Roses in the Ocean
stemming the tide of suicide

A submission for the Mental Health Select Committee:
Inquiry into the opportunities to improve mental health outcomes for Queenslanders

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Roses in the Ocean

Roses in the Ocean exists to save lives and reduce emotional distress and pain.

We are Australia's national lived experience of suicide organisation providing innovative, highly collaborative, bold leadership within the suicide prevention sector, for people with lived experience of suicide, communities, sector organisations & government agencies.

We provide sophisticated lived experience of suicide expertise in developing & delivering best practice & evidence generating training & skill development, engagement, integration, co-design & co-production, Lived Experience & Peer Workforce development. We are a sought-after partner in research, policy reform, service design and delivery.

Our reputation is built on a decade of developing the lived experience of suicide movement, driving system reform, sharing our learnings, and co-designing innovative service solutions that address service gaps, always placing community need above organisational need.

Roses in the Ocean is cited internationally by the World Health Organisation as representing best practice in lived experience of suicide development, engagement and integration.

At our heart and soul are people with a lived experience of suicide. We are dedicated to empowering those with a lived experience to find their voice, and to building their capacity to bring their insights and wisdom to suicide prevention.

We seek to lead the significant cultural shift needed to save lives through harnessing the perspectives of all we represent, along with our own lived experience of suicide. With our actions driven and guided by those with a lived experience of suicide, we innovate and transform suicide prevention, and drive and deliver system reform. We support organisations and government to effectively and meaningfully integrate lived experience expertise into suicide prevention.

Our key focal points in our Strategic Plan:

Improve service experience and outcomes by implementing innovative solutions co-designed to meet the needs of individuals and communities.

Build capacity of individuals and communities to respond to suicide; grow the breadth and diversity of national LE of suicide movement and further develop and support the national Suicide Prevention Peer Workforce

Deliver high-quality, best practice accessible training, resources and services, the positive impact of which is measured and reported on.

Drive reform towards a genuine 'no wrong door' approach by collaborating with and supporting Government and services to embrace and implement Lived Experience of suicide culture change.

Provide respected leadership in lived experience of suicide to individuals, the sector and government.

Build depth and sustainability into the lived experience of suicide movement, our organisation, individuals, communities, services, workforces and safe spaces.

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Suicide Prevention is unaddressed by the Terms of Reference

Roses in the Ocean is pleased to contribute to the deliberations of this inquiry by the Mental Health Select Committee into the opportunities to improve mental health outcomes for Queenslanders.

It is however very concerning that the Committee's Terms of Reference are primarily focused on mental health and mental illness, with just two cursory mentions of suicide or suicide prevention despite the current national landscape of recommendations from various current national reports:

- Productivity Commission Inquiry into mental health identifying suicide prevention as a key finding, with several recommended actions https://www.pc.gov.au/inquiries/completed/mental-health/report
- Prime Minister's National Suicide Prevention Adviser and Taskforce Final Reports and recommendations https://www.health.gov.au/resources/publications/national-suicide-prevention-adviser-final-advice
- The Royal Commission into Victoria's Mental Health System recommendations including significant suicide prevention reform https://finalreport.rcvmhs.vic.gov.au/
- The ongoing Royal Commission into Defence and Veteran suicide https://defenceveteransuicide.royalcommission.gov.au/

The omission of genuine focus and attention on suicide is a persistent policy issue in the suicide prevention field, where suicide prevention is consistently placed under the same umbrella as mental health. This is seriously problematic from policy, funding, and service provision perspectives. The mental health system chronically fails to address suicide and suicide prevention, falls short of meeting the needs of people in crisis, the people who care for their loved ones and tragically when people die by suicide, those who are left behind.

A far-reaching whole of government and whole of society approach in Queensland is required to address suicide in recognition that:

- Only 46% of people who die by suicide have a diagnosed with mental illness (National Alliance Mental Illness 2020) with remainder not related to mental illness, but rather a wide range of social determinants and situational stressors;
- the mental health system was never designed for people in suicidal crisis, and in many cases causes harm and trauma to people who access it;
- 80% of people in community choose not to access the mental health system;
- Many who have previously access the mental health system refuse to access it again.
- the mental health system is not well placed to provide or lead the holistic and whole of community support required to reach people who are at risk of or bereaved by suicide.

