mind
Help, hope and purpose

Mind Australia Limited

Statement in response to the public consultation on the draft Advice on the National Suicide Prevention Strategy

October 2024

About Mind Australia

Mind Australia Limited (Mind) is one of the country's leading community-managed specialised mental health service providers. We have been supporting people dealing with the day-to-day impacts of mental illness, as well as their families, friends and carers for over 40 years. Our over 1200 staff deliver services in our own centres, and outreach programs and residential services in partnerships with clinical agencies around Australia. In the last financial year, Mind provided over 400,000 hours of recovery-focused, person-centred support services to over 11,000 people, including residential rehabilitation, personalised support, youth services, family and carer services and care coordination.

We are committed to an evidence-informed, recovery-oriented approach to mental health and wellbeing that looks at the whole person in the context of their daily life, and focuses on the social determinants of mental health. We value lived experience and support the ongoing development of lived expertise led innovation and transformation in service design and development, alongside improvements in experience, support and opportunity for lived experience workforces. We value the role that carers, families and friends play in providing significant emotional, practical and financial support to those experiencing mental ill-health and psychosocial disability.

Mind significantly invests in research about mental health recovery and psychosocial disability and shares this knowledge, developing evidence informed new service models, evaluating outcomes, and providing training for peer workers and other mental health professionals. We also advocate for, and campaign on basic human rights for everyone; constantly challenging the stigma and discrimination experienced by people with mental health issues.

LGBTIQA+ suicide prevention at Mind

Mind is committed to the development and evaluation of solutions to support much needed mental health and wellbeing services for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and/or other sexuality and gender diverse (LGBTIQA+) communities, including in suicide support and prevention.

Mind’s LGBTIQA+ Aftercare program (Aftercare) provides identity-affirmative support and care for LGBTIQA+ people who have experienced a suicidal crisis. All staff working within Aftercare have a lived experience of suicidality and of being part of the LGBTIQA+ community. As an intensive outreach service, Aftercare can provide up to three months of assistance by a mental health clinician (psychologist, social worker, psychotherapist, or registered counsellor) and an LGBTIQA+ peer practitioner who acts as a ‘mentor’ or exemplar for recovery. At every level, peer practitioners are involved in program design and implementation, ensuring that otherwise marginalised voices are involved in tailoring suicide support that reflects local community needs. Mind’s Aftercare program is recognised as an exemplar in queer and peer-led suicide care.

Introduction

Mind commends the National Suicide Prevention Office (NSPO) on the depth, breadth and ambition of the draft Advice on the National Suicide Prevention Strategy (the draft Advice). We strongly agree with the NSPO's emphasis on the need for broad-based, concerted and coordinated action to reduce the rate of suicide and suicidal distress in Australia.

A holistic response extends well beyond the bounds of mental health and health policy. As such we welcome the NSPO's recognition that suicidal distress comes from the complex interaction of social determinants of mental health and a range of individual risk factors. Similarly, we commend and share the draft Advice's emphasis on the population groups disproportionately impacted by suicide. To this point, Mind's brief statement will speak in particular to our experience in suicide prevention for LGBTIQA+ communities.

For this specific population group, there is significant and rising need for action on suicide prevention. Our Aftercare service has seen a substantial, 65% increase in referrals from 2023 to 2024. Behind this referral statistic sits deepening evidence of hardship in the broader community, in the midst of a housing and cost-of-living crisis. 49% of our service users report financial and/or housing issues, 40% were unemployed and many report skipping meals or experiencing food insecurity. In addition and specific to our LGBTIQA+ cohort, 33% of service users report homophobia or transphobia, while 23% report safety concerns. To underline the complex co-occurrence of determinants indicating disadvantage and other physical and demographic risk factors, an increasing number of our service users report living with chronic pain, and asylum seekers and refugees are also prevalent, fleeing persecution based on their identity. Against a backdrop of program funding insecurity, this last fact underlines the challenge of ensuring a skilled workforce capable of providing culturally safe services to a diverse, intersectional cohort.

