Conversation Café Workshop
LE Summit 2023

Conversation Café was held on Day 2, 10 March, of LE Summit 2023. The workshop invited participants to immerse themselves in a number of conversation topics that have been suggested by people registered for the LE Summit.

Each table hosted different conversation topics. Participants had the opportunity to engage in three different conversations throughout the course of the workshop.

Conversation 1

Table 1 - How do we shield ourselves from vicarious trauma, in the moment, when we are listening to someone share their lived experience of suicide?

- Good support network – e.g., psychologist
- Reminders that are helpful – e.g., this is not my story
- Debriefing with colleagues - knowing that's available as support after
- Reminders – 'everything's okay', 'doing best I can', 'I'm not there to solve the problems, I'm there to listen'
- Acknowledge and accept feelings coming up in the moment
- Deep breaths and grounding in present moment – e.g., feel feet on floor
- Shift attention to person in front of you
- Sensory grounding strategies – e.g., fidget spinner, objects, doodling
- Putting boundaries if needed so that you can show up safely and authentically in the conversation – e.g., saying preference to not discuss methods of suicide
- Seek support if needed

Table 2 - What is the role of mentoring and role models in suicide prevention?

- Provide safe space to debrief – mentoring, help process, opportunity to grow
- Listening/guiding
  - Deep
  - Curious
  - Different perspective
- Person focused
- Connection to individual
  - Informal connect
  - Relatable: are you the right person?
  - Role model
- Provide hope
- Power sharing
- Safe language – LE 'Stories for Change'
  - Culture diversity
  - Intent of connection – end result
- Listen to understand rather than to respond (Listen: Silent)

Table 3 - How are you using or how could you use your lived experience to engage your local community?

- Social media campaigns (Tik Tok, Facebook, Youtube, Instagram)
- Storytelling (lived experience)

- Using lived experience to set up safe spaces
- Starting support groups – by being trained to become a volunteer
- Through multicultural community groups
- Through writing your story as a book
- Joining multicultural play groups
- Creating videos to share lived experience in a relatable way
- Finding available workshops and resources

Table 4 – What could simple self-help look like for when someone feels alone and can't access support?

- Embrace micro moments (e.g., smile from barista or stranger) – being mindful of the moment
- Walk/exercise/body movement
- Dog park/pet shop
- One %'s of suicide prevention
- Proactive in asking for check-ins and touch points
- Plan for communicating to others re signs not well
- Lists of reminders of joys
- Apps/Youtube – meditation, breathing, music
- List of reminders of life/good things
- Distractions/creativity
- Tool kits – sensory box, toys, fidgets, affirmations, aromatherapy etc.

Table 5 - What makes a lived experience of suicide different for Aboriginal and Torres Strait Islander people and communities compared to mainstream definitions of lived experience?

- Highest rate of suicide across Australia but not much further knowledge
- Acknowledging the lack of knowledge in the group
- The role of names after death in Aboriginal cultures
    - Systematic challenges of people changing their names after death
    - Different ideas on how to honour those who have passed
- Dealing with racism and colonisation tensions while grieving
- The systems were developed by "white Australia" (e.g., medicine, hospital systems, Centrelink don't accommodate for Aboriginal and Torres Strait Islander cultural protocol and communities
- Social and emotional wellbeing

Table 6 - How can we support families and friends of people who have made a suicide attempt?

- Listen
- Empathy
- No right or wrong response
- Let them talk about it if they wish to
- Don't try to fix it
- Acknowledge what's happening whilst also supporting them to move with life
- Checking in with what they need
- Empowering
- Not rushing
- Normalising their responses
- Don't make assumptions
- Supporting without imposing your cultural beliefs and religious/faith
- Focus on the now
- Recognise the power of language

- Making sure the person caring for is safe
- Recognising who and what are the triggers

Conversation 2

Table 1 - What's the difference between lived and living experience? Is it divisive in any way?