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It is widely accepted that the Queensland mental health system requires significant reform, which will take considerable time. With more than two people taking their own lives daily in Queensland (a total of 759 people in 2020) we require a far greater sense of urgency in addressing suicide with a strong focus on its specific needs and opportunities as informed by people with a lived experience of suicide.

The mental health system's role is almost entirely in crisis response and its capacity to address the causes of suicide and suicidal thinking are very limited. Continuing to locate suicide prevention within the remit of mental health will reinforce the current over-emphasis on crisis responses in suicide prevention and fail to address the social determinants of suicide which are located mostly outside the health system. Furthermore, people with a lived experience of suicide repeatedly and consistently advise that the mental health system's approach to crisis response results in a vast majority of cases, in creating heightened distress, trauma, and harm.

Action: For genuine mental health system reform to occur, foster innovation and seize opportunities , significant culture change is necessary and a deliberate focus on suicide prevention (outside of the context of mental health). There are several key catalysts for creating this cultural change which, when strategically engaged and embedded within and across the hospital and health services and the broader mental health system, prepare the soil for a lived experience informed suicide prevention..

- Understand and acknowledge the difference between mental illness and suicide prevention
- Embrace a Lived Experience of Suicide Informed and Inclusive Culture Change across the mental health system/ sector and government
- Invest in the innovative non-clinical suicide prevention options and choices
- Invest in the ongoing development and support of the specialised Suicide Prevention Peer Workforces

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Understanding and acknowledging the difference between mental illness and suicide prevention

While there is a significant overlap between mental ill-health and suicide, approximately half the people who die by suicide in Australia do not have a diagnosed mental illness and a large proportion of these people have had no contact with the mental health system in the year prior to their deaths. While the increased awareness of, and commitment to, the engagement and participation of mental health consumers and carers has been vital for mental health reform, the tendency to conflate lived experience of suicide with consumer/carer perspectives has limited genuine engagement with people whose experiences of suicide are not reducible to mental health.

Some people experiencing suicidal thinking specifically avoid the mental health system or have had previous experiences with the mental health system that have been traumatic and harmful resulting into causing increased suicidality. Tragically a concerning number of people who have accessed the mental health system have gone on to take their own lives with a matter of weeks of their contact.

Conceptualising suicidality as a mental health issue, or as comparable with the 'consumption' of mental health services, fails to appreciate the situational and social distress that often leads people to ending their lives or attempting to do so. Poor living circumstances, relationship breakdown, loss of a loved one, drug and alcohol use, bullying, a lack of social support, the onset of disability, chronic pain, economic and legal problems, and a history of trauma have all been shown to contribute to an increased risk of suicide. Furthermore, people who are bereaved by suicide also sit under the umbrella of lived experience of suicide and as bereavement from suicide is not a mental illness, these people are not captured through traditional mental health consumer and carer perspectives.

Likewise, conceptualising suicidality as a mental health issue requiring treatment within the clinical system has not been effective in bringing down suicide rates. If we are to be effective in reducing suicide deaths and attempts and substantially improving support for everyone impacted by suicide, it is clear there must be a meaningful separation between the policy and practice domains of mental health and suicide prevention.

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Embracing Lived Experience of Suicide Informed and Inclusive Culture Change

For culture change to be achieved it is vital there is a shared understanding of the value of lived experience of suicide. The mental health system will meet the needs of people in suicidal distress who access their services far better once they are lived experience of suicide informed.

Creating safe and supportive services for people in distress begins with senior leadership being committed to creating safe and supportive workplaces and services for people with a lived experience of suicide to actively bring their insights and experience to. The Lived Experience of Suicide Engagement Principles guide this change.

