

VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

VICTORIAN SUICIDE PREVENTION FRAMEWORK 2016–25



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PREVENTION
FRAMEWORK 2016–25**



Acknowledgement of Traditional Owners

The Department of Health and Human Services acknowledges the Traditional Owners of the land, pays its respect to the Elders of Victoria's Aboriginal communities both past and present and acknowledges the ongoing contribution made by Victoria's Aboriginal people today.

Throughout this document, the term 'Aboriginal' is used to refer to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

The Victorian Government thanks *beyondblue* and the people with lived experience of mental illness and suicide attempts who have provided permission to publish their stories in this publication.

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MINISTER'S FOREWORD



In 2014, 646 Victorians lost their lives to suicide.

Every year in Victoria, suicide takes more than twice as many lives as the road toll.

For every suicide, there are many more people – family, friends, carers, colleagues and communities – who are deeply affected.

To reduce the road toll, there has been a sustained and coordinated strategy which has seen continuous progress made over a long period time. It's now time we work together, taking a similar approach to see our suicide toll decline.

The *Victorian suicide prevention framework* is a whole-of-government commitment to reducing suicide and suicidal behaviour, and a coordinated strategy that will help to save lives.

It delivers new investment towards the goal of *Victoria's 10-year mental health plan* that all Victorians experience their best possible health, including mental health. The plan guides how Victorians can work together to improve the mental health and wellbeing of all Victorians. It will guide a community-wide shift in attitudes to promote inclusion, support mental wellbeing and combat stigma and discrimination.

We know that suicide is complex, but preventable. Through the *Victorian suicide prevention framework*, we will be working to save one life every day.

To achieve this target, we are investing in local solutions and system-wide reform.

The 2016/17 Victorian Budget invested an additional \$356 million in mental health services and infrastructure, including \$27 million to implement this framework.

I would like to acknowledge the members of the Mental Health Expert Taskforce, whose depth of knowledge and expert advice were critical to the development of the *Victorian suicide prevention framework*, and thank them for their commitment to supporting all Victorians to achieve their full potential.

The *Victorian suicide prevention framework* is dedicated to the Victorians who have taken their own lives and to their loved ones. We acknowledge the struggle, turmoil and at times hopelessness they experienced, and the pain and anguish of their loved ones. We stand with the partners, family members, friends, and the service providers who work together towards hope and recovery.

A handwritten signature in black ink, appearing to read 'Martin Foley'.

Martin Foley MP
Minister for Mental Health

SUICIDE IN VICTORIA


Tragically, there were more deaths by suicide in 2014 than in 2013. In Victoria, the rate of deaths per 100,000 people rose to 15.6 for men and 5.0 for women.

Beneath these statistics, every single death tells a story, but each has the same underlying message for our community: we need to do more to prevent suicide.

Suicide rates vary significantly by age and gender. Using national data, the highest rate of suicide is among men aged 85 and over (37.6 per 100,000), followed by men aged between 40–44 and 50–54 (29.9 and 29.2 per 100,000 respectively). The highest rate of suicide among women is in the 35–39 age group (9.2 per 100,000).

Although suicide rates are lower among young people, suicides account for a larger proportion of deaths of young men and women. The suicide rate is higher in regional Victoria (14.9 per 100,000) than in metropolitan Melbourne (9.4 per 100,000). The suicide rate in the Aboriginal population is twice the general population rate, and suicide generally occurs at much younger ages.

It is important that we work closely with groups within our community experiencing a higher prevalence of suicide or with particular risk factors to understand the complex factors driving these outcomes.



The increase in both the number and the rate of suicide deaths occurred after a decade in which progress in reducing the suicide rate has stalled. This is despite the efforts of families, carers, health professionals, and thousands of concerned people who look after those in trouble and re-connect them with their reasons for living.

Suicide is a complex problem, and rates of suicide are affected by many social, cultural and individual factors. Responsibility for preventing suicide cannot rest on individuals, families and friends alone.

To reduce suicide among Aboriginal and Torres Strait Islander communities, we must work with Aboriginal elders and communities to strengthen connection with culture, self-determination and opportunities for Aboriginal Victorians.

To bring down the number of suicide deaths among people who have previously attempted suicide they must not leave hospital without personal support, follow-up, and information and education for family members, carers or friends who are helping their recovery.

To prevent suicides by people with mental illness and substance abuse issues we must respond appropriately to their experience of trauma.

We are working to reduce family violence, child abuse, alcohol and drug misuse, bullying stigma and discrimination – all known risk factors for suicide.

To reduce the higher rates of suicide among lesbian, gay, bisexual, trans and gender diverse and intersex people we must challenge prejudice and discrimination.

We cannot only focus on risk factors, and neglect the community and personal strengths that give us reasons for living.

Local communities cannot respond with resilience to trauma, disasters, emergencies or the loss by suicide of friends and family members if they do not know who to turn to for help and support.

To reduce suicide, we must take action.

JONATHAN'S STORY

The first time I was diagnosed with depression, it felt like it came from nowhere; it all seemed to happen so fast.

When I was 21, I was studying and working in Scotland, and saving money to travel to Australia. Without warning, I slumped on to a seat at work, and just began to sob almost uncontrollably, not knowing why.

My colleague came over and sat opposite me. This simple conversation helped me realise exactly what had been happening. It was actually a relief to know that there was something really wrong, and that life didn't have to be this way.

The next day, after being pushed by my colleague, I went to the doctor, and was diagnosed with depression and acute anxiety. This was a real shock.

The doctor then started to discuss treatment options, at the time I instantly dismissed the concept of taking medication.

Having not taken the doctor's advice properly the first time, I inevitably suffered a relapse in to much more severe depression some time later. I have had several depressive episodes since then, and will probably continue to have further depressive episodes throughout my life.

The most extreme symptom I have ever had was in one of my more recent depressive episodes. Despite being the sole wage provider for my wife and son, despite having the responsibility to provide for my family and to care for my family, I felt like my depression was a hindrance to them and that they would be better off if I wasn't around.

This clearly couldn't be further from the truth, but that is how I genuinely felt, and that is scary. Scary for my son to grow up without his father, scary for my wife having to raise our son alone and with no income, and scary for me to think that I would not be around to watch my son grow up, go to school for the first time, graduate, get his first job, have his first partner, get married and have children.

That is how important mental health really is. That is why no matter how difficult it may seem to have a conversation with someone you are worried about, it is truly worth it. You only have to ask, 'Are you ok?' Three simple words that can make such a positive difference in a person's life – even simply reminding them that there are people who care about them.

My life has become much better now. I am learning all the time about my mental health, and I have a beautiful family and a steady successful career. There really is light at the end of the tunnel.

