# What do people with lived experience of suicide want to see in suicide prevention strategies?

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Australia's national and state/territory suicide prevention strategies set priorities across multiple years for how governments, non-government organisations, research and the community will work together to reduce the suicide rate. People with lived experience of suicide have an enormous stake in these strategies and seek to be meaningfully included in their development, implementation and evaluation. All suicide prevention strategies must have their own governance arrangements and funding streams that are exclusive to suicide prevention and not merged with other policy areas such as mental health and drug and alcohol treatment, where the focus on suicide prevention is likely to be subsumed or diluted, and where lived experience representation diverges from a focus on lived experience of suicide specifically.

This checklist provides 12 minimum inclusions that people with lived experience of suicide expect from jurisdictional suicide prevention strategies in the 2020s. It has been formulated based on the policy expertise of people with lived experience of suicide, our knowledge of what is emerging as the most effective approaches in suicide prevention, and our paramount desire to see fewer people in our communities in crisis, attempting suicide, and dying from suicide. The checklist also contains elements relevant for regional, local and organisational suicide prevention strategies. It is not a comprehensive or exhaustive list of everything a suicide prevention strategy should contain, but rather the minimum that the Commonwealth, state and territory governments need to include for their strategies to have the most relevance for people with lived experience of suicide.

# The Twelve Minimum Inclusions

## 1. Build lived experience capability

Many suicide prevention strategies require the participation of people with lived experience of suicide, but without mechanisms that develop their skills and capabilities to support this participation. Lived experience partnership involves more than telling our personal stories. It includes contribution to policy discussions, co-design processes, and leadership in decision making, with a range of roles and opportunities available to people with lived experience of suicide to meaningfully contribute and collaborate. Suicide prevention strategies that seek to place people with lived experience at the centre of their implementation must match this commitment with investment in the skills and capacity of a broad range of people with lived experience of suicide. This includes within communities as well as within government and non-government organisations.

## 2. Develop the suicide prevention peer workforce

Effective suicide prevention requires a peer workforce specifically developed for suicide prevention and available both within and outside of the mental health system. People in crisis should be able to access suicide prevention peer workers without first having to access clinical services. The suicide prevention peer workforce needs to be drawn from a wide diversity of lived experience of suicide, and be available for particular settings including suicidal crisis, suicide bereavement, and families and friends of people experiencing suicidal crisis. Key populations, such as Aboriginal and Torres Strait Islander communities, men, culturally and linguistically diverse communities and the LGBTIQA+ community also require culturally appropriate suicide prevention peer workers. Comprehensive development of the suicide prevention peer workforce includes customised training, ongoing support and reorientation of services to ensure that workplace cultures and organisational leaders understand, value and support peer work in suicide prevention.

### 3. Create a lived experience informed whole of government/community approach

It is essential that suicide prevention strategy focuses beyond the health system and develops lived experience expertise across government agencies. Roughly half the people who die from suicide do not access hospital services in the year prior to their deaths, with over 10 per cent not accessing any health services at all (including GPs and prescription medicine) (AIHW, 2022). It is therefore crucial that suicide prevention activities be funded in the community, through non-government organisations not related to mental health, and in many other services that are outside of the health system. Government agencies are some of the largest employers and can build workplace environments that value and support the roles of employees with lived experience of suicide in their agencies' suicide prevention activities. Co-designing services can maximise these services' contributions to suicide prevention and ensure they are not inadvertently exacerbating the community's risk of suicide.

### 4. Train public facing services

Staff in public facing services, whether government or non-government, are potentially able to reduce distress if provided training that builds their skills and confidence and develops their insight into lived experience of suicide. There are many areas where staff in public facing services are likely to encounter people in distress or crisis. These include areas such as corrections, sexual assault, domestic and family violence, homelessness, unemployment, legal aid, the family law system, defence and veterans support, where the links with suicide risk are already well known.

### 5. Provide lived experience 'gatekeeper' training

Gatekeeper training builds suicide prevention skills among key people in communities that may encounter people in distress or crisis. When this training is developed through a lived experience perspective and delivered by people with lived experience of suicide, it has been found to be especially effective and sustained. All people need access to lived experience gatekeeper training so as to provide a minimum level of sensitivity and skills in a community, break down the stigma and silence that surrounds lived experience of suicide, and help normalise public discussion of suicidal thinking and behaviour, and suicide bereavement.