- TRUST & SAFETY
- RESPECT & COMPASSION
- COLLABORATION & POWER SHARING
- TRANSPARENCY & ACCOUNTABILITY
- DIVERSITY & INCLUSION

Source: Lived Experience of Suicide Engagement Principles (LESEP) Guidance Document, Roses in the Ocean

These principles support existing staff to feel comfortable and confident in disclosing their lived experience and bringing their valuable insights to their work. Open conversations must address issues of fear, stigma, discrimination and prejudice.

Full suite of resources to support Lived Experience of Suicide Informed and Inclusive Culture Change are being launched in conjunction with the National Suicide Prevention Office on February 21st, 2022.

Includes: Lived Experience of Suicide Engagement Principles / Lived Experience of Suicide Engagement Participation Integration Framework / Implementation Toolkit / Organisational Toolkit /Decision making and Evaluation Tools / Lived Experience of suicide Language & Imagery Guide / Co-designing with people with Lived Experience of suicide.

Recommendation: Support and embark on the critical culture change across mental health system to address key barriers contributing to suicide deaths in Queensland

Key enablers:

- Develop a deeper understanding and appreciation of the value of lived experience of suicide.
- Improve suicide literacy across government and the mental health system
- Support internal staff who identify with their own lived experience of suicide to speak openly about their own experiences and champion the value of lived experience.
- Establish designated lived experience of suicide roles.
- Appoint people with a lived experience of suicide throughout governance structures.
- Engage internal and external people with lived experience of suicide in the planning, implementation and review of suicide prevention strategy

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Invest in innovative non-clinical suicide prevention choices informed by people with lived experience of suicide

As a direct result of the systemic advocacy of people with a lived experience of suicide, government investment is emerging for non-clinical, alternative supports for people impacted by suicide in Australia.

Peer enhanced services, blended workforces and suicide prevention peer led services are all deserving of attention and investment.

Unfortunately, we are yet to see investment in suicide prevention that is driven by and informed by people with lived experience

The 2019-2020 Budget saw $80.1 million allocated to suicide prevention however the majority of the money was invested in clinical services that people with a lived experience of suicide continue to tell us are not working and they do not want to access:

- 8 x Safe Haven Cafes M$10.8 – tokenistic co-design with people with lived experience of suicide at last minute and ignoring the lived experience of suicide input that was provided resulted in services (now known as Crisis Support Services) primarily located within hospitals staffed with a combination of clinical staff and mental health peer workers. This is not the model they propose to be emulating and the majority of people utilising them are people already caught in the mental health system experiencing mental illness.

- Community mental health – M$28.1 - community support services delivered by non-government organisations for people living with severe and persistent mental illness. People tell us they do not wish to access a service known for working with severe and persistent mental illness when the underlaying cause of their suicidality is not related.

- Community based crisis stabilisation – M$11.3 - The service provides clinical risk-assessment and management, treatment planning and discharge goal-setting. People with lived experience have been included however left out of key decision-making processes, over-ridden by clinicians and health representatives, and some have stepped away from the project due to feeling completely disrespected and invalidated. The service is not favourably viewed by many in the community with lived experience of suicide.

Recommendation: Suicide prevention must be respected as a critical area of focus in its own right, afforded the attention, investment and urgency it deserves. Investment must be made directly into suicide prevention with focus on solutions informed by people with lived experience of suicide.

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National Safe Spaces Network

