Roses in the Ocean

stemming the tide of suicide

Review of National Mental Health and Suicide Prevention Agreement

SUBMISSION BY ROSES IN THE OCEAN

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Submission by Roses in the Ocean

Roses in the Ocean supports further development of the National Mental Health and Suicide Prevention Agreement, 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). We welcome the Productivity Commission's review and the opportunity to contribute to the review from a lived experience of suicide perspective.

Under the umbrella of the National Agreement, Roses in the Ocean has been engaged in several supporting activities including co-designing Lived Experience Service Guidelines for aftercare, postvention and Distress Brief Support, and cooperating with Mental Health Australia to improve the representation of people with lived experience of suicide in the Agreement's governance. We have also been approached by a number of organisations to contribute to tender submissions and other service development activities related to the Agreement's implementation.

Roses in the Ocean would like to raise the following points for the reviewers' consideration.

Governance and lived experience participation

The National Agreement's governance is opaque, remote and lacking in accountability to the suicide prevention field and the community. Very little information is widely or formally available about the Agreement's governance structures, who participates in these structures and which organisations are represented. Although the Senior Officials Group is known to oversee implementation of the Agreement, it is understood that this group is dominated by mental health perspectives and government representatives, with very little representation from people with lived experience of either mental health conditions or suicide.

Lived experience representatives refer to an imbalance of power being evident and a high turnover of lived experience representatives further contributing to dysfunction in the Agreement's governance. There is little flow of information from the various working groups' back to the lived experience advisory group, which was developed substantially later than the signing of the Agreement and has struggled to be integrated into the Agreement's broader governance arrangements. The late formation of this group has meant key national decisions have been made about the Agreement's implementation without lived experience of suicide input.

Lived experience participation in the Agreement's governance has been disorganised and not well coordinated. The mental health sector has been approached by the Department of Health to provide lived experience representation for this purpose, overlooking the fact that lived experience of suicide is not identical to lived experience of mental health conditions. These challenges have been replicated at the regional level in commissioning and service delivery activities. There needs to be significant reassessment of how people with lived experience of suicide are represented in the Agreement's governance at both strategic and operational levels.

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Crisis services and a suicide prevention system

The National Agreement funds only the scantest elements of a suicide prevention service system. Aftercare and postvention are essential services but they are, by definition, not sufficiently pre-emptive to provide early intervention or targeted responses to people experiencing suicidal crisis. Crisis services such as safe spaces that offer an alternative to emergency departments and other peer-based support are needed to complete a more comprehensive approach to suicide prevention than is funded under the Agreement currently.

Likewise, Distress Brief Support needs to be expanded beyond the three states where it is currently under trial. This initiative is a key early intervention service well proven internationally to reduce community distress. Australian trials are of value to assess Distress Brief Support's implementation in the local context but should not be a reason to delay this service's availability nationally.

Dilution of aftercare's focus

One of the effects of there being very limited suicide prevention services funded under the National Agreement is that aftercare services in many areas have become the only in-person suicide prevention service available. This has contributed to aftercare's specialist focus on supporting people who have survived a suicide attempt becoming diluted and made available to anyone who has experienced suicidal thinking whether they have made a suicide attempt or not.

The number of people who experience suicidal thinking is much larger than the number of people who make a suicide attempt, and it is well established that suicide attempt survivors are at high risk of subsequent death by suicide. It is worrying that people who have made a suicide attempt may be on waiting lists for service while others with potentially less imminent needs are supported. This circumstance is also distorting data collection for aftercare, making it impossible to determine to what extent aftercare services are supporting people who have made a suicide attempt.

Additionally, there continues to be a lack of clarity about eligibility for aftercare services with confusion about whether a hospital emergency admission and/or psychiatric inpatient admission is required to access the service. It is likely that there is considerable variability across the country about this point. Greater consistency regarding the eligibility criteria for aftercare throughout the country would be beneficial, noting also that people with a lived experience have consistently called for self connection to be made possible in the service model.

It is also still the case that many people who may be eligible for aftercare services receive involuntary treatment in hospitals when community-based or at-home programs would be preferable for maintaining their autonomy and dignity. It is therefore likely that aftercare is being under-utilised by people who could be provided more appropriate care outside of restrictive and costly involuntary psychiatric admissions.

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Universal access

The National Agreement was announced with commitments for universal access to aftercare and postvention services. However, this commitment has not been realised to date. It is known that there are areas of the country where there is no feasible access to aftercare and postvention, with some postvention services having closed their books to new clients due to excessive waiting lists having accrued.

It remains the case that people in regional, rural and remote areas are especially disadvantaged in this regard. If services are available, they will be limited to telehealth, which brings access issues dependent on communications infrastructure, and can present problems for privacy and confidentiality.

