Mind Australia Limited

Victorian Department of Health

Suicide Prevention and Response Strategy: Discussion Paper

August 2022

About Mind Australia

Mind Australia Limited (Mind) is one of the largest providers of community-managed psychosocial services in Australia with a range of residential, mobile outreach, centre-based and online services. We have been providing support to people, and their families, friends and carers for more than 40 years.

In the 2020-21 financial year, we provided individualised, evidence-based and recovery-focused support to more than 11,000 people experiencing mental health and wellbeing concerns, including disabilities arising from those concerns – otherwise known as psychosocial disabilities.

We are one of the leading specialist community housing providers in Australia for people experiencing psychosocial disability, and a registered NDIS provider – entrusted to deliver federal and state government funded services across Australia. We are one of the largest providers of NDIS funded supported independent living for people with a psychosocial disability in Australia.

We value lived experience and diversity and many of our staff identify as having a lived experience of mental ill health. Mind significantly invests in research about mental health recovery and psychosocial disability and shares this knowledge, developing evidence informed new service models, evaluating outcomes, and providing training for peer workers and mental health professionals.

Introduction

At Mind Australia we support people to find help, hope and purpose in their own lives by providing person-centred recovery support to those who are experiencing mental ill-health. This includes support for people experiencing suicidal ideation or who may be at-risk of suicide. We are strong supporters of the Royal Commission into Victoria's Mental Health System and are encouraged by the transformative reform already underway to rebalance care into the community and provide holistic, person-centred care to all Victorians who need it, when and where they need it.

We are pleased to provide a response to the Department of Health's *Suicide Prevention and Response Discussion Paper*, and welcome the opportunity to contribute to the development of Victoria's suicide prevention and response strategy. We are strong advocates for co-design and lived experience leadership in our own services, and are pleased to see this referenced in the discussion paper. The Royal Commission identified lived experience leadership as critical to system reform. As has been pointed out by others, co-production is mentioned in the paper but there is limited evidence of consumer leaders being partners in its development process.[1]

We are encouraged by the proposed comprehensive and community-wide approach to address the multiple contributing factors which can increase the risk of suicide, although we believe there is more work to be done to address the social determinants which contribute to psychological distress and suicide risk. This is especially the case for diverse communities, such as those experiencing housing insecurity and/or homelessness, and people with psychosocial disability.

We hope this strategy will create a system where people's strengths are recognised and bolstered, so they can regain and build their capacity to participate in the community following a period of crisis.

As the discussion paper recognises, a systems-based approach to suicide prevention which addresses all systems and interrelating factors is essential, and we must work together to provide multiple services and evidence-based interventions in the community which work together to support people. This ecosystem must include psychosocial support in the community, so that people have access to a range of care.

Psychosocial supports can include supports which assist in managing daily living needs, gaining or maintaining a tenancy, or developing the social skills to build community connection and relationships. These can be offered in the community to help people recover, and as alternatives to the Emergency Department. We have experience providing a range of peer-led services which support people in distress. We want to see holistic support for mental health and suicide prevention in the community, including peer-led support like the kind provided in Crisis Support Spaces (based on the Safe Haven Café model) and in our South Australian Connect program.

Importantly, Victoria's response to suicide cannot simply focus on the mental health system. There approach must address the social determinants of health and risk factors for suicide which extend beyond the mental health system. We need integration and partnerships between a range of services, including mental health, housing, financial counselling and financial assistance.

Commissioning Suicide Prevention and Response Initiatives in Victoria

Effective commissioning of suicide prevention and response initiatives in Victoria will require a clear policy framework with agreed roles, responsibilities and targets for commissioning. We understand that in Victoria, initiatives funded under the National Mental Health and Suicide Prevention Agreement[2] will

[1] Simon Katterl. (2022). *Response to suicide prevention and response strategy*. Accessed by: https://www.simonkatterlconsulting.com/writing/ensuring-human-rights-are-part-of-suicide-prevention-submission
[2] Australian Government. (2022). National Mental Health and Suicide Prevention Agreement. Accessed by: https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement

be commissioned by the Victorian Government, rather than Primary Health Networks (PHNs). We support any approach which minimises duplication and clarifies the role of various commissioning bodies.

