

9. IMPLEMENTING VICTORIA'S SUICIDE PREVENTION STRATEGY



In developing Victoria's suicide prevention strategy, the Task Force elected to use a framework that described a broad range of activities, and took into account a number of facts and circumstances.

The Task Force believes it is essential that an effective implementation strategy be developed that takes account of the need for a coordinated, integrated service system to support and treat individuals at risk of suicide.

Consequently, this chapter deals with:

- The roles and responsibilities of different levels of government to achieve coordination and integration.
- Statewide policy coordination and service integration, including the need for quality assurance audits of service delivery agencies.

9.1 VICTORIAN GOVERNMENT ROLE

9.1.2 STRUCTURES FOR IMPLEMENTATION

The Task Force recognises that implementation requiring coordination across several government agencies, with links to the broader Victorian community, is a difficult task. However, it is critical for the successful implementation of the recommendations. Given the breadth of recommendations made in this report, and the number of organisations and agencies involved, the Task Force considers it vital that this issue of coordination be tackled.

The Task Force has given detailed consideration to how this might be achieved. It identifies four key elements it believes, in combination, will provide a model for achieving the desired outcomes of better coordination and greater integration of services directed to preventing suicide. The four elements are:

- A Cabinet subcommittee.
- A Minister responsible for overseeing the implementation of the recommendations from this report.
- A senior adviser responsible to the Minister.
- A broadly based advisory council.

9.1.2.1 CABINET SUBCOMMITTEE RESPONSIBLE FOR SUICIDE PREVENTION

It is critical that oversight of the Task Force's recommendations occur at the most senior government level. For this reason, the Task Force proposes a Cabinet subcommittee made up of senior government Ministers charged with the responsibility for determining the policy direction for suicide prevention in the State. This Cabinet subcommittee would have a similar role to the committee overseeing the Turning the Tide drug and alcohol strategy.

9.1.2.2 MINISTERIAL RESPONSIBILITY

A Minister who is a member of the Cabinet subcommittee and responsible for the Government's overall Youth Life Force initiatives would carry responsibility for seeing through the recommendations. While the suicide focus would essentially be on youth, the Minister could also be given responsibility for implementing and monitoring the overall suicide prevention framework and ongoing policy development.

9.1.2.3 SENIOR ADVISER

A senior adviser, ideally with chief executive status, should be appointed to advise the Minister and, through the Minister, the Cabinet subcommittee on all issues related to suicide research and prevention, and related developments. This person would oversee collaboration and coordination across departments. The adviser would need knowledge in the area of suicide and related issues. The adviser would also be a member of the foundation recommended in the next section.

9.1.2.4 THE VICTORIAN FOUNDATION FOR PREVENTION OF SUICIDE

The fourth key element involves establishing an outside body with the role of advising government on the extent to which recommendations have been achieved. The Victorian Foundation for Prevention of Suicide would include people drawn from health, mental health, community services, education, justice and research organisations, businesses and trusts, and establish links with other foundations. The foundation would provide a means of gaining financial and other support from the corporate sector and other interests. Its role would be to advise government,

through the responsible Minister, on:

- Implementation of recommendations in this report.
- Development of ongoing policy and a research and evaluation program.
- New initiatives for suicide prevention that are likely to draw corporate and other support.
- Development of community initiatives.

The Task Force recommends that:

9.1 The Victorian Government support implementation of Victoria's Suicide Prevention Strategy by establishing the following framework for coordination:

- **A Cabinet subcommittee of senior government Ministers to oversee implementation of the report's recommendations and development of ongoing policy.**
- **A senior Minister with lead responsibility for coordinating action to prevent suicide.**
- **Appointment of a senior adviser to support the Minister.**
- **Establishment of a Victorian Foundation for Prevention of Suicide.**

9.2 LOCAL GOVERNMENT

Local government has a vital role to play in supporting local communities. Its role should be to coordinate existing services at the local level, and ensure the best mix of services for suicide prevention is available and well targeted. A municipal plan should be prepared with targets for improving social and emotional wellbeing. Examples of best practice where local government has already taken on this role were described in chapter 5.

