Submission to

Discussion Paper: Victoria's suicide prevention and response strategy

August 2022

As a key provider of community based health, mental health and social support services cohealth welcomes the opportunity to contribute to the consultation on a Victorian Suicide Prevention and Response Strategy.

As outlined in the Discussion Paper, suicide has devastating and widespread impact on Victorian communities. It affects people of all ages and backgrounds, along with families, friends and communities. It has a significant impact on the services that work with people who have suicidal thoughts and behaviours. cohealth workers in all areas of the organisation are touched by suicide, through working with people experiencing suicidal thoughts and behaviours, and supporting the families, friends and loved ones bereaved through suicide.

While mental illness can be a risk factor for suicide, people without a diagnosed mental illness also die by suicide, and the Royal Commission into Victoria's Mental Health System noted that caution is needed in attributing any causal link between mental illness and suicide.[1]

cohealth supports the development of a comprehensive Victorian Suicide and Prevention Strategy that places lived and living experience at its heart, builds resilience, responds to need and addresses systemic contributing factors.

About cohealth

cohealth is one of Australia's largest community health organisations, delivering care from over 30 locations across the inner, north, and west of Melbourne as well as statewide services across Victoria. cohealth provides integrated general practice, medical specialist, dental, allied health, mental health, alcohol and other drug, counselling, family violence, and social support services to more than 50,000 people each year.

People using cohealth services typically experience social disadvantage and are consequently marginalised from mainstream health services or require a higher level of care and support – such as people who are experiencing homelessness, mental illness, people who use alcohol and other drugs, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, recently released prisoners, LGBTIQ communities and people with chronic and complex health conditions.

[1] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report*, Vol 2 p461 https://finalreport.rcvmhs.vic.gov.au/download-report/

cohealth
care for all

All cohealth programs work with people experiencing suicidal thoughts and behaviours, or with the families, friends and communities bereaved by suicide.

In addition, cohealth also has lengthy experience providing responses to people living with mental ill health. Services include mental health nursing, individual support, outreach services, mentoring, residential programs, homeless outreach, and complex care coordination. We operate several Mental Health and Wellbeing Hubs established in response to COVID-19 and undertake mental health promotion work. With our partners, cohealth will operate the new Brimbank Local Adult and Older Adult Mental Health and Wellbeing Service.

cohealth has a particular focus on providing mental health support that takes account of the social determinants of mental health to ensure support is integrated with physical health care and social support programs, such as housing, employment and family support, and those aimed at reducing social isolation. Recognising that people with multiple and complex needs face greater barriers to accessing services and supports, along with health and social disadvantage, cohealth prioritises working with these people to maximise their mental and physical health and wellbeing outcomes. In response to the significant unmet needs of people with mental illness who are completing corrections orders we have also established a forensic mental health service as part of the overall community health service offering.

Vision

1a. The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate? (Yes/No)

Yes

1b. If not, what vision for suicide prevention and response would you like to see Victoria work towards?

cohealth supports the Royal Commissions proposed 'towards zero suicides' vision for the Strategy, noting that any life lost to suicide is one too many, and that we must reflect and learn in each situation to identify what could be done differently in the future.

At the same time, cohealth observes that complementing this vision with a positive goal focussing on creating a healthy community would lay the foundation for people's health and wellbeing. Such a goal should include working towards a community that prioritises and works toward belonging, social connection and acceptance, along with recognising everyone's right to live free from abuse, violence, stigma, poverty and racism and that policies that support these rights will support mental health in Australia.

Priority populations

2a. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)

The list in the Discussion Paper is broadly appropriate, including Aboriginal people, children and young people, culturally diverse people (including refugees), LGBTIQA+ communities, older and adult men, people living in rural and remote communities, people living with mental illness, people living with substance use and addictions, people with lived experience of suicide, people with disability and neurodiverse people, people working in high-risk industries, veterans and ex-armed services, and women.

