Victoria’s new Suicide Prevention and Response Strategy: Response to the Discussion Paper

September 2022

Jesuit Social Services
Building a Just Society

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Jesuit Social Services: Who we are and what we do

Jesuit Social Services has been working for 45 years delivering support services and advocating for improved policies, legislation and resources to achieve strong, cohesive and vibrant communities where every individual can play their role and flourish.

We are a social change organisation working with some of the most marginalised individuals, families and communities, often experiencing multiple and complex challenges. Jesuit Social Services works where the need is greatest and where we have the capacity, experience and skills to make the most difference. Our services span Victoria, New South Wales and the Northern Territory.

Our service delivery and advocacy focuses on the following areas:

- **Justice and crime prevention –** accompanying people involved in, or at risk of becoming involved in, the justice system.
- **Mental health and wellbeing –** engaging people with multiple and complex needs including, mental health conditions, substance misuse issues, trauma, homelessness and bereavement.
- **Settlement and community building –** supporting recently arrived immigrants and refugees, and disadvantaged communities.
- **Education, training and employment –** helping people who have had limited access to learning, training and job opportunities.
- **Gender justice –** providing leadership on the reduction of violence and other harmful behaviours prevalent among boys and men, and building new approaches to improve their wellbeing and keep families and communities safe.
- **Ecological justice –** advocating and conducting research around the systemic change needed to achieve a 'just transition' towards a sustainable future, and supporting community members to lead more sustainable lives.

Research, advocacy and policy are coordinated across all program and major interest areas of Jesuit Social Services. Our advocacy is grounded in the knowledge, expertise and experiences of program staff and participants, as well as academic research and evidence. We seek to influence policies, practices, legislation and budget investment to positively influence people's lives and improve approaches to address long-term social challenges. We do this by working collaboratively with governments, businesses, the community sector, and communities themselves to build coalitions and alliances around key issues, and building strong relationships with key decision-makers and the community.

Our Learning and Practice Development Unit builds the capacity of our services through staff development, training and evaluation, as well as articulating and disseminating information on best practice approaches to working with participants and communities across our programs.

We acknowledge the Traditional Custodians of all the lands on which Jesuit Social Services operates and pay respect to their Elders past and present. We express our gratitude for First Nations people's love and care of people, community, land and all life.

Introduction

Jesuit Social Services welcomes the opportunity to contribute to the development of Victoria's new Suicide Prevention and Response Strategy. We wish to express our strong commitment to ensuring all Victorians receive the supports, services and resources they require to support their mental health and wellbeing, and ensure the best outcomes in all aspects of their lives.

Over the past 45 years, Jesuit Social Services has addressed a broad range of program participants' mental health challenges through our services. This includes:

- Supporting family members and others impacted by the suicide of a loved one (including children, young people and adults) following the traumatic experience of bereavement after suicide.
- Providing soft entry points, assertive outreach and support for vulnerable and disadvantaged people with mental illness to ensure they receive the help they require in a way that is respectful and appropriate to their specific needs.
- Working alongside young people with mental ill-health and complex trauma who are at risk of dying by suicide or as a result of risk-taking behaviours.

As highlighted by the Royal Commission into Victoria's Mental Health System (the Royal Commission), there has been no significant improvement in the number of people dying by suicide over the last ten years. This is intensely confronting and necessitates assertive and effective action.

Jesuit Social Services advocates for a well-functioning mental health system that truly meets the needs of those at risk of ending their lives and supports families in helping them reduce the risk of suicide.

In this submission, we draw heavily on the experience of our participants, and as such we are specifically focused on how the mental health system supports those on the margins of society, including people involved with the justice system, people from marginalised communities, those with multiple and complex needs and, unfortunately in many instances, people experiencing all of these disadvantages.

Further, we seek to raise the voices of people bereaved by suicide of loved ones, noting the importance of supporting these family members to meaningfully contribute to the conversation about preventing suicides in Victoria.

Recommendations

Recommendation 1: Foster meaningful and equal partnerships between clinical service providers and community service organisations such as Jesuit Social Services to trial and deliver innovative mental health and wellbeing programs.

Recommendation 2: Promote place-based prevention and early intervention initiatives across a broad range of areas, including child and family wellbeing, mental health, housing, family violence, and education, training and employment.

Recommendation 3: Commit to consistent quality and availability of mental health services across all regions of Victoria.

Recommendation 4: Enhance the capacity of mental health services to provide trauma-informed support to people at risk of self-harm or suicide, people who have attempted suicide and families affected by suicide.

Recommendation 5: Support greater integration and coordination between clinical and non-clinical services, facilitated through proactive follow-up support after hospitalisation; the involvement of families and carers; and stronger information sharing across networks.

Recommendation 6: Prioritise people with multiple and complex needs by focusing on the delivery of integrated treatment, care and support as a key action in the Strategy.

Recommendation 7: Increase funding for specialist dual diagnosis programs which provide flexible, integrated care to the significant number of people who experience co-occurring substance use and mental health issues.

Recommendation 8: Provide secure, long-term funding for state-wide post-suicide services for suicide bereavement, including Support After Suicide provided by Jesuit Social Services. This should also include increased access to suicide bereavement services for people in regional and rural areas.

Recommendation 9: Support the inclusion of the 'important role of families and carers' as a principle to drive the development, implementation and evaluation of the Strategy.

Recommendation 10: Include therapeutic residential care for people who have attempted suicide as a key initiative in the Strategy. This should be developed and delivered in partnership with people with lived experience of suicidal behaviour.

Recommendation 11: Ensure the Strategy aligns closely with Victoria's new Mental Health and Wellbeing Workforce Strategy 2021-24.

Recommendation 12: Resource organisations such as Jesuit Social Services to build the capacity of the mental health and social services workforces to support people with multiple and complex needs, and families affected by suicide.

