# Analysis of Australian Suicide Prevention and Postvention Programs

## Final Report

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ACU
AUSTRALIAN CATHOLIC UNIVERSITY

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## Acknowledgement of Country

In recognition of Aboriginal and Torres Strait Islander peoples' deep spiritual connection to Country, and in continuing our commitment to reconciliation, it is customary to acknowledge Country as we pass through it.

We acknowledge and pay our respects to the First Peoples, the Traditional Custodians of the lands and waterways where Australian Catholic University campuses are located, and we thank them for their continued custodianship.

We also acknowledge all First Nations people who are serving or former members of the Australian Defence Force, and their families.

# 1. Executive Summary

## 1.1. PROJECT OVERVIEW

The Department of Veterans' Affairs (DVA) contracted Australian Catholic University (ACU) to determine the number and accessibility of suicide prevention and postvention programs for the Australian veteran community.

Completed by the ACU National Centre for Veterans and Families, this project aims to enhance DVA's understanding of:

- The number and location of Australian suicide prevention and postvention programs.
- The future needs of the veteran community regarding suicide prevention and postvention programs.

## 1.2. PROJECT QUESTIONS

The project addresses the following questions:

1. What suicide prevention and postvention programs are currently delivered within Australia?
2. To what extent are suicide prevention and postvention programs geographically accessible to veteran populations?
3. Are service providers identifying whether a client is a veteran? If so, how are they doing this?
4. How aligned are suicide prevention and postvention programs with the needs of veterans?
5. What are the barriers for the veteran community in accessing suicide prevention and postvention programs?
6. What, if any, operational improvements to suicide prevention and postvention programs would be needed to improve outcomes for the veteran community?

## 1.3. SUMMARY OF DATA ANALYSIS

A high-level summary of the data analysis is as follows.

***1. Suicide prevention and postvention programs currently delivered within Australia***

- The project identified 136 service providers delivering 173 suicide prevention and postvention programs in Australia.
- Non-clinical crisis support is the most common program type (39%), followed by prevention (28%), early intervention (16%), postvention (11%), and aftercare (7%).

***2. Geographical accessibility to veteran populations***

- The state with the most program access opportunities is New South Wales (866, 44%), followed by Queensland (181, 9%) and Western Australia (141, 7%).
- The potential for overburden on services is highest in several 'at risk' veteran hotspots including Townsville, the Australian Capital Territory, and Brisbane Local Government Areas (LGAs).
- Between 16% and 22% of LGAs are potentially service blackspots (with 100+ at-risk veterans and no identified access to certain program types), including in veteran hotspots such as Townsville and Gold Coast LGAs.
- Service providers reported geographical barriers are a challenge particularly in rural areas.

***3. Veteran identification***

- Most service providers reported that they do not formally identify whether a client was a member of the veteran community, as this may deter those who do not wish to disclose this information for various reasons.

4. ***Alignment of suicide prevention and postvention programs to the needs of veterans***

- Most suicide prevention and postvention programs identified do not target their services to the veteran community, however mainstream, person-centred approaches were considered as appropriate for veteran clients.

5. ***Barriers to accessing suicide prevention and postvention programs***

- Veterans often experience a high degree of shame around suicidality and help-seeking.
- Current or ex-serving members may be reluctant to either self-identify as being a veteran, or access programs clearly associated with Defence or veteran-focused organisations.
- Veterans are often not aware of the range of service options available to them.
- Services reported that their capacity to assist can be limited by a lack of funding and trained staff.
- Ensuring programs are geographically accessible to members of the veteran community is critical for improving outcomes.

6. ***Provider suggestions for service improvement***

- Consult with serving members, ex-serving members, and the broader veteran community on how to improve services.
- Provide mainstream suicide prevention and postvention service providers opportunities to learn more about military culture and veteran experiences.
- Establish a Community of Practice comprising suicide prevention and postvention service providers, veteran-focused service providers, and other interested parties.
- Strengthen 'communities of place' by building suicide prevention and postvention awareness and capability among any organisations that offer relevant services in geographical areas known to contain high veteran populations
- Leverage the location, expertise, and community connections of mainstream services to help support the veteran population and DVA.

## 1.4. OPPORTUNITIES FOR IMPROVEMENTS TO SUICIDE PREVENTION AND POSTVENTION PROGRAMS

1. ***Expand service coverage in at-risk veteran hotspots and blackspots***

The project identified drivers of service coverage which may present opportunities for rapidly addressing service gaps. Certain mainstream providers, program types, and formats have achieved wide geographic coverage, and these services could be further leveraged to address service gaps for veterans. Examples include decentralised, community-led support groups, larger multimodal programs with high replicability, and safe spaces/havens which can target key areas of insufficient or non-existent coverage. Suicide prevention helpline providers could also assist in developing a veteran-specific variation of their services.

2. ***Map DVA clients***

DVA reports statistics on its client population at the LGA level. These data would enable more targeted geospatial analysis and mapping, thereby extending on the analysis conducted here. While feasibility would need to be explored, these data could be jointly analysed with the program location data to identify gaps in program accessibility for DVA clients. This activity would align with the Royal Commission into Defence and Veteran Suicide *Recommendation 72: Expand and strengthen healthcare services for veterans* as well as the recommendations related to capitalising on existing data assets for veterans.

3. ***Map non-DVA clients/ex-serving members who do not identify as veterans***

Ex-serving members who do not wish to identify as veterans are unlikely to be DVA clients. Subject to feasibility checks, it may be possible to combine spatial data on the DVA client population data and the broader veteran population (from ABS 2021 Census data) to estimate the geographic distribution of ex-serving ADF members who are not DVA clients. Understanding the areas where non-DVA veterans are located would help to inform DVA as it begins to assume greater responsibility for the wellbeing of ex-serving members

irrespective of their client status (related to the Royal Commission into Defence and Veteran Suicide Recommendation 80: The Department of Veterans' Affairs to take responsibility for supporting members to transition out of the Australian Defence Force and Recommendation 87: Establish a new agency to focus on veteran wellbeing). Such analyses would also enable further targeted research into the characteristics and needs of this subgroup.

***4. Co-design military cultural competency resources and training for providers***

Developing resources and training (co-designed with representatives from the veteran community) would support upskilling of service providers in relation to veterans' needs and circumstances. This includes raising awareness of unique risk factors associated with military service, such as moral injury (related to the Royal Commission into Defence and Veteran Suicide *Recommendation 73: Improve military cultural competency in health professions working with veterans* and *Recommendation 78: Prevent, minimise and treat moral injury*).

***5. Build a veteran suicide prevention and postvention Community of Practice***

Consistent with provider suggestions, it would be beneficial to establish and facilitate a Community of Practice consisting of service providers, veteran organisations, government, and universities undertaking research on veteran suicide prevention and postvention. This initiative would engage peak bodies, primary health networks, and representatives from the veteran community, with potential to capitalise on willingness expressed by providers who engaged in this project.

# 2. Methodology

## 2.1. DEFINITIONS

To inform the development of strategies, frameworks, and programs, DVA seeks to understand the suicide prevention and postvention programs that are currently available to veterans residing within Australia.

Although there may be numerous suicide prevention and postvention related services available, this project focuses on suicide prevention and postvention programs as the primary object of analysis.

In a recent review of programs addressing mental ill health and suicide prevention among veterans and first responders[1], a 'program' is defined as having 'a purpose-built curriculum designed to be taught or given to others and implemented by the learners', as 'based on accepted scientific principles and mechanisms' and as having a way to 'determine that the program does what it says it is supposed to do'. This focus on being purpose-built, replicable/transferable, evidence-based, and able to be evaluated are also consistent with the definition and standards developed by Suicide Prevention Australia (SPA) for assessing the quality of suicide prevention and postvention programs. SPA defines such programs as one which, as its primary purpose, 'addresses, prevents and/or responds to suicidal behaviours and their impact on individuals, families, communities and the Australian population'. The SPA definition and standards were relevant in shaping this project's inclusion criteria.

## 2.2. PROGRAM FOCUS

The focus of a program's activities, intended outcomes, recipients, and beneficiaries must also be considered. The USI Prevention model[2] differentiates between prevention strategies that are 'Universal' (focused on entire populations irrespective of risk), 'Selective' (addressing communities and sub-groups potentially at risk) and 'Indicated' (for high-risk individuals or those exhibiting suicidal behaviour). DVA is concerned with programs with a selective or indicated focus, and which have the primary objective of suicide prevention or postvention. This excludes programs that indirectly contribute to suicide prevention and postvention by addressing other related aspects of wellbeing (e.g., substance usage, chronic pain, or social isolation). Programs addressing these issues were only included if they had an explicit focus on suicide prevention or postvention.

## 2.3. DATA COLLECTION PROCESS

The data collection process was divided into four pillars. Table 1 summarises the alignment between the data collection pillars and the project questions.

### *Pillar 1: Environmental scan*

Pillar 1 involved an environmental scan to determine what programs currently exist, including those specifically designed for veterans and those intended for general or other populations. This pillar addresses Question 1.

### *Pillar 2: Geospatial analysis and mapping*

Pillar 2 involved a geospatial analysis and mapping of the availability and proximity of suicide prevention and postvention programs in relation to the Australian veteran community. This pillar addresses Question 2.

[1] McCreary, D. (2019). Veteran and first responder mental ill health and suicide prevention: A scoping review of prevention and early intervention programs used in Canada, Australia, New Zealand, Ireland, and the United Kingdom, p.8.

[2] NSPP Reference Group (2020) National suicide prevention strategy for Australia's health system: 2020-2023, p.16

*Pillar 3: Provider interviews*

Pillar 3 involved semi-structured interviews with providers of suicide prevention and postvention programs to obtain their views and understandings regarding the use of their services by the Australian veteran community. This pillar addresses Questions 3-6.

*Pillar 4: Email survey*

Pillar 4 involved a brief email survey sent to providers identified in Pillar 1. This includes 4 open-ended questions requesting information about the program or services they provide, the evidence base for these programs, and the suitability and alignment of services for at-risk veterans. This pillar addresses Questions 3-6.

Question 6 is addressed via the synthesis of insights provided from all four pillars.

Table 1. Alignment of project questions with data collection pillars

| | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 |
|---|---|---|---|---|---|---|
| 1: Environmental scan | ✓ | | | | | ✓ |
| 2: Geospatial analysis and mapping | | ✓ | | | | ✓ |
| 3: Provider Interviews | | | ✓ | ✓ | ✓ | ✓ |
| 4: Email survey | | | ✓ | ✓ | ✓ | ✓ |

## 2.4. THE 'AT-RISK' VETERAN POPULATION

Rates of suicide among current serving and ex-serving ADF veterans vary significantly according to a range of population characteristics. To effectively reduce veteran suicide, and its impact on families and communities, opportunities to access appropriate programs must be geographically distributed in a way that reflects this variation in suicide risk.

The Australian Institute for Health and Welfare (AIHW)[3] has published data on the prevalence of suicide and suicidality amongst veterans from 1997 to 2020. These data were used to guide the selection and use of relevant veteran population indicators from the 2021 ABS Census.

As shown in the AIHW figures (see Table 2), age is a key determinant of veteran suicide risk relative to the general Australian population. Highlighted in red, the age-specific suicide rates for both ex-serving men and women under the age of 50 are significantly higher than those for the Australian population. By contrast, the suicide rate of ex-serving veterans aged 50 and over does not statistically differ from the Australian population.

Within the reference population of veterans aged 18 to 49, there is also noted variation in suicide risk across age groups, by sex, and by service status (i.e., Permanent/Regular, Reserves, and ex-serving). Ex-serving women have a lower suicide rate than ex-serving men, but a larger gap relative to the general population. AIHW notes that the suicide rate for ex-serving men is 27% higher than for the wider male population, whereas the suicide rate for ex-serving women is 100% higher than the general female population.

[3] AIHW (2024) Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2022 (last updated 24 September, 2024).

Table 2: Suicide rates by age group, ex-serving males and females vs. Australian males and females, 1997-2022 (Reproduced from AIHW, 2024)

| | Suicide rate (per 100,000 population, per year) | | | |
|---|---|---|---|---|
| **Age group** | Male ex-serving | Male Australian population (age-matched) | Female ex-serving | Female Australian population (age-matched) |
| Under 30 | 38.5 | 22.5 | 18.6 | 6.5 |
| 30-39 | 39.3 | 26.8 | 14.9 | 7.4 |
| 40-49 | 33.5 | 26.8 | 18.0 | 7.9 |
| 50 and over | 20.3 | 21.2 | 8.9 | 6.4 |

AIHW data show that members currently serving in the Permanent or Reserve Force have a much lower suicide rate than those who are ex-serving. Across the period from 1997 to 2022, the suicide rates for permanent and reserve males were 13.2 and 13.7, respectively, per 100,000 population per year (compared to 31 per 100,000 population per year for ex-serving males). For permanent and reserve females, the equivalent rates were 5.0 and 4.2, respectively, per 100,000 population per year (compared to 14.9 per 100,000 per year for ex-serving females).

The suicide rates for permanent and reserve males are reported by the AIHW to be 45% lower and 47% lower, respectively, than for the general male Australian population. The rates for permanent and reserve females do not differ significantly from that of the female Australian population. Nonetheless, it was considered important to incorporate currently serving veterans within the at-risk population for the analysis, given the subsequent increase in risk associated with transition from military service and the focus of many identified programs on prevention and early intervention.

For the purpose of this project, the ‘at-risk’ veteran population has been broadly defined as individuals aged 18-49 who have ever served in the ADF. This includes current and ex-serving members in the Permanent/Regular or Reserve Force.

# 3. Environmental Scan

## 3.1. OVERVIEW

An environmental scan was undertaken to determine what suicide prevention and postvention programs currently exist. This includes programs available to the general population as well as those specifically designed to meet the needs of the veteran community.

## 3.2. SCOPE

### *Inclusion criteria*

Based on the previously stated considerations, and after consultation with DVA, it was determined that to be included in the findings, suicide prevention or postvention services must:

- Be provided through a program[4] (i.e., via structured/purpose-built/repeated delivery, in a standardised, replicable/transferrable format that could be evaluated).
- Be designed to address, prevent, or respond to suicidal behaviours and their impact on individuals, families, and communities as the primary objective.
- Be delivered and accessible in Australia (can include in-person, by phone, or online).
- Involve suicide prevention or postvention services (i.e., activities/services/interventions) that are targeted in focus (i.e., at-risk individuals, groups, or communities).
- Involve prevention, early intervention, non-clinical crisis support, aftercare, or postvention (see Table 2 for program type definitions).
- Deliver programs to adults aged 18+ (except for postvention programs).

While not a formal inclusion criterion, another factor noted was whether a program was accredited against relevant quality standards. Suicide Prevention Australia is the peak body that assesses the quality of suicide prevention programs nationally in accordance with its Suicide Prevention Standards for Quality Improvement (2nd edition). Programs are assessed against six key criteria (see Appendix A). Having this accreditation was accepted as sufficient evidence that an identified program has suicide prevention as its objective, as well as an indicator of program quality.

### *Exclusion criteria*

- Services that are provided in an ad hoc way and cannot be replicated or evaluated.
- Services involving activities or interventions that are universal or untargeted in terms of risk (e.g., public suicide awareness campaigns, programs to increase community connectedness, activities that address social determinants of wellbeing).
- Formal or clinical health care services, or other crisis services, treatments or interventions administered by health care practitioners outside of a program context (e.g., emergency services, hospital services, GP services, psychological/psychiatric services).
- Suicide prevention networks that do not specifically deliver suicide prevention programs.
- Services directed at children or young people under age 18 (postvention programs excepted).

### *Program inclusion/exclusion guide*

A guide has been created to determine what services would be included or excluded in the findings (Table 3). It identifies the five main types of included programs (prevention, early intervention, non-clinical crisis support, aftercare, and postvention) with examples of the services they might provide. It also indicates the services which fall outside of the scope of the project, such as broader wellbeing programs or programs with an untargeted, universal focus.

[4] A program may not necessarily be named as such, e.g., it may still be called a ‘service’ whilst displaying these required characteristics.

Table 3. Program inclusion/exclusion guide

| | Program Focus | | | |
|---|---|---|---|---|
| | **Indicated**<br>At-risk or affected individuals | | **Selective**<br>At-risk or affected population sub-groups | **Universal**<br>Whole population (untargeted) |
| **Program Types** | **Wellbeing**<br>Services to enhance social, emotional and spiritual wellbeing and quality of life, but suicide prevention is not primary objective | Addresses aspects of a veteran's wellbeing that can affect suicide risk (but not focused on suicide prevention) e.g., social belonging, chronic pain, transition issues | Addresses wellbeing in sub-groups with higher suicide risk (but not focused on suicide prevention) e.g., industry-specific employee wellbeing programs, Aboriginal and Torres Strait Islander health | Addressing wellbeing factors associated with suicide risk in the general population e.g., social cohesion, access to housing, employment initiatives |
| | **Prevention**<br>Services to prevent the onset of suicidal behavior | Building suicide prevention awareness, resilience, skills, training, access to peer/lived experience support<br>Reducing risk factors and enhancing protective factors for at-risk individuals and sub-groups (where suicide prevention is the main objective) | | Public awareness, reducing access to means, promoting appropriate media coverage |
| | **Early intervention**<br>Services to identify and assist people showing early signs of suicidal behavior | Facilitating early identification, referrals to care pathways or building self-help capability, safety planning | Facilitating peer, gatekeeper or practitioner training to identify early signs and enable access to care pathways/services | N/A[5] |
| | **Non-clinical crisis support**<br>Services for people who are experiencing a suicidal crisis, not involving clinical care | Crisis support hotlines, access to non-clinical, peer-led 'safe spaces', facilitating referral pathways to emergency or clinical care services | N/A | N/A |
| | **Aftercare**<br>Services for people who have recently attempted suicide to prevent repeated self-harm | Regular contact, facilitating ongoing access to care, safety planning, peer/lived experience support groups, targeted interventions to reduce risk and enhance protective factors | N/A | N/A |
| | **Postvention**<br>Services for people impacted by suicide (e.g., family, friends, social networks) | Facilitating access to support services such as bereavement support groups, training in communication about suicide for those impacted by suicide, referral pathways to clinical care services | | Public awareness/advocacy campaigns |

[5] Not applicable as the program type only applies to individuals at risk or already displaying symptoms.

## 3.3. PROCESS

The environmental scan took place from 30/9/2024 to 18/10/2024 and involved the following stages:

***Program identification***

This stage involved examining a range of data sources to identify programs that potentially met the project criteria and entering these into a preliminary database. The main data sources included:

- All 31 Primary Health Network (PHN) websites
- Suicide Prevention Australia's Accreditation Directory
- Postvention Australia's Post-Suicide Support Service Directory
- Known suicide prevention and postvention support 'gateways' (e.g., Life in Mind, Head to Health, Beyond Blue, Roses in the Ocean)
- General service directories such as Lifeline Service Finder or WayAhead Directory
- ACU's internal veteran service provider database
- Targeted keyword internet searches

Programs were often also identified via a 'snowball' search of provider websites (i.e., where providers of an identified program are found to also deliver other distinct yet eligible programs).

***Program data input and eligibility assessment***

This stage involved gathering information on program characteristics, typically from the source by which the program was identified, or secondary searches targeting the identified program. Details on the following program characteristics were sought:

- Program name
- Provider details – organisation name, ABN, organisation type (not-for-profit/private company/government)
- Program description
- Intended recipients
- Eligibility/referral criteria
- Mode of delivery (in-person/online/phone)
- Evidence description
- Program/provider location, contact information, and website URL

Sources such as the *ABN Lookup Tool* and the Australian Charities and Not-For-Profit Commission (ACNC) registry were used to confirm provider details and validate that providers were currently active. An initial screening of a program's description and intended clients was typically sufficient to assess its eligibility for inclusion in the database. In cases of uncertainty, programs were entered and flagged for further review.