Our statement will comment on specific objectives and action items from the draft Advice, and align critique with the consultation survey questions where possible. It will do so under the following headings:

1. Safe and appropriate suicide prevention services for LGBTIQA+ people
2. Personal safety, social connection, cultural change and LGBTIQA+ suicide prevention
3. Lived experience beyond consultation and designated roles
4. Whole-of-government coordination

1. Safe and appropriate suicide prevention services for LGBTIQA+ people

We are supportive of *support objective 7.3: Appropriate and acceptable delivery of support*. Culturally safe and inclusive support is crucial to quality delivery of suicide prevention services to disproportionately impacted population groups, such as the LGBTIQA+ community. Action item *ko7.3b* under this objective reads as follows:

> *ko7.3b Increase the availability of safe and appropriate suicide prevention services for LGBTIQ+ people:*
>
> - *Embed designated LGBTIQ+ peer workers across suicide prevention services by resourcing dedicated positions.*
> - *Resource an LGBTIQ+ organisation/s to develop and implement a capacity-building program for suicide prevention services to provide a safe and affirming workplace for peer workers and service for LGBTIQ+ people*
> - *Resource an LGBTIQ+ organisation/s to provide support to designated LGBTIQ+ peer workers in suicide prevention services through peer supervision, a community of practice and a resource hub.*

There are two clarifications we would suggest to this action.

First, the draft Advice's emphasis on new funding for LGBTIQA+ capacity building or peer work should not mean current best practice examples are not further developed—quality results can also be achieved through scaling up best practice examples, as well as capacity building for the broader suicide prevention workforce.

Second, while we strongly support increased funding for LGBTIQA+ organisation(s) running such capacity building programs, our experience through the Mind Aftercare program for LGBTIQA+ suicide prevention suggests there is likewise value in building LGBTIQA+ affirmative practices *within mainstream community mental health organisations* led by LGBTIQA+ staff (conditional on strong partnership with community). Models of this kind can also produce best practice suicide prevention and increase the diversity of available suicide prevention services, ensuring options for community in accessing safe and affirmative services both within community and/or through mainstream, generalist organisations.

Such partnership, to ensure enhanced mutual understanding of safe and appropriate delivery of suicide prevention support services to (for example) the LGBTIQA+ community, will be essential to achieving laudable actions such as:

- *ko8.2a Expand the application of aftercare services to accommodate anyone who has recently self-harmed, attempted suicide or experienced a suicidal crisis*
- *ko9.2a Trial and evaluate models that facilitate partnerships between health and nonhealth services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.*

2. Personal safety, social connection, cultural change and LGBTIQA+ suicide prevention

The consultation materials ask respondents to comment on how well the draft Advice articulates what is required for long-term change in suicide prevention, and whether there is anything critical to preventing suicide in Australia that the draft Advice does not address. As such, we re-emphasise the NSPO's important recognition that suicidal distress comes from the interaction of social determinants and individual risk factors and reiterate that this demands a whole-of-government and indeed whole-of-society response. In this vein, although the draft Advice speaks to some matters of sociocultural change, there remains work to be done on this to truly achieve the intent of the draft Advice and allow for success in realising many of the recommended actions. This demands broader whole-of-society education and inclusion efforts—particularly with regards to disproportionately impacted population groups—in addition to (for example) *key objective 6 Culture of compassion*, *support objective 6.1: reduce suicide stigma*. Education efforts must go beyond stigma. While *prevention objective 4.1: Connect communities* and *prevention objective 4.2: Address loneliness and social exclusion* provide some of this focus, the task for society-at-large is not the focus in these actions, rather the critical work falls to marginalised groups and individuals. Affected individuals and population groups cannot be predominantly (if not often solely) responsible for their own emancipation without equal or greater efforts to address the continued impacts of systemic oppression, injustice and marginalisation that operate and impact on them more broadly.

Similarly, achievement of *prevention objective 1.2: address risks to personal safety*—especially ko1.2d on enhanced anti-discrimination legislation protections for groups disproportionately impacted by suicide, such as the LGBTIQA+ community—enforces a negative duty for biased individuals but doesn't actively work towards achievement of positive rights for disproportionately impacted groups through education geared toward preventive cultural change. The NSPO could consider incorporating some additional cultural, education focused actions of this kind.

3. Lived experience beyond consultation and designated roles

Mind welcomes the draft Advice's prioritisation of embedding lived experience in future suicide prevention services and governance. However, the predominant emphasis on the role of lived experience in consultation, or designated roles, somewhat limits the potential contribution of lived experience and lived expertise to these two categories. We acknowledge this is not the intent of the draft Advice. Changes to the scope and ambition of explanations and actions in *critical enabler 2: Embedded lived experience* and *critical enabler 4: Capable and integrated workforce* would highlight the important, transformative potential of people with lived experience in every aspect of the work of government and governments' partners.

This should be supported through a lived expertise led and centred approach. A lived expertise-led approach explores both the story and context of suicidality, mental health crisis, distress, and alcohol and other drug use and invites a response that is centred around dignity, human rights, compassion and connection. A lived expertise-led approach recognises suicidality as interconnected with the sociocultural and political experiences of people's lives, including the role of racism, discrimination, marginalisation, trauma and the ongoing impacts of colonisation and systemic violence. It seeks to counter and repair the impacts of a broken mental health system that is culturally unsafe, too often coercive, and dominated by systems and approaches of a biomedical model that locates the source of the problem within the individual.