Suicide in Victoria

In 2020 to 2021, 695 Victorians took their own lives[1] while 6300 were admitted to hospital for self-harm.[2] According to the Australian Bureau of Statistics, the current rate of suicide in Victoria is 10.1/100,000 people.[3] In 2020, the overall suicide rate for people living in the lowest socioeconomic (most disadvantaged) areas was twice that of those living in the highest socioeconomic (least disadvantaged) areas. [4]

Rates of death by suicide are higher among men, while a higher rate of women attempt suicide.[5] The average annual suicide rate in almost all age groups for males was notably higher for those who reside in regional Victoria than in metropolitan Melbourne.[6] Concerningly, the rate of suicide for Aboriginal people in Victoria is three and a half times higher than non-Indigenous Victorians.[7] On the assumption accepted by the Royal Commission that every suicide touches 135 people, including family members, friends and colleagues, up to 97,000 Victorians are impacted every year by the suicide of someone they know.[8]

Suicide is complex, with no single cause. We know that family violence, homelessness, child abuse, trauma, bullying, drug and alcohol use, mental illness, discrimination, unemployment, relationship breakdown and stigma are all contributing factors. We also know that some people who contemplate ending their lives feel too ashamed to ask for help, are unable to navigate the service system or struggle to find the right support. Jesuit Social Services strongly supports the development of the new Strategy to address these issues.

1. Realising the vision of the strategy: 'Towards zero suicides'

The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate? If not, what vision for suicide prevention and response would you like to see Victoria work towards?

Jesuit Social Services supports the suggested 'towards zero suicides' vision, which has been endorsed by the Victorian and Commonwealth Governments and is supported by the Royal Commission. While we support this vision, we acknowledge that there are conflicting views in relation to stigmatising those who are suicidal and bereaved by suicide. We welcome the emphasis on reducing stigma associated with suicide as outlined in the discussion paper.

We outline the following key areas of focus to prevent suicides in Victoria.

[1] Coroners Court of Victoria. (2022). Monthly Suicide Data Report June 2022 as cited in AIHW. (2022). Data from suicide registers. (Weblink)
[2] AIHW. (2022). Suicide and Self-Harm Monitoring. (Weblink)
[3] ABS. (2021). Causes of Death, Australia. (Weblink)
[4] AIHW. (2022). Suicide and Self-Harm Monitoring. (Weblink)
[5] Ibid.
[6] Ibid.
[7] Coroners Court of Victoria. (2022). Victorian suicides of Aboriginal and Torres Strait Islander people. (Weblink)
[8] State of Victoria. (2021). Royal commission into Victoria's mental health system. Final Report. (Weblink)

1.1 Starting suicide prevention upstream

It is critical that suicide prevention starts as far upstream as possible. We believe that education, opportunities in employment, housing, freedom from violence and discrimination, holistic and family centred support for at risk children and young people, access to healthcare, and social support are fundamental considerations for an effective suicide prevention approach.

We acknowledge and welcome the concurrent development of *Wellbeing in Victoria – a plan to promote good mental health*, as outlined in the discussion paper, which will include a focus on universal suicide prevention initiatives. We look forward to contributing to the development of this plan.

Gender and culture

As previously mentioned, suicide rates are higher among men than women – three-quarters of those who die by suicide are men.[9] Through our work on gender justice, we see boys and men struggling with unhealthy masculinities, with devastating impacts for women, children and communities. Our 'Man Box' research found that men who endorsed rigid and narrow ideas of masculinity (such as acting tough, always sorting out problems on their own and supporting the use of violence to get respect) were 14 times more likely to have used physical violence in the past month.

Percentage of respondents who report experience at some point in the last two weeks

	Man Box	Little interest or pleasure in doing things	Feeling down depressed or hopeless	Having thoughts of suicide
Australia	In	83%*	72%	44%*
	Out	77%*	69%	22%*

Table 1: *The Man Box: Life satisfaction, mental health and wellbeing*[10]

These men were also more likely to have had thoughts of suicide in the past two weeks (twice as likely as those outside the 'Man Box') and reported feeling down, depressed and hopeless. Given these findings, there must also be a renewed focus on addressing the endorsement of rigid and narrow ideas of masculinity as part of suicide primary prevention efforts.

1.2 Implementing the recommendations of the Royal Commission

In 2020, Jesuit Social Services published research into the experiences of family members bereaved by suicide, investigating service system issues.[11] We surveyed 142 current and former participants of our counselling services and found that **70 per cent of people who died by suicide had previously sought help from the mental health system**. This is in line with the Royal Commission hearing evidence that about 60 per cent of people who died by suicide had contact with a public or private health service for mental health related problems in the preceding 12 months. This highlights weaknesses in Victoria's mental health system that are failing to prevent people from taking their own life.

[9] ABS. (2021). Causes of Death, Australia. (Weblink)
[10] The Men's Project. (2018). The Man Box: Life satisfaction, mental health and wellbeing fact sheet. (Weblink)
[11] Flynn, L. 2020. "We were fighting the system as well as the illness": Family perceptions of how Victoria responds to people at risk of suicide and their loved ones. Melbourne: Jesuit Social Services. (Weblink)

Jesuit Social Services believes the Royal Commission into Victoria's Mental Health System recommendations provide a clear roadmap for an evidence-based, trauma-informed, person-centred approach that prevents suicides. To achieve the reforms set out by the Royal Commission, we need culture change across the sector. As noted by Mental Health Victoria, for this to occur, it is critical that the sector as a whole is involved and invested in the change process.[12]

Noting the recommendations for several state-wide services, there are concerns that larger clinical providers will dominate future service delivery in Victoria's reformed mental health system. Community service organisations such as Jesuit Social Services play an important role outside of clinical settings, through the provision of flexible and assertive outreach as well as soft entry points.

Our Way of Working practice framework, underpins Jesuit Social Services' doing and influencing work with individuals and communities (for further details, please see the Appendix). The framework speaks to the inherent humanity of each individual, every community, and their capacity to envisage and achieve a more positive and engaged future, no matter their current circumstances. It articulates the dynamic interplay of the following five components, which work together to help people reach their full potential and become active participants in their communities:

- Valuing self and others
- Affirming goals and aspirations
- Linking individuals and communities to relevant support
- Using skills and building capacity
- Enhancing civic participation

We believe community-based approaches such as these can play a key role in achieving the cultural change required to reform Victoria's mental health system. We therefore advocate for the Victorian Government to foster meaningful and equal partnerships between clinical service providers and community service organisations to trial and deliver innovative mental health and wellbeing programs.

