Roses in the Ocean

stemming the tide of suicide

Mental Health and Suicide Prevention Agreement Review - Interim Report

Roses in the Ocean

July 2025

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Acknowledgement of contribution

Roses in the Ocean acknowledges the important insight and expertise provided by members of the Policy and Advocacy Lived Experience Advisory Group Sub-committee in development of this submission.

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Executive Summary

Roses in the Ocean is Australia's national lived experience of suicide organisation. Founded in 2011, we have developed best practice in lived experience engagement, integration and partnership.

Cited by the World Health Organisation[1] as a global leader in the field of lived experience of suicide, Roses in the Ocean has drawn from our own lived experience of suicide, and that of all the people we have had the privilege of walking alongside.

Through the National Suicide Prevention Leadership and Support Program, Roses in the Ocean provides national leadership in empowering people with a lived experience of suicide to share their experiences and meaningfully engage in the development of suicide prevention research, services and programs.[2]

Roses in the Ocean welcomes the **Mental Health and Suicide Prevention Agreement Review – Interim Report (Interim Report)**[3], in line with our commitment to people with lived experience of suicide (which refers to having experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or been bereaved by suicide).[4] We welcome the Productivity Commission's review and the opportunity to contribute to the Interim Report from a lived experience of suicide perspective.

Roses in the Ocean notes the Productivity Commission's summation that the National Mental Health and Suicide Prevention Agreement (the Agreement) is not fit for purpose.[3] The current Agreement emphasises engagement of people with a lived experience of suicide throughout implementation of the Agreement but says little about how this would be achieved.

It is imperative people with a lived experience of suicide are central to the next iteration of the Agreement as highlighted the National Suicide Prevention Strategy:

> *'People with lived and living experience have the greatest insights into what works, what does not work, and what is missing in suicide prevention. For suicide prevention efforts to be of high quality and effective, it is vital that people with lived and living experience of suicide have a central role in designing, delivering, governing and evaluating suicide prevention activities' - National Suicide Prevention Office.*[5]

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Roses in the Ocean provides the input in response to the following elements of the Interim Report, which provide opportunities to meaningfully embed lived experience of suicide:

- Draft Recommendation 4.7 The next Agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements.

- Information Request 4.2 The Commission is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement be measured?

- Information Request 4.4 The Commission is looking for case studies highlighting best practice in integrating peer workers in clinical mental health and suicide prevention settings. Are there examples that could be adopted more widely?

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Amendment to Draft Recommendation 4.7 - the next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements.

The Interim Report is commended for noting the next agreement should support a greater role for people with lived experience in governance (Draft Recommendation 4.7).[3] It is recommended the next suicide prevention schedule of the Agreement adopt the Lived Experience Partnership Group model implementation by the National Suicide Prevention Office (NSPO). The Lived Experience Partnership Group:

- Ensure lived experience insights and knowledge are incorporated into the operations and work of the NSPO.
- Provide subject matter expertise to the NSPO on current and emerging issues
- Advise the NSPO on effective and inclusive ways of meaningfully partnering with people with lived experience of suicide in the performance of its duties

However, it is of concern that **Draft Recommendation 4.7 is limiting the range of lived experience perspectives by recommending only that *'the next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements'.*** The established national mental health lived experience peak bodies were established with a specific focus to support people with a lived or living experience of mental health challenges[6], raising concern people with a lived experience of suicide would not be represented in governance forums. While some members of these bodies may also have a lived experience of suicide, this is often understood primarily through the lens of mental illness and may not represent the broader range of social, economic, and cultural factors that contribute to suicidal distress.

As highlighted by Professor Keith Hawton and Professor Jane Pirkis, the emphasis of suicide prevention in the past has been on clinical mental health solutions where suicidal thoughts and behaviours have been predominately regarded as symptoms of mental health challenges. A more comprehensive approach requires policy makers to look beyond mental health approaches and place greater emphasis on interventions and supports that address the social and commercial determinants of suicide – such as alcohol use, gambling, domestic violence and abuse, and bereavement by suicide.[7]

The National Suicide Prevention Strategy recommends all government policies should explicitly consider suicide prevention in their development and report on how they have partnered with people who have a lived experience of suicide in their decision-making. To achieve this goal throughout the Agreement, it is essential to establish formal roles that promote meaningful partnerships with those who have a lived experience of suicide. These roles should exist alongside—and be distinct from—the two recently established mental health lived experience peak bodies.

