

# **MENTAL HEALTH ACADEMY SUICIDE PREVENTION ON LINE SUMMIT**

**2.30PM ADELAIDE TIME 12 APRIL 2019**

## **SLIDE 1- TITLE PAGE**

### **A PEER SUPPORT RESPONSE TO THOUGHTS AND FEELINGS OF SUICIDE: ALTERNATIVES TO SUICIDE PEER SUPPORT GROUPS**

GOOD AFTERNOON. THE VIEWS I WILL PRESENT IN THIS TALK ARE MY OWN PERSONAL VIEWS AND NOT THOSE OF ANY AGENCY WITH WHICH I AM CURRENTLY ENGAGED.

I AM A SOCIAL WORKER BY PROFESSION AND FOR 11 YEARS FROM 2005 – 2016 WAS CEO OF RICHMOND WELLBEING OF WEESTERN AUSTRALIA WHICH IS A NON GOVERNMENT MENTAL HEALTH ORGANISATION.

WE HAD A STRONG RECOVERY FOCUS AND INTRODUCED THE HEARING VOICES NETWORK TO AUSTRALIA IN 2005. THIS WAS A PEER TO PEER BASED APPROACH TO MANAGING PSYCHOSIS UNLIKE THE TRADITIONAL MEDICALLY BASED APPROACH BY PLACING THE EXPERTISE IN THE HANDS OF LIVED EXPERIENCE RATHER THAN MENTAL HEALTH PROFESSIONALS. AND THEREFORE CHALLENGED TRADITIONAL APPROACHES TO PSYCHOSIS .

THE APPROACH WAS CO-PRODUCED BY A PSYCHIATRIST AND HIS PATIENT IN 1987 IN HOLLAND. IT WAS MET WITH SOME CONTROVERSY THEN ACROSS EUROPE AND IN 2005 WHEN INTRODUCED IN AUSTRALIA.

TODAY IN 2019 IN AUSTRALIA YOU WILL FIND HEARING VOICES GROUPS IN BOTH THE PUBLIC MENTAL HEALTH SYSTEM AND THE NON GOVERNMENT AND PRIVATE SECTOR.

I BELIEVE THE SAME ACCEPTANCE OF PEER TO PEER SUPPORT GROUPS AROUND THE ISSUE OF SUICIDE INTERVENTION WILL BE SIMILARLY ACCEPTED IN AUSTRALIA IN THE NEXT FEW YEARS.

MY PREVIOUS BACKGROUND INCLUDED WORKING IN CHILD PROTECTION, DISABILITY, FAMILY RELATIONSHIP SERVICES AND JUSTICE, INCLUDING VICTIM SUPPORT. MENTAL HEALTH AND SUICIDE INTERFACED WITH ALL OF THESE AREAS SO MY INVOLVEMENT IN THOSE SECTORS IN RECENT YEARS HAS BEEN A NATURAL PROGRESSION.

SINCE FINISHING FULL TIME EMPLOYMENT IN 2016, MY RECENT CONSULTING WORK HAS EXTENDED MORE FULLY TOWARDS SUICIDE PREVENTION.

I AM A MEMBER OF THE COMMONWEALTH GOVERNMENT SUICIDE PREVENTION PROJECT REFERENCE GROUP WHICH IS ADVISING ON THE IMPLEMENTATION OF THE 5<sup>TH</sup> PLAN .

I AM ALSO INVOLVED IN THE PROGRAM ADVISORY COMMITTEE OF SUICIDE PREVENTION AUSTRALIA FOR ITS ANNUAL NATIONAL SUICIDE PREVENTION CONFERENCE.

THIS INTEREST IN SUICIDE PREVENTION IS WHAT BRINGS ME HERE TODAY.

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## **SLIDE 2 – LEARNING OBJECTIVES**

THE PURPOSE OF THIS PRESENTATION IS TO:

- OUTLINE WHY ENGAGING THE LIVED EXPERIENCE AND PEER SUPPORT ARE SO IMPORTANT IN SHAPING THE FUTURE OF SUICIDE INTERVENTION IN AUSTRALIA;
- IN DOING SO I WANT TO ADDRESS THE MYTHOLOGY AROUND SUICIDE WHICH SHAPES OUR CURRENT APPROACH; AND
- PROVIDE A SNAPSHOT OF A PEER TO PEER APPROACH TO SUICIDE INTERVENTION THAT CAN HELP ADDRESS SUICIDE IN AUSTRALIA, AS THIS A SIGNIFICANT GAP IN OUR CURRENT SUITE OF RESPONSES.

