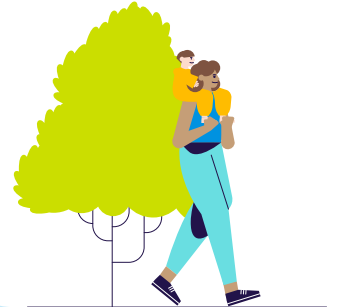
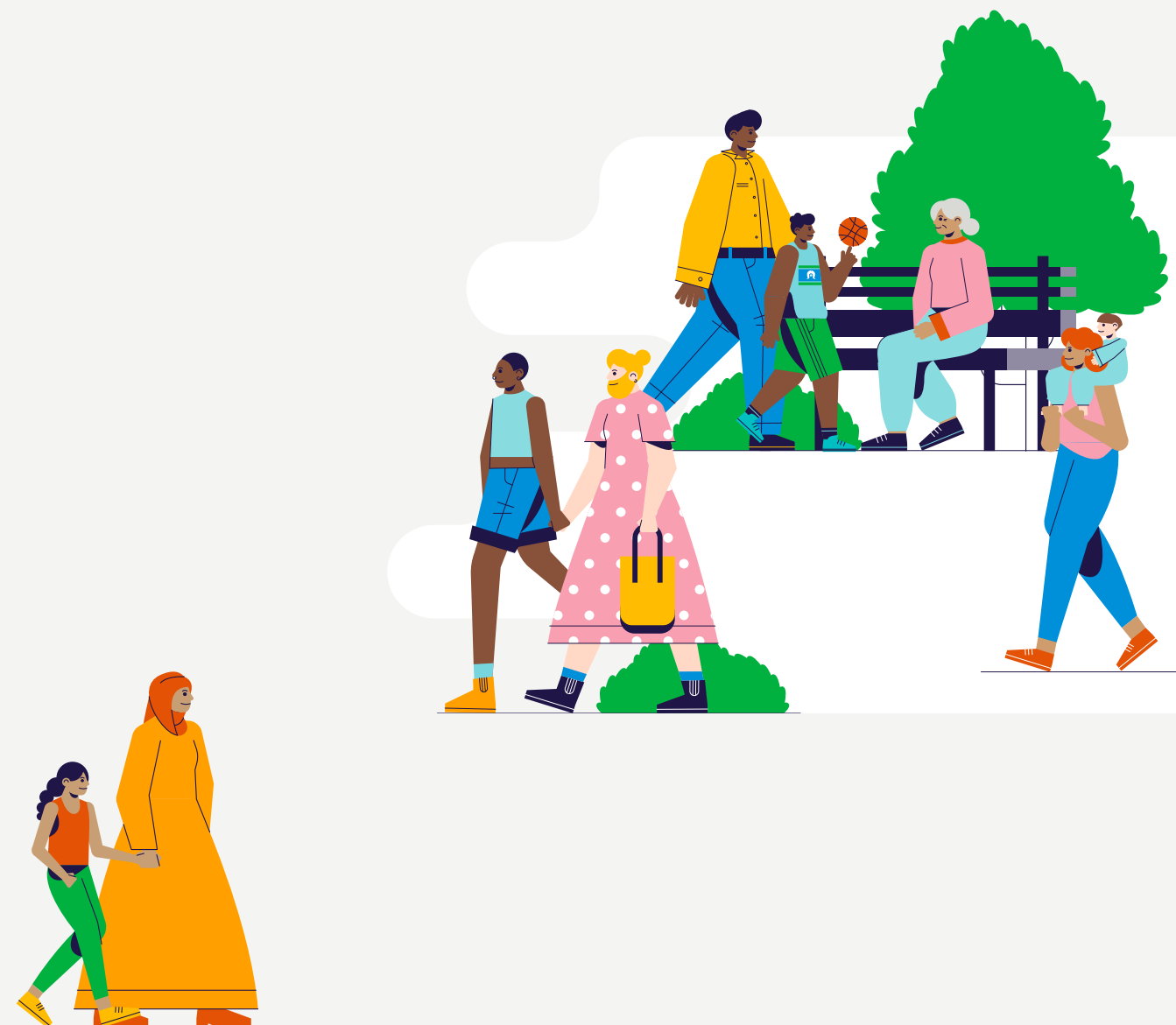




Victorian suicide prevention and response strategy

2024-2034





To receive this document in another format, email the [Suicide Prevention and Response Office](mailto:suicide.prevention@health.vic.gov.au) <suicide.prevention@health.vic.gov.au>.

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Available at [Suicide Prevention in Victoria](https://www.health.vic.gov.au/prevention-and-promotion/suicide-prevention-in-victoria) <<https://www.health.vic.gov.au/prevention-and-promotion/suicide-prevention-in-victoria>>

If you need help

No one needs to face their problems alone. If you or a person you support needs help, the following services are available:

- If you are in a situation that is harmful or life-threatening, contact emergency services immediately on Triple Zero (000).
- If you are not in immediate danger but you need help, call NURSE-ON-CALL on [1300 60 60 24](tel:1300606024).
- For crisis support, call Lifeline on [13 11 14](tel:131114) or visit the [Lifeline website](https://www.lifeline.org.au) <<https://www.lifeline.org.au>>.
- For support to address distress or thoughts of suicide, call SuicideLine Victoria on [1300 651 251](tel:1300651251) or visit the [SuicideLine website](https://www.suicideline.org.au) <<https://www.suicideline.org.au>>. The Suicide Call Back Service is also available on [1300 659 467](tel:1300659467).
- For mental health support, call Beyond Blue on [1300 224 636](tel:1300224636) or visit the [Beyond Blue website](https://beyondblue.org.au) <<https://beyondblue.org.au>>.
- For Aboriginal and Torres Strait Islander people who need support, call Yarning Safe N Strong on [1800 959 563](tel:1800959563) or visit the [Victorian Aboriginal Health Service website](https://www.vahs.org.au/yarning-safenstrong) <<https://www.vahs.org.au/yarning-safenstrong>>.
- For crisis helpline support for Aboriginal and Torres Strait Islander people, call 13YARN ([13 32 16](tel:133216)) or visit [13YARN's website](https://www.13yarn.org.au) <<https://www.13yarn.org.au>>.
- To speak to an Aboriginal and Torres Strait Islander suicide postvention advocate, call the Thirrili postvention support line on [1800 805 801](tel:1800805801) or visit [Thirrili's website](https://thirrili.com.au) <<https://thirrili.com.au>>.
- For children and young people who need support, call Kids Helpline on [1800 551 800](tel:1800551800) or visit the [Kids Helpline website](https://kidshelpline.com.au) <<https://kidshelpline.com.au>>. Young people can also call headspace on [1800 650 890](tel:1800650890) or visit the [headspace website](https://headspace.org.au/our-services/headspace) <<https://headspace.org.au/our-services/headspace>>.
- For LGBTIQ+ people who need support, call Rainbow Door on [1800 729 367](tel:1800729367), text them on [0480 017 246](tel:0480017246) or email [Rainbow Door](mailto:support@rainbowdoor.org.au) <support@rainbowdoor.org.au>.
- If you are looking for a mental health service, visit the [Better Health Channel website](https://betterhealth.vic.gov.au) <<https://betterhealth.vic.gov.au>> or contact your local GP to find out about your options.
- For small business owners who need support, call the Partners in Wellbeing Helpline on [1300 375 330](tel:1300375330), or visit the [Partners in Wellbeing website](https://www.partnersinwellbeing.org.au/small-business-support) <<https://www.partnersinwellbeing.org.au/small-business-support>> for live chat, enquiries and referrals.
- For people living or recovering from addiction, call the Self Help Addiction Resource Centre (SHARC) family drug and gambling helpline on [1300 660 068](tel:1300660068), visit [SHARC's website](https://sharc.org.au) <sharc.org.au> or contact DirectLine on [1800 888 236](tel:1800888236).
- For veterans and ex-service people who need support, call Open Arms on [1800 011 046](tel:1800011046) or visit the [Open Arms' website](https://www.openarms.gov.au/get-support/counselling) <<https://www.openarms.gov.au/get-support/counselling>>.

Minister's foreword

Suicide has a profound, devastating and lasting impact on Victorian communities. More than just a statistic, each loss to suicide is a beloved family member, colleague, friend or community member. And for all those who die by suicide, there are countless others living with thoughts of suicide and carers, families and supporters trying their best to provide care and compassion while also managing their own wellbeing.



The Royal Commission into Victoria's Mental Health System revealed that, to date, our attempts to prevent and respond to suicide have been uncoordinated and too focused on a health or mental health-led approach. It also showed us that we drastically need to change how we collaborate and work with people with lived and living experience of suicide, carers, families and supporters.

In the 3 years since the release of the Royal Commission's final report, I'm proud of the progress we have made to embed the expertise of people with lived and living experience of suicide in the design and delivery of suicide prevention and response programs and services. Our health and mental health clinicians, frontline workers and crisis responders have also been working hard to deliver better care and support.

But, as this strategy shows, we need to do more to build systems that are compassionate and responsive and actively prevent suicidal distress in our community. This is especially

true for groups in our community that are impacted by suicide more than others (including Aboriginal people, LGBTIQ+ people, men and young people) and as we continue to respond to and recover from events that can impact our wellbeing, such as the COVID-19 pandemic. It also shows there are other settings and places where we must identify and respond to suicide risk and that we need to change the conversation and address the stigma that surrounds suicide. By doing this we will have safer discussions about suicide, support help-seeking and enable more compassionate and trauma-informed responses.

The Victorian Government recognises the deeply personal and multifactorial nature of suicide and that reducing its impact and incidence requires a truly whole-of-Victorian Government and community-wide approach that puts people at the centre of what we do. That's why we partnered with people with lived and living experience of suicide to develop this strategy and to understand the changes we need to make now and into the future. People with a first-hand experience of suicide are often the best placed to understand what the system needs, where the gaps are and what needs to happen to prevent suicidal distress in the first place.

The *Victorian suicide prevention and response strategy 2024–2034* outlines a decade-long approach for Victoria's suicide

prevention and response efforts. It draws on the perspectives of hundreds of people who understand how we can better prevent and respond to the complexity of suicide. This includes the unique perspectives of Aboriginal, LGBTIQ+, disability and multicultural communities, mental health clinicians and peer workers, academics, sectors and industries that are disproportionately impacted by suicide, people in contact with the justice system, older people, veterans and young people.

Victoria has a solid foundation to build on and there is good work underway. This strategy supports us to refocus our efforts, try new approaches, continue to build our evidence and implement a systems-based approach that is informed by lived and living experience.

The strategy sets an ambitious agenda that I know we can achieve if we work together collaboratively and compassionately. Everyone in Victoria has a role to play – to support, listen and understand each other, and to take action. Together, I know that we can make a difference.

A stylized, handwritten signature in black ink.

Ingrid Stitt MP
Minister for Mental Health

Parliamentary Secretary's foreword

The *Victorian suicide prevention and response strategy 2024-2034* provides us with an opportunity to learn, grow and mature our shared response to suicide and suicidal distress and harness the collective energies of government, sector, communities and people with lived and living experience.



The courageous stories of those who have survived a suicide attempt or live with thoughts of suicide highlight the resilience and strength that can emerge from moments of despair. Too many Victorians have a direct experience with suicide and each passing leaves an indelible mark on families, colleagues and classmates. The stories of people with lived and living experience of suicide emphasise the urgent need for comprehensive systems and compassionate supports. As a community we all have a role to play in preventing suicide and addressing suicide-related stigma.

By taking a whole-of-government approach to suicide prevention, the strategy recognises the social determinants of suicide and the need to build an understanding of the efforts required to reduce harm across a variety of settings and supporting services and programs. Rolling implementation plans across the ten years of the strategy allow for lessons to be learned and responses to be refocused and reoriented to respond to emerging evidence and trends, while continuing to strengthen approaches that we already know are effective.

The first implementation plan of the strategy seeks to deliver on the first horizon of the strategy through progressing immediate priorities and setting strong foundations for a whole-of-government approach. Initiatives under the first implementation plan will support us to work across portfolios, systems, departments and agencies to build capability and collaborate on suicide prevention and response in a broad range of settings. The second and third horizons will be delivered through future implementation plans, developed in partnership with people with lived and living experience, clinicians, sector experts and across government.

Through this strategy we will grow our suicide prevention and response efforts in a way that builds solid, systems-based, evidence-based and compassionate supports that can wrap around every individual, their supporters, families, colleagues and communities. Supports that are tailored, safe, accessible and respectful of the diversity that our state is known for. We know that this work is already well underway, with programs across the state delivering high-quality and considerate care by workforces that are dedicated to ensuring that individuals, carers, family and supporters receive the care and attention they need.

Victoria's recent experiences with floods, bushfires and the COVID-19 pandemic had significant impacts on people and communities and saw an increase in the number of

mental health presentations to emergency departments and crisis support services that hugely impacted our workforces. The pandemic showed us that the world can change overnight and that we need to remain flexible enough to respond to unexpected events and new challenges.

But these events also taught us valuable lessons about the importance of community connection, and I have been humbled by the spirit of Victorian communities who continue to look after each other through grassroots efforts. It is this spirit that we need to harness to help ensure that suicide attempt survivors, those who live with suicidal thoughts and behaviours, their families, supporters and friends and those bereaved by suicide can access the supports they want in order to thrive.

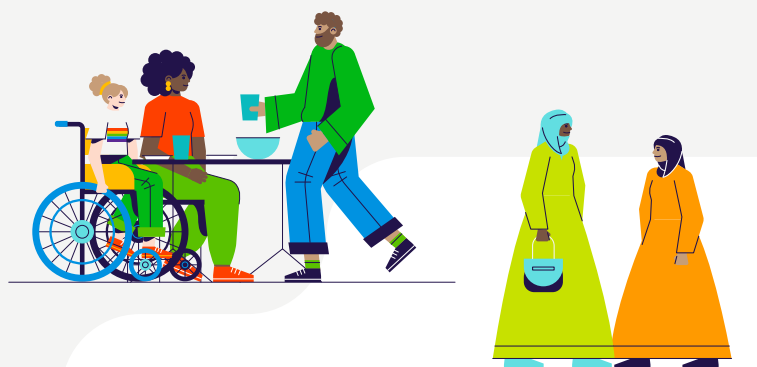
I am honoured to hold Victoria's first dedicated suicide prevention portfolio. It is work that I am particularly proud and excited to be a part of as we work together to build a Victoria where everyone can flourish, backed by a system that learns from past mistakes and constantly improves and evolves based on the needs of our communities.

A handwritten signature in black ink, appearing to read 'Tim Richardson'.

Tim Richardson MP
Parliamentary Secretary
for Mental Health and
Suicide Prevention

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Acknowledgement

We proudly acknowledge Aboriginal and Torres Strait Islander people as Australia's First Peoples and the Traditional Owners and custodians of the land and water on which we live and work. We recognise that Aboriginal and Torres Strait Islander people in Victoria practise their lore, customs and languages and that they nurture Country through their deep spiritual and cultural connections and practices to land and water. We acknowledge Victoria's Aboriginal and Torres Strait Islander communities and culture and pay respect to Elders past and present.

We recognise the invaluable and ongoing contribution of Aboriginal and Torres Strait Islander people and communities to Victorian life and how this continues to enrich our society. We acknowledge the contributions of generations of Aboriginal and Torres Strait Islander leaders who have devoted themselves to protecting the rights of their people and communities. We recognise that sovereignty was never ceded.

We acknowledge that Aboriginal and Torres Strait Islander self-determination is a human right, and we commit to working in partnership with Aboriginal and Torres Strait Islander communities to advance self-determination and self-determined responses to prevent and respond to suicide.

It must be acknowledged that colonisation and establishing the State of Victoria has had long-lasting, far-reaching and intergenerational consequences, including the dispossession of Aboriginal people of their Country. The

reality of colonisation involved establishing Victoria with the specific intent of excluding Aboriginal people and their lore, cultures, customs and traditions, including through horrific violence perpetuated at the individual, societal and systemic levels. We recognise that this history, and the systems it gave rise to, continue to harm Aboriginal and Torres Strait Islander people and communities today, including in contributing to trauma, distress and deaths by suicide.

We acknowledge that Victoria's Treaty process will provide a framework for transferring decision-making power and resources to support self-determination and Aboriginal communities taking control of matters that affect their lives. We commit to working proactively to support this work in line with the aspirations of Traditional Owners and Aboriginal people living in Victoria.

The State of Victoria is committed to continued work with Traditional Owners and

Aboriginal people living in Victoria as equal partners on this journey. It is important for government not to pre-empt what may be in a Treaty – instead, we must listen to the aspirations and outcomes of the Treaty-making process, and work together to deliver a Treaty that will benefit all Victorians.

Despite the far-reaching and long-lasting impacts of colonisation on Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander people remain resilient. We acknowledge the strong connection of Aboriginal and Torres Strait Islander people and communities to Country, culture and community, and that this connection is central to positive mental health and wellbeing.

We are committed to working with Aboriginal and Torres Strait Islander communities to embed cultural responses and acknowledge Aboriginal and Torres Strait Islander ways of knowing, being and doing.

Recognition of lived and living experience

The lessons we learn are often found in the stories we listen to. Sometimes these are the stories of those who have survived or are told to us by the friends and families left behind. Too often, these stories go ignored, fading away from memory as we continue with our lives. Every suicide, suicide attempt or suicidal thought is an experience that we need to listen to and a person we need to hear. This strategy aims to shape these stories and lessons into action.



We would like to recognise and acknowledge those with lived and living experience of suicide. This includes people who have survived a suicide attempt, people who live with suicidal thoughts, the carers, families and supporters of people living with suicidal distress and those bereaved by suicide.

We acknowledge the extraordinary courage and determination of the individual and collective contributions of those with lived and living experience of suicide in creating this strategy. We hope this strategy represents your ambitions and desires for a suicide prevention and response system that works in collaboration with you, your families and support networks and that the system we envision provides the support you need, when you need it. It is only through listening to and partnering with people who have experienced the service system and who understand the complexities of suicide that we will be able to prevent suicide in Victoria.

For those directly involved in co-designing this strategy, we deeply appreciate your knowledge and expertise. For those currently working to help create a better suicide prevention and response system in Victoria, we deeply appreciate your dedication and passion. And for those impacted by suicide, we hope this strategy will help develop a more compassionate response and reform the system to prevent further loss.

Language statement

We recognise the diversity of Aboriginal and Torres Strait Islander people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of southeast Australia, we have used the term 'Aboriginal' to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria.

Unless otherwise specified, the words 'our' and 'we' used throughout this document refer to the Victorian Government.

Language is an important part of our social life and can be a powerful way of promoting inclusion and pride

in people's experiences and identities. Language can also alienate, stigmatise and create barriers for people seeking support and compassion. For those with lived and living experience of suicide, certain language can be unhelpful or distressing, especially if overly clinical or used in an unsafe way. To honour the views of people with a lived and living experience of suicide, we have aimed to use person-centred language throughout the strategy. We recognise that, for some, language alone will never be enough or appropriate to capture and reflect their experiences.

