Expanding the suicide prevention peer workforce:

an urgent and rapid solution to Australia's suicide challenge

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stemming the tide of suicide

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Peer work is an untapped resource in suicide prevention

Peer workforces have developed in many areas of health and social services over the last decade or more. However, in the suicide prevention field, discussion of a peer workforce remains in its infancy. This is in part a symptom of the recency of any openness about lived experience of suicide (a necessary precursor for a suicide prevention peer worker) becoming regarded as even acceptable in the suicide prevention field.

Prior to this, people with lived experience of suicide were essentially invisible due to the now discredited belief that discussing one's experience of suicidal thinking or a suicide attempt, or even the death of a loved one by suicide, would promote suicide to others that had never considered it. As this myth is increasingly challenged and debunked, and more people with lived experience have grown willing to openly discuss their experience, calls for a peer workforce in suicide prevention (that is, people with lived experience of suicide providing support to others who are experiencing a suicidal crisis, suicide bereavement or supporting a loved one in crisis) have increased.

Another part of the reason for there being so little response to these calls to date, is the ongoing reticence and misunderstanding of governments about what people with lived experience of suicide are seeking in terms of a suicide prevention peer workforce, and concern about how to safely go about establishing and maintaining a peer workforce that is distinctively for the purposes of suicide prevention.

National policy calls for the expansion of suicide prevention peer work

The National Suicide Prevention Adviser and Taskforce's 2021 reporting recommended that 'all governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce' (Recommendation 2.3 Executive Summary). [1] Although the prominence of this recommendation is a milestone achievement, there is yet to be any substantial additional actioning of it.

The government response to the Taskforce's recommendations (in the 2021 update of the National Mental Health and Suicide Prevention Plan) refers to the 21-22 Budget commitment to 'support the peer workforce through up to 290 scholarships and opportunities for professional collaboration' (p.31). Unfortunately, these scholarships are being directed through state governments towards peer work in the acute mental health system, despite the recommendation arising from the reporting of the National Suicide Prevention Taskforce. The implementation of this commitment therefore risks

The National Suicide Prevention Adviser and Taskforce's 2021 reporting recommended that 'all governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce'

1 This recommendation makes a distinction between the 'lived experience workforce' which refers to the broad group of people with lived experience who can be or are trained and engaged to contribute to policy and programs in suicide prevention, especially through advisory structures and governance arrangements, but increasingly in lived experience policy, management or coordination roles. The 'lived experience peer workforce' refers to people engaged in specific, often paid roles, to provide support to people in crisis (whether from suicidal distress or following a suicide attempt, bereavement from suicide, or caring for someone who is experiencing suicidal distress).

missing this important opportunity to build a national peer workforce that is uniquely intended for suicide prevention.

Peer workers are mostly inaccessible to people at risk of or impacted by suicide

As the above example illustrates, activity for suicide prevention often defaults uncritically to the state-run acute mental health system. This is problematic in many ways, especially in the context of peer work:

- Many people die from suicide without any contact with the mental health system. A national study of over 10,000 suicides from 2010 to 2017 found that 49% of 15–64 year olds who died by suicide did not have any contact with hospital services (including emergency department presentations and inpatient admissions) in the year prior to their death, with men even less likely than women to have this contact (AIHW, 2022). An unpublished 2019 analysis in a large rural NSW local health district found that more than 80 per cent of the people who had died from suicide in that district were unknown to the state mental health service.
- Many people who are experiencing suicidal distress do not wish to seek help through the mental health system because of previous negative experiences when they have sought help through emergency departments. A Black Dog Institute study of experiences of people who had presented to emergency in suicidal distress found that almost half would never return to seek help with a suicidal crisis in the future (Rosebrock et al, 2021).
- Although some people experiencing suicidal distress may have diagnosed or undiagnosed depression or anxiety, these are often not the conditions for which people are admitted to acute mental health services. High acuity, low prevalence disorders such as schizophrenia, schizoaffective disorder and bipolar affective disorder dominate mental health inpatient admissions (AIHW, CMHC tables, 2019-20 by principal diagnosis). Depression and anxiety, regarded as low acuity, high prevalence disorders but nonetheless strongly implicated in suicides, make up only 10 per cent of mental health admissions.

