We know that the first

person a young person will turn to when in crisis is another young person. Hence, it is so much more powerful for young people in schools to hear the lived experience of another young person; what did and did not help them when in crisis or struggling. All young speakers are aged 18 years and older. They attend workshops, training, and one-to-one sessions with Sarah before going to speak in schools, accompanied by a Batyr staff member for support.

It is an organisation for young people, run by young people.

"The team is pretty much young people in terms of, the average age is 26 years, 80% have a lived experience of mental ill health. And everyone just gets along with everyone and is available as a support. There is just a nice culture of support and wanting to make it work and chipping in when needed."

They admit there are challenges in terms of potential skills gaps and applying for grants, due to lack of experience or maturity in the team. Also, a lack of research around measuring the impact they are having, which is hard to quantify, as they do not have a dedicated person solely assigned to research yet. However, they have made astonishing progress with the organisation with little to no government funding.

"From a government perspective, being able, the challenge has been, to build credibility, and for us to tell the story of the impact that we're having, as best as we can against, some of the other larger organisations that have built a really solid relationship over decades. It's hard to, there's a lot of noise. And it's hard to just put your head through it and say, 'we're doing good stuff and having impact on a lot of people'."

Having said that, the work Batyr does has an incredible impact and is being measured through evaluations with young people. Batyr works because young people are trained to deliver their stories to other young people in schools.

"Having this external group come in, you look up at the front, and it's, they look like you, they talk to you conversationally, and they're not just reinforcing messages they've heard from their parents and teachers, this has seemed to have an impact. And so that's the approach, peer-to-peer."

Sometimes there is a concern from schools or parents that talking about mental health in this way and sharing stories can in itself cause harm, so I wanted to find out how Batyr overcomes this.

"I think certainly what I've noticed over the years is there is more and more openness to talking about it and realising that it can be beneficial. And I think, we feel like what we're doing is very different. It has real, practical implications for young people and the generation of Australians coming through, but we are very aware that we wouldn't have been able to kick off and do what we do and have the traction without some of the amazing campaigns and work that have happened before us from Beyond Blue and RU OK, and all those big mental health organisations that have fought really hard to bring the conversation to the forefront. I think that's a reason why there's an openness to have us come and have this conversation."

This really shows a joined-up approach, multi-agency way of working and how organisations can link their work together. Batyr makes sure there is signposting at the end of sessions, even if that is to talk to a friend, and things to try such as writing and meditation, but they are also able to signpost to organisations like KidsLine, LifeLine and Headspace (the next case study to follow-on from this one).

Batyr were concerned there is a middle gap of young people being missed, that need more than six sessions or are being dropped when too old for services without a good transition and those that are in and out of hospital settings.

"So, we are creating digital storytelling, when young people enter and exit hospital, they can watch these videos of young people that have had the same experience, that talk through what it was like for them, some things to keep an eye on, what was helpful. It's a stigma thing again, so to hear we've been through this, it helps."

We discussed how there are no clear-cut reasons as to why young people have suicidal ideation or intention, but that they know anecdotally it is a very high rate of young people that have these thoughts. But there are things we can be doing to help and support our young people.

"I think that comes down to connection, feeling, a part of place, whatever that is. And that can be really tangible things like real and true community, like, they're a part of a youth group, or they've got some friends at school etc. Or it can be, like what we do here at Batyr, where you are sharing that experience, and someone's looking at, that person and connecting with that story, and not feeling like they're the only ones and seeing that people want to help them and they aren't a burden, or that they would want to help them."

When we discussed what was needed to keep the projects going, we both reached the same conclusions, funding.

"Funding because it allows you the flexibility to do more. The answer is probably a sustainable funding source for us to make our own decisions. Because I think what we need to do is be much quicker and more proactive in trying different things and providing different options for young people, and continually changing and adapting, as the world changes in that. And what we're trying to do is maintain a level of adaptability, and flexibility and innovation around implementation.

Researchers wouldn't say this, but there is a huge amount of funding that goes towards research in this space and has for a long time, that needs to continue. But there needs to be some action. We feel this urgency to do something. Is having outcomes the best use of money, it is impactful, but I think the approach needs to be tested, learnt and continually adapted and improved, rather than wait for some of these major studies to come. There's something not working. And there's money not being spent somewhere in the right place, because the rate is not coming down."

There are two main points here; we need funding to be given to the right projects, but it is hard to measure the impact of those projects without the right research. Also, the rate may not have come down, but it would likely have been much higher without organisations like Batyr doing this excellent work with young people.

"There is a group of people not reaching out for support, there's services available, but there's very little in the middle, trying to help people make that transition from needing support to getting support. And that's kind of the part Batyr play, and I think there's a lot more that can be done in that space. Stigmas one barrier to help seeking but there's thousands of barriers and I think more needs to be done around that. Then let's make sure the services are good, but let's make sure people are accessing them, and both have to happen."

The schools programme really is 'smashing the stigma' as it says in the Batyr offices.

"Batyr is trying to smash the stigma, and the whole peer-to-peer at the base of the lived experience, I think sharing stories, like that is what, obviously Batyr's about, but I personally have seen it, I live and breathe it in my role. And I can just see how much of an impact that really does have, just the whole thing around not feeling alone in this. And it's okay to talk about it. I think that whole messaging is something that's going to make a huge difference."

It works because small cohorts of young people aged 18-30 years meet with Batyr, have the training and support to become speakers. There is a mental health professional present for anyone who may be triggered. Then a team of four goes into the school or university, comprising of two speakers, a co-ordinator and facilitator. All the checks are done with the

school beforehand, making sure they know who the safeguarding lead and mental health lead is for the school. They speak to group assemblies of anything between 50-300 people. Some of the speakers go on to be advocates and it really helps them to maintain their emotional wellbeing too.

When asked what they would like to help their cause:

"Absolutely everyone in Australia, every young person from year nine to university age to see the Batyr program. I think that obviously involves money. But that's the dream. I want everyone to know about it. I want everyone to have heard the story."

How to translate this to the UK:

Batyr's approach is unique. It enables young people to go out to their own peers and share with them their lived experiences about mental health. Their stories are inspiring and encourage other young people to come forward.

We had similar initiatives in the UK, but of course that funding ended. There is merit in the approach of going into schools and having young people speaking with and to other young people. This would make a really big difference here in the UK, with the joined-up approach and other agencies to whom we can signpost. There would be nothing worse than going into schools to give a brilliant presentation and then having nowhere where we can refer these young people to.

We need to have somewhere that is young people focused to refer these young people to, that is a one-stop-shop that incorporates everything that young people need and that is where Headspace comes in and that is the next case study.

Headspace – Nundah, Camperdown, Miranda and Hurtsville

Funding & Commissioning / Involving Young People / Joined-up Services / Outcomes & Evaluation

Headspace – Nundah

When having a conversation around young people's mental health, you cannot avoid mentioning Headspace, because that has been one of the primary innovations or reforms in Australia over the last decade. Headspace itself helped with some of the findings of the suicide prevention strategy but has shown a realisation that there needed to be a more nationally cohesive approach to Youth Mental Health.

The model of Headspace is one that brings a range of professionals across Primary Health Care, Counselling and Psychological Services together in regional service hubs, with some capacity to link in with other services in the region. Drug and Alcohol and a range of employment and education in an environment that is accessible and friendly to young people. Interestingly, Headspace also has a digital presence, as there is not a Headspace in every part of Australia yet, although there is huge Government buy-in to try to reach this aim, so for those hard-to-reach young people there is a digital service.

I visited several Headspace centres and met with several staff in my time in Australia. They were consistently mentioned by other organisations and are pivotal in their support with young people.

At their Nundah branch. I was fortunate to spend time with the Community Engagement Co-ordinator and the Clinical Services Manager.

What struck me about this service was the wrap-around care they provide. Young people aged 12 to 25 years can self-refer and get access to mental health services, a GP, a dietitian, work and study support, alcohol and drug services – all under one roof. And what a roof that was! They have transformed an old bank into a friendly, colourful centre, with non-gendered toilets (all pictured above). Yet more impressive is the fact that the young people they work with helped design the centre.

Headspace also have a youth reference group which helps them to design support programmes and enables consultation to ensure they provide services that young people request. Young people can stay with the service if they want to, some are with them from the

age of 12 to 25. Headspace also works with schools, to deliver assemblies and train teachers in mental health support. They can have up to 10 therapeutic sessions every calendar year.

Headspace are supporting young people with suicidal ideation and intention and they document how their support really helps young people to find hope again. I am in awe of the set-up they have and the funded services they can provide. What a fantastic model of support and one that we can but aspire to in the United Kingdom.

I visited another Headspace centre in Camperdown where I was hosted by Dr Blake Hamilton, the Clinical Services Manager. This centre is closely linked to The University of Sydney through the brain and mind research centre. This centre in Camperdown sees around 1,200-1,500 young people between the ages of 12 to 25 years, for about 5,000 occasions of service. This centre's Headspace early intervention team, funded by the Primary Health Network (PHN), supports more complex cases and provides an early intervention in psychosis service. Other organisations also work out of this centre, including Relationships Australia who run a family therapy clinic one day a week, and Wesley Mission that provides support for young people who are either homeless or at risk of being homeless. They also have University researchers in this office and employment services specifically aimed at young people. In total, more than 45 people work out of this centre providing excellent holistic support and care to young people.

"Headspace in Australia has been something of a victim of its own success in that the marketing campaigns have been very successful, most young people in Australia know what Headspace is and what it does. But what that means is they have the idea that they come to Headspace, they get service for almost anything straight away, and they never get turned away and everybody's suitable.

So, one of the kind of challenges is to service the greatest number of people with efficiency and quality of services, and what to do with the people that simply aren't suitable and manage that process. The last challenge in terms of having other services, working on the services, and making that work seamlessly. As you can imagine, different organisations have different procedures, protocols. So, it's an interesting model. Which, when it works, well, the difficulties would not be seen by patients."

This centre in Camperdown has a unique way to process the waiting list and referrals to try and help with the above challenge:

"We've moved to an online assessment tool, which is being developed in conjunction with a corporate partner in the university and some of the academic staff here. If you ring up today, and say I want to come to Headspace, we get the email address, they can do the online assessment immediately. And then within 48 hours, someone will call them to discuss the assessment. In that regard, there's no waiting time, because the online assessment tool has some things you can do. However, if the assessment tool through intake, suggests that yes, you really need to come in and see a clinical psychologist or psychiatry registrar there will be a nominal wait for that. It might be one to one and a half months for a clinical psychologist, probably a little bit shorter for the other two, because they don't tend to see people weekly or fortnightly."

Interestingly, Headspace encounters similar issues to us in the UK, with the difficulty of not enough specialist services to refer to, such as services who work with children, young people with autism for example, or the crisis team / hospitals not taking referrals from them. We come back to needing a multi-agency approach where all sectors and services are heard and valued, with clear referral pathways.

We agreed that there is not one cause to suicidal ideation in young people but more a shared sense of hopelessness:

"I think it's probably a growing sense of hopelessness, that things can't change won't change, or never feel any better. That is probably what drives people to act on those thoughts. There's a small percentage of people where the thought comes back, and it comes back. And they're a bit worn down to the point where they have a rather odd executive thought, which is, 'if I'm thinking about this so much, maybe that's the answer. Or maybe that's what I ought to do'."

Headspace addresses this by helping young people to not feel alone, to feel supported and to have access to support in young person friendly centres.

"Headspace is 12 to 25, which means a large proportion of people live in families, or perhaps in communities with other students or households. So, if we are talking about preventing people from attempting to take their own life, the fact that somebody is around checking in on them, is probably the single most important thing that may will be the crisis team, it might be a flatmate, might be your best friend or parent.

Beyond that, logically, providing intervention that restores some form of hope, or manages the stress, or at least assists them with the idea that this will not be like this forever. Because I feel somewhat certain that when people take their own lives, there is something that they feel is not going to change, or that it is unbearable, that it is not going to go away soon enough. So pragmatic intervention where somebody is observing them interacting and caring for them. Some other kind of efficient intervention that deals with hopelessness is most effective."

There were also some great initiatives around introducing peer workers to support young people to help reduce the stigma.

I then visited another Headspace centre - this time in Hurstville, where I met the Operations Manager for Miranda and Hurstville. This is the third Headspace centre I visited and although they were all so different, they all provide a range of services to support young people within one building.

"I think the whole initial idea was to make services that are youth friendly and attractive to the youth population, I think Headspace has actually made a really good job of that, one of the biggest achievements is the branding of the promotion, the resources they use are friendly day-to-day. And each headspace is required to have a youth representative group. So, youth from the community to form as we call them a YRG; youth reference group."

Headspace has grown tremendously since its incorporation in 2007, with over 100 sites across six Australian states and three territories. The Headspace centres operate slightly differently dependent upon which organisation funds them, but they all provide tremendous holistic support for young people.

A challenge identified was:

"Meeting the demand. Our biggest challenge is headspace is funded for that early prevention intervention. And then we do have outpatient services as well. But there is a huge gap between the clients that we see and the clients that they see in terms of severity of mental health. So, for that missing middle there is, a large challenge for us to overcome, who would actually be supporting them? They're a little bit too unwell for us, but there well enough for the hospital services that our patient services look after."

When we discussed what needs to happen to support young people, we agreed early intervention is key:

"Introducing mental wellness at schools very early on, and actually explaining and educating young people in the community as well. About the way they can seek support and understanding what resources they do have available to them, rather than waiting for point of crisis to be able to do that. I think that leads into, providing better support for the carers,

whether they are young carers or parents, grandparents, and also really assisting them in seeking that support early on before it gets too challenging for them."