Recommendation 1: Foster meaningful and equal partnerships between clinical service providers and community service organisations such as Jesuit Social Services to trial and deliver innovative mental health and wellbeing programs.

[12] Mental Health Victoria. (2020). From vision to reality: A guide for the successful implementation of recommendations from the Royal Commission into Victoria's Mental Health System. (Weblink)

2. Focusing attention on place-based, trauma-informed and coordinated approaches

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

The proposed priorities areas in the discussion paper include: (a) lived experience partnerships, (b) self-determined Aboriginal suicide prevention, (c) intersectional and targeted approaches, (d) data and evidence to drive outcomes, (e) workforce and community capabilities and responses, (f) whole-of-government leadership, accountability and collaboration, (g) a responsive, integrated and compassionate system.

2.1 Place-based approaches

Last year, Jesuit Social Services' latest Dropping Off the Edge report was released—the fifth edition of research spanning over 20 years, which maps disadvantage by location. The research identifies where entrenched and persistent disadvantage is located and demonstrates the complex web of challenges faced by those communities. Dropping Off the Edge 2021 found that disadvantage is concentrated in a small number of communities within Victoria, with five per cent of locations accounting for close to a third of the most disadvantaged rank positions across all indicators measured.

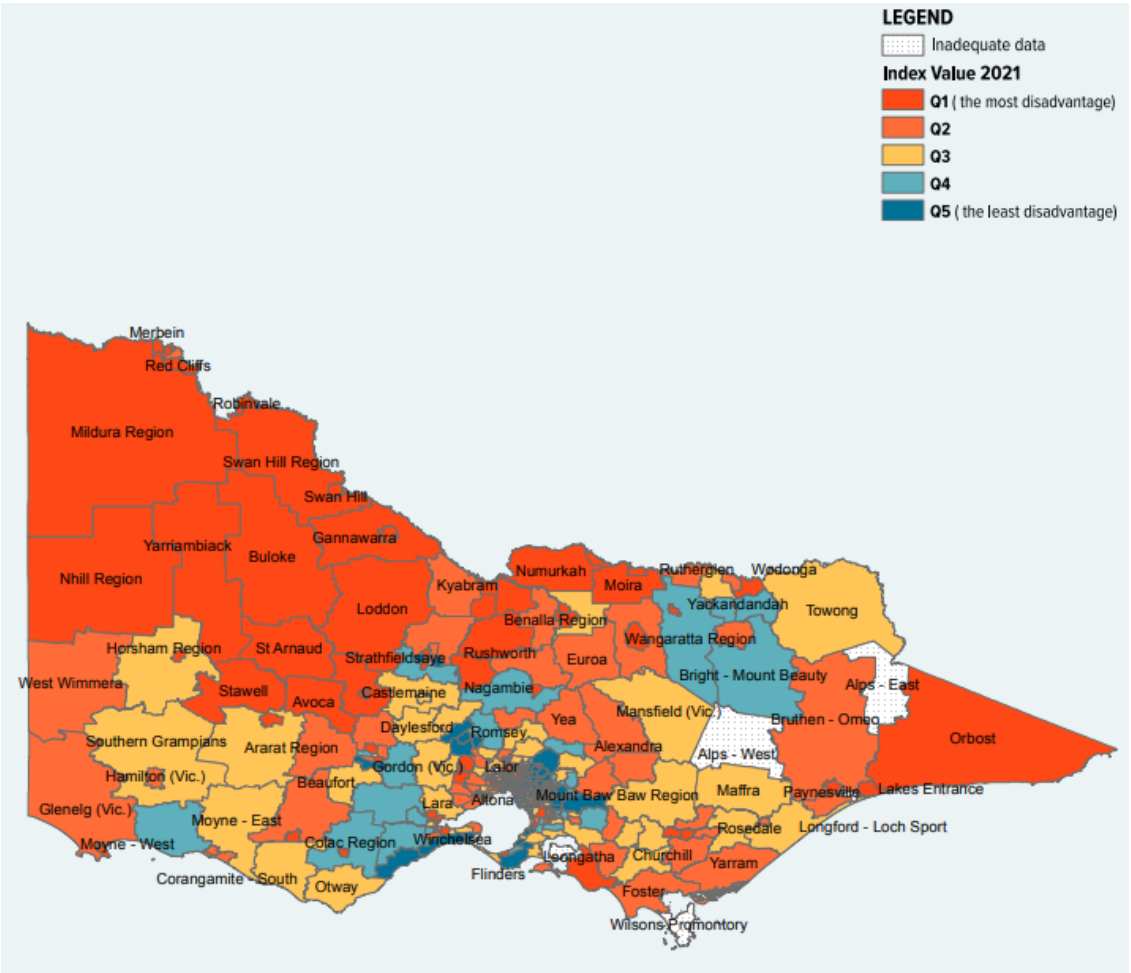


Figure 1: *DOTE 2021 Map of Index for Victoria.*[13]

[13] Jesuit Social Services. (2021). DOTE 2021 Victoria Fact Sheet. (Weblink)

It also demonstrated the entrenched nature of disadvantage in Victoria, with every Victorian location ranked in the top ten most disadvantaged areas also in the 2015 list of the 40 most disadvantaged locations. These communities experience a complex web of disadvantage that make it challenging to improve life opportunities, including contact with the justice system, child abuse and neglect, family violence, low income and higher levels of unemployment. We note that these are contributing factors to suicide.[14]

There is growing recognition that place-based approaches are an effective means of addressing entrenched locational disadvantage. On this basis, Jesuit Social Services recommends that 'place-based' should be added to the priority area: 'intersected and targeted approaches' in the new Strategy. Place-based approaches must encompass interventions from birth across the life span and be led by, and build the capacities and resources of, local communities.