We are seeing more and more funding envelopes from commissioning authorities (including PHNs) that are inadequate to achieve expected outputs. Where the Australian Government and State/Territory Government jointly fund a service, we are seeing administration or corporate levies multiplied, diminishing the amount of money left for service delivery. An anonymised example from a PHN tender for a suicide response service where funding comes from both the Commonwealth and State government shows both the PHN and state health service charged a corporate levy which, when the non-government organisation's (NGO) corporate levy was added on, meant around 30% of the funding was used for corporate overheads. [3]

Providers are increasingly being expected to be agile and operate on extremely lean margins. This means reducing 'overhead' costs, such as supervision for staff, professional development, and adequate ICT infrastructure. Reporting requirements often see our staff collecting data without their time being funded. This does not encourage continuous improvement, and creates difficulties retaining staff who frequently report feeling burnt out. At the end of the day, this risks reducing the quality and availability of services for people with mental ill-health, and leaves the underfunded NGO sector effectively subsidising the funded services.

For services to be provided in a compassionate and continuous manner, with appropriately qualified and experienced staff, they must be commissioned in a way which allows for more secure and permanent employment arrangements. These issues impact the sustainability of the community managed mental health sector, who will be essential to delivering the vision of the Royal Commission and ensuring there is a continuum of integrated care available for people experiencing suicidal distress. Commissioning authorities should be concerned with sustainability, including the financial stability of providers, and the coordination of traditional mental health and peer workforce planning.

We recommend the Victorian Government, in development of this Strategy, review the governance, funding and commissioning of services, to ensure they:

- reduce regulatory burden
- lengthen contracts
- provide funding which covers the full cost of service provision, including the time and emotional labour involved in servicing relationships and liaison between workers, different organisations and service systems.[4]

Response to Consultation Questions

Vision

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

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

[3] Mind Australia, Wellways Australia, Neami National, & Sane Australia. (2020). *Joint Submission: Response to the draft Productivity Commission report into mental health.* Accessed by: https://www.pc.gov.au/__data/assets/pdf_file/0017/252107/sub1212-mental-health.pdf

[4] Mind Australia. (2019). Submission to the Victorian Royal Commission into Mental Health Services. Accessed by: http://rcvmhs.archive.royalcommission.vic.gov.au/Mind_Australia.pdf

A vision of reducing suicides towards zero is laudable, and we agree reducing suicide should be a priority. However, we suggest a more transformative vision would be every Victorian having access to the support they need to keep themselves well and build on their strengths, whilst addressing the risk factors associated with suicide. We echo concerns raised by others that attempts to fully eliminate suicide may lead to practices which focus on risk[5], rather than focusing on rights, recovery, and dignity of risk.

Priority groups

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 Discussion Paper identifies a number of priority groups that would benefit from tailored suicide prevention and response initiatives which are co-designed. We agree the groups identified are more likely to experience multiple contributing factors for suicide. Recognising and responding to this intersectionality will be essential to developing safe and supportive services.

In addition to the groups identified, we believe those experiencing marginal housing, insecure housing and/or homelessness should be prioritised through a tailored response. Linked to this, we believe those experiencing financial stress should be prioritised given this is identified as a risk factor for suicide, and cost of living pressures have not been met with a commensurate increase in income support payments. We have provided further information on this below (2b).

We are supportive of a targeted response for LGBTQIA+ communities in the suicide prevention and response strategy. We were pleased to see the announcement in the most recent Victorian budget to fund the development of a model of LGBTQIA+ Aftercare in Victoria as part of the implementation of Royal Commission recommendations.

