Submission on the Draft Victorian Suicide Prevention and Response Strategy

Introduction

Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With around 330 members, including 50 in Victoria, we provide a collective voice for service providers, practitioners, researchers, local collaboratives and people with lived experience. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

Mental Health Victoria

Mental Health Victoria (MHV) is the peak body for mental health and wellbeing in Victoria. Our members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health and related sectors. Our aim is to ensure that people living with mental health issues can access the care they need, when and where they need it. Our view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, community, or hospital.

On The Line

Founded in 1958, On the Line Australia is a mental health and suicide prevention charity. Operating 24/7, we provide free professional telephone and webchat counselling and referral services in Victoria and nation-wide. Our major services include SuicideLine Victoria (1300 651 251 www.suicideline.org.au), National Suicide Call Back Service (1300 659 467 www.suicidecallbackservice.org.au) and MensLine Australia (1300 78 99 78 www.mensline.org.au).

Context

Every year, over 3,000 Australians die by suicide including around 700 Victorians. Suicide is complex, multi-factorial human behavior, it is more than simply an expression of mental ill-health. Factors that contribute to suicide may include stressful life events, trauma, mental or physical illness, drug or alcohol abuse and poor living circumstance. The link between unemployment, financial distress, and suicide is, sadly, well established.

While Victoria has not reported increases in suicide rates during the COVID-19 pandemic, other measures of distress, self-harm and suicide attempts demonstrate ongoing suicide risks in the community. As we emerge from the pandemic and compounding natural disasters, research shows suicide rates can peak 2-3 years after crises. Accordingly, this Strategy is developed at a critical juncture.

Key Recommendations

1. Towards zero suicides is an appropriate vision for the Strategy
2. The priority population 'people with lived experience of suicide' should more clearly distinguish between the different types of lived experience including persons experiencing suicidal thoughts, survivors of suicide attempts, people experiencing bereavement and carers of people experiencing suicidality
3. The priority population of those impacted by trauma should be separated from the children and young people priority group

4. Priorities around circumstantial risk factors should be considered including:
    a. People experiencing homelessness or housing instability
    b. People experiencing job loss, unemployment, job insecurity and/or financial hardship:
    c. People experiencing loss of relationship/family breakdown
    d. People experiencing, at risk of, or exposed to abuse and violence
    e. People who are or have been in contact with the criminal justice system
    f. People who have come in contact with the child protection system:
5. Additional priority areas should be addressed in the strategy, including:
    a. Responding earlier to distress
    b. Quality including quality standards
    c. Community safety and means restriction
    d. Resources to meet existing demand
6. An additional principle highlighting a whole-of-government, whole-of-community approach should be added to guide the Strategy
7. The following initiatives should also be included in the Strategy:
    a) A *Victorian Suicide Prevention Act* to deliver whole-of-government focus and accountability
    b) The further expansion of aftercare services to ensure universal access and suitable forms of clinical and non-clinical support are available
    c) The development of new supports after a suicide attempt or suicidal distress for family and loved ones impacted
    d) The adoption of the Standards for Quality Improvement to ensure supports commissioned under the new strategy are safe, quality and effective
    e) Initiatives to support means restriction and community safety
    f) Expansion of safe spaces and alternatives to emergency departments including youth-focused alternatives
    g) Preventing gambling-related suicides
    h) Local Suicide Prevention Networks to drive local impact and coordination
    i) Establishment of a Suicide Prevention Unit within the Victorian Public Services Commission to build capability across the Victorian Government
    j) A focus on demonstrably high-risk industries and workplaces
    k) The inclusion of peer support as part of formal postvention supports

Acknowledgements

This submission has been developed with the support of Suicide Prevention Australia's Victoria-Tasmania Joint State and Territory Committee. We acknowledge and thank members of this Committee for their advice on the submission and contribution to its development.

This submission acknowledges the unique and important understanding provided by people with lived and living experience of suicide. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. This submission was developed with support from Suicide Prevention Australia's Lived Experience Panel and Mental Health Victoria's Lived Experience Advisory Group.

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Vision

Recommendation:

1. Towards zero suicides is an appropriate vision for the strategy

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 responses would you like to see Victoria work towards?

Suicide Prevention Australia has not previously supported calls for suicide reduction targets other than a target of zero. Our mission is for zero suicides and members have told us there is no acceptable number of suicides and that there are more effective measures to support accountability.

Targets overseas and in Australia have not proven effective and evidence suggests they are too simplistic for the complicated behaviour of suicide. Existing targets in Scotland and New South Wales are not on track and a United Kingdom target from 2015-2020 failed.

Discussions of targets should also consider the impacts of perceptions of personal failure and increased stigma if a person becomes suicidal as well as impacts on families and carers.

Mental Health Victoria aligns itself to a strategy of towards zero suicide.

There is merit in considering also objectives around reduced suicidal behaviour and attempts.

Priority Populations

Recommendations:

2. The priority population 'people with lived experience of suicide' should more clearly distinguish between the different types of lived experience including persons experiencing suicidal thoughts, survivors of suicide attempts, people experiencing bereavement and carers of people experiencing suicidality
3. The priority population of those impacted by trauma should be separated from the children and young people priority group
4. Priorities around circumstantial risk factors should be considered including:
    a) People experiencing homelessness or housing instability
    b) People experiencing job loss, unemployment, job insecurity and/or financial hardship:
    c) People experiencing loss of relationship/family breakdown
    d) People experiencing, at risk of, or exposed to abuse and violence
    e) People who are or have been in contact with the criminal justice system
    f) People who have come in contact with the child protection system:

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)

Suicide Prevention Australia welcomes the comprehensive approach taken to consider priority populations and the recognition that individuals may intersect with various groups.

