Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF LOUISE FLYNN

I, Louise Flynn, Manager, Support After Suicide, of 326 Church Street, Richmond, Victoria 3121, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Please detail your background, qualifications and expertise.

2 I work at Jesuit Social Services as the Manager of the Support After Suicide program (**Program**). I have worked there for over 14 years.

3 I have been a psychologist for 25 years. For about 16 years, I have worked with people bereaved by suicide.

4 I hold a Bachelor of Arts and a Bachelor of Education (Counselling). In 2015, I completed my Doctor of Philosophy at La Trobe University. My thesis focussed on people bereaved by suicide and the benefits of support groups for those people.[1]

Please describe your role and responsibilities.

5 As stated above, I am the Manager of the Support After Suicide program (explained further below) operated by Jesuit Social Services. As manager of the program, I coordinate the program, supervise the counselling team, and I also provide counselling, facilitate group work, provide education and training to professionals, and facilitate community information sessions for people bereaved by suicide. The role also involves overseeing the online community of bereaved people and social media.

Jesuit Social Services

6 Jesuit Social Services is a work of the Australian Jesuit Province. It is an incorporated organisation and registered charity, and has an independent board of directors.

7 Jesuit Social Services has been operating since about 1977. Jesuit Social Services offers support and hope to the most disadvantaged and vulnerable people in our community. It seeks to change policies, practices, ideas and values that perpetuate inequality, prejudice and exclusion.

[1] http://arrow.latrobe.edu.au:8080/vital/access/manager/Repository/latrobe:41990.

Mental health and wellbeing services

8 In relation to mental health and wellbeing, Jesuit Social Services' programs and advocacy specifically focuses on young people at risk, including marginalised young people aged 16-28 years experiencing high and complex needs, including homelessness, substance abuse and engagement with the criminal justice system.

9 Our mental health and wellbeing work includes counselling, outreach support, group work, assistance with education and training and therapeutic outdoor activities.

10 In 2017-18, Jesuit Social Services delivered five mental health and wellbeing programs:

(a) As noted above, **Support After Suicide** provides counselling, groups and online support and resources to assist people of all ages bereaved by suicide. It also involves delivery of training to health, welfare and education professionals and information sessions for the community.

(b) **Connexions** supports young people with complex needs through counselling and outreach to reduce the harm of substance abuse and deal with mental health concerns.

(c) The **Outdoor Experience (TOE)** engages young people who have alcohol and drug problems in meaningful, safe and appropriate therapeutic adventure activities and journeys.

(d) **Artful Dodgers Studios** offer a flexible and welcoming space for young people to work in fully equipped art and music studios, so they can improve their social connection, self-esteem and employability skills.

(e) **Individual Support Program** provides intensive, flexible, multi-disciplinary and individual support to people with highly complex needs.

11 Jesuit Social Services supported over 1,400 people through these five programs in 2017-18.

Who does Jesuit Social Services serve?

12 Jesuit Social Services works with people in Victoria, New South Wales and the Northern Territory, but mostly operates in Victoria. We help people regardless of where they are based, but some of the programs are location-based.

13 Jesuit Social Services works with various vulnerable groups in the community, including:

(a) disadvantaged and marginalised communities;

(b) people with multiple and complex needs;

(c) people involved or at risk of entering the youth and adult justice systems;

(d) boys and men who are in trouble or causing trouble;

(e) Aboriginal and Torres Strait Islander communities;

(f) people and families seeking asylum; and

(g) people who are bereaved by suicide.

Briefly, how is Jesuit Social Services funded?

14 The majority (65%) of Jesuit Social Services' income is derived from state government funding. A small portion (4%) of its income is derived from federal government funding. The rest of its income is income generated directly through Jesuit Social Services (for example, through selling books), through its service agreements with non-government organisations, and public and philanthropic donations.

How does Jesuit Social Services fit within the mental health system?

15 Jesuit Social Services' programs focus on supporting young people dealing with mental illness and substance abuse, as well as people impacted by the suicide of a loved one.

16 Jesuit Social Services' programs and advocacy specifically focus on young people at risk, including marginalised young people aged 16-28 years experiencing high and complex needs, including homelessness, substance abuse and engagement with the criminal justice system.

17 Our mental health and wellbeing work includes counselling, outreach support, group work, assistance with education and training and therapeutic outdoor activities.

