



Suicide Prevention Australia

SUICIDE PREVENTION AUSTRALIA SUBMISSION TO

The Royal Commission into Victoria's Mental Health
System

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Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for those working in suicide prevention, engaging with Member organisations, governments, businesses, researchers, practitioners and those with lived experience, seeking to reduce the impact of suicide on the community.

We believe that through collaborative effort and shared purpose, we can achieve our shared vision of a world without suicide.

We've been providing national support for Australia's suicide prevention sector for more than 25 years.

As the national peak body our role is to support, facilitate collaboration and advocate for the suicide prevention sector. We support our Members to build a stronger suicide prevention sector.

We're committed to driving continual improvement in suicide prevention policy, programs and services to achieve better outcomes for all Australians.

Suicide Prevention Australia promotes the importance of an integrated and multi-faceted approach to understanding suicidal behaviour and suicide prevention, drawing on the national and international evidence as collected in the World Health Organization's Report on Suicide 2014. We advocate for a whole-of-government approach to reducing suicide. We are focused on an integrated approach to suicide prevention encompassing mental health, social, economic and community factors. A public policy approach that addresses public health related and the social determinants of suicide is required.

Acknowledgement Statement

Suicide Prevention Australia remembers those we have lost to suicide and acknowledges the suffering suicide brings when it touches our lives. We are brought together by experience and are unified by hope. Suicide Prevention Australia acknowledges the traditional owners of country throughout Australia, and their continuing connections to land, sea and community. We pay our respects to them and their cultures, and to elders past, present and emerging.

There are crisis services available 24/7 if you or someone you know is in distress

Lifeline: 13 11 14

Suicide Call Back Service: 1300 659 467

www.lifeline.org.au

www.suicidcallbackservice.org.au



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Summary of Recommendations

1. Update the Mental Health Plan and Suicide Prevention Framework to create more tangible and measurable actions.
2. Give greater attention to a focused and consistent approach to suicide prevention activities within the state with clinical and community based mental health treatment services.
3. Report separately on the measures and actions achieved within the Suicide Prevention Framework.
4. Improve data reporting on suicide attempts and mortality as a matter of priority to better inform service planning and prevention activities.
5. Consider the wider risk factors associated with suicidality in creating suicide prevention initiatives. This would require multi-agency input across the whole-of-government to implement holistic and effective suicide prevention before a person reaches suicidal crisis.
6. Utilise the place based trials to develop a more holistic view of suicide risk and protective factors within communities to increase prevention activities.
7. The Victorian Government should acknowledge that in creating a more fulsome, whole-of-government approach to suicide prevention that oversight and monitoring of those efforts is best placed within the Premier's Department.
8. Provide measurable outcomes for the development and support of the mental health workforce, particularly with regard to retention and training of health professionals, peer workers and non-professional workers in suicide prevention skills and techniques.
9. Create a suicide prevention workforce specific plan, independent of the Mental Health Workforce Plan.
10. Implement a framework of training and support, such as Connecting with People, which focuses on training not just the mental health workforce but other health practitioners in assisting people with potential suicidality, before it escalates to crisis.



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Introduction

In 2017 there were 621 deaths by suicide in Victoria.¹ This was almost the same amount as the year before and the third highest number after NSW and Queensland. However, Victoria does have the lowest rate of suicide per capita. This is interesting because, according to Mental Health Victoria (MHV), as of 2018, Victoria has “the lowest per capita expenditure on mental health in the country (13 per cent below the national average) and access to mental health services that is nearly 40 per cent below the national average.”²

A historical focus on clinical treatment rather than protective factors and a below average spend on mental health services means that there could be a flow on impact on suicides.

SPA believes the Royal Commission is a good first step towards making much needed improvements to Victorian suicide prevention activities. Whilst Victoria maintains some of the lowest rates per capita, it is imperative that a shift in focus and better investment in workforce and training is required to ensure the state can achieve its aim of reducing suicide rates.

It is encouraging that with the implementation of the Fifth National Mental Health and Suicide Prevention Plan, all states should begin to shift their suicide prevention activities towards a national aligned framework which takes a more holistic view of protective and risk factors.