As the discussion paper points out, Victorian LGBTIQ+ community members are significantly more likely to have considered suicide or attempted suicide than the general Australian population, and more likely to have experienced stigma, discrimination and social exclusion, as well as barriers to accessing care. Mind has significant expertise and experience in providing safe and accessible services to the community through development and operation of a model of specialised aftercare for the LGBTQIA+ community. We would welcome opportunities to present our model and contribute to development of the design of LGBTQIA+ suicide aftercare services in Victoria.

Mind's LGBTQIA+ Aftercare

Mind operates an aftercare program offering support to people who are LGBTQIA+ and are having thoughts or intentions of suicide.

All staff in the Aftercare team are part of the LGBTQIA+ community.

The Aftercare team consists of mental health peer support workers and allied health workers who are knowledgeable about LGBTQIA+ identities and the issues and challenges faced by the community. Aftercare offers recovery-focused short-term (up to 3 months) practical outreach and counselling-based support to help individuals, their chosen family members and other important people in their life, to find inclusive and affirming care and strategies for moving forward. There is no fee to access the Aftercare program.

Aftercare was initially funded by North Western Melbourne Primary Health Network as a program pilot. Recently, the Victorian Government provided 12 months of bridge funding to extend the

[5] Simon Katterl. (2022). *Response to suicide prevention and response strategy*. Accessed by: https://www.simonkatterlconsulting.com/writing/ensuring-human-rights-are-part-of-suicide-prevention-submission

program whilst work is underway within the state to develop a model of LGBTQIA+ aftercare as part of implementation of recommendations from the Royal Commission. Funding for LGBTQIA+ Aftercare is subject to the same concerns of many mental health services, in that uncertainty around funding has an impact on service delivery for both the provider and those wishing to access services.

A summary of results from an evaluation[6] of the Aftercare program pilot (March 2020 – December 2020) is below:

- Clients ranged in age between 14 and 68 years and identified with LGBTQIA+ identities.
- Approximately 75% of clients had made a previous suicide attempt, and 25% of clients had experienced suicidal ideation.
- Most clients (85%) identified with having previous mental health issues or diagnoses.
- Clients experienced collectively over 1000 instances of service provision, including 620 peer work sessions, 20 instances of group sessions, and over 340 sessions of clinical psychology and psychotherapy.
- Aftercare experienced a consistently high demand for post-suicide crisis care during the pilot period.
- Providing suicide support reduced active suicidal ideation in the vast majority of participants.
- There were no client deaths during Aftercare service provision.
- Some clients (approximately 10%) found that although their thoughts of suicide were still there, they felt less alone – as isolation and hopelessness is predictor of suicide attempts, we therefore consider this still a success.
- A key success of the program was found to be the role of peer practitioners who were able to provide support, leading to Aftercare clients experiencing a sense of community, reduced isolation, increased self-advocacy skills and political empowerment.
- Clients spoke about the power of being able to access a service that was identity affirming and validated their experiences of minority stress.
- Exit referrals were frequently difficult to organise given most organisations and long term options for care, such as private psychologists, had significant waitlists.
- The Aftercare Circle (drop-in groups program) was therefore critical to provide ongoing support at the end of the three-month service period.

We are also concerned about the lack of available care and support for young people experiencing suicidal ideation and distress. A significant proportion of young people report high or very high levels of psychological distress[7] with young people recording high rates of self-harming behaviours than other age groups. Tragically, suicide is the leading cause of deaths for those aged 15 to 24 years, accounting for 33% of deaths in this age group.[8]

We recognise the significant investment both the Commonwealth and State Government have dedicated to addressing issues of youth mental health and youth suicide, although substantial areas of