How this translates to the UK:

Headspace certainly works for a large proportion of young people. It orientates around being the first port of call with a strong emphasis on primary health responses, it obviously cannot cover the full array of mental health issues and there still is work to be done in Australia around the links to the more specialised services for young people who require more intense treatment or have more complicated life issues.

Headspace has a national commitment to the rollout of the science; it will stand as infrastructure. The infrastructure sits there in the community, and it becomes linked in with the community, that does not just happen because you put it there, but it happens over time.

In the UK we may not have the same geography of Australia of course, but we have a higher population compared to the area of land. Our issue here therefore is how do we service the population. How do we reach them, and how do we do it with a level of consistency across the country?

I like the Headspace model of a one-stop-shop, a multidisciplinary team. It is a high intensity model with vast amounts of resources attached to it. It is a great part of the community for young people to get what they need, if they live near to a Headspace centre. Those that do not are offered eHeadspace, which is the online version. Again, the challenge is once you turn 26, (18 here in the UK) and you are no longer eligible for those services, the coordination of care is not as clear.

I would love to see a similar initiative here in the UK, we have started this at NWCH on a small scale by having an in-house Child Psychiatrist and an Adult Psychiatrist work alongside our team of Psychotherapists. It works incredibly well, and I would like to see more services joining us in supporting young people, in a one-stop-shop approach.

Conclusions

Delivering suicide prevention services that meets the needs of young people is a complex challenge for all services involved which is the same in Australia and New Zealand, as it is in the UK.

Young people are all individuals who experience a range of changes; physically, emotionally, developmentally and hormonally. Their experiences are all different due to traumas experienced, environment, genetic factors, support networks (or lack of) and childhood adverse experiences to name just a few.

Young people with additional needs or mental health needs have added complexities and a lot of services will not work with 'complex' young people or adults. Therefore, a lot of young people fall through the gaps. They do not have any support in place, therein comes the risk of not having the support they need to survive and thrive.

The services we have in the UK are limited, mainly by funds but also by policies, procedures, criteria to access public sector services and waiting lists. We know young people are turned away by services due to not meeting the criteria of the service, therefore not even making the waiting list. We need to remember waiting times for young people feel much longer than they do for adults, a month in a young person's life can feel like the equivalent of a year in an adult's life. Young people have also told us that once in services they have not had consistency with the support they have received, there have been many changes in who their therapist is, and chances are the support has been too short at only 6-12 weeks. The support has also mainly been CBT (Cognitive Behavioural Therapy), which does not suit all young people. They enjoy the variety of art psychotherapy, group therapy with peers with lived experience, pet therapy and other innovative therapies. It can feel a little too much like school with 'homework' tasks. We can see some great work from Third Sector organisations supporting young people, but they are not recognised, valued or funded fairly.

Australia and New Zealand seem to have some similar concerns in terms of funding. However, they have access to a lot more funding than we do here in the UK. The funding seems to be federal funding and from philanthropic people. Our government funding here in the UK mainly is distributed to NHS services and not grass roots organisations. By the time the pot of money reaches Third Sector organisations it is so small and lots of organisations are trying to receive the same pot, so there much competition. I am concerned that here in the UK, a lot of Third Sector organisations will not survive without government backing, especially in our current situation of a global pandemic.

There are similar experiences in Australia and New Zealand with some schools having a reluctance to speak about suicide with young people, feeding the stigma and fear around mentioning suicide. In the UK we need more training to be rolled out to teachers, about how to address suicide appropriately with young people. MHFA and ASIST training needs to be rolled out and to create wellbeing champions in schools and peer groups, to increase suicide prevention and decrease suicide ideation and intention. Batyr have an excellent example of their young person programme, which is rolled out in schools, which encourages speaking about suicide much more widely.

Australia and New Zealand have some excellent projects in place that have the young person at heart, that have been shaped by the young person. They are young person specific, young person lead and young person friendly. Headspace is an amazing initiative, and the concept is so effective, having a one-stop-shop for young people to access with little to no waiting lists and all the experts they need under one roof. The services in these countries seem to be more available, accessible and young person friendly. In the UK we seem to have a fear of giving young people a voice and a fear of talking about suicide to

them. There are some excellent Third Sector organisations doing their best to redress this imbalance.

There are a lot of inspiring organisations doing great things, but not enough of a joined-up approach both in Australia, New Zealand and the UK. It feels as fragmented there as it does here in the UK. There needs to be more focus on the experience of the service user, and their views are paramount to shaping services. Questions to consider are;

- How do we fill the gaps?
- How do we offer something that has not been offered before?
- How are we going to work with other people?

The suicide rate is not necessarily falling in Australia or New Zealand. However, I do not want to consider what the number would be without the many amazing organisations I visited and those that I did not have time to visit. The solution to suicide prevention involves schools, it also involves parents and families, it involves a community response. It should also involve mental health services and a whole range of different people. Co-ordination is important so that everybody sees that they play a role, which is very much along the lines of the Lifespan model created by the Black Dog Institute.

What we are seeing in Australia, New Zealand and what we hear through the conversations that we have with our education sector colleagues is there a shift to well-being, and how we can help all young people to thrive. This idea of a flourishing life and teaching young people how to do well is important. We should not wait until someone is at the point of contemplating suicide; we need to be giving them the necessary tools early on so that they learn some of those strategies around resilience, they can better manage stress and distress. We do need to do more and have more of a multi-agency approach.

All of this made me reflect on how fortunate we are at NWCH Lincoln to be able to provide our funded clients with 18 sessions, though that is unfortunately the maximum available from our funding sources. It appears to be so much easier in Australia and New Zealand to receive government funding for support services and furthermore, that counselling and therapy is highly valued, which I do not believe is the case to the same extent in the UK.

Recommendations

My Churchill Fellowship recommendations endeavour to encourage change within suicide prevention, both at a strategic and operational level, to help ensure that all children and young people, are given every opportunity to thrive and engage in suicide prevention activities and support.

Five recommendations have been made in my report. The proposed actions strive for an innovative approach to suicide prevention, that is funded and supported at government and local council levels and which harbours higher standards of care with changes in systematic apathy towards young people and suicide prevention.

1. **Funding and Commissioning**
   Central and local government, along with statutory agencies, need to commit to funding and commissioning Third Sector organisations to develop and deliver more prevention support for young people and make this their priority.

   Without the necessary funding we cannot provide young people with the support that they need. All Third Sector organisations are continually fighting for funding support. Where public sector services are failing to support our young people and young adults with their mental health concerns, Third Sector organisations continue to be flooded with referrals. Grassroots organisations often have a much more client centred, person-centred, child-centred approach. This is known to be much more effective than clinical settings. Children and young people need to be treated with dignity and respect and the funding needs to go to those organisations who know them best and work with them more than any other service.

2. **Involving Young People**
   There needs to be a commitment to involving young people with lived experience to feed into support programmes. These programmes need to be available in schools and education establishments along with workplaces being flexible to allow young people working to access these programmes.

   If we do not listen to our young people and ask them their opinion, how can we shape services that are designed for them? We need young people to actively tell us what is it that we are not getting right, what is it that they would need to feel supported, to feel that there are more options available to them, than ending their life. Young people's opinions are valued and valid and they should be listened to.

   We need all establishments working with young people to be on board with this programme. Schools and education need to commit to using their budgets, to have in-house services that can support them with suicide prevention. They need to have suicide prevention policies which are adhered to and not sat on the shelf collecting dust. If we do not make young people our priority now, suicide rates will continue to rise in young people, young adults and adults, because concerns they have in their childhood and their youth are not being dealt with effectively. Without the right mental healthcare provision young people's lives will continue to be lost year after year. We need their voices to shape our services.

3. **Joined-Up Services**
   Statutory and voluntary community sector organisations should provide access to therapeutic support in young people friendly spaces. In those spaces there should be access to all support a young person may need, a 'one-stop shop'. The criteria need to be inclusive and not discriminatory.

Services that provide to young people, should have young people in mind. Some of the services that I visited in Australia and New Zealand had very clearly thought about what it was like to walk in the shoes of a young person. Their organisations were young person friendly non-clinical and bright with young people involved. The rooms need to be non-clinical, the approach needs to be non-clinical and at the heart of all decisions, should be the young person.

The staff were mixed in gender and age. Young people fed back that they really liked the Headspace approach in Australia because they were able to get all the support services, they needed in one place. This is something that I really feel we could role model throughout the UK and I would love to have other services under other organisations working together collaboratively instead of competitively, to support young people.

4. **Supporting Families**
   There needs to be appropriate support and psychoeducation for organisations and families affected by suicide, which is timely, accessible and overall empathic in its approach.

   Organisations need to develop something that families can access around suicide prevention. It is not just working with the young person, we need to look at who is in that young person's life, organisations, families, support networks need to feel that they are suitably equipped to manage young people's mental health and their suicidal ideations or intention. This must be from an empathic approach; it must be supportive and it must be accessible.

5. **Outcomes and Evaluation**
   All new and existing services working with young people to establish appropriate suicide prevention services should have an additional focus on outcomes and evaluation to ensure they are delivering effective and empathic treatment and support. Services should incorporate research into their processes.

   To know if our service is effectively helping, we do need to have measurement tools. Whether this is an existing measurement tool, like the Core-10, or whether it is via case studies or feedback from young people themselves, we need to be measuring what we do to see if it is effective, what could be changed and what could be done differently. By actively keeping up with research and doing our own research and engaging young people in participation groups, we can see whether our approaches are effective, or if they need to change. We need a multi-agency approach, it is not enough to just have something, it needs to be fit for purpose.

From Learning to Practice – Next Steps

Dissemination and Implementation

I began by disseminating my Fellowship findings and recommendations within my organisation NWCH (Naomi Watkins Counselling Hub CIC) through presentations to local teams in Lincolnshire and to our Panel.

I produced blogs about my findings whilst I was away, which I plan to expand on. They can all be found on NWCH's website – this is a link to the first one: https://nwcounsellinghub.co.uk/news/greetings-from-brisbane/

This report will also be displayed on our website.

I disseminated my findings more broadly at Lincolnshire's First Suicide Prevention Conference on World Suicide Prevention Day 10th September 2019. This was hosted by NWCH in the city of Lincoln, with over 80 delegates attending: https://nwcounsellinghub.co.uk/news/more-than-80-delegates-attend-lincolns-first-suicide-prevention-conference/

I am a well-established and respected member of the Suicide Prevention Board and the Self-Harm Task and Finish Group for Lincolnshire County Council, where I have shared some of my insights to help shape future practice.

NWCH is an organisational member of NSPA and SASP. We regularly attend suicide prevention conferences and engage in conversations around good practice.

I plan to forward this report to both Universities in Lincoln and to offer to provide lectures on my findings.

We have regular press releases locally, there will be a follow-up with the findings of this report. This will also be presented at our annual birthday event and open days.

We plan to offer workshops to local organisations about the findings and our plans for implementing new services in Lincolnshire.

We plan to launch a suicide prevention, intervention and postvention project in Lincolnshire with group therapy, 1-2-1 counselling, workshops and support groups for young people and their parents in Lincolnshire. Involving lived experience members.

We are planning to ensure schools in Lincolnshire take suicide prevention seriously and feel equipped to handle disclosures sensitively.

We are currently developing a mental health toolkit for postvention for young people accessing our service which can be rolled out nationally. We are also launching an NWCH App this year, which has suicide prevention advice and the access to an online counsellor.

I have linked up with Ananta Dave who was also a Winston Churchill Fellow in the 2019 Suicide Research cohort. Ananta has moved to Lincoln and is the Executive Medical Director of LPFT NHS (Lincolnshire Partnership NHS Foundation Trust) and we hope to collaborate in terms of disseminating findings, in Lincolnshire and beyond.

The biggest goal and challenge that I plan to campaign and lobby for is to encourage policy makers to take the findings seriously and increase the funding nationally for suicide prevention, intervention and postvention. Making sure more funds reach grassroots organisations, Third Sector and community groups.

Appendix 1 – Itinerary

I travelled to Australia and New Zealand in April 2019, on a 6-week research trip. I visited many planned places and had some great ad-hoc opportunities along the way. I am so grateful to these organisations, for giving me their time and being involved in my interviews.