Support After Suicide program

18 Support After Suicide is a suicide postvention program which means that it provides support to people after a death to suicide. That support involves counselling, group work, some online activities and support as well as information that is provided online. The support is provided by psychologists and social workers. Close to half of referrals come through the Victoria Police eReferral System (known as VPeR). We manage these referrals across the whole state.

19 We run a formal group program three times a year called the Early Bereavement group. The program runs for eight weeks and has a maximum of 8 participants.

20 We also run information sessions and provide education for other professionals such as psychologists and counsellors.

21 Jesuit Social Services has delivered Support After Suicide throughout Melbourne and regional Victoria since 2004. In 2017-18, Support After Suicide directly assisted 964 children, young people and adults bereaved by suicide.

Is the program tailored for particular groups?

22 The Support After Suicide program offers support to anyone who is bereaved by suicide. We run specific group programs for parents, partners and siblings. We also have a group program for men.

23 We also have particular groups for children and young people.

Who can use the program? Who uses the program the most?

24 Anyone who has lost someone to suicide can access the Support After Suicide program. Most of our participants are first-degree relatives of the person who was lost by suicide – parents, partners, siblings and children (of any age).

25 For the formal group program we tend to help people who have lost someone more than 3 months ago and less than 18 months ago. Our experience is that these people are able to speak about their experience in a group setting and able to listen to others, as their acute trauma symptoms have subsided so that we are able to help them in the best way possible. The feedback we receive from participants of this group is that it is of great benefit to them.

26 Occasionally we help someone who has witnessed someone suicide or found someone who has suicided. My experience is that this group of people usually need help for a shorter period of time.

Briefly, how is the program funded?

27 The Support After Suicide program is primarily funded by the Federal Government through the Primary Health Networks (PHN). The program does not receive any funding from the Victorian Government.

28 The program is funded by four of the 6 Victorian PHNs (South Eastern Melbourne PHN, North Western Melbourne PHN, Gippsland PHN and Western Victoria PHN. Each PHN has different templates for work plans, reporting and evaluation requirements, and also different reporting regimes with some quarterly and some six-monthly. The administration and paperwork is very time consuming.

29 Funding is provided on an annual basis. Notification of ongoing funding tends to come close to the end of the funding cycle. This creates some anxiety as we look at our budget and planning for the next financial year. It also leads to some stress particularly

in relation to the people we are supporting. It would have a significant and detrimental impact if we were to lose funding. We have a dedicated staff team who continue in their roles despite the uncertainty.

30 It is also the case that we do not receive enough funding to do the work we do. Jesuit Social Services supplements the program from its own funds.

What does it mean to say someone is "bereaved by suicide"?

31 The term 'bereaved by suicide' is a term to describe someone who is significantly affected, either short term or long term, by a suicide death of someone close to them. This doesn't necessarily need to be a relative, but it often is.

32 A person bereaved by suicide will often have their life and day-to-day functioning disrupted, and they are acutely distressed and traumatised as a result of the suicide.

Are there any differences between those bereaved by suicide, and those bereaved by other modes of death? If so, what are those differences?

33 In my experience, there are some shared experiences between those bereaved by suicide and those bereaved by other modes of death, particularly those other deaths that are sudden, unexpected, traumatic and violent.

34 But when someone has deliberately and intentionally ended their own life, it does result in a unique and difficult experience for those close to them. The people I have worked with often say that they feel guilty, or they feel like they failed the person, or that they have let them down; they question whether they caused it or could have prevented it. A person bereaved by suicide often has a relentless and distressing experience of trying to understand how it could have happened. Losing someone to suicide also often has a harmful effect on their sense of self as it undermines self-esteem and confidence. Many also speak about feeling shame and experiencing blame. Family breakdown and estrangement can occur as a result.

35 In my experience, all of these experiences can have a subsequent impact on the mental health of the person bereaved by suicide. They themselves will often suffer psychological distress, will not be able to function or work, or will suffer anxiety.

36 It is also the case that people's experience with the mental health system before the person died can add to the distress of those who are grieving. In some situations, they say they feel let down by the mental health system. We are currently preparing a report that will document experiences of the health and mental health system before the person died. We are looking to see what services people attended and an indication of the quality of the service provided.

37 There is research evidence that people bereaved by suicide are at increased risk of suicide themselves. While there is an acknowledgement of this in suicide prevention strategies it is not often given priority in funding. In our work in Support After Suicide we are very aware that providing care and support to people bereaved by suicide is a suicide prevention strategy. We also see that it reduces the adverse effects on people's mental health and wellbeing.