[6] Impact Co. (2021). LGBTQIA+ Aftercare: Evaluation Report for Mind Australia. Mind Australia: Victoria.
[7] AIHW. (2021). Australia's youth: Mental illness. Accessed at: https://www.aihw.gov.au/reports/children-youth/mental-illness#psychological ABS. First Insights from the National Study of Mental Health and Wellbeing, 2020-21. Accessed by: https://www.abs.gov.au/articles/first-insights-national-study-mental-health-and-wellbeing-2020-21
[8] AIHW. (2020). Suicide and intentional self-harm. Accessed by: https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm
AIHW. (2021)., Leading causes of death. Accessed by: https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death

unmet need remain. The Commonwealth's main contribution to the youth mental health system is a network of headspace centres and associated youth programs. There exist significant waitlists for headspace, with young people languishing without support for extended periods – heightening the risk of suicide. Adequate psychosocial support is currently not available, nor funded at headspace. There is great scope for the psychosocial sector to provide support to people on waiting lists and provide ongoing support to young people who require it once they complete their engagement with a headspace. Intervening early, provides an opportunity to prevent mental health concerns from worsening and limit suicide risk. Further, for those who have suicidal ideation or have made an attempt, psychosocial support can provide a lifeline to rebuild connection with services and the community and work towards personal recovery.

We understand that the reformed mental health system in Victoria will see headspace integrated as part of the Youth Local Mental Health and Wellbeing Services[9], although we are unclear exactly how services will be commissioned and provided to ensure evidence-based services are available to young people in Victoria.

We strongly agree this population group need a tailored intervention that is accessible and appropriate for their developmental age and life stage. We have developed a model which could be further developed, co-designed, and piloted in order to be rolled out as a suicide prevention and response initiative for young people.

Youth Suicide Prevention

"Turn the Corner" – proof-of-concept approach (not currently funded to pilot).

Young people have specific needs that are not well-addressed in current suicide prevention programs. The proposed service model draws on our considerable experience and expertise in working with at-risk young people through our national youth sub-acute services, the Way Back program, Families At Risk Mental Health Program in South Australia, Early Intervention Psychosocial Recovery Service in Victoria, and Crisis Support Space in Queensland.

The model addresses specific needs of young people (12-25 years of age) with complex needs who self-harm, experience suicidality or attempt suicide. Key elements of the approach include:

- Partner with services working with vulnerable young people.
- Offer short-to-medium-term interventions over three-to-six months.
- Implement evidence based tools across the service, which are already embedded in our practice with vulnerable young people in our sub-acute and early intervention services, including:
    - Emotional Regulation and Impulse Control (ERIC) practice tool
    - Mind Youth Recovery College lived-experience delivered psychoeducation.

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

The discussion paper identifies risk factors including barriers to receiving health care, along with financial problems, particularly those related to housing and homelessness. Housing-related factors and suicide

[9] Royal Commission into Victoria's Mental Health System. (2021). Fact Sheet: Infant, child and youth mental health and wellbeing services. Accessed by: https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/01/Fact-Sheet-%E2%80%93-Infant-child-and-youth-mental-health-and-wellbeing-services.pdf

have been linked through several sources, including protracted financial stress, loss of security due to insecure housing, and the impacts of adverse life events on children and young people which affects their present and future mental health.[10] Whilst evidence is sparse, several studies show that people experiencing homelessness have higher rates of suicide than the general population.[11]

We argue that for those who are most severely impacted by mental illness, including during periods of rehabilitation and recovery after extended bouts of illness or suicidal distress, access to safe and appropriate housing can be understood through the lens of health. This offers a different way to view possible suicide prevention and response options. Further, we know psychological distress, financial hardship and insecure housing go hand-in-hand. To support wellbeing, we need an income support system which allows people to meet their basic needs. The discussion paper identifies financial problems (including housing and employment) as contributing factors for suicide. Income support payments, including Commonwealth Rent Assistance, are inadequate to meet the cost of living meaning many face financial pressures.

We make these points to recommend the Victorian Government view addressing the social determinants of health as essential to its suicide prevention and response agenda. Addressing these areas has great potential for improving mental health and having a positive impact on wellbeing. Brackertz (2020) also suggests it is likely interventions which ameliorate protracted financial stress associated with housing may address some of the risk factors associated with suicide.[12]

Priority areas

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

We understand the strategy's priority areas will determine where the Government will focus its attention to have the greatest impact and achieve its shared vision. We are supportive of the proposed priority areas outlined in the strategy, namely:

- 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.