For me, I have learnt that regular exercise is a massive help along with my medication. I go to the gym at least 4 times a week, and regularly play golf socially with family and friends. Even a thing as simple as sitting in the back yard and playing with my dogs is a great way to manage my illness, as it helps me relax, take my mind off things that might be stressing me out, and to just switch off.

VICTORIA'S SUICIDE PREVENTION FRAMEWORK

We know that there is evidence of suicide interventions that work. Better care and follow-up for suicidal people and their families and carers saves lives. Action that builds protective factors – strong communities, relationships, contributing lives with purpose and hope, community and personal resilience – gives people reasons for living. Reducing the risk factors – disadvantage, injustices and social factors that cause distress – reduces the likelihood that people will head into a crisis.

There is evidence that the many tested and proven suicide prevention interventions are best done together, in an integrated care or systems approach to suicide. The National Mental Health Commission set out recommendations to implement this systems approach in *Contributing lives, thriving communities: review of mental health programmes and services*, including setting a target to halve the suicide rate. This report also summarised the evidence from across the world in support of this approach. This includes evidence that whole-of-population and place-based approaches to suicide prevention are effective in reducing suicide. This is particularly true for Aboriginal people, when dealt with in a culturally appropriate manner.

A systems or coordinated approach ensures that all involved in suicide prevention collaborate and focus their efforts on the interventions that are proven to have the greatest impact. This approach can bring down the suicide rate.

This *Victorian suicide prevention framework* sets out how the Victorian Government will implement this approach, including a set of actions that are targeted at suicide prevention.

The framework sets priorities for suicide prevention as part of *Victoria's 10-year mental health plan*. The framework was developed drawing on the extensive community consultation undertaken for *Victoria's 10-year mental health plan*, the work of the National Mental Health Commission on suicide prevention, and additional consultations with Victorian Government agencies, experts, community leaders and the Expert Taskforce on Mental Health.

The first step towards implementing these priorities is the new funding provided in the 2016–17 Victorian budget. The government will continue to invest in suicide prevention over the next 10 years based on these priorities.

Goal: Halve Victoria's suicide rate by 2025

OBJECTIVE 1: BUILD RESILIENCE

- A new focus on building resilience across the Victorian Government, including in schools, health and emergency services

OBJECTIVE 2: SUPPORT VULNERABLE PEOPLE

- Uniting behind groups who are experiencing higher risks of distress and suicide, including early responses to concerns among dairy farmers, regional communities, Aboriginal communities, emergency services workers, paramedics, police, and lesbian, gay, bisexual, trans and gender diverse and intersex people

OBJECTIVE 3: CARE FOR THE SUICIDAL PERSON

- Strengthened approaches to assertive outreach and personal care when a person who has attempted suicide leaves hospital, emergency department or mental health service

OBJECTIVE 4: LEARN WHAT WORKS BEST

- A new commitment to test and evaluate new trial initiatives and share data with local communities

OBJECTIVE 5: HELP LOCAL COMMUNITIES PREVENT SUICIDE

- Trialling over six years a systemic approach to suicide prevention in six local government areas across Victoria

NEW INVESTMENT: \$27 MILLION OVER FOUR YEARS

OBJECTIVES

The objectives reflect the broad public health approach to suicide prevention – with work across three levels as recommended by the World Health Organization: universal, selective and indicated. This approach is the best way to respond to the complex nature of suicide. It includes interventions that address the whole population, people with specific risk factors, and people in need of care.

The most important new innovation in this framework is that all of these strategies will be brought together, with the involvement of local communities, through a place-based approach that will enable the flexibility to tailor approaches to local circumstances. Using the concept of collective impact, this approach will bring together the skills, expertise and resources needed to work with a systemic plan to prevent suicide.

This approach is supported by new investment of \$27 million to support action across all five objectives with two flagship initiatives – local trials to help communities prevent suicide, and outreach services for people who have attempted suicide. The government is committed to evaluating the impact of the trials, and will test the effectiveness of implementing all five objectives at the local level.



PRINCIPLES

Suicide is preventable.

The principles that guide all the initiatives in the framework mirror principles that are important for good mental health care when addressing suicidal behaviour at the individual level.

These principles are that suicide is preventable when we:

- acknowledge that suicide is a complex behaviour
- take a person-centred approach to supporting suicidal individuals, their families and carers
- believe in and commit to change and recovery
- aim for a hopeful future
- make decisions based on evidence and commit to a cycle of continuous learning
- provide health and other social services in culturally appropriate and accessible ways that meet the needs of vulnerable groups
- co-design services and systems in partnership with people who have lived experience of suicide attempts, or have been bereaved by suicide
- empower communities to achieve their goals through place-based approaches.

All initiatives will be required to embed culturally accessible and culturally safe services, and be responsive to the diverse, complex risks, needs and preferences of vulnerable Victorians.

FOUNDATIONS

This approach to suicide prevention is consistent with and builds on work across other areas of government. The current government reform agenda addresses some of the most pressing social issues in Victoria and promotes the vision of a fair, healthy, inclusive and prosperous society.

The government is working to reform health, education and social services that are the foundation on which this framework is built. Some detail on these policies and their links to suicide prevention are highlighted on the next page.

These reforms, including *Victoria's 10-year mental health plan, Roadmap for reform* and implementation of the recommendations of the Royal Commission into Family Violence, share core objectives. All of these reforms aim to:

- strengthen universal services that build community resilience, and intervene early for people at risk
- provide easy access to services in the local community that respond to individual needs and are sensitive to the family and cultural context
- provide integrated wrap-around support to ensure that issues are not treated in isolation and interventions make a real impact
- strengthen safety and crisis support so that people in crisis are provided with the care and protection they need.

POLICY REFORMS SUPPORTING SUICIDE PREVENTION

FAMILY VIOLENCE

Freedom from violence and abuse is a foundation of suicide prevention. The Royal Commission into Family Violence painted a picture of crisis-driven, fragmented and uncoordinated support for victims, survivors and the perpetrators of family violence. The government has committed to implementing all of the commission's recommendations. The 2016–17 Victorian Budget committed \$572 million to implement 65 of the commission's most urgent recommendations.

VICTORIA'S 10-YEAR MENTAL HEALTH PLAN

The goal of *Victoria's 10-year mental health plan* is for all Victorians to experience their best health, including mental health.

People with mental illness and people who misuse substances are at greater risk of suicide. Policies on mental health and alcohol and drug misuse underpin this suicide prevention framework, reflecting the World Health Organization's approach to suicide prevention.

ICE ACTION PLAN

The government developed the *Ice action plan* within its first 100 days in office to protect people from the devastating harm of this drug. The 2016–17 Victorian Budget invests a further \$57.6 million in the *Ice action plan*.