Australia:

Brisbane – 1 week:

- Roses in the Ocean - Bronwen Edwards
- Headspace Nundah
- Children and Young People Solutions - Conrad Townson
- Standby - Monique Broadbent and Kelly Playford-Veal
- Your Town - John Dalgleish and Team

Sydney – 3 weeks:

- Lifeline – Jamie Gray, Fiona Leon, Rachel Bowes and Amy Webster
- Suicide Prevention Australia – Sam Fuller and Alan Woodward
- Headspace Camperdown – Dr Blake Hamilton
- Twenty10 – Jain Moralee
- Black Dog Institute – Fiona Shand
- ReachOut Australia – Dr Kerrie Buhagiar and Mariesa Nicholas
- Headspace Miranda and Hurtsville
- Batyr – Sarah Scales and Nicholas Brown and Team

Melbourne (Online):

- Orygen – Michelle Lamblin

New Zealand:

Auckland – 1 week:

- Mental Health Foundation – Virginia Brooks and Ellen Norman
- Voices of Hope – Genevieve Mora

Christchurch – 1 week:

- Christchurch PHO – Laila Copper and Sandi Malcolm
- Pegasus – David Cairns, Gythlian Loveday and John Roberts
- 298 Youth Health Care – Sue Bagshaw
- Author: Being a True Hero: Understanding and Preventing Suicide in Your Community – Michael Hempseed

Appendix 2 – Interview Schedule

COUNTRY	CITY	INTERVIEWEE	ROLE	SERVICE
Australia	Brisbane	Bronwen Edwards	CEO	Roses in the Ocean
			Clinical Team Leader	Headspace - Nundah
			Community Engagement Co-Ordinator	Headspace - Nundah
		Monique Broadbent	Co-Ordinator for Brisbane	Standby
		Kelly Playford-Veal	Brisbane South Team Leader	Standby
		John Dalgleish and Team	Head of Strategy and Research	Your Town
	Sydney	Jamie Gray	Practice and Operations Lead	Lifeline
		Fiona Leon	Practice and Operations Lead	Lifeline
		Rachel Bowes	Acting Executive Director for Operations	Lifeline
		Amy Webster	Practice Manager of Governance	Lifeline
		Alan Woodward	Advisor	Suicide Prevention Australia
		Dr Blake Hamilton	Clinical Services Manager	Headspace – Camperdown
		Fiona Shand	Senior Research Fellow	Black Dog Institute
		Dr Kerrie Buhagiar	Director of Service Delivery	ReachOut Australia

	Mariesa Nicholas	Director of Research	ReachOut Australia
		Operations Manager	Headspace – Miranda and Hurtsville
	Sarah Scales	Speaker Development Co-Ordinator	Batyr
	Nicholas Brown	General Manager	Batyr
Melbourne (Online)	Michelle Lamblin	Project Manager at the Suicide Prevention Research Unit	Orygen

COUNTRY	CITY	INTERVIEWEE	ROLE	SERVICE
New Zealand	Auckland	Virginia Brooks	Suicide Bereavement Service Co-Ordinator	Mental Health Foundation
		Ellen Norman	Manager of Maori Development	Mental Health Foundation
		Genevieve Mora	Co-Founder	Voices of Hope
	Christchurch	Lalia Cooper	CEO	Christchurch PHO
		Sandi Malcolm	Service Manager	Christchurch PHO
		David Cairns	Suicide Prevention Co-Ordinator	Pegasus
		Gythlian Loveday	Suicide Postvention Co-Ordinator	Pegasus
		John Roberts	Suicide Prevention and Postvention Co-Ordinator	Pegasus
		Sue Bagshaw	Founder	298 Youth Care
		Michael Hempseed	Author	Suicide Prevention

Appendix 3 – Consent Form

The Willow Project

Consent to take part in research.

I…… voluntarily agree to participate in this research study.

I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.

I understand that I can withdraw permission to use data from my interview within two weeks after the interview, in which case the material will be deleted.

I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.

I understand that participation involves being asked some questions around suicide and suicide prevention, which will be audio recorded.

I understand that I will not benefit directly from participating in this research.

I agree to my interview being audio-recorded.

I understand that all information I provide for this study will be treated confidentially.

I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.

I understand that disguised extracts from my interview may be quoted in the researchers Winston Churchill Research Project dissertation, which is published on their website. On NWCH's website, at NWCH's conference and any other conferences where the research is being presented.

I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.

I understand that signed consent forms and original audio recordings will be retained in a locked filing cabinet and online in SharePoint cloud base, which only the researcher and her three project admin staff have access to until May 2020.

I understand that a transcript of my interview in which all identifying information has been removed will be retained for two years.

I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is in storage as specified above.

I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Naomi Watkins, Cert, Dip, BSc Hons, MBACP, AccNCS
Churchill Fellow 2019

Signature of participant: ……

I believe the participant is giving informed consent to participate in this study.

Signature of researcher: ……..

Date: ……..

Optional:

I consent to having photography taken for the report and any social media posts:

Signature of participant……..

Date: …….

I consent to being named as a person/organisation as a credit to this research:

Signature of participant……..

Date: …….

Appendix 4 – Interview Questions

1. How would you describe your organisation? Aim/Purpose?
2. What made you become involved?
3. How would you describe your role within it? How long have you been working there?
4. What would you say your biggest achievements have been as an organisation or you personally?
5. What is your organisation doing that no-one else is?
6. What are your biggest challenges?
7. What do you wish other people understood about your work?
8. What do you wish you had more of? (training/money/support/etc.)
9. What would you change if you had a magic wand?
10. What would you keep the same?
11. In your opinion what do you believe are the common factors for suicidal thoughts in young people?
12. What is making this happen?
13. What age do you think carries the most risk of suicidal thoughts? What makes you say that?
14. What suicide prevention projects do you think are most successful? What makes you say that?
15. In your opinion what gaps are there?
16. What improvements do you think are needed?
17. How do you think we can we best support CandYP?
18. Which agencies/sectors should be doing this?
19. In your opinion should education/schools/colleges/universities be playing a part?

Appendix 5 – LORIC Open Data on Suicide Report

OPEN DATA ON SUICIDE

An overview of resources in the UK, Australia, and New Zealand

DISCLAIMER

The report is for the use of NW Counselling Hub only. It cannot be used, in part or as a whole, to support another LORIC beneficiary. This report can be used as the beneficiary sees fit.

Katya Bozukova

LORIC Open Research Fellow

LORIC is part funded by the European Regional Development Fund (ERDF) and part of Bishop Grosseteste University. The LORIC project is receiving up to £2.1 million of funding from the England European Regional Development Fund (ERDF) as part of the European Structural and Investment Funds Growth Programme 2014-2020. The Ministry for Housing, Communities and Local Government is the Managing Authority for ERDF. Established by the European Union, ERDF funds help local areas stimulate their economic development by investing in projects which will support innovation, businesses, create jobs and local community regenerations.

For more information visit https://www.gov.uk/european-growth-funding

Introduction

This report will look at open data from the UK, New Zealand and Australia that looks at the topic of suicide. It will signpost to existing open data portals in the three countries that might hold relevant data and will aim to present the data in a way that is clear and easy to follow. It has been agreed with the beneficiary that this report, (with attribution) can be used to support the beneficiary in writing interim reports of their own fieldwork in Australia and New Zealand.

Methodology

Data gathered for this report has been collected from open data repositories in the UK, Australia, and New Zealand. There is a focus on data published under Creative Commons With Attribution Licenses, Open Government Licenses, and Crown Copyright Licenses, as they explicitly permit the reuse of data for any purposes, including commercial.

Based on the research carried out for this report, the most open data available on suicide comes from the UK, followed by New Zealand and finally, Australia. This includes not only data, which is large in volume, but also diverse enough to offer insights beyond numbers and age groups.

The beneficiary has also requested open data on young people in general and LGBTQ+ people in particular, unemployment, divorce, lack of support, for all three countries, and if possible, for Lincolnshire as well.

Data on UK

Suicide Data for the UK

The UK has full suicide statistics published for the period 1981-2017, although the latest update to the suicide prevention profile occurred as early as the February 2019.

Data from NOMIS puts suicide (and injury/poisoning of undetermined intent) 19 among the 20 most common causes of death. Although it represented .9% of all deaths that year (2017) it was also the fifth among the causes of death that could be considered even remotely preventable (after cancer, accidents, cirrhosis, and diabetes).

Cause of death	Deaths	Percentage of all deaths (within that sex and age band)
LC02 Cancer (malignant neoplasms)	145,976	27.4
LC18 Dementia and Alzheimer disease	67,626	12.7
LC30 Ischaemic heart diseases	57,673	10.8
LC14 Chronic lower respiratory diseases	31,744	6.0
LC12 Cerebrovascular diseases	31,631	5.9
LC28 Influenza and pneumonia	27,595	5.2
LC01 Accidents	14,019	2.6
LC42 Symptoms, signs and ill-defined conditions	12,439	2.3

LC21 Diseases of the urinary system	8,781	1.7
LC16 Cirrhosis and other diseases of liver	8,424	1.6
LC24 Heart failure and complications and ill-defined heart disease	7,920	1.5
LC27 Hypertensive diseases	6,859	1.3
LC09 Cardiac arrhythmias	6,597	1.2
LC19 Diabetes	6,040	1.1
LC35 Parkinson's disease	5,935	1.1
LC38 Pulmonary oedema and other intestinal pulmonary diseases	5,903	1.1
LC34 Nonrheumatic valve disorders and endocarditis	5,422	1.0
LC04 Aortic aneurysm and dissection	5,128	1.0
LC41 Suicide and injury/poisoning of undetermined intent	4,825	0.9
LC03 Acute respiratory diseases other than influenza and pneumonia	4,673	0.9

(extract from the leading causes of death in the UK, 2017 statistics, NOMIS)

In terms of time-series data, the full dataset on suicide in England and Wales shows a decline since 1981, although the rates are still 10.3 per 100,000 of the population. (For men, that rate was 16 for every 100,000; for women, the rate was 5.2 for every 100,000). The rates were slightly lower for England than they were for Wales, when looked separately, and even higher for Scotland and Northern Ireland.

Total number of deaths for 2017:

- England: 4451, or 9.5 per 100,000
- Wales: 360, or 14.6 per 100,000
- Scotland: 676, or 15 per 100,000
- Northern Ireland: no data, but in 2016 there were 297 registrations, or 20.2 per 100,000

In all four countries, male suicides had higher rates than female ones, with 14.5 to 4.8 per 100,000 in England; 23.4 to 7.3 per 100,000 in Wales; 24 to 7.3 per 100,000 in Scotland; and 30.9 to 11.5 per 100,000 in 2016 in Northern Ireland.

The most deaths occurred in London.

As for the method of suicide, the Office of National statistics cites “hanging” as the most used method, with 59.7% of the men and 42.1% of the women whose death was ruled as suicide. Next were poison (18.2% of men, 38.3% of the women) and other methods (14.2% and 11%). After that were drowning (4% and 5.2% respectively) and fall and fracture (3.7% men, 3.1% women).

Separately from the data on civilian suicides, the Ministry of Defence has also released data on deaths ruled a suicide (or awaiting verdict) for between 1999 and 2018. For both deaths that have been ruled a suicide (n=310) and awaiting verdict (n=19) the men were overwhelmingly overrepresented: 94% of all armed forces suicides were committed by men, and 89% of those awaiting verdict were also by men.

The age-standardised rates of suicide in 2017 on the dataset show that 5.01 in every 100,000 Naval servicemen committed suicide; 8.48 in 100,000 Army servicemen committed suicide; 4.33 in 100,000 RAF servicemen committed suicide; and 7.02 in 100,000 for the Tri-service servicemen committed suicide.

The data shows that there is a decreased risk compared to the UK general population reference line, however - the Tri-Service has a 56% decreased risk when compared to the UK general population; the Naval Service - 61% decreased risk; the Army 47% decreased risk, and the RAF 75% decreased risk. It is unclear whether those decreased risks are due to an improved recruitment process, an improved care process, an improved discharge process, or all three.

As with the general (civilian) population, army suicide rates have dropped since recording first started, with the overall rate of 12.03 in every 100,000 dropping to 7.02 in 100,000 from 1985 to 2017. The group at most risk appears to be servicemen between the ages of 40 and 44, followed by those that are 25-29.

When looking at suicides of people in working ages (20-64), data released shows that for 7 in 10, an occupation was listed at the time of death registration. According to the statistical release, males in lower-skilled occupations had a higher risk of suicide than the male national average, particularly among those working in construction. For women, the risk was a lot higher when they were in culture, media and sport occupations, as well as for health professionals. Male and female carers, according to the release, were twice as likely to commit suicide than the rest of the population. (For more detail and explanation for those trends, please see the release.)

As for age-specific data, the UK's suicide prevention profile broke the information down by gender. For both men and women, the ages where the highest rates of suicides were recorded were between 35-64.

It is without a doubt that suicide is a topic that is frequently discussed in the UK. In 2017, the "Third Progress report of the Cross-Government Outcomes Strategy to Save Lives" stated that each suicide is estimated to cost £1.67 million to the economy. It outlines the government commitment to spend an addition £1 billion by 2020 on mental health and suicide prevention. The National Strategy has identified many of the same high-risk groups that have already been mentioned in this report: young and middle-aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups (doctors, nurses, vets, farmers and agricultural workers) and people with a history of self-harm. The question is whether the same groups have been identified as high risk in New Zealand and Australia, and if so, to what extent are they also being targeted by suicide-prevention initiatives.

Unemployment Data for the UK

Profiles of Jobseekers in the East Midlands:

Males	Aged 16-24	Aged 25-49	Aged 50-64
Student	15,800	1,500	!
Looking after family/home	!	2,900	1,100

Males	Aged 16-24	Aged 25-49	Aged 50-64
Temporary sick	!	1,200	700
Long-term sick	1,800	10,300	8,200
Discouraged	600	!	~
Retired	!	!	~
Other	2,700	2,100	2,200
Females	Aged 16-24	Aged 25-49	Aged 50-64
Student	14,200	2,700	900
Looking after family/home	3,600	24,000	4,900
Temporary sick	!	~	2,800
Long-term sick	900	9,100	11,200
Discouraged	!	!	~
Retired	!	!	1,700
Other	~	5,500	5,900

(Extract from NOMIS Annual Workforce Survey, 2017-2018)

The data on jobseekers for the East Midlands (and by extension, Lincolnshire) shows a division among jobseekers by their genders and reasons for their current unemployment. For both men and women aged 50-64, the reasons why they were out of a job was a long-term illness; however, the most common reasons for young women to be out of a job was because they were looking after the family or their homes, while young men were more likely to be job seeking while students. Total numbers of job seekers were also quite high among females - 87,400 across the region, compared to 51,000 males.

Most importantly, however, women were far more likely to take early retirement and then seek work again, far more so than men in the East Midlands. This is likely an indication that, while early retirement is attractive and/or encouraged among older women, the provisions for them are such that it is not sustainable, thus putting them back on the job market.

According to other NOMIS data on job seeking in general, there were 1858400 job seekers recorded at the last annual population survey (Jan 2018-Dec 2018). Nearly 1.1 million of them were women. The division of gender among active job seekers was comparatively similar - 12% of the whole population not in active employment for women, 9% for men. When examined within their own gender groups, male and female job seekers represented, respectively 20% and 22% of each group.