## **AND OUTLINE OF PRESENTATION**

THIS PRESENTATION BEGINS WITH REFLECTION ON THE CURRENT APPROACH TO SUICIDE PREVENTION AND ITS LIMITATIONS. THERE ARE SIMILAR CHALLENGES IN THE U.S. WHICH IS WHY A PEER TO PEER APPROACH HAS EMERGED THERE

I'LL EXAMINE THE MYTHS THAT SURROUND SUICIDE AND HOW THESE WORK AGAINST POSITIVE CHANGE IN THE RATES OF SUICIDE IN AUSTRALIA. THERE IS ALSO AN APPROACH TO RESEARCH WHICH MAY ACONTRIBUTE TO THE POOR SUCCESS IN REDUCING THE RATE OF SUICIDE.

I WILL ARGUE THAT THE INVOLVEMENT OF PEER SUPPORT – THE LIVED EXPERIENCE – IS AN ESSENTIAL CONTRIBUTOR TO CHANGING THE CURRENT NARRATIVE AND IMPROVING SUICIDE INTERVENTION. THIS TREND TOWARDS PEER SUPPORT IS NOW STRONGLY EVIDENT IN BOTH THE US AND THE UK WITH INCREASING ACCEPTANCE OF A PEER TO PEER APPROACH.

THERE IS IMPORTANT RESEARCH THAT APPEARS NOT TO BE CONSIDERED IN CURRENT APPROACHES TO SUICIDE INTERVENTION IN AUSTRALIA AND THIS IS EXPLORED IN THIS TALK.

I WILL LOOK AT HOW THE ALTERNATIVES TO SUICIDE PEER TO PEER GROUPS IN THE USA ARE RUN AND WHY THEY SUCCEED.

I END WITH AN EXAMINATION OF HOW WE ARE INTRODUCING THIS APPROACH IN AUSTRALIA AND HOW YOU CAN FIND OUT MORE ABOUT THIS APPROACH.

## **SLIDE 3– LIVED EXPERIENCE AND PEER SUPPORT**

THERE IS INCREASING ENGAGEMENT OF PEOPLE WITH A LIVED EXPERIENCE OF SUICIDE IN THE SUICIDE PREVENTION SECTOR IN AUSTRALIA.

ROSES IN THE OCEAN IS POSSIBLY THE MOST WELL KNOWN LIVED EXPERIENCE ORGANISATION IN AUSTRALIA AND HAS ITS ORIGINS FROM A FAMILY PERSPECTIVE. BRONWEN EDWARDS, THE FOUNDER, IS ALSO SPEAKING DURING THIS SUMMIT AND I WOULD ENCOURAGE YOU TO LISTEN TO HER PRESENTATION

IT IS IMPORTANT TO BE CLEAR WHAT WE MEAN BY LIVED EXPERIENCE AND PEER SUPPORT..

- ROSES IN THE OCEAN DEFINE LIVED EXPERIENCE AS . . . ...HAVING EXPERIENCED SUICIDAL THOUGHTS, SURVIVED A SUICIDE ATTEMPT, CARED FOR SOMEONE WHO HAS BEEN SUICIDAL, OR BEEN BEREAVED BY SUICIDE.
- ROSE HOUSE IN THE US DEFINE Peer Support

REFERS TO THE ROLE OF A PERSON WITH LIVED EXPERIENCE USING THAT EXPERIENCE DIRECTLY TO SUPPORT ANOTHER PERSON WHO IS EXPERIENCING THE SAME DISTRESS

## **SLIDE 4 PEER TO PEER SUPPORT**

PEER SUPPORT GENERALLY INVOLVES CLINICAL INTERVENTION IN SOME WAY, USUALLY THROUGH A REPORTING PROCESS OR TEAM ENGAGEMENT.

PEER TO PEER SUPPORT INVOLVES ONLY PEERS AND THIS IS WHAT MAKES IT CONTENTIOUS IN AUSTRALIA AS WE WILL SEE WHEN WE LATER EXPLORE THE MYTHS OF SUICIDE.

## **SLIDE 5 THE CURRENT SUICIDE PREVENTION SYSTEM**

THE CURRENT SUICIDE PREVENTION SYSTEM ASSUMES THAT PROFESSIONALS HAVE THE KEY KNOWLEDGE AND EXPERTISE TO RESPOND TO THE ISSUE OF SUICIDE.

