Roses in the Ocean
stemming the tide of suicide

Roses in the Ocean response to the Tasmanian Suicide Prevention Strategy Consultation Draft

1. Do you agree with the general vision, priority areas, and actions of the strategy?

The draft Strategy is clearly comprehensive and the general vision, priority areas and actions of the strategy are well informed. Key strengths include expanding the availability of Safe Havens in Tasmania, further developing the Tasmanian Suicide Prevention Community Network, and increasing Tasmania's whole of government / cross-agency approach. The role of people with lived experience in the development of the current draft is very welcome.

There could be further improvements however by more specifically strengthening the commitment to lived experience leadership and involvement throughout the Strategy. Although the first sections of the Strategy place emphasis on this point as a fundamental principle for suicide prevention in Tasmania (for example the statements referring to design and implementation based on lived experience knowledge (p.10), the explanation of the first priority on p.15 and the commendable content of Action 1.1.), this emphasis fades as the Strategy progresses with many subsequent actions providing no reference to people with lived experience being specifically engaged or involved in their design, implementation or evaluation. This may seem a minor or superficial point about the use of language, however, it is based on a significant and well-founded concern that unless the specific means of partnering with people with lived experience for each action is described, this engagement may not occur in practice. Greater consideration of and integration of the centring of people with lived experience of suicide throughout the Strategy's actions would be a substantial improvement.

This would also help guard against tokenistic approaches to lived experience involvement where, for example, an untrained and unbriefed person with lived experience is selected to attend a meeting about issues that are unfamiliar to them, simply so the claim of lived experience input can be made. Such an approach is considered poor practice in the lived experience space. People with lived experience should receive specific training to help them direct their lived experience in a purposeful and safe way, be provided with pre-briefing so they understand the context, terminology and key concepts of a meeting or event to which they are contributing, and never be the sole lived experience representative at any event.

Where the Strategy includes a reference to people with lived experience below some actions, there is scope to extend these activities further. For example, Action 2.1 refers to connecting lived experience of suicide peer workers into the service system. This could be strengthened to refer to community-based distress/crisis models being built around suicide prevention peer work as a primary element of the service so that peer support is offered first rather than only secondarily to clinical care and treatment. Action 3.2 refers to establishing a cross-agency working group that can work with other organisations and people with lived experience to co-design support options. A preferred re-framing of this point could include the cross-agency working group engaging people with lived experience of suicide within those agencies and/or having people with lived experience of suicide directly participating in the cross-agency working group.

1300 411 461
enquiries@rosesintheocean.com.au
www.rosesintheocean.com.au

Although it contains many commendable proposals, there are opportunities throughout the Strategy to further strengthen the Tasmanian Government's partnership with people with lived experience of suicide. This can only improve the likelihood that the Strategy will succeed by integrating the perspectives of people with lived experience with greater forethought into many areas of the Strategy's implementation.

2. Are the proposed actions sufficient to achieve the vision?

A more specific and clearer plan on the development of the suicide prevention peer workforce will increase the possibility of achieving the Strategy's vision. There is a surprising lack of content on this issue given how pivotal the support of peer workers is for people with lived experience of suicide. It seems the Strategy does acknowledge a plan to develop the capacity and leadership of people with lived experience, which is essential. Nonetheless, the same focus needs to be applied to the peer workforce, including recruitment, retention and training issues, as well as the cultural and organisational reforms needed to adequately support peer workers and reorient services to value their presence.

The proposed improvements to Tasmania's governance arrangements, where a new Premier's Mental Health and Suicide Prevention Advisory Council will include people with lived experience and will replace the Tasmanian Suicide Prevention Committee, are noted. Obviously the inclusion of people with lived experience of suicide in this structure is greatly welcomed, although the point made above about always ensuring there is more than one person with lived experience providing this representation should be observed.