We recommend future suicide policy and service design and development incorporates nationally recognised lived expertise approaches to governance, leadership, service design and development. It should also recognise that the experiences of the people most impacted are central to all directions and development of further responses. This will involve not only representation through lived experience positions, but an ability, willingness and demonstration from policy makers and service providers to re-shape responses to suicide through a lived expertise lens. This will ensure future responses are better aligned to issues of human rights and social justice, and prompt critical exploration of new evidence and approaches that provide stronger alternatives to medical and clinical interpretations, ineffective risk management models and the continued improvement of current system responses to suicidality.

Mind, in partnership with the Lived Experience Leadership and Advocacy Network (LELAN), has recently released two foundational documents to shape Lived Experience Practice and Governance approaches that can support this work:

- Connection and Community: Transformative Lived Expertise-Led Approaches
- Mind's Lived Experience Governance Framework

4. Whole-of-government coordination

Mind is strongly supportive of the recommended action for critical enabler 1.2: Clarify responsibilities for suicide prevention, ce1.2a. For this exhortation to cross-portfolio and whole-of-governments planning and implementation to be achieved, however, requires simultaneous achievement of actions related to social determinants of health such as:

- *ko3.2c Provide adequate income support to minimise the financial stress experienced by people with income instability.*
- *ko3.2e Provide equitable and inclusive access to safe, secure and affordable housing across the spectrum of housing and housing services, including homelessness services, social housing, private rental housing and home ownership.*

While carriage of such change lies beyond the NSPO's remit, this should not limit efforts to push for systemic reimagination of the politico-cultural environment that produces much suicidal distress. In our aim for a strongly preventive approach we should acknowledge this reality, while at the same time acknowledging the profound challenge it poses.

Prioritisation of actions from the draft Advice

In response to question 8 in the NSPO survey on the draft Advice, Mind Australia suggests the following five actions as priorities, noting earlier comment on modifications as appropriate.

1. ko5.2i Increase support for LGBTIQ+ young people and their families, carers and kin, to facilitate good mental health and supportive relationships, with a focus on the intersections between key coming out milestones and increased suicide risk
2. ko7.3b Increase the availability of safe and appropriate suicide prevention services for LGBTIQ+ people:
   - Embed designated LGBTIQ+ peer workers across suicide prevention services by resourcing dedicated positions.
   - Resource an LGBTIQ+ organisation/s to develop and implement a capacity-building program for suicide prevention services to provide a safe and affirming workplace for peer workers and service for LGBTIQ+ people.
   - Resource an LGBTIQ+ organisation/s to provide support to designated LGBTIQ+ peer workers in suicide prevention services through peer supervision, a community of practice and a resource hub.
3. ce2.3a Establish dedicated lived and living experience roles and governance bodies centrally and/or within departments and agencies to ensure lived and living experience of suicide is integrated into decision-making processes for policies and programs with relevance to suicide prevention.

4. ko9.2a Trial and evaluate models that facilitate partnerships between health and non-health services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.
5. ce1.2a Build on the National Mental Health and Suicide Prevention Agreement to progress a national approach to suicide prevention that enables cross-portfolio and whole-of-governments planning, sets priorities and targets, and outlines responsibilities and accountability for suicide prevention outcomes consistent with the suicide prevention model outlined in this Strategy. Key components of this work include:
    - allocating sufficient funding and developing appropriate funding models to improve quality and outcomes, facilitate effective cross-portfolio collaboration, and reduce funding duplication and gaps
    - establishing processes for data sharing between governments and portfolios to support evidence-informed decision-making, for surveillance, monitoring and reporting, and improvement purposes
    - developing an agreed set of suicide prevention outcomes at national and jurisdictional levels, for all portfolios responsible for actions in this Strategy
    - meaningful collaboration with people with lived and living experience of suicide in the planning, implementation and evaluation of national suicide prevention work
    - strengthened partnerships and shared decision-making arrangements and structures between Aboriginal Community Controlled Organisations, Aboriginal Community-Controlled Health Organisations, governments, Aboriginal and Torres Strait Islander communities, and people to progress a national approach to suicide prevention.

Additional comment on the draft Advice

The NSPO should reconsider the structure of the draft Advice, consolidating the objectives and underlying actions as a single list as part of an executive summary; effectively, presenting these as a list of recommendations.