Through the National Suicide Prevention Leadership and Support Program, the formal role of national support for lived experience of suicide are provided by Roses in the Ocean and Aboriginal and Torres Strait Islander Lived Experience Centre (ILEC). The next agreement should clearly articulate formal roles of both organisations within the relevant governance arrangements.

As previously noted by Suicide Prevention Australia's submission to the Review, the current Agreement takes a mental health lens and primarily focuses on health services.[8] People with lived experience of suicide have an enormous stake in the next Agreement and seek to be meaningfully included in the development, implementation and evaluation.

A recent environmental scan of suicide prevention activity in Australia found mixed progress in the integration of lived experience. Of the 34 policy documents reviewed, about half specifically mentioned 'lived experience of suicide', often referring more broadly to 'mental health lived experience'.[9]

Every jurisdiction must have governance arrangements specific to suicide prevention that share leadership and decision-making with people with lived experience of suicide. There must be people with lived experience of suicide present wherever and whenever there are decisions made to inform 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 of suicide to be involved.

The National Suicide Prevention Strategy (the Strategy) highlights the need to formalise meaningful engagement of people with lived experience of suicide, alongside and separate to, consumers and carers of mental health challenges. The Strategy recommends:

> *Establish dedicated lived and living experience roles and governance bodies centrally and/or within processes for policies and programs with relevance to suicide prevention. departments and agencies to ensure lived and living experience of suicide is integrated into decision-making – National Suicide Prevention Strategy*[5]

Suicidal distress is a complex, human response that arises from a host of factors and should be understood as more than an expression of mental health challenges. Approximately half of the people who die by suicide in Australia do not have a diagnosed mental health challenge and a larger proportion do not have contact with the mental health system in the year prior to their death.[10,11]

The Productivity Commission has highlighted that many people in suicidal distress do not use mental health services. Research found that in the three months prior to suicide, approximately 40% of people accessed primary healthcare and 35% accessed mental health services.[12]

As previously noted in Roses in the Ocean's submission to the Review, governance forums, such as the Mental Health and Suicide Prevention Senior Officials Group and sub-groups, known to oversee implementation of the Agreement, are dominated by mental health representatives, with very little representation from people with a lived experience of suicide.[13]

To support and strengthen genuine participation of people with lived experience of suicide, we would recommend amendment to **Draft Recommendation 4.7, formalising Roses in the Ocean's support role within the relevant governance arrangements**. We believe this should occur alongside our partners ILEC, and the two newly established mental health consumer and carer peak bodies.

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Information Request 4.2: The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums.

Roses in the Ocean welcomes the opportunity to provide insight into the barriers that prevent the authentic inclusion, participation, and influence of people with lived experience of suicide in governance forums. Our organisation works to elevate and embed lived experience of suicide at all levels of suicide prevention governance, and we consistently hear from individuals across Australia who encounter structural and cultural barriers to meaningful involvement.

The experience reported by people with a lived experience of suicide, and supported by Australian research[14], highlight there are critical barriers to the genuine participation and influence of people with lived experience in governance forums, including:

- **Tokenistic Engagement**
    - Many governance forums include lived experience of suicide representatives to satisfy health service accreditation requirements for consumer participation, without granting them meaningful power or decision-making influence. Participation of lived experience is limited to consulting (providing feedback) and rarely having final decision-making power in governance forums.

    - Lived experience of suicide roles in governance forums often lack clarity, are not adequately resourced, and are excluded from strategic decision-making. Lived experience of suicide voices may be heard, but not acted upon, leading to disillusionment and mistrust.

- **Power Imbalances and Cultural Hierarchies**
    - Governance forums are frequently dominated by professionals and mental health subject-matter experts, creating a power imbalance that can marginalise lived experience of suicide perspectives.

    - The experience of lived experience of suicide leaders on governance forums is lived experience and professional expertise are positioned as polarised opposites, where governance forums frame lived experience of suicide as merely personal anecdote or storytelling, lacking the expertise of professionals.

- **Insufficient Preparation, Support, and Remuneration**
    - Many individuals with lived experience of suicide are invited to contribute without adequate preparation, training, or ongoing support. There is often an assumption that lived experience representatives will contribute their time to governance forums voluntarily, which undervalues their expertise and reinforces inequality. Appropriate remuneration, capacity-building, and lived experience of suicide led debriefing and support are essential components of safe and sustainable engagement.