Victoria should also be commended for taking the lead by creating the implementation strategy for the fifth plan and for reviewing their mental health and suicide prevention sector, with a view to improving their patch.

In the last few years, the Department of Health and Human Services (DHHS), who is responsible for mental health and suicide prevention in Victoria have made strides to improve the standard of mental health treatment and suicide prevention with the introduction of a 10-Year Mental Health Plan and subsequent associated Suicide Prevention and Workforce Strategies. However, there has been no significant decline in the number of suicides (47 less deaths since 2015 or a 7 per cent decrease).³

SPA believes this is because neither the Mental Health Plan, nor the Suicide Prevention Framework contain tangible actions for implementation or measurable outcomes which make it hard to ascertain what is actually being done to achieve high level goals.

¹ Australian Bureau of Statistics, 2018, *Causes of Death, Australia, 2017*, viewed 19 June 2019, <
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>>

² *Saving Lives. Saving Money: The Case for Better Investment in Victorian Mental Health*. Report. Mental Health Victoria. Melbourne, VIC, 2018 p.4.

³ *Causes of Death, Australia*



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Therefore, SPA is advocating for a review of the Mental Health Plan and associated Suicide Prevention Framework to balance the competing priorities of treatment post diagnosis of mental ill-health outcomes and prevention initiatives which are rooted in a whole-of government approach.

SPA acknowledges that Victoria has a nation leading approach to suicide data collection with the Victorian Suicide Register. However, this data is not reported on a regular or continuing basis and it is therefore not clear what link this data has with the Suicide Prevention Framework or the wider Mental Health Plan. In fact, the Suicide Prevention Framework calls for better data collection and use in its listed outcomes. Without this link it is hard to ensure investments being made in the space are achieving results.

Finally, SPA is seeking more investment in the mental health workforce and specifically the suicide prevention, post-vention and aftercare workforce as well as for general clinicians to assist in diagnosing and managing potential suicidal crisis before it becomes acute. Without a well-developed workforce, none of the outcomes of the plan and framework can be achieved.

Whilst both of these outcomes appear as focus areas within the Mental Health Plan and the Suicide Prevention Framework, due to lack of measurable outcomes or tangible action items it is hard to measure how far DHHS has come to making inroads in these areas.



Mental Health, Suicidality and Prevention in Victoria

Suicide prevention in Victoria falls under the remit of the Department of Health and Human Services (DHHS) as part of their mental health work. As will be discussed below, mental health is only one facet of suicide prevention however, for the purpose of a fulsome response, the mental health plan will also be discussed.

In creating a new strategy for mental health treatment in Victoria, DHHS created *Victoria's 10-Year Mental Health Plan* (the Mental Health Plan). The Mental Health Plan states that its outcomes based approach is designed to create “better results for people with mental illness, such as more social and economic participation, reduced contact with the criminal justice system and better access to safe, responsive services that join up to work as a whole.”⁴

One of the key objectives of the Mental Health Plan is to reduce the rate of suicide in Victoria. To help achieve this, the *Victorian Suicide Prevention Framework 2016-25* (Suicide Prevention Framework) was released in 2016.

The objectives of the Suicide Prevention Framework are to:

1. Build resilience by improving individual and community strength and capacity to prevent suicide;
2. Support vulnerable people by uniting behind groups who are experiencing higher risks of distress and suicide;
3. Care for the suicidal person by strengthening approaches to assertive outreach and personal care;
4. Learn what works best by testing and evaluating new trial initiatives and share data with local communities; and
5. Help local communities prevent suicide by trialling a coordinated approach to suicide prevention in six local government areas across Victoria.

The Suicide Prevention Framework also features a \$27M investment in two key suicide prevention initiatives – the Hospital Outreach Post-Suicide Engagement (HOPE) program and place based suicide prevention trials.