Equitable access to mental health care in rural and regional areas

For the first time, the 2021 Dropping Off the Edge report included a qualitative component to provide insights from community members in select case study locations. In Victoria, accessible and affordable health services were missing across all of the case study communities. People commented that they often need to travel to larger centres to access specialist health support in a timely manner, pay private health providers locally or endure long wait lists for a range of services including paediatrics and mental health support. Such services, particularly clinical mental health services, are critical for these communities, with three case study communities being in the top 10 per cent most disadvantaged for psychiatric admissions, and two in the top 10 per cent most disadvantaged for suicide.

Jesuit Social Services emphasises that any suicide prevention framework must commit to consistent quality and availability of mental health services across all regions of Victoria. Access to high quality mental health support should not be based on a person's geographic location. This pertains both to suicide specific services and mental health services generally.

Recommendation 2: Promote place-based prevention and early intervention initiatives across a broad range of areas, including child and family wellbeing, mental health, housing, education, and training and employment.

Recommendation 3: Commit to consistent quality and availability of mental health services across all regions of Victoria.

2.2 Trauma-informed systems

Jesuit Social Services has significant experience working with people at risk of self-harm and suicide with histories of complex trauma. Trauma is closely related to all aspects of suicide – people who have experienced trauma are at a greater risk of dying by suicide.[15] Further, many people bereaved by suicide may also experience trauma.[16] We therefore strongly endorse a focus on the experience of trauma in the new Strategy.

[14] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report. (Weblink)
[15] Suicide Prevention Australia. (2021). Trauma-informed approach for suicide prevention. (Weblink)
[16] Ibid.

More specifically, Jesuit Social Services believes that the capacity of mental health services to respond to trauma needs to be enhanced. Currently, people with complex trauma are often excluded from clinical mental health or community services due to rigid service expectations around attending appointments. Further, they may experience indirect exclusion from services where they are not made to feel welcome or perceive that the service is 'not for them'.

While services can and should adjust service delivery to be more inclusive and responsive to people with histories of trauma, Jesuit Social Services has observed that the gap between where they are now and where they need to be is substantial. We recommend that trauma-informed service delivery be included as a key priority area in the new Strategy. This should be underpinned by the principles of safety, trustworthiness, choice, collaboration and empowerment.

Recommendation 4: Enhance the capacity of mental health services to provide trauma-informed support to people at risk of self-harm or suicide, people who have attempted suicide and families affected by suicide.

2.3 Coordination across services

Jesuit Social Services notes that there are often a number of caseworkers from several organisations supporting people with suicidal ideation or who have attempted suicide. We therefore emphasise the importance of ensuring greater integration and coordination between clinical and non-clinical services to enable holistic, whole-of-person approaches. Services must deliver holistic responses with a particular focus on:

- Coordinating and streamlining care;
- Embedding relational ways of working;
- Taking strengths-based and whole-of-person approaches;
- Ensuring a "no wrong door" model of care; and
- Tailoring responses to each individual that are flexible to meet individual need.

Care coordination and integration can be facilitated through proactive follow-up support after hospitalisation; the involvement of families and carers; and stronger information sharing across networks. Relatedly, Jesuit Social Services has observed that transitions from child to adult support systems for those who turn 18 can result in services and supports becoming disjointed. We welcome the Royal Commission's recommendation that the Victorian Government establish one responsive and integrated infant, child and youth mental health and wellbeing system to provide developmentally appropriate mental health and wellbeing treatment, care and support for newborns to 25-year-olds.

Recommendation 5: Support greater integration and coordination between clinical and non-clinical services, facilitated through proactive follow-up support after hospitalisation; the involvement of families and carers; and stronger information sharing across networks.

3. Prioritising at-risk groups

In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

The proposed priority groups in the discussion paper include: (a) Aboriginal people, (b) children and young people, (c) CALD people, (d) LGBTIQ+ communities, (e) older and adult men, (f) people living in rural and remote communities, (g) people living with mental illness, (h) people with a lived experience of suicide, (i) people with disability and neurodiverse people, (j) people working in high-risk industries.

3.1 People with multiple and complex needs

Jesuit Social Services works with some of the most marginalised individuals, families and communities, often experiencing multiple and complex challenges, including co-occurring mental ill-health and substance misuse issues, complex trauma, homelessness, justice-system involvement, and contact with out-of-home care.

Research shows that people experiencing homelessness,[17] people with substance misuse issues[18], people exiting custody[19] and young people exiting out-of-home care[20] are disproportionately at risk of dying by suicide. Jesuit Social Services would therefore like to see the Strategy also prioritise these groups. Further, we advocate for tailored responses that take into account the range of contributing factors that lead to suicide amongst these cohorts.

People exiting custody

Jesuit Social Services advocates for the Strategy to recognise the particular vulnerabilities and higher risk of suicide experienced by people exiting custody. There is extensive evidence to show that people leaving custody are at far higher risk of suicide than the general population.[21] The risk of suicide is even more acute for young people exiting prison, with Australian research finding that one third of deaths of all young people under the age of 25 released from adult prisons were due to suicide.[22]

Currently there is a poor intersect between effective mental health care in a custodial setting and in the community, particularly with regard to Area Mental Health and Wellbeing Services. Issues in relation to privacy and confidentiality, a lack of shared information between agencies and eligibility criteria that

[17] 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. AHURI: Melbourne (Weblink)
[18] Fisher A, Marel C, Morley K, Teesson M, Mills K. (2020). The role of alcohol and other drugs in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours. The Matilda Centre for Research in Mental Health and Substance Use: Sydney. (Weblink)
[19] Carter, A., Butler, A., Willoughby, M., Janca, E., Kinner, S. A., Southalan, L., Feezel, S., & Borschmann, R. (2022). Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review. EClinicalMedicine, 44, 101266. (Weblink)
[20] AHURI. (2021). The staggering reality of life for younr people after leaving out-of-home care. (Weblink)
[21] Carter, A., Butler, A., Willoughby, M., Janca, E., Kinner, S. A., Southalan, L., Feezel, S., & Borschmann, R. (2022). Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review. EClinicalMedicine, 44, 101266. (Weblink)
[22] van Dooren, K., Kinner, S. A., & Forsyth, S. (2013). Risk of death for young ex-prisoners in the year following release from adult prison. Australian and New Zealand journal of public health, 37(4), 377-382. (Weblink)

require a fixed address represent particular challenges. In Victoria, women, Aboriginal people exiting custody and a limited number of high risk men are eligible for some transition support, but this support is limited. There is a need for a holistic through-care model for those at risk of suicide, from custody entry through to exit and then community support.

