After looking at the terms of reference I have highlighted some key areas that I think are relevant to this inquiry

Education/training

- Having completed honours and a masters in psychology, I believe it is a floored training/education system. Suicide is discussed primarily in the context of risk assessment – and then who to refer-on to if deemed high risk. There is no realistic discussion of the services available e.g., long wait times on lifeline or other phone services, the call-back function of other telehealth services, or worst of all, how your local CAT team will almost certainly not help because no one is ever triaged high-risk *enough*
- I also think the education is greatly lacking in advice on what to do *after* someone reports feelings of suicide or self-harm with the intent to cause injury. There is not nearly enough training in how to sit in the discomfort, how to be comfortable listening to someone talk about it. Having the conversation can be incredibly cathartic and experienced as 'a release' for those having suicidal thoughts. Being able to discuss their plan can have the effect of making it less 'taboo', and the conversation can act as the outlet they need and reduce risk. Often addressing the underlying problem of 'pent-up' feelings, lack of emotional release etc.
- It is also not raised that there are not conclusive studies on suicide prevention. The formal tools used to assess suicide risk and intention are inconclusive. Some people who respond 'high risk' will complete suicide, and some won't. Some who respond 'low risk' will not kill themselves, and some will. These tools function more as a conversational tool and not as a reliable indicator of risk. That's an uncomfortable fact but it's incredibly important that students and professionals know this when they enter the field – and are reminded of it regularly.

Funding

- A scheme to help mental health workers seek their own mental health support would go a long way in reducing burnout and supporting self-care in a *meaningful* way. As a frontline mental health worker I don't earn that much, and find it hard to seek my own mental health support e.g. a psychologist. If it's commonly accepted that the nature of my role places me at greater risk of suicide, self-harm and mental ill-health; then why aren't there additional provisions to make sure I can get the support I need?
- Even some kind of formal debriefing. Supervision, as it stands, is more of an opportunity to discuss your case load than how *you* are. If you do end up discussing yourself, it's in the context of how that effects your work and ability to perform.

Types of leave/organisational support

- There is now "family violence/domestic violence" leave at most workplaces as a result of many inquiries and the royal commission. However – this leave only works if you have an active IVO or police matter and can produce evidence. Which is a huge issue in itself.
- I highlight this as an example of how organisations *could* support mental health workers and employees if done properly. We seem to recognise the need for more support around mental health in an organisational setting, but so far this has been in the form of 'raising awareness' campaigns and free yoga on Wednesdays that no one can actually attend. If there were leave for mental health – that didn't require proof of a mental breakdown or a full psychological assessment – that could be one step toward *actual* help.

- As a frontline mental health worker, I am at particular risk of burnout and mental ill-health. Beyond taking sick leave or using EAP (which I have to tell my boss about) there is no recognised ‘mental health’ leave available to me. Self-care is overemphasised and underfunded.