The HOPE program provides dedicated and practical outreach support for people leaving hospital following a suicide attempt or intentional self-harm. The *Mental Health Services Annual Report 2017-18* (the Annual Report) notes that 500 people have been supported through the HOPE program, with each receiving up to three months post-discharge

⁴ Australia. State of Victoria, Department of Health and Human Services. *Victoria's Mental Health Services Annual Report 2017-2018*. Melbourne, VIC: Victorian Government p. 6



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outreach support.⁵ In 2018-19, the program was extended to a further six hospital trial sites.⁶

The place-based suicide prevention trials, delivered in partnership with the Primary Health Networks located in Victoria, support communities to work together to identify what is needed to prevent suicide, foster individual and community resilience and wellbeing, and strengthen systems to prevent suicide in an on-going way.

The Suicide Prevention Framework's overarching goal is to halve Victoria's suicide rate by 2025. According to the 2017/18 Mental Health Annual Report, in 2015 there were 654 deaths by suicide in Victoria.⁷ To achieve the goal of halving the 2015 rate would require a reduction of 418 deaths by suicide in the year 2025.

That annual report notes that there has been a small reduction in the rate of suicide since the implementation of the plan with 624 deaths in 2016 and 621 deaths in 2017.⁸ The report contrasts this however, with the Australian national suicide rate which has increased in the same period.⁹

The Fifth Plan

In 2017 the Commonwealth Government released the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). The plan, which has been endorsed by COAG, commits all governments to work together to achieve integration in planning and service delivery.

The plan sets outcomes in eight priority areas:

- achieving integrated regional planning and service delivery;
- effective suicide prevention;
- coordinating treatment and supports for people with severe and complex mental illness;
- improving Aboriginal and Torres Strait Islander mental health and suicide prevention;
- improving the physical health of people living with mental illness and reducing early mortality;
- reducing stigma and discrimination;
- making safety and quality central to mental health service delivery; and
- ensuring that the enablers of effective system performance and system improvement are in place.

⁵ Ibid

⁶ Ibid

⁷ Ibid p. 5

⁸ Ibid

⁹ Ibid



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With regard to suicide prevention specifically, the plan commits to a whole-of-government, systems based approach which is drawn from the WHO's 11 key areas for strategic action in suicide prevention. These actions are:

1. Engage key stakeholders;
2. Reduce access to means;
3. Conduct surveillance and improve data quality;
4. Raise awareness;
5. Engage the media;
6. Mobilize the health system and train health workers;
7. Change attitudes and beliefs;
8. Conduct evaluation and research;
9. Develop and implement a comprehensive national suicide prevention strategy.¹⁰

These actions are useful for ensuring a considered and holistic approach to suicide prevention.

As all governments are now committed to achieving the outcomes of the plan, it is a good time for Victoria to reflect on their existing mental health and suicide prevention frameworks and activities to align with the Fifth Plan and international best practice.

¹⁰ *Preventing Suicide: A Global Imperative*. Report. World Health Organization. Switzerland: WHO Press, 2014 p. 68 – 69



Commentary on the Victorian Mental Health Plan and Suicide Prevention Framework

Given that the Commonwealth Government has created the Fifth National Mental Health and Suicide Prevention Plan, which seeks to establish a national approach for the collaboration of all Australian governments in suicide prevention, it is the hope of SPA that the whole of the Mental Health Plan and Suicide Prevention Framework will be reconsidered to incorporate the national approach. In so doing, the plan should address the lack of tangible outcomes and measurable actions contained within (including reporting separately on the Suicide Prevention Framework, consider a more balanced approach to clinical and community based risk and protective factors and consider the generation and application of reliable data.

Tangible Actions and Measureable Outcomes

In early 2019, the Victorian Auditor General released a report titled *Access to Mental Health Services* (the Auditor General's Report). The report is sceptical of the Mental Health Plans efficacy noting that one of the key criticisms is the generality of the outcomes and the lack of clear actions to address the problems of access to the mental health services.¹¹

The Mental Health Plan and the Suicide Prevention Framework both offer high level outcomes but no measurable targets or actual action items to achieve their aims. Further the Suicide Prevention Framework is not separately reported on and it is therefore even harder to grasp how the plan is working.

This is particularly concerning as per Mental Health Victoria (MHV's) notes that Victoria spends the least amount on mental health per capita across the nation.¹² If the plan and associated framework cannot be adequately measured, it is hard to tell where this investment is going, except to say that it is not enough.