In other words, active job seeking does not appear to be a gendered issue.

What is a gendered issue, however, is the division of household responsibilities. Along the entirety of the population not in active employment, only 3% of all men were unemployed while looking after the family or home, compared to 21% of all women aged 16-64. With the group that was unemployed while looking after the family or home, men represented a mere

11% of the total. This disparity was not observed across any other reason for economic inactivity - regardless of whether they were students, sick, discouraged or retired, the men represented between 42% and 56% of the groups.

The other area in which women outnumbered men considerably was economic inactivity - across the UK, women aged 16-64 who did not want a job represented 49% of the population that was not in active employment, compared to 30% of all men aged 16-64 of the same group. What this means is that, while women and men actively seek jobs at the same rates, it is women who are more likely to become economically inactive than men (for any of the reasons cited above).

All of this has implications about the degree of vulnerability experienced by people in the UK and job seekers.

Profiles of economically inactive people in the East Midlands:

Males	Aged 16-24	Aged 25-49	Aged 50-64
Student	62,500	6,800	!
Looking after family/home	~	6,200	7,000
Temporary sick	500	1,900	~
Long-term sick	5,800	19,100	30,100
Discouraged	!	!	~
Retired	!	!	34,700
Other	3,700	3,100	7,200
Females	Aged 16-24	Aged 25-49	Aged 50-64
Student	66,100	8,700	~
Looking after family/home	10,500	62,700	21,200
Temporary sick	!	2,500	~
Long-term sick	3,600	17,200	35,000
Discouraged	!	!	!
Retired	!	!	49,100
Other	5,300	8,600	15,400

(Extract from NOMIS Annual Workforce Survey, 2017-2018)

The profiles of economically inactive people in the East Midlands showed some differences along the lines of gender and age, the only exception to which is the student groups. Women who were economically inactive were far more likely to be looking after the family or the home while men who were economically inactive were more likely to be listed as long-term sick than anything else. Having said that, long-term illness appeared recorded at approximately the same rates among men and women, with disparities across the age groups not exceeding 2000 people.

There were large groups of early retirees, but the women's group was bigger by approximately 15000 people, confirming the theory that were likely incentivised or encouraged to retire early rather than work until the cut-off age of 64. When examined in conjunction with the UK-wide findings (that women were far more likely to become economically inactive if not in employment or seeking employment) this adds more dimension to the overall picture.

Support Data for the UK

Data on EA core and work-limiting disabilities from the annual population survey (Jan 2018-Dec 2018) shows that there were approximately 8.5 million people who were listed as having an EA core or a work-limiting disability. About 4.9 million of them were economically active, 3.5 were inactive, and 414,600 were actively job seeking. Among those in employment, women with an EA core or work-limiting disability were slightly more likely to be salaried employees (representing 57% of all employees with disabilities) and men were more likely to be self-employed (representing 60% of all self-employed people with disabilities). Men with disabilities were also slightly more likely to be unemployed/job seeking than women (split 54:46) and women were slightly more likely to be inactive than men (split 58:42).

For comparison, data on people without EA core and work limiting disabilities shows similar splits across groups and genders - men and women were employed at approximately the same rates (54:46 male to female), they tended to seek work at approximately the same rates (53:47 male to female), and they represented almost equally across salaried employees (52:48 male to female). The only areas where there was a bigger gender disparity was in self-employment, where males represented 68% of the group compared to 32% of females, and in economic inactivity, where men were 32% of the total population and women were 64% (which is in line with the findings from the previous section).

Other UK-wide findings of relevance could be that:

- People with disabilities tend to be employed traditionally at lower rates than people without disabilities.
- People with disabilities tended to be self-employed at approximately the same rates as people without disabilities.
- People with disabilities in employment tended to predominately be employees rather than entrepreneurs.
- People with disabilities sought work at the same rates as those without disabilities.
- Economically inactive women with disabilities outnumbered economically inactive men with disabilities by a smaller margin than their able-bodied counterparts.

It is likely that there is good provision and support for disabled people across the UK which allows them to build resilience and thrive in the workplace.

Having said all of this, support can vary from region to region and city to city. Within Lincolnshire, for example, there are Local Authorities without a single LSOA in the 10% more deprived areas in England (North Kesteven and South Kesteven, for example), and there are areas with 18 LSOAs in the 10% most deprived areas in England (East Lindsey and Lincoln). Those same Local Authorities host several LSOAs that are in the 11%-20% most deprived in England. (Data as presented by the Lincolnshire Research Observatory.) What this means is that there are areas in the county where premature death, comparative illness and disability, and morbidity ratios are high. Those are also areas where there are high numbers of adults suffering from mood and anxiety disorders; who must frequently go to the hospital; who claim health benefits; who attempt and succeed at suicide. Indeed, according to the JSNA Suicide Audit for Lincolnshire (2018) the suicide rates in the most deprived areas of the county were nearly 2 times the national average and 3 times those in Lincolnshire's least deprived areas.

There are several reasons why health benefits are claimed. Per data from August 2018, the most common reasons for claiming Disability Living Allowance in Greater Lincolnshire are Learning Difficulties, Hyperkinetic Syndromes, Behavioural Disorders, Neurological Diseases, and Diabetes Miletus (especially for those aged 0-49); for older people, arthritis, heart disease, psychosis, and cerebrovascular diseases were some of the most common reasons for claiming the benefit (data from NOMIS).

It is worth noting, however, that not everyone who is eligible for DLA will apply for it, and it is also worth noting that not everyone who applies for DLA will be found eligible, which means that the data presented in this report does not fully reflect the landscape in Greater Lincolnshire. When looking at the JSNA Suicide Audit for 2018, for example, 67% of all suicides in Lincolnshire had known mental health issues.

The JSNA Suicide Audit is also relevant because it shows, in addition to the fact that 67% of suicides in 2017 had had mental health issues, 39% had known family or relationship issues, 40% had attempted taking their life before, or had had known suicidal tendencies. Most people whose death was ruled a suicide had attempted to access health care provision within a year of their deaths. Half were in employment, a quarter retired, and 1 in 7 were unemployed. This would suggest that, in Lincolnshire at least, access to care is not as good as it can be there are significant disparities from one LSOA to another; and the care provision is not as good as it could be.

Indeed, the key risk factors identified for suicide in Lincolnshire were, from most to least common:

- Mental ill health
- Known suicidal tendencies
- Previous suicide attempts
- Family/relationship issues
- Health concerns (including medical conditions/disabilities)
- Harmful drinking or alcohol misuse
- Financial concerns
- Drug Misuse
- Bereavement
- Recent unemployment/employment concerns
- Housing concerns
- Previous self harm*

*Self-harm was separately identified in the report as an issue, with 1034 emergency hospital admissions in 2016-2017 due to self-harm. The rates for Lincolnshire were lower than the national average, however, it is still a predictor for suicidal ideation.

Divorce Data for the UK

From the Office of National Statistics:

- “There were 101,669 divorces of opposite-sex couples in England and Wales in 2017, a decrease of 4.9% compared with 2016, but similar to the number seen in 2015 (101,055).
- “There were 338 divorces of same-sex couples in 2017, more than three times the number in 2016 (112 divorces); three-quarters (74%) of same-sex couples divorcing in 2017 were female.
- “In 2017, there were 8.4 divorces of opposite-sex couples per 1,000 married men and women aged 16 years and over (divorce rates), representing the lowest divorce rates since 1973 and a 5.6% decrease from 2016.
- “The divorce rate for opposite-sex couples was highest among men aged 45 to 49 years and women aged 40 to 44 years.

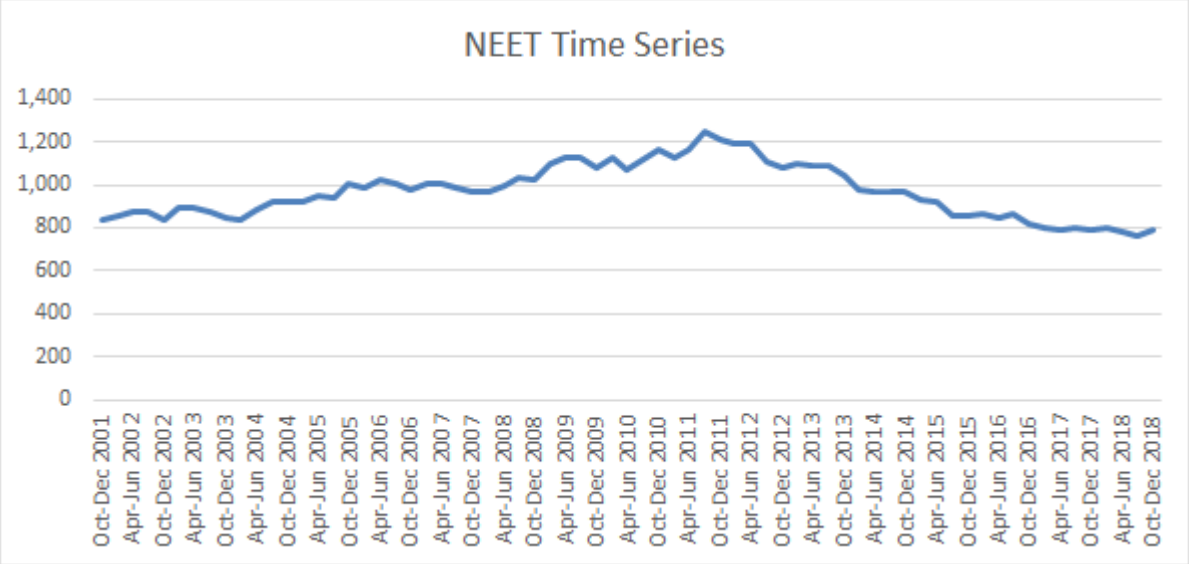
- "The average (median) duration of marriage at the time of divorce was 12.2 years for opposite-sex couples; this matches the high last seen in 1972.
- "Unreasonable behaviour was the most common reason for opposite-sex couples divorcing with 52% of wives and 37% of husbands petitioning on these grounds; it was also the most common reason for same-sex couples divorcing, accounting for 83% of divorces among women and 73% among men."

- Source
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/divorce/bulletins/divorcesinenglandandwales/2017

There was no dedicated data on divorce on the Lincolnshire Research Observatory.

Data on Young People in the UK

Open Data on Young People published in February 2019 shows that, in Oct-Dec 2018, there were a total of 788 of young people aged 16-24 who were not in Education, Employment or Training, which is considerably lower than the highest point in the time series (in Apr-Jun 2011) and slightly lower from when the time series was first recorded in Oct-Dec 2001 (see below).



Most of those young people were aged 18-24, which suggests there is only a small number of 16–17-year-olds in the UK that were, at the time of the recording, not at school. Men and women were equally represented, with young men being slightly fewer than young women. This statistic makes sense when considered in conjunction with other labour market statistics that have been seen on this report.

For those in full-time education, the labour market statistics showed that most students tended to be economically inactive, followed by those in employment and those who were seeking employment. The older the students got for Lincolnshire, the more the gap between the employed and economically inactive groups narrowed.

Great Lincolnshire	16-19 in employment	16-19 unemployed	16-19 inactive	20-24 in employment	20-24 unemployed	20-24 inactive	25+ in employment	25+ unemployed	25+ inactive
Living with parents	8,414	3,179	18,835	1,354	241	1,490	246	52	301
Living in a communal establishment: Total	556	381	1,524	578	257	1,349	37	12	112
Living in all student household	172	130	371	805	206	1,302	566	86	384
Student living alone	27	32	141	93	38	103	284	43	231
Living in a one family household with spouse, partner or children	59	33	103	308	59	282	1,424	121	1,149
Living in other household type	250	148	902	370	78	383	346	54	309

The data for the over 25 cohort shows that those in employment (while also in full-time study) was bigger than the economically inactive one.

The older the students got, the less likely they were to also live with their parents.

It was very unlikely for most students to live alone - far more likely was living in a communal house or in a one family household.

This has implications about their mental wellbeing and their ability to build resilience - particularly when looking at the findings from the Lincolnshire JSNA Suicide Audit 2018.

Other relevant data can be found at the JSNA 2019 Young People in the Criminal Justice System report. According to the data published there, there are fewer young people entering the justice system per 100,000 of the population in 2018 than in 2013. In fact, there are fewer young people receiving custodial sentences in court in Lincolnshire compared to the East Midlands and England, and the percentage that re-offend in the three months following

their involvement with the YOS (2018) was slightly lower in Lincolnshire than in the East Midlands and in England.

This is relevant because youth offenders appear to be at a high risk of self-harm, suicide, and substance misuse. Indeed, as per the JSNA 2019 report:

"12.1% of young offenders have a diagnosed mental health condition."

"31.3% of young offenders have a history of or are at risk of self-harm, with 15.5% identified as being at risk of suicide."

"28% have a special educational need or disability."

"71.2% engage in substance misuse, and 17% have both a substance misuse and a mental health concern problem."

Source: http://www.research-lincs.org.uk/UI/Documents/Topic%20on%20a%20Page_Young%20People%20in%20the%20Criminal%20Justice%20System_2019.pdf

There was no data found on the Lincolnshire Research Observatory that related specifically to LGBT+ people, either youths or adults. On a national level, the ONS has published a paper on its position on Trans Data, basically outlining the difficulties the Office of National Statistics found in collecting data on gender identity (despite identifying a need for it). It would appear as though there is not enough data being collected on any level for there to be significant enough statistical releases, even though it could be related to several health topics - including risk of mental illness and suicidal ideation.