THE KEY INTERVENTION IN AUSTRALIA IS BASED ON RISK ASSESSMENT AND IS UNDERPINNED BY A RESEARCH APPROACH WHICH IS ALSO TOP DOWN. VERY LITTLE FUNDING AND ATTENTION IS PAID TO EARLY INTERVENTION AND PREVENTION IN AUSTRALIA. THERE IS ALSO CURRENTLY A VERY HEAVY EMPHASIS ON SUICIDE PREVENTION TRIAL SITES WHICH ARE PRIMARILY POSTVENTION.

IN RECENT TIMES GOVERNMENTS HAVE RECOGNISED THE NEED TO APPROACH SUICIDE PREVENTION IN A MORE SYSTEMATIC MANNER. SUICIDE PREVENTION HAS THEREFORE RECENTLY BEEN INCLUDED AS A SEPARATE PART OF THE 5<sup>TH</sup> NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN. IT IS LITERALLY AN ADD ON AS IT DID NOT FORM PART OF THE VERY CONTENTIOUS CONSULTATION PROCESS THAT LED TO THE 5<sup>TH</sup> MENTAL HEALTH PLAN. BUT AT LEAST IT IS THERE NOW.

THE SUICIDE PREVENTION COMPONENT HAS ITS OWN IMPLEMENTATION STRATEGY BEING FORMULATED AT THIS POINT AND THERE SHOULD SOON BE A CONSULTATION PAPER RELEASED FOR THE COMMUNITY TO HELP GUIDE FURTHER RESPONSES TO SUICIDE PREVENTION. I URGE YOU TO BECOME ENGAGED IN THAT CONSULTATION PROCESS.

THE CONSULTATION PAPER WILL INCLUDE A SPECIFIC STRATEGY TO RESPOND TO THE ALARMING LEVEL OF SUICIDE IN OUR ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES.

THE CURRENT DEBATE AROUND THE RESPONSE TO SUICIDE PREVENTION IN AUSTRALIA IS NOW ALSO BEGINNING TO RECOGNISE THAT SOCIAL FACTORS SUCH AS POVERTY, HOUSING, EMPLOYMENT AND OTHER FACTORS NEED TO BE CONSIDERED IN THE FORMULATION OF A SUICIDE PREVENTION STRATEGY.

ALTHOUGH THERE ARE MANY CRITICISMS THAT CAN BE MADE OF OUR CURRENT SYSTEM, THIS SHOULD NOT PREVENT US FROM RECOGNISING THERE IS ALSO GOOD WORK BEING UNDERTAKEN BY MANY INDIVIDUALS AND ORGANISATIONS WORKING TOGETHER TO RESPOND TO THE DISTRESS BEING EXPERIENCED BY THOUSANDS OF INDIVIDUALS EACH YEAR.

HOWEVER, IT IS TIME TO CHANGE SOME OF THE APPROACHES IF WE WANT TO REDUCE THE RATE OF SUICIDE IN AUSTRALIA..

## **SLIDE 6 – WHY INTRODUCE A NEW STRATEGY FOR SUICIDE INTERVENTION**

THE RATE OF SUICIDE IS NOT REDUCING IN SPITE OF THE SIGNIFICANT FUNDING AND EFFORT OF MANY PEOPLE AND ORGANISATIONS. EACH YEAR FOR MANY DECADES GOVERNMENTS HAVE INVESTED HUNDREDS OF MILLIONS OF DOLLARS INTO SUICIDE PREVENTION AND THE RATES CONTINUE TO INCREASE. IF THIS LEVEL OF EXPENDITURE OCCURRED IN PRIVATE ENTERPRISE WITH THIS RESULT A CORPORATION WOULD BEGIN TO QUESTION ITS RETURN ON INVESTMENT AND DECIDE SOMETHING NEEDED TO BE CHANGED.

SO LET US LOOK AT SOME AREAS THAT COULD BE CHANGED.

WE NEED TO CHANGE HOW WE RESPOND TO A PERSON'S EXPERIENCE OF DISTRESS

WE NEED TO CHANGE THE NARRATIVE FROM **DOING TO** - **TO DOING WITH** PEOPLE WITH A LIVED EXPERIENCE. THIS IS WHERE THE PEER SUPPORT AND PEER TO PEER APPROACH CAN PLAY AN IMPORTANT ROLE.

IT CAN COMPLEMENT CURRENT PROFESSIONAL AND DIAGNOSTIC APPROACH WHICH COMPLETELY DOMINATES CURRENT APPROACHES TO INTERVENTION.