Recommendation: Update the Mental Health Plan and Suicide Prevention Framework to create more tangible and measurable actions.

Balance of Clinical and Community Care

Further, MHV also notes that a historical focus on acute, as opposed to preventative care and under-investment in community based services and early intervention has led to a "misalignment of resources and capacity with areas of greatest demand and need."¹³ This

¹¹ *Access to Mental Health Services*. Report. Victorian Auditor General's Office. Melbourne, VIC, 2019 p. 9

¹² *Saving Lives. Saving Money: The Case for Better Investment in Victorian Mental Health*. Report. Mental Health Victoria. Melbourne, VIC, 2018 p.4.

¹³ *Ibid* p. 10.



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focus on acute mental health care undermines the potential for earlier impacts related to suicide prevention.

The plan, despite espousing the value of a holistic approach to treatment that involves a myriad of factors, is overwhelming skewed towards the treatment of acute, diagnosed patients experiencing mental ill health and suicidal crisis. And where there are outcomes that focus on prevention, they do not present tangible actions towards achieving that aim.

The next section will talk at length about the need for a more holistic approach to suicide prevention however, it is SPA's position that the Mental Health Plan and the Suicide Prevention Framework should be balanced to better include preventative measures that involve whole-of-government approaches.

One of the key issues with focussing on clinical treatments during and post suicidal crisis is that people in suicidal crisis may not get access to immediate service and support at hospital emergency departments.

A report by the Australasian College for Emergency Medicine (ACEM) found that people presenting with acute mental health crisis generally have to wait longer than other presentations.¹⁴ Further, they were 18 per cent less likely to be seen within the appropriate Australasian Triage Scale timeframe.¹⁵ The report suggests that this can reflect a lack of specialist mental health staff.¹⁶

A lived experience case study contained within the ACEM report notes that the very environment of an emergency room can significantly add to already overwhelming distress, often resulting in ER staff requesting the consumer to "calm down" or requiring chemical restraint.¹⁷ After being seen, the consumer says they are often released because admission may add to their distress, noting that this made them feel unworthy of help and only heightened the crisis for them.¹⁸ To address the increasing crisis, helplines and support only recommended further ER attendance.¹⁹

Staff training is addressed further in this submission, however, this highlights the need to balance the priority focus between clinical health presentations and solutions with community based treatment and prevention options. Clinical treatments are not necessarily

¹⁴ *The Long Wait: An Analysis of Mental Health Presentations to Australia Emergency Departments*. Report. Department of Policy, Research and Advocacy, Australasian College for Emergency Medicine. West Melbourne, VIC, 2018 p. 2.

¹⁵ Ibid

¹⁶ Ibid

¹⁷ Ibid p. 3

¹⁸ Ibid

¹⁹ Ibid



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the best environment for those suffering suicidal crisis and prevention factors should be more readily considered.

The Suicide Prevention Framework does look to close the gap between hospital presentation and post crisis care through the HOPE program and SPA welcomes the decision to extend this trial to a further six trial sites. It is not clear however what will happen at the conclusion of the trial and by what measures the efficacy of this program is being tested.

Recommendation: Give greater attention to a focused and consistent approach to suicide prevention activities within the state with clinical and community based mental health treatment services.

Reporting on Suicide Prevention Activities

DHHS has committed, in the Mental Health Plan to reporting yearly on the outcomes contained therein, however, there is no reporting committed as to the achievements within the Suicide Prevention Framework.

Whilst there is an overarching outcome within the Mental Health Plan to reduce the amount of suicides in Victoria, the annual reporting appears to only focus on some aspects of the associated Suicide Prevention Framework instead of reporting on all of its aims.

Complete reporting on the Suicide Prevention Framework is required to better assess investment in this area.

Recommendation: Report separately on the measures and actions achieved within the Suicide Prevention Framework.

Collection and Application of Reliable Data

Whilst the Victorian Government has put significant investment in the collection of data pertaining to suicidality in the state, it is not clear how this data is being utilised or reported on and how it informs both the Mental Health Plan and the Suicide Prevention Framework.