ROADMAP FOR REFORM: STRONG FAMILIES, SAFE CHILDREN

Child abuse is a major risk factor for suicide and adult mental illness. The *Roadmap for reform: strong families, safe children* articulates the vision that Victoria will be a state with strong families and children who are safe, healthy and well. The 2016–17 Victorian Budget delivered \$168 million to implement the *Roadmap for reform*.

CLOSING THE GAP

Victoria is committed to closing the gap between Aboriginal and non-Aboriginal Victorians, including on mental health outcomes and suicide.

Under *Victoria's 10-year mental health plan*, with leadership from the Aboriginal Social and Emotional Wellbeing Reference Group, Victorian Aboriginal Community Controlled Health Organisation, their member organisations, elders, community leaders and local communities, the development of an Aboriginal mental health and social and emotional wellbeing framework will guide action. The framework will support resilience and promote protective factors, while addressing risk factors for poor mental health.

EDUCATION STATE

The government is building an education system that produces excellence and reduces the impact of disadvantage. Education State will ensure that schools and other education institutions will be a nurturing environment for our children and young people to develop confidence, social skills and healthy life habits. Education State aims to increase the proportion of students who report high resilience by 20 per cent. In addition, the government has invested \$43.8 million in the Doctors in Secondary Schools initiative to ensure that young people are getting the health support, advice and treatment they need so they can reach their full potential.

HEALTH REFORM

The government is investing a record \$2.45 billion extra in health to ensure Victorians get the care they need sooner. This significant boost targets all areas of the health system, including hospital facilities and services, elective surgery, ambulances and mental health.

TARGET

The government is committed to halving the rate of suicide deaths by 2025.

This target is guided by a broader vision, similar to the Vision Zero approach to road safety and the international Zero Suicides in Health Care approach. We aim to keep working on suicide prevention until there are no suicide deaths.

The government aims to reduce the gap in suicide rates between particular vulnerable groups and the general population.

The framework sets these long-term targets and the principles and objectives to guide government decisions over the next 10 years. It also outlines the key actions over the next three years to support progress towards meeting the target. Many of the actions build on existing proven strategies but there is also a focus on investment in new initiatives. The framework includes universal initiatives and initiatives that aim to respond to the needs of vulnerable and at-risk groups.

OUR APPROACH

Delivering this target requires new investment in effective interventions that can make an immediate impact.

New funding of \$27 million supports two major initiatives that will commence in early 2017 and continue for the next six years – place-based local trials and assertive outreach.

Both these initiatives contribute to all five objectives of the framework. They will both work with community and personal strengths to build protective factors against suicide. They will both reduce risk factors and provide targeted support to key vulnerable groups at higher risk of suicide. They will both work with families, personal support and health and social services to improve care for the suicidal person. They will both use and build a stronger evidence base on suicide and what works to prevent it.

Both initiatives are informed by the philosophy – outlined in *Victoria's 10-year mental health plan* and other major policies – that place-based, local approaches can best support individuals to get the right services at the right time, close to where they live.

LEARNING WHAT WORKS

These initiatives will be implemented together with ongoing improvements to established suicide prevention programs, guided by the five objectives of the framework. For many years the Victorian Government has supported successful government and community-based programs to prevent suicide. Especially since the landmark report of the Victorian Suicide Prevention Taskforce in 1997, Victorian Governments have sought to strengthen responses to suicide from all sectors and the broader community within an integrated suicide prevention framework. These programs have been guided in recent years by national mental health plans, the national suicide prevention framework, *LIFE: Living Is For Everyone*, and the National Mental Health Commission's report, *Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*.

The *Victorian suicide prevention framework* builds on and learns from these past successes, as well as emerging evidence on effective approaches. It focuses on the flagship initiatives and priority programs to be delivered over the next three years. Further initiatives will be developed and implemented as we measure our progress towards the target of halving the rate of suicides in Victoria.

The government will report regularly to the community on progress through the mental health annual report to parliament.

PLACE BASED TRIALS

Communities need to act together when suicide affects local families, local schools, friends and neighbours. But it is difficult to bring together the people affected, the services that can help, and the evidence on how to prevent further suicides. Greater leadership from state government at a local level can help local communities put in place the things that work to prevent suicides.

The Victorian Government will trial a systemic, coordinated approach to suicide prevention in six local government areas over six years in partnership with primary health networks and other agencies. Exploring the particular issues related to Aboriginal people will be part of this.

At each site, a local suicide prevention group will develop a plan to reduce suicides in the area. Each site will be supported to implement the nine proven suicide prevention interventions:

- prevention awareness programs
- school-based programs
- responsible media reporting
- gatekeeper training
- frontline staff training
- general practitioner support
- reduce access to lethal means
- high-quality treatment
- continuing care after suicide attempt.

It will be important to include families and support networks who have experience of suicide attempts in developing these local interventions.

The testing of this coordinated approach in specific sites is over and above the focus on suicide prevention across the whole state. The additional work in these sites will not reduce effort in other local government areas.

ASSERTIVE OUTREACH

During the consultations on *Victoria's 10-year mental health plan*, some community members shared their tragic stories of loved ones who took their own lives in the period after they had

left hospital following a suicide attempt and/or treatment for mental illness. Better follow-up (including education and support for families, carers and support people) in this vulnerable period can prevent deaths.

The Victorian Government will provide additional resources to support approaches to assertive outreach and personal care when a person who has attempted suicide leaves hospital, an emergency department or a mental health service. The government will ensure there is a chain of care that links general hospitals and community aftercare services for people discharged following a suicide attempt. This will strengthen connections with, and support for the person's family or other networks. Provision of information and education in the period after leaving hospital will strengthen the personal and informal support provided to the person who is at risk of suicide.

The service will provide immediate follow-up to ensure continuous and coordinated care for the person and their family. First contact will be provided within the first 24 hours post-presentation at hospital, and may extend for up to three months following the suicide attempt. It will provide practical, psychosocial support in addition to direct mental health or other medical treatment.

The importance of culturally appropriate and safe responses to Aboriginal persons, lesbian, gay, bisexual, trans and gender diverse and intersex people, and other groups who have attempted suicide will be acknowledged and developed in this initiative.

A number of models will be tested and these different approaches to delivering the enhanced service will be available initially in six health services from February 2017. An evaluation of the variety of models will inform a decision on the best way to deliver the initiative to all health services, and to embed better care across the state for people leaving hospital after a suicide attempt.

KATHERINE'S STORY

When I finished school, I was lost. I just went to bed for three weeks and didn't respond to anyone or anything. I know now that this was a depressive episode, but at the time I just felt so tired, uninterested in life, in my friends, in anything at all.

Eventually, my father frog-marched me down to the unemployment office to look for something to do. And that's how my thirty-year career in arts management began!