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- As the mental health peer workforce is typically drawn from people with a history of admission to acute mental health services (indeed this experience is usually considered essential for mental health peer workers), the mental health peer workforce has extensive representation of people whose lived experience is drawn from their living with these high acuity low prevalence mental health conditions. Although this group has a high suicide rate, as do most priority populations in suicide prevention, there is a much wider group of people in the community at risk of and who die from suicide than people in contact with the acute mental health system.
- Situational distress, rather than (solely) mental illness, has been identified as a key driver of suicides in Australia (Ashfield, McDonald & Smith 2017). Psychosocial risk factors for suicide also point to a broad range of life experiences that have contributed to a death from suicide, rather than simply living with a mental health condition (ABS 2019, 2020). These include economic, legal, housing, interpersonal and other issues unrelated to mental health. Longstanding reform directions for a whole of government approach to suicide, as prioritised in every state, territory and national strategy or policy for suicide prevention, reflect this realisation.

- Peer workers employed in mental health systems, including in hospital-based and non-government services, are characteristically seen as an adjunct to clinical care. This may be partially due to much of this workforce having previously been patients in these systems, but more generally reflects the primarily clinical nature of these services, and the stratification of different forms of expertise and professions amongst the workforces that deliver these services. It is rare for mental health peer workers to have primary or even significant responsibilities in the care and support of people admitted to acute mental health services. This is even the case in many programs delivered by non-government organisations.

These issues combine to create a service environment that produces the following detrimental effects:

1. People who have experienced a suicidal crisis arising from situational distress or whose suicidality has not resulted in them being admitted to acute mental health services are not typically represented in the mental health peer workforce.

2. The peer workforce available to most people accessing emergency support for a suicidal crisis is located within acute mental health services, beyond the reach of a significant number of people at risk of suicide, and impossible to access without clinical care being the primary and sometimes mandated treatment.

This means that currently Australia is not providing peer support that is relevant and accessible to many people at risk of suicide, even when the danger to their lives is imminent.[2] Likewise, there is no strategy in place to provide peer workers to support 'carers' of people who are experiencing a suicidal crisis such as families, partners or close friends. This is despite this group having widespread and urgent need to gain support from others who have firsthand knowledge of what they may be experiencing.

> Suicide prevention peer workers should be located within services that do not require clinical treatment in order for the support of a peer worker to be accessed.

Suicide prevention requires peer workers with lived experience of suicidal crisis, including from a range of situational stressors. Peer workers for suicide prevention should not be restricted to people with a diagnosed high acuity low prevalence mental health condition resulting in high levels of contact with acute mental health services as is characteristic of the mental health peer workforce. Drawn from a broad cross section of lived experience, suicide prevention peer workers are needed by people in suicidal distress wherever they may be, including in emergency departments but also in many community and non-government settings. Importantly, they should be located within services that do not require clinical treatment in order for the support of a peer worker to be accessed. Indeed, they are ideally placed in services that are specifically non-clinical in nature but should nonetheless be far more widely available in both clinical and non-clinical contexts.

2 This is not to say that mental health peer workers do not play a critical, even undervalued role in supporting people experiencing severe mental health conditions. Peer workers in acute mental health systems can make important contributions to non-clinical service delivery, especially if their service recognises the value of peer support in the treatment of mental health conditions. Similarly, mental health peer workers should have an essential role in mental health services that prioritise suicide prevention in response to the high suicide risk among people with severe mental illnesses. Such a service approach would place great value on the participation of people with lived experience, including as peer workers, as is seen in examples such as the SafeSide or Zero Suicides Healthcare models.

Attempts to create a suicide prevention peer workforce have been very limited

Nationally, governments' efforts to build a peer workforce have been sparse and at times ineffective:

- Consistent with recommendations from the Royal Commission into Victoria's Mental Health System, that state's Hospital Outreach Post-suicidal Engagement teams (HOPE) have begun to include peer workers in a blended, clinical and non-clinical service model that provides aftercare to people who have made a suicide attempt. The HOPE program is itself also expanding from operating in 12 areas to 26 (22 adult and 4 youth) so state-wide coverage of peer worker support is still in progress.

- The NSW Towards Zero Suicides initiatives included peer workers in non-clinical alternatives to emergency departments referred to as Safe Havens and working alongside clinicians in Suicide Prevention Outreach Teams (SPOT). Some local health districts have struggled with the ambition of this reform and have not been successful in establishing these services. There is a high turnover of peer workers in most districts that have managed to establish the roles, with departing peer workers identifying ineffective implementation of peer worker roles in highly clinical settings such as emergency departments, and a lack of workplace support for non-clinical approaches. NSW also created a peer workforce in the Post Suicide Support suicide bereavement program that operates in Sydney and the South Coast of NSW. Peer-based 'postvention' [3] support in other locations outside of this limited catchment is very rare.

