Lived Experience AUSTRALIA

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National Suicide Prevention Taskforce, Interim Advice.

PUBLIC CONSULTATION

ON LINE SUBMISSION

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Submitted to **National Suicide Prevention Taskforce – Interim Advice Public Consultation**
Submitted on **2020-12-03 12:01:55**

Feedback on the National Suicide Prevention Adviser's Interim Advice

Section One – Your details

What is your name?

Name:
Janne McMahon

What is your email address?

Email:
jmcmahon@livedexperienceaustralia.com.au

Are you responding as an individual or on behalf of a community or organisation?

Organisation

Please include your name and/or the community or organisation and any contact details.

Please provide your response below:
Janne McMahon - Executive Director
Lived Experience Australia
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Would you be happy for the Department to contact you in regards to your survey response?

Yes

Include a brief description of your experience, role or interest in suicide prevention.

Please provide your response below:
As a peak national lived experience organisation we provide advice and systemic advocacy on behalf of consumers, families and carers. As such, suicide prevention is core to our activities and anything we can do to assist government, the NMHC and Ms Morgan to implement strategies, distribute information etc to our approximately 2500 members and friends, we would be keen to do so.

We would also be keen to provide skilled consumer and carer representatives to any working groups etc.

Lived Experience Australia can provide both consumer AND carer perspectives, ie we are a one voice national organisation.

Section Two – Interim Advice recommendations

Are the key areas of focus to achieving a national whole-of-government approach to suicide prevention covered by the recommendations? What are the most critical recommendations to achieving this approach?

Please provide your response below:
Yes.
We feel the most critical recommendations are:
1) 1.1 creation of a Ministerial Reform Council
2) 1.2 The responsibility of running out suicide prevention activities must be vested in the local communities particularly in the rural and regional areas that affect their whole of community.
3) 2.1 A stand alone National Suicide Prevention Strategy
4) 2.2 Implementing the Nat Aboriginal and Torres Strait Islander Suicide Prevention Plan. This is a wonderful plan and could certainly form the basis of regional plans.
5) 2.4 Responses to national disasters and strategies for risk and protective factors for suicide
6) 3.1 Fully agree with this inclusion of lived experience
7) 3.2 Lived Experience must be core to governance structures
8) 3.4 develop the lived experience workforce and ensure suicide prevention training eg ASIST is incorporated into that training.
9) 4.1 training for clinical and other health staff on best practice for assessing risk of suicide.
10)4.3increase suicide prevention training for noted services

Are the recommendations feasible and able to be implemented? Why or why not? What considerations, barriers and enablers need to understood?

Please provide your response below:
From LEA's perspective, recommendations 1,2,3, and 4 are critically important from a high level oversight.

Yes we believe the recs are implementable but only if there is full agreement across the federal, states and territory governments.

Are there any critical gaps in the recommendations that need to be addressed?

Please provide your response below:
Not at this stage as these are high level recommendations. The success of the whole approach to suicide prevention, is in the detail. Specific target groups, etc. A crucial part will be what we have learned from the ATSI Suicide Prevention Strategy. This could be used as a blue print as it covers many of the detailed information required for implementation of successful strategies.

Please provide any specific comments on the recommendations related to 'A shift to a national whole-of-government leadership and governance' (recommendations 1, 2, 3 & 4).

Please provide your response below:
There are a couple of recommendations that are particularly pertinent.
1) We fully support a Ministerial Reform Council which should have both consumers and carers affected by suicide as part of that council.
2) Regional coordination is imperative most particularly in the rural and remote areas. Funding and resources must be made available to local governments to offer community based prevention, early intervention and support services
3) Whole of community is the essence here, ie jurisdictional governments must make practical opportunities to deliver suicide prevention activities in conjunction with people who have been affected by suicide as major contributors.
4) upskilling and expanding the peer workforce is an essential component of models of care and services
5) upskilling the workforce, clinical and other, around natural disasters like COVID where children are forced into a closer association than normal with people who may abuse them. Trauma informed care and practice will be a critical component of any training.
6) workforce: training and education must be introduced to country staff including ambulance, police and administrative staff of suicide awareness.

Please provide any specific comments on the recommendations related to 'Improved data and evidence to inform decision-making' (recommendations 5 & 6).

Please provide your response below:
Agree with Rec 5.1 and 5.2 but add that data held by the states and territory coroners should be added. This should be cross referenced to state/territory data collection

Agree with Rec 6.1 and 6.2

However data is not a stand alone process. Learnings must be taken from all the data collected, both at national, and state/territory levels to note the drivers of why people suicide, or barriers or gaps in services to help and support that lead people to suicide or attempt suicide. The quality and safety areas at both national and state/territory levels will be crucial. Just obtaining quantitative data alone will not provide sufficient information.

Please provide any specific comments on the recommendations related to 'Policy and cross-portfolio approaches to reduce and respond to distress' (recommendations 7, 8 & 9).

Please provide your response below:
Fully agree with Recommendation 7 using the Shifting the Focus tool for program effectiveness. Great tool across numerous critical domains that is very practical, useful and informative.
It would be useful for communication across jurisdictions on what and how programs/services are achieving good outcomes through their developed action plans. This could be part of the national communication task of a National Office for Suicide Prevention.
What we miss in Australia currently is the communication of services that are doing very well in meeting the needs of consumers and also carers ie what the programs/services look like, how they are being delivered, barriers, gaps, etc.

Fully agree with Recommendation 8.