***Unique site/service data input***

This stage involved capturing data on eligible programs with multiple sites and service areas. The aim was to identify location information required for the geospatial analysis and contact information needed for the provider consultations. For multi-site programs delivered by a single provider, this information was typically available from the provider's website. For programs operated by multiple providers (such as *The Way Back Support Service*), and for certain program formats (e.g., safe spaces/havens, or suicide bereavement support groups), this was achieved through further targeted keyword searches.

### *Program classification*

The final stage involved assigning the eligible programs to each of the five main program types (prevention, early intervention, non-clinical crisis support, aftercare, postvention). In a small number of instances where a program could be classified as more than one program type, it was assigned a type based on its most prominent characteristics. The most notable ambiguity was in the distinction between prevention and early intervention, and there is potential overlap between some programs in these categories.

At this stage, eligible programs were also classified according to their delivery format, with seven main formats identified (support groups, multimodal programs, safe spaces/havens, training, mental health centres/hubs, helplines, and counselling). See Table 4 for program delivery format definitions.

Table 4: Program delivery formats

| Format Definitions | Program Examples |
|---|---|
| Support group | |
| Programs where a support group is the primary format. Support groups may offer other services such as service linkage or tailored workshops, however these are secondary components of the program. | *Lifeline Suicide Bereavement Support Groups*<br>*The Men's Table*<br>*Dads in Distress* |
| Multimodal program | |
| Multimodal programs deliver a package of non-clinical, psychosocial services, usually targeting at-risk or bereaved individuals. Services are complimentary with no clear primary format, and can include safety planning, counselling, service linkage, lived experience peer support, help with establishing community or cultural connections, and support groups. Multimodal programs are usually structured, individualised and are delivered over a set period. | *The Way Back Support Service*<br>*Culture Care Connect*<br>*StandBy Support After Suicide* |
| Safe space/haven | |
| Programs intended to provide a non-clinical alternative to emergency department attendance for people experiencing emotional or suicidal crisis or distress[6]. These are free, walk-in services provided in a safe and welcoming environment, with peer or lived experience workers, and linkages to other services. A notable inclusion in this category is NSW Health's *Suicide Prevention Outreach Teams (SPOT)*[7] which have been developed to act as a mobile safe haven service. | *Royal Perth Hospital Safe Haven*<br>*Caboolture Safe Space*<br>*Newcastle Safe Haven* |
| Training | |
| Programs which build community capacity for suicide prevention and postvention through providing training courses and other community development activities. | *Standard Mental Health First Aid Course*<br>*Living Perspectives of Suicide*<br>*FoundoBlue* |
| Mental health centre/hub | |
| Federal Government funded *Medicare Mental Health Centres* (formerly *Head to Health Centres*) and other Mental Health Hubs employ a similar service model[8] to safe spaces/havens (free, walk-in services, non-judgmental environment, lived experience support workers) and similarly serve as an alternative to emergency department attendance. As well as immediate crisis care they can provide short to medium term ongoing care and access to a wider range of coordinated, multi-disciplinary services. | *Mount Gambier Medicare Mental Health Centre*<br>*Mental Health Hub – Shoalhaven* |
| Helpline | |
| Helplines include hotlines, warmlines, crisis and non-crisis support lines. | *Lifeline Suicide Call Back Service*<br>*Griefline Helpline* |
| Counselling | |
| Programs where counselling, mentoring or other non-clinical one-on-one psychological support is the primary component. | *RAW Country Program*<br>*Support After Suicide Counselling – Brunswick*<br>*Mentor Training & Life Mentoring in the Community* |

[6] Roses in the Ocean (2022) Discussion Paper: A National Safe Spaces Network: The Dream, The Reality, The Opportunity.

[7] NSW Government (2020) *Towards Zero Suicides – Suicide Prevention Outreach Teams*, NSW Ministry of Health.

[8] Australian Government (2021) *Service Model for Head to Health Adult Mental Health Centres and Satellites, Department of Health*, Department of Health.

## 3.4. OVERVIEW OF IDENTIFIED SUICIDE PREVENTION AND POSTVENTION PROGRAMS

### *Total counts*

The environmental scan identified 136 different providers delivering suicide prevention and postvention programs. A total of 173 unique programs were identified operating across 499 unique sites or service areas (see Table 5). For a complete list of providers and programs, see Appendix B and Appendix C respectively.

Table 5: Count of unique providers, programs, and sites/service areas

| | |
|---|---|
| Unique providers | 136 |
| Unique programs | 173 |
| Unique sites or service areas | 499 |

### *Program types*

Table 6 displays how unique programs and the sites/service areas in which they operate are composed in terms of program type. When considering unique programs, non-clinical crisis support was the most frequently identified program type (67, 39%), followed by prevention (47, 27%), early intervention (28, 16%), postvention (19, 11%) and aftercare (12, 7%).

Table 6: Unique programs and sites/service areas by program type

| | Unique programs | | Unique sites/service areas | |
|---|---|---|---|---|
| **Program type** | Count | Percentage | Count | Percentage |
| Prevention | 47 | 27% | 183 | 37% |
| Early intervention | 28 | 16% | 28 | 6% |
| Non-clinical crisis support | 67 | 39% | 111 | 22% |
| Aftercare | 12 | 7% | 81 | 16% |
| Postvention | 19 | 11% | 96 | 19% |
| **Total services** | 173 | 100% | 499 | 100% |

However, programs also differ in the number of sites or areas in which their services are accessible. On this metric, the broadest program type was prevention with 183 (37%) unique sites or services areas. The program types of non-clinical crisis support, postvention, and aftercare were similar in frequency with 111 (22%), 96 (19%), and 81 (16%) sites/service areas respectively. The least frequent program type was early intervention with 28 (6%) unique sites or services.

### *Program format*

Variation in how programs are delivered (i.e., program format) helps to explain differences in the frequency of unique sites and service areas in which programs operate. For instance, many non-clinical crisis programs delivered helplines nationally with no specific site or service area, whereas prevention programs often involved support groups operating in a larger number of sites/service areas. In the aftercare and postvention categories, prominent programs such as *The Way Back Support Service* and *StandBy Support After Suicide* represent single programs implemented by multiple providers across many sites and service areas nationally.

Table 7 displays how programs and the sites/service areas in which they operate were composed in terms of program format. This classification provides a broad indication of the structure and method of delivery of the program. Programs involving safe spaces/havens were the most frequently identified format (51, 29%), closely followed by those which delivered training (44, 25%), then multimodal programs (26, 15%) and helplines (25, 14%). There were fewer unique programs which employed a support group format (14, 8%), a mental health centre/hub format (6, 3%) or a counselling format (7, 4%).

Table 7: Unique programs and sites/service areas by program format

| | Unique programs | | Unique sites/service areas | |
|---|---|---|---|---|
| **Program format** | Count | Percentage | Count | Percentage |
| Counselling | 7 | 4% | 22 | 4% |
| Helpline | 25 | 14% | 25 | 5% |
| Mental health centre/hub | 6 | 3% | 35 | 7% |
| Multimodal program | 26 | 15% | 123 | 25% |
| Safe space/haven | 51 | 29% | 66 | 13% |
| Support group | 14 | 8% | 184 | 37% |
| Training | 44 | 25% | 44 | 9% |
| **Total services** | 173 | 100% | 499 | 100% |

The format in which different types of programs are delivered has a strong bearing on the breadth of its distribution across sites or service areas. Although there were relatively few programs employing a support group format, these were the most widely distributed programs in terms of unique sites or service areas of operation (184, 37%). This reflects the decentralised, community-led nature of this model and the involvement of specific organisations (such as *The Men's Table*) operating in multiple locations.

The next most frequent program format in terms of sites or service areas was multimodal programs (123, 25%). This category included a diverse variety of programs that are not easily differentiated into smaller categories. Multimodal programs tended to be structured, provide individualised case management and support, and involve multiple measures. Programs focused on training, which represented a quarter of all unique programs, only accounted for 9% of all unique sites/service areas in which a program operates, likely because many programs are delivered virtually or not in a set location.

The program formats with the least sites or service areas were helplines (25, 5%) and counselling (22, 4%). The low frequency of helplines reflects the fact that these tend to operate nation-wide rather than in specific service areas. Counselling services were likely less frequent in general due to their close similarity with clinical psychological services which were excluded from this project.

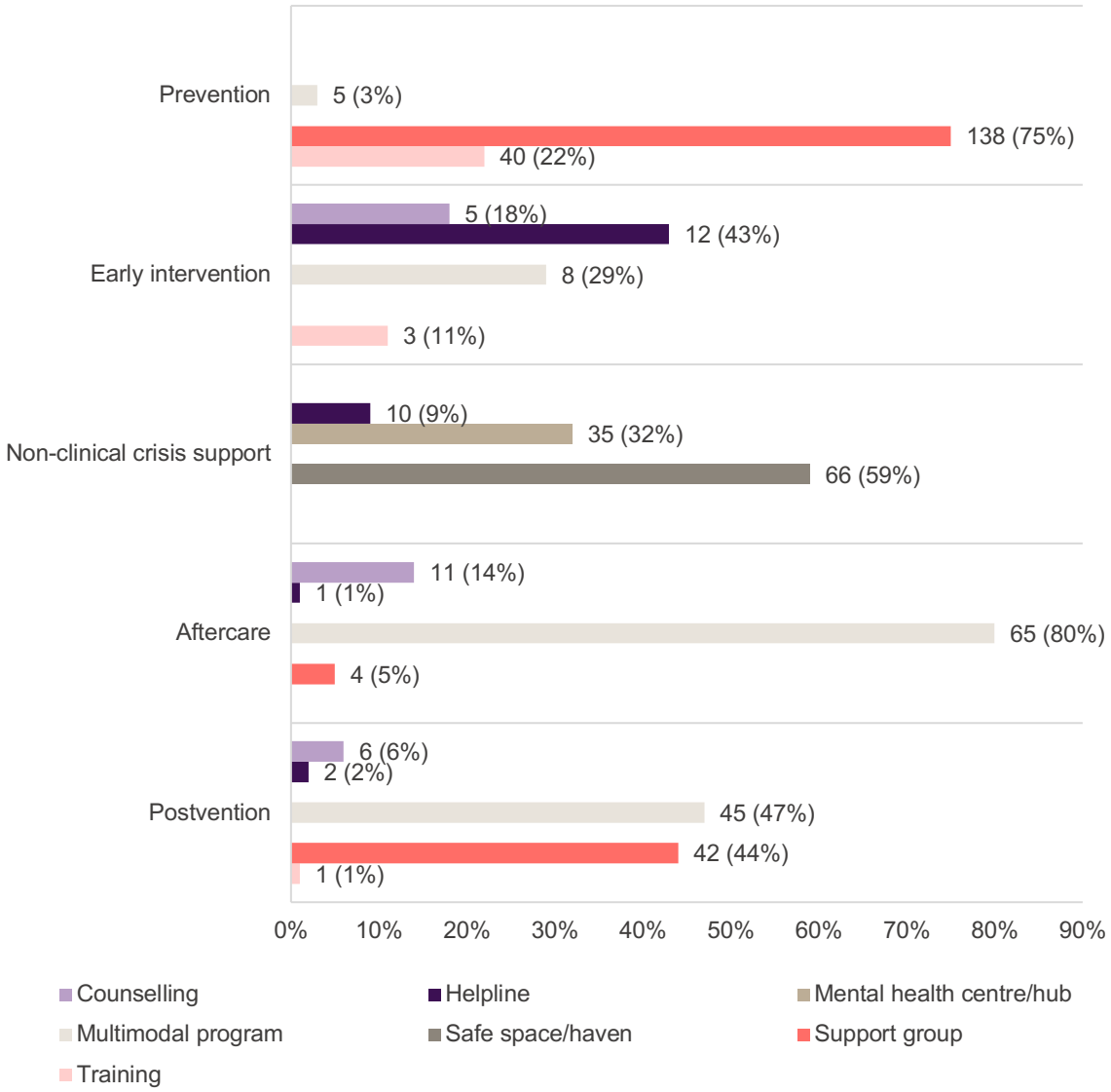
***Relationship between program type and program format***

As has been indicated above, some clustering of program types and formats is evident in the data. Certain types of programs were likelier to employ specific formats than others. The distribution of program formats (for unique sites and service areas) across each of the major program types is shown in Figure 1.

Prevention programs are primarily support groups (75%) and training services (22%), with a small number of multimodal programs being represented (3%). Early intervention programs are a mix of formats, with a focus on helplines (43%) and multimodal programs (29%). Counselling (18%) and training (11%) make up the remainder of the programs. Non-clinical crisis support is primarily associated with safe spaces/havens (59%), as well as mental health centres/hubs (32%), and to a lesser degree helplines (9%). Aftercare programs consist primarily of multimodal programs (80%). A small proportion of counselling (14%), support group (5%), and helplines (1%) programs make up the remainder. Postvention support includes multimodal programs (47%) and support groups (44%).

There is a clear trend of support groups being a relevant program format in both in the early prevention phase and the later postvention phase, with limited significance in the intervening stages. This may reflect a heightened need for professional support during the crisis and surrounding stages of suicide support, which a community led support group structure is less able to provide.

Figure 1. Unique sites/service areas program type by program format



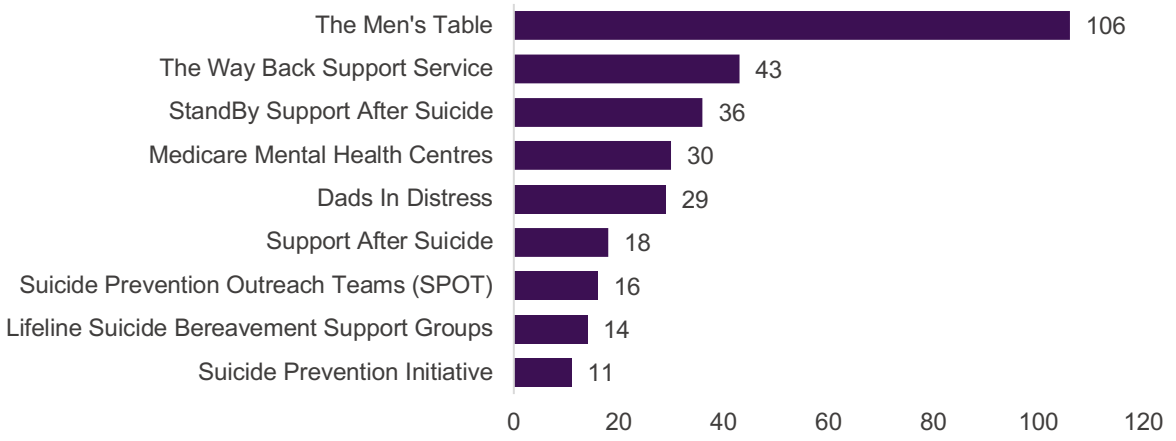

Multimodal programs are common among early intervention, aftercare, and postvention programs reflecting their structured and individualised approach of supporting at-risk or bereaved individuals and their reduced relevance for prevention or crisis support.

Non-clinical crisis support programs are notably different from other program types, relying on formats most suitable for providing crisis support, that being safe spaces/havens, mental health centres/hubs, and helplines.

***Programs with broad distribution across multiple sites/service areas***

A small number of programs accounted for a large proportion of the unique sites/service areas (Figure 2). Among these, the programs with the most unique sites or service areas were *The Men's Table* (106), followed by *The Way Back Support Service* (43), and *StandBy Support After Suicide* (35). Combined, the programs listed in the figure below account for 303 (61%) of the unique sites and service areas.

Figure 2. Top programs by count of unique sites/service areas




### *Mode of delivery*

Most sites/service areas are accessible in-person (448, 90%), with 59% of all sites/service areas being in-person only (Table 8). While a third of sites/service areas are accessible by phone (166, 33%), and a small number are accessible online (79, 16%), very few of these are phone or online only (4% in both cases). Overall, one third of sites/service areas provide more than one mode of delivery (166, 33%).

Table 8. Unique sites/service areas, by mode of delivery

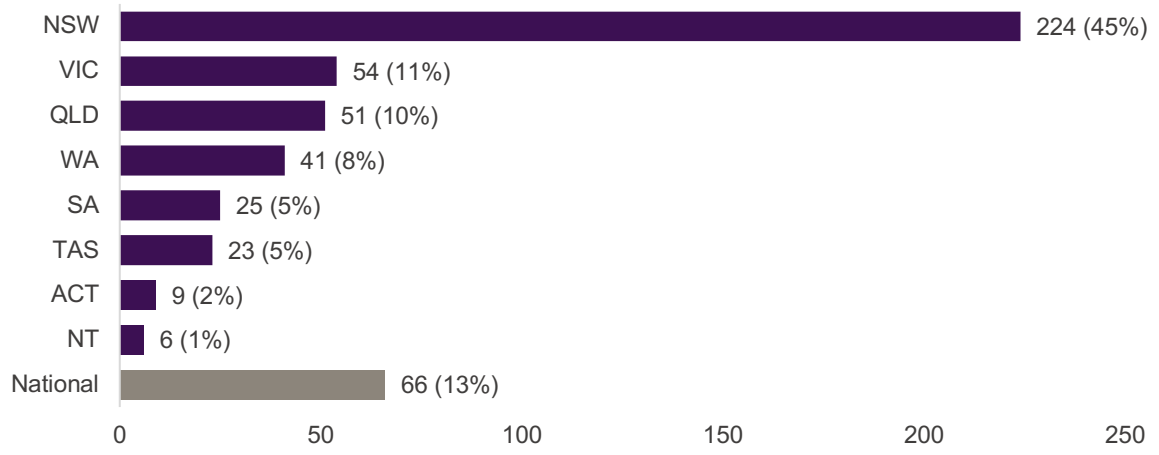
| Mode of delivery | Count | Percentage |
|---|---|---|
| In-person only | 292 | 59% |
| Phone only | 19 | 4% |
| Online only | 22 | 4% |
| More than one delivery mode | 166 | 33% |
| Total | 499 | 100% |
| Total services accessible in-person | 448 | 90% |
| Total services accessible by phone | 165 | 33% |
| Total services accessible online | 79 | 16% |

### *Sites/service areas by state/territory*

Figure 3 displays the distribution of unique sites and service areas by state/territory. Nearly half of all sites/service areas operate in New South Wales (224, 45%). Several programs display a larger presence in New South Wales, such as *The Men's Table*, *The Way Back Support Service*, and the *Suicide Prevention Initiative*. The NSW Government's *Towards Zero Suicides* strategic policy framework has also contributed to the widespread establishment of *Safe Havens* and *Suicide Prevention Outreach Program* (*SPOT*) locations across the state.

Victoria, Queensland, and Western Australia rank next highest in numbers of sites/service areas with 54 (11%), 51 (10%), and 41 (8%) respectively. Sixty-six (13%) of sites/service areas operate nationally. These are primarily made up of training services and helplines that operate nationally.