Is stigma an element of the experience of bereavement after suicide? If so, in what ways?

38 In my experience, people bereaved by suicide experience stigma. Not everyone has this experience but many do. People I work with have told me that sometimes others in their social network avoid them, sometimes by crossing the street so as not to interact with them; that there is a silence around them in that people don't talk about or mention the death or speak about the person who died. Sometimes there are insensitive responses relating to the death and why the person died or negative attitudes expressed about the person who died. These are very distressing to the bereaved.

What is internalised stigma? Is internalised stigma experience by people bereaved after suicide? If so, in what ways?

39 Internalised stigma, sometimes called 'self-stigma', is a term used to describe the devaluation and shame that is triggered by applying negative stereotypes to oneself because of, for example, losing someone to suicide. It is something that is experienced within the person. This is different to the stigma that is experienced when others devalue or isolate a person.

40 Internalised stigma is an element of the experience of bereavement after suicide. In my experience often people bereaved by suicide will say that they feel shame and failure because of the death; or they may say that they feel tainted or less of a person by the death. They may be concerned about what others think of them because this has happened. Others have told me that they have concealed the cause of death to others, or not told someone that the death was as a result of suicide. Some people have told me that they feel like an outsider, or feel like less of a person as a result of the suicide.

41 Stigma, whether social or internalised, is damaging in a number of important ways. It can prevent people from seeking help as they may be worried that they will be judged harshly. Research indicates that stigmatised people experience lower self-esteem and quality of life, and tend to withdraw socially.

What impacts can stigma or internalised stigma have on people bereaved after suicide?

42 In my experience, stigma or internalised stigma can impact on a person's self-esteem, engagement and participation in community life. Often it can be a barrier to seeking

help, for fear that the person will be blamed or seen as responsible for the death, and it can impact on their own mental health. In particular, there is research to suggest that exposure to suicide is itself a risk factor for suicide.

Does the lack of social conventions or rules for discussing suicide affect people bereaved by suicide? If so, how?

43 Yes, there does seem to be a lack of social conventions or norms for discussing suicide. People have told me that when a loved one has died from a different mode of death, people come forward and help, send cards or flowers or talk about it, but when someone has died from suicide, they have experienced a different response. I am told that people will move away, or they won't call, or there is a level of discomfort, awkwardness and silence. This has the effect of bereaved people feeling isolated and abnormal. This doesn't happen in every circumstance but it is a common enough occurrence to be a theme that is spoken about in many of our support groups.

44 Suicide seems frightening to people, and I think people have an over-simplified understanding of suicide; that it is caused by a single event or caused by mental illness. Many people don't understand that it is very complex and so they do not know how to talk about it when it happens. They don't know what to say to the bereaved; they don't know how to speak about the person who has died. In my experience, this can leave the bereaved feeling very isolated and alone, and a bit like an outsider in society.

Exposure to suicide has been identified as a risk factor for suicide. What interventions are effective in reducing this risk factor?

45 In our work at Support After Suicide it is not unusual for us to be seeing someone who is struggling with suicidal thoughts as a result of the bereavement. In my experience, counselling is a very effective method at reducing the risk of suicide. Group support is also very important as participants regain a sense of community and belonging. My experience as a psychologist is that we can assist people with their suicidality and assist them to understand what is happening for them and how they can stay safe. We will engage with other services if needed, e.g. GPs and mental health services.

Based on your research, which interventions are particularly useful or beneficial for people bereaved by suicide?

46 For many people, in my view counselling and group support are crucial. Counselling needs to take into account grief and bereavement, trauma and stigma. Counselling needs to address the impact of suicide on a person's social network as well as the psychological effect of losing someone to suicide.

47 In my experience, group support also restores a sense of belonging and connection, aids in understanding why the person took their own life, and increases a person's ability to speak about what has happened.

48 We also provide information and education about bereavement, trauma and suicide. Much of our information is online. This is very helpful and comforting for some people.

49 Often we find that innovative programs can reach those who may not suit counselling and groups: for example arts-based programs, writing with other bereaved people. These are often useful programs for young people and men.

50 In my view, a general focus on mental health and wellbeing is important. We want people to have a restored sense of being able to participate in life.

In your experience, are there sufficient services available in Victoria for people bereaved by suicide?