Data that is collected should be mined at a regional level to inform strategy. It is also important to note that reliable data includes the collection of data about those that have attempted suicide or had access to interventions throughout the system so that service delivery can be adequately planned.

Improved and coordinated data collection and retrieval is required to ensure that suicide prevention services are fit for purpose. Reliable data is critical to enabling evidence-based



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policy development, the planning and resourcing of suicide prevention activity, the improvement of service delivery and outcomes, and informed research.

The WHO report notes that “for both suicides and suicide attempts, improved availability and quality of data from vital registration, hospital-based systems and surveys are required for effective suicide prevention.”²⁰ It further notes that most countries do not have an adequate reporting mechanism as “suicide registration is a complicated, multilevel procedure that includes medical and legal concerns and involves several responsible authorities that can vary from country to country.”²¹

Victoria does collect data on suicides in the state through the Victorian Suicide Register (the Register), however the Suicide Prevention Framework has, as an objective, the need to build a stronger, more accessible evidence base.²² A key area for improvement includes enhanced collection, analysis and dissemination of suicide attempts and mortality data as well as collect better data on what are effective suicide prevention strategies.²³

Given the Register has been in operation since 2010, no rationale is given for this outcome however, the action specifically states that DHHS will work with the Coroner, among other partners to achieve this.

However, it does not appear that inroads have been made towards this objective and as the Suicide Prevention Framework is not reported on separately to the Mental Health Plan it is hard to ascertain if the Victorian Government has started working towards this goal. However, the Auditor General’s report suggests a lack of adequate data in the mental health space noting that there are shortcomings in the reporting system around functionality and useability which discourage accurate reporting.²⁴

That report notes that data is crucial to determining the need for future mental health (and suicide prevention) systems however “DHHS lacks a comprehensive view of current mental health service demand, and until recently DHHS utilised only basic forecasting.”²⁵ The report found that DHHS “does not adequately capture the extent of mental health illness in the population and the true unmet demand for services.”²⁶

²⁰ *Preventing Suicide: A Global Imperative*. p. 7

²¹ *Ibid* p. 19

²² Victoria, Australia. Department of Health and Human Services. *Victorian Suicide Prevention Framework 2016-25*. Melbourne, VIC: Victorian Government, 2016

²³ *Ibid*

²⁴ *Access to Mental Health Services* p. 46

²⁵ *Ibid* p. 47

²⁶ *Ibid*



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Further, the Suicide Register only collects data about death and does not collect any data about attempts or interventions which would be useful to inform not only the strategy but any associated outcomes.

Recommendation: Improve data reporting on suicide attempts and mortality as a matter of priority to better inform service planning and prevention activities.



Whole of Government Approach

Suicide prevention is more than just a mental health issue and it is more than just a health issue. Whilst health and mental health are components of suicide prevention, a more holistic, whole-of-government approach is required when considering how best to positively impact suicide rates in Victoria.

Better cross-portfolio coordination is essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention. This means that the causes of mental ill-health and therefore potential suicidality are treated before they escalate to suicidal crisis.

The World Health Organization (WHO) has long looked at all health issues through a paradigm of wider social factors. These social factors, known by WHO as the social determinants of health (SDOH), are the conditions in which people are born, grow, live, work and age²⁷ and include physical and biological factors, individual behaviours, social environment, physical environment and access to health services.²⁸

This was confirmed by the Measurement and Evidence Knowledge Network in their final report to the WHO Commission on the Social Determinants of Health. Their report noted that the health of individuals and of populations is determined to a significant degree by social factors.²⁹ For example, the poor and disadvantaged experience more ill health than their richer counterparts.³⁰

Whilst the WHO utilises the SDOH framework in assessing all aspects of population health, they are a particularly useful paradigm from which to base suicide prevention policy as it focusses on the causes (and treatment) of mental ill health that may lead to suicide, rather than treating the symptoms. In its report *Preventing Suicide: A Global Imperative*, The World Health Organization (WHO), notes that "suicidal behaviour often occurs as a response to personal psychological stress in a social context where sources of support are lacking and may reflect a wider absences of well-being and cohesion."³¹

