Response to the Advice on the National Suicide Prevention Strategy (Draft Consultation)

October 27, 2024.

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of trauma, suicidality and interactions within the mental health system. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. These historical and ongoing injustices have compounded the challenges faced by First Nations (Aboriginal and / or Torres Strait Islander) peoples, affecting their social and emotional wellbeing.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit. In honouring their wisdom and experiences, we commit to supporting their self-determination and promoting equitable and culturally responsive approaches to improved social and emotional wellbeing.

Recognition of Lived Experience

The MHLEPQ acknowledges and honours people who have lived and living experience of mental ill-health and suicidality. Many have endured harm due to breaches of their human rights within culturally unsafe systems that they sought out for support. We deeply respect the people who have persistently fought for truth, justice, equity and systemic change, advocating for their collective right to challenge the harmful impacts of these systems.

We are guided by the lived experience, expertise and leadership of MHLEPQ members whose valuable recommendations have the power to create lasting change. We are dedicated to advocating across Queensland and nationally for a human rights-based approach to mental health and social systems, ensuring they are inclusive, responsive and meet the unique needs and rights of people, their families and communities.

Human rights statement

The MHLEPQ recognise the inherent right of all peoples to their dignity and autonomy, to be protected from torture and cruel, inhuman, or degrading treatment, and to live free from discrimination and stigma according to their cultural determination. This right includes access to support addressing the social determinants of social and emotional wellbeing such as adequate housing, a clean and sustainable environment, and health services that are affordable, effective, and culturally safe.

Mental health is a fundamental human right and we are committed to advancing a just and equitable society where every individual can thrive, with particular attention to the unique social and cultural needs of First Nations communities. Human rights in mental health are both a constitutional and operational principle of the MHLEPQ and a central focus of our advocacy efforts. We examine the legal protections and policies affecting lived experience communities to understand whether their rights

are upheld, and how they may be experiencing exclusion, inequity or marginalisation within the mental health system.

Who are the MHLEPQ?

The Mental Health Lived Experience Peak Queensland (MHLEPQ) is an initiative funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health. Our organisation was created in July 2021 and moved to direct contracting with Queensland Health on January 1st, 2023 (formerly auspiced by the Queensland Mental Health Commission).

The MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system with a specific focus on those who are socially disadvantaged and marginalised. Our work is based on the principles of equity, access, cultural safety, recovery, and human rights.

MHLEPQ is a member of the National Mental Health Consumer Alliance, where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth policy and government-funded services.

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Introduction

MHLEPQ welcomes the opportunity to respond to the Advice on the National Suicide Prevention Strategy (consultation draft) (the Draft Strategy). We acknowledge the importance of an effective, implementable national strategy and action plan, responding to a topic that is at the heart of many of our members and partners.

Australia is at a pivotal time to apply an equity lens to systems and structures, focusing on the social determinants of enduring and unacceptably high rates of suicide. We must all take culturally safe, human rights-based action in our spheres of influence to rectify the preventable root causes of suicidal distress across society, at the same time as we create fit-for-purpose organisations that deliver high quality and safe services.

While suicidal distress and many of the factors that lead to it may occur for any person living in Australia, we know by taking a walk through the data the stark realities for certain communities and identity groups, notably First Nations peoples of all ages compared with non-indigenous groups. In addition, while using an equity lens to identify the greatest need, there should be no person left behind, including the expanding “missing middle”.

Our peak body affirms the obligation of national, state and territory governments to partner with people to address the inequities and persisting social determinants of suicidality. All activity should be equity and evidence-driven, guided by the data that shows who and where the communities are that endure high intersectional determinants of distress, trauma and reduced wellbeing.

This submission draws on the lived experience and expertise of MHLEPQ staff, members and the communities they connect to, to respond to the Draft Strategy.

The MHLEPQ approach to this response

Staff compiled a response to the draft Strategy based on institutional knowledge and content expertise of its CEO, Suicide Prevention Consultant and former MATES in Construction CEO, Jorgen Gullestrup.

Staff then consulted with MHLEPQ members who had previously participated in the National Consumer Peak working group on their Draft Strategy response, to amplify the perspectives from that lived experience group. Members with subject matter expertise were also consulted and provided input to the response.

Members made general and specific responses to various aspects of the Draft Strategy and its domains. MHLEPQ member and staff views are represented in the "General comments" section, and responses to specific parts of the strategy are provided in ***Table 1: Specific responses to the Strategy domains*** (pages 12-19, below).

General comments

Overall, we observe that the proposed strategy is **stronger in several key areas** compared to its predecessor.