Data on New Zealand

Suicide Data for New Zealand

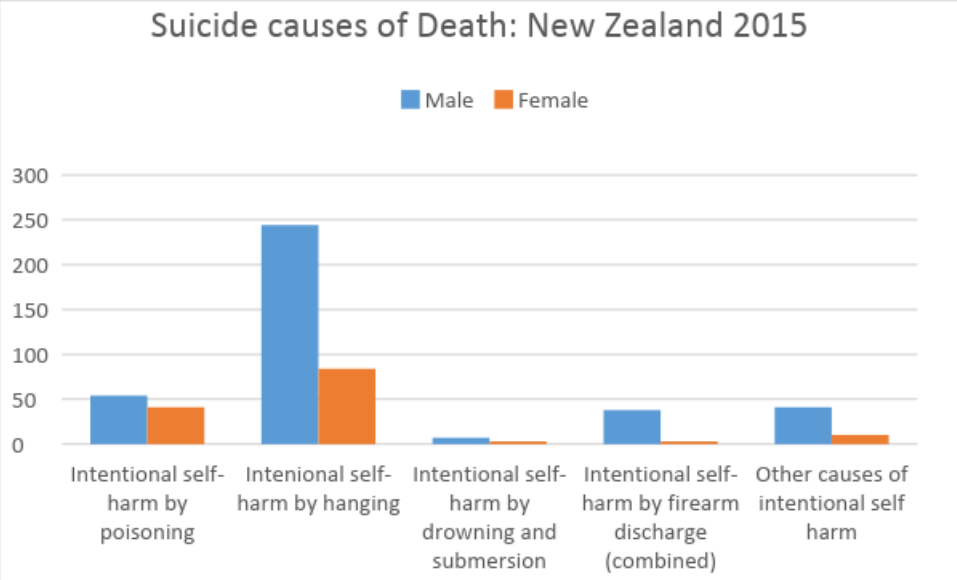
A dataset published on the 16th of April 2018 showed the registered deaths in New Zealand in 2015. Of those, 525 were attributed to intentional self-harm (around 1.7% of all deaths); in other words, an estimated 11 in every 100000 of the population* had died by suicide in 2015.

Of the deaths ruled to be the result of intentional self-harm, 73% were males. The rates varied by both gender and ethnicity – for every 100000 Maori men, approximately 25 had been estimated to have taken their lives in 2015, compared to 14 per 100000 non-Maori men. Among women, 11 in every 100000 Maori females were estimated to have taken their lives, compared to four in every 100000 non-Maori females.

(*Rates per 100,000 population, age standardised to WHO World Standard Population.)

Causes of death from intentional self-harm is catalogued below:

	All	Male	Female
Intentional self-harm by poisoning	95	54	41
Intentional self-harm by hanging	328	244	84
Intentional self-harm by drowning and submersion	10	7	3
Intentional self-harm by firearm discharge (combined)	41	38	3
Intentional self-harm by smoke, fire and flames	5	3	2
Intentional self-harm by sharp object	8	8	0
Intentional self-harm by jumping from a high place	19	16	3
Intentional self-harm by jumping or lying before moving object	11	7	4
Intentional self-harm by crashing of motor vehicle	5	5	0
Intentional self-harm by other specified means	1	1	0
Intentional self-harm by unspecified means	2	1	1



As seen from the tables, the most common causes for death from intentional self-harm were hanging and poisoning (for both genders). The breakdown by age range tended to be too granular to be of any statistical significance. However, the most deaths by intentional self-harm tended to be recorded between the ages of 15 and 50.

In addition to the statistics on intentional self-harm, in 2015 there were a total of 28 deaths recorded as the result of mental and behavioural disorders due to psychoactive substance use, 1752 deaths recorded as the result of organic, including symptomatic, mental disorder, seven deaths as the result of “mental retardation” and 17 deaths as the result of an event of undetermined intent. This is relevant as causes of death are not always recorded as “intentional self-harm”, but suicide can still stem from mental disorders or traumatic brain injury. Therefore, it is worth looking at the relevant data.

New Zealand recorded several causes of death related to mental disorders in 2015:

	Total:	Male:	Female:
F01 Vascular dementia	395	173	222
F03 Unspecified dementia	1,336	458	878
F05 Delirium, not induced by alcohol and other psychoactive substances	19	8	11
F06 Other mental disorders due to brain damage and dysfunction and to physical disease	2	1	1
F10 Mental and behavioural disorders due to use of alcohol	28	19	9
F20 Schizophrenia	8	7	1
F31 Bipolar affective disorder	6	3	3
F32 Depressive episode	9	1	8
F41 Other anxiety disorders	2	1	1
F42 Obsessive-compulsive disorder	1	1	
F43 Reaction to severe stress, and adjustment disorders	1		1
F50 Eating disorders	2	1	1
F55 Harmful use of non-dependence-producing substances	1	1	
F72 Severe mental retardation	3	1	2
F79 Unspecified mental retardation	4	2	2
F84 Pervasive developmental disorders	4		4

F89	Unspecified disorder of psychological development	1	1

As seen from the table above, dementia (both vascular and unspecified) was a far greater cause of death in either gender than mental and behavioural disorders, schizophrenia, BPD, depression, anxiety, OCD, severe stress, eating disorders and harmful use of non-dependence-producing substances combined. Indeed, after dementia the next most common cause of death was a mental and behavioural disorder from the use of alcohol.

Unemployment Data for New Zealand

In New Zealand's statistical release on the employment and unemployment of disabled people, the classification is as follows: "Disabled people are those who have at least a lot of difficulty seeing or hearing (even with glasses or hearing aids), walking or climbing stairs, remembering or concentrating, self-care, or communicating." This definition could include people who suffer from mental health difficulties.

Data on people aged 15-64 in New Zealand showed that, in 2018, the unemployment rate for disabled people was 12.4% (compared to 13% the previous year). The employment rate for disabled people was 39%, down from 39.3% the previous year.

For able-bodied people, the unemployment rate in 2018 was 4.4%, down from 4.7% in 2017. The employment rate was 78.5%, up from 77.3% in 2017.

New Zealand's statistical release included the underutilisation rate and underemployment rate by disability status. For underemployment, the 2018 rate for disabled people was about two percentage points higher than that of able-bodied ones (6.4% to 4.3%, calculated as a proportion of those employed). However, the underutilisation rate for disabled people was over twice as that for able-bodied ones, 25.4% to 11.5% (calculated as a proportion of those in extended labour force). Underemployment, as measured in the statistical release, includes part-time workers who can and want to work longer hours.

This is relevant particularly when examining the median wages and salaries of disabled and non-disabled people. While the hourly rates in 2018 were not dramatically different (median wage of $23.50 for a disabled person, £25.00 for a non-disabled person), the weekly wages were significantly more disparate, with the median weekly income of a disabled person sitting at $358.00, and the median weekly income of a non-disabled person sitting at $712.00. This calculation includes incomes from self-employment, salaried employment, and benefits.

The median (most frequently occurring) weekly income from benefits tended to be the same for both disabled and non-disabled adults, which is interesting considering that the two groups would likely have different needs on a day-to-day basis. Self-employed and salaried employees who were non-disabled, however, tended to bring more money per week than disabled ones, which can account for the further widening of the wage gap. That wage gap widened even further when looking at mean (average) weekly income.

When looking at the main activities of those not in the labour force by disability status, the most common activity (after "free time") was own care due to sickness/injury/disability for the disabled group. For the able-bodied group, the most common activities were study or training, and household work for own household. This is an interesting deviation from the UK data since in there, looking after household and family is grouped together (looking after children and fellow adults were also separate categories, suggesting a need to keep them apart).

The dataset also offers the main reasons for leaving the last job by disability status. In 2018, the reasons were as follows (from most common to least):

Disabled cohort

- Own sickness/illness/injury (41.7%)

- Retired (24.9%)
- Made redundant/laid off/business closed (7.5%)
- Other (6.9%)
- Parental/family responsibilities (5%)
- End of Temporary/seasonal/contract job (4.2%)
- Dissatisfied with job/condition (4.2%)
- Enrolled in education/training (3%)
- Moved location (2.7%)

Non-disabled cohort

- Retired (20.4%)
- Parental/family responsibilities (14.9%)
- Enrolled in education/training (12.8%)
- End of temporary/ seasonal/contract job (12.6%)
- Own sickness/illness/injury (10.6%)
- Made redundant/laid off/business closed (8.6%)
- Moved location (6.9%)
- Dissatisfied with job/condition (6.4%)
- Other (6.3%)

The industry that employed the biggest percentage of disabled workers in New Zealand was the Health Care and Social Assistance one (13%) followed by Professional, Scientific, Technical, Administrative and Support Services (11.8%) and Retail (10.9%). The industries that employed the least disabled people were Rental, hiring and real estate (2.5%), Information, media and telecommunications (2.6%) and Wholesale trade (3.4%).

Support Data for New Zealand

A report published in 2010 on the New Zealand Government Open Data Portal showed the mental health service use in New Zealand for 2007/2008. No later datasets were found at the time of writing of this report.

The total number of clients accessing support services for 2007/2008 were 100575, with 52621 males and 47954 females.

Distribution by ethnicity showed that 3013 of those clients were Asian, 20744 were Maori, 4936 were Pacific and 71882 were “other”.

Among most ethnicities, those aged 15-20 were the biggest group represented as having accessed services; the only exception was for the clients sorted as Asian, who were the most represented between the ages of 20 and 25. There was not significant deviations along the lines of gender - both males and females in most ethnicities were the most represented in the 15-20 age group; the only exception was for those recorded as being “Pacific” - for that ethnic group, the biggest group of males was that aged 20-25. Having said that, the distinction between these two age groups is not very large, and there were significant numbers of people from other age groups that accessed services as well, across all ethnicities.

Another significant extract from that dataset is the clients seen by bed nights and contacts across that year:

Table A8: Clients seen, bed nights and contacts, by service, 2007/08

SERVICE CODE	SERVICE DESCRIPTION	CLIENTS SEEN	BED NIGHTS	CONTACTS
T01	Mental health crisis attendances	28,655	…	143,556

SERVICE CODE	SERVICE DESCRIPTION	CLIENTS SEEN	BED NIGHTS	CONTACTS
T02	Mental health intensive care inpatient occupied bed nights	2588	46,881	…
T03	Mental health acute inpatient occupied bed nights	6867	186,407	…
T04	Mental health sub-acute inpatient occupied bed nights	460	16,760	…
T05	Mental health crisis respite care occupied bed nights	132	1383	…
T06	Mental health individual treatment attendances	86,839	…	1,118,941
T07	Mental health group programme attendances	8159	…	51,087
T08	Mental health care co-ordination contacts	43,638	…	292,207
T09	Early psychosis intervention attendances	1014	…	13,478
T10	Support needs assessment attendances	1432	…	2514
T11	Mental health maximum secure inpatient occupied bednights	62	17,395	…
T12	Mental health medium secure inpatient occupied bednights	292	32,812	…
T13	Mental health minimum secure inpatient occupied bednights	119	18,821	…
T14	Mental health forensic pre-discharge hostel occupied bednights	30	4842	…
T15	Court liaison attendances	2478	…	5667
T16	Substance abuse detoxification occupied bednights (medical)	588	5752	…
T17	Substance abuse detoxification attendances (social)	268	…	639
T18	Methadone treatment specialist service attendances (clients of specialist services)	3605	…	42,580
T19	Methadone treatment specialist service attendances (clients of authorised general practitioners)	630	…	1884
T20	Substance abuse residential service occupied bednights	22	731	…
T21	Psychiatric disability rehabilitation occupied bednights	265	40,479	…
T22	Mental health day treatment programme attendances	1152	…	23,030
T23	Mental health day activity programme attendances	775	…	27,123
T24	Work opportunities programme attendances	202	…	3293
T25	Community mental health residential level 1 occupied bednights	1	183	…

SERVICE CODE	SERVICE DESCRIPTION	CLIENTS SEEN	BED NIGHTS	CONTACTS
T27	Community mental health residential level 3 occupied bednights	26	6746	…
T28	Community mental health residential level 4 occupied bednights	28	2485	…
T30	Respite care occupied bednights	42	1313	…
T31	Home-based care contacts	829	…	13,937
T32	Mental health contact with family/whānau	13,370	…	52,097

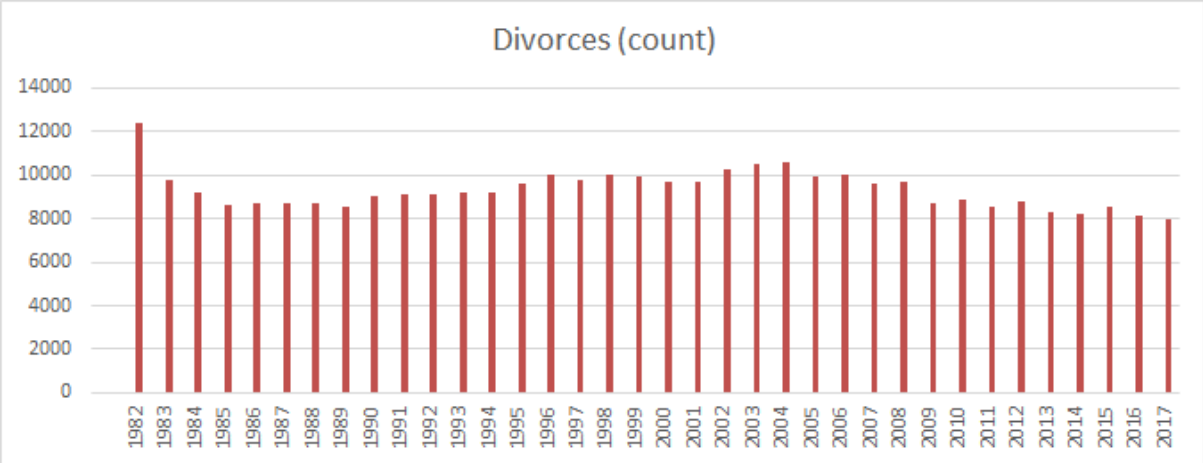
Table A14: Clients seen, bednights and contacts by team type, 2007/08