Supporting people with substance misuse and mental health issues

Jesuit Social Services is also concerned about the risk of death for young people living with both mental ill-health and substance misuse issues. Australian research affirms that people living with co-occurring mental ill-health and substance use issues are at increased risk of self-harm and suicide.[23] Further to this, Jesuit Social Services' program staff have observed a sense of hopelessness, despair and lack of regard for wellbeing amongst this cohort that can lead to death.

People living with both mental ill-health and substance abuse issues often face additional barriers to seeking mental health and wellbeing support:

> "I became homeless, I had a couple of psych unit admissions … What I found during that time was there was a real disconnect between health services for … the alcohol and drug stuff, and … mental health and I require support in both those areas."
>
> – ***Royal Commission, Consumer Human-Centred Design Focus Group.***

It is crucial that the co-occurring issues experienced by some people are not treated in isolation. In particular, specialist expertise and integrated care (often through multi-disciplinary teams) are needed to concurrently address both mental health and alcohol and drug use, in recognition of how the co-occurrence of these issues can impact upon a person's health.

Jesuit Social Services' **Connexions program** started in 1996 as Victoria's first dual diagnosis service working exclusively with young people dealing with concurrent issues of mental illness and substance abuse. Connexions offers a relationship-based approach to intake and assessment, and uses assertive outreach where workers follow up with disadvantaged and hard to engage young people who have been identified as needing support. Specialist assertive outreach focuses initially on developing a relationship of trust to create a foundation that enables discussion of mental health issues.

Flexibility is at the heart of Jesuit Social Services' Connexions model — young people do not require a mental health diagnosis to access support which can be a significant barrier to engaging with clinical and community support services. Further, the Connexions program is not catchment based and therefore can provide a relational model of intervention for young people who are often transient. This includes assertive outreach and a collaborative service response, actively contributing to a coordinated care team support approach. The program links with and refers to clinical mental health service providers as required (for example, Jesuit Social Services has a partnership with Headspace, and strong relationship with St Vincent's and Austin Hospital's inpatient units).

[23] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, final report. (Weblink)

CASE STUDY: Troy's* story ** Name has been changed to protect privacy*

Troy is a 26 year old young man who is a participant of Jesuit Social Services' Connexions program. Troy has a long history of substance misuse, anxiety and depression with a chronic risk of suicide. In the important developmental years of his early life, Troy experienced significant trauma, neglect and abuse. At the age of six years old, he was removed from his family home and placed into out-of-home care. From the age of 14, Troy went on to experience long-term homelessness – he was either living in crisis accommodation or rooming houses, sleeping rough, or couch surfing for more than 12 years.

These co-occurring challenges have resulted in Troy's repeated presentations at hospital emergency departments, leading to involuntary admissions to psychiatric inpatient units. Because of his history of trauma, as well as negative experience with mainstream mental health and drug and alcohol services, it has been difficult for Troy to develop faith in the service system and maintain engagement, often only connecting with services following suicide attempts or drug overdoses. Additionally, Troy has often "slipped through the gaps" of services due to inflexible service models that are office/appointment based, time-limited and do not provide an outreach response.

Troy was referred to Connexions for dual diagnosis support that was flexible and assertive in its approach. At the time of referral, Troy's drug use was escalating and his mental health deteriorating, and he was frequently seeking support in a state of crisis. Despite Troy missing appointments with his Connexions Dual Diagnosis practitioner, the practitioner persisted in going to his house on the same day and time, every week. This persistence has paid off as Troy has been able to develop a trusting relationship with the practitioner largely due to the consistent and reliable approach.

Connexions has been working with Troy for a period of two years now, ensuring continuity of support and working collaboratively with homelessness services, area mental health services and psychiatric inpatient units to support his complex support needs. Troy says that he has not experienced a service response like this before. It has enabled him to better manage his mental health, reduce his risk of suicide and address his drug and alcohol use – he hasn't had any hospital admissions over the past six months.

Another key to the Connexions model is that support is not time-limited, and caseworkers have the opportunity to build a solid relationship with the young person, based on trust, reliability and predictability. In a climate of service responses largely being short-term brief intervention responses, the continuity of support is critical in developing meaningful connectedness and reduces service fatigue thereby leading to an improvement in mental health and wellbeing.[24]

[24] Saeri, A. K., Cruwys, T., Barlow, F. K., Stronge, S., & Sibley, C. G. (2018). Social connectedness improves public mental health: Investigating bidirectional relationships in the New Zealand attitudes and values survey. Australian & New Zealand Journal of Psychiatry, 52(4), 365–374. (Weblink)

We strongly support further development of integrated support and care, such as Connexions, as recommended by the Royal Commission. We note that providing integrated treatment and care is included as a recommendation in Australia's Fifth National Mental Health and Suicide Prevention Plan and advocate for this to be included in Victoria's next Strategy.

Recommendation 6: Prioritise people with multiple and complex needs by focusing on the delivery of integrated treatment, care and support as a key action in the Strategy.

Recommendation 7: Increase funding for specialist dual diagnosis programs which provide flexible, integrated care to the significant number of people who experience co-occurring substance use and mental health issues.

3.2 People bereaved by suicide

Jesuit Social Services is pleased to see the discussion paper recognises the particular vulnerabilities and higher risk of suicide experienced by people who have been bereaved by suicide. The stark reality is that people bereaved by suicide are themselves at a higher risk of suicide.[25] However, we know from our experience that postvention support delivered by experienced practitioners reduces this risk.