We acknowledge the potential of language to shape perspectives and to engage audiences. We have made every attempt in this strategy to be as inclusive and respectful as possible. Due to the evolving nature of language, we acknowledge that the terms and definitions used throughout this strategy have the potential to change in ways that are unique and unpredictable. In all situations, the commonly used terms in this strategy should be taken in context and should be applied using the definitions supplied in the glossary.



Safe language guide

Language to avoid	Preferred language	Issue
'successful suicide' 'completed suicide'	'died by suicide' 'took their own life' 'passing by suicide'	Avoids presenting suicide as a desired outcome Recognises/honours/respects individuals Preferred term for some Aboriginal communities
'committed suicide' 'commit suicide'	'took their own life' 'died by suicide' 'lost someone to suicide'	Avoids associating suicide with crime or sin
'failed suicide' 'suicide bid' 'unsuccessful suicide'	'suicide attempt' 'attempted to end their life'	Avoids glamourising a suicide attempt
'suicide epidemic' 'soaring rates'	'increasing rates' 'higher rates'	Avoids sensationalising suicide and inaccuracy

Source: Adapted from Everymind 2023, [Our words matter: Guidelines for language use](#), Everymind, Newcastle.

Background



Suicide is a significant global public health issue.¹ *The Victorian suicide prevention and response strategy 2024–2034* is a call to action for governments, workplaces, schools, the media, sectors, industries and the Victorian community to come together to reduce the incidence and impact of suicide and suicide-related stigma in Victoria.

While reducing suicide is our main goal, as outlined in our vision, we also aim to be nation-leaders in addressing and reducing factors that contribute to suicide, such as childhood trauma, harmful drug and alcohol use and family violence, and in increasing protective factors such as social inclusion and connection to culture. This includes identifying key intervention points to build a systems-based, whole-of-government and community-wide approach to suicide prevention and response.



What will be different

This strategy replaces the *Victorian suicide prevention framework 2016–2025*. The framework has provided a strong foundation in suicide prevention and response for Victoria to build on, including evidence of what works in aftercare and the important role local communities play in preventing and responding to suicide.

This strategy renews our efforts by including all Victorian Government departments and agencies and communities in suicide prevention, driving action across a diversity of settings (schools, workplaces, transport networks) and supporting services and programs to respond to intersectionality.

A series of rolling implementation plans will support the strategy. This will enable us to respond flexibly to emerging issues and new evidence across the life of the strategy and shift approaches and focus accordingly. It will also allow us to build on lessons learned from evaluations, as they are completed, and knowledge of what works.

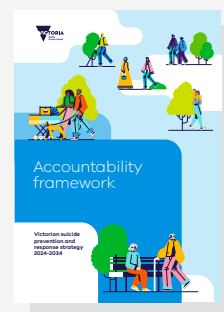
Importantly, the strategy is shaped by extensive consultation and co-design with people with lived and living experience of suicide, clinicians and other experts in the field.

Strategy overview

The Victorian suicide prevention and response strategy 2024–2034 outlines our 10-year vision and the principles, priority areas and objectives that will guide our work to enable us to achieve our intended outcomes.



The strategy is accompanied by rolling implementation plans that detail the initiatives we will deliver over specific periods and an accountability framework. While all parts of this work are urgent, change must be implemented sustainably. The implementation plans will ensure initiatives are phased over the life of the strategy.



The accountability framework outlines how the Victorian Government and community will work together to deliver the strategy, including requirements around monitoring, evaluation and public reporting. The accountability framework will also help us to measure our impact.

Embedding Aboriginal ways of knowing, being and doing

The strategy acknowledges the importance of embedding Aboriginal ways of knowing, being and doing in our efforts to create meaningful change.

All Victorians play an important role in amplifying the voice of Aboriginal communities and challenging deficit narratives surrounding Aboriginal people. This means offering time and space to have brave conversations across divergent standpoints, continually re-visiting themes and sitting in the discomfort of the unknown without pressure to achieve an outcome or decision.

There are different ways of understanding evidence and change. Aboriginal knowledge is passed through oral tradition via yarns, stories and community sharing. This evidence will be respected and incorporated into this strategy and inform practice and everyday decision-making. True reform work is hard, and takes time, but diverging from mainstream, linear processes is needed to achieve the best outcomes for our communities.

The Victorian Government is committed to partnering with Aboriginal communities to deliver the strategy and notes the suicide prevention and response co-design work that is being led by Aboriginal communities through the Balit Durn Durn Centre. This work is a critical part of Victoria's suicide prevention and response efforts and, subject to the outcomes of the process, will be reflected in an updated version of the strategy, accountability framework and implementation plans.

The strategy will also be subject to review and amendment based on Victoria's Treaty negotiations, as well as findings and recommendations made by the Yoorrook Justice Commission.



Why Victoria needs a strategy for suicide prevention and response

Suicide has a devastating and enduring impact on the Victorian community. It can affect people of all ages and backgrounds and has a ripple effect across families, friendship groups, workplaces, schools and communities.



Each year we lose people to suicide, and every suicide is a tragic loss. However, suicide numbers alone do not tell the whole story. They do not capture the number of people who are experiencing suicidal distress, people living with suicidal thoughts as part of their everyday lives, and suicide attempt survivors, some of whom may experience life-changing traumatic injury. They do not tell of the ongoing impact on families, carers and supporters who are supporting someone living with suicidal thoughts or of communities bereaved by suicide. We recognise that behind each incident of self-harm, suicide attempt and suicide are unique stories and experiences and feelings of grief, helplessness and loss.

Despite an increased focus on suicide prevention by government and communities, the suicide rate in Victoria has not decreased over the past decade. According to the Australian Institute of Health and Welfare, the Victorian age-standardised rate (per 100,000) for suicide deaths in 2011 was 9.2, and by 2021 it was 11.1.²

In 2021 the Royal Commission into Victoria's Mental Health System found that Victoria has been unable to reduce its suicide rate due to inadequate coordination of effort, insufficient resources and a primarily health-focused approach.³ It recommended co-producing a new suicide prevention and response

strategy with people with lived and living experience of suicide to deliver a system-based, whole-of-government and community-wide approach to suicide prevention and response.⁴

The *Victorian suicide prevention and response strategy 2024–2034* embeds lived and living experience knowledge at the centre of our efforts. The strategy has been co-designed with people with lived and living experience of suicide, including suicide attempt survivors; people living with suicidal thoughts and behaviours; families, carers and supporters of people living with suicidal ideation and/or distress; and people bereaved by suicide.

The strategy incorporates the advice of experts working in suicide prevention and response and insights from the sectors and services that are in contact with people experiencing distress and at risk of suicide, including clinicians and frontline responders. The strategy aims to respond to the experiences and perspectives of Aboriginal people and diverse communities, as well as other groups affected by suicide more than others. It is informed by the evidence of what works and outlines what we need to do differently.

We have a good foundation to build on and we are not waiting to take action. A range of activities is already being delivered across government to support suicide prevention and response efforts and will complement the initiatives outlined in the strategy's implementation plans.

However, we need a more comprehensive approach that builds and drives community-wide and whole-of-government action if we are to reduce the incidence and impact of suicide. We need to address the policies, processes and structures that can contribute to suicidal distress. We must renew our focus on reducing suicide-



related stigma to enable safe conversations about suicide and encourage early help-seeking before people reach a crisis point. We need to make sure all workforces and services that come in contact with people experiencing distress or at risk of suicide can respond with confidence and help the person find the support they want. This will involve collaboration across a broad range of partners to better understand the drivers of suicide in Victoria and to ensure all policies and programs are responsive.

We also need to support our frontline responders and mental health and wellbeing services to better understand suicide risk and to respond to people with compassion and the understanding that, for some people, systems and services can cause or may be the cause of their distress and trauma.

This is an ambitious 10-year strategy to guide the necessary action and change. We would like to extend our gratitude to all people and organisations that contributed to its development. In particular, we thank our lived and living experience co-design participants for their wisdom and expertise. We will honour what you told us as we continue to work together to prevent and respond to suicide.

System-wide reform

Building the foundation for integrated and coordinated approaches to mental health and wellbeing

The *Victorian suicide prevention and response strategy 2024–2034* is an important part of rebuilding Victoria’s mental health and wellbeing system, as recommended by the Royal Commission into Victoria’s Mental Health System.

In its final report, the Royal Commission recommended that the Victorian Government adopts a system-based and community- and government-wide approach to suicide prevention and response efforts.⁵

As a first step, the Suicide Prevention and Response Office was established in the Department of Health in July 2022. Victoria’s first State Suicide Prevention and Response Adviser leads the office. Its activities are guided by an expert advisory committee comprising people with lived and living experience of suicide, academics, researchers and representatives from clinical services and sectors/services delivering suicide prevention and response policy and programs.

This strategy, which is led by the new Suicide Prevention and Response Office, responds to Royal Commission recommendation 26.2.b to:

... work with people with lived experience of suicidal behaviour, family members and carers, and people with lived experience of bereavement by suicide to co-produce, implement and monitor a new suicide prevention and response strategy for Victoria.

The strategy will align with and be supported by 3 other strategies and frameworks recommended by the Royal Commission. Together, these documents build a foundation for integrated and coordinated approaches to mental health and wellbeing in Victoria. Detailed below and at Figure 1, these include:

- *Wellbeing in Victoria: a strategy to promote good mental health* (recommendation 2.2)
- *Diverse communities mental health and wellbeing framework* (recommendation 34)
- *Mental health and wellbeing outcomes and performance framework* (recommendations 1 and 49).

The forthcoming *Wellbeing in Victoria: a strategy to promote good mental health* will take a statewide approach to promoting the good mental health and wellbeing of all Victorians. The wellbeing strategy will focus on the whole Victorian community. It will aim to promote good mental health and wellbeing and prevent mental ill health, outside the mental health and wellbeing system, in the places where people live, learn, work and play.

The *Diverse communities mental health and wellbeing framework* will provide a 10-year framework to embed diversity, equity and inclusion across the mental health and wellbeing reforms, improving mental health and wellbeing outcomes for diverse communities.



Implementing the suicide prevention and response strategy will draw on prevention elements of the wellbeing strategy and the equity foundation of the diverse communities framework, with the specific lens of preventing and responding to suicide.

The *Mental health and wellbeing outcomes and performance framework* will underpin the suicide prevention and response strategy and assist us in monitoring and evaluating implementation.

Designed in partnership with people with a lived and living experience, carers, families and supporters, including people from diverse communities, the outcomes and performance framework is the Victorian Government's main mechanism for monitoring the impact of the mental health and wellbeing reform agenda on system outcomes and for holding the service system to account for its performance. Implementing the outcomes and performance framework will take an integrated whole-of-government approach and work across the

mental health and wellbeing system to drive collaborative and robust measurement and reporting.

Aligning the strategy's outcomes to outcomes in the framework will enable the strategy to:

- leverage existing data collection for reporting and measuring progress of implementation
- benefit from the outcomes and performance framework's data improvement initiatives
- demonstrate its contribution to the collective reform impact.

Figure 1: An integrated approach to prevention and promotion



Royal Commission reforms that support suicide prevention and response efforts

Royal Commission reforms that improve the availability, accessibility, quality and safety of mental health and wellbeing services will also contribute to Victoria's suicide prevention and response efforts. For example:

- the redesign of Area Mental Health and Wellbeing Services
- the implementation of Mental Health and Wellbeing Locals
- the implementation of the *Mental health and wellbeing workforce strategy*
- improving social and emotional wellbeing in schools
- the Statewide Trauma Service
- the Mental Health and Wellbeing Connect Centres
- the Mentally Healthy Workplaces initiative.

Importantly, Safer Care Victoria's Mental Health Improvement Program will support health services to adopt the evidence-based *Zero suicide framework*, which aims to eliminate suicides in healthcare settings.

The *Mental Health and Wellbeing Act 2022* (Vic) supports the changes underway to transform Victoria's mental health and wellbeing system. The Act contains new rights-based objectives and principles to drive the highest standard of mental health and wellbeing for Victorians. It establishes new roles and entities recommended by the Royal Commission including those with responsibilities relevant to suicide prevention and response. For example, the new Mental Health and Wellbeing Commission.

The Mental Health and Wellbeing Commission is an independent statutory authority that oversees the quality, safety and performance of our mental health and wellbeing system. The commission also has specific functions to monitor and review incidence of suicide in mental health and wellbeing services, as well as a role in addressing stigma.

Whole-of-government contributions

Several other government policies and programs contribute to and play an important role in suicide prevention and response efforts:

- Hospital Outreach Post-suicidal Engagement (HOPE) program
- Hope Inside program (for people in prison)
- Schools Mental Health Fund and the Schools Mental Health Menu
- Pause.Call.Be Heard campaign on our rail network
- Better-Connected Care reform.

The Commonwealth Government also has an important role in suicide prevention and response. Several national policies and strategies will inform implementation of the Victorian strategy including the *National mental health and suicide prevention agreement*.

A list of supporting policies and frameworks can be found in [Appendix 1](#) (page 57).

The suicide prevention and response strategy implementation plans will detail the alignment between government policies and programs (state and Commonwealth) and how they contribute to the strategy priority areas and objectives to deliver on our aim of a comprehensive whole-of-government approach to suicide prevention and response.

All Victorians working together to reduce suicide.



A vibrant, stylized illustration of a diverse group of people walking along a city street. The group includes a man in a green shirt and blue pants, a woman in a pink hijab and dress, a woman in a blue hijab and dress, a man in a yellow shirt and blue pants, a man in a green shirt and yellow pants, a man in a yellow shirt and blue pants, a woman in a pink shirt and blue polka-dot pants, a man in a yellow shirt and blue pants, a woman in a pink shirt and blue polka-dot pants, a man in a yellow shirt and blue pants, a woman in a pink shirt and blue polka-dot pants, a man in a yellow shirt and blue pants, and a woman in a pink shirt and blue polka-dot pants. They are walking past a stylized cityscape with various buildings, including one with a rainbow flag. The scene is bright and colorful, with a green tree on the right and a blue sky.

We have identified six priority areas for action:

1 Build and support connected systems

To improve access, navigation and continuity of care

2 Build on and strengthen existing supports across the suicide prevention and response continuum

To provide more options, at all stages

3 Build and support a compassionate, trauma-informed workforce, strengthened by lived and living experience

To give our workforces the required skills and supports

4 Reduce suicide-related stigma and enable community-wide action

To support and educate communities

5 Drive whole-of-government collaboration and innovation

To drive accountability and coordination

6 Build on and use data and our evidence base in delivery and evaluation

To support improvement and continuous learning



And together we will:



Reduce suicide rates equitably across all groups and communities



Reduce suicide attempts



Reduce stigma around suicide



Reduce access to means for suicide



Respond earlier to people in distress



Increase help-seeking activities



Improve education and awareness of suicide



Deliver more compassionate and connected services and supports



Increase the peer workforce and visibility of lived and living experience roles



Elevate suicide prevention and response across all government decision making and policies and programs



How we developed the strategy

In developing this strategy, we sought broad community input to ensure we understood a diverse range of perspectives, experiences and emerging evidence (Figure 2).

We wanted to understand the views of individuals, sectors and organisations in contact with people experiencing distress and those providing support, care and treatment, as well as other experts working in suicide prevention and response.

Policies, services and programs are infinitely more responsive, safe and appropriate when developed in partnership with

the people who will use them or be affected by them. Therefore, using the outputs and insights from the public engagement process, sector and government consultations and roundtable discussions, we co-designed the strategy's vision, principles, priority areas, objectives and initiatives with people with lived and living experience of suicide.

Figure 2: Scope of stakeholder engagement in developing the strategy

244

submissions and survey results

As part of the public engagement process, a broad range of people and organisations responded to a strategy discussion paper released on Engage Victoria.

30+

sector and government consultations

Targeted discussions were conducted with experts working in suicide prevention and response and in service delivery, including clinicians, peak bodies, non-government organisations, research bodies and government departments and agencies.

14

roundtables

Discussions were conducted with more than 130 people representing communities, groups and industries affected by suicide more than others to better understand what we heard from the public engagement process. The roundtables explored relevant themes with the groups listed in the diagram on the next page.

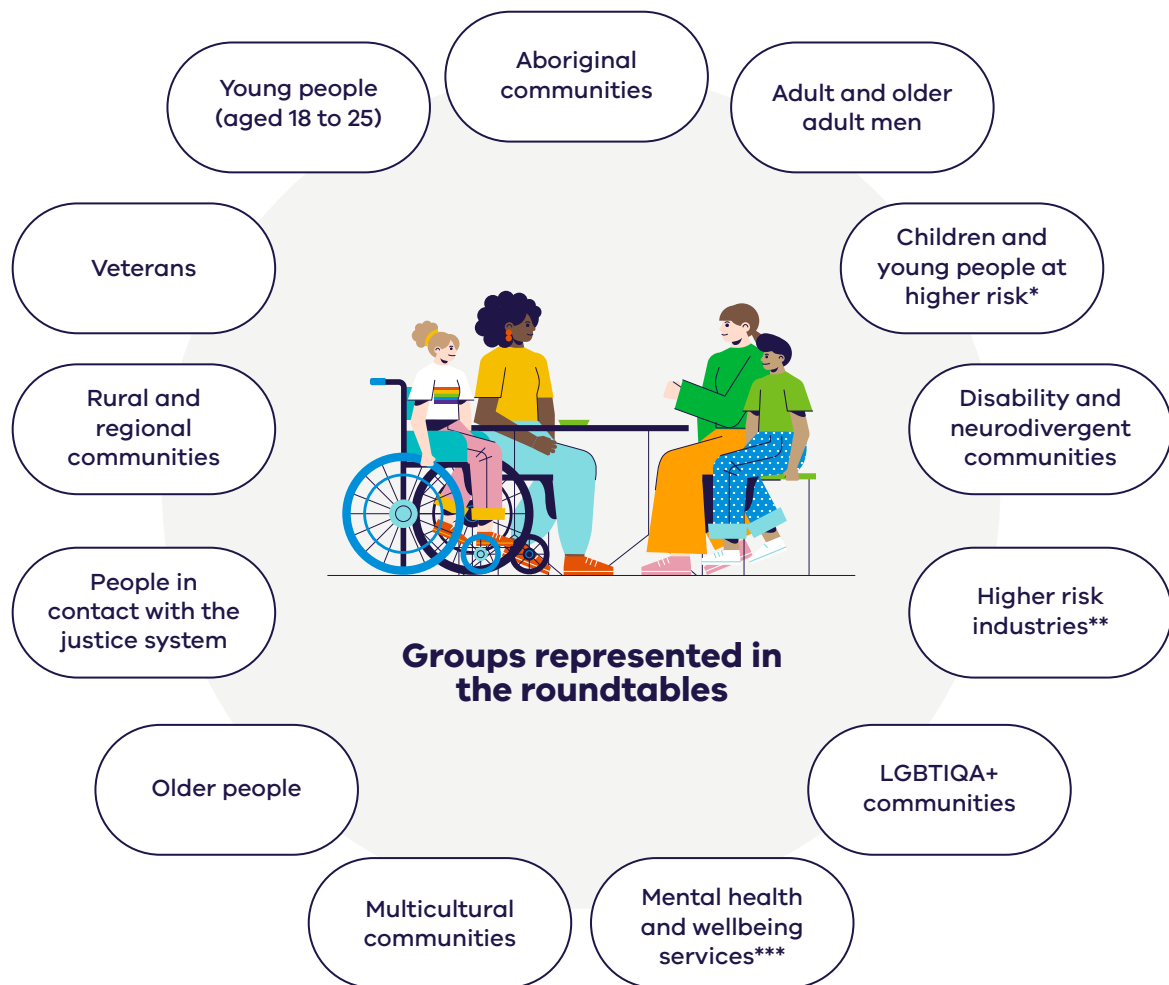
10

lived and living experience co-design workshops

16 people with lived and living experience of suicidal thoughts, suicide attempt survivors, families, carers, supporters and those bereaved by suicide developed the key elements of the strategy.