- Can't have living without lived
- Might not want to think about past – so living focuses on the now
- Lived experience + context
- Living = more empowering, ongoing experience
- Been lived but no longer living it – so for some it is two different things
- Lived = certain point of life/recovery/being well
- Informal vs formal – e.g., job description
- Could divide community them vs us
- Do I pass a threshold of lived experience
- Sometimes two separate things and sometimes past tense is appropriate
- Living = potential risk
- Bias to success story – potential stigma to present not pas

Table 2 - Where would you like to see suicide prevention peer workers so they are accessible in the community?

- ED's
  - Sit beside
  - Paid
  - Permanent
- Education
  - Boarding schools
  - University
  - High schools
  - TAFE
- Crisis support spaces – A/Hs
- Hospitals
  - PW mobile team
  - Staff, patients, carers
  - All wards
- Police services
- Ambulance
- Mobile PW's
- Text service
- Sharehouses – self-admit, life skills
- Online drop-in services
- Cruise ships
- Warmlines
- Safe spaces
  - Hubs
  - Community network
  - Council locations
  - Small business
- Events
  - Festivals
  - Carnivals
  - Community events

- Rural and remote communities – local meeting place

Table 3- Innovation as a catalyst for change: how, where, why?

- Mental health first aid training + resilience training
- Social media campaigns – Tik Tok/Facebook/Instagram/Youtube
- Make more PPIMS groups – e.g., Peer Participation in Mental Health Services
- Innovation in workplaces (e.g., Lived Experience champion) and university sector (e.g., advising on and creating courses on lived experience)
- All community involved – e.g., PHN's carers, consumers – needs government funding
- Data base for all suicide prevention related services
- Do we need to reinvent the wheel? E.g., replicating what works in other areas
- State advocates helping other states to improve
- Art therapy, music therapy, drama therapy for healing
- Starting healthy behaviour education early in kindergarten, primary/high schools, parental/pregnancy education
- Good behaviour game – uni study

Table 4 - What does principled leadership look like in suicide prevention?

- Values driven leadership
  - No place for ego
  - Leadership can be anywhere in the community
  - Training, accountability and resourced to work in the space. Do no harm.
  - LE as driver
  - Culture of safety (i.e., environment, language, hope)
  - Walking the talk
  - Not thinking you have all the answers – inviting others to contribute
  - Compassionate curiosity
  - Finding your tribe, who align with your values – keep seeking out your tribe
  - Authenticity to be open and honest – will assist in building connections
  - Recognising opportunities for change
  - Knowing your non-negotiables even if it means losing funding – values + integrity + intent
  - Being able to bring others along on the journey – lead from behind; supportive (e.g., school is fish – leader being at the back)

Table 5 - How do you think you will benefit from understanding Aboriginal and Torres Strait Islander Lived Experience?

- "Lived experience" is not one lived experience. It is diverse
  - Community care
  - Bereavement
  - Self
  - Cultures, genders, locations, age
- Lived experience looks different across localities. Not one size fits all.
- Diversity and inclusion within management level – First Nations people at manager/decision making level of orgs/gov
- The similarity of values between lived experience advocates and First Nations cultures
  - Respect
  - Communities
  - Shared loss
  - Holistic

    - Person-centred
    - Listening
    - Stories and complexity
    - Trust
    - Relationships
    - Social and emotional wellbeing
- "We don't know what we don't know" – need more education!
- It will help with everything
    - Safer service delivery
    - Working with communities
    - Innovation
    - Working respectfully
    - Solutions – ways forward
    - Prevention
    - SEWB not mental health
    - Indigenous research methodologies
- Every service/organisation can use the specific definition of Aboriginal and Torres Strait Islander lived experience. It is different.
- Agreed that working from this model will encompass improvement for all services

Table 6 - What are the key enablers for ensuring sustainability in suicide prevention support and services?