My next major depressive episode wasn't until over a decade later, when my marriage broke up. This was a traumatic event, which of course relationship breakdowns are for everyone – but this was pretty extreme. I was crying constantly, unable to work, unable to sleep, unable to eat. I thought about suicide a lot and if it hadn't been for my two Golden Retrievers who are now both in doggy heaven, I probably would have taken some serious action on those thoughts.

My thinking was not clear, my physical state was dreadful. My best friend took me to the GP as I was incapable of making the appointment on my own – or even understanding that I needed to. This was the first time I was prescribed medication and it certainly helped. I slowly recovered through medication, exercise and the strong support of my close friends, who were absolutely wonderful.

Ultimately, I did try to kill myself. Through the intervention of friends (literally breaking the door down when I wouldn't answer) I got help. I was again prescribed medication and I started working with a psychologist. I was very lucky my friends and colleagues supported me and that I had a great GP and a good psychologist.

One of my friends said something I've never forgotten, when I said I felt bad about asking for help she said 'We all want to see a happy Katherine, not a sad Katherine. Asking us for help is you giving us a gift of doing something to help you be happy, and that makes us happy.'

In 2009, I was diagnosed with bipolar disorder. All these symptoms – insomnia, being very speedy, drinking a lot – had been around for a while, but no one had joined the dots before. What followed was more medication and lots of trial and error around what worked and what didn't. It was all a bit hit and miss, but by 2010 I was pretty stable. A change in medication in 2013 had a dramatic effect and I have been much better. I was so lucky my job offered a structured return to work program and I was able to continue and grow my career in arts management.

I use a lot of tools to manage my recovery: I keep a mood diary; I monitor my food and alcohol intake; I exercise every day and use my Fitbit to keep me on track; I read a lot about new treatments; I take my medication consistently and get it reviewed regularly; I go to therapy regularly; I use mindfulness techniques and meditate regularly. And I am blessed with a wonderful supportive partner and friends.

It might sound like a lot of work, but it's just good management and the price of not managing it is way too high.

You can live a great life with depression, anxiety, bipolar disorder and other conditions if you manage it in the way that works for you.



OBJECTIVE 1: BUILD RESILIENCE

OBJECTIVE

Improve community and individual strength, resilience and capacity in suicide prevention.

WHY IS THIS IMPORTANT?

Resilience describes the ability to bounce back after trauma, stress, distressing change or difficult situations. Individuals can build their resilience by maintaining positive relationships, thoughts and identity, taking care of their health and wellbeing, seeking help and nurturing connections and relationships with family, friends and the community. Families and carers can strengthen their support for someone by learning about early warning signs and how to provide the best support for a person at risk of suicide.

Communities can build resilience through fostering social cohesion, increasing understanding of diverse cultural and social identities, providing a safe and secure environment, and ensuring access to healthcare and health promotion. Participation in community groups of all kinds – from formal clubs to informal peer support groups – provides social and cultural connections, encourages positive beliefs and reasons for living, and establishes networks of personal and informal support that strengthen resilience. Peer-based volunteer groups also protect people from the effects of discrimination and stigma, and provide a source of social and personal strengths for many vulnerable or marginalised people, such as people with mental illness, Aboriginal people, those from culturally and linguistically diverse backgrounds and recently arrived communities including refugees and asylum seekers and those who misuse substances, have disabilities, or identify as lesbian, gay, bisexual, trans and gender diverse and intersex.

These reserves of social and personal strengths can be drawn on to improve mental health, to restore a hopeful belief that every life is worth living, and to bolster protective factors against suicide.

Seeking help for social and emotional problems is an important coping strategy, so it is important to reduce the stigma associated with mental illness, self-harm and help seeking. The experience of stigma and discrimination is very common among people with mental illness, and for Aboriginal people and other marginalised groups it can be particularly problematic. The anticipation of discrimination can also lead people to give up on important life goals, known as the 'why try' effect. Discrimination can be experienced from family members, in employment and in the attitudes of health professionals. Stigmatising attitudes can also impact on access to treatment and mental health services. While stigmatising attitudes from health professionals may be unintentional, they can have significant consequences that contribute to suicide risk, such as embarrassment, shame, distress, reduced help-seeking from both health professionals and personal support.

Developing an individual identity is one of the key challenges of adolescence and young adulthood. Same-sex attracted and gender diverse young people can face particular challenges affecting their personal identity when they experience stigma or discrimination related to their sexuality or gender identity. A safe school environment, understanding and acceptance by family members, and a compassionate community helps all young people thrive and develop to their full potential, and not be held back by reactions to their sexuality, gender or cultural identity.

PRIORITY ACTIONS 2016–19

This action area builds on well-established successful programs. The key areas where these programs will be extended and improved will be:

A NEW FOCUS ON BUILDING RESILIENCE ACROSS VICTORIAN GOVERNMENT

The Victorian Government will work across state government agencies to build resilience among Victorians, especially among young people. Education State commits the government to increasing young people's resilience by 20 per cent over the next 10 years. Through the *Victorian public health and wellbeing plan*, the government is improving resilience through a focus on the social determinants of health. VicHealth's *Mental health and wellbeing strategy 2015–19* aims to support one million more Victorians to achieve better health and wellbeing, and will continue to work with young people to develop innovative programs that help them to shape their identity and engage with the world in ways that promote health and wellbeing.

RESPECTFUL RELATIONSHIPS

Education State is supporting schools to focus on the health and wellbeing of students in order to improve both health and education outcomes, and to close gaps in outcomes for disadvantaged schools. Evidence highlighted by the Royal Commission into Family Violence shows that teaching children and young people about respectful relationships and gender equality, and taking a whole school approach to this education, can prevent domestic and family violence in the long term.

The reforms include delivering new teaching and learning materials focused on respectful relationships and violence prevention in the school curriculum from prep to year 12, and a range of resources that support respectful and

safe school communities. A recent investment of \$21.8 million will strengthen and expand the delivery of respectful relationships across Victorian schools and early years services. This funding will help schools not only teach respectful relationships education as part of the school curriculum, but extend the focus to school cultures, practices and partnerships, helping to reinforce and model respectful relationships and gender equity in everything schools do. In addition, up to 4000 early childhood educators will receive professional learning focused on how to build and develop respectful relationships aligned with the Victorian Early Learning and Development Framework.

SAFE SCHOOLS COALITION

The Victorian Government will continue to support the Safe Schools Coalition Victoria to provide flexible resources and training opportunities in every Victorian government secondary school to support same-sex attracted and gender diverse students. The resources provided through the Safe Schools Coalition Victoria help to reduce homophobic and transphobic behaviour and intersex prejudice in Victorian schools. The resources increase support for, and actively include, same-sex attracted, intersex and gender diverse students, school staff and families.