Figure 3: Roundtable discussions



*including those in contact with child protection services, with youth justice and those who have experienced trauma

**including frontline and emergency responders

***including clinicians and peer workers

What we heard

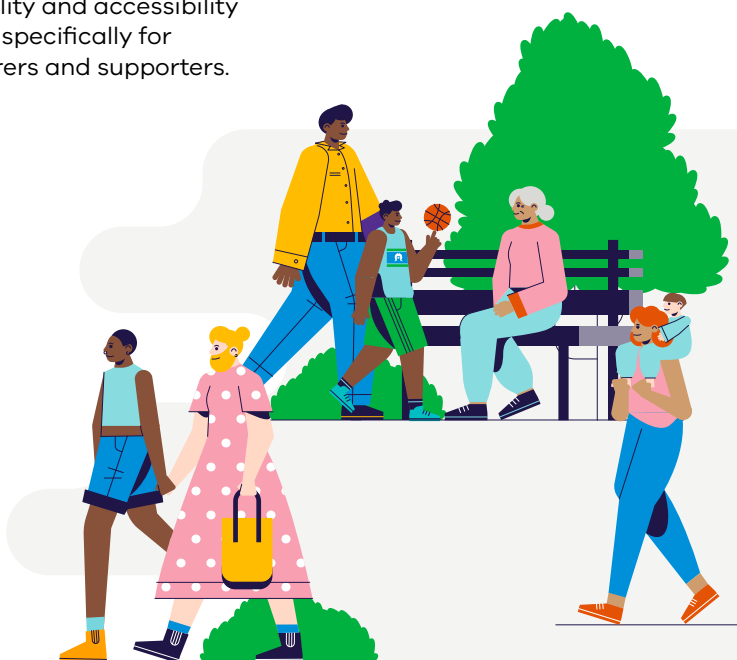
Through our engagement and co-design processes we heard that we need to:

- take a more collaborative, intersectional and innovative approach to suicide prevention and response, including expanding our understanding and definition of the suicide prevention workforce
- build more connected systems that offer greater choice and agency, with more peer-based models and non-clinical alternatives
- bolster and enhance our existing suicide prevention and response supports across the continuum – from prevention, early intervention and crisis response through to aftercare and postvention
- ensure our workforces are supported to deliver compassionate, trauma-informed and evidence-informed responses, including de-escalation and use of least restrictive practices
- ensure our workforces have lived and living experience knowledge and leadership embedded at all levels
- better support the wellbeing of our workforces (including clinical and non-clinical staff) to minimise the impact of vicarious trauma and burnout
- provide education and raise awareness to address suicide-related stigma in the Victorian community
- enable communities (geographic and identity-based) to deliver community-led and tailored responses
- continue to build our evidence-base – through data, research and lived experience expertise
- enable governments, services, workplaces and communities to act earlier to understand and support people in distress.

Throughout our engagement, we also heard about the ways in which our current suicide prevention and response system has not only failed people experiencing distress and suicide attempt survivors but has also failed families, carers and supporters. People who support or care for those experiencing suicidal distress shared their stories of anger and frustration at a complex system that they often navigate with little or no formal support.

It is important that we acknowledge the vital role played by families, carers and supporters and that we give them the supports they need.

The strategy aims to do this through recognising the unique needs of families, carers and supporters in its principles, priority areas, objectives, outcomes and in our settings for action. The strategy's rolling implementation plans will also include initiatives that increase the availability and accessibility of supports specifically for families, carers and supporters.



Suicide in Victoria



Suicide affects people from all ages and backgrounds. It impacts people living with suicidal thoughts who may be unable to live and thrive in the way they want. It affects families, carers and supporters who provide care and support while navigating disconnected health systems and services, which in turn has an impact on their own mental health and wellbeing.

It affects communities, schools, workplaces and social groups that struggle to process the grief and sudden loss that suicide brings. Suicide also has a significant impact on first responders, people who may have witnessed the event and the care teams supporting those involved.

Suicide Prevention Australia estimates that each suicide can affect up to 135 people.⁶ In 2022 we lost 761 Victorians to suspected suicide⁷ and 3,249 Australians.⁸ On this basis, more than 103,000 Victorians, and 438,000 Australians were affected in 2022 alone. In 2023, 799 Victorians were lost to suspected suicide⁹, a 4.3% increase from the previous year.¹⁰

However, these numbers do not convey the number of people living in suicidal distress and suicide attempt survivors and the ongoing impact on their lives. For those who have

survived a suicide attempt, feelings of shame, guilt, stigma, exhaustion and remorse may be common. Without the right aftercare support, these feelings can increase their distress and lead to more attempts to take their own lives. This distress can affect a person's sense of self-worth, their relationships and their ability to engage in work or study.

For family members, carers and supporters, there can be ongoing distress and fatigue related to keeping a watchful eye on a vulnerable person while trying to navigate complex service systems. This can affect their own ability to work and study and to balance family and other commitments; it can have a lasting impact on their mental health and wellbeing. People bereaved by suicide can be confronted with stigma, shame and trauma, facing barriers to accessing help for their own mental health and wellbeing.

There is also the impact on workers in industry sectors that are regularly exposed to suicidal events such as emergency services and transport operators. In these areas, beyond the tragic loss of life, suicides can result in trauma and work-related stress and increase the risk of acute and chronic health and wellness issues.



In Victoria, between 2016 and 2023

75%

of those who died by suicide were **men**.^{11, 12}

70%

of **primary carers** – including those caring for people experiencing suicidal thoughts or distress – are **women**.¹⁴

In 2019

48%

of suicide deaths and self-inflicted injuries (self-harm) in Australia

were due to **4 contributing factors**

1

child abuse and neglect during childhood;

2

alcohol use among people aged 15 or older;

3

illicit drug use among people aged 15 or older;

4

intimate partner violence among females aged 15 or older.¹³

Suicide is the leading cause of death among young Australians age

15–24¹⁵



In 2023,

16%

of all suicide deaths in Victoria were among **men and women aged 65 or older**.¹⁶

Between 2018 and 2023 in Victoria, **Aboriginal people died by suicide at a rate nearly**

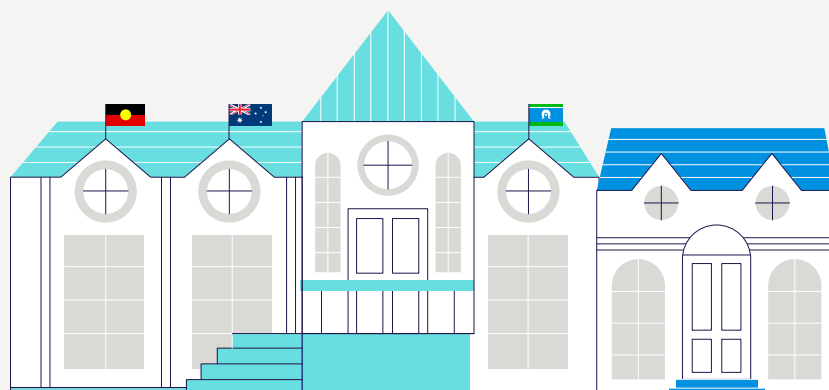
3x higher

than non-Aboriginal people.¹⁷

In Victoria between 2019 and 2023, approximately

56%

of all suicide deaths occurred in those **aged between 25 to 54 years old**.¹⁸



What do we know?

Some people and groups are affected by suicide more than others and are over-represented in suicide and suicide attempt data such as adult and older men. This also includes Aboriginal people and trans and gender diverse people, who experience stigma, racism and discrimination, which affects their wellbeing. This is compounded when coupled with a lack of access to safe, responsive and culturally appropriate mental health and wellbeing care and other key supports.

Some people may be at an increased risk of suicide. This includes:

- suicide attempt survivors
- people bereaved by suicide
- people who have experienced or are experiencing trauma
- people with a mental health diagnosis.

This is especially true if they also experience concurrent life stressors or barriers to accessing the support they want and need.

The social determinants of health also influence suicide. The impact of the social, material, political and cultural conditions that shape our lives and our behaviours can influence our

mental health and wellbeing. Some of these can affect people from childhood or even intergenerationally. In some cases, the relationship between the social determinants of health and suicidality are obvious, such as the correlation between low income and higher levels of stress and anxiety. Government policies can also directly or indirectly influence our health and wellbeing. These include environmental policies, including how we care for the environment and address climate issues, and economic policies such as welfare support.

Major events, such as bushfires, floods and the COVID-19 pandemic, and government responses to these can also impact on the mental health and wellbeing of communities. The COVID-19 pandemic highlighted the importance of understanding and responding to both contributing and protective factors for suicide. Despite increased psychological distress in the community, the suicide rate in Victoria did not significantly increase during the first year of the pandemic.¹⁹ While the long-term impacts of

the pandemic are still unclear, the COVID-19 pandemic response provides a helpful insight into the potential benefits of a whole-of-government approach that seeks to address and reduce multiple contributing factors for suicide, such as financial and housing distress, relationship breakdown, isolation and barriers to service access.

Transition points that occur throughout a person's life (for example, leaving school, entering or exiting the justice system, job changes or leaving the armed services) can create significant stressors. When coupled with experiences of colonisation, childhood trauma or other contributing factors, this can develop into suicidal distress.

Intervention at the time of a suicidal crisis – for example, means restriction through safety fencing on transport networks or restricted access to medication – can reduce fatalities.

Suicide is preventable. Prevention measures, such as supporting and enabling Victorians to have safe conversations about suicide, can reduce stigma and support help-seeking before people reach a crisis point.

What influences suicide?

There is a range of complex and interrelated factors that can influence suicide, and they can occur at multiple levels:

- personal (individual) – influenced by our biological makeup, age, experiences, preferences, physical health and personality
- relational (interpersonal) – the nature and quality of our relationships affect our behaviours, attitudes and expectations of others
- communal (community) – where we live, learn, work and play – our communities, social circles, neighbourhoods, environment, local services

and facilities. This is where our identities and roles are developed and understood, how we are accepted, and where we feel a sense of belonging

- societal (big picture) – our state or country – this encompasses the government, laws and policies that shape the rules, social norms and resources that affect our wellbeing. It is where things like health care, education, housing and infrastructure are provided.

Contributing factors can increase a person's likelihood of

experiencing suicidal thoughts and behaviour. Protective factors can reduce the risk of suicide and help ensure a person is supported and connected during difficult times. Examples of protective and contributing factors are outlined in Figure 4.

We acknowledge there are limitations in discussing protective and contributing factors. They do not reflect every person's experience of suicidal thoughts and behaviour, of suicide attempt, or those of their families, carers and supporters, or of people bereaved by suicide.

Figure 4: Protective and contributing factors for suicide

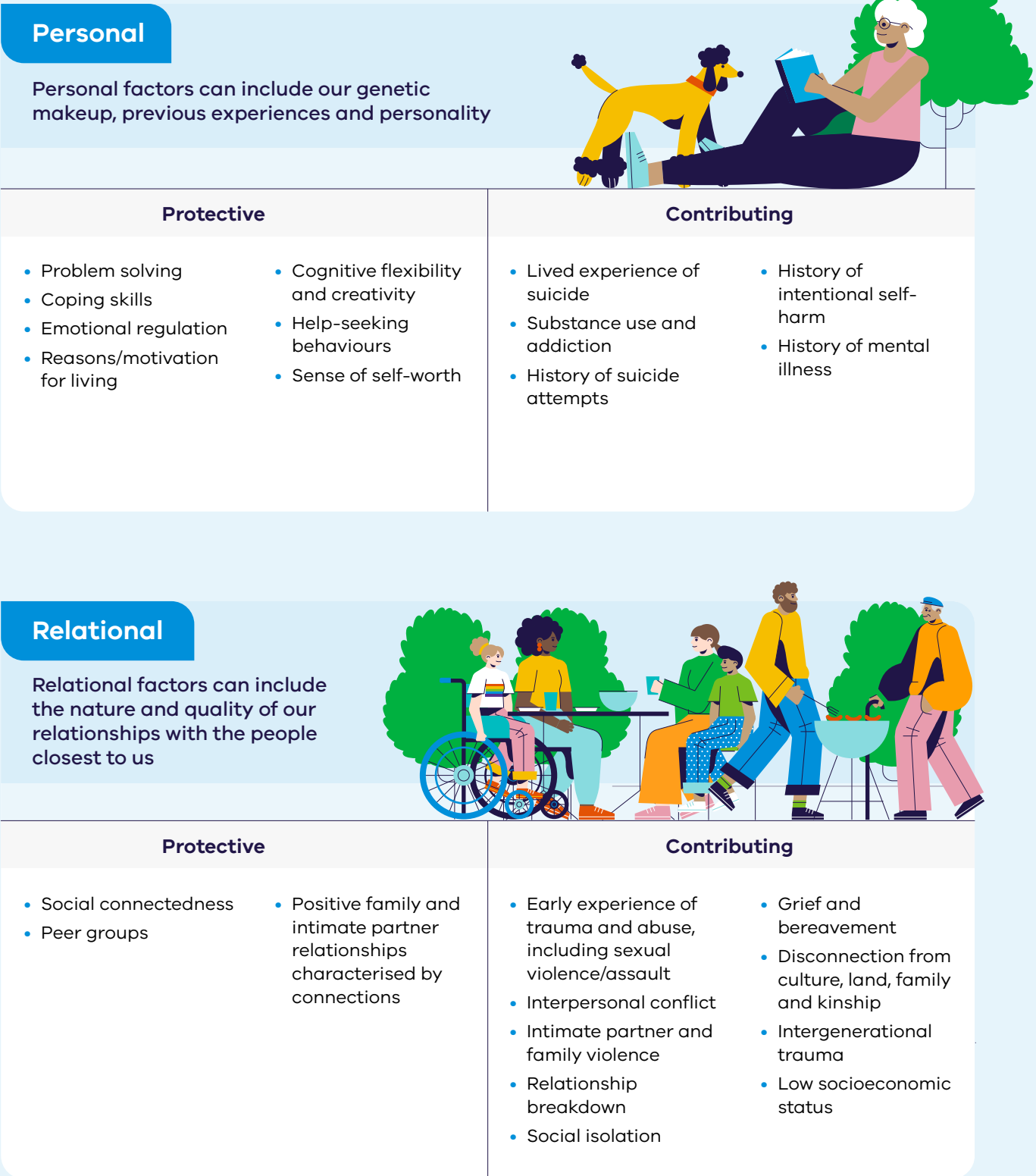


Figure 4: Protective and contributing factors for suicide (continued)

Communal

Communal factors can include how we are understood, how we are accepted and how we feel a sense of belonging where we live, work, learn and play



Protective

- Safe and supportive environments
- Membership of groups
- Sense of belonging and inclusion

Contributing

- Experiencing legal problems
- Contact with social services and child protection
- Child custody issues
- Contact with the justice system
- Isolation and loneliness
- Financial problems – particularly linked to housing, gambling and work
- Lack of access to safe, affordable and stable housing conditions

Societal

Societal factors can include the structures that create the rules, norms and opportunities that shape our lives



Protective

- Availability and accessibility of culturally safe and responsive mental health and wellbeing supports
- Access to compassionate services and trauma-informed care
- Limitation of access to methods used for suicide
- Safe and appropriate media reporting, including links to help-seeking resources
- Proactive information sharing through the Child Information Sharing and Family Violence Information Sharing Schemes

Contributing

- Barriers to receiving and accessing health care
- Stigma, discrimination and racism
- Barriers to service access
- Availability of lethal means
- Barriers to disclosing abuse, including family violence
- Inadequate responses to abuse
- Impacts of colonisation
- Unsafe language and reporting in the media and exposure to harmful self-harm and/or suicide content online, including on social media platforms



Aboriginal communities

Aboriginal communities are strong, proud and resilient. For Aboriginal people and communities, connection to culture, spirit, land, community, family, kinship, mind, emotions and Country build protective factors and can improve mental health and wellbeing. The disruption of these connections can increase the likelihood of developing poor mental health or mental illness and contribute to the risk of suicide.

As a result of the ongoing impacts of colonisation, and Australia's history of racist and discriminatory behaviours and policies, many Aboriginal families experience increased social, financial, emotional and physical pressures and stressors that contribute to increased risk of suicide. These include:

- violence
- substance misuse
- unresolved trauma
- high incarceration rates
- physical health problems
- economic and social disadvantage
- discrimination based on race or culture
- the Stolen Generations and removal of children
- separation from culture and associated identity issues.

For far too long, systems have been designed using a Western model of care that does not always meet the unique rights of Aboriginal people as outlined in the *United Nations Declaration of the Rights of Indigenous People*.

No single factor can account for the levels of trauma Aboriginal people experience. Instead, it is the collection of contributing factors at the individual, family/relational, community and societal levels that increase the likelihood of poor social and emotional wellbeing for Aboriginal people.

Addressing social inequality and discrimination and promoting the protective factors that support social and emotional wellbeing and the strong mental health of Aboriginal people and communities is crucial and the responsibility of all Victorians.

From 2018 to 2023, there were 134 passings of Aboriginal and Torres Strait Islander people by suicide in Victoria. Analysis shows that stressors contributing to these passings included contact with the justice system around the time of passing, family conflict and violence, substance use and mental ill health.²⁰

Social and emotional wellbeing

For Aboriginal people, health is more than just the physical health of an individual; it encompasses the social, emotional and cultural wellbeing of the entire community.

The social and emotional wellbeing model is a holistic concept that recognises the importance of Aboriginal people's connection to land, culture, spirituality, ancestry, family and community. The social and emotional wellbeing model recognises a concept of wellbeing that differs from Western concepts. It is critical that this is acknowledged and accounted for when addressing suicide prevention and response activities.

The social and emotional wellbeing wheel (Figure 5) has interconnected domains that encompass various aspects of wellbeing. These include connection to body, mind and emotions, family and kinship, community, culture, Country, spirit, spirituality and ancestors. The outer wheel speaks to how these factors interact with social, historical and political determinants of health and wellbeing, and the importance of each element in keeping well.

These determinants of health and wellbeing are defined as:

- social determinants – the impact of poverty, unemployment, housing, educational attainment and racial discrimination
- historical determinants – the historical context of colonisation and its ongoing impacts; the impact of past government policies and the extent of historical oppression and cultural displacement
- political determinants – the unresolved issues of land rights, control of resources and cultural security, and the rights of self-determination and sovereignty.

