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Suicide Prevention and Response Office
Mental Health and Wellbeing Division
Department of Health, Victorian Government
1 Treasury Place
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Submitted via: suicide.prevention@health.vic.gov.au

Dear Sir/Madam

Victorian suicide prevention and response strategy

The Australian Psychological Society (APS) welcomes the opportunity to contribute to the development of the Victorian Suicide Prevention and Response Strategy (*the Strategy*). Prevention is central to the ethos of the APS and many of our members are involved in suicide prevention throughout their daily work. Psychologists are also involved in the response to suicide, including the provision of psychological support to individuals and groups directly affected, as well as through developing appropriate responses at systemic and organisational levels.

As with all our work at the APS, we consider our response in light of the Sustainable Development Goals (SDGs).[1] Of particular relevance are SDG 3, which seeks to "ensure healthy lives and promote well-being for all at all ages"[2] and target 16.7 which aims to "ensure responsive, inclusive, participatory and representative decision-making at all levels".[3]

Thank you again for the opportunity to respond to the Discussion Paper. If any further information is required from the APS, I would be happy to be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Yours sincerely,

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

The APS would like to acknowledge the input and expertise of APS members that were generously shared to create this submission.

Australian Psychological Society Response to the Discussion Paper for the Victorian Suicide Prevention and Response Strategy

Vision

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

Yes. The concept of 'towards zero suicides' is now generally familiar in the Australian suicide prevention context. For example, it is an aim that has been endorsed at the federal level by the National Suicide Prevention Office and the National Mental Health Commission.[4] Beyond being just an aim or target, 'Zero Suicide' also refers to an evidence-based mission and quality improvement framework for healthcare systems predicated on the assertion that deaths by suicide are preventable.[5] This approach has been adopted by a number of health services across Australia and internationally.[6]

Nonetheless, the idea of 'zero suicide' can sound unrealistic and idealised. At worst, it may unintentionally and incorrectly imply that all deaths by suicide could have been prevented, or that that any death by suicide represents a failure by the person or those around them. It has been acknowledged by advocates of the Zero Suicide model that the term may increase stigma, guilt and distress for survivors, family and friends.[7] It is therefore important that the aim of zero suicide is seen clearly as an 'aspirational challenge'[8] at a systems level, and that it is communicated and implemented with compassion and clarity. The vision of 'zero suicide' within the Strategy will only be meaningful if it is understood and embraced by the entire Victorian community.

Priority populations

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

No.

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

<u>A dedicated First Nations suicide prevention and response strategy</u>

Although we acknowledge that the Discussion Paper includes Aboriginal people as a 'priority group' with a higher suicide rate than mainstream Australia, we believe that much greater attention is required to adequately address the needs of, and factors impacting, Victoria's First Nation's peoples. This would be through a distinct arm of the Strategy or, ideally, in a dedicated strategy which is co-produced utilising the expertise, leadership, and knowledges of Aboriginal people and communities. The design of a distinct suicide prevention and response strategy in this way should be part of a national conversation regarding Aboriginal and Torres Strait Islander suicide prevention and response.

There are multiple reasons that point to the importance of a dedicated Aboriginal suicide prevention and response strategy in Victoria, including:

- The unique impact of colonisation which means that Aboriginal people are not the same as other vulnerable groups. There must be deep recognition of the intergenerational trauma and ongoing disenfranchisement that has been created in Australian society.
- The important role of culture as a protective factor and as part of the recovery of individuals and groups[9]. This can be expressed or experienced in a number of different forms such as being on country, or through language or art. These factors all need due attention and must be responsive to the individual and community's needs. Culture can be used to build and strengthen social and emotional wellbeing and resilience.[10]
- Acknowledging that many of the social determinants of suicide are not uniform across communities. Interaction with the criminal justice system,[9] racism and discrimination,[11] service inequalities, education outcomes, health outcomes, are some of the many factors that may explain the increased suicide rate in Aboriginal people. These must be addressed appropriately in order to see tangible progress.

- Recognising that access to mainstream services is not equitable. When dedicated services for Aboriginal people are not available, some initiatives need to be adapted to become more responsive to the particular needs of Aboriginal people.