OUR SYSTEM VIEWS SUICIDE AS BEING THE PROBLEM. FOR PEOPLE IN DEEP DISTRESS SUICIDE MAY BECOME THE SOLUTION NOT THE PROBLEM. WE NEED TO HELP PEOPLE FIND ALTERNATIVE SOLUTIONS TO THEIR DISTRESS AND THIS REQUIRES THAT WE REVIEW HOW WE ACTUALLY RESPOND TO A PERSON'S DISTRESS. WE WILL LOOK MORE CLOSELY AT THIS LATER IN THE PRESENTATION.

### WE NEED TO REVIEW HOW WE DEFINE EVIDENCE

THE CURRENT SYSTEM IS PREDICATED ON A NARROW DEFINITION OF WHAT CONSTITUTES EVIDENCE, ONE WHICH DOES NOT PLACE MUCH FOCUS ON LEARNING FROM THE LIVED EXPERIENCE.

TO ACHIEVE CHANGE WE NEED TO REVIEW WHAT WE MEAN BY EVIDENCE:

- RESEARCH THAT DOESN'T CAPTURE THE VARIETY OF POPULATIONS WITH LIVED EXPERIENCE EXCLUDES THOSE VOICES OF LIVED EXPERIENCE. THIS MEANS THAT THE CURRENT EVIDENCE THAT INFORMS POLICY AND SERVICES WHICH IS CLAIMED TO BE EVIDENCE BASED ACTUALLY EXCLUDES EVIDENCE THAT IS HELD BY PEOPLE'S LIVED EXPERIENCE.
- THE CURRENT RELIANCE ON HIGHLY PRESCRIPTIVE UNIVERSITY AND OTHER INSTITUTIONAL GUIDELINES THAT EXCLUDES AN UNDERSTANDING OF THE EXPERIENCE OF

DISTRESS ACTUALLY EXCLUDES THE VOICES OF THE VERY PEOPLE WE ARE TRYING TO ASSIST

- IF LIVED EXPERIENCE VOICES ARE MISSING FROM RESEARCH AND SERVICES, THE LIVED EXPERIENCE AND THEIR VOICE BECOME INVISIBLE AND THEIR EXPERIENCE BECOMES OBJECTIFIED RATHER THAN REAL, HENCE THE EMERGENCE OF A PLETHORA OF RISK ASSESSMENT AND DIAGNOSTIC TOOLS.
- INNOVATION AND QUALITATIVE APPROACHES NEED TO BE AN INTEGRAL PART OF FUTURE RESEARCH AND PROGRAM SERVICE DELIVERY
- AND RESEARCH NEEDS TO BE CO-PRODUCED TO ACHIEVE THIS. CURRENT APPROACHES DO NOT CAPTURE THE RICHNESS AND DEPTH OF LEARNING THAT IS EVIDENT IN THE PEER APPROACH AND THE EXPERIENCES OF OTHERS WITH A LIVED EXPERIENCE.

### THE PROFESSIONS NEED TO RE-EXAMINE THEIR ROLE

IT IS A FACT THAT THE PROFESSIONS AS WE KNOW THEM ALL HAVE THEIR ORIGINS IN THE LIVED EXPERIENCE ACROSS SOCIETY. PROFESSIONS HAVE FORGOTTEN THIS AND NOW TELL PEOPLE WITH A LIVED EXPERIENCE WHAT THEY SHOULD THINK, FEEL AND DO RATHER THAN UNDERSTAND WHAT IS DRIVING THEIR DISTRESS.

IT WAS THE CURIOSITY OF THE HUMAN MIND THAT ENABLED THE DEVELOPMENT OF THE PROFESSIONS IN RESPONSE TO TRYING TO FIND SOLUTIONS TO THE PROBLEMS OF HUMAN EXPERIENCE. HOWEVER, THESE PROFESSIONS AND OTHER GROUPS SEEM NOW TO HAVE TAKEN THE CONTROL OF THE PROCESS WHEREAS THE REAL LEARNING BEGINS WITH THE INDIVIDUAL EXPERIENCE.

IT IS IMPORTANT TO REMEMBER THAT THERE IS NO SUICIDE INTERVENTION SECTOR WITHOUT PEOPLE WHO HAVE THE LIVED EXPERIENCE OF SUICIDE IN WHATEVER CAPACITY. THEY ARE THE ONLY REASON THERE ARE RESEARCHERS, SERVICE PROVIDERS AND POLICY MAKERS IN THIS SECTOR.