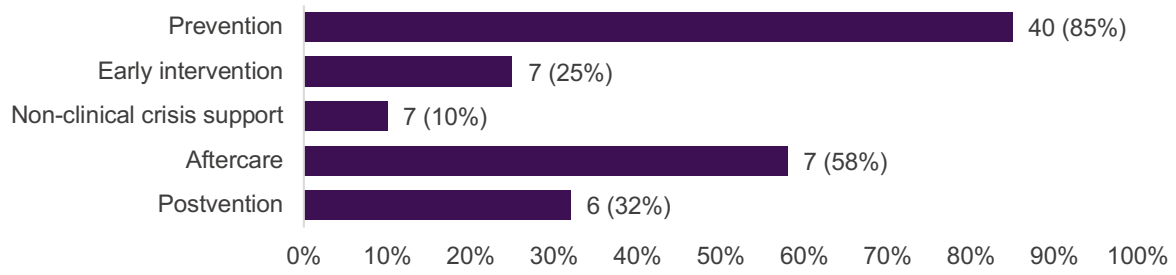
Figure 3. Unique sites/service areas by state




### *Accreditation*

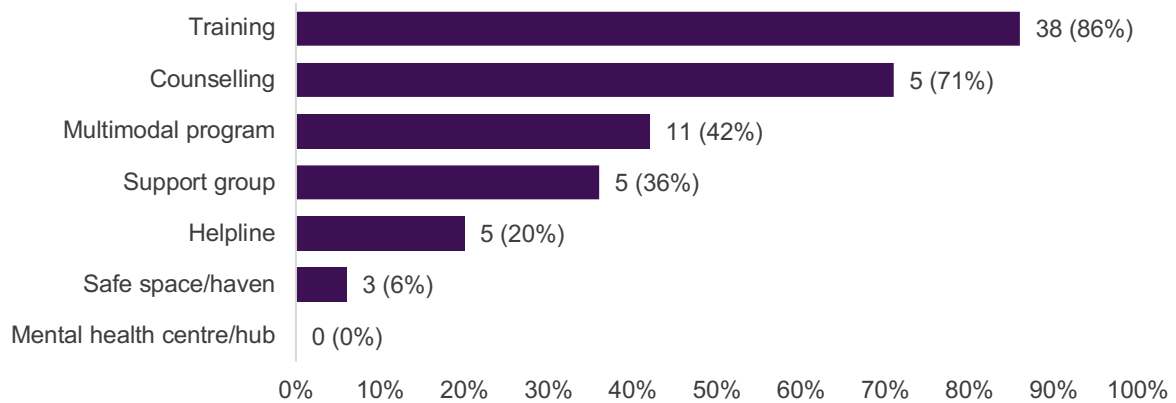
Thirty-nine percent of the identified unique programs have been accredited by *Suicide Prevention Australia* (67, 39%), with the remainder either not being accredited (99, 57%) or registered to undergo accreditation (7, 4%). Figure 4 shows that the program types most likely to be accredited were prevention (40, 85%), aftercare (7, 58%), and postvention (6, 32%). Early intervention (7, 25%) and non-clinical crisis support (7, 10%) programs were the least likely to have been accredited.

Figure 4. Accreditation of unique programs by program type




As shown in Figure 5, training (38, 86%), counselling (5, 71%), and multimodal programs (11, 42%) were the likeliest program formats to have been accredited. Support groups (5, 36%), helplines (5, 20%) and safe spaces/havens (3, 6%) were unlikely to be accredited, and no mental health centres/hubs were accredited.

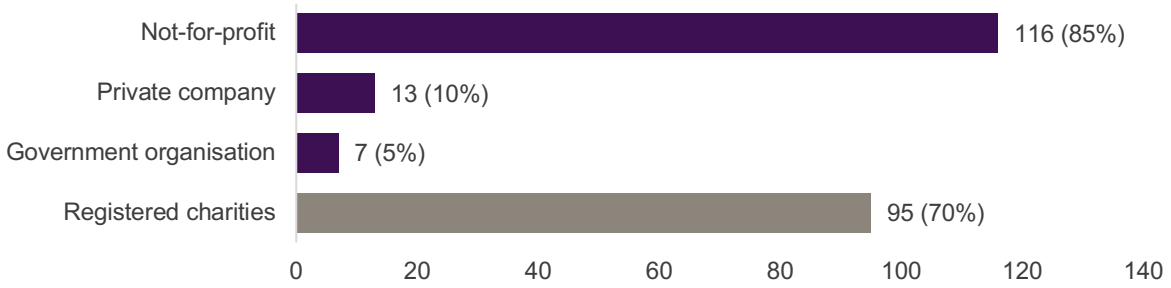
Figure 5. Accreditation of unique programs by program format



### *Provider characteristics*

Figure 6 shows that most providers were not-for-profit organisations (116, 85%) with the remainder being private companies (13, 10%) and government organisations (7, 5%). Two-thirds of providers were registered charities (95, 70%).

Figure 6. Providers by provider type and charitable status

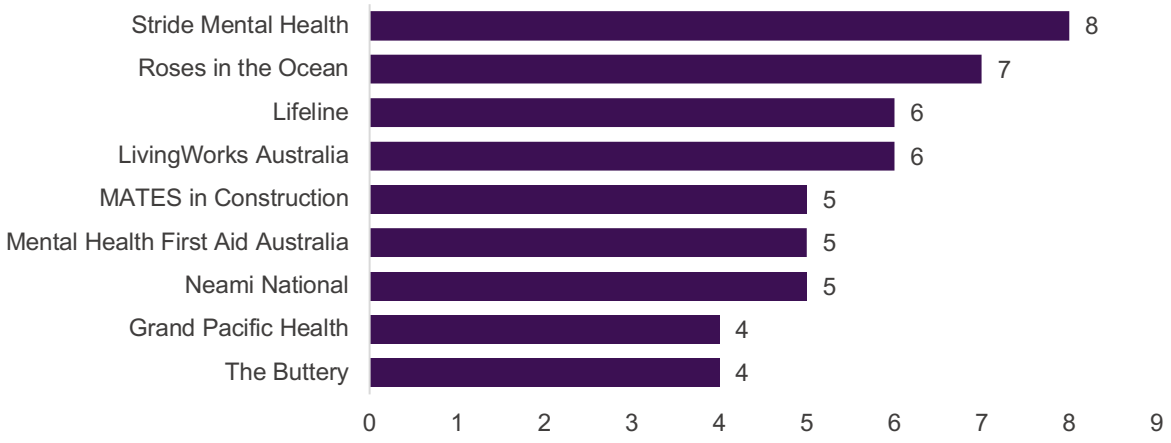



Programs were broadly distributed across providers with two-thirds of providers delivering one program (92, 68%). As displayed in Figure 7, there were also nine providers (i.e., 7% all providers) who between them are involved in delivering 50 programs (i.e., 29% of all unique programs).

In some cases, these multi-program providers offered services spanning different program types or formats. For instance, an organisation such as *Roses in the Ocean* delivered several suicide prevention training programs (prevention/training), as well as operating a 'warmline' call-back service (early intervention/helpline) and supporting development of safe spaces (non-clinical crisis support, safe spaces/havens).

In other cases, providers primarily offered multiple programs of a specific type and format. For instance, *Stride Mental Health* was observed to operate five safe spaces/havens as well as several *Medicare* mental health centres/hubs, and *The Buttery* operates four safe spaces/havens. Similarly, organisations such as *LivingWorks Australia* and *Mental Health First Aid Australia* offer a range of prevention training programs.

Figure 7. Top providers by count of programs delivered (4 or more programs)



# 4. Geospatial Analysis and Mapping

## 4.1. OVERVIEW

A geospatial analysis and mapping of the availability and accessibility of suicide prevention and postvention programs has also been undertaken in relation to the Australian veteran community.

This section includes three parts. First, spatial unit data from the 2021 ABS Census is used to map the geographic distribution of veterans who are within the age group where there is a heightened risk of suicide. Next, locational data on the programs identified in the environmental scan is used to map the geographic distribution of opportunities to access these programs across Australia. Finally, the geographic accessibility of these programs to the at-risk veteran population is explored.

## 4.2. MAPPING PROCESS

Based on best availability across the data sets, the decision was made to focus on the Local Government Area (LGA) spatial scale, which are ABS-defined areas that approximately group suburbs in urban centres or large towns and outlying areas in rural localities.

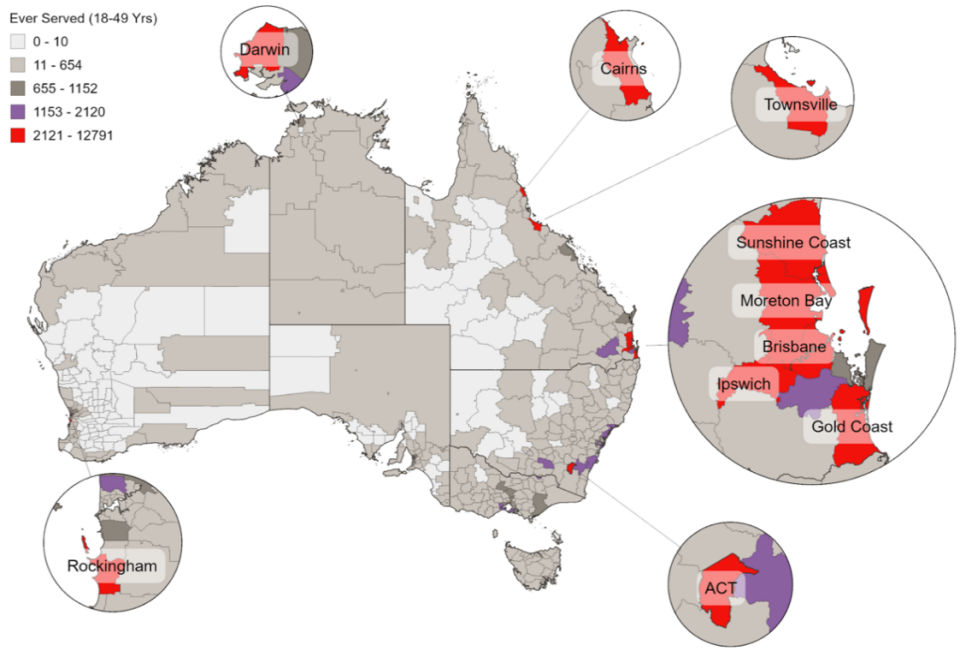
The first phase of the mapping process aimed to visualise and describe the spatial patterns of those within the at-risk veteran population age group. The second phase focused on visualising and describing the physical locations and spatial patterns of the programs available to support veterans located in an LGA. These are described hereafter as 'program access opportunities' (i.e., the total number of opportunities to access a program in an LGA). As this analysis examines geographic accessibility, it excludes programs which are only delivered online or via phone. The third and final phase of the mapping process focused on visualising the program access opportunities available to at-risk veteran communities in Australia.

## 4.3. GEOGRAPHIC DISTRIBUTION OF VETERAN POPULATIONS WITHIN THE AT-RISK AGE GROUP

### *Total population of ADF members within at-risk age group (18-49) who have ever served*

The 2021 ABS Census data show 173,427 individuals within the at-risk veteran population age group who have ever served (Figure 8). The state with the most veterans in this group is Queensland (51,405), followed by New South Wales (45,886) and Victoria (26,269). Most of this population are located along the eastern Australian seaboard (i.e., 71% of the population are in LGAs in Queensland, New South Wales and Victoria). In Figure 8 (and similarly in Figures 9 through to 14) the 10 LGAs containing the highest numbers of at-risk veteran population are shaded in red. The LGA with the highest population in this group is Brisbane (12,791) followed by the Australian Capital Territory (10,534).

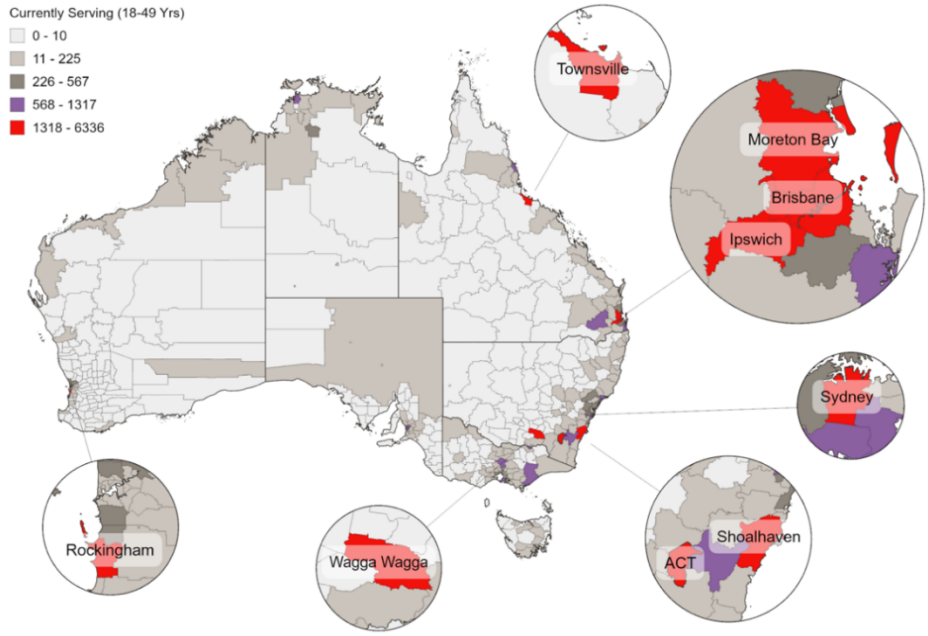
Figure 8: Distribution of all ADF members within at-risk age group (18-49) who have ever served




***Currently serving ADF members within at-risk age group (18-49)***

There are 70,307 currently serving ADF Permanent or Reserve Force members within the at-risk age group (Figure 9). The state with the largest number is New South Wales (20,357), with a similar number in Queensland (19,564), followed by Victoria (8,723). The LGA with the highest population in this group is the Australian Capital Territory (6,336), followed by Brisbane (5,509) and Townsville (5,034).

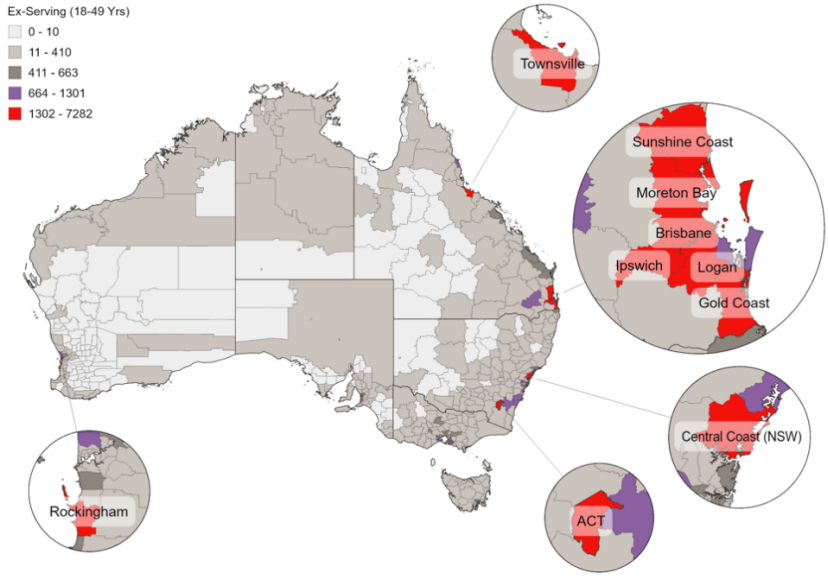
Figure 9: Distribution of currently serving ADF members within at-risk age group (18-49) by LGA



### *Ex-serving ADF members within at-risk age group (18-49)*

There are 103,113 ex-serving ADF members within the at-risk age group (Figure 10). The highest number is in Queensland (31,842), followed by New South Wales (25,534) and Victoria (17,543). The LGA with the highest population is Brisbane (7,282), followed by the Australian Capital Territory (4,195). The geographic distribution of the ex-serving population is similar to that of the currently serving population, although currently serving members are more concentrated in LGAs close to major military bases.

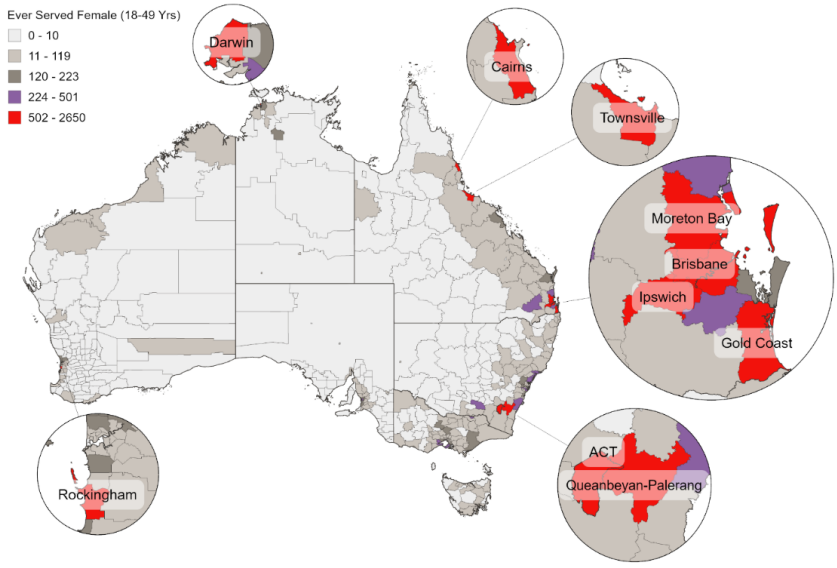
Figure 10: Distribution of ex-serving ADF members within at-risk age group (18-49) by LGA




### *Total female veteran population within at-risk age group (18-49) who have ever served in the ADF*

The total female veteran population within the at-risk age group (18-49) who have ever served is 34,015 (Figure 11). The state with the largest population is Queensland (10,083), followed by New South Wales (8,807) and Victoria (4,673). The LGA with the most females within the at-risk age group is the Australian Capital Territory (2,650), followed by Brisbane (2,381) and Townsville (1,563).

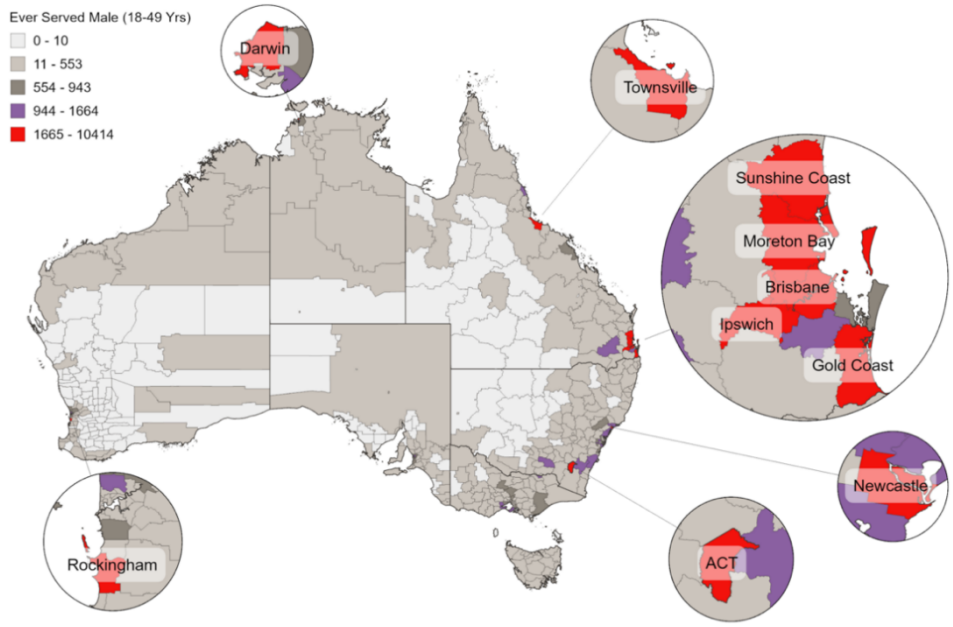
Figure 11: Distribution of female veterans within at-risk age group (18-49) who have ever served in the ADF by LGA



### *Total male veteran population within at-risk age group (18-49) who have ever served in the ADF*

The total male veteran population within at-risk age group (18-49) who have ever served is 139,416 (Figure 12). The state with the largest population is Queensland (41,323), followed by New South Wales (37,085) and Victoria (21,597). The LGA with the most male veterans in this group is Brisbane (10,414), followed by the Australian Capital Territory (7,881) and Townsville (6,308).