- **Lack of Diversity and Inclusion**
    - There is a lack of a lack of representation for population groups disproportionately impacted by suicide in decision-making forums. People with lived experience of suicide from marginalised communities—including First Nations peoples, culturally and linguistically diverse communities, LGBTQIA+ individuals, people living with disability, and those in rural and remote areas—face additional systemic barriers. These include a lack of culturally safe spaces and representation in governance processes.

- **Risk Aversion and Systemic Stigma**
    - Mental health and health sectors can be risk-averse in involving people with lived experience of suicide, often due to outdated perceptions of capacity, risk, and vulnerability. Governance forums unintentionally perpetuate systems and structures that may cause harm for people with lived experience of suicide. This can result in exclusion or over-regulation of participation, particularly for people with recent or ongoing experiences, denying the sector access to the richness and immediacy of lived experience of suicide expertise.

- **Jurisdictions lack an agreed approach to demonstrate success or impact of embedding lived experience.**
    - There is a lack of a consistent, agreed framework across jurisdictions to measure the success or impact of embedding lived experience in governance forums. Without clear indicators or shared definitions of what constitutes meaningful participation, it becomes difficult to evaluate the effectiveness of lived experience roles and to demonstrate their value beyond anecdotal feedback.

    - Co-design is often referenced in policy and program funding/commissioning documents, in practice, it is frequently misunderstood, rushed, or entirely absent. People with lived experience of suicide are too often brought into the process after key decisions have already been made, limiting their ability to shape objectives, priorities, and design elements from the outset. This undermines the principles of authentic co-production and results in missed opportunities to leverage the unique insights and innovations that the people impacted by policy and programs can offer.

Integrating lived experience of suicide in formal roles within governance forums to inform design, implementation, and evaluation of the Agreement can support reform to be inclusive and responsive to the needs of those with lived experience of suicide. Professor Jane Pirkis, and national and international colleagues, highlight that:

Policies that influence suicide and self-harm are likely to be more effective and more sustainable if relevant groups of stakeholders have genuine ownership of them. Solutions are more likely to come from those who are affected by the social

determinants of suicide and self-harm, living with them as part of their reality every day…

We need to ensure that people who are at heightened risk of suicide and self-harm have a genuine, meaningful influence over policy decisions in the "big-ticket" non-health areas that perpetuate their disproportionate level of risk. Their experiences need to be fully incorporated into agenda setting across the full gamut of relevant policies.[14]

To foster genuine participation in decision-making, governance forums must:

- Embed co-design and co-production principles from the outset - Adapted IAP2 Spectrum of Public Participation for lived experience of suicide context.[15]
- Provide lived experience of suicide led training, mentorship, and embed appropriate remuneration in all suicide prevention governance forums.
- Embed lived experience of suicide chair or co-chair for all Agreement advisory groups pertaining to the implementation of the suicide prevention schedule.
- Ensure lived experience of suicide roles have equal decision-making authority.
- Include people with a lived experience of suicide in the design and assessment of tenders.
- Create safe, inclusive, and culturally responsive spaces.
- Commit to transparency and accountability through the audit and publication of how lived experience of suicide input informs decisions.

Roses in the Ocean would recommend all government departments and agencies tasked with implementing the Agreement implement tailored tools and resources to support embedding lived experience of suicide into relevant governance structures and decision-making processes.[1]

Finally, it is recommended the Agreement require funding and commissioning bodies of suicide prevention related services demonstrate meaningful inclusion of lived experience of suicide in governance forums and decision-making processes through applications for tenders and ongoing reporting arrangements.

[1] Further information on resources to support organisations and government departments build a lived experience informed and inclusive culture is available https://rosesintheocean.com.au/lived-experience-organisational-design/

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Information Request 4.2 How could successful inclusion and engagement of people with lived and living experience in governance be measured?

As noted by the National Suicide Prevention Office, it is well established that the voice of lived experience of suicide is essential to achieving lasting reform. Those who have accessed the system or experienced challenges in accessing the system know best what improvements need to be made and how best to measure progress.

It is imperative that measurement of inclusion and engagement of people with lived experience of suicide in governance, should not be taken as a one-off measurement at the conclusion of engagement, but rather track and report the journey of lived experience of suicide partnership in decision-making.