SO IT MAKES SENSE THAT THE PROFESSIONS RECONSIDER THEIR APPROACH TO ENGAGEMENT WITH THE LIVED EXPERIENCE AND BEGIN TO MORE GENUINELY CO-PRODUCE ACTIVITIES WITH LIVED EXPERIENCE IN THE SUICIDE PREVENTION SECTOR.

WE NEED TO RECOGNISE THE IMPORTANT ROLE OF THE LIVED EXPERIENCE PARTICULARLY IN THE FORM OF PEER SUPPORT

SO LIVED EXPERIENCE NEEDS TO BE THE FOUNDATION STONE OF ANY INTERVENTION AND RESEARCH. GENUINELY WORKING TOGETHER IS THE KEY – NO LONGER CAN THE LIVED EXPERIENCE BE CONSIDERED TO BE AN ADD ON, NOR SHOULD PEER SUPPORT BE CONSIDERED TO BE A LESSER APPROACH IN RESPONDING TO SUICIDE.

AS WINSTON CHURCHILL ONCE SAID:

PROFESSIONALS NEED TO BE ON TAP, NOT ON TOP.

WITHOUT A DOUBT OUR SUICIDE PREVENTION SYTEM CURRENTLY PLACES PROFESSIONALS ON TOP IN EVERY RESPECT.

## **SLIDE 7 LEUNIG CARTOON - WELCOME**

THERE ARE SOME CHANGES OCCURRING IN OUR SUICIDE PREVENTION SYSTEM. PEERS AND THE LIVED EXPERIENCE OVERALL ARE GRADUALLY BEING INCLUDED IN SERVICES AND RESEARCH. HOWEVER, THIS IS SLOW AND UNVEN AND EVEN A BIT CONFUSED IN ITS PROCESS.

FOR EXAMPLE, MANY ORGANISATIONS ARE NOW INCLUDING LIVED EXPERIENCED NETWORKS, BUT OFTEN THEIR ROLE IS INCIDENTAL RATHER THAN CENTRAL TO DECISION-MAKING IN MANY CASES.

EVEN IN **SUICIDE PREVENTION AUSTRALIA**, THE PEAK BODY IN THE SUICIDE PREVENTION SECTOR, A PERSON WITH A LIVED EXPERIENCE CAN BE AN ASSOCIATE MEMBER OF SPA AND EVEN NOMINATE FOR THEIR BOARD – HOWEVER, THEY ARE NOT ALLOWED TO VOTE IN ELECTIONS. THEY CAN'T EVEN VOTE FOR THEMELVES.

SPA IS DOING SOME GREAT WORK AND NOW HAS THE OPPORTUNITY TO DEMONSTRATE LEADERSHIP BY ENGAGING MORE FULLY WITH THE LIVED EXPERIENCE BY CHANGING ITS RULES AROUND THAT ISSUE.

IT MIGHT ALSO WANT TO CONSIDER QUARANTINING TWO POSITIONS ON THE BOARD EXCLUSIVELY FOR THE LIVED EXPERIENCE AS THIS IS A PRACTICE THAT IS BEING INTRODUCED IN OTHER SECTORS.

## **SLIDE 8– THE ACES STUDY**

I MENTIONED EARLIER THE LINK TO MORE CLOSELY RELATE RESEARCH WITH THE LIVED EXPERIENCE. I WANT TO SPEND SOME TIME LOOKING AT RESEARCH WHICH DRAWS STRONG LINKS BETWEEN EARLY TRAUMA AND DISTRESS IN LATER LIFE. I BELIEVE THIS RESEARCH HELPS US UNDERSTAND WHY CONCENTRATING ON RISK ASSESSMENT IN SUICIDE RATHER THAN UNDERSTANDING WHAT HAS HAPPENED TO PEOPLE IN THEIR LIVES IS NOT HELPING OUR CURRENT SUICIDE PREVENTION INTERVENTIONS.

1980S VINCENT FELITTI CREATED A CLINIC FOR CHRONICALLY OBESE PATIENTS AT KAISER PERMANENTE HOSPITAL IN SAN DIEGO.

HE NOTICED A VERY HIGH DROPOUT RATE ALMOST EXCLUSIVELY LIMITED TO PEOPLE WHO WERE LOSING WEIGHT SUCCESSFULLY.

IN HIS REVIEW OF ONE PATIENT WHO HAD LOST SIGNIFICANT WEIGHT THEN PUT IT BACK, HE WAS TOLD THAT THE HEIGHTENED INTEREST IN HER BY MEN AFTER HER WEIGHT LOSS TRIGGERED HER ACTION IN PUTTING WEIGHT BACK AS SHE HAD A HISTORY OF SEXUAL ABUSE. FURTHER EXPLORATION WITH OTHER PATIENTS REVEALED THEY WERE USING OBESITY AS A SOLUTION TO DEEPER PROBLEMS.