9.3 COMMONWEALTH AND STATE COORDINATION

It is important that service developments fostered by Commonwealth and State Government approaches to suicide prevention are coordinated. Therefore, a national strategic approach to suicide prevention is required. The Task Force believes the Commonwealth Government should take the lead role in facilitating collaboration between the Commonwealth and the States/Territories in developing a national approach to suicide prevention.

9.4 STATEWIDE POLICY COORDINATION AND SERVICE INTEGRATION

The suicide prevention framework adopted by the Task Force assumes an holistic approach with a system able to respond comprehensively along a continuum of services. However, a recurrent theme brought to the attention of the Task Force has been that, despite its many strengths, the service system as it currently operates in Victoria is made up of a series of unrelated responses and lacks coordination and integration. The system was seen, in many instances, as failing to provide continuity of care, particularly for people with multiple needs. The reasons for this were complex and, in part, reflected the multidimensional nature of suicide risk and vulnerabilities. Some of the common features of this lack of coordination and collaboration between agencies were:

- Many sectors are crisis oriented and do not give priority to broader prevention activities that could prevent multiple disadvantage.

The system is geared towards crisis. If you slit your wrists, you will end up in the hospital...we have various specialist workers, but there is a lack of generalist workers... (Community consultation)

- Providers have poor levels of information about the existence and nature of services provided by related agencies.

One of the problems we have is that there is very little communication between sectors. (Community consultation)

- Different professional disciplines use different definitions and classification systems that serve as barriers to clients accessing appropriate services across more than one sector.
- Service purchasing arrangements can impede collaboration and cooperation between agencies, particularly when narrow definitions of service are specified. This narrow definition of the core business of service agencies means that people in crisis who have multiple needs do not receive integrated services, but experience a compartmentalisation of their needs. This is ineffective and costly, as clients have to negotiate their way through the service system maze.
- Concerns about confidentiality of clients can impede information sharing, joint case planning, or any prospect of continuity of care for clients with multiple needs.

I understand the ethics of confidentiality, but an integrated response from the key players involved—the at risk person, family, psychiatrist/psychologist, general practitioner...police...telephone counselling service etc—could jointly and effectively provide support, develop a plan to try to prevent attempts and work to restore hope. [Written submission]

- Funding arrangements tied to regional boundaries can define transient and homeless people out of a service or any prospect of continuity of care.
- Age criteria and narrow service definitions, particularly within the mental health system, can be used to impose 'policies of exclusion'. For this reason, the Task Force has recommended purchasing services from consortia of providers to improve continuity of care for clients.

The Task Force has identified a number of strategies and initiatives that need to be considered to improve collaboration and achieve better integration of relevant service sectors in the field of suicide prevention. These proposals may also have broader applicability beyond suicide prevention.

9.4.1 SERVICE FUNDING

The primary aim of the service system is to meet the specific needs of individual clients. To effect the coordination and integration necessary to achieve this, the Task Force suggests that the Victorian Government adopt a number of guiding principles for funding services. One mechanism for bringing this about would be for the Department of Human Services to modify current tendering arrangements to promote integrated program funding through purchases of services from consortia of agencies that should, where possible, apply the principles outlined below. The Department should, within any given region, purchase a proportion of services to operate outside normal hours to:

- Provide 24-hour coverage through better allocation of resources.
- Incorporate multidisciplinary service models, cross-sectoral protocols, collaborative arrangements, resource sharing, and effective case conferencing.
- Balance coverage and integration of prevention, early intervention, intervention and postvention responses.
- Recognise and achieve delivery from a range of sites: schools, youth services, primary health services, crisis intervention services and mental health services.

The Task Force recommends that:

9.2 The Minister for Health and Minister for Youth and Community Services invite tenders for delivery of client services as service partnerships or consortia of services that demonstrate the capacity to provide integrated client-oriented services based on the principles outlined in the report.