The social and emotional wellbeing wheel highlights the essential role of connection in promoting holistic wellbeing. It recognises that building and maintaining connections to culture, land, family, community and spirituality is vital for the emotional, mental and social health of Aboriginal people and communities.



Figure 5: Aboriginal social and emotional wellbeing wheel



Source: Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Inc 2020, *Balit Durr Durr* VACCHO Inc, Melbourne. Credit: Gee, Dudgeon, Schultz, Hart and Kelly 2013.

This concept of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.

We would like to express our deep thanks to the Balit Durr Durr Centre and the Knowledge Holders for their contribution to this section and the strategy, more broadly.

Intersectionality

We acknowledge the importance of applying an intersectional lens when describing contributing and protective factors. It is important to be mindful that the ways in which services, initiatives and programs are sometimes designed and delivered can cause unintentional harm to certain members of the community.

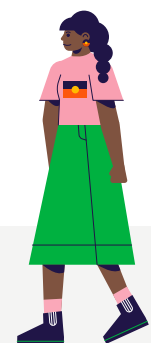
Experiences such as racism and homophobia can worsen harm and discrimination, leading to unequal health outcomes and more distress. Often these incidents, experiences and feelings are not adequately captured or represented by traditional data collection methods and reporting. This can create feelings and experiences of not being valued or recognised. Continuing to design and deliver services, policies and programs that are not culturally safe, inclusive and responsive to intersectionality will ensure they are underused, inefficient and harmful.

A person's sexuality, gender, age, ethnicity, socioeconomic status, disability or culture is not itself a contributing factor for suicide. It is instead the way the community and society responds or fails to consider a person's identities that can cause harm and distress and create unequal access to services. Experiences of racism, ageism, homophobia, transphobia or ableism are an unfortunate reality for many groups. Delivering programs, training and resources that educate people and prevent harmful behaviours that lead to these experiences should always be the first response.

Applying an intersectional lens in suicide prevention and response has traditionally meant prioritising groups as 'high risk' based on a build-up of marginalised identities. Viewed in this way, these identities become individual 'risk factors' that need to be either controlled or suppressed. Being gender diverse, neurodivergent or Aboriginal does not increase a person's likelihood of experiencing suicidal thoughts or behaviour. What is a contributing factor is the negative and harmful experiences people with these

identities face when forced to navigate through relationships, situations and structures that do not appropriately address or respect their needs.

To build a comprehensive suicide prevention system, it is important for us to enhance protective factors that work to reduce the risk of suicide. This strategy, the accountability framework and implementation plans aim to take an intersectional approach to suicide prevention and response. This approach provides us with different ways of thinking about contributing factors for different people and communities and how programs, services and initiatives can be tailored to ensure people receive a response that is compassionate and respects their unique identity and experiences. For many people, having a sense of belonging or connection to a community based on identity or shared experience can increase feelings of collective identity, guiding morality and communal support and care. An intersectional approach will also allow space to build unique protective factors that offer strength and hope for their respective communities.



Our vision

Suicide prevention and response strategy

All Victorians working together to reduce suicide



We invited people with lived and living experience of suicide to share their future aspirations for suicide prevention and response in Victoria. They told us that we will know we've achieved our vision when:

- everyone plays a part in building stronger communities and personal connections
- services and supports for individuals, families, carers and supporters are underpinned by compassion, are trauma-informed and respond to culture and context
- choice and accessibility enable every person to get the support they want – when, where and how they need it
- there is no stigma around suicide and help-seekers are met with compassion and support
- lived and living experience voices are integrated, valued and based on true partnerships
- robust evidence and data drives decision making
- there is a coordinated whole-of-government and community-wide approach to suicide prevention
- the Aboriginal social and emotional wellbeing model is embedded across all suicide prevention and response models of care.

Guided by our principles, we will work across government, with service providers and the community to deliver the objectives under our 6 priority areas and achieve our vision.

Our principles

The following principles guided the development and will guide the implementation, monitoring and evaluation, including any future updates, of this strategy.

The principles cover a range of values and behaviours that must be included in the actions and work of government, service providers and the Victorian community in our efforts to prevent and respond to suicide.



Value lived and living experience

- We value all lived and living experiences of suicide, including that of:
 - suicide attempt survivors
 - people who have had or still experience suicidal thoughts and behaviours
 - families, carers and supporters of people living with suicidal ideation and/or distress
 - people bereaved by suicide.
- We recognise and engage with the diversity of experiences and perspectives within those with a lived and living experience of suicide. We prioritise lived and living experience expertise.
- We partner with people with lived and living experience in all aspects of our work and embed experiences, knowledge and lessons into systems and solutions. We ensure there is a safe, supportive culture and climate to do this.
- We integrate the voices of lived and living experience in our evidence base.



Advance Aboriginal self-determination

- We recognise and respect Aboriginal people as Australia's First Peoples, with their own decision-making and knowledge systems.
- We acknowledge that Aboriginal people know what is best for themselves, their families and their communities. We support Aboriginal people to lead, design and deliver supports and services for Aboriginal communities.
- Government and mainstream services take accountability for delivering accessible and culturally safe systems, services and supports and ensuring Aboriginal people and communities have access to the information needed to make informed decisions.



Apply an intersectional lens

- We understand there are communities within communities; groups of people should not be viewed as being all the same.
- We take a holistic approach in supporting individuals, families, carers and supporters, acknowledging and respecting unique identities and how these result in different experiences, opportunities and barriers.
- We will use intersectionality as an analytical lens and approach in developing objectives and initiatives under our priority areas of focus, recognising the impact of inequalities, power imbalances and discrimination on systems and service delivery, and the role we all need to play in addressing these.



Be compassionate and trauma-informed

- We treat people with compassion and empathy, regardless of where they come from, who they are, or what has happened in their life, and support them to feel safe accessing support.
- We listen first, seek to understand the unique lived and living experiences of people and then act in response.
- We prioritise emotional and physical safety in every interaction and balance risk with a strengths-based approach, recognising the unique protective factors and resilience that help enrich our lives.
- We collaborate in everything we do – working with people, their families, carers and support networks, not working *on* them.



Be proactive and prevention-focused

- We embed prevention at every stage of the suicide prevention and response continuum.
- We respond to the drivers of suicidality, including the social, political, cultural and historical determinants of health and broader challenges in life or society.
- We support strengthened social, relational and peer connections and invest in protective factors.
- We plan ahead, are proactive and offer support before a crisis hits.
- We actively work to reduce suicide-related stigma, build understanding of suicidality and the importance of community-based prevention.



Be person-centred and human rights-driven

- We engage and support people with dignity and respect, free from judgement and stigma.
- We take a strengths-based approach with all people.
- We actively promote equality and non-discrimination.
- We ensure people can take part in and access information relating to the decision-making processes that affect their lives and wellbeing.
- We ensure supports, care and treatment are equitable and accessible for all and are adaptable to their individual needs and preferences.



Be evidence-informed and accountable

- We use empirical data and human insights to be responsive and make informed decisions.
- We drive a culture of continuous improvement and proactively respond to emerging issues.
- We adopt transparent, accessible and practical approaches to reporting progress.
- We are accountable for our actions and outcomes and align our work nationally and with other states and territories.
- We make space for new, alternative or lesser-known interventions while seeking to understand and document them better.
- We incorporate diverse and relevant knowledge and evidence streams such as the Aboriginal social and emotional wellbeing model.



Be place-based and community-focused

- We acknowledge that geographical, cultural and identity-based communities have unique needs, strengths, settings and histories and are best placed to understand the issues and concerns that affect their members.
- We work with our diverse communities to build service systems that recognise and respond to their needs.
- We support communities to respond to their members through prevention, support and recovery.
- We support collaboration and knowledge sharing between communities.

Where we need to focus our efforts



To ensure we deliver on our vision, we need to focus our efforts. Informed by input from the roundtables, the public engagement process and the Royal Commission’s findings, the strategy’s priority areas and objectives were developed and then refined through the co-design process.

The priority areas and objectives described in this section outline the work we will do to achieve our vision. The implementation plans that accompany the strategy will take the objectives one step further and outline the specific initiatives (such as policies, programs and services) that we will deliver under each objective.

Priority areas are not listed in any particular order – area 1 is no more important than area 6 – and we recognise there are dependencies between the areas. For example, priority areas 5 and 6 support effective delivery of priority areas 1 to 4.

We also acknowledge that it is not possible to implement all objectives and supporting initiatives at once. To ensure sustainability of implementation, including availability of the workforce, objectives and initiatives will be phased and will guide our work over the life of the strategy.

Priority area 1:

Build and support connected systems



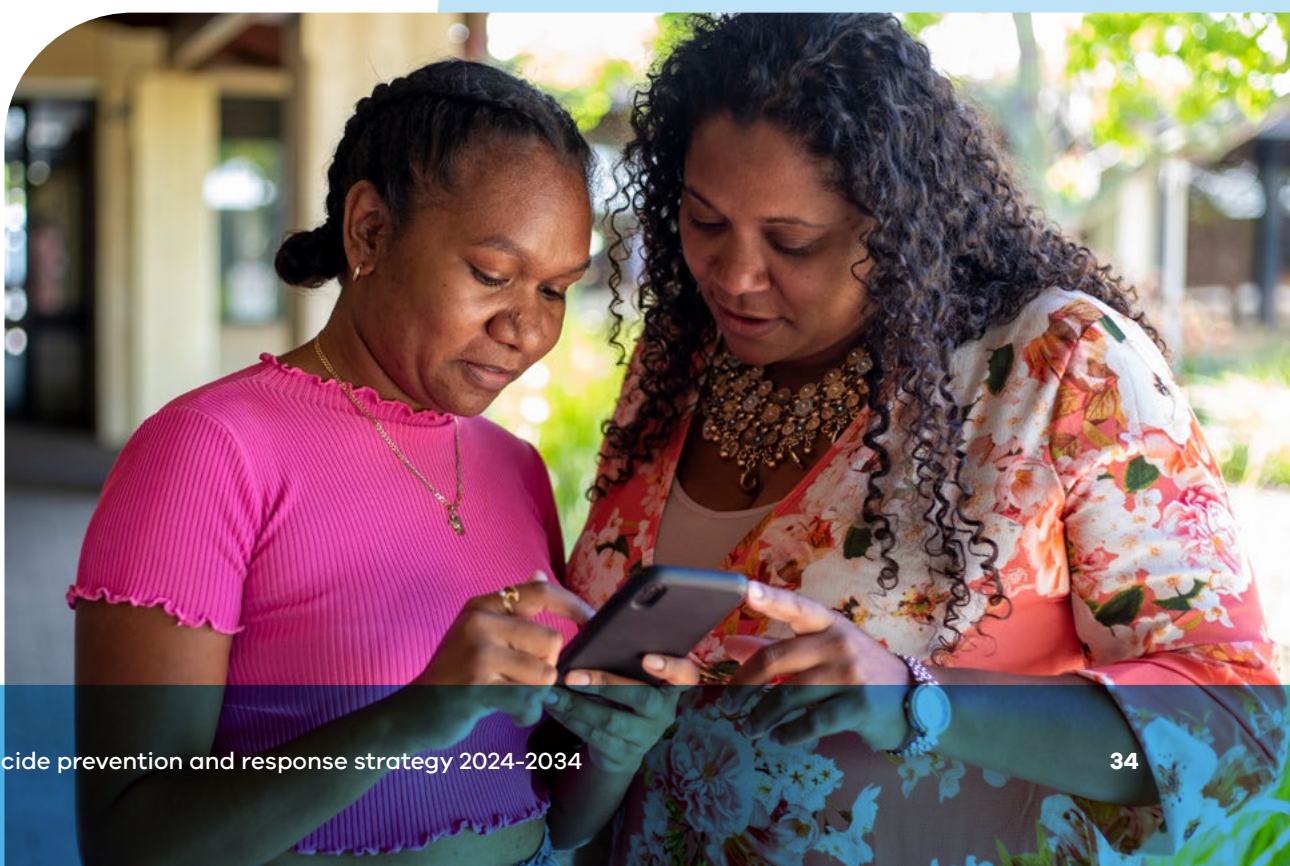
Why it matters

We understand that our existing systems are complex and disjointed, and it can be difficult to find appropriate and integrated supports. In developing the strategy, we heard that care and support is often fragmented across systems, how progress and trust is lost as people transition through and across different service systems and how these challenges unevenly affect people seeking culturally appropriate supports, such as recent migrants, LGBTIQ+ people and Aboriginal people.

We need to ensure that interacting with our various service systems does not create, or contribute to, distress. Regardless of whether people are engaging with education, health or housing systems, we need to make it easier for people to navigate systems, make choices and access the supports they want. Anyone experiencing distress, their families, carers and supporters should be met with services that are empathetic to their unique challenges and assisted in connecting to support and

care that is appropriate, well-resourced and readily available.

We aim to build and strengthen connections into and between systems, including the mental health and wellbeing, suicide prevention and response, family violence, child protection, alcohol and other drug, justice, health, education and housing systems. By collaborating across settings, we aim to build integrated, holistic responses that ensure continuity of care and prevent suicide.



Our objectives

- Improve ways to access and navigate between support, care, emergency response and treatment systems, ensuring responsiveness to the needs of diverse Victorian communities and groups.
- Create and improve connections across service systems to ensure continuity of care and simplified referral pathways to a broader range of access points.
- Explore integration opportunities and new ways of working that support people through transition points such as entering or being released from correctional settings, exiting out-of-home care, finishing or disengaging from education and vocational settings, engaging with aged or supported care services and exiting military service.
- Increase the accessibility of the mental health, alcohol and other drug and suicide prevention and response systems.



What we expect to see

Focusing on connecting systems will help people to access and navigate service systems and ensure they experience continuous and connected care across key transitions. Over time it is expected that this will support people to access the right support at the right time for their needs.

Alignment with mental health and wellbeing outcomes and performance framework

This priority area will likely contribute to multiple indicators under domain 2 – *People are supported by mental health and wellbeing services to live the life they want* – including:

- increased satisfaction with the outcomes from their care and support
- increased ability for people to effectively navigate and receive all the services they need
- increased continuity of care across different services
- increased diversity and ease of access points into the system
- increased awareness of human rights in care and support.



Priority area 2:

Build on and strengthen existing supports across the suicide prevention and response continuum

Why it matters

Our current suicide prevention and response system is too focused on crisis response within the health system and clinical and hospital settings, with limited prevention and early intervention programs in the community. Participants involved in developing the strategy spoke about the

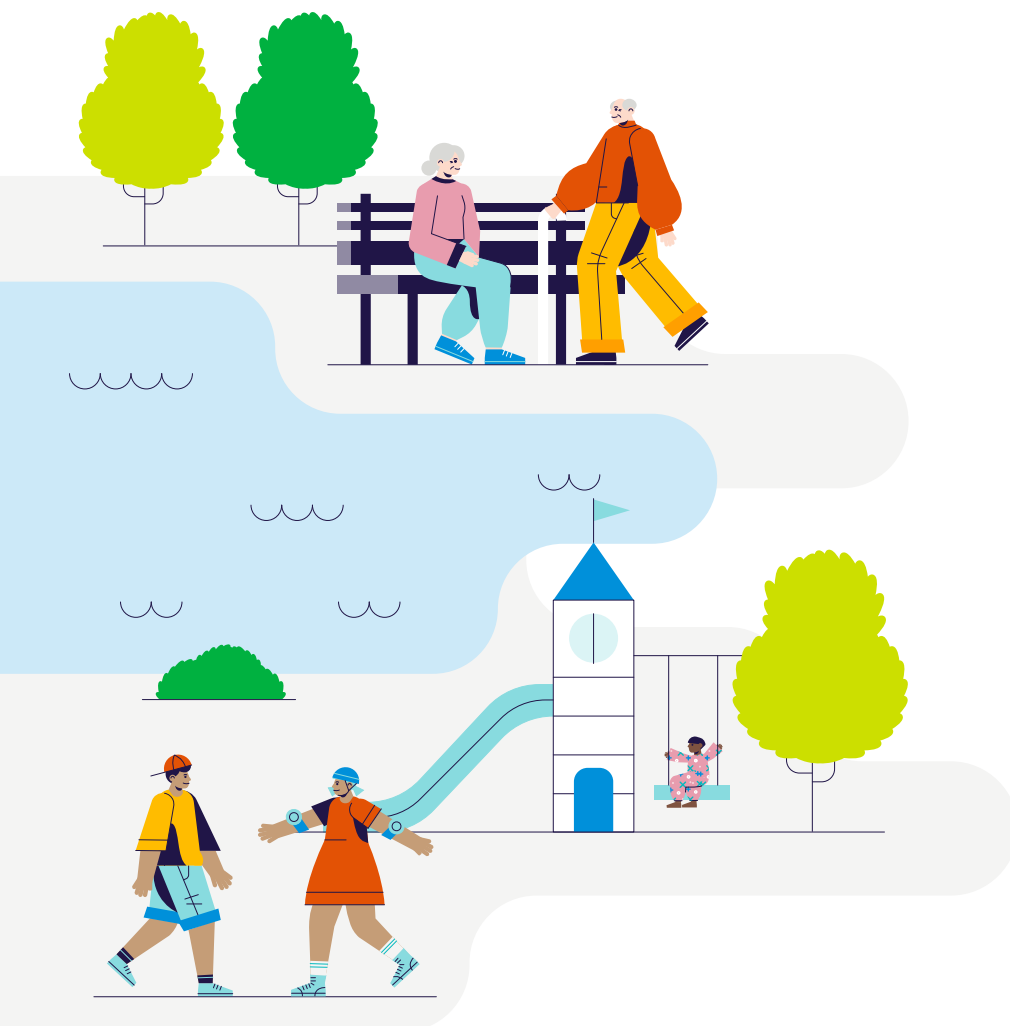
importance of choice, agency and autonomy for effective suicide prevention and response, the opportunity to invest in early and targeted intervention programs, as well as the challenges in balancing the role of families, carers and other supporters.

While responding compassionately and appropriately to crisis is fundamental, we need to:

- increase the focus on prevention and expand the range of programs and services offered
- ensure targeted early intervention programs are available and tailored to the experiences of those who are affected by suicide more than others, as well as their families, carers and supporters
- expand our aftercare services
- provide comprehensive postvention supports to every person affected by suicide.

We will deliver a more comprehensive suicide prevention and response system that gives individuals and their families, carers and supporters agency and choice by:

- enhancing the cultural safety of existing services
- finding new ways and opportunities to meaningfully intervene to prevent suicide beyond typical health settings
- trialling new models of care, support and treatment and exploring innovative uses of technology, including social media.