REDUCE THE STIGMA ASSOCIATED WITH MENTAL ILLNESS

The Victorian Government will influence and challenge discriminatory behaviour by advocating for positive change and prompting discussions across Australia. It will inform and connect people to enable them to achieve their best possible mental health and access support when they need it. It will innovate and initiate effective ways to improve access to support and improve outcomes for people, families and communities.



OBJECTIVE 2: SUPPORT VULNERABLE PEOPLE

OBJECTIVE

Improve identification and support to vulnerable individuals and groups at risk of suicide, including providing support after a suicide for bereaved people and communities.

WHY IS THIS IMPORTANT?

Suicide can affect anyone, but it disproportionately affects some individuals and groups. The higher rates in some subgroups of the population reflect common risk factors, shared experiences and multiple causes. The risk of mental illness for an individual who is a member of multiple minority groups is even higher.

Patterns of behaviour, beliefs and social conditions affecting suicide risk factors are constantly changing. Education, health and social services seek to better identify and respond to these risks, and develop targeted programs that meet the changing needs of vulnerable groups today. This requires active monitoring of suicides, suicide attempts and patterns of self-harming behaviour to ensure targeted action is adapted to current concerns, risk factors and vulnerable groups. It also requires ongoing consultation with a wide range of community groups who can report on current concerns causing distress for vulnerable groups. Professional services seek to listen respectfully to family members, carers and friends of suicidal people who have valuable knowledge to share and can sometimes be vulnerable to suicide themselves because of their grief.

Evaluation of the effectiveness of suicide prevention for subgroups of the population is difficult given the variety of causes of suicide, and the changeability of some risk factors and suicidal behaviour. Still, the World Health Organization, drawing significantly on research evidence from Australia, identified effective targeted interventions for vulnerable groups, including people who have experienced abuse, trauma, conflict or disaster, refugees and migrants, Aboriginal peoples, prisoners, lesbian, gay, bisexual, trans and gender diverse and intersex people, those bereaved or affected by suicide, and military and veteran populations.

SUICIDE, SELF-HARM AND MENTAL ILLNESS IN THE LGBTI COMMUNITY

Across the world, lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTI) people are a vulnerable group at higher risk of suicide. The World Health Organization's *Preventing suicide: a global imperative* (2014) urged action to reduce the risk of suicide among LGBTI people. The higher suicide risks reflect community risk factors, such as prejudice, discrimination and outdated models in some health and social services that do not cater well to the needs of LGBTI people. LGBTI people also report higher rates of mental illness and substance abuse than the rest of the community.

In 2015 the Australian Institute for Suicide Research and Prevention completed a major study for *beyondblue* on suicidal behaviours in LGBTI people in Australia. It found that the key factors related to suicide in LGBTI people were 'a lack of acceptance by family and self, a high incidence of romantic relationship conflict and aggressive behaviours, and a greater prevalence of depression and anxiety and alcohol and substance use disorders.' These findings supported a need for targeted approaches in mental health services, including relationship and family counselling, school-based programs, and public health and stigma reduction campaigns, particularly around supporting full and healthy development of an LGBTI identity and the provision of culturally appropriate and accessible services.

Suicide prevention for LGBTI people needs to address risk factors, including stigma, prejudice and individual and institutional discrimination. It needs to promote mental health for LGBTI people throughout their lives – including through programs for young people, such as Safe Schools, and for older LGBTI people, such as the range of programs and services that have been developed to make aged care services safer and more welcoming environments for older LGBTI people. In addition, there is a need for system and process change in the provision of health services to better meet the needs of LGBTI people, and ensure they receive culturally appropriate and accessible services. The government is working to reduce the higher and specific risk relating to trans and gender diverse people, and to provide more accessible health and social support services for those experiencing gender incongruity.



PRIORITY ACTIONS 2016–19

This action area will strengthen and adapt a wide range of prevention programs targeting specific vulnerable groups. Throughout the life of the framework, the government will seek to partner with at-risk community groups to improve understanding and awareness leading to better use of appropriate services.

ABORIGINAL VICTORIANS

All state-funded suicide prevention initiatives and services will be required to address cultural accessibility and cultural safety. Through the development of an *Aboriginal social and emotional wellbeing framework*, a strategy to build on the cultural, community and personal strengths of Aboriginal Victorians will be supported. This work will build on the renewed focus on building the community and cultural strengths of the Aboriginal community across Victorian Government and in many community-led initiatives in health, child care, social services, sport, arts and other fields. This focus recognises the critical importance of elders and communities leaders, particularly in the engagement of young people.

The government is providing funding for demonstration projects to ensure disadvantaged Aboriginal people with moderate severity mental illness and trauma do not fall through the gap between primary and tertiary mental health treatment services. Improving access to treatment for Aboriginal persons not currently receiving treatment will reduce the risk of suicide in this vulnerable cohort. This initiative will complement other suicide prevention activity for Aboriginal people by providing mental health treatment and associated support.

LESBIAN, GAY, BISEXUAL, TRANS AND GENDER DIVERSE AND INTERSEX PEOPLE

The government will partner with lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTI) people and community groups to tackle discrimination and to improve inclusiveness of health and social services. These partnerships will help build the evidence base on patterns of self-harm and suicidal behaviour in LGBTI. Services will be encouraged to support LGBTI people to develop full and healthy identities, and provide culturally appropriate and accessible services across all ages and in both metropolitan and regional settings. These services include the Victorian AIDS Council, community health services, alcohol and drug treatment services, and both clinical and community mental health services.

For young LGBTI people, the government and the Youth Affairs Council of Victoria continue to fund the Health Equal Youth (HEY) Project and HEY grants. The grants support organisations to undertake mental health promotion and community engagement activities focusing on same-sex attracted and sex and gender diverse young people up to the age of 25, and their families.

The government is also supporting the development of a Pride Centre for Victorian LGBTI community organisations, associations and groups, and delivering an education and training program to combat homophobia across Victoria. In May 2016 the Victorian Parliament apologised for laws criminalising homosexuality and the harms caused. The apology is a powerful statement, especially for older members of the Victorian LGBTI community.

RURAL COMMUNITIES

Suicide rates are higher in regional and rural communities, and mental health services can be difficult to access. Rural communities are also more affected by fire, flood and drought. The government will support programs that promote mental health, recovery from disaster and strengthen resilience and community support across rural and regional Victoria. The Victorian Government will ensure that the National Centre for Farmer Health can continue to improve the health and wellbeing of Victorian farmers and their families. The government will work in partnership with the centre to identify further training and program opportunities, such as brief intervention programs to reduce emotional distress and the risk of suicide.

