Roses in the Ocean

stemming the tide of suicide

Submission to the Victorian Suicide Prevention and Response Strategy consultation

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August 2022

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The development of Victoria's next Suicide Prevention and Response Strategy comes at a critical moment of many coinciding developments in the suicide prevention field including:

- Implementation of the recommendations from the Royal Commission into Victoria's Mental Health System
- Implementation of the National Mental Health and Suicide Prevention Agreement
- Increasing suicide risk in the community due to the ongoing effects of COVID-19, climate disasters, rising cost of living and economic uncertainty

Roses in the Ocean strongly endorses Victoria's direction in suicide prevention reform. We note with gratitude the emphasis the Victorian Government is placing on meaningful partnership with people with lived experience of suicide in the development, implementation and evaluation of suicide prevention initiatives.

We would also like to highlight the following issues for consideration in addition to the commendable actions the Victorian Government is already taking in suicide prevention reform and the development of the Strategy. These additional proposals are offered in the context of general support for the content of the discussion paper previously distributed for the Strategy's consultation, including the priority groups identified in that paper.

An overarching vision for zero suicides

A vision of 'Towards Zero Suicides' appropriately captures the fundamental aspiration of suicide prevention – for there to be no deaths from suicide. It also avoids the problematic territory of establishing any other goal or target besides zero.

Where targets for suicide prevention are introduced, such as the 20 per cent reduction target established in NSW alongside that state's 'zero suicides' approach, a communications problem is created almost immediately. How has the target been formulated? Who is the focus of the 20 per cent target, and who is allocated to the remaining 80 per cent? Ethical questions relating to a perceived acceptance of a certain level of suicide in the community are raised. Opportunities to reach the target by manipulating data or taking superficial or unsustainable actions become a focus, diverting attention from the real goal of preventing suicides. Currently, there is insufficient evidence in suicide prevention to credibly set a target with a viable method for its achievement.

For these reasons, it is recommended that a zero suicides aspiration be the overarching vision for the Strategy without the complication and distraction of debating, identifying and reaching targets.

A secondary point however is that the objective of the Strategy should not only be limited to the prevention of death by suicide (by for example further restricting lethal means), but also to reduce the levels of distress in the community that lead to suicidal thinking and suicide attempts. There is significant personal, social and economic cost arising from all three of these phenomena (suicides, suicide attempts and suicidal thinking), so the focus of the Strategy should importantly promote a more compassionate society in which early intervention and primary prevention are widely available.

Principles and priority areas

Meaningful partnership with people with lived experience

People with lived experience must be at the centre of suicide prevention and responses to suicides, and this is the single most critical structural change required in the suicide prevention field.

Building meaningful and multi-faceted partnerships with people with lived experience into the Strategy will provide:

- Crucial insights into the effectiveness or otherwise of systems and services contributing to suicide prevention and responses to suicides,
- Highly sought after peer support from people experiencing or recovering from a suicidal crisis or bereaved by suicide, and
- Accountability for suicide prevention and postvention initiatives to be well designed, informed by lived experience, effectively managed and accessible to the people who most need them.

It is important however that this partnership be real in more than a stated principle. There are several actions or initiatives that logically extend from a position of centring people with lived experience of suicide. These include:

- Investment in comprehensive development of the skills and capability of people with lived experience,
- Significant and supported involvement of people with lived experience in governance arrangements, including for the implementation of the National Agreement, and
- Expansion of the suicide prevention peer workforce in multiple settings across the suicide prevention system.

These proposals are expanded on further below in Actions & initiatives.

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A genuinely whole of government approach

A whole of government approach has become a longstanding reference in the suicide prevention field but few jurisdictions have managed to create this approach in reality. The rationale for a whole of government approach is well known: the causes of the personal crises that lead to suicide are largely located beyond the remit of the health system. Currently, the focus of suicide prevention being primarily in the health system has created burden on emergency and crisis responses without corresponding attention to reducing the number of people requiring these responses.

To make a whole of government approach meaningful, the following features are required:

- The Premier and ministers of key portfolios with relevant whole of government responsibilities for suicide prevention should jointly sign the Strategy. This will prevent the bureaucracy from being hamstrung by a Strategy endorsed by the Health Minister but lacking the cross-departmental ownership needed for prioritising suicide prevention outside of Health. This ministerial level endorsement should be followed by senior executive departmental participation in energised governance arrangements that take forward the implementation of the Strategy and maintain accountability for departments' engagement with their responsibilities under the Strategy.
- Departments should be supported to systematically engage in a lived experience informed cultural change process that builds lived experience capacity within departments and reviews departments' activities for their contribution to or alleviation of suicide risk in the community. Roses in the Ocean submitted a discussion paper on this process to the Victorian Government earlier in 2022 (attached).

Actions & initiatives

Develop the skills and capabilities of people with lived experience of suicide

As stated above, effective suicide prevention and responses to suicides require a well supported community of people with lived experience of suicide.