51 In my view, there are not enough services available in Victoria for people bereaved by suicide. This is the case in metropolitan Melbourne and even more so in regional and rural areas. While Support After Suicide operates in some regional areas, its ability to provide robust services, in spite of increased demand, is limited due to restricted funding.

52 My view is that Support After Suicide is seriously underfunded. We are not able to respond to all the requests for support that we receive. For example, we would like to have more counselling locations in metro Melbourne and in rural and regional areas – even by phone or Skype – but we don't have enough funding to do this. We are also limited in the number of education sessions we can provide.

53 Our formal group programs are always full. We do not take more than eight people for the eight week program because we need sufficient time for each person to have their turn speaking. That is an important part of the therapeutic model.

54 We do not advertise our services because we do not have capacity to assist any more people. Our clients come through referrals from Victoria Police, Coroner's office, our website and a range of other education, health and welfare services.

What needs to be done in Victoria, if anything, to better assist people bereaved by suicide?

55 There needs to be more services to help people bereaved by suicide. It is an acutely difficult experience with serious implications for mental health and wellbeing. People's participation in work, study and community life can be severely restricted by the

experience as well as increasing the risk of suicide for some. Making it a priority in terms of funding is essential. The current funding model is insecure, leads to fragmentation of services and not enough people receive support when they want it.

56 Jesuit Social Services has built strong relationships with the Primary Health Networks that fund Support After Suicide to deliver services in Victoria. However, as already noted each PHN has different reporting and evaluation requirements, which places a sizable administrative burden on Support After Suicide.

57 To better assist people bereaved by suicide, in my view the Victorian Government needs to commit to secure and expanded funding for postvention, early intervention services for suicide bereavement, including Support After Suicide.

58 Another aspect of postvention support that can be beneficial is assisting communities to respond after a suicide. This is important in terms of avoiding potential clusters of suicide. There is a range of models that have been developed or are currently being developed that have been helpful to communities. Support After Suicide participates in a number of these initiatives.

59 There is emerging research on how postvention services reduce the risk of suicide. Another issue is that research funding is required to develop a strong evidence base on the impact of suicide on others, and the effectiveness of bereavement support in reducing risk.

What do you consider to be the most significant challenges facing the mental health system in suicide prevention and supporting people affected by suicide?

60 My experience is that the bereaved are affected by the quality of care that their loved one received from the health and mental health systems before they died; they may be distressed because of the sometimes poor or inadequate quality of care provided before the person died.

61 Support After Suicide has consulted with our participants about their experiences with the mental health system. Participants in the past have told me that:

(a) there are uncaring and/or judgmental attitudes from professional staff;

(b) carers are not listened to or are not included in care;

(c) there is a lack of coordination of care, that the system is fragmented and difficult to navigate, and there is a poor system of providing referrals; and

(d) there is often a lack of information about the person's diagnosis, medication, side effects, discharge plan, risk of suicide, or how to support the person.

What key changes to the mental health system do you consider would bring about lasting improvements to Victoria's ability to prevent suicide and support people affected by suicide?

62 In my view some of the key changes are as follows:

(a) Implementation of different models of care for people who are suicidal and attend Emergency Departments (ED) and mental health units. One example is the Zero Suicide framework that when implemented leads to a more collaborative and compassionate attitude and approach to people. Latrobe Regional Health and the Gold Coast Mental Health Service are two services that have been implementing this framework. The framework More information can be found on the website: http://zerosuicide.sprc.org/

(b) Implementation of current suicide management strategies (e.g. Collaborative Assessment and Management of Suicidality, CAMS). CAMS is a therapeutic framework for psychologists and others who are working with suicidal people. It provides a comprehensive, evidence-based model of assessment and care for people who are suicidal. More information can be found at: https://cams-care.com/

(c) Implementation of proactive referral and follow-up from those attending ED such as the current HOPE trials.

(d) The establishment of short-term residential, non-medical care for people following a suicide attempt or for those in a suicidal crisis (for example Maytree in the UK).

(e) Specific care provided for at risk groups, including Aboriginal and Torres Strait Islander people, the LGBTQI+ community and those in contact with the justice system.

(f) Secure, long-term funding for postvention and early intervention services for suicide bereavement support, including Support After Suicide.

(g) Mental health teams making themselves available to speak with family and friends after someone has taken their own life.

(h) Establish suicide postvention protocols (coordinated response in a community after a suicide, particularly of a young person in order to reduce the possibility of a cluster).

sign here ► 

print name Louise Flynn

date 5 July 2019