The National Mental Health and Suicide Prevention Evaluation Framework[16] provides a guide for a principles-based approach to measurement of successful inclusion and engagement with people with lived experience of suicide in governance. The following principles adapted from the National Mental Health and Suicide Prevention Evaluation Framework are suggested:

- **Lived experience of suicide and person-centred measures**
    - People with lived experience of suicide are actively involved in the design and delivery of evaluations to ensure they are useful and meaningful. (This may include co-design or co-production).
    - Evaluation processes are safe and accessible to people accessing the service, including for diverse populations.

- **Robust and fit-for-purpose measures**
    - Measurements are considered upfront when a governance forum is being designed and embedded into the terms of references to ensure that data collection is built in, and outcomes measures are meaningful.
    - Quantitative measurement is a powerful tool, but its benefits can be enhanced further by mixed methods approaches that have strong lived experience of suicide integration in the design, collection and analysis of any governance activities.

- **Trauma-responsive and ethical measures**
    - Measurements are designed in a way to avoid traumatisation and/or re-traumatisation.
    - The measurement of engagement follows ethical standards, including specific guidance for Aboriginal and Torres Strait Islander communities.

- **Focused on learning and building the evidence base inclusion and engagement of people with lived experience**
    - Measurements enable improvement by being clear about what is working well and what needs to be improved and the context in which this is occurring.

- Measurements are conducted in a way that they can contribute to the broader knowledge about best practice inclusion and engagement of people with lived experience in suicide prevention in Australia.
- Measurement of inclusion and engagement in governance forums provide clear and actionable implications or recommendations that can be shared with relevant stakeholders.

The primacy of quantitative data means the depth and richness of qualitative measures is under-utilised. Quantitative data is a crucial and powerful tool, but its benefits can be enhanced further by mixed methods approaches that have strong lived experience of suicide integration in the design, collection and analysis of any activities that generate outcomes and impact useful for suicide prevention.

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Information request 4.4 - The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

Roses in the Ocean welcomes the opportunity to share examples of best practice in the integration of lived experience of suicide peer workforce within suicide prevention and health settings. As the national organisation dedicated to elevating and embedding lived experience of suicide, we have been at the forefront of designing, supporting, and strengthening the suicide prevention peer workforce across Australia.

Peer workforces have developed significantly across many areas of health and social services over the past decade. However, in the field of suicide prevention, the development and integration of a dedicated suicide prevention peer workforce remains in its early stages.

Until recently, individuals with lived experience of suicide—whether through personal suicidal thoughts, a suicide attempt, bereavement by suicide, or supporting someone in distress—were largely absent from the clinical mental health and health service landscape. This absence was reinforced by the once-prevalent but now discredited belief that open discussion of suicide could lead to an increase in suicidal behaviour.

Alongside this shift is a growing recognition of the need to develop and support a dedicated suicide prevention peer workforce. This workforce, comprised of individuals with lived experience, plays a critical role in supporting those experiencing suicidal crisis, bereavement by suicide, or who are caring for someone in crisis.

In research exploring perceptions of suicide prevention peer work, it was highlighted that peer-led Safe Spaces (Roses in the Ocean Non-clinical Services) address a critical gap in existing healthcare service systems.

> *The findings showed that peer-led safe spaces are addressing a critical gap in existing healthcare systems, fostering genuine connections, and providing a more supportive environment that contrasts with the often impersonal nature of clinical services.*[17]

The suicide prevention peer workforce fosters genuine connection and offers supportive environments unlike many clinical services.

However, concerns raised by participants in the research point to significant barriers to the recognition of peer-led Safe Spaces as legitimate models of care in suicide prevention. Barriers highlighted by participants include:

- Traditional healthcare hierarchies undermine suicide prevention peer workers' roles.

- Negative perceptions of suicide prevention peer work, including concerns about undermining clinical authority.

- Funding constraints and peer workforce staffing shortages.[17]

As noted by research commissioned by the Australasian College for Emergency Medicine, Emergency Department resourcing must include new workforce models which embed suicide prevention peer workers within multidisciplinary teams.[18]

Suicide prevention is often casually and uncritically referred to as being synonymous with mental health. Unfortunately, in the Agreement's implementation, this conflation has had practical effects regarding the skills and attitudes of staff in both Primary Health Networks and state government agencies as well as non-government organisations.

Roses in the Ocean strongly supports the continued development of this emerging workforce and urges the Productivity Commission to recognise its critical role in a compassionate, person-led, and effective suicide prevention system.