We also recommend a priority area within a responsive, integrated and compassionate system be reviewing links with other agencies and services. This is to ensure the social determinants impacting suicide risk factors are addressed so that protective factors can be maintained and enhanced wherever possible. Further, a system-wide approach needs to have integrated partnerships so that people can access holistic care for the factors in their life causing distress.

Principles

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

[10] Brackertz, N. (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, commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia, Australian Housing and Urban Research Institute Limited, Melbourne.
[11] Ibid
[12] Ibid

The principles of the strategy should inform the priority areas, groups, and response initiatives and actions. These principles should echo those of the broader system, and capture the vision laid out in the Royal Commission into Victoria's Mental Health System Final Report. The principles of the strategy should also be informed by a human rights framework.

We are supportive of the example principles included in the discussion paper, namely:

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

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?

The initiatives built into the National Mental Health and Suicide Prevention Agreement, including statewide postvention and bereavement support and universal aftercare should be integrated into the strategy. They will form part of the suicide prevention and response system, and there should be seamless delivery of services regardless of whether they are funded by the State or Commonwealth Government.

Programs for people experiencing psychological distress is highlighted as a priority initiative to be addressed through the Strategy and implemented by the newly set up Suicide Prevention and Response Office. We recommend a range of programs for people experiencing psychological distress be available across different settings to ensure there are safe places to access support. This should include hospital diversion programs to offer people alternatives to the Emergency Department (ED), such as Safe Space Cafes, Crisis Support Spaces, and other peer-led psychosocial support services. Safe Spaces are referred to in the Royal Commission as a cost-effective alternative to the ED. They offer a safe, warm and welcoming environment for people to go to for safety during times of crisis and are usually staffed by mental health clinicians and peer support staff.

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?

Awareness raising campaigns are just one tool required to eliminate stigma and discrimination and education efforts should be accompanied by mechanisms to eliminate structural stigma and discrimination across all tiers of our community. We cannot afford to have short term and short-sighted plans to change the community's attitudes and behaviours. Public mental health awareness campaigns must be sustainable and seek to create a social movement working to change the way we all think and act about mental health issues.[13]

There should be safe spaces to decrease the stigma associated with accessing support in crisis. As well as this, there should be a focus on intersectionality to reduce the complex layers of stigma associated

[13] Mind Australia, Wellways Australia, Neami National, & Sane Australia. (2020). *Joint Submission: Response to the draft Productivity Commission report into mental health.* Accessed by: https://www.pc.gov.au/__data/assets/pdf_file/0017/252107/sub1212-mental-health.pdf

with experiencing suicidal thoughts and, for example, being a member of diverse communities such as Culturally and Linguistically Diverse, LGBTQIA+, and Aboriginal and Torres Strait Islander peoples.

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?

Training and supervision will be essential for supporting frontline workforces and other social and health services to respond compassionately to people experiencing suicidal thoughts and behaviour, suicide survivors, and families and carers. An appropriate quantum of skilled and experienced workers will support this, as in a climate of resource-scarcity, high demand, and staffing shortages, it is challenging to respond compassionately at all times, with the workforce risking moral injury and burnout.

Further, a comprehensive review of data gathering infrastructure to better capture rates of suicide for priority groups will assist in estimating demand and service planning.

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?

See above.

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

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?

Approaches which respond compassionately to those bereaved by suicide are essential to supporting people to recover in the community and lead meaningful lives following the loss of a loved one. These approaches should differ across various communities/groups to address intersectional needs. We recommend the Victorian Government work with communities and priority groups to co-design tailored responses which are appropriate and safe.

We recommend the Victorian Government work closely with the Commonwealth Government to implement the postvention and bereavement support initiatives funded in the National Mental Health and Suicide Prevention Agreement to ensure they reflect the vision of the Royal Commission and provide a compassionate and practical response to those bereaved by suicide.

A trusted provider of community mental health support services to people and their families, friends and carers for over 40 years.

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