The National Agreement must reassert governments' commitments to providing universal access to these services and provide the needed resources to meet community demand.

Unrealistic commissioning and service delivery timeframes

There have been numerous tenders relating to services funded under the National Agreement. However, in many cases, the tenders themselves and the service development they are proposing, are extremely rushed. Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.

The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas, largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. These very compressed timeframes arise from the funding periods for the tendered contracts being very short, sometimes only twelve or eighteen months in duration, creating further challenges for recruiting qualified and experienced staff and sustaining service delivery.

Additionally, the rush to commission suicide prevention services has produced other inappropriate outcomes including instances of services simply being awarded to organisations without any public tender, and organisations with no record in suicide prevention claiming to speak for people with lived experience of suicide or being engaged to deliver suicide prevention activities such as workforce training. These are very detrimental outcomes that reveal a lack of diligence, commitment to quality results and genuine focus on delivering effective suicide prevention, not least due to an absence of lived experience participation in tendering processes. The review of the Agreement should look closely at the compromises and conveniences taking place in some jurisdictions that have obscured the commitment to properly embed the perspectives of lived experience in the Agreement's implementation of suicide prevention services. Organisational claims to represent people with lived experience of suicide should be backed up by tangible representative processes for the community being represented.

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Workforce capability for suicide prevention

A significant concern relates to the capability of the workforce funded or engaged by the National Agreement in terms of suicide prevention. 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.

While there is some variation in workforce capability across the country, there is a general problem of staff with no experience in suicide prevention being recruited into suicide prevention roles. In some cases, these staff have experience in mental health but no specific suicide prevention experience and therefore do not understand the unique issues in this field such as the greater community, non-clinical and social determinants focus on suicide prevention. Because of the frequent and unquestioned merging of suicide prevention with mental health, many staff with a professional background exclusive to mental health erroneously believe they have an accurate understanding of suicide prevention due to its perceived lack of distinctiveness from mental health. Likewise, there is an assumption on the part of government and others that any mental health organisation is automatically capable of providing suicide-specific services.

Some attempt is made to address these issues by rolling out training to staff. However, much of this training is either superficial brief online modules, 'gatekeeper' training offering very minimal suicide prevention intervention skills, or qualifications that are not fit for purpose for suicide prevention such as the Certificate IV in Mental Health which includes only one unit on suicide prevention which is an elective. There is substantial work to do in developing appropriate accredited training for professionals in suicide prevention. Much workforce development remains primarily focused on mental health with little attention paid to suicide prevention.

Of course, receiving training – whatever its quality – is not in itself a guarantee that the unique features of suicide prevention are understood. More reorientation of services, including a needed paradigm shift in the leadership and management of services, is needed for this to be achieved successfully.

There also appears to be role confusion in some places between Primary Health Networks and non-government service providers, especially in relation to the responsibility for co-design of services. Greater clarification and consistency about the roles and responsibilities of the various agencies tasked with implementation would be beneficial.

Across the suicide prevention initiatives funded under the National Agreement, there is very little evidence of the development of the lived experience and peer workforces needed to effectively deliver these services. There remain no nationally coordinated efforts to recruit and train new lived experience or peer workers, and to address the significant barriers to the recognition and integration of this workforce, and their needs for ongoing support, mentoring and leadership. This is a high priority for further development of the initiatives funded under the Agreement.

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Head to Health's rebranding as Medicare Mental Health Centres

There is concern about the renaming of Head to Health Centres to Medicare Mental Health Centres. This is seen as reducing the accessibility and desirability of these services by invoking the stigma associated with clinical mental health services. The Head to Health branding implied a less biomedical, more community-oriented service. The rationale for the change, to align with other government-funded clinical services, is not a person or consumer-focused approach.

Limited addressing of social determinants

The National Agreement's scope is primarily on delivering services to communities through Commonwealth-state/territory coordination. However, at the same time, the community need governments to increase their focus on the causal factors or social determinants that are now well-known to contribute to suicidal distress and deaths from suicide. These factors include poverty, homelessness, disability, lack of access to critical services including dental care, and many other factors that coronial reports, research and lived experience have identified.

In some contrast to the National Agreement, the National Suicide Prevention Strategy includes unprecedented strategic attention on these 'upstream' factors, in addition to the need to maintain or expand 'downstream' services such as those funded under the Agreement. There is opportunity for these differing priorities to be better integrated and it would be helpful for this review to consider how implementation of the National Suicide Prevention Strategy will link with continued implementation and reform of the National Agreement. This challenge will need to be addressed for there to be effective coordination between these two significant national policy instruments for suicide prevention.