27th October 2024

Consultation – Advice on The National Suicide Prevention Strategy Consultation Draft

Submitted to:

nspo@nspo.gov.au

For:

The National Suicide Prevention Office (NSPO)
Department of Health and Aged Care, Australian Government

Address Details:
National Suicide Prevention Office
PO Box R1463
Royal Exchange
NSW 1225

Lived Experience Australia Ltd
Contact: Sharon Lawn
Executive Director
slawn@livedexperienceaustralia.com.au
PO Box 98, Brighton SA 5048
Phone 1300 620 042
ABN: 44 613 210 889

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include approximately 9000 people across Australia with lived and living experience of the many intersecting causes and consequences of mental health concerns, including suicide and suicidality, and their impacts. This includes lived and living experiences with all parts of the mental health care and suicide prevention (and postvention) systems and services, across public and private service options (within LEA's enduing advocacy for the many who rely primarily on general practitioners, and privately provided psychological therapy and psychiatry). It includes NDIS and psychosocial disability support outside the NDIS, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both. Experiences of suicide sit alongside these experiences.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions. Suicide prevention is core to this advocacy.

We support, and have also actively contributed to, the submissions to this consultation made by Suicide Prevention Australia (SPA) and the National Mental Health Consumer Carer Forum (NMHCCF).

We welcome the opportunity to provide our feedback to this crucially important issue for individuals, families, carers, kin and supporters and the Australian community.

Purpose of this Consultation

The National Suicide Prevention Office (NSPO) has released this draft strategy for comment before finalising its advice to the Australian Government. **Of note,** this consultation is not a draft 'National Strategy'; it is a consultation draft on advice that will form a future national strategy, yet to be finalised. This is an important distinction.

The Hon Minister Butler, in a media statement launching the consultation, has stated that the NSPO has worked closely with its advisory board, members of the Lived Experience Partnership Group, a jurisdictional forum and working groups to inform this draft strategy. Many Australian and international academics, service providers, people with lived and living experience and members of the public also contributed. The Minister has also stated that the Government is committed to reforming the suicide prevention system, so every Australian has access to support when and where they need it. The advice from the NSPO will be an important part of this process.

Response to the Consultation Draft

Lived Experience Australia provides the following comments based on hearing the concerns of our 'friends' network across multiple consultations and projects that we have conducted ourselves or in collaboration with lived experience partner organisations and allied in our sector. A number of key points are apparent:

- There is strong support for the need for a National Strategy on suicide prevention to reduce suicide rates.
- The whole-of-government approach of the draft is welcome and reflects the many intersections of causes and consequences that can only be addressed with such an approach.
- The broad approach is welcome to ensure that suicide prevention is not limited to narrow understandings and then narrow actions/implementation. Suicide is not merely an 'individual', 'clinical' or 'mental health' issue; it is a societal issue.
- The overall content of strategy is supported, with some suggested improvement to specific aspects (see details below)

- Like our peers and allies in other organisations, there is a significant amount of frustration in the sector that the actions in the strategy have not already been implemented. Further to this, framing of the draft as 'advice' is also frustrating and worrying. We believe strongly that the government should demonstrate its commitment by releasing the final version as a strategy and not merely as advice on a strategy.
- We call for the government to begin work immediately on high priority actions.

We welcome the focus on improved governance as a critical enabler that recognises a whole-of-government approach is needed. We recognise that many factors that are outside the remit of the government's health portfolios contribute to or protect against suicide. The lived experiences of our friends are replete with examples of often long paths of distress, need and help-seeking long before their eventual contact with health and mental health services, often experienced as crisis contact, and far too late. We know that there are some individuals who suicide without ever coming to the attention of health or mental health services.

Our friends have told us of so many examples across their lives of failures in earlier suicide prevention awareness and support relevant to multiple portfolios of government influence on policy, laws and practice: education and schools, family and domestic violence, child abuse and neglect, poverty and income support, housing, employment and fair work (including Defence), legal and corrections systems, gender equity, immigration, industry/farming and trade, drug/alcohol/gambling policy and regulation, social media regulation, construction and road safety, and so forth. These signify multiple examples of where suicide prevention and early intervention could have occurred but didn't occur.

As a mental health community, we are grappling with crisis driven service policy and practice as the dominant focus, and significant unmet needs for people with ensuring mental health experiences and their families, carers, kin and supporters. So much of all this could have been prevented or ameliorated with more attention to the 'causes of the causes' that sit squarely much earlier and beyond the health and mental health sector.

We also wish to draw your attention to the following issues that we believe should be more visible within the draft document:

- The false dichotomy between mental health and suicide prevention which creates a divide that is counterproductive. Please see NMHCCN's submission for further detail. Also, this divide perpetuates silos in policy and actions, and breeds competition for already scarce resources; it also creates the potential of perpetuating discrimination and stigma for certain sub-populations.

- Equally, a whole-of-government approach must be cognisant of the potential for unintended consequences that can arise within systems in which 'making something everyone's business and responsibility might mean that no-one then takes responsibility'.

- The peer workforce is an important emerging group within the mental health and suicide prevention landscape. There is significant goodwill and rhetoric about the potential for this lived experience workforce in helping to shift stigma, improve the culture of service systems, improve outcomes for people who experience mental illness or distress, and more. Peer work in suicide prevention services should be paid and professional. They meet people when they are at their very worst and they deserve to be treated by a trained peer. Whilst the consultation draft identifies 'Embedding lived experience' and a 'Capable and integrated workforce' as critical enablers, we believe it could go further in discussing potential roles and requirements for the peer workforce. Currently, the document makes reference only to a suicide prevention peer workforce, despite the issues and challenges noted in the document being pertinent also to the mental health peer workforce. This siloing is not helpful and doesn't recognise the many people at the intersections of services experiencing suicide and suicidality (60% of deaths by suicide have a diagnosed or known mental illness), and who also require postvention support.

- The consultation draft is missing whole-of-government approaches that exist within Australia. One useful example is the SA Suicide Prevention Act 2021 which is one such approach for government agencies (notably with large workforces) focused on Suicide Prevention Plans development and associated reporting requirements under the Act. https://www.legislation.sa.gov.au/__legislation/lz/c/a/suicide%20prevention%20act%202021/current/2021.51.auth.pdf

- We want to stress the importance of the government taking action on the National Stigma and Discrimination Reduction Strategy which is yet to be implemented. Like many other national strategies (such as The National Plan to End Violence against Women and Children 2022–2032), suicide prevention must aim to link with other national strategies and plans if integration of effort as part of whole-of-government and whole of community approaches are to be realised.

- Finally, we also want to stress the importance of an independent National Suicide Prevention Office that can monitor and report on the implementation of a national suicide prevention strategy.

Contact

We thank the National Suicide Prevention Office for their work, and for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our lived and living experience perspectives to any future discussions about this important topic.

Your sincerely

Sharon Lawn

Professor Sharon Lawn, Executive Director
Lived Experience Australia Ltd
Email: slawn@livedexperienceaustralia.com.au
Mobile: 0459 098 772