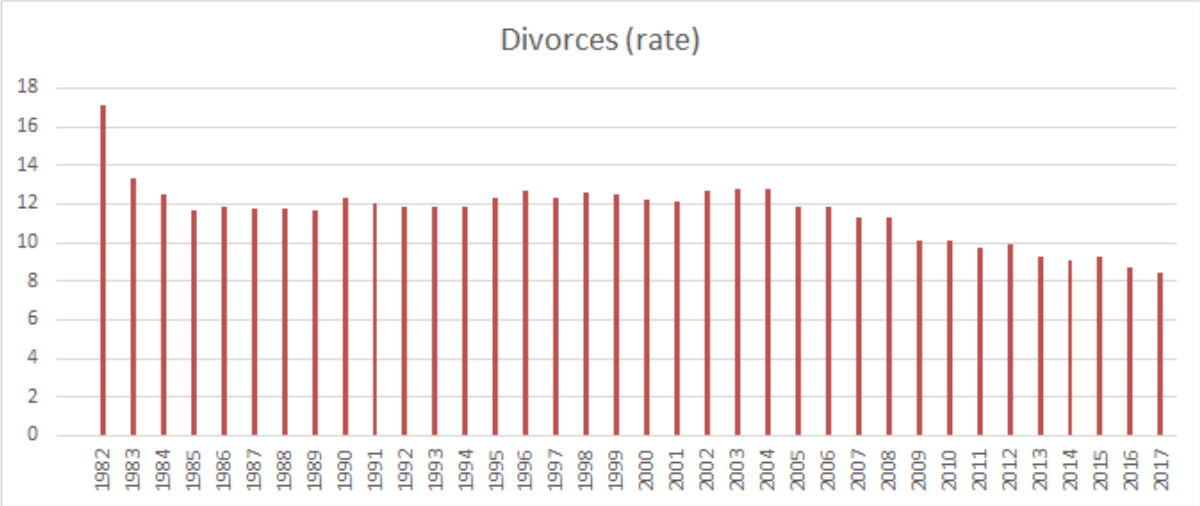
TEAM TYPE CODE	TEAM TYPE DESCRIPTION	CLIENTS SEEN	BEDNIGHTS	CONTACTS
01	Inpatient team	7476	270,436	2674
02	Community team	54,504	723	1,020,941
03	Alcohol and drug team	20,561	5587	190,037
04	Child, adolescent and family team	15,918	6308	194,408
05	Forensic team	4298	61,126	44,000
06	Kaupapa Māori team	4305	303	68,338
07	Pacific Island team	1456	…	32,252
08	Residential team	112	4978	393
09	Community skills enhancement team	676	19	35,308
10	Alcohol and drug kaupapa Māori team	1516	32	10,203
11	Alcohol and drug dual diagnosis team	1162	…	10,839
12	Intellectual disability dual diagnosis team	684	7171	8290
13	Psychogeriatric team	6210	18,619	74,445
14	Youth specialty team	3093	4558	42,680
15	Maternal mental health team	2303	761	27,432
16	Eating disorder team	499	2369	7885
17	Needs assessment and service coordination team	1812	…	11,396
18	Specialist psychotherapy team	320	…	5545
20	Refugee team	54	..	296
21	Children and youth, alcohol and drug services	134	…	824
22	Kaupapa Māori tamariki and rangatahi (child and youth) mental health services	81	…	983
99	Other	1158	…	2864

The full dataset is linked in “Sources” for further consideration.

Divorce Data for New Zealand

The data on divorce for New Zealand has been made available from 1982 to 2017. Since the collection started, the data has shown a steady decrease, both in count and rate per head of the population (for both marriages and civil unions taken together).





In 2017, the number of divorces in New Zealand was 8001, or 8.4 per 1000 existing marriages. The median duration of marriages and civil unions was 13.6 years in 2017 (up from 12.3 in 1995 when that dataset started) and the median age at divorce was 47 for men, and 44.5 for women (which had also increased from 40 and 37.5, respectively). All in all, the data for New Zealand suggests that marriages are lasting slightly longer, fewer people divorce, and if they do divorce, they do so at a later age.

A little under half of all divorces (3321) involved children. The average number of children involved per divorce was around two.

There were significantly more marriages registered for opposite-sex couples than same-sex couples in 2017 (22773 to just 960), and slightly more civil unions for opposite-sex couples than for same-sex couples (63 to 36). About a third of the civil unions registered in New Zealand for same-sex couples involved overseas residents.

Data on Young People in New Zealand

Child Poverty Statistics for New Zealand showed that in 2018, 183000 children were estimated to live in households that were low income (16.5%). The number of them defined as living in material hardship was 148000, or 13.3%. The number of those who fell into severe material hardship was 65000, or 5.8% (source linked below).

Another statistic made available for New Zealand was that for adoptions between 2009 and 2018. Most applications tended to be granted, with only 44 of 199 applications in 2018 not being granted. The percentage of applications being granted over the ten-year period was between 71% and 87%. Total new applications in 2018 were 173 (the presumption being

that several cases carried over from previous years for a decision). The numbers of applications showed a decline over the ten-year period, going from 286 in 2009 to 173 in 2018. Gender-wise, there were not a great many differences in the number of boys to girls being adopted - the differences between the two genders never exceeded 10 percentage points in any given year. Most children tended to be adopted while they were still under 12 months old (46% of all adoptions). 22% of all adoptions involved children between the ages of 1 and 5, and 32% of all adoptions involved children aged 6 years or more. This could have significant implications depending on the circumstances that led to those children being adopted and the health outcomes they will experience later in life.

Data on Australia

Suicide Data for Australia

The data on mortality in Australia shows that suicide is a serious issue. According to a governmental statistical release, 12.6 in every 100000 of the population died of suicide in 2017, compared to 11.7 per 100000 in 2016. To cite from the release:

“Suicide remains the leading cause of death for Australians aged between 15 and 44. In 2017, the overall age-standardised suicide rate was 12.6 per 100,000 in Australia.

The Australian Bureau of Statistics, Causes of Death, Australia, 2017 reports the preliminary figure for death due to suicide in 2017 at 3,128.”

- https://data.gov.au/dataset/ds-dga-27feba4c-ef8b-4cd2-b2ad-bdb054d287a8/distribution/dist-dga-ae6cad7c-6f51-4614-a15c-013b558c71c9/details?q=mortality

The statistics are a dramatically different from those in New Zealand, where only 1.7% of all deaths were deemed to be from intentional self-harm.

Further data from the General Record of Incidence Mortality (GRIM) shows the following breakdown for 2016:

AGE GROUP	MALES		FEMALES		PERSONS	
	deaths	rate	deaths	rate	deaths	rate
0–4	0	0	0	0	0	0
5–9	0	0	0	0	0	0
10–14	9	1.2	7	1	16	1.1
15–19	101	13.4	36	5	137	9.3
20–24	202	23.3	64	7.7	266	15.7
25–29	188	20.7	64	7	252	13.9
30–34	246	27.5	75	8.3	321	17.9
35–39	198	24.7	60	7.4	258	16
40–44	220	27.2	69	8.4	289	17.7
45–49	180	22.9	68	8.3	248	15.4
50–54	181	23.7	82	10.4	263	17
55–59	161	22.2	49	6.5	210	14.2
60–64	134	21	34	5.1	168	12.9
65–69	94	15.9	25	4.1	119	10
70–74	63	14.4	23	5.1	86	9.7
75–79	66	21.4	25	7.3	91	14

80–84	45	22.2	13	5.1	58	12.7
85+	61	34	19	6.3	80	16.6
MISSING	0		0		0	
TOTAL	2149	17.9	713	5.8	2862	11.8

The data shown above is without the age standardised rate. In age standardised rates, the total count per 100,000 is 11.7, same as reported separately. The biggest group of men to have been affected by suicide in 2016 was between the ages of 40-44, compared to women, where the age was 30-34. When examining the dataset, working age adults appeared to be at the greatest risk, with men being nearly three times more likely to take their own lives than women.

Additional data reported by GRIM that is worth putting out here: in 2016, a total of 9931 deaths were recorded as having been caused by mental and behavioural disorders, or 31 per 100,000 of the population. GRIM did not record any more granular data, such as whether the death was the result of poor management of depressive disorders, schizoid disorders, BPD, etc. GRIM also did not record data on morbidity due to alcohol or drug misuse.

Other data available through the Australian open data portals tagged with “suicide” was either not relevant (i.e., data mistakenly tagged) or was over 20 years old (such as data on a gambling inquiry from 1999). The only other more recent dataset that keeps appearing in searches is that on rail safety-related fatalities and hospitalisations, which covers a period from 2009 to 2016.

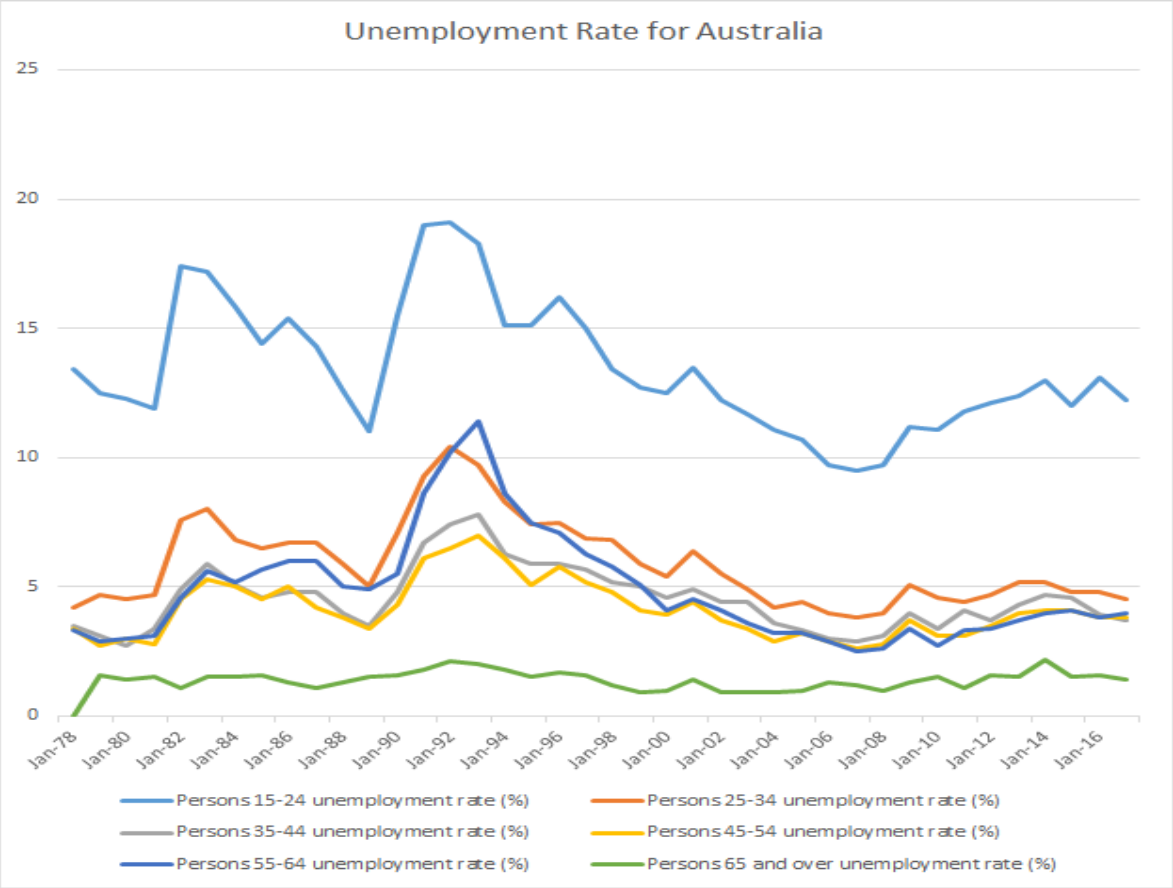
None of the incidents were recorded as “suicide” explicitly. Incident codes that might be relevant are: slip, trip or fall; level crossing collision with person, level crossing collision with road vehicle, running line collision with person, running line collision with road vehicle, or yard collision with person. For the whole period covered, there were 27 fatalities and 141 serious injuries recorded from such incidents, although it is worth noting that only eight were recorded in 2016, and none of them resulted in a fatality.

All in all, while the Australian government has taken steps to making some of its data open, data on suicide is not as detailed or comprehensive as that of New Zealand.

Unemployment Data for Australia

Australia has made data available on their unemployment rates from 1978 to 2017. According to that data, the latest unemployment rates are neither the highest nor the lowest, although it impacts most strongly young people aged 15-24 (their unemployment rate was 12.2% in 2017). The ‘lowest unemployment rate was among persons aged 65 and over.

Overall unemployment rate for the working-age population (15 to 64) was 5.7%. For those aged 15 and over (including pensioners who are interested in getting more work) the overall unemployment rate was 5.5% in 2017.



The same statistical release included data on disability and unemployment from 2012 which shows to what extent disability was a factor in the unemployment of male and female Australians.