We note there are some challenges with such a broad range of priority cohorts listed, a combination of which represent the entire Victorian population. Notwithstanding, we acknowledge the importance of identifying groups as part of a Suicide Prevention and Response Strategy so that a future Strategy and any initiatives meet the unique needs of these groups identified.

In addressing the needs of priority populations, the voice and knowledge of individuals with lived experience from particular priority populations is essential to ensuring policies and practices meet the needs of those at-risk or impacted by suicide. For example, LGBTQI+ or Aboriginal and Torres Strait Islander people with lived experience of suicide should guide work related to LGTBQI+ or Aboriginal and Torres Stratier suicide prevention. Their leadership, knowledge and insights are uniquely placed to inform suicide prevention policy and practice.

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

This submission support the priority groups listed in the discussion paper, including

- Aboriginal and Torres Strait Islander people
- Children and young people
- People from culturally and linguistically diverse communities
- LGBTIQ+ 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 a lived experience of suicide
- People with disability and neurodiverse people
- People working in high-risk industries
- Veterans and ex-armed services
- Women

Lived experience of suicide

The priority population 'people with lived experience of suicide' should more clearly distinguish between different types of lived experience and how this impacts suicidal risk, priority and needs separately. As with all identified groups, there is often crossover for those with lived experience of suicide, however a clearer distinction should be made given the varied nature, objectives and other differences associated with lived experience among those experiencing suicidal thoughts, survivors of previous suicide attempts, people experiencing bereavement and carers.

Persons experiencing suicidal thoughts

The Australian Institute of Health and Welfare reports people who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts and those who experience all forms of suicidal thoughts and behaviours are at greater risk of dying by suicide.[1] In 2020-21, 1 in 6 (16.7% or around 3.3 million) of Australians aged 16–85 had serious thoughts about taking their own life at some point in their lives.[2]

Survivors of previous suicide attempts

There is a significant amount of research to show that survivors of previous suicide attempt/s are at a higher risk of death by suicide.[3] This risk is generally thought to be elevated for the period immediately following a suicide attempt, but the elevated risk can remain for years following a suicide attempt.[4]

In a Queensland report from 2021, it was found that of the 2,316 deaths by suicide, around one-third had attempted suicide in their lifetime and 17.2% had made a suicide attempt within the 12 months leading up to their death.[5] While self-harm does not always reflect a suicidality, the most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'.

Further, the reference to lived experience on page 22 of the strategy should be changed to align with the definition in the glossary of the discussion paper. The current reference on page 22 does not explicitly include a reference to suicide attempt survivors and this should be addressed wherever lived experience is defined in the strategy.

People experiencing bereavement, including those bereaved by suicide

It has been found that bereavement, particularly sudden death bereavement is associated with increased suicide risk.[6] Within this group, the highest risk for suicide was among those bereaved by suicide specifically.[7] Common risk factors associated with bereavement and elevated risk of suicide include stigma, low levels of social support and social isolation, avoidance behaviours and significant psychological distress.[8]

Carers

There is evidence of a heightened risk of suicide among carers. A comprehensive study of peer-reviewed journal articles identified the proportion of caregivers experiencing suicidal ideation from as

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[1] Australian Institute of Health and Welfare, Australian prevalence estimates of suidical behaviors, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/prevalence-estimates-of-suicidal-behaviours.

[2] ABS (Australian Bureau of Statistics) 2022. National Study of Mental Health and Wellbeing – Summary statistics on key mental health issues including the prevalence of mental disorders and the use of services.

[3] Bostwick, J., Pabbati, C., Geske, J. and McKean, A., 2016. Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew. American Journal of Psychiatry, 173(11), pp.1094-1100.

[4] Probert-Lindström, S., Berge, J., Westrin, Å., Öjehagen, A. and Skogman Pavulans, K., 2020. Long-term risk factors for suicide in suicide attempters examined at a medical emergency in patient unit: results from a 32-year follow-up study. BMJ Open, 10(10), p.e038794.

[5] S. Leske, I. Schrader, G. Adam, A. Catakovic, B. Weir and K. Kõlves, 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia.

[6] Hamdan, S., Berkman, N., Lavi, N., Levy, S. and Brent, D., 2020. The Effect of Sudden Death Bereavement on the Risk for Suicide. Crisis, 41(3), pp.214-224.

[7] Pitman, A., Osborn, D., Rantell, K. and King, M., 2016. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open, 6(1), p.e009948.

[8] Molina, N., Viola, M., Rogers, M., Ouyang, D., Gang, J., Derry, H. and Prigerson, H., 2019. Suicidal Ideation in Bereavement: A Systematic Review. Behavioral Sciences, 9(5), p.53.; Stroebe, M., Stroebe, W. and Abakoumkin, G., 2005. The Broken Heart: Suicidal Ideation in Bereavement. American Journal of Psychiatry, 162(11), pp.2178-2180.

low as 2.7% to as high as 71%.[9] A cross-sectional survey found sixteen per cent of carers had contemplated suicide more than once in the previous year.[10]

Trauma

The children and young people priority group identifies how childhood trauma and other adverse childhood experiences can increase vulnerability to suicide. According to the AIHW 'child abuse and neglect' is recorded as the leading behavioural risk factor contributing to the years of healthy life lost due to suicide and self-inflicted injuries for men and women. [11]

This is an important point yet this priority should be separate to the children and young people group as often this risk will be present among adults. For example, survivors of childhood sexual abuse often experience isolation, shame and guilt in the context of masculine stereotypes which can compound into self-harm and attempted suicide later in life.[12] This could also be broadened to include people impacted by other forms of trauma, for example refugees.