Victoria has a number of unique strengths upon which the creators of a dedicated Aboriginal suicide prevention and response strategy can draw, including:

- Momentum after the Royal Commission[12] means that there is appetite for change;
- The dedicated Koori Engagement Unit as part of the Coroner's Court, which undertakes an important role including interacting with families and kinship groups in a culturally respectful ways and ensuring that every Aboriginal death is recorded so that the true scale of the problem is known; and
- As acknowledged in the Discussion Paper, the development of a dedicated strategy can build on good work already been done. Specifically, we suggest making use of the *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*,[9] *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027*,[13] *Balit Murrup: Aboriginal Social Emotional Wellbeing Framework 2017-2027*,[14] and the *Aboriginal Social and Emotional Wellbeing Plan*.[15]

We would suggest that the development of a dedicated Aboriginal suicide prevention and response strategy be led by an Aboriginal community-controlled health organisation in collaboration with government and professional bodies, including the APS.

Older men

Although it appears in the media and public discourse that younger groups of men are more likely affected[16], in absolute terms, that is because there are more younger men overall. According to the Australian Bureau of Statistics, the highest age-specific suicide rate was found in males aged over 85 years.[17] Critically, Australians over the age of 85 are not included in some national wellbeing studies or measurements.[16]

There is much speculation about the unique circumstances that lead to such a high suicide rate in this age group but theories include a reduced sense of belonging and a perception of being burdensome.[18] Unfortunately, traditional expectations of 'masculinity' may also undermine the chances of seeking help and increase expectations of managing mental health issues alone.[19–21] It is important that any initiatives developed under the Strategy are tailored to the specific needs of this population. For example, it has been shown that older men prefer informal opportunities[22] to discuss suicide in socially acceptable ways. This requires flexible and creative multi-sector approaches to priority populations under the Strategy.

Other groups

There are many vulnerable groups which require unique approaches which may not be directly related to suicide prevention and response but where successful interventions will have positive downstream effects. This would include populations in contact with the criminal justice system and people in correctional facilities.[23] Another vulnerable group includes homeless people who may be facing a number of challenges apart from housing insecurity, such as financial pressures, ontological security, as well as previous, current and future impacts on mental health.[24]

Suicide among residents of residential aged care facilities in Australia has also been an overlooked issue. Research suggests that key factors associated with suicide in this context include residents' isolation and loneliness and the experience of difficulty adjusting to life in an age care facility. There has also been a disappointingly limited range of preventative and response actions that have been implemented to date.[25,26]

Priority areas

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

We agree with the priority areas included in the Discussion Paper and commend the Office on their consideration and inclusion in the Strategy. We also suggest the following:

- Consistent with the APS position on the importance of prevention across our work as psychologists,[27,28] we would recommend the inclusion and adequate resourcing of primary suicide prevention initiatives, as well as early intervention initiatives, as a priority area under the Strategy.
- Climate change should be included as a priority area,[29] given the links between heatwaves,[30,31] drought,[32] natural disasters[33] and suicide rates particularly in rural and remote communities and amongst farmers and farm workers.
- As previously mentioned, we also recommend the development of a dedicated Aboriginal suicide prevention and response strategy.

Principles

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

We propose three guiding principles for the development and implementation of the Strategy: that it should be *person-centred, systems-based*, and *adaptive*.

Person-centred

The standout principle should be a person-centred approach to guide all aspects of the development and implementation of the Strategy. A failure to implement a person-centred approach can lead to suicide prevention initiatives being reduced to a risk mitigation exercise through a 'checklist' mindset or through the inappropriate application of tools or measures to provide a depersonalised, categorical outcome - especially within clinical contexts. Such an approach is consistently one-dimensional, offering neither a person-centred perspective, nor a holistic assessment of a person's risks and protective factors.

In contrast, a person-centred approach allows each person to convey their own unique experiences of suicidality, thus enabling initiatives to more effectively conceptualise the risk factors, warning signs and protective factors that directly reflect that person's experience of suicidality.