- From 2019, in Wagga Wagga, there has been a trial of a peer worker enhancement to Beyond Blue's The Way Back Support Service for people who have made a suicide attempt. This trial has found that service users who accessed the support of a peer worker were more likely to maintain contact with the service than those who had only accessed a generic support coordinator. 66% remained involved after 9 weeks if they had accessed peer support compared with only 39% for those not accessing peer support. The peer enhancement is yet to be extended to other sites of The Way Back Support Service.

A peer enhancement trial of The Way Back Support Service for people who had made a suicide attempt found that service users who accessed the support of a peer worker were more likely to maintain contact with the service than those who had only accessed a generic support coordinator.

- In the 2021-22 budget, the Commonwealth Government announced funds for Roses in the Ocean to expand its peer-based call back service for people in suicide-related distress called Peer CARE Companion. This service had been operating on very minimal self-raised funds from its commencement in 2019. The funds for this expansion were received by Roses in the Ocean in August 2022.

- A small number of other non-government organisations have started to employ suicide prevention peer workers, notably in New South Wales, Victoria and Western Australia. This includes roles within Aboriginal and Torres Strait Islander community-controlled organisations, and services for the LGBTI community. However, the breadth of this workforce remains extremely insufficient with sparse coverage of the Australian population.

3 'Postvention' is a term widely used in the suicide prevention field when referring to services for people bereaved by or impacted by a suicide.

Although there are some limited recent successes in establishing a peer workforce in suicide prevention, the above examples are essentially the total of Australia's activity in this area to date. Of note is that much of this activity is in services that can only be accessed following a suicide attempt or discharge from a hospital. Equally important is that most states and territories have engaged in no activity to create a peer workforce for suicide prevention at all. These constraints make the empathetic and compassionate support of a peer worker difficult if not impossible to access for almost every person in Australia who is at risk of suicide.

The suicide prevention peer workforce can reduce pressure on clinicians, save money, contribute to system reform, and get help to more people more rapidly

A peer workforce in suicide prevention has the potential to contribute significantly to addressing the crisis in the availability of support for people in distress being seen throughout Australia since the onset of COVID-19. A review of emergency mental health care commissioned by the Australasian College of Emergency Medicine identified non-hospital and peer-led alternatives as an important ingredient in improving responses to people who would otherwise present to emergency departments in crisis (Duggan et al 2020).

Even prior to the pandemic, Australia's approach to suicidal thinking and behaviour has been almost entirely delivered through clinical emergency services (ambulances, emergency departments and acute mental health services), GPs, and the Better Access program that provides a capped number of subsidised psychology sessions. These services were frequently overwhelmed by people in distress even in places where they were comprehensively available prior to COVID-19. Some additional support through phone lines such as Lifeline is provided, but these services too have long been unable to meet demand. In any case, it is common practice in phone line services to encourage people in distress and seeking help because they are experiencing suicidal thinking to contact their GP or mental health clinician or to attend an emergency department, compounding the limitations of support available through these systems, and highlighting the lack of options available to people experiencing a suicidal crisis. As mentioned, many people in Australia are dying from suicide each year without ever having been in contact with any of the above services.

> By focusing most suicide prevention activity on clinical services, Australia is directing people at risk of suicide to the most expensive form of support, as well as a form of support that is under unprecedented stress.

A peer workforce can be more readily deployed than more clinical services for people experiencing suicidal distress. This is because peer workers can be trained in much shorter timeframes than general practitioners, psychologists and nurses. It is also because the pool of potential suicide prevention peer workers throughout Australia from which potential trainees for crisis services could be drawn is as large as the number of people who have made a suicide attempt (estimated at 65,000 people per year by Slade et al, 2009) or experienced suicidal thinking (estimated at 700,000 people a year by the recent ABS Mental Health and Wellbeing Survey). Likewise, suicide bereavement services have a very large pool of potential trainees for peer roles given the roughly 3000 suicides per year create at least 21000 closely bereaved family and friends (Cerel et al, 2019, have estimated at least 7 close relations and up to a further 135 people are bereaved or impacted by every death from suicide).

Currently, by focusing most suicide prevention activity on clinical services, Australia is directing people at risk of suicide to the most expensive form of support, as well as a form of support that is under unprecedented stress. Even if it is assumed that

clinical services are always the necessary or correct response to every person in crisis, these services are unlikely to ever be available at the scale needed to respond to everyone in need.