However, the merging of mental health and suicide prevention has rarely served the interests of people with lived experience of suicide. This risks the likely outcome that suicide prevention becomes secondary to the Council's agenda, with the profound and widespread reform issues facing the mental health system (many of which are peripheral to or of very little relevance to suicide prevention such as NDIS access, seclusion and restraint practices, availability of the clinical workforce etc.) eclipsing the focus on suicide prevention, which requires a much broader, whole of community approach extending far beyond the mental health system. The increasingly recognised danger of conflating mental health and suicide prevention, or of positioning suicide prevention as simply one of many issues addressed by the mental health system, is that the very large number of people at risk of suicide who do not relate to the mental health system, will not access it, or have had negative and traumatic experiences within it, are not effectively reached. These issues need to be considered at the level of governance given this is such a key location for policy issues to be framed and responses devised. If the distinctions between mental health and suicide prevention are not expressed at this level, this oversight will have far reaching effects throughout the implementation of the Strategy. This may then counteract the Strategy's emphasis on broadening the approach of suicide prevention beyond the health system.

3. Are there any other actions you can suggest to achieve the vision of the strategy?

The need for greater focus on the mechanisms of developing the suicide prevention peer workforce is stated above. More explicit attention to providing non-clinical community-based approaches would also be warranted. For example, group-based peer support programs such as Alternatives to Suicide or Eclipse are important, innovative and low-cost forms of support that can help to reduce suicidality in the community and minimise people's need for acute clinical intervention. These models may be especially appropriate in rural and regional areas of Tasmania where strategies that prevent escalation to clinical services are most needed.

More generally, the whole of government / cross-agency content in the Strategy is meritorious. This can be more specifically strengthened by referring to causal or upstream factors that are driving people towards suicide (Action 3.2 goes some way towards this). Ultimately, any successful suicide prevention strategy will not only implement interventions for people in crisis (due to housing stress or job loss for example), but will also aim to prevent these crises from occurring in the first place (by ending homelessness and long term unemployment, to continue the example). Suicide's intersections with domestic and family violence, sexual assault, out of home care, justice including family law and corrections, and other major social policy problems require further consideration and action.

The uptake of the Connecting With People training program in Tasmania's health system has been an important achievement in recent years. Further uptake of the program throughout Tasmania's government and non-government organisations, particularly those that are in frequent contact with people in states of crisis or distress would be a key achievement for the forthcoming Strategy. Whole of government / cross-agency approaches to suicide prevention lack meaning without public facing staff across services being prepared and confident to provide compassionate responses to people in crisis.

4. How well does the TSPS reflect the experiences and needs of your community?

People with lived experience of suicide need state strategies to go further than ever before in bringing us from the margins of suicide prevention to the centre where we can play a meaningful and influential role. The draft Strategy is commendable for its significant statements that aim to make this a reality. We would encourage the Tasmanian Government to seek to make this a deeper commitment that explicitly extends throughout the Strategy. There are many areas where this is possible including in making co-design with people with lived experience of suicide mandatory for services, growing and supporting the suicide prevention peer workforce, and improving the quantity and diversity of lived experience representation and participation in programs, policy, surveillance, governance and research.

5. Do you think that the action areas will have a sufficient impact on service provision?

As noted above, greater attention to the peer workforce and on non-clinical models of support would improve the Strategy's impact on service provision. More broadly, it is important that there be more explicit reference to how services will partner with people with lived experience of suicide. Currently although the Strategy states this as an overall aim, the actions do not sufficiently carry this concept

through to implementation. This creates scope for services to not adhere to the concept in practice, as the view may be formed that lived experience involvement is corralled into one action rather than seen as a cross-cutting theme with relevance for every action in the Strategy.

6. What could be included in the TSPS that has not already been included?

Please note the comments above regarding peer workforce development and group-based peer support options. Additionally, a methodology for prioritising suicide prevention in the mental health system such as Zero Suicides Healthcare would be useful. Mental health systems often have confused or even ambivalent relationships with suicide, and a proven methodology that focuses attention on suicide prevention specifically, rather than as incidental to mental health treatment, would strengthen the Tasmanian mental health system's approach to suicide prevention and postvention.

7. What do you think success looks like for the TSPS?

Obviously in the medium term, a reduction in the suicide rate is the only viable success measurement for suicide prevention. However, in the short term, the centrality of people with lived experience throughout the Strategy's implementation, the effective adoption of a whole of government / whole of community approach that seeks to reduce causal factors that facilitate suicide risk, and more options for people at risk of suicide, including non-clinical alternatives, would all be regarded as indicators of success for the Strategy.

8. Are there any other comments you would like to add?

No further comments. Thank you for the opportunity for Roses in the Ocean to provide this feedback. Should you wish to discuss any of our comments further, please do not hesitate to contact us.