ALONG WITH OTHERS, FELITTI LED SUBSEQUENT ACE STUDIES. ADVERSE CHILDHOOD EXPERIENCES ARE COMMON. ACROSS A POPULATION OF APPROXIMATELY 17,000 HEALTH MAINTENANCE ORGANISATION MEMBERS FROM SOUTHERN CALIFORNIA RECEIVING PHYSICAL EXAMINATIONS COMPLETED CONFIDENTIAL SURVEYS REGARDING THEIR CHILDHOOD EXPERIENCES AND CURRENT HEALTH STATUS AND BEHAVIOURS. ALMOST TWO THIRDS OF STUDY PARTICIPANTS REPORTED AT LEAST ONE ACE OUT OF THE TEN ACES QUERIED.

## **ACE STUDY MEASURES**

PHYSICAL ABUSE

SEXUAL ABUSE

EMOTIONAL ABUSE

PHYSICAL OR EMOTIONAL NEGLECT

EXPOSURE TO DOMESTIC VIOLENCE

HOUSEHOLD SUBSTANCE ABUSE

HOUSEHOLD MENTAL ILLNESS

PARENTAL SEPARATION OR DIVORCE

INCARCERATED HOUSEHOLD MEMBER

THE ACE SCORE, A SUM TOTAL OF DIFFERENT CATEGORIES OF ACES REPORTED BY PARTICIPANTS, IS USED TO ASSESS CUMULATIVE CHILDHOOD STRESS. AS THE NUMBER OF ACES INCREASES SO DOES THE RISK FOR A RANGE OF ISSUES LATER IN LIFE .

### **SOME OF THE CONSEQUENCES IN LATER LIFE**

ALCOHOLISM AND ALCOHOL ABUSE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DEPRESSION

FETAL DEATH

HEALTH-RELATED QUALITY OF LIFE

ILLCIT DRUG USE

ISCHEMIC HEART DISEASE

LIVER DISEASE

POOR WORK PERFORMANCE

FINANCIAL STRESS

RISK FOR INTIMATE PARTNER VIOLENCE

MULTIPLE SEXUAL PARTNERS

SEXUALLY TRANSMITTED DISEASES

SMOKING

UNINTENDED PREGNANCIES

EARLY INITIATION OF SMOKING

EARLY INITIATION OF SEXUAL ACTIVITY

ADOLESCENT PREGNANCY

RISK FOR SEXUAL VIOLENCE

POOR ACADEMIC ACHIEVEMENT

AND, FINALLY, SUICIDE ATTEMPTS

UNDERSTANDING A PERSON'S LIVED EXPERIENCE INVOLVES UNDERSTANDING AND LISTENING TO THEIR LEVEL OF DISTRESS. THIS IS THE BASIS OF THE PEER TO PEER BASIS OF SUICIDE INTERVENTION. THIS IS WHAT THE ACES STUDY IS TELLING US.

YOU CAN SEE FROM THIS SLIDE THAT THE SCORE OF FOUR OR MORE ACE INDICATORS SHOWED A PERSON IS 1200% MORE LIKELY TO MAKE AN ATTEMPT TO END THEIR LIFE THAN A PERSON WITH LESS THAN FOUR INDICATORS.

## **SLIDE 9 – MYTHS OF SUICIDE**

AS I OUTLINED EARLIER, OUR SUICIDE PREVENTION SYSTEM IS LARGELY PREDICATED ON WHAT PROFESSIONALS THINK IS THE BEST. I AM NOT SUGGESTING WE THROW THE BABY OUT WITH THE BATH WATER, BUT I AM SUGGESTING WE NEED TO MORE DEEPLY EXAMINE THE BASIS OF WHY WE ARE DOING WHAT WE ARE DOING AND, AS PROFESSIONALS, ASK OURSELVES WHAT IT IS THAT WE NEED TO DO DIFFERENTLY.

THE ACES STUDY SENDS CLEAR MESSAGES ABOUT THE NEED TO UNDERSTAND HOW A PERSON'S EXPERIENCES MIGHT IMPACT THEIR LATER LIFE.

I THINK THIS MIGHT ALSO LEAD US TO REVIEW SOME OF THE MYTHS THAT SURROUND SUICIDE THAT WE AS PROFESSIONALS SEEM TO ACCEPT AS THE TRUTH.