2b. If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

Other cohorts important to include in the list of priority populations are:

- People who have experienced trauma, who have an increased risk of suicide. This can include people who have experienced adverse childhood events, sexual assault, family violence, are victims of crime and experience Post Traumatic Stress Disorder.

- People experiencing homelessness. While the evidence base on the links between homelessness and suicide is sparse, particularly in an Australian context, it does indicate that homeless populations have higher rates of suicide than the general population in Australia.[2] There are three main channels by which housing is linked to suicide: extended periods of financial stress due to the cost of housing; lack of security due to eviction, insecure housing and homelessness; and the impacts of adverse life events on children and young people on their present and future mental health.[3]

While recognising the increased risk of suicide of the various population groups, cohealth has some reservations that such an extensive list encompasses almost everyone in society. While the Discussion Paper recognises that some members of these groups will experience multiple contributing factors for suicide, and the importance of taking an intersectional approach, a more nuanced approach to identifying priority groups would provide a firmer foundation for tailoring initiatives to meet the needs of these groups. Having a greater focus on the contributing factors to suicide (Discussion Paper p13) may help refine groups to be prioritised for comprehensive action now.

[2] https://lifeinmind.org.au/news/the-link-between-homelessness-and-suicide-risk
[3] Brackertz, Nicola (2020) *The role of housing insecurity and homelessness in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours: a review of the evidence*, Evidence Check prepared by AHURI for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce.

Priority areas

3. What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?

The Discussion Paper lists a comprehensive range of priority areas:

- Lived experience partnerships
- Self-determined Aboriginal suicide prevention
- Intersectional and targeted approaches for groups disproportionately affected by suicide
- Data and evidence to drive outcomes
- Workforce and community capabilities and responses
- whole-of-government leadership, accountability and collaboration
- A responsive, integrated and compassionate system.

To this cohealth recommends adding:

- Having a clear prevention focus – one that identifies contributing factors and creates cultural change to prevent or reduce suicide risk. This will require a whole-of-government and whole-of-community approach. Particularly important areas of focus include supporting the wellbeing and resilience of families and young people.

- That the data and evidence used to drive outcomes is made available to services in an accessible and coordinated manner. A centralised repository of knowledge, evidence-based best practice and community data that is accessible to services and the community would provide a valuable resource.

Principles

4. What principles should guide the development and implementation of the strategy?

Examples of principles to guide the Strategy's development, implementation and evaluation in the Discussion Paper are:

- Valuing lived experience
- Supporting equity and taking an intersectional approach
- Supporting Aboriginal self-determination
- Being adaptable and evidence-informed
- Taking a person-centred approach

cohealth recommends that the principle of 'valuing lived experience' should be strengthened so that it is central to all aspects of the Suicide Prevention and Response Strategy, and all actions that flow from it.

Other principles that should guide the Strategy include:

- Promoting protective factors in a holistic manner, including addressing socio-economic factors such as income, employment, education and housing
- Underpinned by a structural understanding of contributing factors, and works to address these systemic issues
- Trauma informed
- Family centred
- Place based – responses should be local and accessible
- Adopts a recovery framework
- Understands and responds to different cultural norms and perspectives on suicide and contributing factors for suicidal thoughts and behaviours
- Principle of hope
- Healing and wellbeing approach
- Reducing the stigma for people experiencing suicidal thoughts, and the families and communities that have experienced suicide
- Collaborative approach
- Integrated care and continuity of care
- Quality and safety
- Timely access to supports and services when they're needed, for people experiencing suicidal thoughts and behaviours and their families, friends and communities.

Suicide prevention and response initiatives and actions

5a. In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?

Peer led programs for people experiencing suicidal thoughts and behaviours to enable them to connect with others in a non-judgemental environment, encouraging relational recovery, mutuality and healing. These programs should be designed by people with lived experience. An example of such a program is *DISCHARGED: An alternative to suicide approach*.[4] Programs must have the flexibility to respond to the diverse needs of different communities, and different cultural norms and attitudes about suicide.