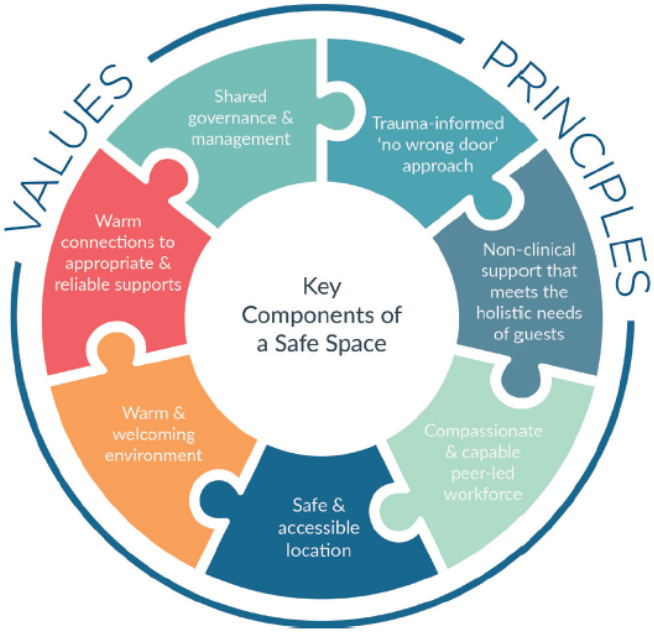
Perhaps the most innovative of non-clinical alternative to the mental health system for people in crisis are Safe Spaces – drop-in style spaces for people experiencing significant emotional distress or suicidal crisis that offer a genuine alternative to emergency departments and can provide a warm, welcoming environment for people to be supported to reduce their distress.

They are staffed by suicide prevention peer workers with their own lived experience of suicidal crisis and/or attempt who can connect with others through the mutual understanding that comes with meaningful shared experience.

In February 2019, Roses in the Ocean in conjunction with Beyond Blue, Wesley Mission Qld, Australian Red Cross, Everymind and the Australian Institute for Suicide Research and Prevention submitted a proposal to Government, 'Trialling a National Safe Spaces Network to reduce the risk of suicide', outlining a phased approach to the development of the National Safe Spaces Network.

The National Safe Spaces Network was proposed and supported through the national Phase 1 Scoping conducted by KPMG, on the basis that the issue was that Emergency Departments are not suitable for supporting people in suicidal crisis and that Australian's wanted non-clinical alternatives staffed wholly by well trained and supported Suicide Prevention Peer Workers with their own lived experience of suicidal crisis and/or attempt.

Through our extensive experience leading the co-design of twenty + safe spaces in a broad range of metropolitan and regional communities in Australia and with a rich and varied range of community stakeholders, we identified the seven key components of an ideal safe space



However, several substantial challenges have become apparent as funding for these new services is typically funnelled through the hospital system and mental health services, these co-design processes are often constrained by:

- Clinical decision-makers and staff deeply entrenched in the biomedical model and intrinsically risk averse and resistant to non-clinical models of care
- Unrealistically tight timeframes that limit the capacity to build relationships with people with lived experience who have understandably low levels of Institutional trust whose Insights are central to service Improvement
- Inability by some traditional experts to appreciate the purpose of involving people with lived experience in a meaningful way.
- Unnecessary parameters being imposed on the service model that pre-determine it before the co-design process has started.

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If we are to offer a genuine alternative to what is currently available for people through the Emergency Department and other traditional clinical services, it is imperative that there is a genuine understanding of, and commitment to, the full Tiered model of National Safe Spaces Network. For suicide prevention this means investing in the pure Tier 4 & Tier 5 Safe Space models of non-clinical, suicide prevention peer-led services.

In doing so, we will demonstrate that the voice and opinion of people with a lived experience of suicide has been acknowledged and their opinion has been valued and acted upon as part of the solution.

The current Safe Haven Cafes (Crisis Support Services) funded through 2019-2020 budget do not meet the criteria. The recently funded Safe Space Hubs in Brisbane North PHN represent the Tier 3 model.

Tier 5 A non-clinical peer run residential safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience of suicide crisis/attempt (a new service option staffed with suicide prevention peer workers)

Tier 4 A non-clinical peer run safe alternative to emergency departments - 24/7 Safe Haven Cafes with suicide prevention focus, staffed by suicide prevention peers with lived experience of suicide crisis/attempt (a new service option staffed with suicide prevention peer workers)

Tier 3 A Safe Space to access psychosocial support and safety planning e.g. PHN commissioned services (primarily existing mental health services enhanced by peer workers)

Tier 2 A Safe Space to talk to someone and access a referral e.g. community centres/services/chemists that are already operational, with staff who are gatekeeper trained. (likely a multi-disciplinary team)

Tier 1 A safe 'refuge' to sit e.g. library, coffee shop, hairdresser, barber (community based non-clinical support)

Recommendation: With the 2021 Federal Budget funding announced for Phase 2 of the 'Trialling a National Safe Spaces Network to reduce the risk of suicide' proposal - establishing standards for the National Safe Spaces Network, we have the opportunity now to safeguard the pure intent of Tier 4 & 5 spaces, and importantly focus on their development as a matter of priority.