Situational risk factors

The priority groups recognise a range of demographic and individual risk factors but not a range of important situational risk factors. Suicide is complex human behaviour with many varied risk factors. Evidence suggests individual life stressors, situations and events can result in an increased risk of suicide. Whether as additional priority groups or acknowledged in a separate part of the strategy, it is important to identify the situational risk factors that contribute to suicidal risk, for example:

- **People experiencing homelessness or housing instability**: people experiencing homelessness or housing instability are exposed to a range of additional risk factors and stressors, making them a particularly vulnerable group in terms of suicide risk. Risk factors include the following: social isolation, mental illness, unemployment, substance use, relationship breakdown and physical and/or sexual abuse.[13] People experiencing homelessness also face a number of barriers to help-seeking including cost, waiting times, lack of available appointments, illness/poor health, stigma and physical barriers (e.g transportation).[14]
- **People experiencing job loss, unemployment, job insecurity and/or financial hardship:** those experiencing job loss, unemployment, job insecurity and/or financial hardship are also at elevated risk of suicide. From 2015-2017 in Queensland, 31.3% of individuals that died by suicide were either unemployed or pending unemployment and financial problems were reported in 20% of all male suicides.[15] One study found that a 1% increase in global unemployment rates was associated with a 1% increase in male suicides.[16]

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[9] O'Dwyer, S.T., Janssens, A., Sansom, A., Biddle, L., Mars, B., Slater, T., Moran, P., Stallard, P., Melluish, J., Reakes, L., Walker, A., Andrewartha, C. & Hastings, R.P. (2021). Suicidality in family caregivers of people with long-term illnesses and disabilities: A scoping review, *Comprehensive Psychiatry,* available online: https://www.sciencedirect.com/science/article/pii/S0010440X21000390.

[10] O'Dwyer, S.T., Moyle, W., Zimmer-Gembeck, M. & De Leo, D. (2016). Suicidal ideation in family carers of people with dementia, *Journal of Aging Mental Health*, 20(2), available online: https://pubmed.ncbi.nlm.nih.gov/26161825/.

[11] AIHW (Australian Institute of Health and Welfare) 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Cat. no. BOD 22. Canberra: AIHW. DOI:10.25816/5ebca2a4fa7dc.

[12] Easton S., Renner, L. & O'Leary, P. (2013). Suicide attempts among men with histories of child sexual abuse: Examining abuse severity, mental health, and masculine norms. Child Abuse & Neglect.

[13] Coohey, C., Easton, S., Kong, J. and Bockenstedt, J., 2014. Sources of Psychological Pain and Suicidal Thoughts Among Homeless Adults. Suicide and Life-Threatening Behavior, 45(3), pp.271-280.

[14] Australian Institute of Health and Welfare (AIHW) 2021, Health of people experiencing homelessness. [online] Available at: https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness

[15] S. Leske, I. Schrader, G. Adam, A. Catakovic, B. Weir and K. Kõlves, 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia.

[16] Ibid.

- **People experiencing loss of relationship/family breakdown:** Relationship or family conflict and breakdown have also been identified as a common risk factor for suicide. One study reported that there was a 3-fold increase in suicidal ideation and an 8-fold increase in suicide plans and attempts following a relationship separation.[17] Another study in Queensland found that relationship separation was reportedly a preceding life for 26.7% of all suicide deaths between 2015-2017, however for male suicides, the proportion was slightly higher at 28.8%.[18]
- **People experiencing, at risk of, or exposed to abuse and violence***:* There is also an association between suicide and a history of domestic violence and abuse. Various studies have found that adults with a history of sexual and/or physical abuse in childhood are more likely to self-harm and experience suicidal ideation and behaviours.[19] Domestic violence, exposure to domestic violence and childhood sexual abuse have been found to be the most common risk factors for suicide attempts after adjusting for mental illness.[20]
- **People who are or have been in contact with the criminal justice system:** A study conducted in England and Wales found that suicide was 5.1 times more common for male prisoners, and 20x more common for female prisoners compared to the general population.[21] Incarcerated adults are also far more likely to report experiencing suicidal ideation and suicide attempts. A study from the ACT found that 48% of detainees reported lifetime suicidal ideation and 31% reported attempting suicide at least once.[22]
- **People who have come in contact with the child protection system:** Suicide was 4.9 times more likely for young people in care compared to young people without a history of child abuse and neglect.[23]

Priority areas

Recommendations:

5. Additional priority areas should be addressed in the strategy, including:
    a) Responding earlier to distress
    b) Quality including meeting suitable quality standards
    c) Community safety and means restriction
    d) Resources to meet existing demand