Our objectives

- Strengthen current and explore new prevention activities, service models and programs to support people in a broad range of settings (such as in community groups, schools and workplaces), with a focus on groups disproportionately affected by suicide.
- Investigate opportunities for non-clinical, peer-led and/or technology-based models to increase the availability of alternative support options, facilitate help-seeking engagement and to support and enhance traditional treatments, recovery and healing practices.
- Recognise and embed Victorian Aboriginal communities' rights to practise traditional medicine and healing practices and work with Aboriginal communities to create these pathways and modalities into practice so Aboriginal people in Victoria have the information and option to choose their healing and/or recovery journey.
- Ensure, where appropriate, mechanisms, tools and resources exist for families, carers and supporters to have their needs understood and met as part of the care, treatment and recovery of the person they support, including maintaining their own emotional safety and wellbeing.
- Continue to build cultural safety and inclusive practice of mainstream services to meet the diverse needs of the Victorian community.
- Promote Aboriginal social and emotional wellbeing models of care and invest in Aboriginal Community Controlled Organisations and the Aboriginal workforce to deliver suicide prevention and response initiatives.
- Utilise data and evidence to explore opportunities (for example, bystander intervention, enhanced surveillance and restricting access to means in the built environment and other settings) to support early identification and intervention of people experiencing suicidal crisis.
- In collaboration with the Commonwealth Government, service providers and local communities, enhance postvention and bereavement supports.

What we expect to see

Focusing on delivering a range of supports and activities across the suicide prevention and response continuum will help ensure services match the diversity of needs in the community, including enabling people to access support from peers who understand them and their story. It will also support outcomes relating to increased help-seeking activities, earlier responses to people in distress and reduced access to means for suicide.

Alignment with mental health and wellbeing outcomes and performance framework

This priority area will likely contribute to multiple indicators under domain 4 – *System structures and leaders drive real change and accountability* – including:

- increased system capacity to provide appropriate, culturally safe and timely care
- increased ability for people to access the care they want, when they want and where they want
- increased services being designed, led and delivered by people with lived experience.

It will also likely contribute to indicators under domain 2 – *People are supported by mental health and wellbeing services to live the life they want* – such as:

- increased cultural safety of services
- increased meaningful inclusion of families, carers, kin and supporters in care and support (consistent with human rights and the principles of privacy and dignity)
- an increase in families, carers, kin and supporters being supported in their own mental health and wellbeing
- an increase in tailored and accessible information, resources and supports for families, carers, kin and supporters.

Priority area 3:

Build and support a compassionate, trauma-informed workforce, strengthened by lived and living experience

Why it matters

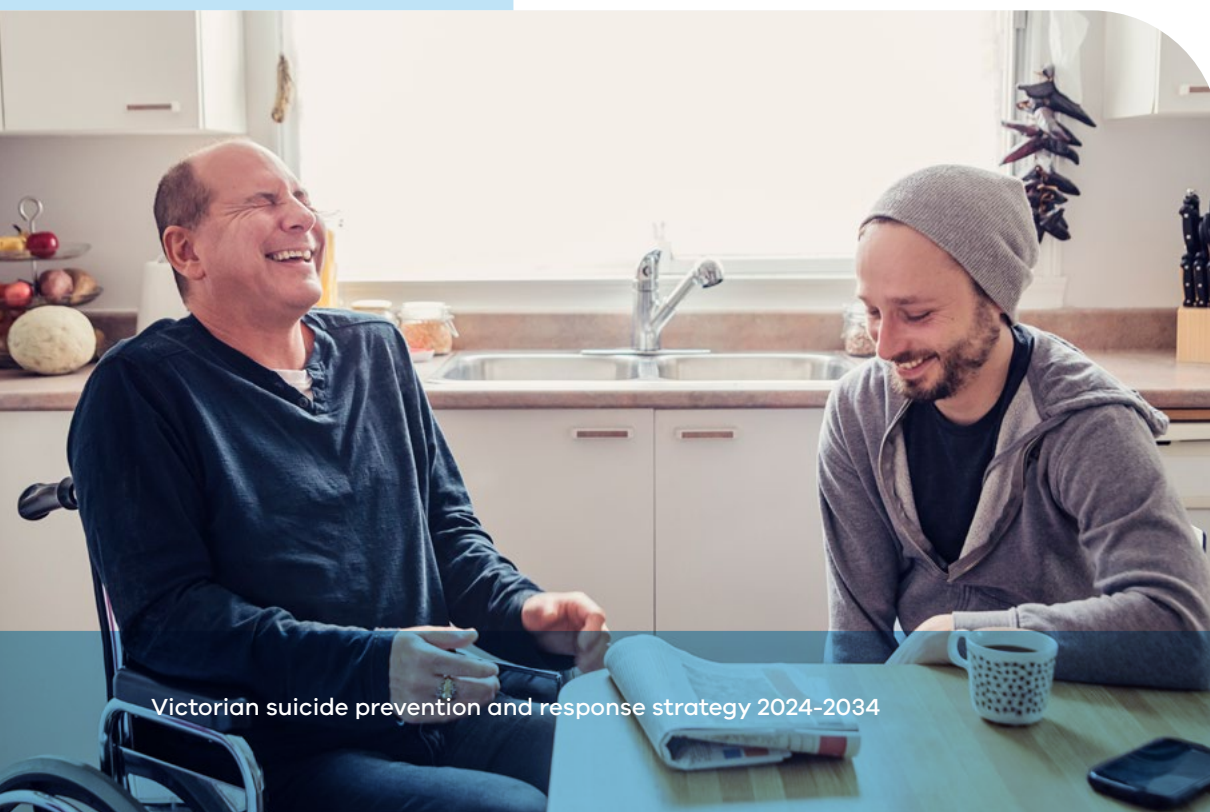
While people in the suicide prevention and response sector work tirelessly to support Victorians' wellbeing, we know that more needs to be done to ensure our workforces are well resourced and supported and reflect the diversity and lived and living experiences of the community. Roundtable participants told us that skill shortages in the health, mental health and suicide prevention workforces create challenges, reduce quality of care and increase pressure on staff.

More relevant and consistent suicide prevention training is needed for the existing and incoming workforce to ensure appropriate levels of capability and that their work is guided by a trauma-informed and compassionate approach. We also need to support and train workforces outside of the mental health and suicide prevention and response systems who are likely to come into contact with people in distress to ensure a compassionate and appropriate response.

We need to ensure our existing peer and lived and living experience workforces are properly supported and have clear roles and obligations in delivering suicide prevention and

response initiatives. The peer support workforce is an essential and growing part of the mental health system. Making greater use of this workforce will also help ensure people have access to a compassionate, empathetic workforce and positive stories of recovery from suicide attempt, and suicidal distress and behaviour.

It is also vital that we recognise the impact of working within and in partnership with the suicide prevention and response sector. First responders (such as emergency services), clinicians and others who provide support to people need to have access to appropriate supports themselves.



Our objectives

- Define and communicate the roles, responsibilities, capabilities and standards for all workforces involved in suicide prevention and response.
- Strengthen the lived and living experience and peer workforces through advancing the role of peer workers (including bicultural peer workers) and lived and living experience of suicide roles in clinical and non-clinical settings.
- Support workforces who come into contact with people experiencing suicidal distress and crisis (such as family violence, relationship, alcohol and other drug, employment, legal aid, gambling and financial services and frontline workers in sectors like transport) to better understand suicide and contributing factors and support help-seeking activities.
- Support improved suicide prevention and response capability across clinical and non-clinical staff working in mental health and wellbeing services.
- Improve the wellbeing and sustainability of workforces involved in suicide prevention and response.

What we expect to see

Focusing on building and supporting our workforces will help workforces across all relevant services and programs to have the skills and supports they need to deliver high-quality responses. This should lead to increased help-seeking activities, as supports across the suicide prevention and response continuum become more compassionate and responsive to individuals' needs.



Alignment with mental health and wellbeing outcomes and performance framework

This priority area will likely contribute to multiple indicators under domain 3 – *People in the mental health and wellbeing workforce are adaptive and collaborative, and bring together diverse knowledge, skillsets and experiences* – including:

- increased workforce skills, knowledge and capability
- increased integration of lived and living experience roles throughout the workforce
- increased genuine authority of lived experience expertise and leadership in workforce practices and design
- increased numbers of people choosing to enter and remain in the mental health and wellbeing workforce
- improved workforce mental health and wellbeing.

It will also likely contribute to indicators under domain 2 – *People are supported by mental health and wellbeing services to live the life they want* – including:

- increased person-driven and dignified care and support
- increased care and support that is compassionate and trauma-informed.

Priority area 4:

Reduce suicide-related stigma and enable community-wide action

Why it matters

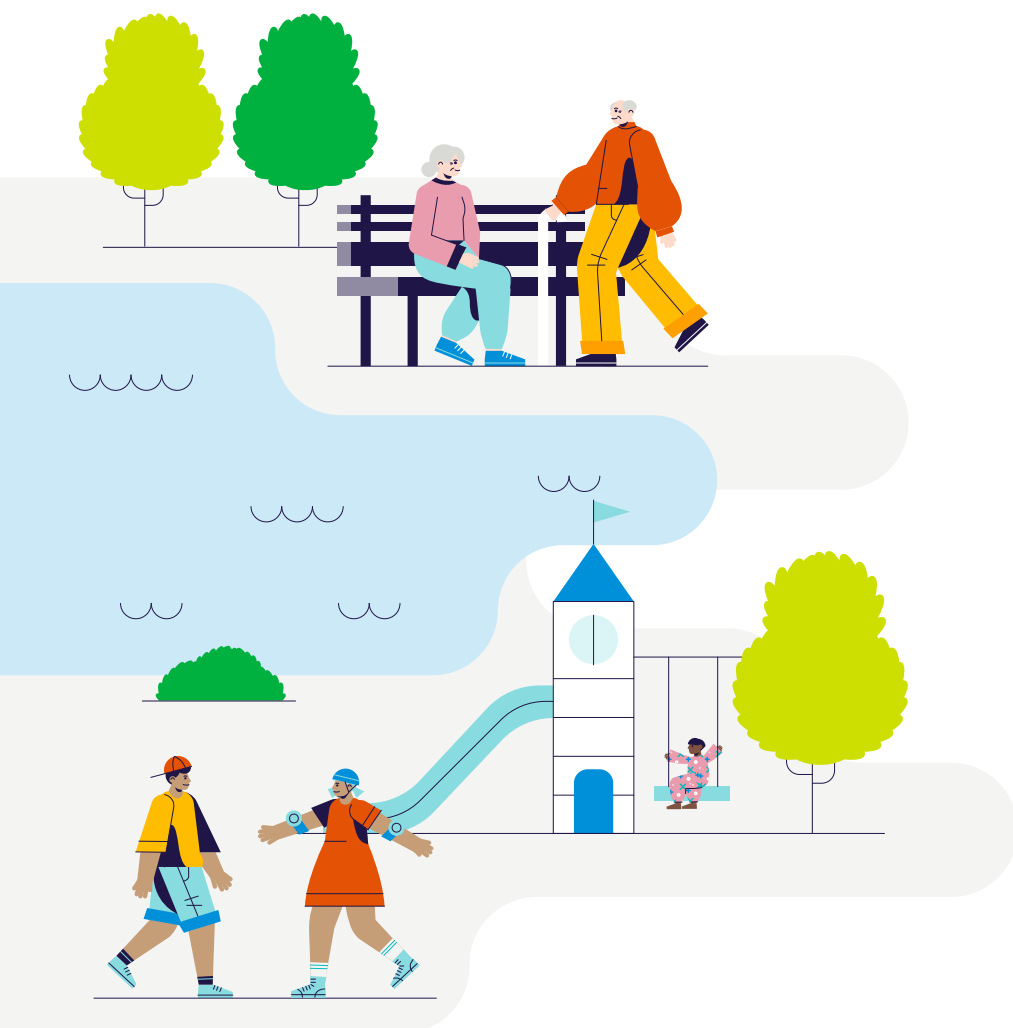
Addressing suicide-related stigma was a top priority for participants involved in developing the strategy due to the role it plays as a driver of suicide, a barrier to help-seeking and as an ongoing challenge for all those touched by suicide. While 'mental health' and 'wellbeing' have become less stigmatised following the COVID-19 pandemic, people

with lived and living experience shared that this is not true for suicidality. This stigma can be especially pronounced for communities where discussions about suicidality are inhibited by cultural beliefs or gender norms.

We need to assist the Victorian community to be better equipped to understand, respond to and prevent suicidal

distress before people reach a crisis point. We also need to build protective factors by supporting individuals to feel connected and a sense of belonging and by empowering communities to enhance their own unique community-specific protective factors.

We need a whole-of-community response that makes clear the role of workplaces and employers, educational settings, community groups and networks and others in preventing suicide, encouraging help-seeking behaviour and reducing suicide-related stigma and shame.



Our objectives

- Deliver community-wide and targeted education and awareness initiatives to reduce suicide-related stigma and support help-seeking.
- Implement actions that grow and build communities that are inclusive, connected and respectful.
- Continue to invest in initiatives that promote good mental health and wellbeing for children and young people in school and good mental health in the workplace.
- Explore opportunities for communities (geographical, cultural and others) to co-design initiatives that respond to community-specific drivers of suicidal distress and enhance community-specific protective factors.
- Support communities and workplaces to implement suicide prevention and response activities.
- Build knowledge and understanding of transgenerational and intergenerational trauma in Aboriginal communities and of Aboriginal social and emotional wellbeing models of healing.
- Support Aboriginal communities to self-determine, co-design and deliver community-specific suicide prevention and response initiatives.

What we expect to see

With a focus on reducing suicide-related stigma and supporting community-wide action, this priority area will assist communities to better understand and safely discuss suicide and have the systems and skills in place for effective prevention and response. In the medium term, this will likely help to build protective factors and reduce suicide risk, support earlier responses to people in distress and increase help-seeking activities. Ultimately, this area will seek to reduce stigma around suicide.

Alignment with mental health and wellbeing outcomes and performance framework

This priority area will likely contribute to multiple indicators under domain 1 – *People and communities are enabled to experience the mental health and wellbeing they want* – including:

- increased sense of belonging and purpose
- increased social inclusion and community connection
- increased supportive, respectful relationships
- reduced experiences of discrimination and exclusion
- reduced discrimination around mental health challenges and psychological distress
- increased self-determination and increased connection to culture.

It will likely also contribute to increased positive mental health and wellbeing in workplaces and increased positive mental health and wellbeing for children and young people in education settings (domain 4 – *System structures and leaders drive real change and accountability*).

Priority area 5:

Drive whole-of-government collaboration and innovation

Why it matters

Suicide prevention and response requires action across all areas of government, recognising that suicide is influenced by experiences in a wide variety of settings, including workplaces, communities and schools and the built environment. However, historically, government efforts have focused on the health and mental health systems only or, where other parts of government are involved, have been disjointed and piecemeal, with discrete

initiatives delivered by specific departments and agencies with no connection or integration. As a result, roundtable participants spoke about the difficulties associated with delivering services in complex and fragmented funding environments. Organisations highlighted challenges in providing continuous, high-quality and consistent care when their clients navigated between health, mental health, alcohol and other drug, housing, education and justice settings.

To meaningfully address suicide, we need to expand our understanding of suicide prevention. We need to ensure we are building capacity and competencies in all areas of the Victorian Government so we can better partner with people with lived and living experience of suicide and identify and respond to contributing factors that exist outside of the mental health portfolio.

We need to ensure we are effectively and efficiently collaborating across jurisdictions and that suicide prevention and response efforts are coordinated nationally. We also need to ensure we are learning from what has worked across Australia and globally, adapting key insights and evidence to the Victorian context to improve the success of the strategy.



Our objectives

- Support all Victorian Government departments and agencies to understand how their work and the settings they influence contribute to suicide prevention and response efforts.
- Develop innovative new ways of working across government departments and agencies to ensure a suicide prevention lens is applied across all policies and programs and lived and living experience of suicide perspectives are embedded in all suicide prevention and response policies, programs and initiatives.
- Work collaboratively across government departments and agencies to trial and test new innovations and solutions to address social determinants that disproportionately contribute to suicidality and suicide such as family violence, gambling harm, homelessness, incarceration, financial insecurity and trauma in children and young people.
- Develop integrated responses to people experiencing time-critical mental health and/or suicidal crises.
- Collaborate with the Commonwealth and state and territory governments and government partners, including Gayaa Dhuwi (Proud Spirit), to deliver a coordinated national approach to suicide prevention and response.
- Work with the Commonwealth Government and Victorian Primary Health Networks to deliver a coordinated approach to suicide prevention and response in Victoria.

What we expect to see

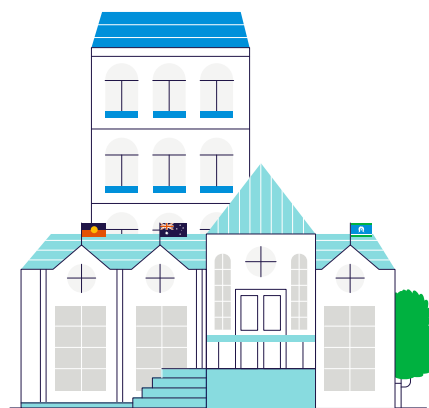
With a focus on collaboration and innovation, we expect that, in the short term, this will support government departments and agencies and the systems they oversee to understand suicide and how to prevent and respond to it in their work. In the longer term, this priority area aims to ensure government action responds effectively to meet system-wide need.

Alignment with mental health and wellbeing outcomes and performance framework

This priority area will also likely contribute to indicators relating to domain 4 – *System structures and leaders drive real change and accountability* – including increased support for mental health and wellbeing in:

- workplaces
- the child protection and out-of-home care systems
- aged care and other long-term care settings
- the justice system
- public and social housing
- education settings.

It should also support increased ability for people to effectively navigate and receive all the services they need (domain 2 – *People are supported by mental health and wellbeing services to live the life they want*).