Fully agree with Recommendation 9. However, a target group particularly in the COVID climate, is children at risk of abuse who can be/are isolated with perpetrators. Additionally, trauma informed care and practice is a must for training of clinical staff. See recommendation 4 (workforce strategy)

Please provide any specific comments on the recommendations related to 'Targeted approaches to meet the needs of priority populations' (recommendations 10 & 11).

Please provide your response below:
Support all categories noted in 10.1 and 10.2.

Support 11.1 and 11.2. As mentioned the Aboriginal and Torres Strait Islander Suicide Prevention Strategy includes critical information about how services and ATSI people/communities/organisations should be engaged to bring about the best result. We can learn a great deal from this Strategy in bringing this across to mainstream.

'After care' for people experiencing a suicide attempt or families affected must be targeted for specific attention.

A range of targeted community mental health supports to reduce the risk of subsequent suicide following discharge from hospital or other care must be introduced. Follow up should occur through multiple channels (in person, by phone), and should not be dependent on the nature of any other service the person is receiving or has received, or how that service is funded (Commonwealth or State).

Also targeted support programs for smaller communities in rural and remote areas should be factored in for specific attention.

Please provide any specific comments on the recommendations related to 'Health and mental health reform as critical to suicide prevention' (recommendations 12 & 13).

Please provide your response below:
Recommendation 12: LEA believes this is perhaps the most important recommendation as it relates to the personal level of care and support and encompasses the person centred approach all services should provide.

This is a critical part of the whole suicide prevention strategy. We believe it should be longer if we are to make effecting programs/service delivery, and to evaluate the effectiveness. We believe there should be a focus of 5 years to ensure the greatest opportunity to prevent suicide.

People with a lived experience, including their families/carers, see the ED as the first port of call with many hoping that this will provide that 'safe space' Unfortunately this is often far from perfect or appropriate, so the specific needs of people attending the ED in crisis, should be prioritised with explicit referral and follow up.

LEA also believes that attention should be made for targeted intervention/prevention for people with specific diagnoses that are known to have a high level of suicide attached, ie schizophrenia, major depressive disorder, borderline personality disorder etc.

We believe there should also be introduced a mandated, routine use in public and private mental health services of a clinician rated, validated suicide risk assessment tool at discharge from inpatient settings, and 3 monthly review in community settings. Whilst assessment tools are necessary, staff should also ask the person if they feel safe to leave, ensure there is support available and they know how to access it, and what to do and where to go if they feel they are in danger of taking their lives. Care plans on discharge are an essential to complement these strategies.

LEA also believes the introduction and routine use of a clinician rated, validated suicide risk assessment tool for all people in contact with community mental health support organisations.

Additionally we believe that reporting protocols should be implement of deaths within 28 days of discharge from a mental health facility and linked to either data collection protocols and coronial reporting requirements.

Implement the reporting of any death within 28 days from consultation with a health professional for a mental health issue, should also be linked to data collection protocols and coronial reporting requirements.

Agree with recommendation 13.

Please provide any specific comments on Compassion First – designing our national approach from the lived experience of suicidal behaviour.

Please provide your response below:
Please provide your response below
As mentioned, this is essential reading. How will we know what services/interventions are needed and work best, unless we ask those people who have been affected by suicide.

Funding should be targeted to consumer and family/carer needs and services/interventions designed from and with them, rather than designing services and expecting and hoping that the services/interventions will work.

This is confronting ready, a tragedy that lives are lost because people feel overwhelmed by lack of hope, lack of appropriate services and supports. Families and carers also must be supported, they are on the front line of care just as much, if not more so than clinicians.

They must be listened too when they are concerned about the person they are supporting.

The needless loss of life must stop if at all possible.

Please provide any specific comments on Shifting the Focus – a national whole-of-government approach to guide suicide prevention in Australia.

Please provide your response below:
LEA has been in total support of the Prime Minister and government in his appointment of Ms Christine Morgan in the capacity of Suicide Prevention Advisor. Christine has a wealth of knowledge, compassion that comes through, a real desire to know how to do things better, and an understanding of the need for services/interventions/strategies to be driven by the lived experience.

Please provide any additional comments for the National Suicide Prevention Adviser to consider for the Final Advice in December 2020.

Please provide your response below:
Lived Experience Australia has been in operation for 19 years, is professional in approach, has a wealth of information, perspectives, and advice from both a consumer and carer perspective, ie the 'one voice' organisation.

LEA has recently appointed Ms Heather Nowak (an SA Mental Health Commissioner) as our Lived Experience Suicide Prevention Advisor, with the task to keep LEA up to date on suicide prevention activities and how we can best assist and support suicide prevention programs across Australia. Additionally, Heather will ensure LEA keeps a suicide prevention focus in our activities. Heather is involved in the SA Suicide Prevention Taskforce and brings personal lived experience as well as that of her brother who took his life a few years ago.

We would welcome any involvement or engagement going forward particularly in relation to the membership of any national committees, such as a Ministerial Reform Council.

We have people who have attempted suicide, or been affected by the death of a person close to them that they were supporting that we would call upon as representatives.

We would welcome a close association with Christine Morgan going forward.

Acknowledgment prior to submitting survey

I understand that the giving of my consent is entirely voluntary

Yes

I am over the age of 18 years

Yes

I understand the purpose of the collection, use, publication or disclosure of my submission

Yes

I understand that copyright in the content of my submission will vest in the Commonwealth of Australia

Yes

Where relevant, I have obtained the consent of any individuals whose personal information is included in my submission, to the Department collecting this information for the purposes outlined in this notice

Yes