DAIRY INDUSTRY

The government has provided a \$1.5 million mental health wellbeing package for dairy farmers. This included extra counselling services, mental health first aid training, support for community events and a \$100,000 boost towards the Look Over the Farm Gate program. This forms part of an \$11.4 million support package for dairy farmers affected by the global fall in milk prices and decisions by some processors to cut the prices paid to their suppliers. The support package, which was developed in consultation with the Dairy Industry Taskforce, will ensure dairy farmers and their families experiencing financial and emotional stress get the support they need. The package also includes financial counselling, and a flexible fund of \$4.5 million to support affected farming communities.

SCHOOL COMMUNITIES AFFECTED BY SUICIDE

The Department of Education and Training in partnership with headspace will continue to provide on-the-ground support to schools in instances of attempted suicide or suicide. School Support is an evidence-based world-first program that supports Australian secondary schools affected by suicide. It works closely with education systems, principals, school wellbeing staff and teachers to appropriately prevent and respond to the suicide of a young person.

FAMILIES, FRIENDS AND CARERS OF SUICIDAL PEOPLE

The grief, loss, strain and vicarious trauma experienced by those close to suicidal people can make them vulnerable to suicidal or self-harming behaviour themselves. In addition, the support provided by families, friends and carers is essential to preventing suicide. We need to engage with and support them to take care of both the suicidal person and themselves. The government will encourage services to involve families, carers and support people in care planning and decision making, especially around discharge planning and support. They will receive more information, education and support, and will be involved in developing, implementing and evaluating new initiatives.

SPORTING CLUBS

Sporting clubs are an essential part of the community fabric. Victorians of all ages and backgrounds come together in grassroots clubs to be active, enjoy themselves in a positive environment and socialise. Many people with higher risk factors participate in club sport – for example Aboriginal, LGBTI, rural communities, young people affected by suicide and families and friends of suicidal people. This makes sporting clubs an important setting to reach out to those who need help. The government will continue to work with the sector to improve mental health and wellbeing outcomes for Victorians.

HEALTH, POLICE AND EMERGENCY SERVICES WORKERS

The Victorian Government will require all agencies that employ frontline health and emergency services staff to develop and implement mental health and resilience plans as part of a comprehensive occupational health and safety framework. This will include Victoria Police, Ambulance Victoria, Metropolitan Fire Brigade, Victoria State Emergency Service, child protection and health services.

Victoria Police will develop a comprehensive mental health strategy to address the issues and gaps identified in the *Victoria Police mental health review*. The review highlighted the positive work that police have done to provide internal health and support services to staff, but acknowledged more needs to be done. Its recommendations address the need to increase the awareness and understanding of mental health issues, reduce the stigma and improve support services for people after they have left the force.

For paramedics, a partnership between Ambulance Victoria and *beyondblue* will design training programs covering topics such as depression and anxiety, trauma, substance abuse

and suicide prevention. The training will support paramedics to understand mental health issues, recognise and respond to those at risk of suicide, and receive advice on getting the help they need.

These plans to protect the mental health of these groups of workers will be implemented hand in hand with training that supports these staff to protect and support better mental health outcomes for clients, such as trauma-informed practices.

OTHER OCCUPATIONAL RISK FACTORS

The government will work with the trucking industry, construction industry and the security guard industry to co-design industry approaches to improving mental health and reduce suicide for these workforces.

PRISONERS

The government will continue to implement the *Correctional suicide prevention framework: working to prevent prisoner and offender suicides in Victorian correctional settings*.

REFUGEES

The World Health Organization recognises refugees as a priority group for suicide prevention. The government promotes positive mental health outcomes through maximising successful settlement and supporting recovery from experiences of torture and trauma. For asylum seekers in the Victorian community on bridging visas or in community detention, services are available at critical points when legal decisions about their refugee status are made.

In addition, the government supports specialist refugee services and mainstream services to respond to specific issues for refugees and asylum seekers in a culturally responsive way.

Victorian health and human services also provide intensive support for people at risk of suicide and self-harm who are transferred from detention centres in Australia and offshore.

ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING FRAMEWORK

Across Australia, the rate of suicides by Aboriginal Australians is twice the rate of non-Aboriginal Australians. Higher suicide rates reflect underlying higher levels of psychological distress, high rates of mental illness, substance abuse and self-harm, and the experience of intergenerational trauma.

Suicide generally occurs at younger ages among Aboriginal people than in the general population. The gap in suicide rates is greatest in men and women aged 15–19, and the highest age-specific rate is among men aged 25–29. This rate is approximately 90 deaths per 100,000 people, more than four times the rate for other Australian men of the same age.


Suicide is a distressing event that disrupts the lives of families, friends and communities who are bereaved. Within the Aboriginal community, bereavement through suicide is complicated by its traumatic nature, issues of stigma and the frequency of suicide as a cause of death for Aboriginal people. Since the impact of suicide on both the individual and community lives of Aboriginal Victorians is profound, we need specific action to prevent suicide in the Victorian Aboriginal community.

To address the inequality that Aboriginal people experience in mental illness and suicide, the Victorian Government will work with the Aboriginal Social and Emotional Wellbeing Reference Group to develop an Aboriginal social and emotional wellbeing framework, with a focus on co-design. The framework will encompass promotion, prevention, early detection, treatment and recovery. It will develop the right way to approach social problems by partnering with the people who face them head on. It will recognise the fundamental role of culture, community and spirituality in Aboriginal wellbeing.

The *Aboriginal social and emotional wellbeing framework* will acknowledge that Aboriginal mental health encompasses all aspects of an individual's life, including the social, physical, emotional, cultural and spiritual wellbeing of the individual and their family and community. It will recognise the risks that discrimination and unresolved grief and trauma have on mental health, and the influence that spirituality, connection to country and strong cultural identity have on building resilience and protecting against poor mental health.

The government will work closely with Aboriginal organisations, elders, leaders and communities to build existing knowledge and best practice, while also developing Aboriginal services and universal platforms to be more culturally appropriate. The peak body for Aboriginal health in Victoria, Victorian Aboriginal Controlled Community Health Organisations, will develop a consultation mechanism to ensure all 27 Aboriginal community controlled health organisations can contribute.

This plan will complement the *Aboriginal health and wellbeing strategic plan* and *Victorian Aboriginal children and families strategy*.



OBJECTIVE 3: CARE FOR THE SUICIDAL PERSON

OBJECTIVE

Improve response, treatment and early support for people with suicidal behaviours, including post-episode care for individuals and engagement with families and support networks.

WHY IS THIS IMPORTANT?

The most significant indicator of risk of future suicide is a previous suicide attempt. This risk is especially high in the days and weeks after discharge from hospitalisation or treatment following a suicide attempt. One study in the United Kingdom found that 43 per cent of deaths by suicide occurred within one month of discharge from hospitalisation or treatment following a previous suicide attempt, with nearly half of those deaths occurring before the first follow-up appointment.