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

[17] Batterham, P., Fairweather-Schmidt, A., Butterworth, P., Calear, A., Mackinnon, A. and Christensen, H., 2014. Temporal effects of separation on suicidal thoughts and behaviours. Social Science & Medicine, 111, pp.58-63.
[18] S. Leske, I. Schrader, G. Adam, A. Catakovic, B. Weir and K. Kõlves, 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia.
[19] Mina, E. and Gallop, R., 1998. Childhood Sexual and Physical Abuse and Adult Self-Harm and Suicidal Behaviour: A Literature Review. The Canadian Journal of Psychiatry, 43(8), pp.793-800.
[20] Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L., Deyessa, N., Heise, L., Durand, J., Mbwambo, J., Jansen, H., Berhane, Y., Ellsberg, M. and Garcia-Moreno, C., 2011. Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. Social Science & Medicine, 73(1), pp.79-86.
[21] Fazel, S., Benning, R. and Danesh, J., 2005. Suicides in male prisoners in England and Wales, 1978–2003. The Lancet, 366(9493), pp.1301-1302; Fazel, S. and Benning, R., 2009. Suicides in female prisoners in England and Wales, 1978–2004. British Journal of Psychiatry, 194(2), pp.183-184.
[22] Butler, A., Young, J., Kinner, S. and Borschmann, R., 2018. Self-harm and suicidal behaviour among incarcerated adults in the Australian Capital Territory. Health & Justice, 6(1).
[23] Trew, S., Russell, D. H., & Higgins, D. (2020). Effective interventions to reduce suicidal thoughts and behaviours among children in contact with child protection and out-of-home care systems – a rapid evidence review. Institute of Child Protection Studies, Australian Catholic University. https://doi.org/10.26199/5f1771a5a6b9e 3 | Suicide prevention rapid evidence review by ICPS.

The listed priorities areas are welcome and Suicide Prevention Australia supports the priorities of:

- 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.

There are additional priority areas that require focus in a new Strategy, including:

- **Responding earlier to distress**: As outlined in response to the priority groups' question, there is a missed opportunity to prioritise actions around those individual life stressors, situations and events that can result in an increased risk of suicide. As outlined in the Final Advice, "as people move through different stages in life, they will encounter a range of stressors, transition points and times of disconnection. These can contribute to distress, which can develop into suicidal behaviour in the context of other risk factors."[24] There should be a specific priority around responding earlier to distress and intervening early where a trajectory towards suicidal behaviour might emerge, including by promoting help seeking earlier rather than when a person might enter a crisis point.
- **Quality**: There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability factored into their design. Communities need to have the assurance that Australia's suicide prevention programs provide a consistent, high quality and safe standard of care. The data and evidence priority area could be expanded to include quality.

  Note: *the following paragraph includes discussion of means, if this content causes you distress please contact Lifeline on 13 11 14 or SuicdieLine Victoria on 1300 651 251. Reference to specific means has been redacted, an unredacted version can be requested at policy@suicidepreventionaust.org.*
- **Community safety and means restriction:** Access to the means of suicide has been associated with increases in suicidal behaviour while reducing access to means of suicide has shown effective in reducing suicide deaths.[25] Numerous studies have confirmed that when lethal means are made less available or less deadly, suicide rates by that method decline, and frequently suicide rates overall decline.[26] This has been demonstrated in a number of areas including [redacted]. Increasing community safety through means restriction should be an additional priority area.
- **Resources to meet existing demand:** An additional existing priority is to ensure current services are properly resourced to meet existing demand. Across the sector, providers are reporting more demand than ever before, over the past 12 months, 88% of respondents to the annual State of the National in Suicide Prevention reported increased demand. For example, SuicideLine Victoria is unable to respond to 6,500 calls for help per annum due to insufficient

[24] National Suicide Prevention Advisor (2021) *Connected and Compassionate: https://www.health.gov.au/resources/publications/national-suicide-prevention-adviser-final-advice*.
[25] Ibid.
[26] Harvard School of Public Health (2022) *Means Reduction Saves Lives:* https://www.hsph.harvard.edu/means-matter/means-matter/saves-lives/.

and inconsistent funding arrangements. While the ten-year horizon of this strategy is important to give a long-term focus, people are in crisis now and urgent commitments to funding and reform are needed in the early years of this strategy.

Principles

Recommendations:

6. An additional principle highlighting a whole-of-government, whole-of-community approach should be added to guide the Strategy

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

The suggested principles are suitable to guide the development of the Strategy, including:

- valuing lived experience
- supporting equity and taking an intersectional approach
- supporting Aboriginal self-determination
- being adaptable and evidence-informed
- taking a person-centred approach.

An additional principle around a whole-of-government, whole-of-community approach would strengthen these principles and make clear that a whole-of-government, whole-of-community approach is central. Importantly, this should ensure the Victorian strategy aligns with a new national suicide prevention strategy and work underway at the Commonwealth level. It is important that the new Victorian strategy aligns with and does not duplicate work underway at a national level.

Suicide prevention and response initiatives and actions

Recommendations:

7. The following initiatives should also be included in the strategy:
    a) A *Victorian Suicide Prevention Act* to deliver whole-of-government focus and accountability
    b) The further expansion of aftercare services to ensure universal access and suitable forms of clinical and non-clinical support is available
    c) The development of new supports after a suicide attempt or suicidal distress for family and loved ones impacted
    d) The adoption of the Standards for Quality Improvement to ensure supports commissioned under the new strategy are safe, quality and effective
    e) Initiatives to support means restriction and community safety
    f) Expansion of safe spaces and alternatives to emergency departments including youth-focused alternatives
    g) Addressing gambling-related suicides
    h) Local Suicide Prevention Networks to drive local impact and coordination
    i) Establishment of a Suicide Prevention Unit within the Victorian Public Services Commission to build capability across the Victorian Government
    j) A focus on demonstrably high-risk industries and workplaces
    k) The inclusion of peer support as part of formal postvention supports

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

Suicide Prevention Act

To deliver clear accountability under the new Strategy, Victoria should legislate a *Suicide Prevention Act*. An Act is the missing link to the whole-of-government approach to suicide prevention. With half of those who die from suicide not accessing mental health services, an Act legislates the need for suicide prevention activities in key portfolio agencies, including human services, education and justice.