### 6. Support lived experience leadership in governance and decision-making

Every jurisdiction must have governance arrangements specific to its suicide prevention strategy that share leadership and decision-making with people with lived experience of suicide. People with lived experience of suicide need to be selected on the basis of their capacity to network with and represent the views of their peers, and be trained and supported to constructively engage in policy processes and governance structures. Having only one person with lived experience involved in a committee is not sufficient and is regarded as poor practice that fails to support the lived experience representative and risks tokenism. There must be people with lived experience of suicide present wherever and whenever there are decisions made about the development, implementation and evaluation of a jurisdiction's suicide prevention strategy including policy, programs and surveillance. Procurement and commissioning processes are also essential sites for people with lived experience to be involved.

### 7. Use co-design and co-production methodology

Co-design with people with lived experience of suicide is widely recognised as the mandatory approach for developing suicide prevention activities, including research, services and policy. Co-production takes lived experience participation further by engaging people with lived experience of suicide in the delivery of those activities as service managers, peer support workers, lived experience researchers and other roles. Co-design and co-production must be universally applied in suicide prevention, with funders and policy makers requiring the methodology be used. When co-design outputs are ignored or distorted, this creates community mistrust, cynicism and disengagement. It is therefore essential that co-design processes be honoured and their results acted upon in good faith.

### 8. Deliver peer-led and non-clinical services

Innovative non-clinical peer-run and peer-led services where support is delivered by suicide prevention peer workers are increasingly recognised among the most promising approaches in suicide prevention. Non-clinical alternatives to emergency departments (referred to as Safe Havens), and community-based alternatives to the health system (referred to as Safe Spaces) are highly valued by people with lived experience of suicide. Aftercare services for people who have made a suicide attempt, postvention services for people bereaved by suicide, and support for family, friends and kin of people experiencing suicidal crisis and/or attempt must all be delivered by workforces that include suicide prevention peer workers with the relevant lived experience for the service. Proactive and responsive outreach including suicide prevention peer workers that provide compassionate support and follow-up is an especially effective service.

### 9. Provide peer-led group-based options

There are now a range of increasingly well-evidenced, peer-led group-based programs and individual support options available that will enhance any suicide prevention strategy. These models, delivered by or in collaboration with appropriately trained facilitators with lived experience of suicide, have an important function in helping people remain safe in the community, manage their own distress, and prevent suicidal feelings escalating into suicide attempts. This reduces demand for clinical services and avoids preventable emergency presentations. Some of these models such as Alternatives to Suicide and bereavement support groups, are run as ongoing drop-in style groups, while others are time-limited, multi-week workshop programs such as Eclipse for people who have made a suicide attempt.

### 10. Provide population specific programs and services

Parts of our communities that experience disproportionately higher rates of suicide such as men, Aboriginal and Torres Strait Islander people, LGBTIQA+ communities, veterans and other groups require their own programs and services, delivered using culturally relevant, peer-based, community development approaches. Most mainstream, universal services will struggle and often fail to reach or be appropriate for these groups. Every jurisdictional suicide prevention strategy should contain specific measures that have been developed by populations with the greatest suicide risk. Importantly, these programs and services should be delivered at scale so that everyone within the specific population they serve has some means to access them, including in rural and remote areas.

### 11. Prioritise suicide prevention in the mental health system

The mental health system has contact with high numbers of people at risk of suicide but rarely has specific methods to prioritise suicide prevention. Traditional risk assessment and treatment strategies have been discredited in recent years however most mental health systems are still built on assumptions that treatment of mental illness alone is sufficient to prevent suicides. Jurisdictional strategies must strive for the elimination of suicides among people in contact with the mental health system, in both inpatient and community settings, while avoiding coercive practices. Contemporary approaches such as Zero Suicides Healthcare include a specific suicide prevention care pathway with robust support from mental health peer workers with specialised skills in suicide prevention. Innovative, lived experience informed suicide prevention training such as SafeSide can bring the most current evidence-based insights in the care of people who are at high risk of suicide to the mental health system. Just and restorative practices are vital for effective postvention for staff and compassionate support for bereaved families and friends.

## 12. Build the lived experience evidence base including real time suicide data

Suicide data and suicide prevention research represents personal stories of lived experience of suicide. It is therefore critical that people with lived experience of suicide be closely involved in all surveillance and research related activities. Suicide surveillance must include people with lived experience of suicide in governance and operational arrangements as a matter of ethical practice. Every state and territory needs to have a suicide register that publicly reports at least monthly so that communities and services can provide targeted postvention and respond to emerging trends for suicide prevention. Likewise, people with lived experience of suicide must be partners in all stages of research including determining its focus, methodology, data collection and analysis, and reporting. Research can expand the understanding of how lived experience contributes to suicide prevention, and engage researchers and data analysts with lived experience of suicide.

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