SO I WANT TO EXPLORE WITH YOU SOME OF THE MYTHS THAT UNDERPIN OUR CURRENT APPROACH TO SUICIDE PREVENTION.



IN DOING SO I DRAW ON THE WORK OF THE WESTERN MASSACHUSETTS RECOVERY LEARNING COMMUNITY WHOSE WORK IN PEER TO PEER SUICIDE INTERVENTION I WILL COME TO LATER.

### **MYTH 1. TALKING ABOUT SUICIDE IS A BAD IDEA**

HOW OFTEN HAVE WE AVOIDED THIS SUBJECT WHEN TALKING TO PEOPLE IN DISTRESS? HOW OFTEN HAVE WE DISCOURAGED THOSE IN DISTRESS TALKING TO OTHERS WITH SIMILAR FEELINGS, ARGUING THAT SUCH CONTACT MIGHT ONLY ENCOURAGE PEOPLE TO SWAP IDEAS ABOUT SUICIDE?

TALKING ABOUT SUICIDE SHOWS THAT YOU CARE ABOUT THEM AND TAKE THEM SERIOUSLY AND THAT YOU ARE WILLING TO SHARE THEIR PAIN. IT GIVES THEM AN OPPORTUNITY TO EXPRESS WHAT IS GOING ON FOR THEM.

THIS APPROACH IS ALSO STARTING TO BECOME ACCEPTED IN AUSTRALIA WITH THE YOU CAN TALK ABOUT IT COMMUNICATION STRATEGY THAT IS BEING PROMOTED BY AN ALLIANCE OF AGENCIES. THE CHALLENGE IS FOR PROFESSIONALS TO DO THIS WITHOUT HAVING THEIR TRADITIONAL RISK AVERSE APPROACH GETTING IN THE WAY OF THEIR LISTENING.

SADLY MANY PEOPLE WITH A LIVED EXPERIENCE WILL SAY THEY WEREN'T LISTENED TO BUT HAD TO ENDURE RISK ASSESSMENTS INSTEAD OF RELATING THEIR PAIN.

## **SLIDE 10 – MYTHS OF SUICIDE**

### **MYTH 2. WE SHOULD USE RISK ASSESSMENTS**

DR MATTHEW LARGE, QUOTED IN THE MEDICAL JOURNAL OF AUSTRALIA, FROM UNI OF NSW SCHOOL OF PSYCHIATRY SAYS IT IS SIMPLY NOT POSSIBLE TO PREDICT SUICIDE IN AN INDIVIDUAL PATIENT.

EVEN AS RECENTLY AS JANUARY 2019 AUSTRALIAN RESEARCH HAS SHOWN THAT PEOPLE DO NOT NECESSARILY SAY WHAT THEY ARE REALLY THINKING WHEN BEING INTERVIEWED BY PROFESSIONALS.

RISK ASSESSMENTS CAN SHUT DOWN CONVERSATION AND CAN PREVENT “LOW RISK” PERSONS FROM ACCESSING SERVICES.

AS PROFESSIONALS WE ARE TRAINED TO LISTEN. HOWEVER, WHEN WE FOCUS ON ASSESSING RISK WITH OUR CHECK LISTS OR DIAGNOSTIC TOOLS WE STOP LISTENING. PEOPLE SOON WORK OUT WHAT NOT TO SAY BECAUSE THEY DON'T WANT TO BE SECTIONED OR RECEIVE OTHER FORMS OF INTERVENTION WHICH SIMPLY INCREASE THEIR PAIN.

## SLIDE 11 – MYTHS OF SUICIDE

### MYTH 3. WE WILL BE LIABLE

MANY PROFESSIONALS AND ORGANISATIONS FEAR THE RISK OF LITIGATION IF THEY DO NOT INTERVENE.

IN A PEER TO PEER SCENARIO THE INDIVIDUAL MAKES THE CHOICE TO ENGAGE IN PEER TO PEER SUPPORT. IT IS NOT BY REFERRAL FROM A PROFESSIONAL OR ORGANISATION.

STEFAN SAYS:

“THE ODDS OF NON PRESCRIBING OUTPATIENT CLINICIAN BEING HELD LIABLE FOR CLIENT SUICIDE ARE THE SAME AS BEING STRUCK BY LIGHTNING.”

Rational Suicide, Irrational Laws

Examining Current Approaches to Suicide in Policy and Law

**Susan Stefan** [American Psychology-Law Society Series](#) April 2016

GROUPS SUCH AS GROW, HEARING VOICES GROUPS AND AA ARE SIMILAR IN THAT THEY ARE SELF HELP, NON CLINICIAN BASED AND NOT THERAPEUTIC. IF INDIVIDUALS SELF REFER THEY ARE TAKING RESPONSIBILITY FOR THEIR DECISION.