- Good support and collaborative partnerships – other agencies (e.g., housing, family and community [holistic aspect]) recognise domino effect
- Keeping up to date with everything. Look at the bigger picture. Adapt to what's going on (e.g., covid pandemic changes)
- Evaluation and monitoring. Keeping up to date on what's working/what's not (tweaking reform)
- Transparency and continuity
- Maintain mutuality – don't bring biases and ideologies; work with different viewpoints
- Check-in with person – is it working for them? Then being okay with making changes
- Auditing (checking accountability)
- Ensuring inclusivity/diversity – be prepared to educate staff/services → training/education in recovery model being mindful of cultural practices
    - End result: positive recovery model/person-centred

Conversation 3

Table 1 - How can people as individuals advocate for more accessible services and support?

- Tell stories to organisations
- Joining organisation boards and committees in community
- Scope alignment of values and visions of companies to be involved with
- Advocate through press and media
- Conversations
- Talk to people outside your circle
- Get involved, get out of your comfort zone
- Connect with those already convinced
- Guerrilla tactics
- Advocate where resources are available

Table 2 - Language is always evolving. Are there words, phrases emerging or ones that need defining more clearly? How do we collectively capture the evolution of language?

- Listening and being receptive
- Being conscious of where the ownership lies in a statement
- Using first-person statements to hold space for the second person
- Listening to lived experience stories
- Training helps us stay up to date
- Hearing other people's perspective and checking in about what language is most suitable
- Reflecting for ourselves and comparing our reflections with others
- Considering when language itself can be a barrier – looking to other forms of expression
- Steering away from assumptive language

Table 3 - What might be the role of peers in social prescribing? What needs to happen to pave the way for their inclusion?

- Social wellbeing
- F2F contact preferred
- Moving away from GP's (clinical supervision) to the community
- Huge role for peers
- Lived experience not the only pre-requisite. Training. Degrees? Cert 4 minimum requirement?
- Recognising gaps in your community – community-led
- Peers know their community. Social prescribing is finding peers who can help and grow their community.
- GP's to refer patients to peer-led community groups
- Steer people away from GP's to help alleviate pressure of time for GP's
- Mapping community supports + building connections

Table 4 - There are major workforce shortages in suicide prevention. In what roles can people with lived experience expand the workforce?

- Opportunities – involved when you are well, different age groups
- Question of whether volunteer/free workforce or paid
- Genuine and easily accessible – alternative clinical and peer alongside one another
- Working hard to address gaps of trained and supported people in diverse communities
- Grassroots – sporting clubs, faith places
- Where does advocacy fit in
- What's the incentives
- Peer work or LE work pay standard – putting a value to this work
- What happens to other stories – compassion fatigue
- Transporting/teaching learnings from peers
- How to support new people interested
    - How do people do this? It is unclear
    - Better mentoring pathways
    - Affordability to train

Table 5 - Is there anything that you want to ask us to help you better work with Aboriginal and Torres Strait Islander Lived Experience?

- Where is the best place to get information on how to encompass these perspectives?

    - BDI ILEC (Aboriginal and Torres Strait slander Lived Experience Centre)
    - Use google
    - Go to your local land council
    - Hire Aboriginal staff, especially those that are front facing
    - Visual indicators are powerful to make a safe space (e.g., flags, artwork, resources)
    - Look at guides made by Aboriginal people and groups (e.g., Kimberley Aboriginal Medical Service SEWB strategy)
- Cultural awareness/cultural safety training
- Read about social and emotional wellbeing model
- Anything that you do should be developed, reviewed and delivered by First Nations people

Table 6 - How could we improve the suitability of suicide prevention supports and services?

- Be risk tolerant
- Hold safe spaces for people in crisis in organisations/services
- Understand your cohorts and their various presentations and needs
- Educate first responders and frontline staff in crisis intervention → having mandatory re-accreditation in suicide prevention
- Have peer workers (suicide prevention) to buddy up with first responders
- Have a unit specific for people in crisis as part of the hospital but a wing which has holistic recovery model (physical, emotional, neurological, medical, psychiatric issues which leads to suicidal ideation)
- Follow-up services – flexible but not playing hot potato