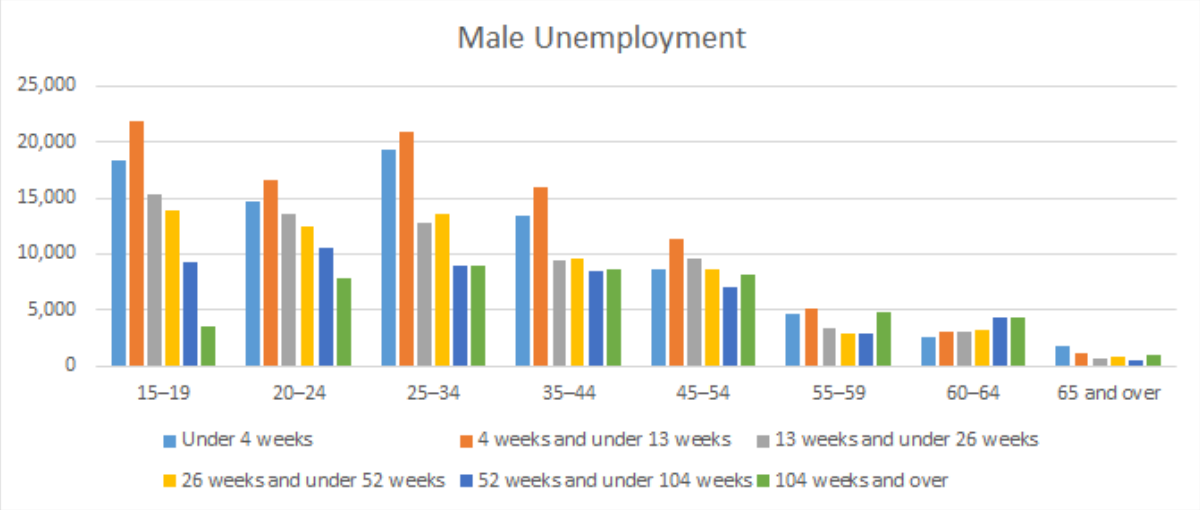
Disability type	Male	Female	Total
Profound or severe core activity limitation unemployment rate (%)	9.7	10.9	10.3
Moderate core activity limitation unemployment rate (%)	8.2	10	10.3
Mild core activity limitation unemployment rate (%)	9.7	9.2	9.4
Schooling or employment restriction unemployment rate (%)	13.2	11.5	12.2
All with specific limitations or restrictions unemployment rate (%)	11	10.5	10.7
All with reported disability unemployment rate (%)	9.5	9.3	9.4
No reported disability unemployment rate (%)	4.8	5	4.9

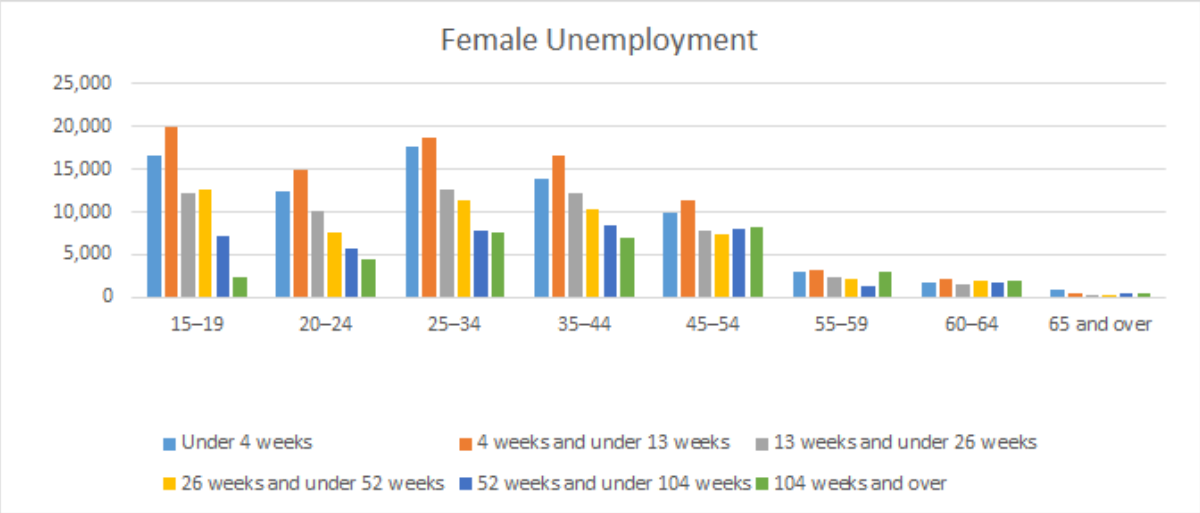
In 2015, the same data looked like this:

Disability type	Male	Female	Total
Profound or severe core activity limitation unemployment rate (%)	14.6	14.5	13.7
Moderate core activity limitation unemployment rate (%)	11.5	7.7	9.4
Mild core activity limitation unemployment rate (%)	13.3	8.3	11.4
Schooling or employment restriction unemployment rate (%)	16.4	12.1	13.9
All with specific limitations or restrictions unemployment rate (%)	13.6	9.5	11.6
All with reported disability unemployment rate (%)	11.2	8.3	10
No reported disability unemployment rate (%)	5.4	5.1	5.3

Additional data made available was on duration of unemployment (the latest dataset was 2014-2015). According to that dataset, most often for people the duration of unemployment

was between four and 13 weeks. After that, most people found employment in either under four weeks, or between 13 and 26 weeks. There were slightly more men than women dealing with unemployment in 2014/2015 (411300 men to 351400 women). In either group, the biggest unemployed group was between the ages of 25 and 34.



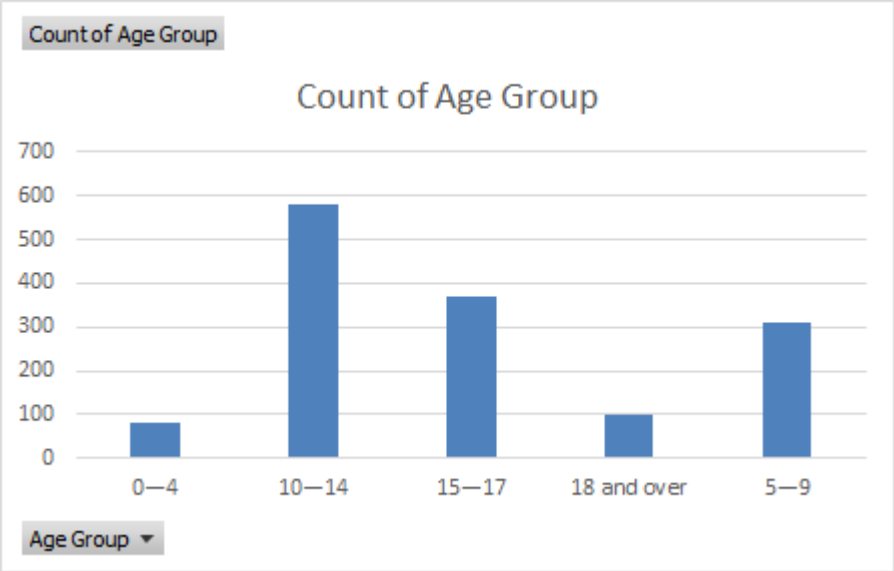


However, the older the groups got, the more the duration of unemployment evened out - if it was rare for younger people to be unemployed for over 104 weeks, there were almost equal numbers of people looking for employment in all time categories, from those who found work in under four weeks to those who needed 104 or more.

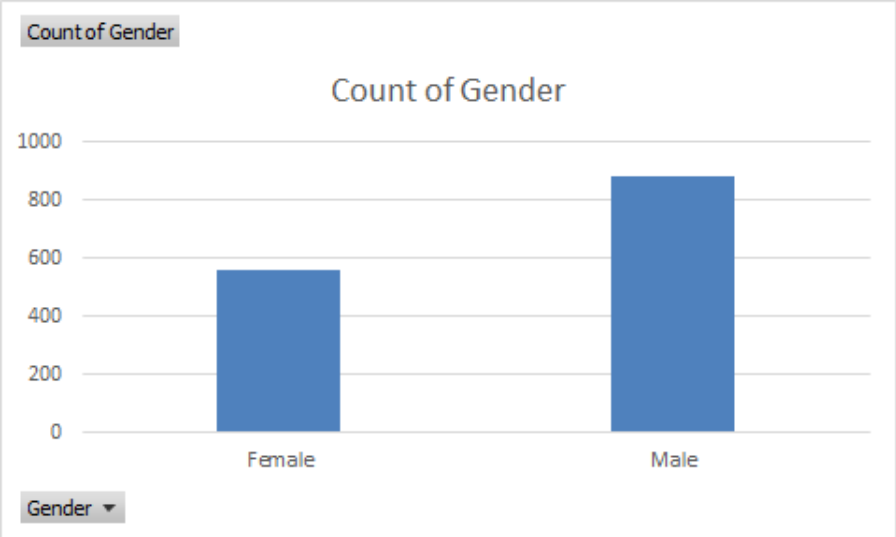
Support Data for Australia

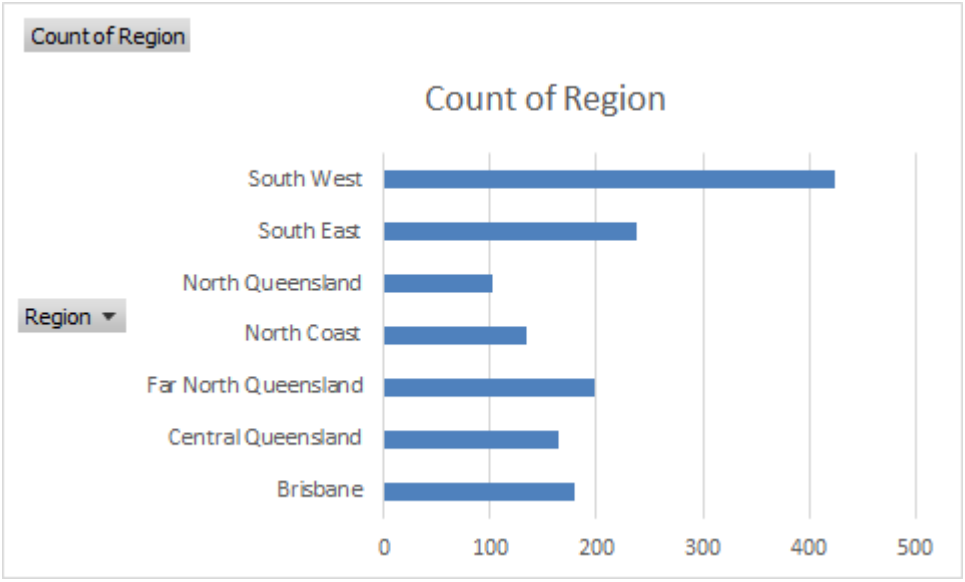
There was not much available in terms of open data about support access in Australia. However, there was a dataset made available on victim support services, which is separately made available to NW Counselling.

A dataset was also available on child placements and number of children in child placements by age group for the period 2012-2013. By far, at the time the biggest age group was 10-14.

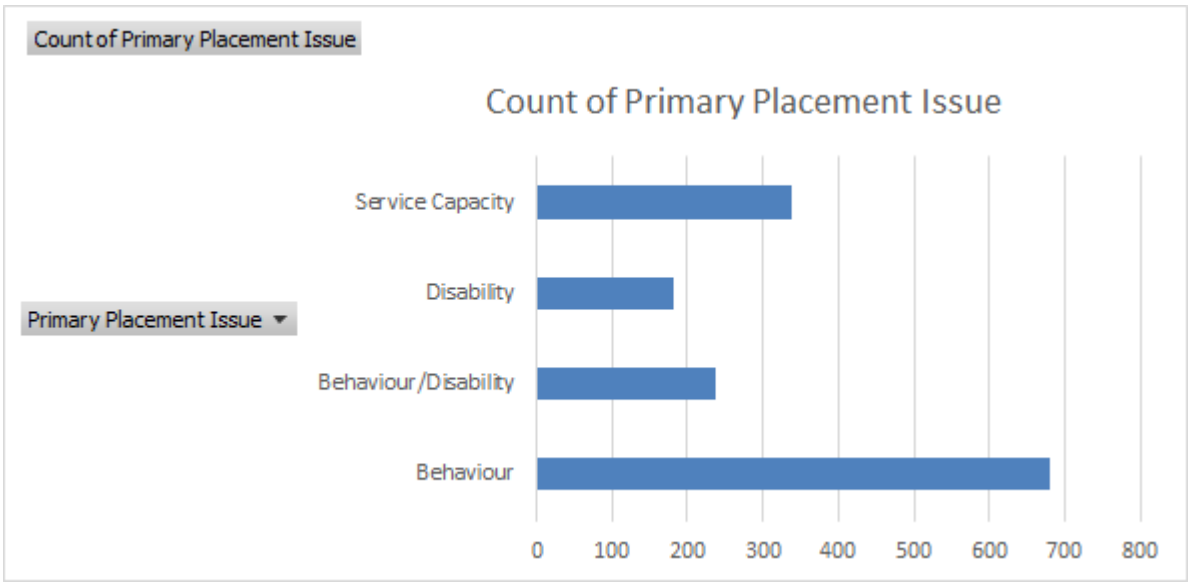


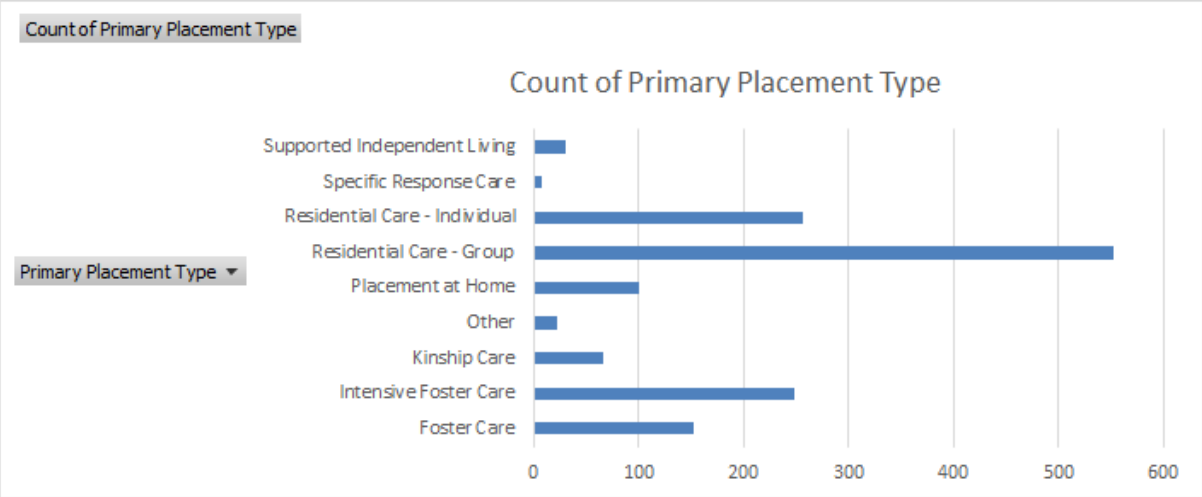
Most children in this case were male, and the most children who were in a placement were in the South West.