1. We support the whole system approach to all-of-government and community-centred strategy and implementation.
2. The change of focus from treatment to prevention of suicidal distress (rather than suicide) is a crucially important change of orientation.
3. We strongly agree with the importance of the development of restorative just and learning cultures under the umbrella of trauma-informed and empathetic support. We note that the progression of human rights perspectives involves the increasing use of "reparative justice" for victims/survivors and constitutes an important aspect of healing trauma.
4. We note in the ***Overview of the National Suicide Preventions Strategy*** and ***Appendix B: Development of the Strategy*** that the

Strategy was informed *by Gayaa Dhuwi (Proud Spirit) Australia,* the final report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project and the *National Agreement on Closing the Gap.* In addition to a strong commitment to partner with First Nations peoples, we advocate for a stronger focus throughout the strategy on the principles of Aboriginal peoples and Torres Strait Islander peoples' cultural rights, and cultural safety. We recommend advocating for a National Human Rights Strategy, alongside the promotion of UNDRIP and other international human rights instruments.

5. We support the Life Course approach that underpins navigating key life transitions, particularly in the first 2000 days of life from conception.
6. We see some strengthening of a focus on community-based services, although this could go further.
7. We support the focus on lived experience engagement and involvement in policy and delivery.
8. We strongly support the development and appropriate resourcing of the lived experience (peer) workforces, tailored to First Nations peoples, priority populations and where the intersectionality of multiple forms of oppression or disadvantage are present.
9. We applaud the visibility of building on anti-discrimination and anti-racism legislation and policy, as structural and public discrimination continues to be a major cause of distress for many people. Australians must continue this area of work alongside embedding a human rights culture as business as usual. People with mental ill-heath, distress, and / or suicidality are a group who are highly discriminated against and stigmatised and the MHLEPQ would like to see this group added to the Draft Strategy as people who are disproportionately represented.

There are several **key areas we would like to see strengthened** further in the Draft Strategy:

1. We were pleased to see the recommendation for implementation planning to be collaborative across governments and portfolios due to the broad nature of suicide prevention. Implementation actions in general, however, are not highly visible apart from Table 30, ko11.1a, where there is a broad action for implementing the Support domain. We suggest either strengthening the implementation actions throughout the Draft Strategy or removing the occasional section peppered throughout.
2. We note the presence of general human rights perspectives, but in the absence of a National Human Rights Act and frameworks, their discussion should be framed using international conventions including but not limited to the CRPD, UNDRIP, UNCROC and OPCAT[1]. This will provide more clarity about the rights of people in distress, including their human right to mental health, autonomy, dignity and freedom of movement.
3. We understand that it is contentious to discuss the right to die and assisted dying in the context of suicide prevention, however, our members describe the ongoing harm when seeking support for suicidal distress, and it is responded to in inappropriate or unsafe ways. For some people, having a suicide plan is protective, rather than increasing their risk. It is harmful to these people to disclose their suicide plan and be either rejected from services or forcibly treated. The MHLEPQ believes this perspective should be acknowledged and represented across the suicide prevention sector.

[1] United Nations Convention on the Rights of Persons with Disabilities (CRPD); United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP); United Nations Convention on the Rights of the Child (UNCROC); Optional Protocol to the Convention Against Torture and other Cruel, In human or Degrading Treatment or Punishment (OPCAT).

4. We believe prevention should be framed intergenerationally and culturally, rather than through an individualistic lens. Prevention and early intervention for priority populations relating to the impacts of transgenerational suicide are crucial.
5. People with lived experience have expressed difficulty with the terminology/conceptualisation of "compassion and empowerment". We understand that these are desirable values for directing the behaviours of organisations and service providers, but instead, we prefer framing person-centred values of "autonomy and dignity" as inherent human rights.
6. The objectives set out in the National strategy are different from the Queensland strategy. This is problematic as some of the national objectives fall under state jurisdiction (for example, child protection in KO1.1 Safety and Security). We suggest creating stronger links between national and state / territory strategies to enable a more seamless collaborative approach between different jurisdictions, authorities and implementing bodies.
7. Clear actions for national systems such as Medicare, Centrelink, ATO, and the NDIS would provide a mechanism to link national strategy to state and territory plans for partnership and collaboration with the organisations that administer the strategies.
8. Harm reduction / minimisation approaches, while present in the Draft Strategy, are too light touch in our opinion. We suggest strengthening them, as they are important models for recovery and peer-led approaches.
9. The Strategy is at risk of being too broad and / or vague to be actionable, with some confusion about jurisdictional responsibility.
10. We suggest that the approach to "means and methods" be addressed, including removing it from the "culture of compassion" domain. While reducing knowledge of and access to suicide methods is an important factor in the overall approach, people with lived experience of suicidality sometimes describe a "safety net of having a plan / means" and do not always view the approach to

addressing access to means as "compassionate", rather care is received as coercive and paternalistic.