The report also lists a number of wide ranging factors that influence suicidality and risk. Whilst more traditionally focussed on factors such as barriers to accessing care and access to means are considered, WHO also lists disaster, war and conflict, discrimination, sense of

²⁷ "About Social Determinants of Health." Social Determinants of Health. Accessed June 18, 2019. <https://www.who.int/social_determinants/sdh_definition/en/>

²⁸ "NCHHSTP Social Determinants of Health: Definitions." Centers for Disease Control and Prevention. March 10, 2014. Accessed June 18, 2019. <<https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>.>

²⁹ Kelly, Michael P., Antony Morgan, Josiane Bonnefoy, Jennifer Butt, and Vivian Bergman. *The Social Determinants of Health: Developing an Evidence Base for Political Action*. Report. Measurement and Evidence Knowledge Network. 2007 p. 7.

³⁰ Ibid

³¹ *Preventing Suicide: A Global Imperative*. p. 36



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isolation and, relationship discord or loss as key risk factors for suicide.³² The report further notes that these factors are not an exhaustive list and the importance of each risk factor varies from individual to individual.³³

The Suicide Prevention Framework does turn its mind to the idea that suicide is more than just simply a mental health issue, noting that “action that builds protective factors – strong communities, relationships, contributing lives with purpose and hope, community and personal resilience, gives people reason for living.”³⁴ It further notes that reducing risk factors such as disadvantage and injustice reduces the likelihood of suicidality.³⁵

However, the actions contained within the plan do not address these factors, instead focussing on health based solutions for people already experiencing suicidal crises and specific vulnerable groups. Whilst these are important initiatives in helping to reduce the rate of completed suicides, they do not necessarily address the wider risk factors that lead to suicidality. The Victorian Government should also consider wider, more holistic ways to reduce suicide risk in general.

For example, housing is a key factor in suicidality. As per the SDOH framework, homelessness affects a person’s physical health, mental health and their sense of belonging and/or isolation, amongst other things. In its report *Mental Health, Housing and Homelessness in Australia*, The Mental Health Council of Australia found an increased risk of suicidality amongst young homeless people. The research, conducted in Melbourne, found that 37 per cent of homeless young people had attempted suicide, with 11 per cent of those having done so in the preceding three months with these figures being much higher than the general youth population.³⁶

The report notes that this is a key period of a person’s life for education, commencement of employment and the formation of a firm basis for financial stability.³⁷ The same research showed that only 38 per cent of homeless youths were attending an educational institution with almost half attending less frequently when their accommodation situation deteriorated.³⁸

It should be noted that whilst mental illness can contribute to causing homelessness (25 per cent of people accessing homelessness services identify mental illness as a contributing

³² Ibid p. 31

³³ Ibid p. 30

³⁴ *Victorian Suicide Prevention Framework 2016-25*. p. 5.

³⁵ Ibid

³⁶ *Home Truths: Mental Health, Housing and Homelessness in Australia*. Report. Mental Health Council of Australia. Deakin, ACT, 2009 p. 16.

³⁷ Ibid p. 17.

³⁸ Ibid



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factor to their homelessness)³⁹ it is not just the provision of stable housing to those with diagnosed mental illness that would contribute to the prevention of suicidality. This is true for other wellbeing factors such as access to education and general societal interaction.

This research demonstrates why a holistic approach to suicide prevention is appropriate and necessary. A young person experiencing homelessness also struggles with education which has long reaching implications for their lives. They have a higher rate of suicidality and self-harm than their counterparts in the general population and this can be directly related to their living situation.

Recommendation: Consider the wider risk factors associated with suicidality in creating suicide prevention initiatives. This would require multi-agency input across the whole-of-government to implement holistic and effective suicide prevention before a person reaches suicidal crisis.

Part of the Suicide Prevention Framework includes the use of place-based trials which were one of the first tangible measures to be introduced.

The place based trial involved creating a local suicide prevention group to develop a localised plan to reduce suicides in the local area. The Suicide Prevention Framework notes that each trial site is supported to implement key “proven” suicide prevention initiatives. The key prevention initiatives include:

- Prevention awareness programs;
- School-based programs;
- Responsible media reporting;
- Gatekeeper training;
- Frontline staff training;
- General practitioner support;
- Reduced access to lethal means;
- High-quality treatment; and
- Continuing care after an attempted suicide.