About a third of the children recorded that year came from an indigenous background, and in just about 30% of all placements the child was flagged as having a disability. Disability was also one of the primary placement issues, alongside behavioural problems and service capacity. The primary placement types were residential group care, followed by individual and foster care.





Having said all of this, the data is for 2012-2013, meaning that, if there have been any significant changes in the distributions of the data on support access, it would not be visible.

Other data available on support was that for Performance Measures for Students with Disabilities for 2013-2014. The data shown suggests that 8182 students accessed appropriate travel, 4% were funded under the disabilities program in government schools, and parents expressed 85% satisfaction with special education. While interesting in and of itself, it is not a very complete dataset or offer a lot of information.

Other useful data was for mental health average length of stay and readmission in South Australia:

Financial Year	MH Average Length of Stay (ALOS) (days) - all acute wards combined (c)	MH ALOS - General Acute Adult (d)	MH ALOS - Specialist acute	MH ALOS - Short Stay (e)	MH ALOS - all Adult acute wards combined	MH ALOS - General Acute Older Persons	MH ALOS - Child and Adolescent acute	MH ALOS - Forensic acute
2013-14	17.5	17.4	18.8	1.4	15.7	38.0	5.1	40.9
2014-15	15.4	16.5	19.5	1.7	13.7	41.7	4.2	63.5
2015-16	12.2	12.5	18.8	2.1	10.6	34.7	3.6	62.2
2016-17	11.3	12.2	18.4	1.9	10.2	29.4	3.8	17.1
2017-18(b)	11.7	12.0	18.6	2.1	10.5	32.8	3.9	17.1

Mental health readmission within 28 days (a)(b)

Financial Year	MH 28 Day readmission rate - all acute wards combined (d)	MH 28 Day readmission rate - General Acute Adult (e)	MH 28 Day readmission rate - Specialist acute	MH 28 Day readmission rate - Short Stay	MH 28 Day readmission rate - all Adult acute wards combined	MH 28 Day readmission rate - General Acute Older Persons	MH 28 Day readmission rate - Child and Adolescent acute	MH 28 Day readmission rate - Forensic acute
2013-14	10%	11%	9%	13%	10%	5%	14%	0%
2014-15	13%	12%	11%	14%	12%	6%	24%	8%
2015-16	14%	14%	9%	14%	14%	8%	25%	0%
2016-17	14%	14%	13%	17%	15%	6%	22%	8%
2017-18(c)	14%	14%	9%	18%	15%	5%	20%	9%

As seen from the data, the longest stays are for the acute older persons team, and the highest rate of readmission is for child and adolescent acute care. On average, the stays at an acute ward are about 12 days and the readmission rate over a month is 14%. For all the acute wards, data on mental health community care within 7 days of discharge was at 68% - for child and adolescent acute care, that was 87%.

It is worth noting that “Specialist Mental Health” wards for adults includes sub-wards like veterans, perinatal, eating disorders, anxiety, and gambling services. So, if an adult were receiving support for any of those services, their data would be coded and recorded in that field.

Data made available from the South Australian government also shows that it employed several consultancies in 2016/2017 and 2017/2018 with the purpose of evaluation and advise. Indeed, according to the data provided, the **South Australian** government spent $100931 in 2016/2017 and $92531 in 2017/2018 on mental health consultancy contracts above $10000 each.

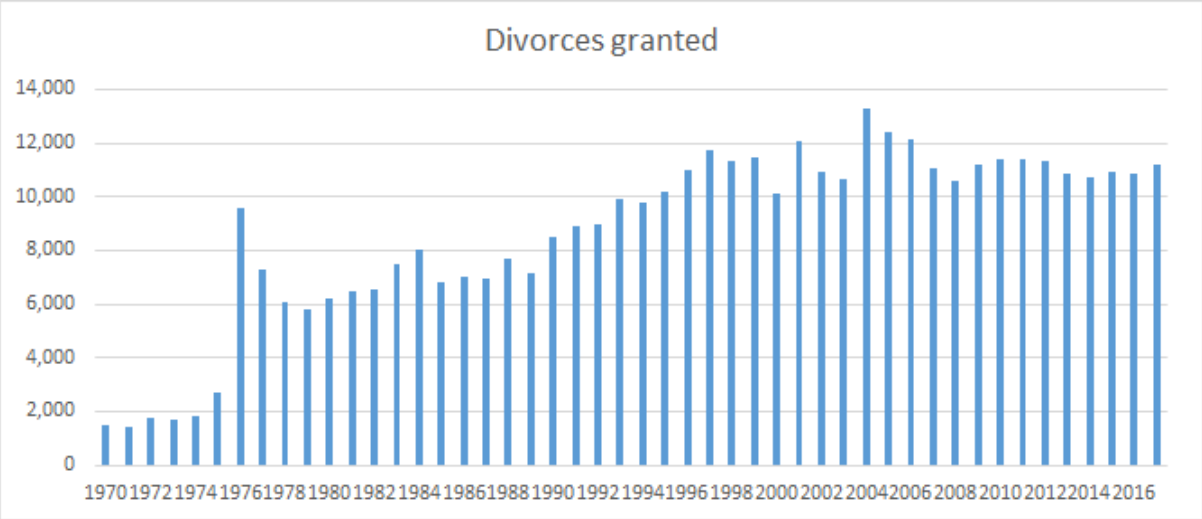
2016/2017	Purpose	Value
All consultancies above $10,000 each		
EMDF Consulting	Develop and oversee Wellbeing, Capital and Wealth Workshop, and Business Luncheon	$22,453
Ellie Hodges	Develop a proposal to build capacity for people with lived experience of mental health in SA	$15,887
Judy Hardy	Provide lived experience and advice regarding communication, media and various projects	$10,830
Sarah Reece	Advise the SA Mental Health Commissioner regarding the SA Mental Health Strategic Plan and project steering groups	$10,262
Vuca	Facilitate and plan the SAMHC Strategic Plan workshop	$21,499
Relationships Australia	Provide a written report about mental health issues after consulting with culturally and linguistically diverse people.	$20,000
Total Consultancies Above $10,000 each	$100,931	

2017/2018	Purpose	Value
All consultancies above $10,000 each		
VUCA	Facilitate and prepare the SA Mental Health Strategic plan	$11,576
Judy Hardy	Provide lived experience and advice regarding communication, media and various projects	$13,020
University of Newcastle	Facilitate and undertake the SMS4DADS project	$15,125
Ellie Hodges	Develop a proposal to build capacity for people with lived experience of mental health in SA	$22,810
VUCA	Undertake a review and provide advice on the implementation of the SA Mental Health Commission	$30,000
Total Consultancies Above $10,000 each	$92,531	

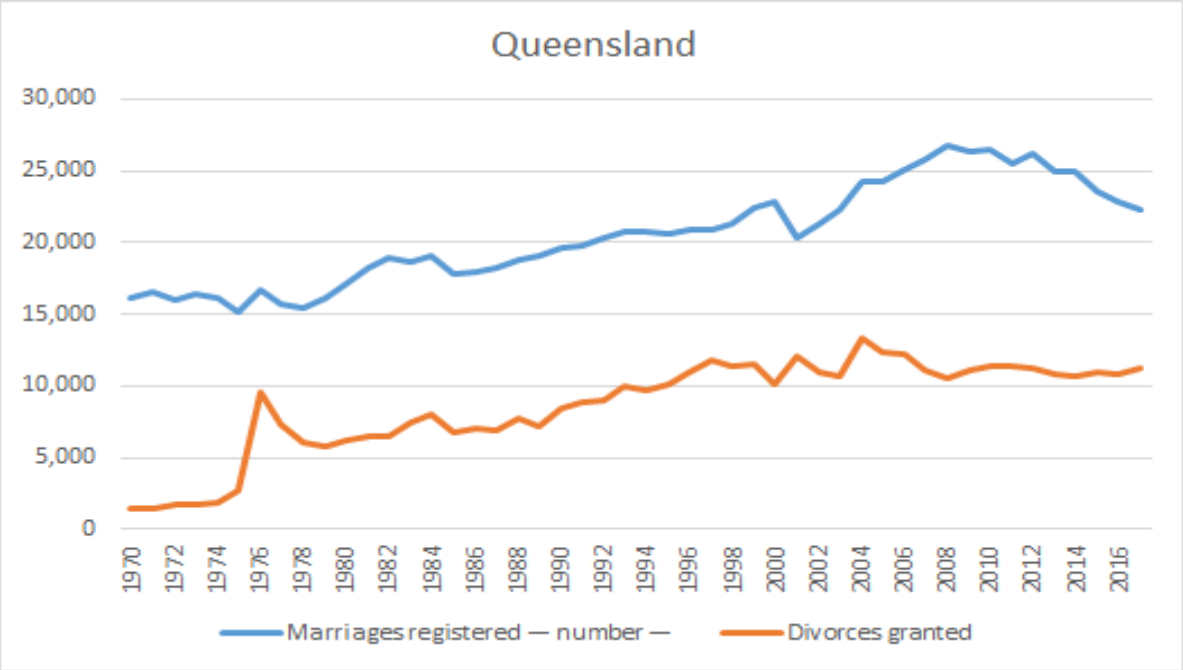
While this is interesting in and of itself, it is not enough to give the full picture for all of Australia.

Divorce Data for Australia

The only county that had made its marriage and divorce data open in Australia was Queensland. Per data from 1970 to 2017, divorce numbers have been climbing, although it is difficult to determine rates.



Compared against marriages registered, it would appear as though the divorce rate has been rising at a similar proportion:



Nonetheless, without additional data for the rest of Australia, this data only shows part of the picture.

Data Conclusions

Suicide is a complex and constantly evolving field of study. The open data from Australia, New Zealand and the UK presents a concerning picture where risk factors are slowly rising, and mitigation efforts appear invisible in the data.

However, just because those mitigation efforts are not yet reflected in the data does not mean they do not give results or are not widely felt. For that reason, in depth qualitative research and widespread quantitative research is needed.

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https://www.yourtown.com.au/who-we-are

https://www.lifeline.org.au/

https://www.suicidepreventionaust.org/our-ambition/

https://www.blackdoginstitute.org.au/ - https://youtu.be/4iZJGUAQQQ0

https://au.reachout.com/

https://www.batyr.com.au/ - https://youtu.be/VyOpluOsklA - https://vimeo.com/144066026

https://headspace.org.au/headspace-centres/nundah/

https://headspace.org.au/headspace-centres/headspace-camperdown/

https://headspace.org.au/headspace-centres/hurstville/

https://www.mentalhealth.org.nz/

https://www.thevoicesofhope.org/ - https://youtu.be/St9gqp3AYJQ

https://www.chchpho.org.nz/

https://www.pegasus.health.nz/

https://298.org.nz/

Other organisations / people I met:

I met a man called Conrad Townson from Children and Young People Solutions. We both used to work in North Wales but in different areas, so a mutual contact put us in touch. Conrad moved out here three years ago and is helping Australian authorities to better understand CSE – child sexual exploitation and identify it at the earliest possible stage. He trains organisations to spot the signs and symptoms of CSE and has established an innovative CSE panel. We know young people who experience CSE are more at risk of suicidal ideation and/or intention, so being able to spot the signs and symptoms earlier reduces this risk and the risk of CSE. What a remarkable man with a clear passion to make a difference in the world of CSE.

You can read more about his business here: https://www.cypsolutions.com.au/

I was invited to Twenty10's LGBTQIA+ event 'Well Played'. Twenty10 is a New South Wales based not-for-profit organisation that supports LGBTIQA+ young people. Their new campaign 'Well Played' highlights the importance of diversity and inclusion in sport and physical activity and the positive impact it has on young people's health and wellbeing. The campaign was launched on the night by Kate Jenkins – Sex Discrimination Commissioner, Australian Human Rights Commission, and it comprised of a film screening and a live panel discussion. It was both incredibly moving and exciting to see such forward thinking here in Australia. Watch the film here: https://vimeo.com/336077916 and read more about the organisation here: https://www.twenty10.org.au/

I met with Michael Hempseed author of Being a True Hero – Understanding and preventing suicide in your community.

Michael has made big strides in supporting communities to tackle suicide prevention. He trains people and provides advice about how best to support people. He is an avid ambassador for suicide prevention and has a wealth of knowledge. We had a long chat about the impacts of sleep deprivation on mental health and suicide ideation, which I found very interesting. I urge everyone to read his book and check out his website for more details: https://www.michaelhempseed.com/