11. We support "navigating life transitions" being placed in the prevention domain, however, the reference to parenthood in ko5.2a, p.32 describes an interventionist approach with programs "to help those experiencing parenting-related difficulties and distress". We would like to see this reviewed to more strongly reflect prevention.
12. The Draft Strategy only touches lightly on the perinatal period and there were no actions described. Perinatal suicide is the leading cause of death for perinatal women in Queensland, and the number two (2) cause of death across Australia – a public health emergency. Given the strong evidence base for the links between poor infant mental health and mental health in adulthood, as well as the continuing high rates of maternal death by suicide[2], we would like to see the Draft Strategy focus more strongly on the perinatal period. Possibilities include:
    i. Table 1: The table of disproportionate impacts
    ii. Table 4: Addressing the risks to personal safety
    iii. Table 14: Include actions relating to the prevention of perinatal suicide
    iv. Considering transgenerational and intersectional impacts of suicide for women in the perinatal period is important for the prevention and early intervention of key drivers of distress.
    v. Recommendation for a National Strategy/Guideline on the prevention of perinatal suicide.

[2] We suggest integrating perinatal/maternity evidence from several states to inform the Draft Strategy including:

1. Queensland Mental Health Commission (2024): Consultation Paper: Development of a whole-of-government Trauma Strategy for Queensland: Pregnancy and Early Parenting
2. Queensland Health (2021): Queensland Mothers and Babies 2018-2019 Report of the Queensland Maternal and Perinatal Quality Council 2021
3. Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. Preventing maternal deaths from suicide in Victoria.

13. We acknowledge the crucial importance and inherent difficulty with representing priority populations according to equity principles in the Strategy. Giving specific recommendations for priority groups while trying to keep the actions generalisable is quite inconsistent across the Strategy. We note that the “missing middle” is increasingly important to identify and is absent in the Strategy. In addition, the “young person” life stage hasn’t traditionally been based on development, which excludes young people between the ages of 18-25. We suggest expanding the description of young people to include 18 to 25-year-olds, accompanied by sector advice to follow this approach.
14. There is little detail about approaches to engaging with communities, and we would like to raise our concerns about this. Explicit information about representation, inclusion, participation, partnerships and lived experience-led ways of working are important to describe and embed before any action is undertaken.
15. While we agree that connection to personal and community networks is crucial for wellbeing, it should be acknowledged that not all “supports” are experienced as “safe”, particularly where there has been abuse and neglect within family systems. We see one mention of “chosen family” on page 81, but request that “chosen family” be more visible in the strategy, a crucial resource for many of our members.
16. As a whole-of-government strategy, we would like to see advocacy for bipartisan support included. Political levers are an important part of the discussion.

Responses to specific domains

RESPONSE TO THE ADVICE ON THE NATIONAL SUICIDE PREVENTION STRATEGY		
SOURCES OF SUPPORT (p.3)		
Provide a box with the contact details for the national PANDA helpline for people with perinatal mental health conditions: PANDA National Helpline (Monday to Saturday) 1300 726 306 https://panda.org.au/		
DOMAIN: PREVENTION OF SUICIDAL DISTRESS		
OBJ #	**SECTION**	**MHLEPQ RESPONSE**
1	Safety and security	• Table 1: Disproportionate impacts of suicide. Add perinatal women and the national statistics to this table – suicide is a leading cause of death for women, particularly in the first postpartum year following birth • Ko1.1a: the MHLEPQ strongly support this action and advises endorsing the MHLEPQ Shining a Light: recommendation 3 to appoint a mental health and wellbeing HR Commissioner to oversee and advise • New recommendation: increase the safety of MH facilities by eliminating coercive practices and adhering to international human rights instruments. A major risk factor for suicide is recent contact with or release from the MH system. Just after discharge is the highest risk period. • Ko1.2, Table 3: in the risk to personal safety due to child abuse and neglect section, include a comment about the cumulative impacts of FDV for pregnant women, increased risk for the