There does not appear to be an overarching framework or guidance through which these prevention initiatives come together to reduce suicidality in the local community. Further, it is not clear how the efficacy of the strategy is being measured, with the 2017/18 Annual

³⁹ Australia. State of Victoria, Department of Health and Human Services. *Victoria's Mental Health Services Annual Report 2016-2017*. Melbourne, VIC: Victorian Government p. 23



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Report only reporting on initiatives implemented by the trials but no tangible measures of achievement such as reduction in suicide or less attempts or presentations during crises.

Further, whilst the place based trials do have an intrinsic view of holistic care, its remit could be widened to include key local organisations and programs dealing with other risk factors such as homelessness, unemployment or social isolation. The 2017/18 Annual Report notes that resilience building is a key goal for the place based trials. Suicide prevention efforts should focus on the wider causes, in addition to resilience and the treatment of mental ill health. This could be achieved through an overall shift for suicide prevention from health, to whole-of-government.

Recommendation: Utilise the place based trials to develop a more holistic view of suicide risk and protective factors within communities to increase prevention activities.

SDOH also speak to an integration of services, both community and clinical in treating suicidality. It is apparent that the Victorian Government, in both the Mental Health Plan and the Suicide Prevention Framework has contemplated a need for better integrated services, this is not echoed in the tangible outcomes of either document.

The Mental Health Plan notes that “universal education and healthcare, liveable cities, good jobs, safe communities, stable and affordable housing and healthy families are among the building blocks of mental health and wellbeing.”⁴⁰ However, the plan and its outcomes overwhelmingly focus on clinical, mental health based solutions.

In acknowledging the shortcomings of the system, the Mental Health Plan notes “our service systems are not very good at responding to people who have multiple needs, especially when those needs are linked to social disadvantage. As a result, people are expected to access separate services, often without coordinated intervention to address all of their needs. In some cases, people move from service to service and ultimately fall through the gaps.”⁴¹

Clearly it is difficult for DHHS to have carriage and/or oversight of a whole-of-government approach to wellbeing and to address the concerns of integrated care as noted above. Therefore, it is suggested that suicide prevention be separated from the DHHS and moved to the remit of Premier and Cabinet who are best placed to have manage a whole-of-government program.

⁴⁰ Victoria, Australia. Department of Health and Human Services. *Victoria's 10-Year Mental Health Plan*. Melbourne, VIC, 2015 p. 10.

⁴¹ Ibid p. 20.



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Recommendation: The Victorian Government should acknowledge that in creating a more fulsome, whole-of-government approach to suicide prevention that oversight and monitoring of those efforts is best placed within the Premier's Department.



Workforce Investment

Comprehensive planning for the current and future suicide prevention workforce is required to properly meet demand for suicide prevention, early intervention and response to people in distress.

The suicide prevention workforce is often placed within the umbrella of the mental health sector and in Victoria, this sector has approximately 5,000 employees.⁴² This sector notoriously suffers from issues pertaining to attracting and retaining staff.

The Victorian Government considered these challenges in the creation of the Mental Health Plan committing to creating a new mental health workforce strategy, guided by an expert reference group on workforce. It is stated that the purpose of this strategy will be to find ways to “attract, develop and retain staff with the mix of skills and values that will support the outcomes set out” in the plan.⁴³

A new workforce strategy was completed in June 2016. It focusses on making the workforce available and adequately skilled, providing support and training, innovation, co-delivery and ensuring there is integration across services.

Encouragingly, the strategy takes a whole of government approach to workforce integration noting that “to ensure that service users have access to high-quality integrated services, workers need to collaborate and communicate across service and sector boundaries... such as community mental health and acute mental health services, and across different sectors, such as housing, justice, health and employment.”⁴⁴

However, the three published annual reports do not provide any tangible outcomes achieved in this space.