Suicide prevention peer workers can alleviate pressures on the clinical workforce by ensuring that the limited time of emergency department staff, general practitioners and psychologists subsidised under Better Access is directed to the most clinically relevant presentations. Meanwhile suicide prevention peer workers can provide more appropriate and cost-effective responses to the psychosocial factors and situational distress at the root of many suicidal crises.
Suicide prevention peer workers can also provide support in lieu of the extended waiting times being faced for psychologists, counsellors, social workers and other disciplines since the start of the pandemic, or in place of these services in the many locations where they are unavailable in regional, rural and remote areas.

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Aside from reducing pressure on the clinical mental health workforce, expanding the suicide prevention peer workforce will also help to address the broader workforce shortage faced by many suicide prevention services. A recent national survey of over 280 people working in Australian non-government suicide prevention organisations found that 83% did not currently have sufficient staff or volunteers (Suicide Prevention Australia, 2022). 80% of the respondents reported the peer workforce was not appropriately funded or resourced. A rapid introduction of peer workers into the suicide prevention field would significantly address this deeply concerning lack of workforce capacity in the organisations most critical to reducing suicides in Australia.

Suicide prevention peer workers provide unique, evidence-based benefits

Suicide prevention peer workers can be the most relevant form of support for many people living through a suicidal crisis and can even provide the first or only positive professional intervention a person in crisis receives. Peer workers' understanding of a shared experience, promotion of mutuality, reciprocity and collaboration, practice of walking alongside the person in crisis, and offering them freedom of choice and self-determination in their own care, can contrast with common experiences of a lack of any available support, or coercive and involuntary approaches within the acute mental health system.

Peer-based suicide prevention services are characterised by rapid access, low cost, availability outside of business hours and enhanced privacy and are able to reach people who would not have otherwise sought help.

Although research on suicide prevention peer work is in its infancy, evidence of the effectiveness of suicide prevention peer workers shows positive and promising results (Schlichthorst et al 2019). Suicide prevention programs using peer workers have been found to promote a better understanding of why suicidal thoughts occur, decrease the intensity of suicidal thoughts, and provide constructive advice. Peer workers have demonstrated capabilities in relating, listening, advising and providing support (Pfeiffer et al 2019). Importantly, peer-based suicide prevention services are characterised by rapid access, low cost, availability outside of business hours and enhanced privacy;

are able to reach people who would not have otherwise sought help; and are associated with reductions in suicides and suicide-related hospitalisations among vulnerable groups such as the LGBTI community, first responders and the military (Bowersox et al 2021).

Peer work is highly valued and increasingly evidence-based in suicide prevention among Aboriginal and Torres Strait Islander communities. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) noted many successful programs that utilise peer to peer approaches and recommended that governments support the training, employment and retention of Indigenous people as peer workers in suicide prevention (Dudgeon et al 2016). Peer workers in Aboriginal and Torres Strait Islander suicide prevention provide culturally safe support that acknowledges suicide prevention's links to culture, country, intergenerational trauma and experiences of racism. They play a critical and increasing role in addressing the disproportionately high rate of suicide among Indigenous people.

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Suicide prevention peer workers are crucial to reducing the economic cost of suicide

Providing much more accessible peer-based crisis support for people at risk of suicide has the potential to generate significant economic benefits for Australia. This can be achieved with relatively small investments compared to expansions of the clinical workforce, which although necessary, will take longer and most likely require significant skilled migration to meet demand, as well as requiring substantially greater salaries.

Significant economic benefits can be achieved with relatively small investments in suicide prevention peer work, compared to expansions of the clinical workforce, which although necessary, will take longer and most likely require significant skilled migration to meet demand.

Deloitte Access Economics estimated that the economic and financial cost of suicides, suicide bereavement and suicide attempts in NSW in 2019 was $2.12 billion with a further $3.04 billion in lost wellbeing incurred by the morbidity and mortality of suicide attempts and lower quality of life due to bereavement (November 2020, Deloitte Access Economics / NSW Ministry of Health). The cost resulting from suicides was $3.08 billion, from suicide attempts was $1.94 billion and from suicide bereavement was $0.14 billion. The Federal Government bore the greatest financial and economic drain due to lost productivity and the funding of health services to support people impacted by suicide and suicide attempts, with State Governments also impacted.