Peer led programs for the families, friends and communities of people experiencing suicidal thoughts and behaviours. These should be developed with, and respond to, the diverse needs of different communities, including Aboriginal and Torres Strait Islanders, culturally and linguistically diverse communities and LGBTIQA+ communities. These programs can provide vital support, coping skills and information.

Increased focus on, and resourcing of, **prevention**, in areas such as maternal health care and early family support to address contributing factors early.

[4] https://www.discharged.org.au/alternatives-to-suicide

Strategies and pathways for people living with **chronic high risk** that acknowledge their pain, retains hope for a different experience and provides support to validate them on their recovery journey.

Ensure **lived experience residential programs** are available to people who experience suicidal ideation. Residential programs such as PARCs often will not admit someone with this experience.

Programs must be **widely promoted** to the community so those that need them are aware of them. This includes through GPs, hospitals and other health providers, mental health services, schools, tertiary education providers, community and sporting groups and wide-reaching community campaign.

State-wide community campaign to **reduce the stigma and discrimination** associated with suicide, in addition to supporting communities to develop localised activities.

5b. What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness, and prevent suicide?

A wide range of opportunities should be available for the Victorian community to be part of the change. Suicide prevention and response requires a whole-of-community response to be most effective. This should encompass a number of aspects:

- Creating opportunities for conversations about the culture of our community, and what is important. This includes creating a community where people feel accepted by others and themselves, socially connected and valued, along with exploring ways to respond when a person feels like they don't fit, to support them and bring them into the community.
- Expanding the Place-Based Suicide Prevention Trials described in the discussion paper. These collaborative, community-based initiatives harnessed local skills, expertise and resources to implement tailored, evidence-based interventions in local communities.
- Increasing the wellbeing literacy across community, and shifting away from negative, deficit-based language of illness.
- Ensure diverse communities, including those from culturally and linguistically diverse backgrounds, have opportunities to develop community-led responses that take account of cultural differences and understanding of suicide thoughts and behaviours and associated stigma.
- Ensure that community programs such as safeTALK (suicide alertness workshop), ASIST, Emotional CPR, Mental Health First Aid, CALM Suicide Intervention Training, and the like, are accessible to as many in the community as possible. This may require financial assistance to some groups as program fees can be prohibitive for some community members.

5c. In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?

A cultural shift is required to move away from a medical model that perceives suicidal thoughts and behaviours as an illness that needs to be responded to with risk assessment and treatment, towards a more holistic and compassionate approach that acknowledges humanity and focusses on healing.

Increase peer-led supports, to listen, connect and support without judgement, along with peer-led groups to enable people to connect with others and support each other.

Adequate resourcing to ensure that support, of all types, is available whenever a person needs it, and for as long as it is needed. A person experiencing suicidal thoughts needs time, and may presents later in the day when other distractions are not available. Too often calls to support services go unanswered due to volume. It is critical for people to have access to the right support at the right time.

Frontline services, such as GPs, must be supported to have the capability and time resources to respond to people with suicide thoughts and behaviours. GPs are often a point of contact for people with suicidal thoughts, yet may not have the time to attend training due to the financial strains of operating a GP practice.

Appropriately resourcing services is also vital to supporting the frontline workforce, enabling them to fully utilise their skills and experience and prevent vicarious trauma. Frontline workforces need to have allocated time for individual and group supervision, debriefing and reflective practice and capacity to seek secondary consultation as required (eg from Area Mental Health Services or HOPE teams). Senior, experienced staff or clinicians need to be available to support junior staff, particularly when people present with particularly complex circumstances. Importantly, adequate resourcing would mean the frontline workforce is not left with the psychological weight of being unable to respond to everyone who approaches their service.

These staff supports must complement training, not replace it. Training appropriate to a staff members role should be provided on a regular basis, and may include Collaborative Assessment and Management of Suicidality (CAMS), Dialectical Behaviour Therapy, mindfulness and many more options.

Suicide response approaches need to move away from focussing on reducing risk, resulting in an overemphasis on potential liability and documentation, and towards supporting the person in distress.