The strategy also focusses on creating better and safer working environments, addressing occupational violence and training and development opportunities for leaders within the sector. The 2017-18 Annual Report notes that a new Centre for Mental Health Learning was established in 2018 with an aim to create a platform for learning and development activities, practice support resources, research, increased collaboration and access to expertise.⁴⁵

The strategy however, does not provide measurable targets and outcomes and the Auditor-General’s Report found that, as of March 2019, recruiting, retaining and managing the

⁴² Victoria, Australia. Department of Health and Human Services. *Victoria's 10-Year Mental Health Plan: Mental Health Workforce Strategy*. Melbourne, VIC, 2016 p. 5.

⁴³ *Victoria's 10-Year Mental Health Plan*. 2015 p. 23.

⁴⁴ *Ibid* p. 20.

⁴⁵ *Victoria's Mental Health Services Annual Report 2017-2018* p. 10



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workforce was still a significant obstacle in providing pivotal support.⁴⁶ The area mental health services consulted for the report stated that low morale and an ageing, stretched workforce was a key contributor to the lack of retention.⁴⁷

Recommendation: Provide measurable outcomes for the development and support of the mental health workforce, particularly with regard to retention and training of health professionals, peer workers and non-professional workers in suicide prevention skills and techniques.

As noted above, mental health and suicide prevention whilst intrinsically linked, are separate. The workforce strategy does not turn its mind specifically to the capabilities of a suicide prevention workforce. The strategy does touch on the notion that services need to be better integrated without forming firm, actionable measures to achieve this.

Whilst the strategy is a good start in workforce planning it should include more measurable targets and measures for the ongoing training and support for the full spectrum of the workforce addressing specifically suicide and suicide-related behaviour.

Recommendation: Create a suicide prevention workforce specific plan, independent of the Mental Health Workforce Plan.

Whilst more investment is required in both the mental health and suicide prevention workforce, an overhaul of training for all clinicians in dealing with both potential suicidality and immediate suicidal crisis is paramount. As noted above, the lack of training for the general population of clinicians and emergency department workers is a major cause of delay in treating acute suicidal or other mental health crisis.

The South Australian Suicide Prevention Plan features a specific goal to retrain clinicians, including most emergency department staff, PHNs and private providers in the *Connecting with People* (CwP) best practice approach to suicide mitigation.⁴⁸ The CwP approach shifts the paradigm from assessing the risk of a person's suicidality to safety planning and mitigating focussing on individual factors.⁴⁹

⁴⁶ *Access to Mental Health Services*. p. 35.

⁴⁷ *Ibid*

⁴⁸ South Australia. SA Health. Office of the Chief Psychiatrist. *South Australian Suicide Prevention Plan 2017 - 2021: Making People Our Priority, Employment Communities, Translating Evidence into Practice*. Adelaide, SA, 2017 p. 11-12.

⁴⁹ *Ibid* p. 12.



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Recommendation: Implement a framework of training and support, such as Connecting with People, which focuses on training not just the mental health workforce but other health practitioners in assisting people with potential suicidality, before it escalates to crisis.



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Appendix 1: SPA Victorian Members

Anxiety Recovery Centre Victoria	https://arcvic.org.au/
Ballarat & District Suicide Prevention Network Inc	
Beyond Blue	
Central Hume Suicide Prevention Network on behalf of Organisation Albury Wodonga Health	
Centre for Mental Health, University of Melbourne	http://mispgh.unimelb.edu.au/centres-institutes/centre-for-mental-health
Chasing Change - Frankston & Mornington Peninsula Suicide Prevention Network	
Gippsland Primary Health Network	https://gphn.org.au/
headspace National Youth Mental Health Foundation Ltd	http://headspace.org.au
Mental Health First Aid Australia	https://mhfa.com.au
Mental Health Victoria Ltd	http://vicserv.org.au/
North Western Melbourne PHN	
Orygen, the National Centre of Excellence in Youth Mental Health	https://orygen.org.au/
PANDA Inc	https://panda.org.au/
Roses in the Ocean	http://rosesintheocean.com.au/
SuperFriend	https://superfriend.com.au/
Support After Suicide Geelong Region	
Switchboard Victoria	http://www.switchboard.org.au/
The Movember Foundation	https://au.movember.com/