Systems-based

A person-centred approach is compatible with a system-based approach to the development and implementation of the Strategy, as outlined in the Discussion Paper. The APS affirms that effective suicide prevention and response must be informed by an understanding of people and communities in systems. This involves understanding and strengthening the interpersonal relationships which underpin the systems in which we live our lives – as well as addressing the isolation or absence of meaningful relationships which are needed for healthful systems, communities and people. A systems-based approach also requires us to recognise and address harmful dynamics of power within systems which increase vulnerability or impede recovery.

The APS notes that there is no specific reference to health and mental health professionals in the Discussion Paper. While the Discussion Paper's emphasis on lived experience and consumer participation is welcome and necessary, we would caution against an approach which partitions or segments people with lived experience and survivors away from their therapeutic and relational context, including the role played by health and mental health professionals.

Psychologists are an important part of the ecosystem for suicide prevention and response, and the sustained and unique therapeutic relationships which are established between clients and psychologists need to be acknowledged within the context of suicide prevention and response. Psychologists are also directly and often adversely affected through their work with clients at risk of suicide and when their clients have died by suicide.[34,35] A system-based development and implementation of the Strategy would mean recognising that health and mental health professionals need to be appropriately supported, resourced and equipped in order for the Strategy to be maximally effective in its aims.

Adaptive

The implementation of the Strategy must be accompanied by an express commitment to ongoing quality assurance, improvement and the regular review of the appropriateness of initiatives and programs. Such a commitment would further safeguard initiatives from reverting to an unhelpful checklist mindset, as mentioned above, while also recognising that our understanding of what works in suicide prevention and response is always developing.

In addition to developments in the scientific evidence base in relation to suicide, an adaptive approach to suicide prevention and response also needs to be attentive to practice-based evidence (PBE). PBE seeks to use information gleaned from practical procedures that produce beneficial outcomes in applied settings.[36] This is a particularly important approach in relation to practice and initiatives with Aboriginal and Torres Strait Islander peoples and groups for whom the evidence-based is limited or not applicable because other ways of knowing and sharing evidence have been privileged instead.

An adaptive implementation of the Strategy also means developing a learning culture around suicide prevention and response. This is reflected through a concerted effort in information sharing, an openness to new evidence, and a willingness to acknowledge past errors through restorative processes.[6]

Suicide prevention and response initiatives and actions

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

The APS advocates for a multi-faceted set of initiatives to be addressed through the Strategy. We wish to highlight some potential additional initiatives which draw on the capabilities and expertise of the psychological workforce in Victoria:

Public campaigns

We advocate for the development of media, workplace and other campaigns, informed by psychological research and evidence, which normalise talking about suicide or feeling suicidal.[37] These campaigns should also help people to be become aware of who might be most helpful to talk to in relation to thoughts or intentions relating to suicide. These campaigns should focus on the priority populations discussed above and in the Discussion paper, where such conversations might be less likely to occur.

Suicide prevention across the lifespan

The Discussion Paper helpfully outlines some of the risk factors associated with suicide. Missing from this discussion are the factors associated with the research showing that suicide risk begins very early in life. Perinatal factors such as low birth weight, lower parental educational attainment and teenage parenthood can increase the likelihood of suicide later in life.[38] While child abuse and neglect is a known risk factor for suicide later in life,[39] there are other psychological influences and relational experiences beginning in early childhood which affect suicidal ideation, attempts and help-seeking later in life.[40]

These risks are amenable to primary prevention and early intervention initiatives, including through evidence-based psychological interventions. For example, the following actions which have been endorsed by experts to prevent child abuse are likely to have both a direct and indirect effect on reducing suicide risk over a person's lifetime:[41]

- Training programs to improve the quality of parenting;
- Home visiting programs where an appropriate health professional visits at-risk families with young children;
- School programs to prevent bullying;
- Psychological therapies for children exposed to trauma.[39]

Dealing with the social inequalities that enable these risk factors is essential to addressing suicide holistically and across the lifespan. Such actions require a long-term perspective in the Strategy with accessible and appropriate initiatives which start at birth and continue through the person's life.

Community-building

Suicide prevention can be facilitated through social, relational and community-based initiatives which have the effect of increasing belonging, participation and connection, even without an obvious or direct reference to suicide or mental health. Such initiatives address some of the known risk factors (e.g. reducing isolation, social disengagement and barriers to help-seeking or help-giving) while building protective factors over time and through iterative processes.

