Roses in the Ocean
stemming the tide of suicide

Submission to the Productivity Commission Inquiry
into the Social and Economic benefits of Improving Mental Health

Dear Commissioners,

We appreciate the opportunity to provide feedback on the Productivity Commission's draft report and thank you for the comprehensive, potentially once in a lifetime generational change guiding document and related draft recommendations.

Roses in the Ocean is a national lived experience of suicide organisation contributing to best practice and a growing evidence base. We exist to reduce emotional pain and distress, and to save lives.

Roses in the Ocean collaborates with individuals and organisations across community, corporate, health and government sectors to effectively and meaningfully engage lived experience expertise within all aspects of suicide prevention. Our work is informing, influencing and enhancing suicide prevention nationally and internationally, through the development of an insightful and supported workforce of empowered individuals with personal, lived experiences of suicide.

We know that individuals who have experienced suicidal thoughts, survived a suicide attempt, cared for loved ones through crisis, or been bereaved through suicide, can provide us with powerful insights and opportunities to inform, influence and enhance suicide prevention activities.

As such, our submission is focused on suicide prevention, acknowledging that regardless of how a person arrives at a place where ending their own life is considered a viable option, what matters is that we have a highly visible, accessible and trusted scaffolding of support to help them stay safe and services to empower them towards recovery.

We support and call for bold system change.

Drawing on solid evidence, knowledge and expertise and harnessing the critical insights and wisdom of those with a lived experience of suicide, we must re-imagine a system and suicide prevention landscape that provides services and supports that people actually trust and want to engage with.

We do not have time to wait while the current mental health system is 'fixed'… so many people are dying every day.

- *We must develop a non-clinical, person centred, lived experience informed network and system of care in parallel with the existing mental health system, enabling strong intersection and collaboration.*
- *Of equal urgency is the development of a Suicide Prevention Peer Workforce specific to the multiple contexts of suicide*

Indeed, much progress has been achieved already, and we applaud the unprecedented appetite for and inclusion of people with a lived experience of suicide in system reform over recent years. We further acknowledge the excellent progress being made toward parallel non-clinical alternatives to traditional medicalised options. We must forge ahead with peer led models based on national and international evidence base, integrate them with existing clinical services and learn what works best within the Australian context.

We are keen to continue to play our part alongside all Australians, organisations, leaders and communities towards enhancing the social and emotional wellbeing of everyone living in our geographically dispersed communities.

In relation to the draft report we offer the following feedback and suggested recommendations.

1. Recommendation 8.1: *Improve Emergency Mental Health Service Experiences*

It is encouraging to see emphasis given to addressing suicidal crisis by exploring and investing in innovations relating to non-clinical alternatives to emergency departments, particularly around the importance of developing innovative peer-led services. Hospital environments have a tendency to exacerbate the crisis resulting in people feeling like they have no safe option but to fend for themselves, often alone, but also noting, often supported by worn out desperate families and carers. People in distress and their loved ones are often left feeling that, for them, hospital is now their 'wrong door'. We are pleased to see an acknowledgement around addressing and finding solutions, including new exemplars of compassionate care for people experiencing emotional distress and suicidal crisis by noting in the report that calmer more compassionate places for people to go, beyond the not 'fit for purpose' hospital ED's is urgently needed.

Specifically, we support the recommendations for:

- Improved alternatives to hospital emergency departments
- Supporting paramedics through improved access to resources in the field
- Improving the emergency department experience through designated, low sensory, welcoming spaces for people in distress

In addition, we recommend to the Commission:

- Alternatives to hospital emergency departments are located both on and off hospital grounds to cater for those people who are reluctant to step foot on hospital grounds and those who do not relate in any way to their crisis and distress being associated with mental illness. Opportunities exist to think laterally to university grounds, shopping centres etc.
- A suite of alternatives to emergency departments are supported to meet the diverse needs of people experiencing emotional pain, distress and crisis. This could include safe haven cafes, residential safe houses of varying stay lengths and long-term residential retreats where complex trauma can be addressed in a continuously supported environment for those who are never able to safely address underlying causes of suicidality in the current medical model of fortnightly psychology appointments.
- Co-responder models continue to be implemented and expanded nationally with mental health support workers and/or lived experience peers accompany first responders and crisis support teams to people's homes, sit with them through their pain and crisis, and in many cases negate the need to attend the emergency department.
- Suicide Prevention Peer Workers work alongside clinical and other professional supports.