At a high level, it signals the commitment of the Government to suicide prevention and at a practical level, it will require agencies and officials to consider the impact of – and opportunities for – suicide prevention in the work they do. An Act is necessary to ensure decision-makers across Government are united in working to prevent suicides. Legislation can ensure clear shared and individual accountability and focus agencies on practical and measurable steps to reduce and prevent suicide.

A *Suicide Prevention Act* provides a legislative framework to work towards zero suicides in Victoria. It would legislate:

- The tabling of the new and any future strategies to Parliament as well as transparent annual, outcomes-focused reporting
- A requirement for relevant Agencies to deliver suicide prevention plans for both their employees and those they support
- Effective governance arrangements to ensure: the potential suicide impact of policies is considered, multi-agency collaboration and that the perspectives of lived experience inform design and delivery

Suicide Prevention Acts have been delivered overseas and in Australia. The Japanese Basic Act for Suicide Prevention set priorities for cross-government, whole-of-community suicide prevention. Between 2008-2011, hospital admissions almost halved and from 2009 suicide deaths declined dramatically and hit a 15-year low in 2012.[27] Canada, South Korea and Argentina have also progressed Act. South Australia passed the first Australian Act in 2021 and the NSW Opposition has committed to an Act if elected in early 2023.

Victoria should pass its own Suicide Prevention Act to enable the delivery of the new strategy and ensure clear, whole-of-government action and accountability to drive down suicide rates. This could align the with new *Mental Health and Wellbeing Act* and support the delivery of objectives under this act and other reforms underway or as part of a future legislative review

Expanded aftercare

The Royal Commission recommends strengthening aftercare following a suicide attempt by extending the referral pathways into HOPE. The Commonwealth-Victorian bilateral agreement under the National Mental Health and Suicide Prevention Agreement funds this expansion. While an expansion of HOPE is welcome, more needs to be done to ensure aftercare is available universally to all suicide attempt survivors and that support is both clinical and non-clinical.

A previous suicide attempt is the strongest risk factor for subsequent suicide death. The relative risk for suicide after an attempted suicide is between 20 to 40 times higher than in the general population.

[27]Takeshima, Tadashi et al (2014). Suicide prevention strategies in Japan: A 15-year review (1998–2013). Journal of public health policy. 36. 10.1057/jphp.2014.42; 2Nakanishi, M. et al. (2017). The Basic Act for Suicide Prevention: Effects on Longitudinal Trend in Deliberate Self-Harm with Reference to National Suicide Data for 1996–2014. Int. J. Environ. Res. Public Health 2017, 14, 104. https://doi.org/10.3390/ijerph14010104.

A suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population:[28]

- Between 15 and 25% of people who make a non-fatal attempt at suicide will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[29]
- The relative risk for suicide after an attempted suicide is between 20 to 40 times higher than in the general population.[30]
- The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'.[31]

Evaluations of a range of aftercare modelling currently in-place in Australia show further steps need to be taken to ensure support is provided to those who need it, how they need it and when they need it most.

The following key issues need to be considered in the transition to universal aftercare:

1. No one model will work for all suicide attempt survivors, different approaches are needed
2. Clinical and non-clinical supports are key to the recovery journey including long-term supports
3. More proactive outreach is needed to reach those most at-risk including a 'no wrong door approach' and overcoming existing barriers to reaching people in distress (e.g. privacy restraints)
4. Multiple pathways are required (not just emergency departments); people should be referred through community organisations, Head to Health, police, counsellors, psychologists, GPs and paramedics etc, there could also be referrals from the new Mental Health and Wellbeing Local Services and Area Services developed in response to the Royal Commission.
5. Workforce development (including the peer workforce) and better data on attempts are key enablers

The expansion of HOPE must take into account these issues and consideration should be given to how other aftercare models could complement HOPE or how changes to the HOPE model could improve the current service to drive better outcomes for survivors of suicide attempts.

Support after a suicide attempt or suicidal distress for family and loved ones

Suicide attempts and suicidal distress have significant impacts not only on the individual experiencing suicidality but also on the carers, family and friends surrounding them. While aftercare services support survivors of suicide attempts and postvention supports those bereaved by suicide, there is a major gap in the support available to those loved ones impacted by a suicide attempt or suicidal distress. These friends, families and communities are missing out and need support.

With an estimated 65,000 people who attempt suicide each year and many more who experience suicidal thinking and distress, there is a need to address this major service gap. A peer-led model, co-designed with individuals with lived experience including across other priority cohorts, should be developed. Similar to effective postvention models, a non-clinical model that offers counselling,

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[28] Shand, F., Woodward, A., McGill, K., Larsen, M. & Torok, M. (2019). Suicide aftercare services: an Evidence Check rapid review. brokered by the Sax Institute for the NSW Ministry of Health

[29] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf.

[30] Sax Institute. (2019). Suicide aftercare services, Evidence Check, available online: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf.

[31] AIHW. (2021). Psychosocial risk factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide.

emotional and practical supports and can connect individuals in need with relevant services is required. These services should be delivered in tandem with, and connected to, existing aftercare and postvention services.