Such initiatives should be developed by local communities responsive to local needs and concerns. Psychologists are well-placed to provide input and guidance in any collaborative design and implementation process to ensure that there is effective alignment with evidence-based practice and practice-based evidence in relation to suicide prevention.

Psychological Workforce

For these initiatives to be realised and for the Strategy to be successful, there needs to be an adequate, sustainable and appropriately resourced health workforce in place. There must be people, including psychologists, to be available to deliver these and other initiatives under the Strategy, and to support others in their contribution to this common endeavour.

The psychological workforce, however, is already under significant strain, and is at best currently able to meet only 35% of national demand for mental health services in Australia.[42] This leaves little capacity for psychologists to contribute their expertise and skills in clinical service delivery, supervision and training, community partnerships, prevention initiatives and research in relation to suicide. The Strategy must therefore be attentive to the workforce required to implement the Strategy and to address workforce pressures and unsustainability directly.

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

Stigma is created when a certain characteristic is not accepted in society or considered a 'deficiency'.[43] Suicide can bring about feelings of shame or perceived rejection which may also affect those who are bereaved.[44] It may also lead to causes of death not being openly discussed as well as the causes of suicide not being well known in the community.[44] As a society, we need to have much more open discussions about suicide in order to raise awareness, to aid early identification of those at risk and to enable people affected by suicide to access the supports (including informal supports and community-based resources) that they need. Suicide will continue to be hidden unless opportunities are made to discuss suicide in age- and culturally-appropriate ways. This may include:

- Early evidence-based prevention and education efforts in schools[45] and anti-bullying initiatives;[39,41]
- Initiatives in workplaces to create a forum for discussion as well as addressing suicide risk factors;
- Informal opportunities for older adults (particularly men);[22]
- Promotion of community ambassadors and those with lived experience of suicide attempts or affected family members to share their stories and create 'safe spaces' for open dialogue about suicide.

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

While this question is seeking input about factors other than training, we would emphasise that training on suicide prevention and response is essential and must be role-appropriate, rather than generic. For instance, staff in a supervisory or specialist position may require more in-depth behavioural training beyond the basics, which may include adopting trauma-informed approaches to engagement with at-risk individuals, dynamic risk assessment and de-escalation and negotiation skills.

This approach of targeted training can offer a balanced and more economical way forward for employers with frontline employees. It also ensures that the critical engagements with individuals presenting with self-harm are escalated to more highly trained specialists. It is critical to recognise that one-off training programs to build skills and capability for suicide prevention are not sufficient to maintain skill and confidence. Employees must be engaged in regular refreshers on skills and simulations to ensure readiness for response when such situations present during work interactions. It is also vital that those in trained positions are offered ongoing supervision with a supervisor (including a psychologist) who has expertise and competency in suicide prevention and suicide prevention practice.

A further initiative is to ensure that frontline workforces and workplaces have a clear policy framework for managing incidents associated with suicide. In addition to training employees on how to manage potential threats of self-harm, organisations where such risks are likely to emerge must have a documented process for managing such incidents (including referral pathways for expert support, incident reporting and debriefing support). Having clear processes can equip frontline employees with the confidence to respond to such incidents and activate timely supports and available referral mechanisms to support the individual in question. The provision by government of clear, consistent and actionable guidance to workplaces, informed by psychological research and expertise, would assist workplaces in developing appropriate policy frameworks.

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

The APS recommends using the integrated intervention approach as outlined in the Blueprint for Mentally Healthy Workplaces[46] and the Victorian Public Sector Mental Health and Wellbeing Charter.[47] Both of these approaches have a three-pillar approach to actions and commitments which are also applicable to workplace suicide prevention and response:

- **Protect (identify anticipated risks and adopt measures to mitigate these risks).**

In the case of suicide prevention, potential workplace risk factors could include:

  - Isolation and low social support
  - Vicarious and cumulative trauma
  - Compassion fatigue and burnout
  - Moral injury
  - Workload
  - Bullying and harassment[48]

Each of these factors may increase the risk of suicide, particularly, when compounded by individual circumstances (relationship issues, financial circumstances, etc.) and health factors. Managers should be trained to recognise and manage these risks proactively as part of implementing the proposed Occupational Health and Safety Amendment (Psychological Health) Regulations.[49] Similarly, employees should be trained to understand and manage these risks, and be supported by professional debriefing programs and psychological support where warranted by exposure to such risks.