Priority area 6:

Build on and use data and our evidence base in delivery and evaluation

Why it matters

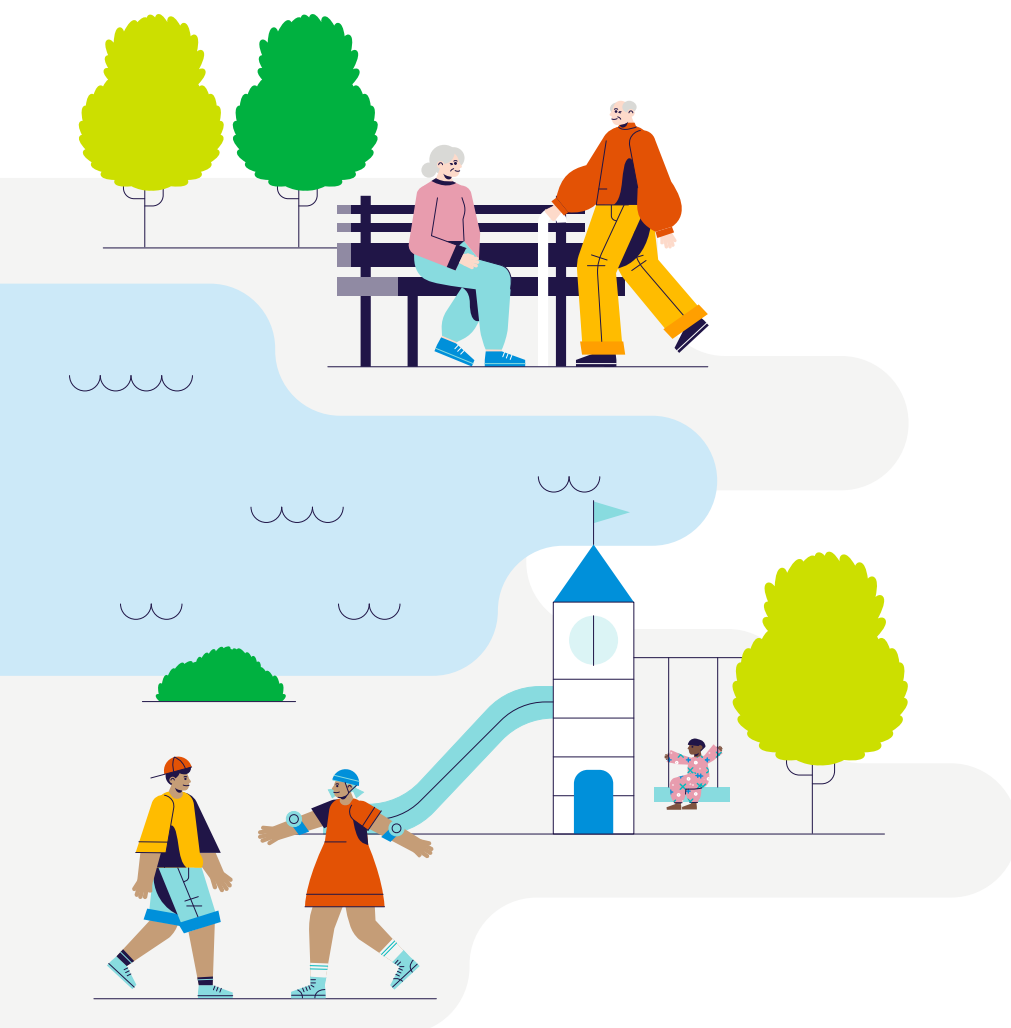
Participants involved in developing the strategy affirmed that having a clear understanding of people, suicidality and the effectiveness of supports is essential for suicide prevention and response. Despite previous attempts to standardise and improve collection practices, participants

outlined challenges with collecting consistent data across the system and the impact this has on communities that are already affected by suicide more than others such as Aboriginal people, LGBTIQ+ people, people from multicultural and multifaith backgrounds, people who are neurodivergent and people with disability.

Co-design participants also highlighted that, even in circumstances where the data does exist, analysing suicide and experiences of suicide through numbers can hide the nuanced lived and living experience an individual has.

While we have a strong evidence base to build from, our knowledge and understanding must continue to develop and mature, including through improving the collection, linkage and use of data from a range of sources and recognising and valuing different types of evidence.

Ongoing research and collection of evidence and knowledge is needed to better understand, prevent and respond to suicidal distress and suicide, including contributing factors, protective factors and emerging trends, and ensuring the strategy continues to learn, evolve and respond to change over the next 10 years.



Our objectives

- Establish a consistent approach for collecting and sharing data related to suicide attempts, intentional self-harm and deaths from suicide and other key data, including overdose and family violence, to inform prevention and response efforts.
- Identify opportunities for data integration and linkage where it will provide useful insights to inform decision making.
- Identify critical gaps in suicide prevention and response knowledge and advance research, engagement and partnerships to continuously improve understanding, including learning from other jurisdictions.
- Elevate lived and living experience evidence and support lived and living experience-led research that includes diverse perspectives, including the perspectives of Aboriginal people, people who are neurodivergent, multicultural people, young people, LGBTIQ+ people and trauma survivors.
- Explore opportunities to translate Western concepts into the Aboriginal context to ensure Western terms and clinical models of care align with Aboriginal ways of knowing, being and doing.
- Conduct, share the findings of and act on evaluations of suicide prevention and response initiatives to understand what works and what should change.

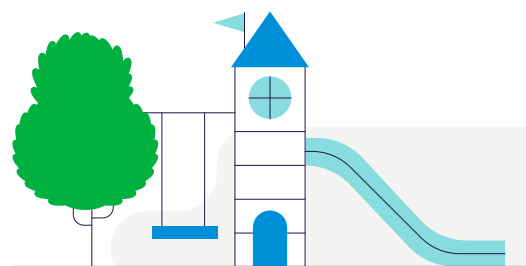
What we expect to see

We expect that a focus on data and evidence will support government, sectors and the community to better understand need and what works in suicide prevention and response. It will also ensure decisions, services and training are shaped by those with lived and living experience.

Alignment with mental health and wellbeing outcomes and performance framework

This priority area will also likely contribute to indicators relating to domain 4 – *System structures and leaders drive real change and accountability* – such as:

- increased leadership of people with lived experience in research, innovation and evaluation
- increased use of research and evaluation
- increased reliability of mental health and wellbeing data.



Outcomes



Outcomes help us to understand what needs to change in order to:



Be successful



Make decisions about where to invest our resources



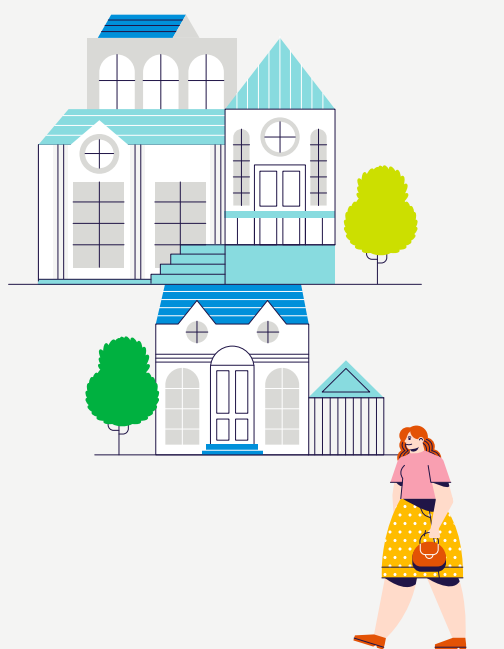
Use data to understand what works and what needs to change



Respond and adapt to community needs.

They also help us communicate our shared priorities with government and communities.





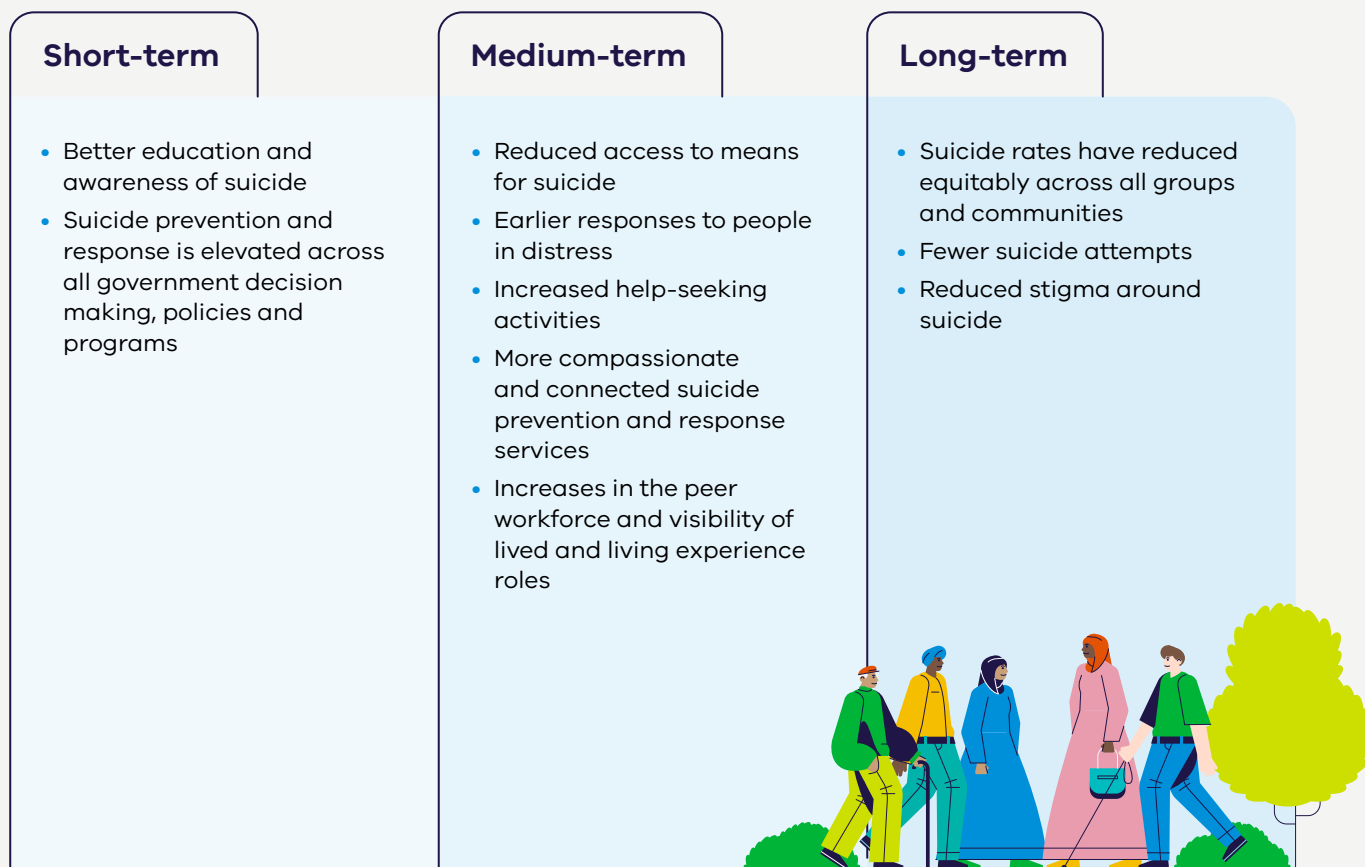
How will we know if we are making a difference?

In delivering the suicide prevention and response strategy, there are several outcomes we are seeking to achieve.

All priority areas will contribute to some or all these outcomes. However, improved outcomes in suicide prevention and response will require a long-term commitment and will be subject to the pace of implementation of initiatives, associated

investment and commitment of all partners. While we will need sustained action to make a real difference, we expect improvement in our outcomes over the periods outlined in Figure 6.

Figure 6: Time horizons for outcomes



As outlined under each of the 6 priority areas, implementation of the strategy will have a positive impact on a range of outcomes and indicators in the *Mental health and wellbeing outcomes and performance framework*. A table view of priority areas and associated indicators can be found at Appendix 2.

While developed to monitor and assess the outcomes, performance and accountability of the mental health and wellbeing system specifically, the outcomes and performance framework takes a broad view of mental health and wellbeing, assessing outcomes across 4 domains (Figure 7). It is expansive, aspirational, ambitious and drives collective responsibility and accountability for outcomes across government portfolios, drawing on a range of diverse inputs. Consequently, it is a useful and appropriate framework to use as the primary tool for measuring the progress of this strategy.

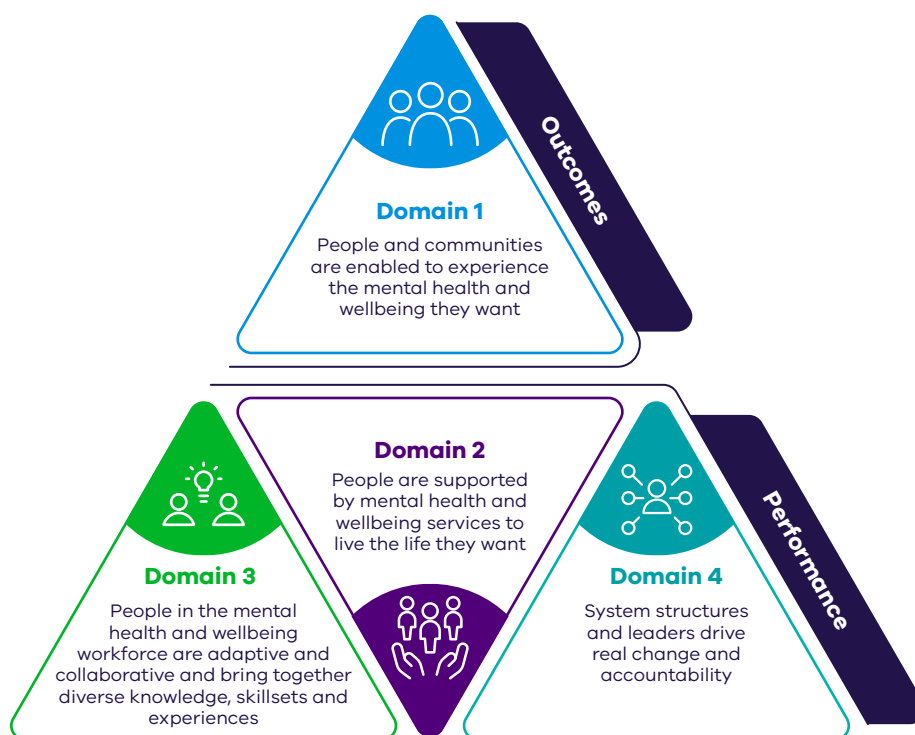
Acknowledging that this suicide prevention and response strategy is a whole-of-government and community-wide strategy, outcomes will also be aligned to other key government outcomes frameworks including the *National Agreement on Closing the Gap* (outcome 14: Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing) and *Our promise, your future: Victoria's youth strategy 2022–2027* (domain one: healthy, well, safe and secure).

The strategy's accountability framework includes more detail on alignment and integration with the outcomes and performance framework and other government frameworks and associated reporting mechanisms, noting that measures and reporting will continue to be built and iterated over time as the supporting data, collections and systems improve.

Implementation of the outcomes and performance framework will support the strategy through:

- designing meaningful common measures that align with the strategy's outcomes and monitoring requirements
- leveraging existing data to report on these measures, where possible, to reduce duplication and to provide a baseline for tracking progress of the strategy
- designing data collection systems and instruments to collect new data essential to outcomes-informed accountability
- facilitating co-design of reporting against the strategy
- establishing an ongoing process of reporting reform, as the data improves over time.

Figure 7: The 4 domains of the Mental health and wellbeing performance and outcomes framework



How we will implement the strategy

We all have a role to play in delivering this suicide prevention and response strategy and in preventing and responding to suicide in a broad range of settings.

Achieving the vision of the strategy will require a range of complex and, at times, interconnected activity across departments, agencies, sectors and communities. To support successful delivery and implementation, an accountability framework and rolling implementation plans complement this strategy.

Implementation plans

Implementation plans will outline the specific initiatives (programs, services and policies) that we will deliver over the implementation period. Each initiative will align with the strategy's priority areas and objectives and will have a lead government department, agency or community partner.

The strategy's objectives will be sequenced across the 3 horizons detailed in Figure 8.

We are committed to advancing Aboriginal self-determination and will continue to work in partnership with Aboriginal communities on Aboriginal-led approaches to suicide



prevention and response. These approaches will be prioritised in each implementation plan.

The Suicide Prevention and Response Office will lead the development of implementation plans in partnership with people with lived and living experience of suicide, government and community.

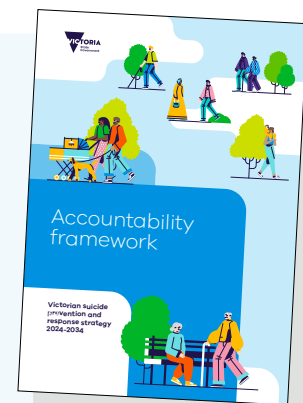
Accountability framework

Monitoring and reporting on progress keeps all stakeholders accountable and allows continuous learning. It also helps with transparency and information sharing, which can build trust and strengthen engagement with people with lived and living experience as well as groups unequally affected by suicide.

The strategy's accountability framework aims to support, monitor, promote and assess the progress of the strategy.

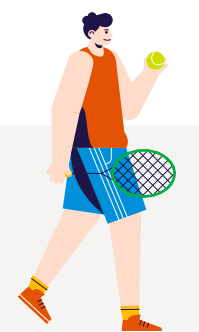
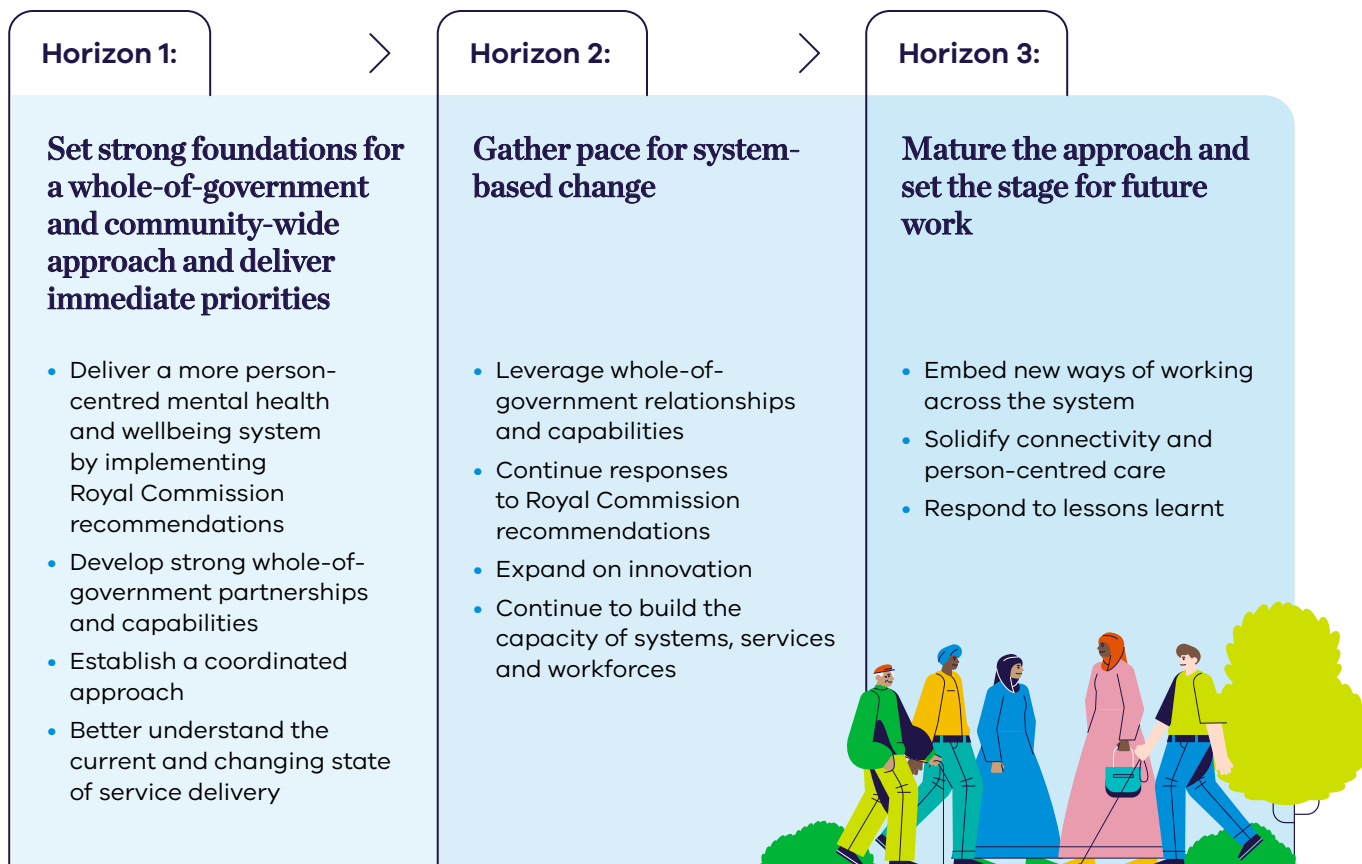
It supports the strategy's whole-of-government and community-wide approach. It sets out the responsibilities of government and the community, as well as the ways we will ensure the Victorian Government and our partners deliver on our joint commitment.