Figure 12: Distribution of male veterans within at-risk age group (18-49) who have ever served in the ADF by LGA




It is important to note that there are generally few differences in the spatial patterns of female versus male at-risk veteran populations. However, two notable differences in gender balance can be seen when two of the LGAs (Brisbane and the Australian Capital Territory) that have high at-risk populations are compared. The Brisbane LGA has a notably greater number of males (81%) when compared with the Australian Capital Territory (75%). To place these values in context, the total at-risk population identified in this study who have ever served is 80.4% male. As a percentage, these differences may not appear substantial, but it is a signal that proportionally there are substantially more females in the at-risk population in the Australian Capital Territory (3:1 male to female) when compared with Queensland (4:1 male to female).

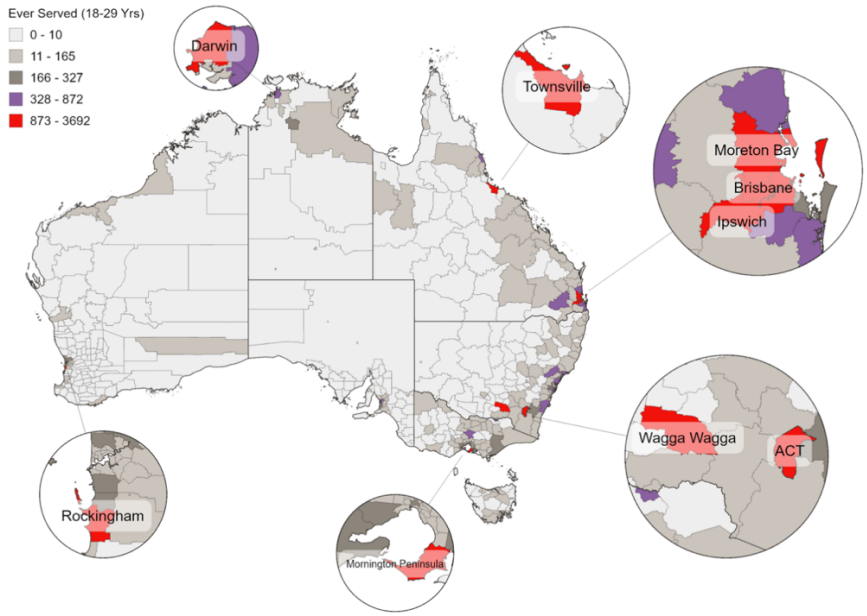
### *Veteran population by at-risk age sub-group*

#### *18-29 Years*

There are 45,593 veterans aged 18-29 years who have ever served in the ADF (Figure 13). The state with the largest number in this younger age group is Queensland (13,727), followed by New South Wales (12,487), and then Victoria (6,438) (Figure 13). The LGA with the most veterans in this age group is Brisbane (3,692), with a similar number in Townsville (3,449).

The top 10 LGAs for this younger group include parts of the country that do not feature in the top 10 LGAs for older age groups. This includes the Wagga Wagga and Mornington Peninsula LGAs. Another notable difference in geographic distribution is that compared to older veterans, the dominance of LGAs of southeast QLD is reduced, with only three LGAs from this region (Moreton Bay, Brisbane, Ipswich) in the top 10.

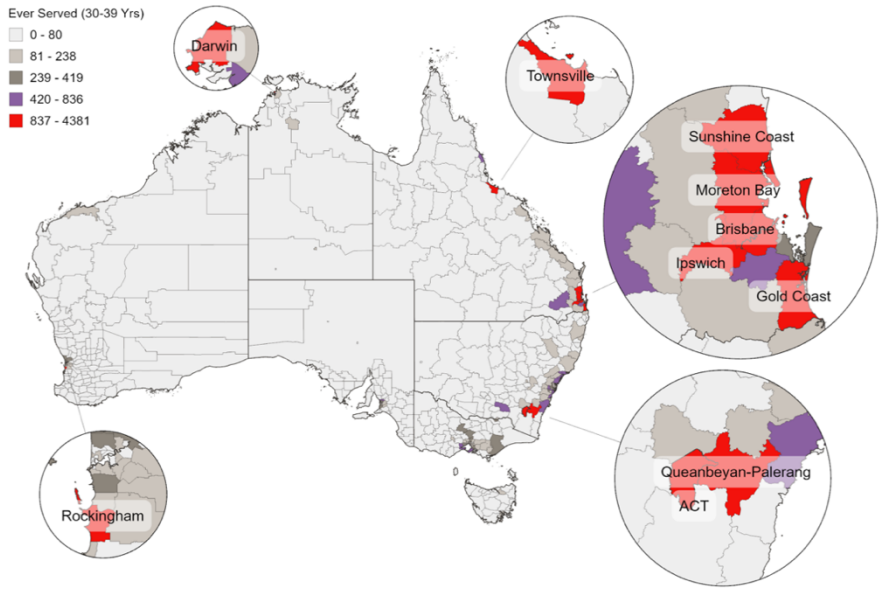
Figure 13: Distribution of ADF members who have ever served aged 18-29




### *30-39 Years*

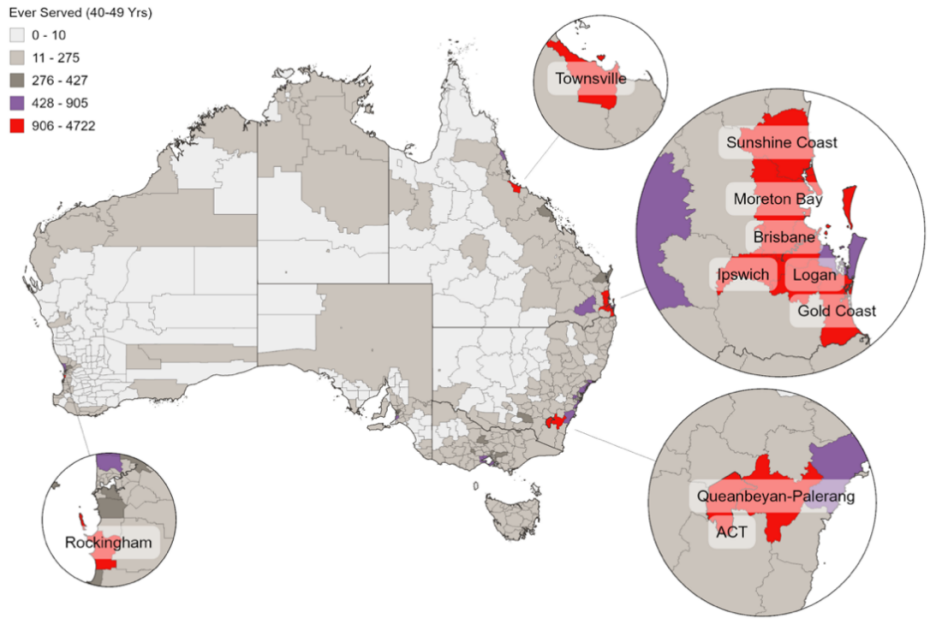
There are 60,196 veterans aged 30-39 years who have ever served in the ADF (Figure 14). The state with the most veterans in this group is Queensland (17,556), followed by New South Wales (16,654), and then Victoria (8,884), The LGA with the most veterans in this group is Brisbane (4,381), with the next largest group located in the Australian Capital Territory LGA (3,486). No Victorian LGAs are in the top 10 most populated area for this age group, whereas half of the top 10 LGAs for this sub-group are located in southeast Queensland (Sunshine Coast, Moreton Bay, Brisbane, Ipswich, Gold Coast). These LGAs have large population centres that are not significantly separated from one another, located in the fastest growing region in Australia.

Figure 14: Distribution of ADF members who have ever served aged 30-39



There are 67,637 veterans aged 40-49 who have ever served in the ADF (Figure 15). The state with the largest number in this older age group is Queensland (20,114), followed by New South Wales (16,739), and Victoria (10,935). The LGA with the most veterans in this age group is Brisbane (4,722), while the LGA with the next largest population is the Australian Capital Territory (4,023). For this older age sub-group, the LGA of Darwin is no longer in the top 10 most populated regions, and instead, the LGA of Queanbeyan-Palerang (bordering the at-risk veteran population hotspot of the Australian Capital Territory) is included in the most populated LGAs by this sub-group. The geographic concentration of at-risk veterans in southeast Queensland LGAs continues with this age group, with an additional LGA in this region (Logan) included in the top 10. These six LGAs in southeast Queensland contain just over 20% of all at-risk veterans in this age group.

Figure 15: Distribution of ADF members who have ever served aged 40-49




## 4.4. GEOGRAPHIC DISTRIBUTION OF PROGRAM ACCESS OPPORTUNITIES

***Program access opportunities for veterans within the at-risk age group***

The analysis of the geographic distribution of suicide prevention and postvention programs reveals that there are 1,989 records of programs available to be accessed in LGAs located across Australia. We refer to each of these instances as a unique program access opportunity in an LGA.

The number of unique program access opportunities (1,989) is larger than the number of unique program sites/service areas identified in the environmental scan (499). This is mainly because the service areas identified in Pillar 1 often span multiple LGAs. The *StandBy Support After Suicide* program illustrates this point. *StandBy* is a single program being provided in all 31 Primary Health Network areas nationally. At the LGA level, these 31 unique service areas encompass all 566 LGAs in Australia. As it is possible for individuals living in each of these LGAs to access the *StandBy* program, this equates to 566 unique access opportunities. While no other identified programs display this breadth of reach, it is common for programs to be offered in larger spatial regions encompassing multiple LGA areas, such as Local Health Districts (NSW) or Health and Hospital Catchment areas (QLD) resulting in similar differences between unique sites/service areas and unique program access opportunities at the LGA level.

Other scenarios can also shape the opportunities to access a particular program within an LGA. For instance, a single program may be offered in multiple physical locations within an LGA. In some instances, programs not offered in-person at a particular LGA may instead be accessed remotely by individuals engaging with providers based in a different LGA (e.g., via phone, internet). A focus on program access opportunities at the LGA level enables such scenarios to be modelled as accurately as possible with the available data.

The analysis excludes 81 programs that are only accessible online or via phone, or which operate nationally without a location. In all cases these programs have no mappable location of access. These were most often prevention programs (47, 58%) and programs focused on training (35, 43%). Such are typically accessible from any location, including LGAs with no other access opportunities.

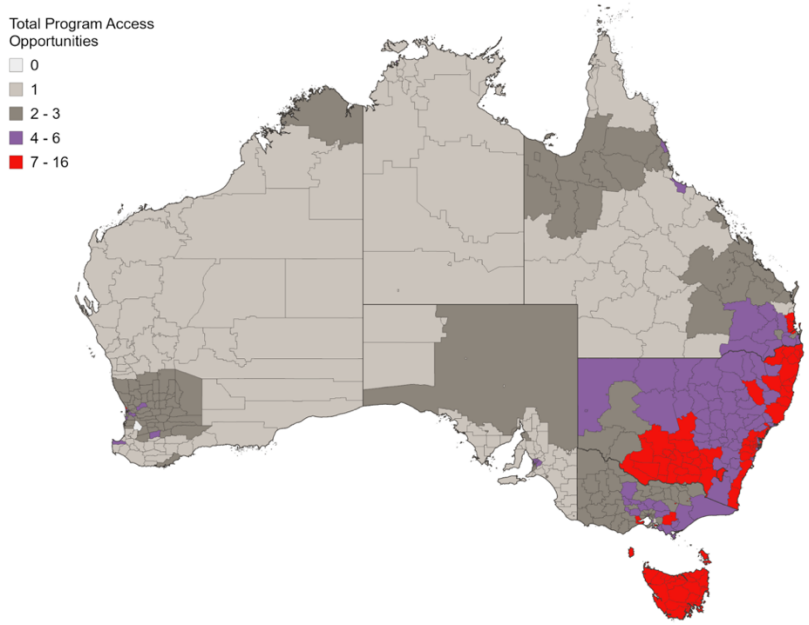
***Geographic distribution and spatial patterns, all program types***

New South Wales has the largest number of identified program access opportunities (866, 44%), followed by Queensland (181, 9%) and Western Australia (141, 7%). Fewer access opportunities were available to residents in Victorian LGAs (82, 4%), in South Australia (72, 4%), Tasmania (52, 3%) and the Northern Territory (23, 1%). The LGAs with the greatest number of opportunities available are Sydney (16) and Parramatta (15), both being in the Greater Sydney region. The spatial distribution of LGAs with high numbers of access opportunities (seven or more) is very uneven, with nine of the top 10 LGAs for opportunities located in one state, New South Wales. The relatively high number of program access opportunities in New South Wales means every LGA in the state has three or more available.

Several drivers of this concentration of access opportunities in NSW were noted in the Pillar 1 findings. These include the larger number of sites/service areas for programs such as *The Men's Table*, *The Way Back Support Service*, and the *Suicide Prevention Initiative*, as well as initiatives stemming from the NSW Government's *Towards Zero Suicides* strategic policy framework, such as the establishment of *Safe Havens* and *Suicide Prevention Outreach Program* (*SPOT*) locations across the state.

There are 163 LGAs in Australia where only one access opportunity (of any type) is available (shaded light grey in Figure 16). The single physically accessible program in these areas will typically be *StandBy Support After Suicide*, a national postvention program. These lower-resourced LGAs are largely located in non-urban and remote parts of Western Australia, Northern Territory, South Australia and Queensland (Figure 16).

Figure 16: Distribution of total unique program access opportunities by LGA

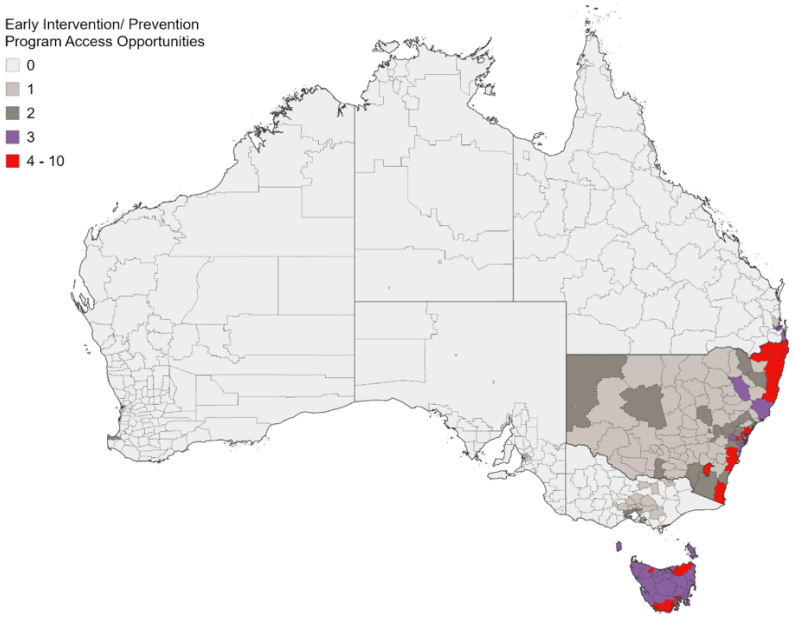


### *Early intervention and prevention*

Across Australia, there are 453 identified early intervention and prevention program access opportunities across 215 LGAs (Figure 17). Early intervention or prevention program access opportunities are largely concentrated in LGAs in New South Wales, with 61% of opportunities (279 out of 453) located in this state. Mapping of these opportunities shows that Tasmania has extensive state-wide coverage, with every LGA in the state containing three or more program access opportunities. In contrast, in Queensland, the opportunity to access an early intervention or prevention program is listed in just four LGAs (three in the southeast corner of the state, and one in Cairns, leaving most of the state's LGAs with no opportunities for these types of programs). The remaining states similarly have very few LGAs with opportunities (nine for South Australia, seven for Western Australia, and just one LGA in the Northern Territory, Darwin).

The LGAs with the greatest number of access opportunities available are Sydney (10) and Parramatta (7), both being in the Greater Sydney region of New South Wales. The distribution of LGAs with good availability of access opportunities (four or more) is highly uneven, with all the top 10 LGAs located in New South Wales. For most of Australia (311 LGAs), there are no early intervention or prevention program access opportunities (see regions shaded light grey in Figure 17). However, as noted above, early intervention and prevention programs were among the likeliest program types to be administered in an online-only format.

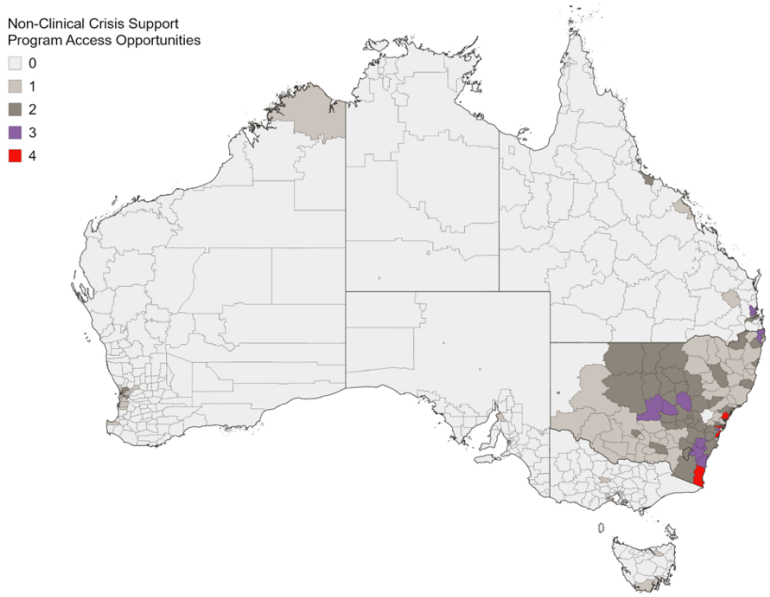
Figure 17: Distribution of early intervention and prevention program access opportunities by LGA




### *Non-clinical crisis support*

Figure 18 shows the distribution of 273 identified non-clinical crisis support access opportunities across 176 LGAs. Opportunities to access non-clinical crisis support programs are largely restricted to LGAs in New South Wales (202 opportunities). The LGAs with the greatest number of non-clinical crisis support program access opportunities available (four opportunities) are in the Greater Sydney region of New South Wales (Sydney, Bega Valley, Central Coast, Canterbury-Bankstown, Wollongong and Liverpool). The spatial distribution of LGAs with good availability of program access opportunities (four opportunities) is highly uneven, with the top 16 LGAs located in one state, New South Wales. For most of Australia (370 LGAs), there are no non-clinical crisis support program access opportunities (see regions shaded light grey in Figure 18). For these areas, access may be limited to online or phone-based programs (e.g., such as crisis support hotlines).