9.4.2 IMPROVING CASE MANAGEMENT

The Task Force believes that clients with multiple needs should have direct access to a range of coordinated and integrated services. Coordinated service delivery relies on the different parties agreeing to their respective roles, relationships and responsibilities in addressing the needs of at-risk young people. Mechanisms for achieving this will include:

- Further development of cross-sectoral protocols. Consultations stressed that protocols need to be 'embedded in the culture of the agency, rather than in a document that no-one looks at'. Protocols need to be implemented effectively to ensure that all workers are familiar with them, and implementation should then be evaluated.
- Improvements to current systems of case conferencing. It is critical that case conferences include all relevant professionals across agencies and sectors.
- Improvements to case management procedures to allow the nomination of a single case coordinator. A system that allows people with multiple needs to collect multiple case managers from different agencies without a coordinator is problematic. It is essential that a single case coordinator takes on a broader advocacy role on behalf of the client across all services required.

The Task Force also recognises the importance of providing continuity of care for people who have moved but still wish to access the same services with which they have become familiar and/or the worker with whom they have developed rapport. As noted by the Victorian Council of Churches:

The regionalisation of service provision has provided major problems for young people who are mobile and transient. The mental health system in particular seems unable to respond efficiently to transfer of responsibility and information about individual young people who move between regions. Many young people in the high risk groups associated with mental illness and dual diagnosis [mental illness and drug problems] have not had access to services they need as a consequence of mobility and transience. (Written submission)

The means of achieving this could be for purchasing arrangements to be established and/or by transferring funds between regions to follow the client. If the funds were allocated to the client, there should be greater competition and improved service responsiveness. The Task Force believes no client should be refused a service on the basis of living in the 'wrong' region or catchment area.

The Task Force recommends that:

9.3 The Minister for Health and Minister for Youth and Community Services require the Department of Human Services to collaborate with other government departments to plan and provide direct services as integrated service packages to meet client needs, wherever possible.

9.4 The Minister for Health and Minister for Youth and Community Services require the Department of Human Services to ensure that no client is excluded from accessing service/s on the basis of regional boundaries.

9.4.3 QUALITY ASSURANCE

The Task Force is concerned that for clients with multiple needs, there is no mechanism for reviewing case management practices and access to services. If clients are excluded from a service due to the service deciding their primary problem is the responsibility of another agency, they have no way of gaining assistance. Someone with a mental health problem who also has a drug and alcohol problem may be defined by each service as belonging to the other with neither taking responsibility. Another common problem is where a client is receiving different services from different agencies and is sometimes receiving conflicting advice because there is no coordinated case plan.

Given these issues, there is a need to establish a capacity within government to assist such clients to gain access to improved, coordinated service delivery from government services and government-funded services. In disputed cases, a primary case manager/broker should be appointed for the client.

The Task Force also considers there is a need for the Department of Human Services to ensure that agencies are providing the quality client services they are funded to provide. As most services are funded by government and delivered by community sector agencies, funding agreements provide an outline of the service to be provided. However, government needs to undertake quality assurance audits to ensure that agencies are meeting government standards for delivering high-quality client services.

The Task Force considers the Department of Human Services should implement an extensive program of performance and quality assurance audits for all its government-funded services, particularly in the mental health and community service sectors, to ensure organisations are providing the type and quality of service for which they have been funded. Auditors should spend time in agencies to get a first-hand impression of their culture and responsiveness, and to obtain feedback from clients. Client surveys are an important part of any quality assurance program.

The Task Force recommends that:

9.5 The Minister for Health and the Minister for Youth and Community Services identify an appropriate structure which appoints a primary case manager or broker for people with multiple needs where there is a dispute with service providers.

9.6 The Minister for Health and Minister for Youth and Community Services implement an extensive program of performance and quality assurance audits, including site visits and client surveys, for all government-funded services relevant to suicide prevention to ensure organisations are providing the type, standard and quality of service for which they were funded, and to obtain feedback from consumers.

9.4.4 REGIONAL/LOCAL AREA SERVICE INTEGRATION

To be effective, many of the early intervention and intervention responses to suicidal behaviour described in this report require regional or local cooperation and collaboration. In considering how to put good practice principles into action in regional and local service provision, the Task Force found a range of models upon which better coordination of the current service system can be built.