2. Recommendation 11.4: *Strengthen the Peer Workforce*

We are pleased to see that the Commissioners recommends that the NMHC submit a proposal for the operationalisation of a professional body for the lived experience workforce. We are aware that the NMHC is developing a framework for the lived experience workforce. However, our concerns are that in its current format this framework is specifically focusing on the mental health peer workforce. It is critical that the specialist skill sets required by peers with a lived experience of suicide, to work within a variety of suicide contexts, is recognised and invested in to develop national and state-based peer workforce frameworks and related professional bodies. This work must proceed without delay.

We firmly believe that a collaborative approach is paramount, including the premise that it is not a matter of peers alone nor clinicians alone who need to be involved in this life protecting work. Rather, we believe this requires a model that sees peers *and* clinicians working side-by-side and/or integrating through referral and stepped model approaches as equals, opposed to the dominant practices of a peer or clinician 'them and us' approach.

Specifically, we support the recommendations for:

- Peer Workforce Guidelines supported by work standards for particular areas of practice
- The establishment of a professional organisation to represent peer workers
- Support meaningful integration and respect of the value of the peer workforce into health settings through programs with clinicians
- A comprehensive system of qualifications and professional development for peer workers

In addition, we recommend to the Commission:

- Leverage the existing frameworks established for the Mental Health Peer Workforce and customise for the Suicide Prevention Peer Workforces and AOD Peer Workforces – we do not need to reinvent the wheel entirely.
- Recognition is given to the nuances of the Suicide Prevention Peer Workforce within the range of suicide contexts – supporting people in crisis; post attempt; bereaved and carers of people in crisis is very different. The Suicide Prevention Peer Workforce is required in prevention, intervention and postvention.
- The Suicide Prevention Peer Workforce receives immediate, equal attention and investment to establish an appropriate and comprehensive system of qualifications and professional development for peer workers, and this work is in partnership and potentially led by, suitable lived experience organisations.
- The Suicide Prevention Peer Workforce is adequately and appropriately resourced inclusive of suitable governance mechanisms implemented to ensure its sustained viability and impact success.
- The Suicide Prevention Peer Workforce is inclusive of Peers from diverse cultural backgrounds, Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and other priority populations.
- Models and continuums of professional development including consideration given to remuneration, mentoring, supervision and training needs also must be developed.
- Peer Educators are included in Suicide Prevention Peer Workforce development to facilitate meaningful integration within services.

3. Recommendation 13.1 – 13.3: Increased support for the wellbeing and role of carers and families

We are pleased to see that the Commissioners recommend increased support for carers and families of people with mental illness but wonder why the impact of caring for people through suicidal crisis is not recognised. For some this is a single, often traumatising experience while others spend year doing all they can to keep their loved one alive. It has profound and long lasting emotional, financial and social impacts that deserve recognition and support.

Specifically, we support the recommendations for:

- Reducing barriers for income support
- Family-focused and carer-inclusive practice

In addition, we recommend to the Commission:

- Investing in the development and implementation of programs and services to better support those supporting others through suicide
- A Peer Warm Line for carers is trialled and evaluated

4. Recommendation 20.1: *National Stigma Reduction Strategy*

It is promising to see that the Commissioners recommend a national stigma reduction strategy. In order to truly understand what needs addressing we must unpack what stigma actually is – discrimination, prejudice and fear. Only then can we begin to design a strategy that will break through these extreme emotions fostered through lack of understanding and generations of narrow mindedness.

Roses in the Ocean looks forward to contributing to help deliver the seismic shift that is needed in these areas. Lived experience stories and insights are powerful catalysts for cultural change. We believe one of the keys to successfully delivering on a nation-wide stigma reduction strategy must include addressing cultural attitudes, practices and policies and procedures in workplace settings such as in hospitals, schools and broader community-wide workplaces. We also know that addressing stigma in families, local community groups and diverse cultural groups must also be intrinsically woven into any national approach. We hope this will be considered as part of the overall plan for a new national stigma reduction strategy.

Specifically, we support the recommendations for:

- Recognising and positioning people with a lived experience to lead stigma reduction nationally
- Development of an evidence base of effective stigma reduction including the trial and assessment of different interventions for different audiences and areas.