Jesuit Social Services has delivered **Support After Suicide** throughout Melbourne and regional Victoria for almost 20 years. The program provides critical supports to people after a death of a loved one to suicide through specialist counselling, group programs and online support to people bereaved by suicide (including children and young people), and secondary consultation to professional education and other professional organisations working with people bereaved by suicide. It provides services in multiple locations across Melbourne and Geelong, and also offers counselling by phone or video call to people living in rural and regional areas where it is funded to do so.

The program provides direct support to more than 1000 people bereaved by suicide each year. It is an integral part of the first response to suicide in Victoria with Victoria Police making referrals directly to the program. Despite this, while the StandBy model is referenced in the discussion paper, Support After Suicide and the provision of specialist and high-quality bereavement care is not mentioned. It is important to note that StandBy and Support After Suicide offer distinct models of care – StandBy provides people bereaved by suicide immediate practical support on a short-term basis while Support After Suicide engages on a deeper, more personalised level through specialist counselling services.

[25] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, final report. (Weblink)

CASE STUDY: Chris' story

Chris still recalls the feeling she had when she first discovered Support After Suicide.

"It was a connection with other people in the same experience to you – for the first time, I actually felt ok," she says. The year was 2005 and Chris' 21 year old son Luke had tragically taken his own life months earlier. A friend recommended Support After Suicide, and Chris was surprised that such a specialist service existed. "In the early days, we weren't capable of even looking or thinking that there would be specific support for those left behind after suicide. "We didn't think there would be any other normal, everyday person like we used to be, going through what we were going through."

After attending the program's Early Bereavement Group, Chris began coming to monthly meetings and engaged in individual counselling. "It was a life saver for me as my husband and I returned to work and tried to reshape our family and our whole life in some way," she says. Chris now volunteers with the program and is able to use her family's own experiences to assist others who are bereaved. "It is very satisfying to be able to give something back to a program which has helped me so much."

Support After Suicide is currently only funded by the Commonwealth Government to June 2023 and has no long-term funding certainty. This puts Victorians at risk of missing out on timely service, including the high numbers of people referred by the Victoria Police. Additionally, while Support After Suicide operates in regional areas (the Macedon Ranges and Geelong), its ability to provide robust services, in the face of increased demand, is limited due to restricted funding. In Jesuit Social Services' view, there are not enough services available in Victoria for people bereaved by suicide, particularly in rural and regional areas.

The Royal Commission outlined that all Victorians bereaved by suicide should have access to evidence-informed postvention bereavement services. We thoroughly support this, and would welcome the opportunity to work with the Victorian Government towards a sustainable funding model to ensure that all Victorians have access to effective services to help them navigate the complex grief and trauma associated with the suicide of a loved one. We believe this should include access to specialist counselling services and group support. Further details of our proposed postvention model is outlined below.

Recommendation 8: Provide secure, long-term funding for state-wide post-suicide services for suicide bereavement, including Support After Suicide provided by Jesuit Social Services. This should also include increased access to suicide bereavement services for people in regional and rural areas.

4. Supporting people bereaved by suicide

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

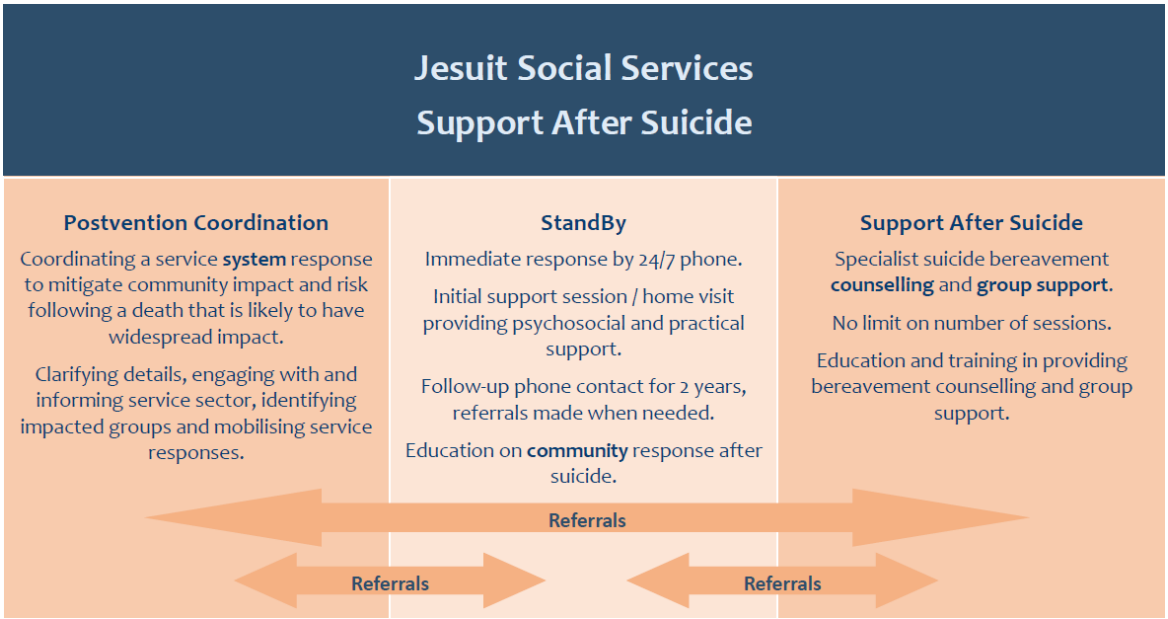
The suicide of a loved one is a time of intense anguish for family members and their mental health can suffer greatly in the immediate aftermath but also for years after. They are likely to experience feelings of grief, guilt, loneliness, anger, regret, and hopelessness. Family members are also likely to ruminate on the circumstances leading up to the death, as well as the death itself. People bereaved by suicide must automatically be offered compassionate and informative responses from the mental health professionals who treated their loved one to help them understand and process what has happened.