Investment in support services of this kind would be expected to reduce psychological distress, promote help-seeking and improve wellbeing for individuals whose loved ones face suicidal distress or attempt suicide. It would also support understanding and relationships between those experiencing suicidal distress and their loved ones and could in turn support the recovery journey of suicide attempt survivors. Such a service could work in tandem with the proposed state-wide, peer call-back services for families, carers and supporters and supported by a clinical framework adopted by professional organisations.

Accreditation

Embedding accreditation and standards into the commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason, Suicide Prevention Australia partnered with people with lived experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

As outcome-oriented standards, the Standards are designed to support the suicide prevention sector and provide assurance to consumers that the suicide prevention programs developed by an organisation are safe, high-quality and effective. The Standards offer an opportunity for organisations to participate in an accreditation program that will provide consistency in delivery and quality improvement. These are bespoke, fit-for-purpose standards reflecting the unique aspects of suicide prevention. Over 120 programs have now registered for accreditation including many providers in Victoria.

A new Victorian Suicide Prevention and Response Strategy should embed accreditation standards into the commissioning processes for suicide prevention services. This is consistent with standards forming part of other commissioning services e.g., drug and alcohol, homelessness services. Any services commissioned under the new Strategy should be accredited or working towards accreditation. This will ensure safe, quality and effective practice across the State.

Means restriction and community safety

The following paragraph includes discussion of means, if this content causes you distress please contact Lifeline on 13 11 14 or SuicdieLine Victoria on 1300 651 251. Reference to specific means have been redacted, an unredacted version can be requested at policy@suicidepreventionaust.org.

Means restrictions and other community safety measures have proven as effective ways of preventing suicides. For example:

- Stronger [redacted] legislation, including following the Port Arthur Massacre, has been linked to declines in suicide deaths[32]
- Restrictions on [redacted] in a number of countries have been followed by a reduction in suicides[33]

[32] Chapman S, Alpers P, Agho K, et al Australia's 1996 [redacted]: faster falls in [redacted]

[33] Gunnell D, Knipe D, Chang SS, Pearson M, Konradsen F, Lee WJ, Eddleston M. Prevention of suicide with regulations aimed at restricting access to [redacted]. Lancet Glob Health. 2017 Oct;5(10):e1026-e1037. doi: 10.1016/S2214-109X(17)30299-1. Epub 2017 Aug 11. PMID: 28807587.

- The replacement of [redacted] corresponded to a major decrease in suicides in the United Kingdom[34]

Means restriction has also been found to be cost-effective. A recent Australian economic evaluation found that barriers installed at multiple bridge sites across Australia were a cost-saving intervention with a return of US $2.40 for every US $1 invested over 10 years.[35] These results suggest that means can be a cost-effective measure associated with reduced rates of suicide and a warranted strategy for suicide prevention.

The recent South Australian *Suicide Prevention Act* includes important measures to support means restriction within state jurisdiction. The Act authorises the Minister to make recommendations relating to reduce the risk of suicide at a particular place, that steps to be taken in relation to packaging, manufacture or sale of controlled lethal means or those specific persons or bodies limit or control access to controlled lethal means by particular groups of people. Similar powers could be considered as part of a *Victorian Suicide Prevention Act*.

Safe Spaces and Safe Haven as alternatives to emergency departments

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environments are not the most appropriate point of care for people who experience mental distress and people with lived experience report distress can be exacerbated by this setting.[36]

Safes Spaces aims to provide an alternative and are an umbrella term referring to non-clinical, peer-led support for people in suicidal crisis. They are also known in some areas as safe havens or safe haven 'cafes'. They do not replace clinical mental health interventions but support people to navigate the mental health system, connect to local services and develop self-management skills.[37]

The original concept was trialled as the Safe Haven Café in 2014 in Aldershot, United Kingdom. Individuals experiencing a mental health problems were able to visit the centre and converse with mental health professionals and peer workers. An evaluation found a 33% reduction in the number of admissions to acute in-patient psychiatric beds within the Safe Haven's catchment areas.[38] Safe Spaces and Safe Havens have been rolled out in most States and Territories in Australia.

In Victoria, the Safe Haven Café at St Vincent's Hospital in Melbourne was an early local example. Recognising that one in nine patients presenting to the Emergency Department cited a primary mental health reason, it was established in 2018 as a non-clinical alternative and to offer respite and peer support. Evaluation has found the model has improved consumer experience and community connectedness, reduced mental health presentations, and delivered savings of more than $30,000 per annum by diverting patients to more appropriate care.[39]

A new Strategy should consider the development of additional Safe Spaces and Safe Havens as alternatives to emergency departments for those experiencing suicidal distress. Additional facilities should be coordinated with Primary Health Networks and the Commonwealth in line with any future national standards and to support a national network of Safe Spaces.

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[34] Kreitman N. The [redacted]. United Kingdom suicide rates, 1960-71. Br J Prev Soc Med. 1976 Jun;30(2):86-93.
[35] Bandara P, Pirkis J, Clapperton A, et al. Cost-effectiveness of [redacted] for Suicide Prevention in Australia. JAMA Netw Open. **2022;5(4):e226019. doi:10.1001/jamanetworkopen.2022.6019.**
[36] Roses in the Ocean. (2021). Discussion Paper: A National Safe Spaces Network, available online: https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf.
[37] Life in Mind. (2021). Safe Spaces, available online: https://lifeinmind.org.au/safe-spaces.
[38] National Health Service UK. (2016) Case study: Safe Haven Café in Aldershot. Available from: https://www.england.nhs.uk/mental-health/case-studies/aldershot/
[39] PricewaterhouseCoopers Consulting Australia. (2018) Economic impact of the Safe Haven Café Melbourne.