- **Promote (promote positive wellbeing as protective factors).**

The Health Benefits of Good Work initiative of The Royal Australasian College of Physicians (RACP)[50] provides compelling evidence that being meaningfully engaged within the workplace can benefit one's physical and mental health (i.e. that good work is good for you). This can serve as a protective factor for individuals who might be experiencing challenges and distress in other aspects of their life (e.g. family relationships, financial hardships, health complications) and are at a higher risk for suicide. Employers should look for opportunities to maximise positive workplace drivers such as relatedness, autonomy, mastery and purpose (RAMP)[51] that stem from participating in a workplace.

Programs to promote positive wellbeing through a focus on strengths, mental fitness, etc. can also help boost individual protective factors in employees. Awareness campaigns, including through mental health and wellbeing calendar events, provide opportunities to promote key messages and resources through the workplace. Employers can leverage these events to share targeted resources and build capability amongst employees to recognise and support colleagues who may be at risk or have experienced suicide in their family or social circle.

- **Address/respond (providing access to expert supports to facilitate early intervention and recovery from mental injuries).**

As referenced earlier, organisations need to have a clear and documented process for responding to emerging risks of suicide or self-harm. In addition, organisations should also ensure that they have access to a range of trained and skilled supports to activate in response to an emerging suicide risk. These could include (but are not restricted to):

  - Mental Health First Aiders[52]
  - Peer Support Programs (where peer supporters are trained to provide Psychological First Aid)[53]
  - Critical Incident Support (typically via an Employee Assistance Program (EAP) provider to ensure rapid response and wrap-around support)
  - EAP providers
  - Return to Work Coordinators and support plans to assist with recovery from mental injuries.

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

Collaborative consultation with industries, sectors and workplaces is needed in order to identity, prioritise and design appropriate actions and initiatives. These actions should not be externally imposed by government on any given industry/workplace without first having internal buy-in and cooperation. Nonetheless, there are categories of work which are associated with higher levels of risk, and for which initial scoping and collaborative discovery work could be prioritised. These include:

- **High intensity professions**: Roles involving high exposure to trauma and distressed individuals, including:
  - first responders and emergency workers
  - healthcare and social care workers
  - staff in corrections and community justice settings
  - the legal profession (including the judiciary)
  - education professionals (including principals and school staff).

- **Staff in high public contact roles:** Roles involving high volume and frequent exposure to angry, frustrated or distressed individuals due to their circumstances, including call centre employees (e.g. complaints staff, customer service officers for banks, utilities, or government services)
- **Remote and isolated workers:** Roles in remote locations with limited access to specialised support, limited workplace connections, or a fly-in-fly-out (FIFO) workforce.[48]
- **Industries with a higher proportion of workers from higher-risk demographics combined with industry-specific cultural factors.** For example, the suicide rate among young male trades workers is more than two times higher than for other males.[54] This is a population likely to hold particular views about masculinity resulting in reduced help-seeking and help-giving behaviours, further exacerbating underlying risk factors.

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

The ideal response would be for people bereaved by suicide to have a community already around them to provide the compassionate, practical responses appropriate to their needs and in the context of existing and positive relationships. This is also known as a 'compassionate community', where support is provided through family members, friends, neighbours, workplaces and other formal and informal social groups in a way which is natural, normalised and easier to accept.[55] Developing such compassionate communities requires sustained community-building efforts, as described above, so that there are resources and networks available to respond to those bereaved by suicide.

In addition to these community-based responses, peer-led support services or psychological supports are important postvention processes. These services need to be accessible to people (in terms of ease of access, cultural appropriateness and cost) and should be resourced to provide ongoing and consistent support beyond the immediate period of bereavement if needed. That is, postvention services which only provide time-limited, fragmented support are unlikely to be experienced as providing the compassionate, practical response which is being sought.

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