		development of mental health disorders or ill-health in the perinatal period, and the resulting significant increased risk of suicidal distress perinatally. • Ko1.2: discussion about workplace bullying should include "mentally safe workplaces" and "workplaces that manage psychosocial hazards". • Define work-related suicide and investigate, record, and regulate workplace responsibility for work-related suicide. Acknowledge work-related suicide as a compensable injury. • Ko1.2: when discussing the "impact of disability", physical, mental conditions and psychosocial disability should be named. • Ko1.2a, table 4: specific recommendations need to be made in these frameworks for women and infants in the perinatal period
2	Good health	• Ko2.1 Table 5, p.18: Improving health outcomes in the perinatal period could be included here as part of the broad preventative approach. Keeping the parent/primary caregiver and baby together promotes infant attachment and development and must always be kept in mind when parents need specialist support, different support environments and resources to minimise the impact of disrupted caregiving. • Ko2.2a: services require transformation to be fit for purpose. (not simply to "expand and enhance"). Community-based support where possible. A human rights culture of care is required to transform the MH system, which arguably increases suicide risk in individuals. • Ko2.2e: this is an important action and must address existing inpatient and community settings for LGTQIA+ people, not just future services • K02.2f – Include "harm minimisation/reduction approaches" in all situations alongside "prevent and minimise" to avoid further stigmatisation or harming of people who use drugs and alcohol (see ko2.2g), including with diet/eating concerns • Ko2.2h: the "how to" of improving support for people experiencing co-morbidities and high intersectionality will be an important focus of the action plan

		• Ko2.2i: significantly expand the lived experience (peer) workforce across mental healthcare, particularly connected to first contact points with the MH system. • Address systemic stigma relating to suicide and mental health • Ensure reparative justice processes are available to mental health consumers
3	Economic security	• Ko3.2a: Instead of providing incentives, social inclusion obligations for diversity in employment through governments' procurement policy(ies). • Ko3.2e – develop a national supported housing strategy setting targets for supported housing in each state and territory.
4	Social inclusion	• Ko4.1a We support the progress of the national anti-racism strategy, led by the Australian Human Rights Commission. This will be important for embedding cultural safety across government and promoting social inclusion. Create incentives and funding for building community through urban design. Create community spaces. In England, there is a movement toward suicide prevention through architecture. Building safer buildings but also buildings that foster community and connection through common spaces. • Ko4.1a: engagement has historically not been empowering, or at worst paternalistic and harming for communities. Suggest a shift of language from “actively reach out” and “build the capability” to “resourcing community-led and community-determined activity”. • KO4.2: Stronger regulation and minimum standards for nursing homes and retirement villages. An elder person's suicide prevention strategy with focus on social connection will be important for that group.
5	Navigating life transitions	• Ko 5.1, pg 28 Thrive in key life stages: suggest adding a dot point about infant and young children programmes before they enter early childhood education. Suggest “resource programmes for infants and young children before they enter early childhood education that provide perinatal screening and early parenting support; infant and toddler

		developmental checks and parental/caregiver supports". Close consideration should be given to parents who have lost a partner to suicide in the perinatal period. • Ko5.1: We support the concept of "thriving in key life stages" but advocate for expanding the language around the perinatal period. Discourse about the childhood life stage should include conception and infancy, and babies shouldn't be discussed separately from mothers and families – children don't "make their own healthy start to life", they are fully dependent on their primary caregivers and healthy, safe communities to develop optimal physical, social-emotional and psychological wellbeing. Suggest re-working the sentence "with a safe and secure foundation, children can make a healthy start to life…" • Ko5.1a: Advocate for peer-based young person programs such as ***Batyr.*** • Ko5.1a, table 12: The perinatal period and parents are absent in this table. Raise the visibility of young infant and parental health in the description, rather than including the crucial perinatal life stage in the "childhood" bucket. The table jumps from school-age to older Australians and ignores the middle age parenting years. They need to have a dedicated section. • Ko5.2: People exiting mental health services and experiencing medical trauma are an important missed priority group from Table 13, p.30. • Ko5.2, Table 13: the perinatal period is described for the first and last time in the document here, with a very old reference (2005). Data are strong and concerning relating to the perinatal period. Suggest updating with relevant and contemporary literature, both national and state (see footnote 2). • Ko5.2: Table 13, "Places of detention" includes people who have been incarcerated or are asylum-seekers. In Queensland, the locked ward policy means our Authorised Mental Health Services are categorised as places of detention and monitored by the UN Subcommittee for the Prevention of Torture (whether people are voluntarily or involuntarily treated). Please add this priority population to the National strategy to raise the visibility of people receiving mental health services within places of detention.