Youth-focused alternative to emergency departments

In addition to Safe Spaces and Safe Havens open to the general population, there is a need to consider youth-focused initiatives. Suicide Prevention Australia has recently released a report addressing the negative experiences young people too often have when attending hospital emergency departments (ED) after attempting suicide or self-harm. A substantial body of research, as well as the young people consulted in this project, make it clear that too often they do not receive the support they need. Drawing on the insights of 85 young people, experts in youth wellbeing, and published research, this report examines what is needed for young people who attend ED following self-harm or suicide attempts. What the young people who were consulted with have said about improving ED aligns closely with previous research. However, one of the key insights from young people has not previously been sufficiently highlighted. There was a strong consensus that EDs are fundamentally unsuited to meeting the needs of young people who have made a suicide attempt, have self-harmed, or are at a point of suicidal distress. What is needed is effective youth-specific alternatives to ED.

The reports give a set of recommendations outlining steps to respond to the insights of young people, including:

- Fund a program to design and trial a number of youth-specific alternatives to ED
- Upgrade ED's capacity to address the needs of young people who are presenting after having made a suicide attempt or self-harmed
- Trial a program of increased training for ED staff on responding to young people who have attempted suicide or self-harm, and the introduction of an ED Suicide Response Team which includes youth peer workers.
- Co-design with young people clear and accessible information on ED processes

Addressing gambling-related suicides

More research is needed but NSW data suggests of those who seek help for gambling problems, as many as 11% attempt suicide. Victorian research found almost one in five people presenting with suicidality also experience problems with their gambling. More broadly, we know gambling-related suicides are under-reported and not getting the policy attention they deserve.

In early 2022, Suicide Prevention Australia and Financial Counselling Australia released *Gambling and Suicide Prevention: A roadmap for change*, which outlines key opportunities for action. Actions under the new Strategy could take meaningful steps towards addressing gambling-related suicide including to better identifying and recording gambling-related suicides; increased investment in treatment and support; universal pre-commitment and showing national leadership.

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?

Local Suicide Prevention Networks

Suicide Prevention Networks or collaboratives operate in many communities in Australia. Typically, a collaboration between different levels of Government, service providers and community members facilitates community-led responses. Networks can raise awareness, increase understanding of suicide and reduce stigma. They provide a valuable local opportunity to share lessons, coordinate supports and increase connection.

Evaluations have found networks both deliver benefits to members but can also result in increased community knowledge and awareness of, stronger linkages between, local support services; and increased community confidence and capacity to assist those at risk of suicide.[40]

Overall, beyond the positive impacts for Network members, there is good evidence to suggest that Network activities resulted in perceived increases in community knowledge and awareness of, as well as stronger linkages between, local support services; and increased community confidence and capacity to assist those at risk of suicide.

There is scope for further networks in Victoria. For example, the South Australian Government support 45 networks. There are also positive examples of local solutions targeting at-risk cohorts. For example, Youth Life4Live has developed a successful community-grown model designed for rural and regional communities. It involves local partnerships to lead conversations about mental health and suicide and builds lasting community capacity.

The Strategy should include further opportunities for place-based suicide prevention networks. This could align within existing system boundaries to ensure coordination not any potential silos.

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?

As the national peak body for suicide prevention, Suicide Prevention Australia launched Australia's first national framework for suicide prevention in the workplace, called Suicide Prevention: A competency framework. The framework was created in collaboration with experts in workplace suicide prevention and suicide prevention training and over 50 of our members were involved. It provides a starting point for employers and staff to ensure they are promoting wellbeing in the workplace and have the skills and confidence to intervene when someone is in distress.

The framework is designed to provide organisations with the knowledge and education to respond appropriately to people experiencing suicidal thoughts and behaviours at work. It could be one of their staff or a customer or consumer. Many workplaces have programs to learn CPR or first-aid, in the same way, the Suicide Prevention competency framework provides a roadmap for workplaces to learn the skills and knowledge in suicide prevention.

The Victorian Government employs around 300,000 people. The framework can be used by employers to identify gaps in the workplace when it comes to induction, education, training and most importantly the support and wellbeing of their staff. This is an important opportunity for the Victorian public sector to build capability in human services departments that interact daily with those at risk of suicide.

A case study of building public sector capability can be seen in the recent establishment of a Mental Health and Suicide Prevention Unit within the Australian Public Service Commission. The Unit promotes whole-of-service development of APS workforce literacy, capability and expertise in mental health and suicide prevention and early signs are promising with the roll-out of tailored, public sector training.

A dedicated Suicide Prevention Unit should be established in the Victorian Public Service Commission. This dedicated Unit would similarly promote sector-wide workforce literacy, capability and expertise in mental health and suicide prevention and apply the competency framework across the Victorian public sector.

The employment of peer workers will be an important addition to mental health and suicide prevention workforces. For example, 60 local Mental Health and Wellbeing Centres opening in Victoria over the

[40] Reifels L, Williamson M, Schlichthorst M, Too T, Morgan A, Roberts R, Mercer P, Munkara-Murray K, Jordan H (2020). Wesley LifeForce Suicide Prevention Networks Evaluation: Final Phase 1 & 2 Report. Centre for Mental Health, The University of Melbourne.

next five years should employ peer workers who can work with individuals in distress and support them to access other support networks and alternatives e.g. Safe Spaces.