Extrapolated to the whole of Australia, this cost is estimated at $16.38 billion per year although this may be an underestimate given the higher rates of suicide in states other than NSW.

Although it may not be possible to prevent every death from suicide or to eliminate the experience of suicidal distress in the community entirely, current approaches will sustain or increase the cost of suicide by maintaining the widespread lack of

availability of peer support for people at risk.

Significantly expanding the suicide prevention peer workforce should be seen as an essential, low cost component of addressing the greatly unmet demand for crisis services.

As a specialised workforce, suicide prevention peer workers have specific professional needs

There are important organisational elements necessary for suicide prevention peer workers to provide the best possible support to people in need. Merely employing peer workers in suicide-related services is not sufficient without the following supportive conditions being in place around their roles:

1. A work environment that is strongly supportive in both policy and operational senses including at executive level: The organisation's leaders should be clear in their understanding of the strategic basis for peer work in suicide prevention and be resolute about their backing for the organisation's engagement with peer work approaches. Without executive support, it is unlikely that the appropriate workplace culture will be created to best support the delivery of peer-based support.

> It is vital that managers undergo specific training to appropriately support suicide prevention peer workers. Poor management orientation of suicide prevention peer work has led to high staff turnover in some settings.

2. Managers that value peer workers' presence and understand their role: Staff managing suicide prevention peer workers have a crucial role in determining the success or failure of their service's provision of peer support. It is vital that managers undergo specific training to appropriately support suicide prevention peer workers. Poor management orientation of suicide prevention peer work has led to high staff turnover in some settings.

3. Opportunities to reflect on their practice as peer workers: Suicide prevention peer workers require sufficient opportunity to de-brief, reflect upon and be supported in their practice as peer workers. This is particularly important because of the newness of the field and the emerging knowledge about maximising the effectiveness of peer work in suicide prevention. In addition to usual managerial supervision, it is necessary that this be made available regularly with other staff, preferably externally, who also have experience in peer support for suicide prevention.

4. Customised training in peer work and suicide prevention: It can not be understated how essential it is that suicide prevention peer workers receive training specially designed for peer workers in suicide prevention. This can include generic peer support training (such as Intentional Peer Support), suicide prevention skills training (such as ASIST, SafeSide or Connecting With People) and customised suicide prevention peer worker training (such as Roses in the Ocean's Suicide Prevention Peer Workforce curriculum). There have been instances of suicide prevention peer worker roles being recruited and staff provided no further training to support their professional development, leading to disengagement and staff turnover. Given the complexities for people with lived experience of suicide working in peer-based roles, ongoing training for all peer work roles is critical.

5. Opportunities to network with other peer workers and share experiences: It is important that suicide prevention peer workers are linked up with the emerging suicide prevention peer workforce in their regions and states/territories as

well as nationally. This reduces isolation, builds collegial support and transfers skills and knowledge as the suicide prevention peer workforce further develops.

6. **Ongoing professional development and career planning:** Professional development should seek to retain the peer worker so they flourish in their role, and build their skills and potential for future development of their careers. Most peer workers have essentially no option for advancement within the services they work because of the primacy of the clinical workforce. Further consideration us required of how peer workers in the suicide prevention field can develop their careers as staff with expertise in lived experience.

Government services and non-government organisations can build the suicide prevention peer workforce now

The key environmental conditions for an expanded suicide prevention peer workforce are now present: a growing evidence base, an enabling policy environment, an appealing cost-benefit ratio, and the emerging additional systems needed to support peer workers, such as specialised training for them and their organisations, as well as mentoring, reflective practice and networking strategies. Moreover, the ongoing unacceptably high levels of suicide (with approximately 8 lives lost per day), rising suicide risk in the community in the wake of the pandemic, and unsustainable pressures on the health system to respond effectively, necessitate new approaches that provide easily accessed peer support in non-clinical settings.

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Governments are urged to invest in the growth of the suicide prevention peer workforce, and particularly to locate this workforce so it is available to people in crisis without them first being required to have accessed clinical care. Further reform is needed to make peer support a primary element of the suicide prevention system accessible from both within and outside health services.

Non-government suicide prevention organisations, especially those with large workforces and a national footprint, have an important role to play in enhancing their services with a peer workforce, or converting them over time to peer-based services. Key suicide prevention services can make peer support systematically available through their service delivery and facilitate access to it as a routine offer to every person they support. National advocacy from these services for the continued growth of the suicide prevention peer workforce is also necessary.

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