The Victorian Chief Psychiatrist's investigation into inpatient deaths between 2008 and 2010 reported that people with mental illness are at greatest risk of suicide in the first year after being discharged from hospital, particularly the first five weeks. In some cases, patients who are leaving mental health services are returning to the same difficulties, stresses and risk factors that triggered their suicide attempt. Sometimes they lack social support, and once they leave hospital they receive less immediate emotional support and feel more isolated. Sometimes there is poor communication between the health professionals and the personal family and support people helping a vulnerable person.

For these reasons, follow-up, open and respectful dialogue between health professionals and the personal support team of a suicidal person, as well as connections with community support, are important in reducing suicide deaths and attempts.

The period after leaving hospital or the emergency department is a critical time in which better care and support for people can save lives. The World Health Organization notes that follow-up and community support have been effective in reducing suicides and suicide attempts among people who have recently been discharged from hospital after an attempted suicide.

The government is implementing Suicide Prevention Australia's recommendation to establish personal support services in emergency departments and hospitals, and during transitions between care. These services would work alongside mental health, other medical care, and a range of education, social and community support to ensure suicidal patients receive emotional support.

The effective assessment and management of suicidal behaviours is a central part of the responsibility of health services and healthcare workers – both specialised mental health workers and non-specialised staff. Crucial suicide prevention strategies include improving the quality of care for suicidal people through workforce education, recovery-oriented mental healthcare and psychosocial support and the implementation of the best available clinical guidelines for caring for the suicidal person. Appropriate training in responding to people with mental illness and at risk of suicide needs to be provided not only to healthcare workers but to other frontline staff – such as police officers, firefighters and other emergency service workers – who are often in contact with people with mental health or substance abuse problems and who may be suicidal.

PRIORITY ACTIONS 2016–19

These actions will strengthen models of care for suicidal people, and provide additional support to frontline staff, healthcare professionals and the family members, carers and friends who support suicidal people.

ASSERTIVE OUTREACH

Through the assertive outreach initiative, the Victorian Government will provide additional resources to support people after leaving hospital, an emergency department or a mental health service when they have attempted suicide.

The government will ensure there is a chain of care that links general hospitals and community aftercare services for patients discharged following a suicide attempt.

- The assertive outreach service will identify and support suicide attempt survivors while they are still in hospital in emergency departments, general medical or mental health services, and provide follow-up support to the person after they leave hospital.
- The service will provide immediate follow-up to ensure continuous and coordinated care for the person and their family. First contact will be provided within the first 24 hours after leaving the health service, and for up to three months immediately following the suicide attempt
- The service will strengthen connections with and support for family or other people in the suicidal person's life.
- The assertive outreach will be guided by clinical expertise, and be offered free of charge to people of all ages, gender and background.
- The services will be implemented in ways that are culturally aware and informed, and sensitive to the cultural issues faced by the suicidal person and vulnerable groups in the community.
- The Department of Health and Human Services will implement several approaches to the enhanced service initially in six health services for three years.
- An evaluation will be undertaken to identify the best models and how they may need to be tailored to the needs of local communities or particular target groups.

ASSERTIVE OUTREACH TRIAL LOCATIONS



HOW CAN ASSERTIVE OUTREACH AND CONTINUITY OF CARE AFTER A SUICIDE ATTEMPT MAKE A DIFFERENCE?

In Baerum, Norway, one leading hospital formed a multidisciplinary suicide prevention team with the goals of: securing aftercare prior to discharge for people who attempted suicide, their family and community; engaging the health and mental health professional community in education and supervision pertaining to suicide; and providing prevention services to patients referred to the suicide prevention team. Hospital researchers undertook a comprehensive survey of the impact of the program on patients and suicide. Nearly nine in 10 patients participated in the aftercare program they were referred to. Over 12 years, there was a 54 per cent decline in the incidence of suicide attempts.

CHAIN OF CONTINUOUS CARE

More broadly, the evidence on effective suicide prevention programs shows that:

- maintaining follow-up with people who present to an emergency department after a suicide attempt reduces repetition of suicide attempt in the following 12 months
- emergency-department based interventions that provide follow-up case management and encouragement of adherence to treatment reduced suicide rates compared with usual care
- supportive letters sent to patients who had exhibited suicidal behaviours, did not adhere to treatment and had been discharged from an inpatient unit were shown to decrease the suicide rate within the first two years of intervention
- using postcards for patients who had attempted self-poisoning reduced risk of repeated overdose.

There are many ways that health services can implement a chain of continuous care for patients when they leave hospital after a suicide attempt. The assertive outreach initiative will support local health services and health professionals developing innovations that work best for patients.

OTHER PRIORITY ACTIONS

Other actions that will complement this early and continuing follow-up care and support for people who have attempted suicide following discharge from hospital will be:

PRIMARY CARE RESPONSE TO PEOPLE AT RISK OF SUICIDE

The Department of Health and Human Services will work with the primary health networks to deliver local, placed-based training for general practitioners to build their capability to respond to suicidal behaviours in patients and support patients after suicide attempts.

The department will continue to broker relationships between primary health networks and health services networks to build stronger pathways between tertiary care and primary care to support patient transition from hospital after a suicide attempt. The department will encourage person-centred, family-sensitive and recovery-oriented models of care in these settings.

REVIEW OF WORKING WITH THE SUICIDAL PERSON

In 2010 the Victorian Department of Health published *Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services*. These guidelines were based on an extensive literature review and consultation with both clinicians and people with lived experience. Some aspects of the guidelines need to be updated since the introduction of the *Mental Health Act 2014*, and emerging evidence of current risks and effective approaches. In particular, the guidelines will incorporate more guidance on follow-up, discharge practices and involvement of families, carers and support people. The government will establish a technical advisers group to undertake a rigorous and comprehensive review of the guidelines to incorporate current research on best practice and consultation with all key stakeholders. Revised guidelines will be issued in 2017.

FRONTLINE STAFF RESPONSE

The Department of Health and Human Services will support the delivery of training, practice guidelines, clinical supervision packages and community of practices for frontline staff to manage suicidal behaviour. This training and professional development will be offered to both mental health professionals and the full range of other non-specialist staff who support suicidal people. Training will be developed to suit the needs of individual agencies and their staff. A new Centre for Mental Health Workforce Development will disseminate best practice and promote trauma-informed care and other practice improvements to both specialist and non-specialist workforces.

NEW CENTRE FOR MENTAL HEALTH WORKFORCE DEVELOPMENT

The Centre for Mental Health Workforce Development will become the go-to platform for mental health learning and development, practice support, research and access to expertise. New specialist training units accessible through the centre will build capability in the areas of trauma-informed practice and multiple and complex needs – both fields critical to improving both health and social care for the suicidal person.

OBJECTIVE 4: LEARN WHAT WORKS BEST

OBJECTIVE

Build a stronger, more accessible evidence base.