Cross-sectoral approaches to service provision can be conceptualised as a staged approach. The first stage is to know what related services exist. The second stage is to achieve cooperation. Higher level stages are represented by coordination and formal collaboration of services. Community consultations suggested that, in many regions, services

have not reached the first stage of informing themselves of the existence of related services. On a more encouraging note, some excellent examples of sophisticated cooperation and collaboration were found to exist in pockets of the service system across the State.

Coordination mechanisms include joint service planning at regional or local level, and joint case planning for individual clients. Features of collaboration include joint location of services, resource sharing, staff exchanges and multidisciplinary training. It is important there is a strong commitment for agencies to work together if a comprehensive and thorough program of early intervention and intervention is to be created alongside broader suicide prevention initiatives.

Many agencies and professionals (including community health, mental health services, schools and support services) need to be involved to ensure that scarce resources can be mobilised and delivery of services is effectively coordinated. (Community consultation)

Examples of multisectoral models of service provision currently operating across a range of sectors (schools, community, child protection, mental health) and across sites provide a basis upon which to build. Some existing models of effective, integrated practice are described below. Taken together, they illustrate what can be achieved through better coordination of services between sectors and regions.

Jesuit Social Services has formed an alliance with St Vincent's Hospital, the Centre for Adolescent Health and the Turning Point alcohol and drug centre to run the Youth Substance Abuse Service recommended by the Premier's Drug Advisory Council. This service provides a good example of interagency collaboration that recognises that serious drug problems in young people rarely occur in isolation from many other health, mental health and social problems.

The Mildura Aboriginal Cooperative Mental Health Program, an Innovative Health Service for Homeless Young People (IHSY), demonstrates how a brokerage model of collaborative service provision can significantly improve outcomes for people. The Task Force believes this model deserves more attention and could be replicated as an example of best practice in rural areas across the State for Aboriginal and non-Aboriginal people.

MILDURA ABORIGINAL COOPERATIVE

This program promotes health care for homeless and at-risk young people by increasing access to mainstream and specialist services, particularly mental health services.

The project objectives are to:

- Undertake psychological assessments.
- Provide ongoing youth counselling in individual and group settings.
- Foster reconciliation between homeless young people and their families or, where this is not possible, assist homeless young people to live independently.

This program is not based on funding a staff position; rather, program funding is used to purchase services for clients. The funds form a pool of resources for the project steering committee: a group of workers from all of the key health and welfare agencies in Mildura.

The project has major links with the Koori educational resource centre, child protection services, juvenile justice, Department of Social Security, DEETYA/CES, community policing squad, and the education sector. A case management approach to family mediation is a feature of the initiative.

Initial evaluation of this initiative suggests that it is operating effectively. The steering committee for the project has established an effective, ongoing case conference mechanism that has led to significant improvements in staff approaches to service provision and new linkages between services. Creating parent support groups as part of the service has been successful.

THE BARWON ADOLESCENT TASK FORCE (BATFORCE) MODEL

BATForce is a further example of a highly effective regional peak body that excels in developing coordinated responses to youth needs in the Barwon area. The Task Force was impressed by the level of coordination within the youth service system in the Geelong and Barwon areas. This success is partly due to the work of BATForce.

Funded by the Department of Human Services, BATForce is a coalition of youth organisations that has been in existence for 17 years. In the past 12 months, BATForce has provided:

- Operation of a comprehensive network of youth and community workers, information sessions and mail-outs, coordination of professional development for affiliated agencies, and further development of links between youth agencies and others in the community.
- Studies on the needs of low-functioning young people and on counselling services.
- Support for the Clockwork Youth Health Service.
- Suicide prevention education for the Colac community and work with schools on students at risk.
- Development of a youth and municipal health plan.

The Task Force believes these models, and others mentioned through the report, should be examined with a view to replicating the elements of the service approach to other areas.

The Task Force recommends that:

9.7 The Victorian Government establish a program of small grants to support initiatives that increase coordination and collaboration of regional and local service agencies.