Figure 18: Distribution of non-clinical crisis support program access opportunities by LGA



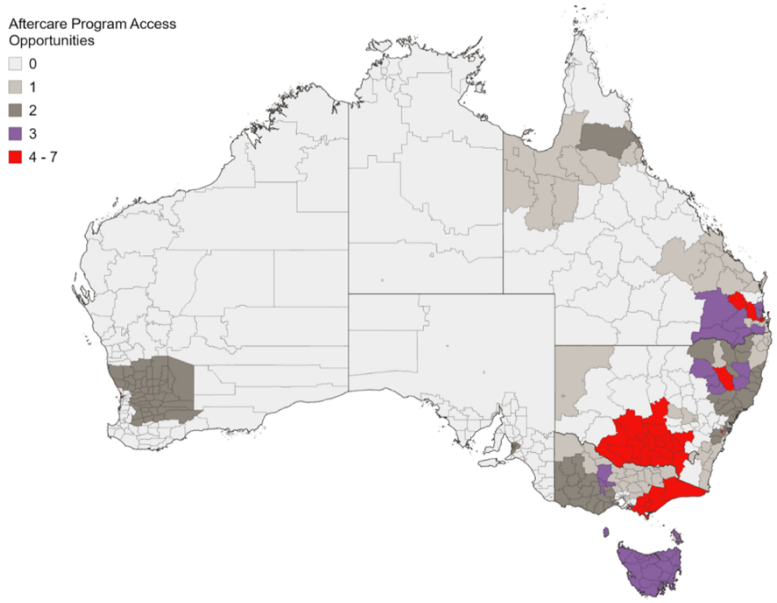

### *Aftercare*

Figure 19 shows the distribution of 599 identified aftercare program access opportunities across 283 LGAs. These opportunities are largely concentrated in LGAs in the eastern states. Tasmania has extensive coverage with every LGA in the state containing three different program access opportunities. In the Northern Territory there are no identified aftercare program access opportunities. While most other program types are concentrated in urban areas and more populated regions, a large multi-LGA region exists in Western Australia with aftercare program access opportunities, meaning the state has 44 LGAs that each feature two opportunities to access aftercare programs.

Unlike other program types, aftercare programs are most common outside major capital cities and urban areas. The top 10 LGAs for aftercare program access opportunities are outside major urban centres and state and territory capitals. The LGAs with the greatest number of aftercare program access opportunities available are Camden (5), Tamworth (5) and Wagga Wagga (5) in New South Wales and Joondalup (5) in Western Australia.

For many parts of Australia (273 LGAs), there are no aftercare program access opportunities available (see regions shaded light grey in Figure 19). In these areas, there appear to be few if any remote (online or phone-based) aftercare programs available to mitigate this lack of access.

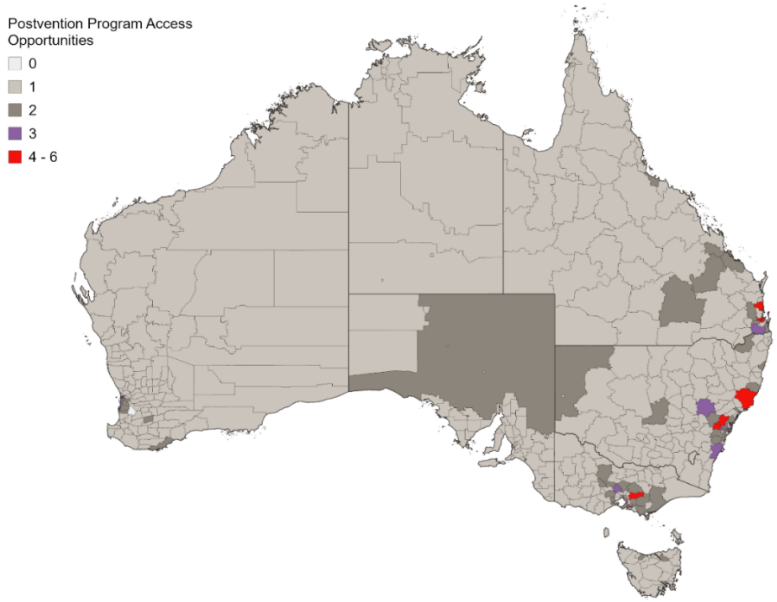
Figure 19: Distribution of aftercare program access opportunities by LGA




### *Postvention*

Figure 20 displays the distribution of 664 identified postvention program access opportunities across all LGAs. Opportunities to access a postvention program are located in every LGA, primarily due to the national coverage of the *StandBy Support After Suicide* program. LGAs with three or more postvention program access opportunities are concentrated in the eastern states. The LGAs with the greatest number of postvention program access opportunities available (between 4 and 6 per LGA) are in New South Wales (3 LGAs), Victoria (3 LGAs) and Queensland (2 LGAs). The top 10 LGAs for postvention program access opportunities are typically in or close to capital cities and major urban centres in Queensland, New South Wales and Victoria. The LGAs with the greatest number of postvention access opportunities available are Yarra (6) and Yarra Ranges (4) LGAs, the Blue Mountains (4), Hawkesbury (4) and Camden (4) LGAs on the outskirts of Sydney, and the Brisbane (4) and Sunshine Coast (4) LGAs in southeast Queensland.

Figure 20: Distribution of postvention program access opportunities by LGA



## 4.5. ACCESSIBILITY OF PROGRAMS TO VETERANS WITHIN THE AT-RISK AGE GROUP

Accessibility to health services is commonly measured using provider-to-population ratios (PPRs). The PPR is the ratio of health services (or workers) to population requiring the service, for a defined geographical area[9]. To measure accessibility to programs at the LGA-level across Australia, a PPR-related metric (the number of at-risk veterans in an LGA per program access opportunity) was determined. This measure is the inverse of the traditional PPR measure of accessibility and allows us to consider the potential demand on programs available within an LGA. High values show LGAs where the number of at-risk veterans is high relative to the number of access opportunities available to them.

The analyses include a focus on the ten LGAs with the most at-risk veterans per program access opportunity. These are regions with the fewest opportunities per at-risk veteran – one indicator of low accessibility at the LGA level. Each of the program type maps in this section also indicate LGAs in which there are at least 100 or more at-risk veterans located but no opportunities to access programs. These program accessibility 'blackspots', which are shaded in black, are discussed at the end of this section.

Figure 21 shows that the accessibility of programs across Australia features large spatial inequalities. The ratio of at-risk veterans to access opportunities at the LGA level varies from 1,968 to low single digits, with an average value for all LGAs in Australia of 91 (that is, on average, there are 91 veterans in the at-risk age group per program access opportunity of any type). The LGA with the highest ratio of at-risk veterans to access opportunities of any type is Townsville (1,968). Here, there are 7,871 veterans in the at-risk age group and four program access opportunities available to them.

Regions that have the greatest potential demand on program opportunities (see Table 9) are typically those same regions that have high at-risk populations (such as the Townsville, Australian Capital Territory and Brisbane LGAs). However, there are also regions that have relatively lower at-risk populations, but high population-to-program opportunity ratios, such as the Litchfield, Casey and Palmerston LGAs. In the case of Casey, situated on the outskirts of Melbourne, and the neighbouring LGA of Mornington Peninsular, there are two adjacent LGAs with relatively high at-risk populations (971 and 924, respectively), but Casey has only one program access opportunity listed for the LGA, compared with two in Mornington Peninsula, leaving the Casey LGA with a much higher population-to-program opportunity ratio.

Outside of the 10 LGAs with the highest ratios, it should be noted that LGAs adjacent to these also tend to record high ratios (shaded purple in Figure 21). The LGAs north and south of the Brisbane and Logan LGAs in southeast Queensland exemplify this. When considered together, these constitute a large region of multiple LGAs that are either in the top 10 for low accessibility or in the next band of the classification.

[9] Australian Government (2024) District of Workforce Shortage, Department of Health and Aged Care.

Figure 21. Ratio of at-risk veteran population to all program access opportunities by LGA

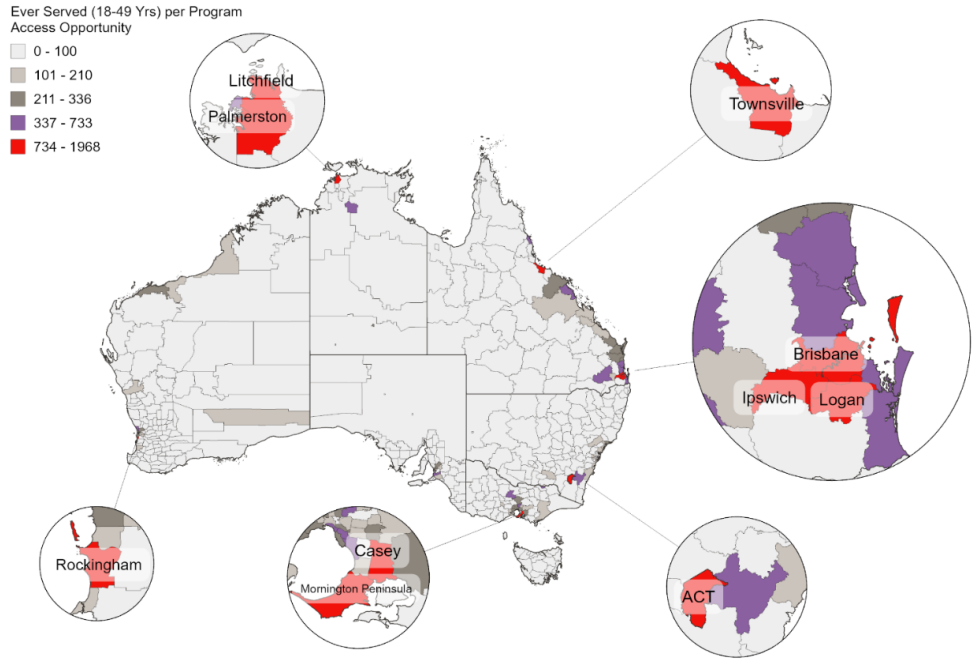



Table 9: The top 10 LGAs for at-risk veteran population per program opportunity for all program types

| Top LGA | LGA Name | Ratio | Ever served (n) | Opportunities (n) |
|---|---|---|---|---|
| 1 | Townsville | 1,968 | 7,871 | 4 |
| 2 | Australian Capital Territory | 1,317 | 10,534 | 8 |
| 3 | Brisbane | 984 | 12,791 | 13 |
| 4 | Casey | 971 | 971 | 1 |
| 5 | Logan | 958 | 1,915 | 2 |
| 6 | Ipswich | 948 | 4,741 | 5 |
| 7 | Mornington Peninsula | 924 | 1,848 | 2 |
| 8 | Litchfield | 862 | 862 | 1 |
| 9 | Rockingham | 856 | 3,423 | 4 |
| 10 | Palmerston | 734 | 1,468 | 2 |

### *Accessibility of early intervention and prevention programs*

Figure 22 shows that access to early intervention and prevention programs is unevenly distributed across Australia. Regions that have the greatest potential demand on program access opportunities (see Table 10) tend to be those same regions with high at-risk veteran populations (for example, Brisbane, Australian Capital Territory, Darwin, Cairns). However, four of the 10 LGAs also have relatively lower at-risk populations (under 1,500 veterans), but high population-to-program opportunity ratios, such as the Moreton Bay, Wagga Wagga, Port Stephens, Salisbury and Wodonga LGAs. These LGAs are especially important to note, because each of these have only one early intervention or prevention program access opportunity available for over 1,300 at-risk veterans in their LGA. The Moreton Bay LGA has the highest ratio in this category (5,617 at-risk veterans per program opportunity), but it should be noted that this LGA is adjacent to other LGAs with greater access opportunities. The fact that early intervention and prevention programs are likelier than other program types to be delivered remotely may help to mitigate against some of the accessibility issues identified here.

Figure 22: The ratio of at-risk population to early intervention and prevention program access opportunities by LGA

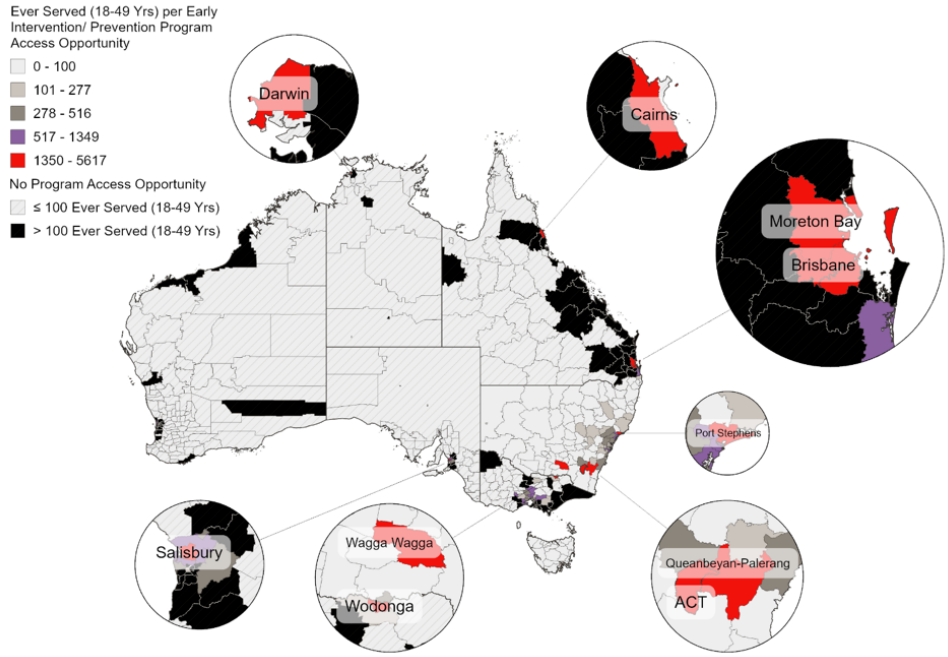



Table 10: The top 10 LGAs for at-risk veteran population per early intervention and prevention program access opportunity

| Top LGA | LGA Name | Ratio | Ever served (n) | Opportunities (n) |
|---|---|---|---|---|
| 1 | Moreton Bay | 5,617 | 5,617 | 1 |
| 2 | Brisbane | 4,264 | 12,791 | 3 |
| 3 | Darwin | 2,354 | 2,354 | 1 |
| 4 | Cairns | 2,121 | 2,121 | 1 |
| 5 | Australian Capital Territory | 2,107 | 10,534 | 5 |
| 6 | Queanbeyan-Palerang | 2,060 | 2,060 | 1 |
| 7 | Wagga Wagga | 1,688 | 1,688 | 1 |
| 8 | Port Stephens | 1,441 | 1,441 | 1 |
| 9 | Salisbury | 1,418 | 1,418 | 1 |
| 10 | Wodonga | 1,350 | 1,350 | 1 |

### *Accessibility of non-clinical crisis support programs*

Figure 23 shows the uneven spatial distribution of access to non-clinical crisis support programs in Australia. Regions that have the greatest potential demand on program access opportunities (see Table 11) are typically those same regions that have high at-risk populations (for example, Brisbane, Australian Capital Territory, Townsville, Darwin). However, four of these top 10 LGAs have relatively lower at-risk populations (under 2,000 veterans), but high population-to-program opportunity ratios, such as the Moreton Bay, Sutherland, Port Stephens, Salisbury and Wodonga LGAs. We note that Moreton Bay and Port Stephens LGAs were also in the top 10 LGAs for low access to early intervention and prevention program opportunities.

These LGAs are noteworthy because each of these areas has only one opportunity to access a non-clinical crisis support program for over 1,300 at-risk veterans. As noted previously, the Moreton Bay LGA is adjacent to several other LGAs with greater access opportunities. However, the regions of Wagga Wagga and

Salisbury (one program access opportunity each) are surrounded by areas with few or no other access opportunities, leaving at-risk veterans potentially geographically isolated (compared with at-risk veterans in or near capital cities and other larger urban centres where additional access may be located in adjacent LGAs).

Figure 23: Ratio of at-risk veteran population age group to non-clinical crisis support access opportunities by LGA

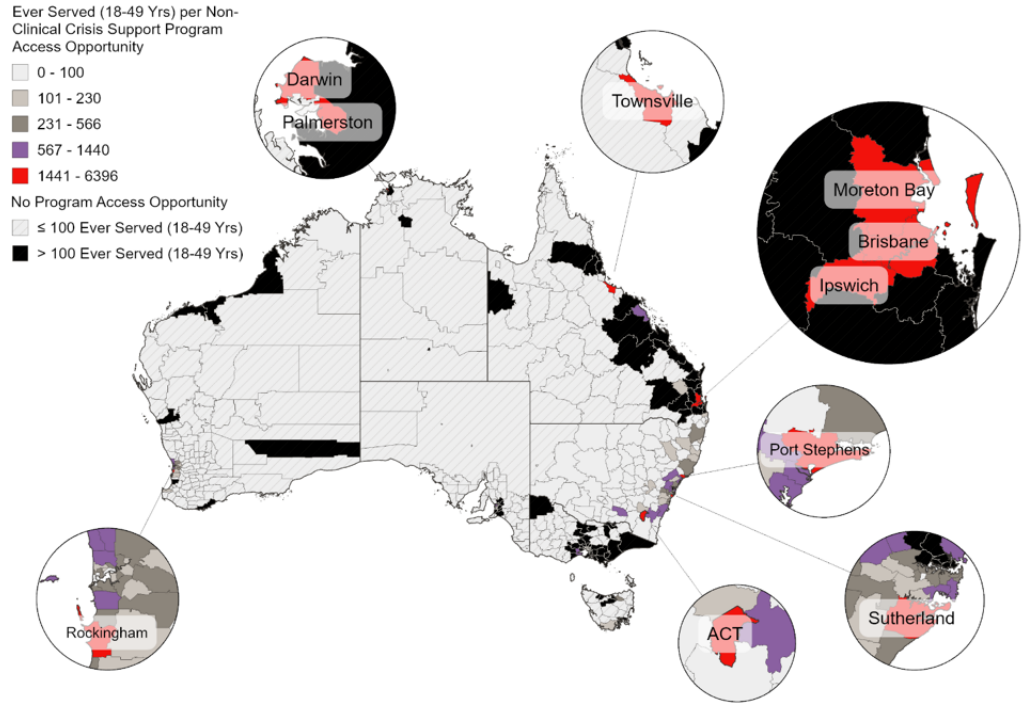



Table 11: The top 10 LGAs for at-risk veteran population per non-clinical crisis support program access opportunity

| Top LGA | LGA Name | Ratio | Ever served (n) | Opportunities (n) |
|---|---|---|---|---|
| 1 | Brisbane | 6,396 | 12,791 | 2 |
| 2 | Australian Capital Territory | 5,267 | 10,534 | 2 |
| 3 | Townsville | 3,936 | 7,871 | 2 |
| 4 | Rockingham | 3,423 | 3,423 | 1 |
| 5 | Ipswich | 2,370 | 4,741 | 2 |
| 6 | Darwin | 2,354 | 2,354 | 1 |
| 7 | Moreton Bay | 1,872 | 5,617 | 3 |
| 8 | Sutherland | 1,551 | 1,551 | 1 |
| 9 | Palmerston | 1,468 | 1,468 | 1 |
| 10 | Port Stephens | 1,441 | 1,441 | 1 |

### *Accessibility of aftercare programs*

Figure 24 shows that access to aftercare programs in Australia is unevenly distributed, with areas that have such opportunities primarily located in eastern Australia. Regions that have the greatest potential demand on such program opportunities (Table 12) are typically those same regions that have high at-risk populations (for example, Brisbane, Ipswich, Sydney, Australian Capital Territory). However, three of the top 10 LGAs have relatively lower at-risk populations (under 2,000 persons), but high population-to-program opportunity ratios, such as the Logan, Moreton Bay and Sutherland LGAs. We note that Moreton Bay and Port Stephens LGAs were also in the top 10 LGAs for low access to other types of program opportunities.

These are LGAs in which there is access to one identified aftercare program for over 1,500 at-risk veterans in the LGA. As noted previously, the Moreton Bay LGA is adjacent to LGAs with greater access opportunities. This is also the case for the Sutherland LGA, situated on the southern border of the Sydney LGA, but in this case, both Sutherland and Sydney have only one listed aftercare program each – across both LGAs, there are 3,605 at-risk veterans.