Queensland can support this by investing in:

Tier 4 Safe Spaces – genuine community co-designed, managed and delivered non-clinical services staffed with specialist suicide prevention peer workers only. Available and accessible to anyone experiencing emotional distress, suicidal crisis and aligned with the key components as determined by people with lived experience of suicide.

Tier 5 Safe Spaces - non-clinical, suicide prevention peer led residential houses where people in suicidal crisis and/or at risk of suicide attempt are able to be supported. Tier 5 residential Safe Spaces provide intensive, short-term support to allow individuals in suicidal crisis who do not require medical attention a sanctuary to manage and resolve crisis in a residential setting (rather than hospital). Staffed 24/7 by suicide prevention peer workers, individuals can stay in a safe, peaceful environment, connect with others and reflect on contributing factors to their suicidality, personal experiences, possible options for moving forward, and begin to find a path out of crisis

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Invest in the ongoing development and support of the specialised Suicide Prevention Peer Workforces

The establishment of new suicide prevention services that utilise lived experience expertise is an important development in Australia's quest to reduce the rate of suicide. The emerging Suicide Prevention (SP) Peer Workforce is being called to extensively use its lived experience of suicide in new environments. The recently released Prime Ministers Suicide Prevention Advisor: Interim Report (Nov 16, 2020) cites the suicide prevention workforce in Recommendation 4. Our commitment to the success of these new services must include support for this new workforce.

A supported, capable and confident SP Peer Workforce will be pivotal to the success of new suicide prevention services. SP Peer Workers will commence their new position with enthusiasm and passion, but their retention requires their work to be sustainable and their professional needs to be met. Investment in the SP Peer Workforce is essential for their retention. The benefits of retaining SP Peer Workers as long-term members of the broader suicide prevention workforce will flow to the workers themselves, the organisations that employ them and people who seek their support during a suicidal crisis.

Working in other peer work roles prepares an SP Peer Worker for using their lived experience, however further professional development is required for sustainable, continuous and effective sharing of lived experience of suicide in a suicide prevention service.

Confidently and successfully using lived experience expertise for suicide prevention requires all members of the suicide prevention team to have knowledge, understanding and respect for SP Peer Work. Managers can benefit from general courses about managing peer workers and teams can benefit from courses that provide an introduction to peer work. These courses do not, however, specifically explore inclusive practices for workers who use their lived experience of suicide to promote change. Inclusive teams can only be created by openly discussing and challenging misunderstandings, myths and assumptions about people who have survived a suicidal crisis.

The full benefit of including lived experience expertise in the team can only be realised if anxieties around the use of peer approaches in suicide prevention are aired and addressed by all members of the team. Managers need guidance around unique issues that can arise when managing a team that includes workers with a lived experience of suicide. Organisational Readiness Training addresses and meets these needs and promotes inclusive workplaces.

SP Peer Workers will have ongoing personal and professional development needs. Line supervision, debriefing and EAP counselling will be sources of support and guidance for SP Peer Workers, however these alone will not meet unique needs associated with using lived experience for suicide prevention. External supervision provides all workers the opportunity to speak more freely about workplace challenges and gain perspective from an experienced individual who is independent. SP Peer Workers need this opportunity too.

Recommendation: Queensland invests as a matter of urgency, in the suicide prevention peer workforce by providing specialised training for people with a lived experience of suicide wishing to work in formal peer roles within suicide prevention services, and a range of peer support services and resources for them and the organisations who engage them. This specialised contextualised curriculum and development services are already developed and being utilised in other parts of Australia.

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