4.1 Jesuit Social Services' model of postvention: Support After Suicide

Jesuit Social Services offers people bereaved by suicide a multifaceted approach to healing and recovery. We have developed a model of support based on *Our Way of Working* practice framework, which underpins all the work we do with individuals and communities (for further details, please see the Appendix). Critically, the Support After Suicide postvention model was developed based on research and consideration of best practice counselling approaches to reduce the suicide risk and improve the mental health and wellbeing of people bereaved by suicide. The development of the program has been informed by those with lived experience; a thriving volunteer peer support has ensured that new activities and resources are developed by people with lived experience of suicide bereavement.

Jesuit Social Services' model of suicide bereavement support encompasses three postvention support programs. Implementing these three components of postvention support is providing a unique opportunity to develop a coordinated response. From a systemic perspective, working collectively and strategically to provide a response is reducing the risk of fragmentation, siloing of services and duplication.

***Figure 2**: Jesuit Social Services' model of postvention support - Support After Suicide*



The three postvention programs are:

- **Postvention Coordination.** This program involves coordinating a service system response after a suicide with the aim of mitigating community impact and reducing the risk of suicide following a death that is likely to have widespread impact. More specifically, it involves, clarifying the details of who is involved and what has occurred, then engaging with and informing the service sector. It also involves identifying any impacted groups, particularly young people and mobilising service responses.

  Postvention coordination is governed by a documented protocol that guides communication, privacy and confidentiality. The agencies and organisations that may be engaged in this service system response include mental health services, headspace, headspace BeYou, local councils, education department, Support After Suicide and StandBy.

  This program is operating in southern Melbourne (City of Greater Dandenong, City of Casey, Shire of Cardinia) and Frankston Mornington Peninsula and will soon be set up across Gippsland.

- **StandBy** provides an immediate response with a 24/7 phone line. An initial support session / home visit is provided which offers psychosocial and practical support. Follow-up phone contact is made at specific intervals for 2 years and if any needs are identified, referrals to appropriate services and organisations are made, including to counselling and group support with Support After Suicide. Education to community on how to respond after a suicide is also provided. This program is operating across Victoria; the areas covered by Jesuit Social Services are metropolitan Melbourne and Gippsland.

- **Support After Suicide** which offers specialist suicide bereavement counselling and group support. In this program there is no limit on the number of sessions. The program also provides education and training in how to provide bereavement counselling and group support. Support After Suicide provides services to north western Melbourne, south eastern Melbourne, Gippsland and Western Victoria.

Referrals are made between each of the three programs, for example, StandBy and Support After Suicide regularly refer individuals and families to the other program. Support After Suicide may notify the Postvention Coordinator of a death by suicide that may need a service system response.

4.2 Key aspects of our approach to support for bereaved individuals

Counselling

Support After Suicide provides free individual, couples and family counselling to people bereaved by suicide. Our experienced counsellors have particular expertise and knowledge around suicide, grief, trauma and the impact of stigma. By speaking with a counsellor, participants learn how to manage the intense and complex experience of losing a loved one to suicide. Sessions can provide a greater understanding of people's experiences and those issues unique to their situation. We provide counselling in metro Melbourne, regional Victoria and in other areas by phone or video call. We also provide home visits and out-of-hours counselling as needed.

Group support

Many people benefit from being in a support group with others bereaved by suicide. Jesuit Social Services' Support After Suicide conducts several groups each year for those recently bereaved and provides specific programs for children, young people, parents, partners, siblings, adult children and men. Our support groups offer people bereaved by suicide the opportunity to: meet together in a group setting; interact with others bereaved by suicide; and better understand their situation by receiving up-to-date and reliable information.

Tailored support

Support After Suicide has developed programs specifically for children and young people. Our program for young people includes adventure camps and other activities. We also offer 'Serious Fun' – An activity day for suicide bereaved children which runs in the school holidays. Primary-school-aged children can: get to know others who have also lost someone significant to suicide; see how other children have been going and have been feeling; and learn different ways to act and talk about what has happened.

As mentioned earlier in our submission, Jesuit Social Services would welcome the opportunity to work with the Victorian Government to implement the above model of suicide postvention to ensure that all Victorians have access to effective services to help them navigate the complex grief and trauma associated with the suicide of a loved one.

5. Refining the underpinning principles of the Strategy

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

The proposed principles in the discussion paper include: (a) valuing lived experience, (b) supporting equity and taking an intersectional approach, (c) being adaptable and evidence-informed, (d) taking a person-centred approach.

5.1 Valuing the role of families

The experiences of those most affected by the system must be at the heart of discussions about preventing suicide. As previously highlighted, in 2020, Jesuit Social Services released research with family members bereaved by suicide, investigating service system issues. We presented the findings in a report - "We were fighting the system as well as the illness": Family perceptions of how Victoria responds to people at risk of suicide and their loved ones. The research described family members' experiences of being excluded from decisions about their loved one's care and being unable to advocate for them in the mental health system when they were too ill or vulnerable to do so themselves.

Key findings of the survey

- Around half (47 per cent) of people who took their lives were known to have attempted suicide in the past.
- Almost three quarters (70 per cent) of people who died had previously sought help from the mental health system.
- 41 per cent of those who suicided were reported by loved ones to have experienced bullying or harassment (more than one-third of these at work).

- 79 per cent of family members said they felt there were barriers to them accessing information or help in caring for their loved one.
- 27 of 28 participants interviewed expressed concerns that mental health professionals did not have the skills to recognise their loved one was at risk of suicide or to complete an adequate treatment plan.

Four significant implications for Victoria's mental health system arose from the report

1. There may have been situations where weaknesses in Victoria's mental health system failed to prevent a person taking their own life.
2. These weaknesses may still be affecting Victorians currently at risk of suicide.
3. There may be Victorian families currently feeling a lack of confidence to advocate for their loved one in the mental health system because they don't feel supported or informed enough to do so.
4. There may be hundreds of family members currently not receiving the support and information they need as they experience the significant grief and trauma that comes when a loved one takes their own life.

We therefore strongly support the inclusion of 'the important role of families and carers' as a principle to drive the development, implementation and evaluation of the Strategy. Further, Jesuit Social Services would like to see consideration of the above research implications in the development of the new Suicide Prevention and Response Strategy.