It is important that suicide prevention and response work is connected to other areas of reform of the mental health system, including the State-wide Trauma Centre and Local Mental Health and Wellbeing Services.

5d. How can we better educate and build the capacity of workplaces to reduce the risk of suicide and better support staff? What capabilities or supports are required?

Support workplaces to improve workplace wellbeing (eg through conducting forums and linking with WorkSafe initiatives).

Ensure training to support mental health and wellbeing is widely available and accessible to workplaces. The cost of programs can be prohibitive, particularly to smaller community organisations and businesses. Programs could include Mental Health First Aid, along with training in understanding safety and collaboratively building safety plans.

5e. What higher risk industries/workplaces should we prioritise for immediate suicide prevention action and why?

The Discussion Paper, along with the research cited in it[5], provides a comprehensive list of higher risk industries and workplaces, including: health workers, construction, agricultural workers, police, cleaners, labourers, emergency services, transport industry workers and veterinarians.

All industries that have higher risk of suicide should be prioritised for prevention activity. These programs should focus on worker-led initiatives, informed by people with lived experience of suicidal behaviour and those bereavement by suicide.

5f. For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

The most compassionate and appropriate supports for people and communities bereaved by suicide will vary depending on the community and individuals, and must be designed and delivered with communities. Individual and group responses that have specific skills and experience responding to people bereaved by suicide should be available in a range of settings to respond to different preferences – including clinical and hospital settings, community based, outreach and phone and online. Peer led approaches are particularly valuable.

The ability for settings such as schools, sporting clubs and workplaces to be able to rapidly access and implement skilled supports immediately after a suicide is important.

Due to the stigma associated with suicide, bereaved people may be uncomfortable talking about how their loved one died. It is critical that all responses remain sensitive to the needs of people who are bereaved and sensitive to cultural differences.

[5] Case R, Alabakis J, Bowles K-A, Smith K, 2020. High-risk occupations - Suicide: an Evidence Check rapid review the Sax Institute.

It is important to emphasise that support for family, friends and communities must be available as soon as a person expresses suicidal thoughts or behaviours (see 5a, above), and not only be provided after suicide.

Concluding comments

Georgie Harmon, Beyond Blue CEO, is quoted in the Final Report of the Royal Commission into Victoria's Mental Health System:

> '…life stressors can be the 'tipping factors' that can contribute to suicidal behaviour and suicide attempts: of people who think about suicide or attempt suicide, or indeed die by suicide, many do live with mental health conditions; but some don't, and it can be those tipping factors in life that actually cause suicidal distress … homelessness, losing your job, living in extreme poverty, or you're just not able to put food on the table or pay the rent, relationship breakdowns, these are the life stressors that can massively contribute to suicidal behaviour and suicide attempts.'[6]

Given the significant role that stressful life events play in relation to suicide it is imperative to address key stressors to reduce or remove their influence on people's mental health and wellbeing. These include:

- Reducing poverty, including through advocating to the Commonwealth to increase the level of JobSeeker payment to an adequate level
- Increasing secure and affordable housing
- Eliminating homelessness
- Ensure people have opportunities for secure and meaningful employment
- Addressing racism
- Embracing people from refugee and asylum seeker backgrounds, including advocating to the Commonwealth to ensure all humanitarian entrants have access to income, employment rights and the health care they require
- Addressing climate change

cohealth recommends the Victorian Suicide Prevention and Response Strategy clearly recognises the importance of these factors and articulates how they will be addressed.

Providing support for community-led initiatives is vital, particularly ensuring that communities that face disadvantage are provided adequate resources to develop, implement and evaluate approaches appropriate to their communities.

[6] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report*, Vol 2 p459 https://finalreport.rcvmhs.vic.gov.au/download-report/

cohealth would welcome the opportunity to discuss this submission and our perspectives on suicide prevention and response. Please contact Jane Stanley, Advocacy and Policy Manager on jane.stanley@cohealth.org.au

cohealth
care for all