This begins with making training opportunities available to prepare people with lived experience to safely and purposefully discuss their lived experience, contribute to co-design, governance and advisory processes, and break the stigma and silence that discourages people at risk of suicide from accessing the help they need. Many people with lived experience of suicide describe transformative healing effects when provided the capabilities and opportunities to contribute to suicide prevention and postvention through these and other activities.

Developing the lived experience movement is a critical step to reshaping attitudes towards suicide within local communities, but it also has the potential to create far reaching structural and cultural reform of the suicide prevention system. There are many contexts throughout suicide prevention that can be strengthened by greater and more robust lived experience participation including commissioning of services, evaluation research and policy development.

Training and ongoing debriefing and support, as well as the continued leadership of the Victorian Government in signalling the importance of partnering with people with lived experience, are essential to fulfil the potential of lived experience engagement across the Strategy's priorities. This is an especially key point in the context of the National Mental Health and Suicide Prevention Agreement which commits jurisdictions to a more significant role in suicide prevention. Although the implementation of Victoria's bilateral schedule is in its early stages, it is of concern that the schedule itself does not fund anything specifically in relation to people with lived experience of suicide. (This is not a unique result for Victoria. Every bilateral schedule under the Agreement contains this notable oversight.) This means attention must be paid to developing the capacity amongst the Victorian community for people with lived experience to become the key partners in design and implementation sought by the Victorian Government.

Expand the suicide prevention peer workforce across various settings

Building on the previous point, all suicide prevention services can be enhanced by a suicide prevention peer workforce. Peer support is increasingly recognised as one of the most important tools in suicide prevention but it remains under-resourced and out of reach for many people in distress.

The Victorian Government is expanding its peer support workforce available through the Hospital Outreach Post-Discharge Engagement program. It would be highly desirable to see this commitment extend to many other initiatives so that suicide prevention peer workers are available for people throughout the service system and not only in an aftercare context. Suicidal thinking is a frightening and isolating experience and peer workers can play a critical role in providing a trusted and understanding space for people in distress who may be reticent to disclose their thoughts to clinical staff.

Particularly with the current workforce shortages in the health system, peer workers can make an important contribution to alleviating pressure on emergency staff, general practice and psychiatry and psychology services facing long wait times. Both government and non-government organisations can be appropriate locations for an expanded suicide prevention peer workforce.

Diversify peer support options

An excellent supplement to formal suicide prevention services are peer-based group support programs such as Alternatives to Suicide. These innovative approaches have been gaining in popularity around the world and in Australia, and represent ongoing and low cost options particularly for people who live with enduring suicidal thinking but also those experiencing periodic suicidal thoughts.

They also have the potential to alleviate demand for crisis services by providing opportunities for early intervention in local communities. Even modest investments would be sufficient to resource this type of service which would provide a currently unavailable additional option for people at risk of suicide.

Non-clinical alternatives to emergency and in the community

Significant momentum has developed towards expanding non-clinical alternatives for people seeking help for suicidal thinking or a suicidal crisis. Despite the appeal and innovation of such services their coverage and accessibility for the community are still extremely limited.

Given emergency departments will continue to be a primary source of help for people in acute distress for the foreseeable future, these services ought to be accessible in or close to hospital emergency departments, like the case of the Safe Haven service at St Vincent's Hospital in Melbourne. However, we must establish more non-clinical services, staffed by peer workers, ~~should also be~~ available in the community so that people with sufficiently low acuity do not feel they have no option other than to present to emergency and have more appropriate alternatives than doing so.

The integration of such services, whether within hospitals or in the community, with the wider service system requires support alongside their establishment so that connections can be promoted through phone support services, general practice, counselling and other mental health services, and the many other sectors that are frequently in touch with people in distress, such as homelessness, legal, post-correctional and financial services. This is also important for raising the recognition of the validity of this type of service among more established or mainstream systems.

Prioritise suicide prevention in the mental health system

People with severe mental health conditions are at high risk of suicide, indicating that the state mental health system should methodically prioritise suicide prevention. The Zero Suicides Healthcare approach, widely applied in many settings globally and with significant evidence for its effectiveness, emphasises the identification and treatment of suicidal symptoms as a primary focus, rather than viewing them as secondary to, and resolved incidentally by, treatment of any associated mental illness.

Although many clinical and non-clinical staff may already be making effort to prioritise suicide prevention in their work, the Zero Suicides Healthcare approach takes a more systemic approach to staff safety, service quality, leadership, culture, team work and care pathways for people experiencing suicidal thinking or actions. Importantly, it strongly values lived experience involvement and the care and support of people bereaved or impacted by suicides within the health system.

While efforts should be made to position suicide prevention as a whole of government responsibility with greater increased suicide prevention activity within the community, it is equally appropriate that the state mental health system prioritise the prevention of suicide among its consumers, given that this is technically one of the easiest groups to reach. It is important that suicide prevention be emphasised in both inpatient and community settings to support the system-wide culture change promoted by a Zero Suicides Healthcare approach, and to keep pace with the increasing delivery of mental health care in the community. This approach provides yet another opportunity to utilise a specialised suicide prevention peer workforce to enhance the experience for people within the health system.