		• Anti-discrimination towards people who use mental health services is important work to advance, at the same time as moving towards non-coercive care in mental health, aged care and disability spaces. • KO5.2e – not only transition into age care but more regulation on existing providers to reduce elder abuse in nursing homes. • KO5.2f – we are talking about access to support for the bereaved. However, peer-led support for survivors should also be included (universal aftercare) particularly with a focus on social re-integration after a suicide attempt.
DOMAIN: SUPPORT		
OBJ #	**SECTION**	
Pg.34 Introduction: suggest adding one dot point to the five (5) already there, "workforce education from primary through to tertiary healthcare on screening, supportive, warm referral and appropriate intervention during disclosed or recognised risk and crisis response (and this is then expanded in later sections.		
6	Culture of compassion	• Pg35: We have questions about the framing of "restriction of means" – is it meant in the context of government policy, or individual service delivery and Care? We suggest that the last dot point is removed, "reduce knowledge of and access to means of suicide" as it is not a compassionate statement when viewed through a lived experience lens. • We acknowledge that there are cases for some means restriction/reduction (not removing but slowing a person down in the crisis by placing barriers) but it should not be in the "Culture of Compassion" section. Removing means may be necessary, but not it's not compassionate.
7	Accessibility	• Ko7.1: There is a significant group of people who don't have access to technology due to impoverishment – this needs to be reflected in the Strategy. • Ko7.1.e/Ko7.2b: The Medicare Mental Health Centres (previously Head to Health) reinforce the medicalisation of suicide and need to undergo **lived experience** evaluation. The models

		of care need to move towards being self-referring, peer-led, and focused on a person's recovery, human rights, autonomy and dignity, for example alt2su, blak alt2su and LGBQTI+SB. Models need to be non-coercive and partnership-based, otherwise they risk further harming the person seeking support. **10.** KO7.2b: We agree with the need for evaluating safe space services and we would like to see them represented more strongly under the umbrella of peer-led, non-biomedical, non-coercive spaces accessible for people in suicidal distress. Their design must be led and informed by representative and diverse priority groups.
8	System-level coordination	• Ko8: Non-medical care pathways and models such as alt2su, blak alt2su and LGBQTI+SB must be resourced and scaled to provide care not centred on pathology/diagnosis/treatment. • Ko8, Table 22. Suggest adding an action to provide pathways and access to mother-baby units across Australia, including ongoing community and peer support after discharge. • Ko8.2a and ko8.2b: we support this action and would like to see specific reference to social reintegration after suicidal distress as an element of aftercare. • Ko8.3a: there is major concern in lived experience communities about the safe sharing of clinical information in a system that is not care-based and is highly discriminating and stigmatising. • Ko8.3a: This action could be strengthened by recommending that clinical records are person-led and authorised by the person receiving care, "nothing about us without us".
9	Holistic approaches	• Strongly support the review of EDs and the use of restrictive practices. • We advocate for shifting safety planning from imminent risk to collaborative strength-based approaches and develop tailored approaches across population and priority groups. • Ko9.1b: strong support for this action, however "assessment" is problematic language.

		• Ko9.1b Perinatal specialists advocate for a national approach to nuanced risk assessment, management and implementation for parents/caregivers in the perinatal period. • Ko9.3a Support this action for community-based models, but it should include both chronic and acute suicidality.
10	Increased connection	• Ko10: there needs to be acknowledgment through a trauma-aware approach that not all family and community "systems/networks" are "safe". • Ko10.1a-c: we would like to see the inclusion of "chosen family" for strengthening personal support. Aftercare is an important aspect of all three (3) actions, and we would like to see it named. • Ko10.2a: social prescribing supported • Table 30, p56
DOMAIN: CRITICAL ENABLERS		
#	**SECTION**	**MHLEPQ RESPONSE**
1	Improved governance	• Ce1.1: Supported. It is the MH and Suicide impact statement
2	Embedded lived experience	• Ce2.1a: Building capacity to work with lived experience is also something that should be promoted nationally. • Ce2.2a: remuneration of lived experience and expertise should be equitable with other participants in government processes – pay parity is important for signalling value in different professions and skill sets.
3	Available and translated evidence	• Ce3.2a: suggest an extra dot-point about perinatal suicide prevention research, "fund research, case studies and adequate data collection co-designed with lived experience consumers, looking at prevalence, outcomes and impacts in the perinatal period".

4	Capable and integrated workforce	• While we agree that GPs are one key workforce, there is concern about the continued focus on GPs as the central point for suicide prevention, given that they are already preferentially funded, referred into, and gatekeepers of access to specialist care.

Table 1: Specific responses to the Strategy domains

Communication

We invite further communication about this response or associated matters via contact made with:

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