In addition, we recommend to the Commission:

- Once again, recognise and acknowledge formally the need for stigma reduction and education across mental health, suicide prevention and alcohol and other drugs – not just mental health and mental illness.
- Investment is made into building the confidence of community to recognise and respond to people experiencing emotional crisis and/or at risk of suicide, and those bereaved through loss of a loved one. Building capacity is one thing, but we must do better than that, and actually build confidence. Our experience is that learning through people with lived experience gives others the confidence they need to proactively reach out and support others.

5. Recommendation 20.2: *Awareness of Mental Illness in the Insurance Sector*

The Insurance Sector has a significant role in helping support people with a lived experience of suicide – those experiencing intense emotional pain through personal crisis or bereavement. The nature of interaction has the potential to support or exacerbate an individual's situation, be that in seeking income protection claims or activating a deceased's life insurance. Equally as important is the impact on insurance sector staff who are regularly exposed to the needs of people in crisis and those bereaved through the tragedy of suicide.

Specifically, we support the recommendations for:

- A Financial Services Council update of mental health training requirements for insurers in Life Insurance Industry Standard 21, in consultation with a national consumer and carer organisation.
- An ASIC evaluation of the operation and effectiveness of the insurance industry Codes of Practice and industry standards.

In addition, we recommend the Commission:

- Recognise the need for 'fit for purpose' training for the insurance sector, acknowledging the varying needs of a range of roles, for example – training requirements for Claims Officers differ from that of Underwriters.
- Address current practices regarding disclosure of mental health history in determining insurance eligibility and premiums, which can lead to reduced help seeking, reduced disclosure and reduced accessing of mental health plans. Noting that insurance is based on determining risk, and therefore specific questions need to be asked, the approach by the industry could be addressed through fit for purpose training being informed by Lived Experience.
- The ultimate goal is for a holistic approach to recovery and assessment of a person's mental health state be adopted. To obtain the full picture, psychosocial factors also need to be considered to inform and guide training, policy and procedures – through increased data and evidence from not only the life insurance industry, but workers compensation and private health insurers.
- Incorporate lived experience into all training materials to underpin and inform content.

6. Recommendation 21.3 and 22.1: *Approach to suicide prevention & A National Mental Health and Suicide Prevention Agreement*

We agree that a new National Mental Health and Suicide Prevention Agreement be developed. We fully support the inclusion of people with a lived experience of suicide as partners noting however that they should ideally be equal partners in this work.

Specifically, we support the recommendations for:

- COAG develop the Agreement between Australian States and Territory Governments
- A truly whole of government approach to suicide prevention is created
- The national Suicide Prevention Implementation Strategy be extended to include strategic direction for non-health government portfolios & recognise the importance of psychosocial supports

In addition, we recommend to the Commission:

- The alcohol and other drugs sector are captured in this important national recommendation
- Global issues, such as climate change, are recognised as contributing factors to suicide through the impacts on communities and the very real and overwhelming concern being experienced particularly amongst Australia's youth

7. Our responses to recommendations relating to the reform area of monitoring, reporting and evaluation

Specifically, we support the recommendations for:

- We are supportive of and hope that this will lead to service improvements in terms of both quality, efficiency and appropriateness of services.

In addition, we recommend to the Commission:

- People with lived experience be included as team members of all monitoring, reporting and evaluation work groups. Whilst we acknowledge the immeasurable value lived experience people make in peer support worker roles, it is also important for us to highlight that lived experience people can and are currently contributing in a broader range of areas beyond and in addition to peer support work. This includes those working in the areas of research and evaluation.

Once again, thank you for this important piece of work and due the consideration given by way of recommendations in the draft report. To summaries our observational and suggested additional recommendations are the following:

1. A national stigma strategy: should include changing cultures in all community-wide settings such as: workplaces, hospitals, schools, community groups, cultural and family groups. This should include the rollout of training delivered by lived experience people;
2. Peer workforce developments: suicide prevention and alcohol and other drug (topic specific) organisations be consulted or preferably requested to lead the development of peer workforce frameworks and establishment of professional bodies for the lived experience workforce; and
3. Reforms relating to monitoring, reporting and evaluation: lived experience with relevant skills and lived experience expertise be included as part of the work groups teams for these activities.

We also know that these changes require united and collaborative efforts. No single organisation, person or even professional group of people can make the shifts required to improve outcomes for people with a lived experience of suicide.