The Australian Capital Territory LGA has an exceptionally high ratio (10,534) reported for this program type, the highest recorded for any program type, suggesting very low availability and access to identified aftercare programs. The LGA with the fifth highest ratio for this category (Queanbeyan-Palerang) is adjacent to the Australian Capital Territory LGA, but also has only one aftercare program access opportunity for its at-risk population of 2,060 veterans. Similarly, this access issue persists further north to the next adjacent LGA, Shoalhaven (with the seventh highest ratio for this category), creating a very large region of high at-risk population with relatively limited access to aftercare services. Compounding this issue is the existence of adjacent LGAs to the south of the Australian Capital Territory that have no aftercare programs, meaning that at-risk populations cannot easily locate possible support in an adjacent LGA.

Figure 24: Ratio of at-risk veteran population to aftercare program access opportunities by LGA

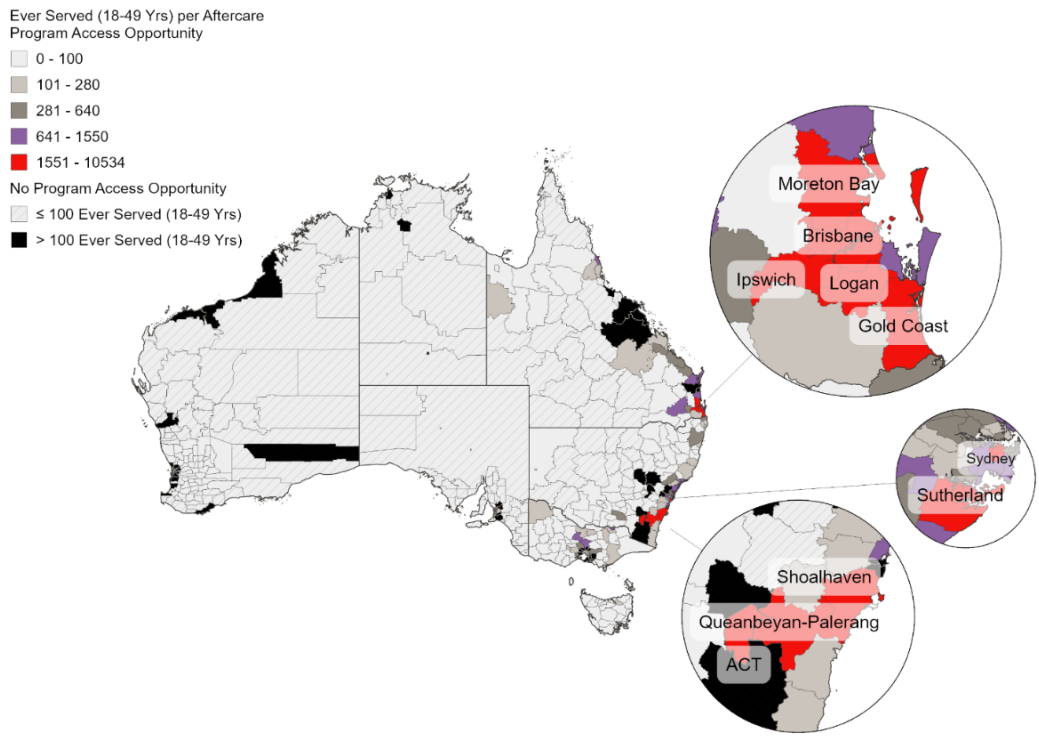


Table 12: The top 10 LGAs for at-risk veteran population per aftercare program access opportunity

| Top LGA | LGA Name | Ratio | Ever served (n) | Opportunities (n) |
|---|---|---|---|---|
| 1 | Australian Capital Territory | 10,534 | 10,534 | 1 |
| 2 | Ipswich | 4,741 | 4,741 | 1 |
| 3 | Gold Coast | 3,602 | 3,602 | 1 |
| 4 | Brisbane | 3,198 | 12,791 | 4 |
| 5 | Queanbeyan-Palerang | 2,060 | 2,060 | 1 |
| 6 | Sydney | 2,054 | 2,054 | 1 |
| 7 | Shoalhaven | 2,027 | 2,027 | 1 |
| 8 | Logan | 1,915 | 1,915 | 1 |
| 9 | Moreton Bay | 1,872 | 5,617 | 3 |
| 10 | Sutherland | 1,551 | 1,551 | 1 |

### *Accessibility of postvention programs*

Figure 25 shows that access to postvention programs across Australia is uneven, with opportunities to access such programs located primarily in eastern Australia. Regions with the greatest potential demand on such program opportunities (see Table 13) tend to be the same regions with high at-risk populations (for example, Brisbane, Ipswich, Sydney, Australian Capital Territory). Seven of the top 10 LGAs with the highest ratios of at-risk population to access opportunities are located in Queensland, with five located in southeast Queensland. This is an especially tightly constrained concentration of LGAs which (collectively) have the lowest levels of accessibility, per population, to postvention programs.

As with accessibility to aftercare program opportunities, the Australian Capital Territory LGA has an exceptionally high ratio (10,534) reported for postvention programs, the highest for any program type, suggesting insufficient availability and access for postvention programs. The LGA with the seventh highest ratio in this category (Queanbeyan-Palerang) is adjacent to the Australian Capital Territory LGA, but also has only one postvention program accessible to its at-risk population of 2,060 veterans.

Figure 25: Ratio of at-risk veteran population to postvention program access opportunities by LGA

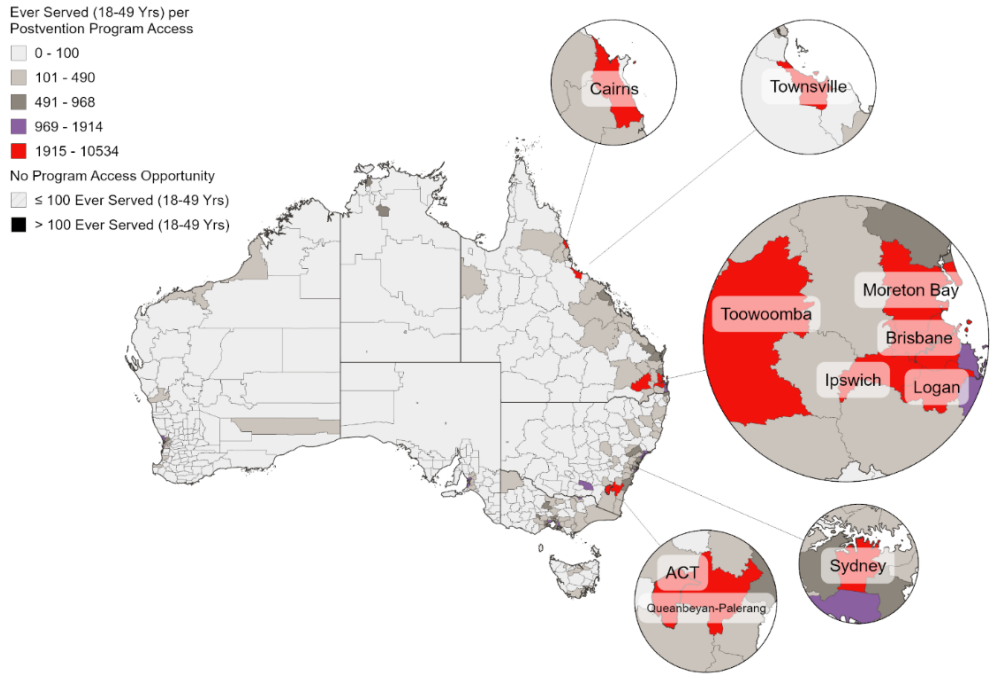



Table 13: The top 10 LGAs for at-risk veteran population per postvention program access opportunity

| Top LGA | LGA Name | Ratio | Ever served (n) | Opportunities (n) |
|---|---|---|---|---|
| 1 | Australian Capital Territory | 10,534 | 10,534 | 1 |
| 2 | Moreton Bay | 5,617 | 5,617 | 1 |
| 3 | Townsville | 3,936 | 7,871 | 2 |
| 4 | Brisbane | 3,198 | 12,791 | 4 |
| 5 | Ipswich | 2,370 | 4,741 | 2 |
| 6 | Cairns | 2,121 | 2,121 | 1 |
| 7 | Queanbeyan-Palerang | 2,060 | 2,060 | 1 |
| 8 | Sydney | 2,054 | 2,054 | 1 |
| 9 | Toowoomba | 1,922 | 1,922 | 1 |
| 10 | Logan | 1,915 | 1,915 | 1 |

### *Suicide prevention and postvention accessibility blackspots across Australia*

The geospatial analysis of the at-risk veteran population and suicide prevention and postvention programs also identified LGAs across Australia in which no program access opportunities are located, despite containing at least 100 or more at-risk veterans. These areas are shaded black on the above maps in Figures 21-24. These LGAs (and multi-LGA regions) can be described as accessibility blackspots with respect to the availability of particular program access opportunities. While the focus on ratios in Tables 9-13 illustrates accessibility issues in areas where programs are located, examining the numbers of at-risk veterans located in accessibility blackspots is equally important for addressing potential gaps in program accessibility.

Our findings on these accessibility blackspots are:

1. There are 97 LGAs (17% of all LGAs) across Australia that have 100 or more at-risk veterans (18-49 years) where there are no identified early intervention program access opportunities (Figure 22, Table 10). The Townsville LGA has the highest at-risk population (7,871) with no early intervention program access opportunities.
2. There are 124 LGAs (22% of all LGAs) across Australia that have 100 or more at-risk veterans (18-49 years) where there are no non-clinical crisis support program access opportunities (Figure 23, Table 11). The Gold Coast LGA has the highest at-risk population (3,602) with no identified non-clinical crisis support program access opportunities.
3. There are 91 LGAs (16% of all LGAs) across Australia that have 100 or more at-risk veterans (18-49 years) where there are no identified aftercare program access opportunities (Figure 24, Table 12). The Townsville LGA has the highest at-risk population (7,871) with no identified aftercare program access opportunities.
4. It is imperative to highlight that there are some LGAs with 100 or more at-risk persons that do not have identified access opportunities for any of the three program types above and are in regions that are geographically very isolated, such as Alice Springs. There are also, notably, LGAs with very high at-risk populations that do not have identified access opportunities to multiple program types, such as Townsville.

# 5. Provider Consultations

## 5.1. OVERVIEW

The final stage of the project involved consulting with providers of suicide prevention and postvention programs to better understand the use of their services by veterans and their families.

This involved undertaking interviews with selected providers and conducting a broader email survey.

## 5.2. CONSULTATION PROCESS

### *Provider interviews*

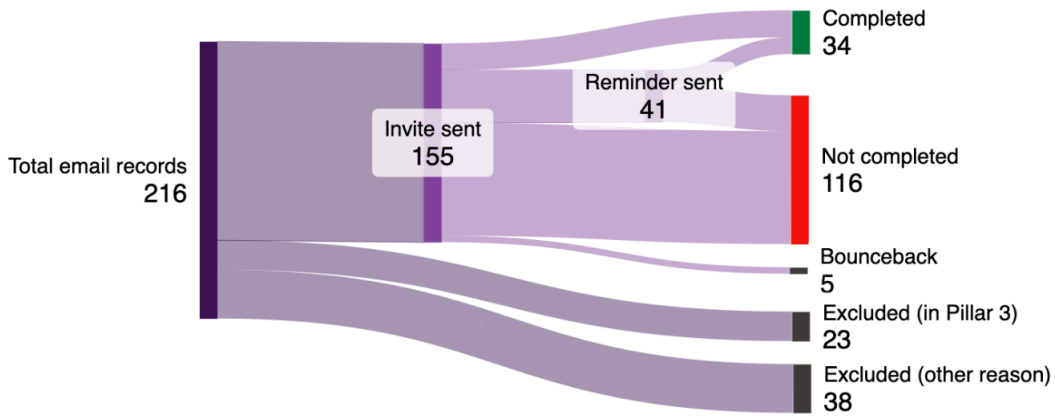
Seventeen service providers were approached for an interview. Although they were from across Australia, those operating in geographical areas with higher numbers of veterans were prioritised for inclusion. Twelve service providers agreed to be interviewed. Interviewees typically included CEOs, project managers, or research officers. A breakdown of those interviewed is provided in Appendix D. Interviews were undertaken via online conferencing and lasted for approximately one hour.

### *Email survey*

An email survey was sent to 155 unique service provider email addresses which were collected during the environmental scan. It requested a response to four questions related to those addressed in the interviews. A total of 34 responses were received via email (see breakdown of email respondents in Appendix E).

Figure 26 summarises the Pillar 4 email fieldwork and outcomes. An attempt was made to send the email survey to each program site or service area in which a service provider operates a program, providing an opportunity to gather insights about service delivery that are localised to these specific sites or areas. However, in many instances there was only one 'generic' email address that could be used to contact organisations operating a program in multiple sites or areas. Cases were excluded if the provider was already being approached as part of the Pillar 3 interview fieldwork, or for other reasons, such as the only identified contact method being a website enquiry form or an email address designated for patients or service users.

Figure 26: Pillar 4 email fieldwork and outcomes



## 5.3. ANALYSIS OF CONSULTATION DATA

Data from the interviews and email consultations were combined into one dataset and thematically coded.

## 5.4. CONSULTATION FINDINGS

***Veteran identification***

Many service provider respondents reported that their organisations had no formal processes for identifying members of the veteran community. Crisis support helplines including those offered by SAMSN, Lifeline, and Roses in the Ocean reported recording veteran status if voluntarily disclosed. Alternatively, it was possible that a client's status as a veteran might be relayed via a third party as part of a handover process (e.g., through emergency services or a clinical referral pathway). Furthermore, a Queensland-based *StandBy* program provider reported that the new Primary Health Network's *HealthPathways* identification process had led to more reporting. However, a view strongly held by many respondents was that any disclosure of veteran status should be voluntary and that it was important for the client to choose what information they would share and when.

It was also observed that veterans often preferred programs where disclosure was not required. As the BrookRED representative explained, veterans preferred having the anonymity to participate without repercussion or stereotyping. Programs like BrookRED's *Alternatives to Suicide* were smaller in scale and had minimal paperwork requirements, which made them more attractive to veterans than other programs run by the organisation.

> *A lot of our people don't want to fill out paperwork, don't want anyone knowing that they're accessing that sort of a service... a number of the people that attend fairly regularly have identified that they're from the veteran community.*

The goal was to give clients control and allow them to enter, leave, repeat, or move between programs as they wished. This was thought to be essential to a person-centred approach and one of the distinguishing features of non-clinical programs. If disclosure of this information was required, it was felt that people might be less willing to engage with the service, and service providers would potentially lose clients who were in need. As a representative from Roses in the Ocean explained:

> *If we start capturing all that information, we'll probably get a group of people who won't access the service anymore.*

***Veteran client prevalence***

The lack of formal data collection on a client's veteran status meant that most service providers could not accurately report the prevalence of veterans using their services. From the organisations consulted, Lifeline had the clearest sense of the prevalence of their veteran clients (i.e., accessing their helpline service):

> *A disproportionate number of contacts from veterans and their families - or from people with military background - and their families...around about four or five percent of our calls are from that cohort.*

For most other programs, there was only anecdotal and informal information available that suggested while veterans would access their services, the frequency was low (e.g., less than five program enrolments within a calendar year). The only exceptions were Darwin's *Medicare Mental Health Centre (MMHC)* and a Brisbane-based *StandBy* program provider who described veterans' program attendance as "regular" or "often". It should be noted, however, that providers operated in areas containing higher numbers of at-risk veterans as identified in Section 4 and there was no indication that the rate of veteran self-disclosure was higher for these providers. Instead, the larger overall volume of veteran clients in these areas simply increased the number of clients who disclosed their veteran status.

***Perceived alignment with veteran needs***

The organisations consulted typically noted that their programs could be accessed by anyone who wished to engage with them, with multiple respondents saying that they subscribed to a "no wrong door" approach. The belief was that a suicide-focused program could meet the needs of a veteran client even if that program was not specifically veteran-focused. As one respondent explained:

> *We don't claim to be experts on the unique experiences of veterans, just as we don't claim to be experts on the experiences of other groups. But we are extremely knowledgeable when it comes to the impacts of suicide and how to support people who are impacted by suicide.*

Instead, their practices were informed by approaches most appropriate for suicide prevention and postvention such as trauma-informed interventions (Beam Health), an emphasis on lived experience (Blue Mountains Safe Space, Selectability) and peer-led interventions (Lifeline Mid-Coast). It was considered important that experienced staff adapt to the unique needs of their clients through, what LivingWorks described as, "unfolding the wisdom in the room". This referred to the higher impact of lived experience of program participants and facilitators compared to demographic-specific knowledge. For example, the Roses in the Ocean representative explained the benefits of having staff with a lived experience of suicide:

> *All of our organisation have a lived experience [of suicide] from our CEO, right through to our HR, finance. Our recruitment [process] is that people come with a lived experience to understand the work that we're doing.*

Some respondents felt that veterans will avoid broader veteran support services and benefit from more "neutral support" (MMHC) rather than approaching an organisation that could be linked to the ADF. A respondent from Lifeline observed that a formal connection to Defence or a Defence-affiliated organisation could itself be a barrier to access for some veterans. This respondent noted that a service's independence was particularly valued by veteran clients:

> *There is value to some people with military backgrounds in accessing a service that does not have any ties to the ADF.... I know that for a lot of people, the fact that we do have that perceived independence is one of the issues that, I guess, reduces barriers to engaging with us.*

As a gendered prevention program that deals with overarching mental health matters, The Men's Table explained how their clients often required the tools to understand the impact of trauma and to learn how to "listen" rather than "fix". As such, their program was a useful adjunct to other therapeutic interventions that address more veteran-specific needs. Similarly, Mentoring Men noted that many of their clients struggled with the same challenges often experienced by members of the veteran community such as "transitionary periods" of life and showing "vulnerability with emotional experiences", suggesting their approach could also work well for veterans.

Although respondents did not provide programs specifically tailored to veterans, many did report having experience in assisting veteran clients, and it was through this exposure that they had developed an understanding of some of the challenges veterans might face. Given that none of the programs discussed were veteran-exclusive, providers generally applied person-centred approaches with their veteran clientele, as with all their clients. It was typical for programs to address veterans' needs by focusing on their goals as a whole person rather than specifically as a veteran. As the representative from BrookRED explained, a veteran client might "unpack" aspects of their veteran experience while sharing their broader story in group programs:

> *For the folks who have talked about their experience serving, often they will talk about very positive things as well as challenges that they've had... But when people access our services, they're usually accessing with a mental health goal in place. And so you see them, they'll be talking about a broad raft of experiences that they have... but it's obviously interesting, the way that their lived experience is sort of tied in. Service can have been quite traumatic or also being a primary support network [for someone else] as well. So, it's just an interesting component to unpack.*

However, it was acknowledged that a veteran could potentially share more of their service-related history those who had a greater understanding of these experiences. For this reason, respondents expressed a wish to learn more about military culture and veteran experiences.

Some providers had also worked with Defence, DVA, or veteran-focused organisations such as Legacy, RSL, Mates4Mates, or Open Arms to assist with training in suicide prevention or postvention. For example, a respondent whose organisation offers the *StandBy* program said they are "pretty active in collaborating" with veteran organisations, citing workshops they had facilitated for Open Arms and Legacy on postvention planning. Also, LivingWorks referred to a recent series of workshops they had delivered in partnership with an RSL. While these collaborations are based more on capacity building than veteran-specific service delivery, these partnerships were viewed as a useful basis for knowledge-sharing.