Addressing fatigue and the potential for vicarious trauma are significant issues. The implications of the pandemic and operating in resource constrained environments are having a major toll on workers across the suicide prevention system. Additional workforce growth, alongside resources for better supervision and support, are needed to respond to increased demand and further investment made under any new Strategy.

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?

The above Suicide Prevention: A competency framework provides a starting point for employers and staff to ensure they are promoting wellbeing in the workplace and have the skills and confidence to intervene when someone is in distress. It includes a range of capabilities required.

There is also a need to invest more broadly in evidence-based suicide prevention training. Only 4 out of 10 people tell a health professional of suicidal thoughts before an attempt. Friends, family and coworkers are often those closest to an individual in distress. Research shows the first conversation someone has about thoughts of suicide is critical and can determine whether they seek additional help or not.

Suicide prevention training has been proven effective to build awareness, increasing capability, addressing the reluctance to intervene and reducing stigma. Investments in suicide prevention across the workforce should be prioritized, especially for those who interact with people at-risk (e.g., first responders, caseworkers, teachers, GPs, and industries).

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

There are a number of groups that are exposed to occupational risk factors which contribute to suicide risk. There are a number of occupations that for a number of reasons see a higher proportion of employee suicides. Such areas of work include technicians and trade workers, labourers, managers,[41] farmers, pharmacists, health professionals[42] and emergency service workers.[43] The aspects of these professionals that contribute to a higher risk of suicide are varied but include: increased access to means,[44] high levels of stress,[45] exposure to traumatic events,[46] socioeconomic factors,[47] social isolation[48] and even high levels of physical pain.[49]

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[41] S. Leske, I. Schrader, G. Adam, A. Catakovic, B. Weir and K. Kõlves, 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia.
[42] Roberts, S., Jaremin, B. and Lloyd, K., 2012. High-risk occupations for suicide. Psychological Medicine, 43(6), pp.1231-1240.
[43] Milner, A., Witt, K., Maheen, H. and LaMontagne, A., 2017. Suicide among emergency and protective service workers: A retrospective mortality study in Australia, 2001 to 2012. Work, 57(2), pp.281-287.
[44] Roberts, S., Jaremin, B. and Lloyd, K., 2012. High-risk occupations for suicide. Psychological Medicine, 43(6), pp.1231-1240.
[45] Milner, A., Spittal, M., Pirkis, J., Chastang, J., Niedhammer, I. and LaMontagne, A., 2017. Low Control and High Demands at Work as Risk Factors for Suicide: An Australian National Population-Level Case-Control Study. Psychosomatic Medicine, 79(3), pp.358-364.
[46] Lawn, S., Roberts, L., Willis, E., Couzner, L., Mohammadi, L. and Goble, E., 2020. The effects of emergency medical service work on the psychological, physical, and social well-being of ambulance personnel: a systematic review of qualitative research. BMC Psychiatry, 20(1).
[47] Kennedy, A., Adams, J., Dwyer, J., Rahman, M. and Brumby, S., 2020. Suicide in Rural Australia: Are Farming-Related Suicides Different?. International Journal of Environmental Research and Public Health, 17(6), p.2010.
[48] Ibid.
[49] Milner, A., Spittal, M., Pirkis, J., Chastang, J., Niedhammer, I. and LaMontagne, A., 2017. Low Control and High Demands at Work as Risk Factors for Suicide: An Australian National Population-Level Case-Control Study. Psychosomatic Medicine, 79(3), pp.358-364.

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?

Sufficient funding for postvention services is essential to ensuring timely, quality and compassionate responses after suicide. Ongoing work with the Commonwealth as part of the new bilateral agreement should ensure sufficient service investment is made to deliver postvention services across the State.

Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide. Bereavement by suicide has been evidenced as a risk factor for subsequent suicidal behaviour, making postvention services an essential component of suicide prevention.[50] An effective form of support is peer support groups, and meeting with others bereaved by suicide.[51]

There is consistent evidence that such peer support is beneficial for people bereaved by suicide.[52] Other postvention services include tailored responses through direct compassionate, person-centered, trauma-informed and coordinated local support services matched to individual needs, which can also include support from a peer companion, and outreach by trained support teams.[53] Postvention supports also mitigate adverse impacts including the risk of a bereaved person engaging in suicidal behaviour. People who are bereaved by suicide are themselves at elevated risk of suicide, particularly if they have a history of prior trauma, suicidal behaviour or depression.[54]

Partnerships with experts across the country can support more compassionate and practical response in Victoria.

[50] Andriessen, K., Krysinska, K., Kolves, K., & Reavley, N. (2019). Suicide postvention service models and guidelines 2014-2019: a systematic review, *Frontiers in Psychology,* 10:2677.
[51] Harrington-LaMorie, J., Jordan, J.R., Ruocco, K. & Cerel, J. (2018). 'Surviving families of military suicide loss: Exploring postvention peer support', Death studies, 42(1):1-12
[52] Bartone, P., Bartone, J. V., Violanti, J. M., Gileno, Z. M. 2017. 'Peer Support Services for Bereaved Survivors: A Systematic Review'. Journal of Death and Dying. 80(4).
[53] Harrington-LaMorie et al. (2018). 'Surviving families of military suicide loss: Exploring postvention peer support', Death studies, 42(1):1-12
[54] Andriessen, K., Krysinska, K., Hill, N.T.M. et al. (2019). 'Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes'. BMC Psychiatry, 19, 49.