Recommendation 9: Support the inclusion of the 'important role of families and carers' as a principle to drive the development, implementation and evaluation of the Strategy.

6. Implementing additional initiatives

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

6.1 Short-term residential care

Jesuit Social Services calls for the establishment of short-term residential care following suicide attempts, beyond a clinical environment. We can look to the UK for examples of this model – the Maytree Respite Centre offers a free stay in a non-medical setting, filling a gap in service provision for individuals experiencing suicidal crisis. However, we note that the Maytree facilitates a stay of up to five days. Jesuit Social Services believes that a longer term program, of up to six weeks, would be more effective in delivering holistic support.

We support a short-term residential care model that is therapeutic and offers relationship-based support and counselling, and connection to peer support. A residential option will help fill a service gap for the most vulnerable who may have limited family and community support.

In addition, programs should include families of individuals who have attempted suicide, providing education on responding to suicide and suicide attempts. Tapping into family and community networks around individuals, and ensuring this network is well-informed, gives individuals at risk of suicide much-

needed support. We believe the period immediately after a suicide attempt is a critical time in which to provide support to individuals in crisis.

Recommendation 10: Include therapeutic residential care for people who have attempted suicide as a key initiative in the Strategy. This should be developed and delivered in partnership with people with lived experience of suicidal behaviour.

7. Building the capacity of health, social and mainstream workforces

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?

The Royal Commission found that Victoria's mental health workforce is significantly under-resourced and overworked. Jesuit Social Services has also observed this issue. While there are concerning staff shortages across the entire mental health system, we note that these shortages are even more acute in rural and regional areas.

7.1 Develop the size and capacity of the mental health workforce

In our experience, stress, workforce supply issues, fatigue and burnout are key issues which contribute to staff shortages across the mental health sector. The Royal Commission recognised that workforce shortages are impacting the system's capacity to meet demand and deliver high-quality care and support. Workforce shortages are more apparent in certain locations, service settings, professional disciplines and specialist positions.[26] Factors relating to recruitment and retention can lead to reduced service delivery, less effective responses to individuals and their families/carers, and risks to staff wellbeing and burnout.

Jesuit Social Services welcomes Victoria's Mental Health and Wellbeing Workforce Strategy 2021-24 (the Workforce Strategy) released in December 2021 to address these issues. We are particularly pleased to see initiatives to provide more secure employment arrangements, attract and retain people to mental health careers, ensure the workforce meets rural and regional needs, and embedding a system-wide capability focus. We emphasise the importance of the new Suicide Prevention and Response Strategy aligning closely with these initiatives.

Supervisory and secondary consultation

Jesuit Social Services works with people who have a multitude of needs and therefore require a mental health workforce that is capable and has a broad range of skills. We build capacity across care teams by upskilling and developing a broader skill set though secondary consults with a multidisciplinary team.

Additionally, we educate and train professionals to support those who are affected by suicide. Many people working in health, welfare and education come into contact with people who are bereaved by suicide. Our training empowers professionals in these roles to: understand the unique issues and experiences associated with bereavement by suicide, and respond effectively and sensitively to people bereaved by suicide. Topics we cover include current bereavement theory, the unique issues in suicide

[26] State of Victoria. (2021). Royal Commission into Victoria's Mental Health System, Final Report. (Weblink)

bereavement, trauma, and providing effective care and support to people bereaved by suicide and suicide risk assessment. Our education and training helps foster stronger and more supportive communities and schools.

Jesuit Social Services believe that the Strategy should set out action areas that create opportunities for such capacity and knowledge building across care teams. We would also like to see training include how to best support people with multiple and complex needs as well as carers and families living with the chronic risk of a loved one's suicide ideation and/or attempts.

Recommendation 11: Ensure the Strategy aligns closely with Victoria's new Mental Health and Wellbeing Workforce Strategy 2021-24.

Recommendation 12: Resource organisations such as Jesuit Social Services to build the capacity of the mental health and social services workforces to support people with multiple and complex needs, and people bereaved by suicide.

Conclusion

Jesuit Social Services believes the above recommendations can help ensure that all Victorians receive the supports, services and resources they require to support their mental health and wellbeing, and ensure the best outcomes in all aspects of their lives. We would welcome the opportunity to discuss these ideas with you further.

For further information regarding this submission or to arrange a meeting, please contact:

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Appendix

Jesuit Social Services' Practice Framework: Our Way of Working

Our Way of Working underpins all Jesuit Social Services doing and influencing work with individuals and communities. The framework speaks to the inherent humanity of each individual and every community, and their capacity to envisage and achieve a more positive and engaged future, no matter their current circumstances. It articulates the dynamic interplay of five components, which work together to help people reach their full potential and become active participants in their communities.

The five domains in the Our Way of Working framework

- **Valuing self and others**: practising and encouraging respect so that that those with whom we work enhance their capacity to establish and maintain meaningful and respectful relationships in their personal lives and respect for the environment, recognising the interconnectedness of all life.
- **Affirming goals and aspirations**: engendering hope through envisioning new futures and the establishment of supportive and reciprocal relationships. Accompanying people as they explore new ways of working collaboratively and sustainably.
- **Linking individuals and communities to relevant supports:** assisting people to realise their potential, to improve their mental, physical and emotional health, and to remove the barriers they face in achieving social and economic inclusion through access to services, supports and resources.
  • Using skills and building capacity: delivering education, training and therapeutic programs that develop living skills and improve pathways to further education and employment, and by working collaboratively with communities to build social cohesion and shared outcomes.
- **Enhancing civic participation:** where individuals and communities build 'communities of justice' and exercise their right and responsibility to create a just, inclusive and sustainable world.

Our vision of building a just society is central to *Our Way of Working*. The fifth domain in the framework, enhancing civic participation, reflects our understanding that it is through relationships and participation that people are most fulfilled, are able to create shared futures, and become active players in advancing a just society; a society where the answers to environmental and social concerns are inextricably linked through ecological justice.