Several organisations within the suicide prevention and postvention sector appear to play a lead role in assisting others to improve the quality of services for veterans. For instance, the Black Dog Institute, Lifeline, and Suicide Prevention Australia were mentioned often as sources of information on how to tailor services for veteran clients. The respondent from Roses in the Ocean also noted that they had collaborated with providers of the *StandBy* program to offer a lived-experience perspective, and that this sharing of knowledge was common.

There was also a strong focus on learning from international organisations that operate overseas. For example, two aftercare models – *ECLIPSE,* implemented locally by Lifeline Mid-Coast and *Alternatives to Suicide (Alt2Su)*, run by BrookRED – are both based on models from the United States. LivingWorks also actively sought to maintain veteran-specific best practices based on the international context. As well as referencing knowledge of programs in Canada, Norway, Singapore, Ireland, and Korea, this respondent spoke of two program implementations in the US and how they hoped to learn more about these.

***Barriers to service access***

*Shame*

Several respondents spoke of the intense shame associated with help-seeking or attempting suicide that appeared to be prevalent among veteran clients accessing their services. Some viewed these attitudes as associated, to some extent, with the organisational culture within Defence. Respondents pointed to the "cultural elements of showing toughness" (BrookRED), the "hyper-masculine environment" (SAMSN) and "soldier bravado" (LivingWorks) which are likely instilled in ADF members from early in their career. As a LivingWorks representative identified:

> *Everything in Defence is about being successful... your whole world is about achieving goals*

Certain providers noted that, because of this emphasis on strength, achievement, and success, former serving members may struggle with emotional awareness and vulnerability, with the potential to see it as a "sign of weakness to access…a service like this" (BrookRED). A *StandBy* program provider in Adelaide stated that veteran clients expressed ideas like "*I'm not supposed to have these feelings...that's a weakness and a problem*".

As the veteran community is typically close-knit, it was flagged that veteran clients may be concerned about their circumstances being shared amongst colleagues and peers. LivingWorks and MMHC also noted that serving members may be reluctant to connect with support services within Defence, or disclose their suicidality, for fear of possible repercussions in terms of their career and employment.

For instance, the respondent from MMHC observed that their veteran clients were hesitant to access Defence or veteran-focused services that might see them interact with colleagues:

> *It is common for veterans to disclose that they don't want to access veteran services. This may be because there are people running or accessing programs that they don't want to see, (prior senior officer etc.)... Not wanting veteran community to know their challenges. Younger service personnel report that accessing our service allows them to maintain their privacy and protect their career.*

More generally, the respondent from Lifeline felt that services which have a strong veteran focus "repelled" some potential clients:

> *We do know that there is value to some people with military backgrounds in accessing a service that does not have any ties to the ADF... the fact that we do have that perceived independence... makes it easier for them to use us as a support mechanism.*

### *The 'veteran' label*

There was a common view among the respondents that being labelled as a 'veteran' was a barrier to current and ex-serving members seeking assistance from veteran-focused support services. Given some of the aspects associated with military identity noted in the previous section, it was observed that the term 'veteran' carried potential connotations that some individuals were reluctant to be associated with when seeking assistance. Such a label may shape how clients' needs are framed, reducing complex challenges and life experiences to a singular demographic attribute. As the representative from Selectability explained:

> *They are labelled with the [term] 'veteran'... that may not be the cause of their problems. But that's what they're labelled as.*

Providers observed that their veteran clients' problems were not always necessarily a consequence of service. A *StandBy* program provider felt suicide can sometimes be misrepresented as "one event" by suicide prevention services. In contrast, postvention services would more often understand suicide as the culmination of "a series of events over a lifetime of dysregulation, relationships and disconnection for whatever reason". This representative emphasised that greater consideration of veterans' experience before their time in Defence was required, reflecting on the prevalence of existing trauma amongst those who have died by suicide:

> *Why do people join the Defence Force? So, are they already in a space where they might have a risk for suicide in their future before they even are part of the Defence Force?*

The respondent from Selectability made a similar observation, re-emphasising the importance of taking a person-centred approach to understanding the life cycle of each individual veteran:

> *If you're a kid who's not doing too well at school or if you're playing up... 'into Defence, that'll sort you out'. So that's not really dealing with the problems before they get in there. So, I don't think sometimes it always has anything to do with Defence. I think it's something that's already existing before they go in and I don't think that's ever spoken about.*

Furthermore, former service members – particularly those who are younger – may not consider themselves a veteran or engage with services advertised for veterans. As our respondent from LivingWorks explained, drawing on their own lived experience within Defence communities:

> *I know the younger cohorts of previously serving Defence members don't always see themselves as [being] a veteran. It's a weird term to say that... not a lot of people, whether they be serving or veterans, want to necessarily engage either vocally or just themselves personally with VSOs or DVA or whatever the current mechanisms of support are there within the community.*

For these reasons, those who have served but do not identify as a veteran could view mainstream services as being more appropriate to their needs.

### *Veterans' limited awareness of service availability and suitability*

Another issue commonly identified was that members of the veteran community may be unaware of services available to them or unsure of how they are applicable to their needs. This applied both to mainstream suicide support services identified in this project, as well as services within the veteran support ecosystem.

Providers highlighted the transition stage as being as a missed opportunity to build veteran awareness of available services. LivingWorks highlighted that currently it is the responsibility of the individual to identify and

access health and wellbeing services when transitioning from Defence, if required. Given the multiple and competing pressures veterans may experience during transition, mental health support may be de-prioritised for more material issues such as relocation, housing and family affairs. If a veteran then enters a state of crisis, they may be unaware of available services for veterans specifically or know how to access mainstream services. This uncertainty places individuals at risk of becoming overwhelmed and not engaging with services, as highlighted by the representative from Selectability:

> *Say you're in a crisis - and this is for Defence, ex-defence, anybody - and you Google one of the numbers, do you know how many come up?... A lot! So, you're confused, right? So say you're someone who's got problematic substance use, but you've also got basically chronic anxiety, [and] PTSD because you transitioned out of Defence...Who are you going to call first? None of them because you can't decide.*

A related issue was raised by a Lifeline provider, who linked veterans' uncertainty about services to fragmented service journeys amongst the veteran cohort. As a result, Lifeline could sometimes be a "last resort" service for these clients:

> *What we do find with some of those contacts from veterans is that they have engaged in help seeking and they've found it not a positive experience. So they're coming to us to try again, which is a big deal... we as a sector, we'll get possibly one chance at providing support... It is concerning to me that, numbers of people who are from a military background who are reporting that they've tried [seeking help and] it was not good. So they're turning to Lifeline as sort of a last resort.*

This representative emphasised the risk of a 'back-and-forth' experience when trying to access services, which may result in some veteran clients missing out on services altogether. This is significant as service providers often have a small window of opportunity to engage and retain clients who may be reluctant to access services.

*Resource constraints*

Respondents reported difficulties relating to their capacity to meet demand due to resource constraints. These included both lack of funding and skilled staff.

One service provider was very well known in their local community but had been operating on year-to-year funding for almost forty years. Newer services generally had less funding, less community connections and fewer staff. Smaller organisations needed funding to expand the scope of their supports (through programs and staffing) and generate community awareness. Advertising of services was important, but with limited funding, was often sacrificed in favour of capacity building. Even for larger organisations and programs, funding and capacity limitations affected the extent to which programs could feasibly be tailored to meet veterans' needs. This was summarised by a *Standby* program provider located in Adelaide:

> *The only way we could meet that need would be to employ people with ADF experience, which our current level of funding doesn't allow.*

The resulting restriction in opening hours constrained providers' capacity to meet client demand. Crisis support was the main program type impacted by this due the urgent, on-demand nature of these services.

As is the case in the broader not-for-profit sector, program availability was also affected by over-reliance on a volunteer workforce. This tends to be a larger issue in suicide prevention and postvention due to the need for support workers with lived experience. Both Busselton Community Safe Space and Blue Mountains Safe Space noted this, explaining how the need to have the "right demographics" in their "volunteer pool" potentially prolonged volunteer recruitment processes.

Recruitment of staff was generally viewed as less of an issue than retention. Although services might be able to attract staff the nature of the roll lead to high levels of stress among staff which resulted in high levels of burnout.

*Geographical barriers*

Underscoring the geographical access issues explored in this report, respondents who were rurally located articulated how this can be a limiting factor for veteran engagement, citing the impact of their location on access practicalities and service awareness.

Both Mental Health Hub Shoalhaven and *StandBy* (Northern QLD) cited their remote location as a potential barrier to veterans seeking access to their face-to-face offerings. Busselton Community Safe Space also pointed to transport, considering their premises difficult to reach for veterans who do not drive. While some services (e.g., Network Bereavement Support Group, the Men's Table, and Anglicare WA) address this barrier by offering online access to programs, this tended to be a short-term or interim aspect of programs with a greater emphasis on face-to-face engagement. It was therefore not seen as suitable as a standalone mode of delivery for all clients.

For The Men's Table specifically, participation in an initial online "entree" could only develop into full in-person group enrolment based local context, including geographic location, premises availability, and group size. To work around some of these barriers, the respondent explained that "in regional areas" groups made up of "shift workers" would take on larger memberships knowing that "not all... are going to be there every month".

While rural and regional services generally aimed to increase availability and community visibility, the higher visibility of services in urban areas was also seen as a potential access barrier for veteran clients, due to the stigma of being seen accessing these services. One urban provider, Safe Haven Belconnen (ACT), noted how their central position may put off veteran clients wishing to maintain anonymity during service access:

> *The entrance to Safe Haven Belconnen is in a public place near a city centre, and this may deter people who are concerned about being seen accessing such a service*

This issue of access visibility connects to the previously highlighted themes of veteran status disclosure, shame, and the subsequent impact on help-seeking behaviours.

***Provider suggestions for service improvement***

*Consult with the broader veteran community.*

Respondents were adamant that extensive consultation with those who are serving, or have previously served, was needed to identify opportunities for service improvement. The Roses in the Ocean representative argued that it was imperative to consult the veteran community before any operational improvements are implemented, to assess what the veteran community wants and increase the likelihood of service uptake.

Consistent with Roses in the Ocean's ethos on lived experience, this respondent stated:

> *I'm not the right person to ask because I'm not a veteran. I would say, the people that are going to tell you what the best fit is, is veterans.*

Respondents also stressed the importance of being mindful that veterans are not a homogenous group and that a wide range of views must be represented. For example, not all current or ex-serving members want to be identified as a veteran or want their views to be represented by veteran groups, and it is problematic to assume that they do. It would therefore be important to learn more about those who have served and who do not wish to identify with the 'veteran' label, and to consider how their views are appropriately represented in consultations.

Any consultation activities would also require a high degree of independence from the ADF or DVA if a wide range of individuals were to participate. As the Roses in the Ocean representative elaborated:

> *You'd have to position very carefully to make sure that you're bringing all the right people into the room, but not creating the perception that this – if you were to build a service – not creating the perception that the service is beholden to the ADF, because then you create that barrier that other services have.*

As the Lifeline representative put it, *"you've got to build services with people".* Only through consultation with the veteran community can a clearer picture emerge of gaps in the suicide prevention and postvention system and how these shortcomings can be addressed.

### *Increase opportunities for training in military culture and veteran experiences*

As noted previously, respondents recognised that a complex range of life experiences often contributed to suicidality among individuals who have served, and that these were not solely attributable to military service or accurately captured by the 'veteran' label. There was, however, a widespread openness to learning more about the uniqueness of military service and of this aspect of veteran experiences. It was felt that better understanding this context could improve the suitability of mainstream services for veterans.

As the BrookRED representative observed, it is always important for providers to be skilled in different approaches to meet their client where they are and adapt their approach if necessary. Similarly, in postvention support, Hope Bereavement Care felt that while their "staff would be equipped" there was an "extra layer of complexity" involved for those bereaved by a veteran suicide. As the respondent from RAW articulated:

> *Trauma from a returned soldier or from the forces, I think is different to a trauma experience within, you know, domestic violence, or it is different because there's behaviours that are conditioned to what they experience.*

Respondents have requested training resources co-created with the veteran community to equip them in better understanding the intersection of military culture, veteran experiences and suicidality. Providers noted that training would need to be accessible and affordable to allow for flexible, low-cost engagement. For example, the Busselton Community Safe Space representative suggested that an online package be developed and provided so that staff and volunteers could engage independently and at their own pace.

### *Establish a Community of Practice*

Across all providers there was a clear appetite for building partnerships within the suicide prevention and postvention sector (i.e., between different types of suicide prevention and postvention services) and beyond the sector (i.e., with broader veteran support services).

Providers noted the usefulness of connecting with other services who have expertise in a specific area, rather than creating new services and risking program over-saturation. As Lifeline shared:

> *We've got a strong partnership with Beyond Blue…they've handed a service across to us 'cos it fits better in our remit than theirs.*

While this is an example of program absorption, Lifeline also spoke of the importance of bringing services together and their role of "being a connector" as a large-scale national operator. Similarly, Roses in the Ocean spoke of "having more formalised partnerships and supporting different communities". One example of this was moving towards MOUs with aftercare programs. As a provider of a diverse range of programs, including prevention, early intervention and non-clinical crisis support, Roses in the Ocean felt they had capacity to offer additional support to clients following aftercare program completion. Similarly, one rural provider, Safe Space Blue Mountains, suggested that a "free directory of services" for veterans and those supporting veterans would be a useful starting point for mainstream services with little veteran experience.

Providers were also interested in opportunities to work with services who have veteran-specific knowledge. BrookRED, for example, suggested collaborations between their programs and organisations who have an existing "risk framework" identifying population-specific risks for veteran wellbeing. Medicare Mental Health Centre (Launceston) also highlighted how useful it can be to have exposure to other services through a shared space, even if not a formal partnership:

> *We have a new, co-locating relationship with Open Arms who use our facility to host a support group weekly as well as individual sessions provided by the Open Arms mental health worker and lived experience worker.*

This proximity to Open Arms enabled opportunities for learning and sharing, with this provider citing plans for collaboration:

> *Open Arms are also attending a session with our staff next year to explore how we can ask screening questions as part of our assessment process, to better identify clients who identify as part of the veteran community, as well as who is best placed in community to support them.*

Building closer partnerships and stronger communication channels had the potential for better client-provider matching. As such, providers were keen to improve their understanding of the veteran experience by partnering with the Department of Defence and the Department of Veterans' Affairs, due to their expertise in veteran transition and veteran support. Lifeline and Roses in the Ocean suggested this partnership could involve co-design to adapt successful existing program models, such as the helplines that these providers operate, as a starting point for combining expertise. The respondent from Roses in the Ocean suggested that such collaboration would better support veterans' needs:

> *Rather than saying, 'hey, you know, DVA, go and create this thing that could work for you, that we already do', how can we support you to create something together that supports the community's need?*

The breadth and extent of provider engagement with the consultation – which ranged from larger, peak organisations within the sector to smaller, local organisations – demonstrates a strong willingness for dialogue. There was enthusiasm amongst providers for this dialogue to continue, to share knowledge (including the project findings) and evidence regarding best practice with respect to offering the veteran community suicide prevention and postvention services. This suggests that there is significant potential for partnership development within a community of practice.

### *Strengthen 'communities of place'*

In identifying the potential benefits of a community of practice, providers also emphasised the importance of place and knowledge of local contexts for understanding veteran needs. Service providers prided themselves on their knowledge of local clinical and non-clinical supports and spoke about how they worked to build and maintain local partnerships across the suicide prevention and postvention service sector. Their work was particularly important in high-density veteran population areas (such as Queensland) for incoming and outgoing referrals across a range of service types.

Local knowledge was also vital for service responsiveness and efficiency. Many providers belong to region-specific suicide prevention networks which facilitate collective approaches in several areas such as health promotion and awareness, knowledge sharing and training, and implementation of higher-level suicide prevention plans and strategies. In one example, RFQ spoke about "responding to a cluster of suicides", which involved drawing on networks with "all the different services in the community" to try and address the issue. Similarly, LivingWorks advocated for community-wide training rather than establishing community gatekeepers:

> *We need to reduce the burden on health services and crisis supports, not add to it.*

For LivingWorks and other providers, communal knowledge sharing means "not everyone needs to go to ED" and can be supported by family, friends, or colleagues. This LivingWorks representative concluded that widening the availability of *ASIST* training, via strengthened networks and partnerships, can prioritise place-based support for transitioning veterans. This also included investment in workplaces where veterans "go next" including "mining, construction, first response, security, SES". The respondent from Lifeline Mid-Coast (who facilitate the *ECLIPSE* aftercare program) gave examples of how community connections benefitted clients. When clients had previously experienced non-clinical pathways, their visits to clinical supports were "not so escalated", and had less issues with "drugs and alcohol":

> *We have this reported back by clinicians as well. When someone is entering back through the hospital system and they've been through ECLIPSE, they're going back in a much calmer way.*

An awareness of place was also highly practical and led to unexpectedly positive results. BrookRED for example, described running a program after work hours and utilising the floorspace of a local tattoo parlour. This kind of impromptu flexibility, according to the interviewee, was important for promoting access. The sharing of space and physical resources can help to normalise mental health conversations and foster community-based experiences of support and belonging.

Respondents were also keen to work with key government agencies from the Department of Defence and the Department of Veterans' Affairs to help increase service visibility and diversify program provision for the close-knit but mobile Defence and veteran communities. They felt this would be particularly useful during veteran transition out of Defence, with a respondent from LivingWorks emphasising the development of a wider "network of safety" for transitioning veterans:

> *The spouses always want to have the training, but the training's never aimed at the spouses. It's always aimed at the veterans... My partner who was formerly a soldier, now an airman... very different human at work to who he is at home...if we were to aim our training more at the spouse community, so whether it be the partner, the mums and dads, the aunties or the children...to me, that is such a great way to facilitate knowledge about how to keep people safe, not just aimed at the veterans.*

This emphasises the importance of building capacity around veterans, as well as within veteran communities and known areas containing high veteran populations (e.g., such as those identified in Section 4.3 of this report). Such practices not only have potential to reduce risk but to strengthen connections of those in veteran support networks.

*Leverage mainstream services*

Most importantly, providers felt that their services were essential in reducing the number of veteran suicides in Australia and were open to expanding their services to better meet the needs of the veteran community.

Providers noted successful precedents for the expansion of mainstream service offerings to priority population groups, with targeted programs offered to LGBTQI+ communities, family violence survivors, and Aboriginal and Torres Strait Islander communities.

For expansion into the veteran space, both Roses in the Ocean and Lifeline suggested that their helplines could be used as a starting point. Roses in the Ocean suggested that their warmline could be used as a "point of connection and referral from other programs" specific to Defence. Lifeline drew on the example of 13 YARN to demonstrate their approach to expansion, noting it was possible to "quickly develop some capabilities where we had gaps".

Essentially, the consensus was that mainstream services played a critical role in serving the veteran community and their skills and services should be better leveraged to support Australian veterans.