The accountability framework was developed in partnership with people with lived and living experience of suicide and other key partners including



the Suicide Prevention and Response Expert Advisory Committee and Victorian Government departments and agencies.

Figure 8: The 3 horizons of the suicide prevention and response strategy



Evaluation approach

We will work with people with lived and living experience of suicide to evaluate the strategy. Evaluation will consider all levels of the strategy from initiatives outlined in implementation plans, to the strategy priority areas and objectives, and the strategy as a whole. The 8 principles defined in this strategy will underpin the evaluation approach, with people with lived and living experience involved at each level of evaluation.

Our partners

Governments (federal, state and local) have a responsibility to lead elements of this work, but they cannot reduce suicide alone. A joint effort across governments, communities and individuals is needed. Figure 9 outlines the high-level roles and responsibilities of all the partners involved in preventing and responding to suicide in Victoria. More detail is in the strategy's accountability framework.

Figure 9: Whole-of-government and community-wide approach

A whole-of-government approach involves:



Figure 9: Whole-of-government and community-wide approach (continued)

A community-wide approach involves:

Schools (primary and secondary)

Can promote connection, inclusion and build protective factors. Schools can play a role in early intervention and in postvention efforts.

Community-managed and non-government organisations and networks

Provide a range of programs and services and play an important role in advocating for and supporting change, reducing stigma, creating social connections and building protective factors. Includes Aboriginal Community Controlled Organisations, lived and living experience peak bodies and identity-based, cultural and/or ethno-specific groups and networks.

Workplaces and education institutions

Play a key role in supporting wellbeing, inclusivity and cultural change, reducing stigma and discrimination, responding compassionately to suicidal distress and providing education and training about suicide prevention.

Businesses and the private sector

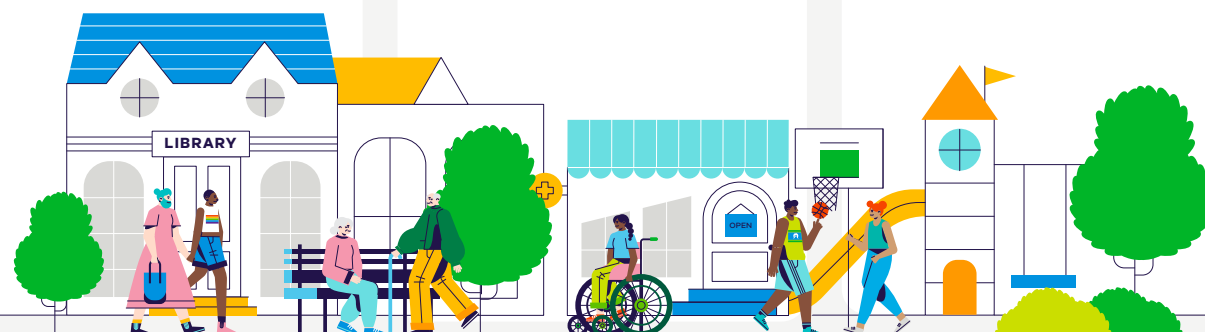
Play a role in responding compassionately to people in distress. Examples include the legal and financial sectors, energy providers, technology providers, leisure and recreational facilities, and the hospitality and entertainment industries. Private psychologists, psychiatrists, social workers, counsellors and hospital services play an important role in preventing suicide in the mental health and wellbeing system.

Media (print, online and social)

Can increase access to positive messaging (including stories of healing, recovery and of getting help) and promote services and supports, which can contribute to suicide prevention. Media also has a responsibility around the safe reporting of suicide.

Individuals, families, friends and community and volunteer groups

Have a role in building safe, secure and compassionate relationships and communities. Can assist in building protective factors and are often the first people to recognise and respond to suicidal distress.



Our settings

A community-wide approach must also look at the various settings where we can respond to suicidal distress and support suicide attempt survivors, people living with suicidal thoughts, their families, carers, supporters and people bereaved by suicide.

The suicide prevention and response continuum covers prevention, early intervention, crisis response, aftercare and postvention. It can be a useful way of thinking about who is involved in suicide prevention and response in which settings (Figure 10).

The objectives under priority area 2 (*Build on and strengthen existing supports across the suicide prevention and response continuum*) will seek to drive action across these settings.

Figure 10: Settings for action

Prevention	Early intervention	Crisis response	Aftercare	Postvention
Where				
- Schools and educational settings - Workplaces - Communities (such as sporting clubs, libraries and cultural and/or faith groups) - Aboriginal Community Controlled Organisations	- Helplines - School and education settings - Transport networks and built environment - Social, health or financial support settings - Residential care - Primary care - Aboriginal Community Controlled Organisations	- Health and mental health services - Frontline services - Transport networks and built environment - School and education settings	- Mental health services, community services/ outreach - Peer-based support groups (in-person or virtual) - Aboriginal Community Controlled Organisations	Affected schools, workplaces and communities



Figure 10: Settings for action (continued)

Prevention	Early intervention	Crisis response	Aftercare	Postvention
Who				
• Individuals, families, friends • Teachers, educators, school wellbeing staff, school leadership and parent/carer community • Sports coaches and instructors • Local governments and staff (library staff, youth workers, social workers, outreach teams, maternal and child health nurses, neighbourhood house staff) • Community and/or faith group/church leaders and members • Parents groups • Urban planners/designers • Community volunteers • All workplaces, small business, corporate and government staff • Researchers/academics	• Transport workers • Gambling and financial counselling service staff • Suicide and mental health helpline staff • Housing service staff • Family violence staff • Disability and aged care workers/nurses • Relationship counsellors • Alcohol and other drug service providers • Social workers or allied health professionals • School mental health practitioners and psychologists • General practitioners • Victoria Police, Ambulance Victoria • Child protection staff • Correctional staff • Court services staff • Families, carers and supporters	• Mental health and wellbeing clinicians and peer workers • Emergency department teams • Victoria Police, Ambulance Victoria • Families, carers and supporters • Department of Transport and Planning and public transport operators • School wellbeing teams, school mental health practitioners, school leadership	• Peer workers • Mental health and wellbeing clinicians • Allied health and psychosocial/wellbeing professionals • Families, carers and supporters	• Postvention service providers • Bereavement counsellors • Community leaders (schools, sporting clubs) • Mental health and wellbeing service clinicians (including headspace staff) • Local government staff • Primary Health Networks • Victoria Police and other first responders • School mental health practitioners and psychologists

This suicide prevention and response strategy lays the foundation for a robust, adaptive and accountable system to prevent and respond to suicide. It aims to build a systems-based approach, involving whole-of-government, sectors, services and communities to address all the systems and connected factors that can lead to, or

protect against, suicide. This approach is based on the idea that no single action, service or treatment will work alone to prevent and respond to suicide.

Our approach involves building whole-of-government and community-wide collaboration to support innovation, action and change. It is the beginning

of an ongoing process to better understand how we can prevent and respond earlier to suicide and build supports across different services and systems.

**All Victorians
working together
to reduce suicide.**

Thank you



The development of the *Victorian suicide prevention and response strategy 2024–2034* was guided by the *Mental health lived experience engagement framework*. The framework sets out the principles that help inform how we move from a ‘deliver and inform’ approach to a true collaborative process.

Our thanks to Roses in the Ocean, Tandem and the Victorian Mental Illness Awareness Council for their advice and support, including their support of our co-design participants.

We acknowledge the strength, courage and commitment of people with lived and living experience of suicide and thank you for your meaningful and deeply personal contributions to developing this strategy.

We would especially like to thank Anna, Wendy, Sue, Maddison, Julie, James, Trevor and all the other lived and living co-design participants who shaped the strategy.

We also acknowledge the numerous clinicians, sectors, services and other experts who contributed to developing the strategy including:

- the Balit Durn Durn Centre
- submission and survey respondents
- Suicide Prevention and Response Expert Advisory Committee members
- roundtable participants
- targeted discussion participants.

Roundtable participants

Mental health and wellbeing services

Alfred Health; Austin Health; Australian College of Emergency Medicine; Barwon Health; Epworth HealthCare; Forensicare; Mental Health Victoria; Mercy Health; Northern Health; Royal Australian and New Zealand College of Psychiatrists; The Royal Melbourne Hospital; and The Royal Women's Hospital.

Adult and older adult men

Australian Men's Health Forum; DadsInDistress / Parents Beyond Breakup; HALT (Hope Assistance Local Tradies); Macedon Ranges Suicide Prevention Action Group; Australian Men's Shed Association; Northern Health; Outside the Locker Room; Resilience Builders; and Suicide Prevention Australia.

LGBTIQA+ communities

Drummond Street Services (Queerspace); Melbourne Bisexual Network; Rural Rainbows; Switchboard Victoria; Thorne Harbour Health; Transgender Victoria; Victorian Commissioner for LGBTIQ+ Communities; and Vixen.

Children and young people at higher risk

Association for Children with a Disability; Berry Street School – Narre Warren' Child and Family Services – Ballarat; Commission for Children and Young People; Frontyard Youth Services; Orygen; Spectrum: The Royal Melbourne Hospital; Victorian Aboriginal Child Care Agency; Wellways Australia; and Youth Insearch.

Multicultural communities

Australian Association of Social Workers; cohealth; Foundation House; Global and Cultural Mental Health Unit; The University of Melbourne; Multicultural Centre for Women's Health; Neami National; Project Respect; St Vincent's Hospital Melbourne (St Vincent's Health Australia); and Victorian Transcultural Mental Health.

Higher risk industries

Australian Nursing and Midwifery Federation; Emergency Services Foundation; Health and Community Services Union; Hope Assistance Local Tradies (HALT); Mercy Health; National Centre for Farmer Health; Northern Health; Metro Trains; Victorian Ambulance Union; Victoria Police; and Victorian Trades Hall Council.

Disability and neurodivergent communities

Alfred Health – Child and Youth Mental Health Service neurodevelopmental team; AMAZE; Deaf Victoria; Healthy Autism Life Labs; and Mind Australia.

Older people

Better Place; Caulfield Hospital (Alfred Health); Centre for Mental Health Learning; cohealth; Council on the Ageing Victoria; Australian Men's Shed Association; Neami National; Office of the Commissioner for Senior Victorians; and U3A Network Victoria.

Rural and regional communities

Barwon South West Interim Regional Body; Echuca Regional Health; Gippsland Primary Health Network; Youth Live4Life; Macedon Ranges Health; Nexus Primary Health; Royal Flying Doctor Service; Tracking Better;

Victorian Council of Social Service; Wellways Australia; and Western Victoria Primary Health Network.

People in contact with the justice system

Berry Street; Centre for Innovative Justice; ermha365; Federation of Community Legal Centres; Forensicare (Ravenhall Correctional Centre); Law and Advocacy Centre for Women; Orygen; Spectrum; and Victoria Legal Aid.

Veterans

Austin Health; Bravery Trust; Melbourne Legacy; Phoenix Australia; RSL Victoria; Solider On Australia; Vasey RSL Care; Veteran Housing Australia; and Victorian Veterans Council.

Young people (aged 18–25)

Youth representatives from the Centre for Multicultural Youth; Orygen; Satellite; Youth Advisory Council Victoria; and Youth Live4Life.

Aboriginal communities

Thirrili and the Victorian Aboriginal Community Controlled Health Organisation.

People who use alcohol and other drugs

Alcohol and Drug Foundation; Australian College for Emergency Medicine; Orygen; Victorian Alcohol and Drug Association; Western Victoria Primary Health Network;

Windana Drug and Alcohol Recovery; and Western Region Alcohol and Drug Centre.

Targeted discussion participants

- Alliance for Gambling Reform
- Black Dog Institute
- EveryMind
- LifeLine Australia
- On the Line Australia
- Orygen
- Roses in the Ocean
- StandBy After Suicide Support (Wellways Australia, Jesuit Social Services and Standby National)
- Suicide Prevention Australia
- The University of Melbourne
- Turning Point
- Victorian Alcohol and Drug Association
- Victorian Aboriginal Community Controlled Child Care Agency
- Victorian government departments and agencies.

We would also like to thank the team at Nous Group, Caraniche and Ingrid Ozols AM for their support with the roundtable discussions and co-design workshops. Thank you for the care and compassion you showed throughout this project.

We have worked hard to ensure all contributions are recognised, but there may be instances where we have unintentionally missed some. We apologise for any inadvertent omissions.

Our limitations

We acknowledge the limitations in developing the strategy. We were not able to reach everyone, and not all unique perspectives are represented. We will undertake further engagement and co-design to develop initiatives linked to the strategy's objectives and as part of the ongoing implementation, monitoring and evaluation of the strategy.

Appendix 1

Supporting policies and frameworks

The *Victorian suicide prevention and response strategy 2024–2034* does not operate in isolation. There are several policies and frameworks (existing and in development) at both the state and national levels that will contribute to the success of the strategy through a variety of ways, including by enhancing protective factors or through addressing drivers of distress. These include, but are not limited to, the following:

Victoria

- [Aboriginal social and emotional wellbeing plan](https://www.justice.vic.gov.au/aboriginal-social-and-emotional-wellbeing-plan) <<https://www.justice.vic.gov.au/aboriginal-social-and-emotional-wellbeing-plan>>
- [Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction needs](https://www.health.vic.gov.au/mental-health-reform/recommendation-35#learn-about-how-the-guidance-will-inform-other-reform-work) <<https://www.health.vic.gov.au/mental-health-reform/recommendation-35#learn-about-how-the-guidance-will-inform-other-reform-work>>
- [Mental Health and Wellbeing Act 2022](https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001) <<https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001>>
- [Building from strength: 10-year industry plan for family violence prevention and response](https://www.vic.gov.au/building-strength-10-year-industry-plan) <<https://www.vic.gov.au/building-strength-10-year-industry-plan>>
- [Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027](https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027) <<https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>>
- [Correctional suicide prevention framework](https://www.corrections.vic.gov.au/correctional-suicide-prevention-framework) <<https://www.corrections.vic.gov.au/correctional-suicide-prevention-framework>>
- [Diverse communities' mental health and wellbeing framework and blueprint for action](#) (once released)
- [Drought preparedness and response framework](https://agriculture.vic.gov.au/farm-management/managing-for-and-during-drought/drought-preparedness-and-response-framework) <<https://agriculture.vic.gov.au/farm-management/managing-for-and-during-drought/drought-preparedness-and-response-framework>>
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- [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027](https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017) <<https://www.health.vic.gov.au/health-strategies/korin-korin-balit-djak-aboriginal-health-wellbeing-and-safety-strategic-plan-2017>>
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- [Homelessness and rough sleeping action plan](https://www.dffh.vic.gov.au/publications/victorias-homelessness-and-rough-sleeping-action-plan) <<https://www.dffh.vic.gov.au/publications/victorias-homelessness-and-rough-sleeping-action-plan>>
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- [Self-determination reform framework](https://www.firstpeoplesrelations.vic.gov.au/self-determination-reform-framework) <<https://www.firstpeoplesrelations.vic.gov.au/self-determination-reform-framework>>
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- [Youth justice strategic plan 2020-2030](https://www.justice.vic.gov.au/youth-justice-strategy) <<https://www.justice.vic.gov.au/youth-justice-strategy>>
- [Zero suicide framework](https://www.zerosuicide.com.au/) <<https://www.zerosuicide.com.au/>>

National

- National suicide prevention strategy 2024-2023 (once released)
- National Aboriginal and Torres Strait Islander suicide prevention strategy (once released)
- National preventive health strategy 2021-2030
- National women's health strategy 2020-2030
- Royal Commission into Defence and Veteran Suicide: interim report
- National alcohol and other drug strategy
- National mental health and suicide prevention agreement
- National Agreement on Closing the Gap
- Lived experience workforce development guidelines
- National eating disorder strategy 2023-2033

Appendix 2:

Alignment with the *Mental health and wellbeing outcomes and performance framework*



Domain 1: People and communities are enabled to experience the mental health and wellbeing they want

Outcome	Indicator	Strategy priority area
People's mental health and wellbeing enable them to live a life they want	Decrease rates of suicide	① ② ③ ④ ⑤ ⑥
	Decrease rates of psychological distress	① ② ③ ④ ⑤ ⑥
	Increase sense of belonging and purpose	① ② ③ ④ ⑤ ⑥
Communities support and enable mental health and wellbeing	Increase social inclusion and community connection	① ② ③ ④ ⑤ ⑥
	Increase supportive, respectful relationships	① ② ③ ④ ⑤ ⑥
People's mental health and wellbeing is supported by every aspect of their life	Reduce experiences of discrimination and exclusion	① ② ③ ④ ⑤ ⑥
	Reduce discrimination and stigma around mental health challenges and psychological distress	① ② ③ ④ ⑤ ⑥
Aboriginal people enjoy high levels of social and emotional wellbeing	Increase self-determination	① ② ③ ④ ⑤ ⑥
	Increase connection to culture	① ② ③ ④ ⑤ ⑥

Domain 2: People are supported by mental health and wellbeing services to live the life they want		
Outcome	Indicator	Strategy priority area
Mental health and wellbeing services are safe, inclusive and accountable	Increase cultural safety of services	1 2 3 4 5 6
Mental health and wellbeing services are holistic and effective	Increase people's satisfaction at their outcomes from care and support	1 2 3 4 5 6
Mental health and wellbeing services are connected and integrated	Increase people being able to effectively navigate and receive all the services they need	1 2 3 4 5 6
	Increase continuity of care across different services	1 2 3 4 5 6
	Increase diversity and ease of access points into the system	1 2 3 4 5 6
Mental health and wellbeing services are person-driven and human rights-compliant	Increase person-driven and dignified care and support	1 2 3 4 5 6
	Increase care and support that is compassionate and trauma-informed	1 2 3 4 5 6
	Increase people's awareness of their human rights in care and support	1 2 3 4 5 6
Mental health and wellbeing services recognise the unique knowledge and experience of family, carers, kin and supporters	Increase meaningful inclusion of families, carers, kin and supporters in care and support (consistent with human rights / the principles of privacy and dignity)	1 2 3 4 5 6
	Increase families, carers, kin and supporters being supported in their own mental health and wellbeing	1 2 3 4 5 6
	Increase tailored and accessible information, resources and supports for families, carers, kin and supporters	1 2 3 4 5 6

Domain 3: People in the mental health and wellbeing workforce are adaptive and collaborative and bring together diverse knowledge, skillsets and experiences		
Outcome	Indicator	Strategy priority area
The mental health and wellbeing workforce has the necessary skills, knowledge and capability to work to the top of their individual and collective scopes of practice	Increase workforce skills, knowledge and capability	1 2 3 4 5 6
The mental health and wellbeing workforce reflects the people and communities it serves	Increase integration of lived and living experience roles throughout the workforce	1 2 3 4 5 6
	Increased genuine authority of lived experience expertise and leadership in workforce practices and design	1 2 3 4 5 6

Domain 3: People in the mental health and wellbeing workforce are adaptive and collaborative and bring together diverse knowledge, skillsets and experiences

Outcome	Indicator	Strategy priority area
The mental health and wellbeing workforce is regenerative and sustainable	Increase people choosing to enter and remain in the mental health and wellbeing workforce, particularly in rural and regional areas	1 2 3 4 5 6
Services provide safe, rewarding and innovative working environments for the workforce	Improve workforce mental health and wellbeing	1 2 3 4 5 6

Domain 4: System structures and leaders drive real change and accountability

Outcome	Indicator	Strategy priority area
The mental health and wellbeing system is driven by people with living and lived experience	Increase services being designed, led and delivered by people with lived experience	1 2 3 4 5 6
Wellbeing is supported in the places people learn, live and work	Increase positive mental health and wellbeing for children and young people in education settings	1 2 3 4 5 6
	Increase positive mental health and wellbeing in workplaces	1 2 3 4 5 6
	Increased support for mental health and wellbeing in the child protection and out-of-home care systems	1 2 3 4 5 6
	Increase positive mental health and wellbeing for people in public and social housing	1 2 3 4 5 6
	Increase awareness of and support for mental health and wellbeing in the justice system, including youth justice	1 2 3 4 5 6
	Increase positive mental health and wellbeing in aged care and other long-term care settings	1 2 3 4 5 6
The mental health and wellbeing system is accessible	Increase people being able to access the care they want, when they want, where they want	1 2 3 4 5 6
	Increase system capacity to provide appropriate, culturally safe and timely care	1 2 3 4 5 6
The mental health and wellbeing system continuously and collaboratively learns and improves	Increase use of research and evaluation	1 2 3 4 5 6
	Increase leadership of people with lived experience in research, innovation and evaluation	1 2 3 4 5 6
	Increase reliability of mental health and wellbeing data	1 2 3 4 5 6

Glossary



The following definitions are used for terms used in this strategy or are common terms used in our work in suicide prevention and response and in the sector.