WHY IS THIS IMPORTANT?

Victorians who are working to prevent suicide need timely, accessible evidence on what works, and good local intelligence on how to adapt general models to the unique needs of each community.

The World Health Organization's *Preventing suicide report* (2014) identifies surveillance on suicides and suicide attempts as a fundamental requirement for planning, implementing and evaluating a comprehensive suicide prevention strategy. Victoria's target to halve the suicide rate will not be achievable without all stakeholders understanding current risk factors and the most cost-effective interventions.

More generally, when designing effective local suicide prevention strategies we need access to quality research and evaluation findings, so that all users and stakeholders learn from past successes and failures.

Making better use of data on suicide deaths, attempts, self-harm and risk factors, and better use of research on the most effective interventions, will be fundamental to the success of the place-based trials.

These local trials will also need to make clear decisions on the most effective interventions for their local area, based on current assessments of concerns in their community. The local trials will all share a common framework for research and evaluation, and the interpretation of local suicide data. The findings of the evaluation will inform the design and approach to future initiatives.

PRIORITY ACTIONS 2016–19

This action area will strengthen suicide and self-harm data collection, research and evaluation. There will be a strong focus on ensuring timely and accurate information is available to support local suicide prevention plans, and a systematic use of local data to help local communities prevent suicide.

Key areas for improvement are:

Evaluation of the cost-effectiveness of interventions

The government will evaluate the effectiveness of local and statewide interventions to ensure that effort is directed to the most effective interventions.

Local analysis of suicide trends and impact of programs to support local plans

Each place-based trial site will be supported by high-quality data analysis of current patterns of suicidal behaviour and an audit of local suicide prevention programs and services.

Analysis of suicides and suicide attempts

The Department of Health and Human Services will enhance the collection, analysis and dissemination of suicide attempts and mortality data and information, and work with the State Coroner and other research partners to assess opportunities to intervene to prevent suicide deaths. This work will improve processes to develop and gather suicide attempt data, such as agreed nomenclature across health systems and standardised methods of recording of information by emergency departments, ambulances and police.



Use of ambulance data for local plans

The Department of Health and Human Services will work with Ambulance Victoria and research partners to strengthen analysis of ambulance attendance data to identify local patterns and hot spots for suicidal behaviour.

Data sharing systems and protocols

All Victorian Government agencies will collaborate on developing a data and information sharing system that builds on existing data collections and improves the sharing of this information at local, regional and state levels.

OBJECTIVE 5: HELP LOCAL COMMUNITIES PREVENT SUICIDE

OBJECTIVE

To help local communities to prevent suicide through a coordinated place-based approach that delivers both universal and targeted interventions in communities across Victoria.

WHY IS THIS IMPORTANT?

More suicides can be prevented if there is effective local action to reduce risk factors and support people who are contemplating suicide, especially people who have been in recent contact with health services and whose suicidal thoughts fluctuate. It is also important to bring together the friends, family and support people of those with suicidal thoughts, since they may have information that the person does not share with professional services.

A coordinated approach to suicide prevention means having well-planned prevention, intervention and crisis responses. It brings together professionals, people with lived experience and organisations in health, policing, employment, housing, justice, education, community organisations and all levels of government. These organisations all work together towards a shared vision to halve suicide deaths.

This approach has succeeded overseas, and the Black Dog Institute is implementing such an approach in New South Wales with philanthropic funding. The Victorian Government will deliver a similar place-based approach, and is proposing a partnership with interested primary health networks so that the Commonwealth and the state government work together to put in place the right solutions for local communities.

HOW WILL IT WORK?

Victoria will trial the coordinated place-based approach to suicide prevention in six sites. This will enable local governance and coordination of government and non-government organisations to deliver multiple interventions in targeted local areas.

The core features of a coordinated approach to suicide prevention are:

- implementing a range of evidence-based strategies at the same time
- multi-sectoral involvement by all government, non-government, health, business, education, research and community agencies
- governance within a localised area
- demonstrating sustainability and long-term commitment.

This approach emphasises all relevant organisations and services working together in an integrated way, simultaneously and at a local level. It implements suicide prevention strategies that are proven to be effective, and builds the evidence base for emerging approaches.

Each site will then develop a suicide prevention action plan based on a needs analysis. It will set out the specific actions to be taken to reduce suicide risk in the local community. This plan will consist of a set of core principles based on evidence of effective interventions, and specific strategies will be tailored to address unique community needs.

Each local plan will include locally adapted action from nine key suicide prevention interventions:

- appropriate and continuing care once people leave emergency departments and hospitals
- high-quality treatment for people with mental health problems
- training general practitioners to assess depression and other mental illnesses, and support people at risk of suicide
- suicide prevention training for frontline staff every three years, including police, ambulance and other first responders
- gatekeeper training for people likely to come into contact with at-risk individuals
- school-based peer support and mental health literacy programs
- community suicide prevention awareness programs
- responsible suicide reporting by media
- reducing access to lethal means of suicide.

The Department of Health and Human Services will provide central coordination as well as support to each local site. This coordination and support will assist local communities to develop innovative, evidence-based suicide prevention plans that both support the policy directions of *Victoria's 10-year mental health plan* and promote learning at the local community level about the most effective strategies. The coordination and support will include advice on effective strategies, data analysis, access to research experts, coordination of effort across agencies, and shared learning and evaluation activities across sites.

The sites will commence operation during the 2016–17 year. The program may be expanded to more sites through real-time assessment of the impact of initial implementation sites and the needs of local communities. In each site the government will seek to partner with the primary health network, and provide coordination, support, and access to specialist expertise to ensure successful implementation.

PLACE BASED TRIAL LOCATIONS



WORKING TOGETHER AND REPORTING PROGRESS

The government will drive the implementation of the *Victorian suicide prevention framework* through ensuring cross-government leadership and accountability.

The government will consult regularly with the Expert Taskforce on Mental Health on progress with the suicide prevention strategy and emerging issues in the community, and on the development of new initiatives. The government will also consult other key advisory groups on the effective approaches to suicide prevention in key vulnerable groups, including specifically the Aboriginal and the lesbian, gay, bisexual, trans and gender diverse and intersex communities.

Local suicide prevention groups will be established to oversee the development of the place-based trials. These groups will be supported by the Department of Health and Human Services and partners.

These cross-government groups will strengthen collaboration, shared learning and improve effectiveness across the whole strategy.

The government will report annually on progress, with suicide prevention as part of the annual report to parliament on mental health.

The measure for assessing progress will be the age-standardised rate of deaths from intentional self-harm as reported annually by the Australian Bureau of Statistics in its *Causes of death* publication.

The suicide prevention framework will be evaluated, including evaluation of the effectiveness of individual interventions.