> *'Hey, Defence takes care of Defence.' I love that. That's great. You've got your brotherhood and stuff like that, but there's a few people here that can jump in.*

# 6. Appendices

## APPENDIX A: SIX COMPONENTS OF SUICIDE PREVENTION AUSTRALIA'S ACCREDITATION STANDARDS

| | |
|---|---|
| **Alignment** | Clear 'line of sight' between the program's aims and objectives and those of the broader organisation (or partnership). |
| **Lived and living experience of suicide** | The voice of people with lived and living experience of suicide informs all aspects of the program. |
| **Collaboration** | Actively seeking and building relationships, partnerships and collaborations, both formally and informally. |
| **Program framework** | The 'behind the scenes' functions that wrap around the program when it is being delivered. |
| **Program management** | How the program is designed and implemented to ensure a safe and supportive environment for all who interact with it. |
| **Program outcomes and knowledge sharing** | How the program collects, analyses and learns from feedback, implementing those learnings to improve the program and inform the wider suicide prevention sector. |

## APPENDIX B: LIST OF PROVIDERS WITH UNIQUE PROGRAM AND SITES/SERVICE AREAS COUNTS

| Provider | Number of unique programs | Number of unique sites/service areas |
|---|---|---|
| 13Yarn | 1 | 1 |
| 360 Health + Community | 1 | 5 |
| 4 Mental Health | 1 | 1 |
| Anglicare | 2 | 2 |
| Anglicare Central Queensland | 1 | 1 |
| Anglicare SA | 3 | 7 |
| Anglicare Tasmania | 1 | 3 |
| Anglicare WA | 3 | 14 |
| Australian Department of Defence | 1 | 1 |
| Australian Public Service Commission | 1 | 1 |
| Ballarat and District Aboriginal Co-Operative | 1 | 1 |
| Beam Health | 1 | 4 |
| Bereaved Through Suicide | 1 | 2 |
| Beyond Blue | 1 | 1 |
| Blue Mountains Safe Space for Suicide Prevention | 1 | 1 |
| Brook Red | 2 | 2 |
| Busselton Community Safe Space | 1 | 1 |
| Caloundra Living Beyond Suicide Support Group | 1 | 1 |
| CAREinMIND | 1 | 1 |
| Castlemaine Safe Space | 1 | 1 |
| Cherbourg Regional Aboriginal and Islander Community Controlled Health Services | 1 | 1 |
| Coast & Country Primary Care | 1 | 1 |
| Communicorp | 1 | 1 |
| Communify | 2 | 2 |
| Cygnet Community Hub | 1 | 1 |
| Directions Health | 1 | 1 |
| Driven | 2 | 2 |
| Ergonomie | 1 | 1 |
| Family Services Australia Health and Wellbeing | 1 | 1 |
| Flourish Australia | 1 | 1 |
| FocusOne Health | 1 | 1 |
| Foundation House | 1 | 1 |
| Friends for Good | 1 | 1 |

| | | |
|---|---|---|
| Gladstone SBSG | 1 | 1 |
| Government of Western Australia: Mental Health Commision | 2 | 2 |
| Grand Pacific Health | 4 | 10 |
| Grassroots Action Palmerston Aboriginal Corporation / Aunties Place | 1 | 1 |
| Griefline | 1 | 1 |
| Headspace | 1 | 1 |
| HealthWISE | 1 | 11 |
| Holyoake | 3 | 3 |
| Hope Bereavement Care | 1 | 1 |
| HSW Global | 1 | 1 |
| Hunter New England Local Health District | 2 | 2 |
| Hunter Primary Care | 2 | 2 |
| Jesuit Social Services | 2 | 21 |
| KAIZEN Business Support | 1 | 1 |
| Kentish Regional Clinic | 1 | 1 |
| Let'sTALK | 1 | 1 |
| Lifeline | 6 | 6 |
| Lifeline Harbour to Hawkesbury Sydney | 1 | 1 |
| Lifeline Central Coast | 1 | 3 |
| Lifeline Direct | 1 | 1 |
| Lifeline Macarthur and Western Sydney | 3 | 3 |
| Lifeline Mid Coast | 3 | 4 |
| Lifeline North Coast | 1 | 1 |
| Lifeline Northern Beaches | 1 | 1 |
| Lifeline Queensland | 1 | 3 |
| Lifeline Tasmania | 2 | 4 |
| LivingWorks Australia | 6 | 6 |
| LivingWorks Partnered with DVA, Mental Health First Aid | 1 | 1 |
| Love Me Love You/Never Alone Foundation | 1 | 1 |
| Mariposa Trails Suicide Prevention Network | 3 | 3 |
| MATES in Construction | 5 | 5 |
| Mental Health First Aid Australia | 5 | 5 |
| Mentoring Men | 1 | 1 |
| Mid North Coast Local Health District | 1 | 1 |
| Mind Australia Ltd | 1 | 1 |

| | | |
|---|---|---|
| Mind Blank | 1 | 1 |
| Mission Australia | 2 | 3 |
| Mowana Safe Space Incorporated | 1 | 1 |
| Mulungu Aboriginal Corporation | 1 | 1 |
| Murrumbidgee Local Health District | 2 | 2 |
| Neami National | 5 | 14 |
| New Horizons | 1 | 1 |
| Northern NSW Local Health District | 1 | 1 |
| NSW Central Coast Local Health District | 1 | 1 |
| NSW Health | 1 | 16 |
| Nunyara Aboriginal Health Service | 1 | 1 |
| One Door Mental Health | 1 | 1 |
| Open Minds | 1 | 4 |
| Parents Beyond Breakup | 2 | 30 |
| Perinatal Anxiety & Depression Australia | 1 | 1 |
| Proveda | 2 | 2 |
| QLife | 1 | 1 |
| Queensland Government | 1 | 1 |
| Quest for Life Foundation | 2 | 2 |
| RedSix | 1 | 1 |
| Relationships Australia Tasmania | 2 | 2 |
| Richmond Fellowship Queensland | 2 | 8 |
| Riverina Medical and Dental Aboriginal Corporation | 1 | 1 |
| Roses in the Ocean | 7 | 7 |
| Ruah Community Services | 1 | 1 |
| Rural Alive & Well | 1 | 1 |
| Sabrinas Reach 4Life | 1 | 1 |
| Selectability | 2 | 2 |
| Shining Hope WA | 1 | 1 |
| Social Futures | 2 | 5 |
| Sonder Australia | 3 | 3 |
| South Eastern Sydney Local Health District | 1 | 1 |
| South Western Sydney Local Health District | 2 | 2 |
| Southern NSW Local Health District | 1 | 1 |
| St John of God Healthcare | 1 | 4 |
| St Vincents Hospital, Sydney | 1 | 1 |
| Stride Mental Health | 8 | 9 |

| | | |
|---|---|---|
| Suicide Prevention Pathways | 1 | 1 |
| Suicide Programs | 3 | 3 |
| Survivors & Mates Support Network | 2 | 3 |
| Survivors of Suicide Bereavement Support Association (SOSBSA) | 1 | 2 |
| SwitchBoard (Victoria) | 2 | 2 |
| Sydney Community Safe Space Inc. | 1 | 1 |
| Sydney Local Health District | 1 | 1 |
| Tamil Safe Space Inc | 1 | 1 |
| Tasmanian Dept of Health | 1 | 1 |
| The Buttery | 4 | 4 |
| The Men's Table | 1 | 106 |
| The Network | 1 | 5 |
| The Salvation Army | 1 | 3 |
| The Samaritans | 1 | 1 |
| Think Mental Health | 1 | 1 |
| Thirrili | 2 | 2 |
| TrackSAFE Foundation | 1 | 1 |
| Transcultural Mental Health Line | 1 | 1 |
| UnitingCare | 2 | 7 |
| University of South Australia | 1 | 1 |
| WA Country Health Service | 1 | 1 |
| Wellways | 3 | 19 |
| Wesley LifeForce | 2 | 2 |
| Wesley Mission Queensland | 3 | 4 |
| Western NSW Local Health District | 2 | 2 |
| Western Sydney Local Health District | 1 | 1 |
| Woden Community Service | 1 | 1 |
| Wuchopperen Health Service | 1 | 1 |
| Yourtown | 1 | 1 |
| Youth Space Redcliffe | 1 | 1 |
| Youturn | 1 | 7 |

## APPENDIX C: LIST OF PROGRAMS WITH UNIQUE SITES/SERVICE AREAS COUNT

| Program | Number of unique sites/service areas |
|---|---|
| 13Yarn | 1 |
| Aboriginal and Torres Strait Islander Mental Health First Aid Course | 1 |
| Aboriginal and Torres Strait Islander Aftercare Program | 1 |
| Accidental Counsellor Program | 1 |
| Active Life Enhancing Intervention (ALIVE) Program | 5 |
| Active Response Bereavement Outreach (ARBOR) | 4 |
| After Suicide Support | 1 |
| Aftercare Co-ordinator | 1 |
| All Hours Suicide Support | 1 |
| Aunties Safe Space / Perfectly Imperfect NT | 1 |
| Bardon Safe Space | 1 |
| Bega Valley Safe Haven | 1 |
| Belconnen Safe Haven | 1 |
| Bereaved by Suicide Support Group NT Services | 1 |
| Bereaved Through Suicide | 2 |
| Beyond Blue | 1 |
| Blacktown Safe Space | 1 |
| Blue Mountains Safe Space for Suicide Prevention | 1 |
| Broken Hill Safe Haven | 1 |
| Bunbury Community / Hope House Safe Space | 1 |
| Busselton Community Safe Space | 1 |
| Caboolture Safe Space | 1 |
| Calm | 1 |
| Calm Care | 1 |
| Campbelltown Safe Haven | 1 |
| CAREinMIND Suicide Prevention Service | 1 |
| Castlemaine Safe Space | 1 |
| Children & Young People Responsive Suicide Support (CYPRESS) | 2 |
| Compassionate Foundations | 1 |
| Connecting With People | 1 |
| Conversations About Suicide | 1 |
| Cores Suicide Prevention Training | 1 |
| Crossing Paths Carer Support Program | 1 |
| Culturally Responsive Suicide Prevention Training For Human Service Workers | 1 |

| | |
|---|---|
| Culture Care Connect (NACCHO) | 6 |
| Cygnet Garden Safe Space | 1 |
| Dads In Distress | 29 |
| Darlinghurst Safe Haven | 1 |
| Defence Member and Family Helpline | 1 |
| Dubbo Safe Haven | 1 |
| Eight-Week Support Groups | 2 |
| First Floor Program – The Salvation Army | 3 |
| FoundoBlue | 1 |
| Gladstone Suicide Bereavement Support Group | 1 |
| Glenelg Safe Space | 1 |
| Gold Coast Community Support Program | 1 |
| Gosford Safe Haven | 1 |
| Griefline Helpline | 1 |
| Griffith Safe Haven | 1 |
| Headspace | 1 |
| Healing Your Life | 1 |
| High Adversity Resilience Training | 1 |
| Hope Bereavement Care Support After Suicide | 1 |
| Ifarmwell | 1 |
| Illawarra Shoalhaven Safe Haven | 1 |
| In-Person Alt2su Group | 1 |
| Kids Helpline | 1 |
| Kogarah Safe Haven | 1 |
| Kununurra Safe Place | 1 |
| Let's TALK Program (Workplace) | 1 |
| Lifeline | 1 |
| Lifeline Crisis Support Suicide Aftercare Program | 1 |
| Lifeline ECLIPSE Support Groups | 4 |
| Lifeline Hospital to Recovery | 1 |
| Lifeline Suicide Bereavement Support Groups | 14 |
| Lifeline Suicide Call Back Service | 1 |
| Lismore Safe Haven | 1 |
| Liverpool Safe Haven | 1 |
| Living Beyond Suicide Support Group - Caloundra | 1 |
| Living Perspectives of Suicide | 1 |
| LivingWorks ASIST | 1 |

| | |
|---|---|
| LivingWorks Faith | 1 |
| LivingWorks I-ASIST | 1 |
| LivingWorks LGBTIQ+ ASIST | 1 |
| LivingWorks safeTALK | 1 |
| LivingWorks Start | 1 |
| Mackay Safe Harbour Crisis Support Service | 1 |
| Mariposa Trails - From Helpless to Hopeful | 1 |
| Mateline | 1 |
| MATES ASIST Training | 1 |
| MATES Case Management Program | 1 |
| MATES Connector Training | 1 |
| MATES General Awareness Training | 1 |
| MATES Helpline | 1 |
| Medicare Mental Health Centre | 30 |
| Men's Wellbeing Matters | 3 |
| Mensline Australia | 1 |
| Mental Fitness @ Work | 1 |
| Mental Health Emergency Response Line | 1 |
| Mental Health Hub – Anglicare | 1 |
| Mental Health Hub – Directions Health | 1 |
| Mental Health Hub – Family Services Australia | 1 |
| Mental Health Hub – Flourish Australia | 1 |
| Mental Health Hub – Stride Mental Health | 1 |
| Mental Health Protect – Free Training for the Veteran Community | 1 |
| Mentor Training & Life Mentoring In The Community | 1 |
| Mind Blank – Workplace Mental Health Workshop | 1 |
| Moving Beyond Trauma | 1 |
| Mullumbimby Safe Haven | 1 |
| Mums in Distress | 1 |
| Murwillumbah Safe Haven | 1 |
| Newcastle Safe Haven | 1 |
| Newtown Safe Haven | 1 |
| Next steps | 6 |
| North Hobart Peacock Centre Safe haven | 1 |
| Older Persons Mental Health First Aid Course | 1 |
| Our Voice In Action | 1 |
| PANDA’s National Perinatal Mental Health Helpline | 1 |

| | |
|---|---|
| Para Hills Safe Space | 1 |
| Parkes Safe Haven | 1 |
| Peer Care Companion | 1 |
| Penrith Safe Haven | 1 |
| Pop-Up Safe Spaces | 1 |
| Port Macquarie Safe Haven | 1 |
| Postvention Response Service | 1 |
| QLife | 1 |
| Rainbow Door | 1 |
| RAW Country Program | 1 |
| Reach Out and Connect Training | 1 |
| Redcliffe Safe Space | 1 |
| RedSix | 1 |
| Relationships Australia Tasmania Suicide Prevention Program | 1 |
| Resilience First Aid | 1 |
| Richmond Crisis Support Space | 1 |
| Roses in the Ocean | 1 |
| Royal Perth Hospital Safe Haven | 1 |
| RuralLink – WA | 1 |
| Salisbury Safe Haven | 1 |
| Samaritans Phone Support | 1 |
| Sonder Suicide Prevention Service | 1 |
| Speak Up! Stay Chatty Sports Program | 1 |
| Standard Mental Health First Aid Course | 1 |
| StandBy Support After Suicide | 36 |
| Strathpine Safe Space | 1 |
| Suicide Bereavement Support Groups – SOSBSA | 2 |
| Suicide Prevention Carer Support Program | 1 |
| Suicide Prevention for Seniors Program | 1 |
| Suicide Prevention Initiative | 11 |
| Suicide Prevention Outreach Teams (SPOT) | 16 |
| Suicide Prevention Peer Workforce Development Service | 1 |
| Suicide Prevention Service | 1 |
| Suicide Prevention Virtual Reality Training Tool | 1 |
| Suicideline Victoria | 1 |
| Summer Hill Safe Space | 1 |
| Support After Suicide | 18 |

| | |
|---|---|
| Support After Suicide/Bereaved by Suicide | 1 |
| Survivors & Mates Support Network Peer Support Phone Line | 1 |
| Sydney's Northern Beaches MoWaNA | 1 |
| Talk Suicide Support | 1 |
| Talking About Suicide: Aboriginal and Torres Strait Island MHFA | 1 |
| Tamworth Safe Haven | 1 |
| The Men's Table | 106 |
| The Network Bereavement Support Groups (BSG) | 5 |
| The Way Back Support Service | 43 |
| Touchpoints | 1 |
| TrackSAFE Foundation Suicide Awareness Training | 1 |
| Transcultural Mental Health Line – NSW | 1 |
| Tweed Heads Safe Haven | 1 |
| Uniting Care SBSG | 1 |
| University Crisis Line (UCL) | 1 |
| Wadda Mooli – The Welcome Space | 1 |
| Wagga Wagga Safe Haven | 1 |
| Welfare Warrior Training | 1 |
| Wentworthville Tamil Safe Space | 1 |
| Wesley Lifeforce Suicide Prevention Training for Community | 1 |
| Wesley Lifeforce Suicide Prevention Training for General Practitioners and Practice Nurses | 1 |
| Westmead Safe Haven | 1 |
| WINGS of Hope | 1 |
| Wollongong Safe Haven | 1 |
| Woodburn Safe Haven | 1 |
| Wooloongabba Crisis Support Space | 1 |
| Workbench for the Mind | 1 |
| Workplace Mental Health Essentials (All Staff) | 1 |

## APPENDIX D: SERVICE PROVIDER INTERVIEWEES

| Service Type | Organisation | Interviewee Role |
|---|---|---|
| Prevention | The Men's Table | Table Concierge, North |
| | LivingWorks | Executive Vice President |
| | | Suicide Prevention Manager |
| Early Intervention | Rural Alive and Well | Outreach Manager |
| | BrookRED | Assistant Manager |
| Non-Clinical Crisis Support | Selectability | Regional Coordinator, Burdekin |
| | Roses in the Ocean | General Manager – Service Delivery |
| | Lifeline Helpline | Chief Research Officer |
| Aftercare | Richmond Fellowship Queensland (The Way Back Support Service) | Area Manager, Darling Downs |
| | Lifeline (ECLIPSE Support Groups) | Postvention Manager |
| Postvention | Anglicare WA | Community Access and Development Coordinator |
| | StandBy Support After Suicide (QLD) | Service Leader/Coordinator |
| | Hope Bereavement Care | Community Access and Development Coordinator |

## APPENDIX E: SERVICE PROVIDER EMAIL RESPONDENTS

| Service Type | Organisation |
|---|---|
| Prevention | SAMSN Survivors & Mates Support Network |
| | Mariposa Trails Suicide Prevention Network |
| | Wesley Mission |
| Early Intervention | Mentoring Men |
| | Communicorp |
| Non-Clinical Crisis Support | 13 Yarn |
| | Anglicare (Mental Health Hub – Shoalhaven) |
| | Beam Health (Medicare Mental Health Centre – Warners Bay) |
| | Blue Mountains Safe Space for Suicide Prevention |
| | Busselton Community Safe Space |
| | Neami National (Medicare Mental Health Centre – Darwin) |
| | Neami National (Medicare Mental Health Centre – Geelong) |
| | Neami National (Medicare Mental Health Centre – Penrith) |
| | Stride Mental Health (Belconnen Safe Haven) |
| | Stride Mental Health (Launceston Medicare Mental Health Centre) |
| | The Butterfly (Lismore, Mullumbimby, Murwillumbah & Woodburn Safe Havens) |
| | Western Sydney Local Health District (Westmead Safe Haven) |
| | Youth Space Redcliffe (Redcliffe Safe Space) |
| Aftercare | Anglicare SA (Suicide Prevention Service) |
| | Anglicare Tasmania (The Way Back Support Service – Devonport, Hobart & Launceston) |
| | Coast & Country Primary Care (The Way Back Support Service – Central Coast) |
| | Communify (The Way Back Support Service – Brisbane North) |
| | Hunter Primary Care (Aboriginal and Torres Strait Islander Aftercare Program; The Way Back Support Service – Hunter New England) |
| | Lifeline Harbour to Hawkesbury (ECLIPSE Support Groups) |
| | Proveda (The Way Back Support Service – Northern Sydney) |
| Postvention | Anglicare SA (StandBy Support After Suicide – Adelaide) |
| | Anglicare SA (StandBy Support After Suicide – Country SA) |
| | Anglicare WA (StandBy Support After Suicide – Pilbarra region) |
| | Jesuit Social Services (StandBy Support After Suicide – Eastern Melbourne & Gippsland) |
| | Kaizen Business Support (Workbench for the Mind) |
| | The Network (The Network Bereavement Support Groups) |

| | |
|---|---|
| | UnitingCare (StandBy Support After Suicide – Brisbane North & South) |
| | UnitingCare (StandBy Support After Suicide – Central QLD, Wide Bay & Sunshine Coast) |
| | UnitingCare (StandBy Support After Suicide – Northern QLD) |