Roses in the Ocean has led the development and implementation of a national approach to supporting the suicide prevention peer workforce. This includes:

- **Lived experience led organisational readiness training for services seeking to embed peer workers, which includes educating clinical staff on the value, role boundaries, and contributions of peer workers to foster respect and collaboration.**
    - The organisation's leaders and managers should be clear in their understanding of the strategic basis for peer work in suicide prevention and be resolute about their backing for the organisation's engagement with suicide prevention peer work approaches. Without executive support, it is unlikely that the appropriate workplace culture will be created to best support the delivery of peer-based suicide prevention support.

- **Purpose-designed training programs tailored to the unique aspects of suicide prevention peer work, including safe story sharing, boundary setting, trauma-informed practice, and self-care.**
    - It cannot be understated how essential it is that suicide prevention peer workers receive training specially designed for peer workers in suicide prevention. It is common for suicide prevention peer worker roles to be recruited, without suicide prevention specific training to support their professional development. Customised suicide prevention peer worker training, such as Roses in the Ocean's Suicide Prevention Peer Workforce training, can support induction and orientation of these roles.

- **Lived experience led mentoring frameworks and practice supports developed specifically for the suicide prevention context, ensuring peer workers receive reflective and specialised guidance.**

- Suicide prevention peer workers in clinical mental health and suicide prevention settings report the challenges of peer drift – suicide prevention peer worker roles employed specifically for their lived experience of suicide become more clinical, administrative, or case management roles. This is experienced because the suicide prevention peer workforce in clinical mental health services fall under clinical governance supervision and practice supports.

  Evaluation of NSW Towards Zero Suicides Initiatives highlighted this in the implementation of initiatives where risk management practices and clinical governance, was a barrier to the roll-out of peer led suicide prevention models.[19]

- For suicide prevention peer work to be sustainable and effective, supportive strategies are needed within organisations employing peer workers. PEERnet, coordinated by Roses in the Ocean, is a secure virtual hub for suicide prevention peer workers and their allies. It facilitates collaborative discussions, critical reflection, and access to resources.

Peer Work Integration in Clinical Settings

While integration into acute clinical settings remains emergent, there are promising signs. Roses in the Ocean has partnered with health services piloting peer work roles in suicide prevention teams and led the development of community-based non-clinical services.

In several regions across Australia, Roses in the Ocean has worked with Primary Health Networks (PHNs), Local Health Districts, and community-managed organisations to embed suicide prevention peer workers into aftercare and crisis support services. These peer workers:

- Offer person-centred, compassionate support grounded in shared experience.
- Collaborate with clinicians and support coordinators as equals in the team.
- Play a critical role in building trust, improving service engagement, and reducing feelings of isolation and stigma.

An example of this approach is a Roses in the Ocean led project with Eastern Melbourne Primary Health Network. Roses in the Ocean is implementing a suite of resources and training focussed on building and supporting suicide prevention lived experience voice, workforce, and leadership. The project comprised three themes:

- **Lived Experience Voice:** provide individuals with lived experience of suicide with the necessary skills and support to safely engage in advocacy, engagement, and advisory roles.

- **Workforce Development**: deliver comprehensive training and support to develop a dedicated peer workforce in suicide prevention.

- **Workplace Support:** provide specialised training to the clinical workforce, incorporating the lived experience of suicide. Additionally, provide guidelines and skills development for managers to effectively supervise and support a peer workforce.

In our experience and the experience of people with a lived experience of suicide in peer roles, Roses in the Ocean would suggest the key enablers of success include:

- Training for clinicians delivered by experienced suicide prevention peer workers as lived experience facilitators to deepen understanding, challenge misconceptions, and highlight the peer workforce's unique contributions.

- Clear role descriptions and team protocols to define suicide prevention peer workforce scope and foster mutual respect.

- Ongoing co-reflection opportunities between clinicians and peer workers to promote learning and shared problem-solving.

- Ongoing lived experience led support and professional development for suicide prevention peer workforce.

- Consultative mentoring and tailored support for supervisors to lead suicide prevention peer workers based on peer work values, fostering leadership that respects the distinct peer role rather than traditional management approaches.

- Intentional pairing of individuals seeking support with a suicide prevention peer worker who shares a similar lived experience.

- Systematic review and revision of organisational policies to explicitly support suicide prevention peer workers practicing within peer work values and principles that differ from clinical frameworks, ensuring organisational alignment with peer workforce needs.

- Training and tools to support organisations build a lived experience informed of suicide informed and inclusive culture.

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