Aboriginal self-determination

The ability for Aboriginal people to freely determine their political status and pursue their economic, social and cultural development.²¹ Self-determination is a right that relates to groups of people, not only individuals.

Inherent to self-determination is the right of Aboriginal people to define for themselves what self-determination means. Aboriginal self-determination encompasses a spectrum of rights that are necessary for Aboriginal people living in Victoria to achieve economic, social and cultural equity, based on their own cultural values and way of life.

Aftercare

Aftercare is the support provided to those who have attempted suicide to reduce the risk of and/or prevent a subsequent suicide attempt. Evidence shows that follow-up care from a multidisciplinary team for people who have attempted suicide will reduce the likelihood of future suicide attempts.

Agency

The ability to take action or to choose what action to take.

Bereaved/bereavement

In the context of suicide, lived experience of bereavement refers to someone who has lost to suicide a loved one or significant person with whom they had a close personal relationship.

Carer

A person, including a person under the age of 18 years, who provides care and/or support to another person who is experiencing or experiences mental illness, psychological distress, suicidal thoughts and behaviours, having survived a suicide attempt and/or substance use or addiction.

This may also include people who are bereaved by suicide and who provided care and support to the person who has died.

It is important to recognise that this term may not reflect the experience of everyone, and there are many who do not feel the word is suitable for the work they do or role they play. Throughout our work, a carer may also be referred to as 'family, carer and supporter'.

Co-design

Co-design is the process of designing *with* people rather than *for* people. It typically works best where people with lived and living experiences, communities, government and professionals work together to improve something they all care about. Overall, the primary role of co-design is to elevate and centre the voices and considerations of people with lived and living experiences in designing policies, programs and services that improve their lives.

Co-production

Co-production involves people with lived or living experience of suicide leading or partnering across all aspects of an initiative or program from the outset – that is, co-planning, co-designing, co-delivering and co-evaluating.²²

Community-wide

An approach to working that involves input and consideration from different areas of the community. Within suicide prevention and response, this may include engaging with of bodies and groups that are not typically part of the formal mental health and suicide prevention and response systems.

Consumer

A person with lived or living experiences of mental illness, psychological distress, suicide and/or substance use or addiction, whether or not they have a formal diagnosis, have used mental health or alcohol and other drug services and/or received support, care and treatment.

It's important to note that some people object to the term 'consumer' to refer to themselves, particularly if they have limited choice in their support, care and treatment (such as people on a compulsory treatment order or who have limited options for services in their area or for their condition).

Contributing factors

Characteristics that can increase the likelihood of suicidal distress, thoughts or behaviours. These may include a range biological, psychological, social and environmental factors or structural and systemic issues that can cause distress. These are also known as risk factors.

Clinicians may refer to contributing or protective factors that do not change over time (such as a history of a suicide attempt or a person's age) as 'static' and factors that can change over time (such as current stressors) as 'dynamic'.

Cultural safety

An environment that is safe for people – where there is no assault, challenge or denial of their identity or background, of who they are, of the discrimination or exclusion they experience and of what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.

Cultural safety is a key practice principle for providing person-centred, holistic and equitable mental health care and negotiating power in service encounters.

Disability

In line with the *Disability Discrimination Act 1992 (Cth)*, the definition of disability includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities and chronic health conditions. In our work, we use the human rights model of disability, which recognises that:

- disability is a natural part of human diversity that must be respected and supported in all its forms
- people from disability communities have the same rights as everyone else in society
- impairment must not be used as an excuse to deny or restrict people's rights.

That means we recognise that people from disability communities are experts in all matters that affect them and that as a government we have

accountability to take proactive steps to uphold, promote and protect the rights of people from disability communities.

Family

Family refers to family of birth, adopted family and chosen family, as well as intimate partners. The term 'chosen family' is often used in LGBTIQ+ communities to refer to non-biologically or non-legally related kin-like relationships that offer deep levels of support and connection.

Individual

In recognition that the term 'consumer' does not capture everyone's experience, especially those with a lived and living experience of suicide who may not have received a formal mental health diagnosis or treatment, throughout this document we often use the term 'individual' in place of consumer.

Intentional self-harm

Deliberately causing physical harm to oneself but not necessarily with the intention of dying.²³

Intersectionality

Intersectionality describes how systems and structures interact on multiple levels to oppress, create barriers and overlapping forms of discrimination, stigma and power imbalances based on characteristics such as Aboriginality, gender, sex, sexual orientation, gender identity, ethnicity, colour, nationality, refugee or asylum seeker background, migration or visa status, language, religion, ability, age, mental health, socioeconomic status, housing status, geographic location, medical record or criminal record. This creates more barriers for a person to access what they need to prevent mental and/or suicidal distress and promote wellbeing.

LGBTIQ+

This inclusive umbrella abbreviation encompasses a range of sexualities, genders and sex characteristics. We use it to refer to people who are lesbian, gay, bisexual, trans and gender diverse, intersex, queer/questioning or asexual. The '+' is for people whose gender identity or sexual orientation is not represented by the letters. We use variations of the term throughout our work depending on the context or language originally used by communities. We also note that some Aboriginal communities use the terms 'sistergirls' and 'brotherboys'.

Lived and living experience of suicide

Includes suicide attempt survivors; people who have had or still experience suicidal thoughts and behaviours; families, carers and supporters of people living with suicidal ideation and/or distress; and people bereaved by suicide.

Lived and living experience workforce

An umbrella term to capture a range of people whose position description specifies that they have a lived and living experience of suicide. The lived and living experience workforce can include numerous positions within clinical, non-clinical and community health and mental health services, as well as those in advocacy and advisory positions. They are employed to provide discipline-specific expertise, knowledge and skills based on their lived and living experience.

Means restriction

Removal or restriction of access to a lethal method changes the context of a potential suicide by preventing potentially fatal actions or forcing the use of a less lethal method.

Mental health and wellbeing

An optimal state of mental health, including as it relates to people with lived or living experience of mental illness or of psychological or suicidal distress. It can also be used to refer to the prevention, avoidance or absence of suicidal distress or mental illness.²⁴

Multicultural communities

This includes people who or whose families have migrated to or entered Australia through a variety of pathways including through humanitarian, family, child and skilled migration. This term includes people on working visas, people seeking asylum in Australia, people on temporary protection visas, undocumented migrants, refugees, people on provisional spouse visas, international students, people who have been trafficked and people born in Australia whose families migrated to Australia. It includes people from a wide range of cultures, ethnicities and faiths who speak a variety of languages, and both well-established and newer communities.

Neurodiverse

Neurodiversity refers to the diversity of all people. It is often used in the context of autism spectrum disorder as well as other neurological or developmental conditions such as attention deficit hyperactivity disorder or learning disabilities.

Postvention

A range of suicide prevention activities that support people following a suicide, including psychosocial supports (such as employee assistance programs), practical supports, counselling and bereavement services. They are essential in helping people to cope with suicide loss and in reducing further suicidal distress.

Social and emotional wellbeing

An inclusive term that enables concepts of mental health to be recognised as part of a holistic and interconnected Aboriginal view of health that embraces social, emotional, physical, cultural and spiritual dimensions of wellbeing. Social and emotional wellbeing emphasises the importance of individual, family and community strengths and resilience; feelings of cultural safety and connection to culture; realising aspirations; and experiencing satisfaction and purpose in life.

Substance use and addiction

This incorporates a diversity of experiences related to alcohol and drug use. For the purposes of this document:

‘Substance use’ refers to the use of alcohol or other drugs, both legal and illegal. In some cases, substance use may become harmful to a person’s health and wellbeing and have other related harms, including impacts on family and supporters.

‘Addiction’ is a medical term used to describe a condition where someone continues to engage in a behaviour – in this case substance use – despite experiencing negative consequences. The medical term for a substance addiction is a ‘substance use disorder’, although not all people with a substance use disorder experience symptoms like physical dependence or withdrawal.

Stigma

When someone views a person in a negative way because of a particular characteristic or attribute. Stigma can lead to discrimination. Stigma is a fundamentally social process because different characteristics or traits are not inherently negative but become seen and treated as negative by individuals or groups in society.

Suicidal distress

An umbrella term that refers to and encompasses a range of thoughts, feelings or behaviours that may or may not be experienced by someone who is thinking about suicide or who has attempted suicide. It can typically be categorised as feelings of helplessness, fear, despair and worthlessness, among others, and should be differentiated from general psychological distress, where there are no presenting suicidal thoughts or behaviours.

Suicidal thoughts and behaviours

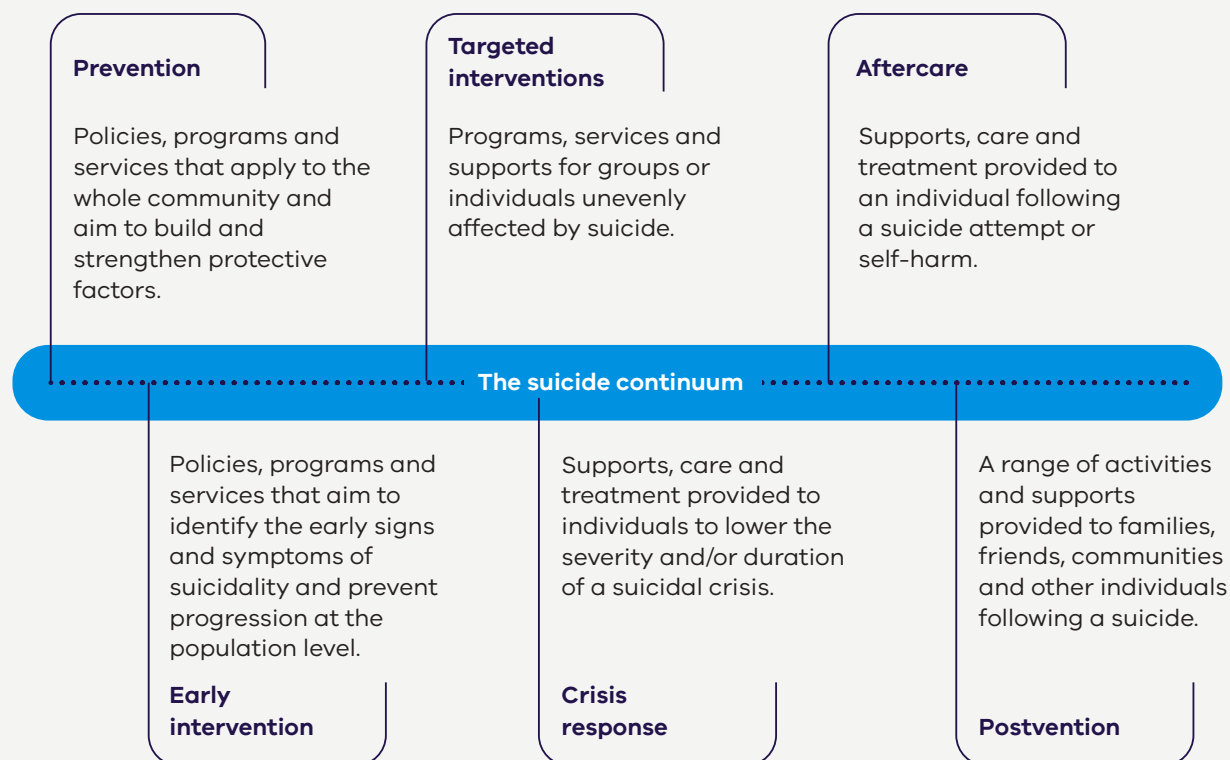
Thinking about or planning a suicide (suicidal ideation), attempting suicide or a person taking their own life.²⁵

Suicide attempt

An intentional act of self-harm with intent to die.

Suicide prevention and response continuum

Thinking about suicide prevention and response on a continuum can be a useful way of framing experiences and identifying our opportunities for intervention.



Trauma-informed

An approach that promotes wellbeing by ensuring the policies, procedures and environments in a workplace, school or healthcare setting, for example, are mindful of people's trauma histories and support the physical, psychological and emotional safety of its workforce. Trauma-informed care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatise.²⁶

Wellbeing

A positive, holistic state of being where people feel good and can function well in their personal lives, in their relationships with others, and as members of their communities and society more broadly. Wellbeing can be experienced whether a person is experiencing mental illness and psychological distress.

Whole-of-government

An approach to working that involves input and consideration from different areas of government (for example, health, justice, education and transport) to achieve shared goals. This differs from an approach where actions and outcomes are tied to a specific area.

Notes



- 1 Refer to World Health Organization 2014, Preventing suicide: a global imperative <<https://www.who.int/publications/i/item/9789241564779>>.
- 2 Sources: AIHW National Mortality Database and ABS Causes of Death, Australia, 2024.
- 3 Refer to the Royal Commission into Victoria's Mental Health System final report, vol. 2 <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>, p. 458.
- 4 Refer to the Royal Commission into Victoria's Mental Health System final report, vol. 2 <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>, p. 451.
- 5 Refer to the Royal Commission into Victoria's Mental Health System final report, vol 2 <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>, p. 451.
- 6 Refer to Suicide Prevention Australia 2016, The Ripple Effect: Understanding the exposure and impact of suicide in Australia <<https://www.indigenousjustice.gov.au/wp-content/uploads/mp/files/resources/files/understandingexposureimpactsuicide-layout-full-web-single-scroll-1.v1.pdf>>, p. 7.
- 7 Refer to Coroners Court 2024, Annual suicide data report, December 2023 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>>.
- 8 Refer to Australian Institute for Health and Welfare: Deaths by suicide over time, <<https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time>>
- 9 Refer to Coroners Court 2024, Monthly suicide data report, June 2024 update <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>>.
- 10 It is important to note that Victoria's suicide frequency can vary substantially from month to month and annually. This is not unique to Victoria – it is a feature of suicide data around Australia and the world. Suicide numbers may change as the Coroners Court of Victoria investigates each suspected suicide.
- 11 Refer to Coroners Court 2021, Monthly suicide data report, December 2020 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2021-01/Coroners%20Court%20Monthly%20Suicide%20Data%20Report%20-%20December%202020.pdf>>.
- 12 Refer to Coroners Court 2024, Monthly suicide data report, June 2024 update <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>>.
- 13 Refer to Australian Bureau of Statistics: Associated causes of death in mortality <<https://www.abs.gov.au/articles/associated-causes-death-mortality>>.
- 14 Refer to Recognising and supporting Victoria's carers – Victorian carer strategy 2018–22 <<https://www.carersvictoria.org.au/media/1091/dhhs-victorian-carer-strategy.pdf>>.
- 15 Refer to the Australian Institute for Health and Welfare: Deaths by suicide among young people <<https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-among-young-people>>.
- 16 Refer to Coroners Court 2024, Annual suicide data report, December 2023 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>>.

vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>.

¹⁷ Refer to Coroners Court 2024, Suicides of Aboriginal and Torres Strait Islander people, Victoria 2018–2023 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-03/Suicides%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20people%20in%20Victoria%2C%202018%E2%80%932023.pdf>>.

¹⁸ Refer to Coroners Court 2024, Annual suicide data report, December 2023 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf>>.

¹⁹ Refer to Dwyer J, Dwyer J, Hiscock R, O'Callaghan C, Taylor K, Millar C, et al. COVID-19 as a context in suicide: early insights from Victoria, Australia, Australian and New Zealand Journal of Public Health 2021 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8441721/>>.

²⁰ Refer to Coroners Court 2024, Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018–2023 <<https://www.coronerscourt.vic.gov.au/sites/default/files/2024-03/Suicides%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20people%20in%20Victoria%2C%202018%E2%80%932023.pdf>>.

²¹ Refer to the Victorian Aboriginal affairs framework 2018–2023 <https://content.vic.gov.au/sites/default/files/2019-09/Victorian-Aboriginal-Affairs-Framework_1.pdf>.

²² Refer to the Royal Commission into Victoria's Mental Health System final report, vol. 1 <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>, p. 659.

²³ Refer to the Australian Institute for Health and Welfare: Suicide and self-harm monitoring <<https://www.aihw.gov.au/suicide-self-harm-monitoring/summary>>.

²⁴ Refer to the Royal Commission into Victoria's Mental Health System final report, vol. 1 <<https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report>>, p. 665.

²⁵ Refer to the National suicide prevention strategy for Australia's health system: 2020–2023 <<https://www.health.gov.au/resources/publications/national-suicide-prevention-strategy-for-australias-health-system-2020-2023>>, p. 70.

²⁶ Refer to Phoenix Australia: Trauma-informed care <<https://www.phoenixaustralia.org/consultation-services/trauma-informed-care/>>.