## **SLIDE 12– MYTHS OF SUICIDE**

### **MYTH 4 FORCED HOSPITALISATION HELPS PEOPLE**

SOMETIMES PEOPLE CHOOSE TO GO TO HOSPITAL BECAUSE THEY FEEL UNSAFE AND THERE ARE NO CRISIS RESPITE OPTIONS AVAILABLE. SOMETIMES PEOPLE DON'T WANT TO LEAVE HOSPITAL BECAUSE THEY FEEL THEY CAN NOT FACE THEIR EXTERNAL ENVIRONMENT. YET WHEN THEY ASK – SOMETIMES BEG – TO STAY THEY ARE TOLD THEIR BED IS NEEDED. HOW MANY CORONIAL INQUIRIES HAVE COVERED THAT SCENARIO WHERE A PERSON HAS BEEN DISCHARGED – SOMETIMES TO HOMELESSNESS – AND THEN CHOSEN TO END THEIR LIVES WITH A MATTER OF DAYS?

WHAT FORM OF COGNITIVE DISTORTION CAPTURES HOSPITAL ADMINISTRATORS AND STAFF TO THE EXTENT THAT THEY VALUE A HOSPITAL BED MORE THAN A PERSON'S LIFE?

HOWEVER, MORE OFTEN THAN NOT THE EXPERIENCE OF FORCED HOSPITALISATION IS EXTREMELY DAMAGING TO AN INDIVIDUAL.

QIN NOTES - SUICIDE RATES INCREASE DURING AND AFTER HOSPITALISATION (QIN AND NORDENOFF: SUICIDE RISK IN RELATION TO PSYCHIATRIC HOSPITALISATION: EVIDENCE BASED ON LONGITUDINAL REGISTERS. ARCH GEN PSYCHIATRY 2005;62: 427 – 32).

ELEVATED SUICIDE RATES CAN LAST FOR UP TO TWO YEARS AFTER HOSPITALISATION.

PEOPLE LEARN TO STOP TALKING ABOUT SUICIDAL THOUGHTS WHEN THEY EXPERIENCE SEVERE FORMS OF INTERVENTION..

JOY HIBBINS, A LIVED EXPERIENCE ACTIVIST IN THE UK, AND FOUNDER OF THE SUICIDE CRISIS CENTER WHICH IS PEER RUN, SAID

- FEELING OF POWERLESSNESS DOMINATED MY EXPERIENCE OF MENTAL HEALTH SERVICES. AND THIS FEELING WAS AT ITS WORST WHEN I WAS SECTIONED. SECTIONING REPLICATED ASPECTS OF THE TRAUMATIC EXPERIENCE THAT INITIALLY CAUSED MY SUICIDAL CRISIS. I FELT TRAPPED, CAPTIVE AND UTTERLY OUT OF CONTROL. I COULDN'T ESCAPE. .

JOY HIBBINS, GUARDIAN SEPT 2017, FOUNDER SUICIDE CRISIS CENTRE

## **SLIDE 13 – MYTHS OF SUICIDE**

### **MYTH 5. SUICIDAL PEOPLE MUST BE MENTALLY ILL**

PEOPLE GET TRAPPED IN THE DIAGNOSIS LOOP. - MEDICATION DOESN'T ADDRESS THE REASONS WHY A PERSON IS EXPERIENCING DEEP DISTRESS.

BEYOND DIAGNOSIS THERE ARE ALSO SITUATIONAL FACTORS WHICH CAN CONTRIBUTE TO DISTRESS AND SUICIDAL IDEATION.

LISTENING AND PROVIDING PRACTICAL AND EMOTIONAL SUPPORT ARE IMPORTANT, RATHER THAN JUDGING OR DIAGNOSING.

## **SLIDE 14 – MYTHS OF SUICIDE**

### **MYTH 6. SUICIDE PREVENTION IS THE AIM**

THE GOAL IS NOT TO FORCE SOMEONE TO STAY ALIVE FROM MOMENT TO MOMENT. THE GOAL IS TO SUPPORT SOMEONE IN CREATING A MEANINGFUL LIFE THAT THEY WANT TO LIVE. NOT KILLING ONE'S SELF IS SIMPLY A SIDE EFFECT OF THAT.

WE NEED TO BE ADOPTING A LIFE PROMOTION APPROACH IN SUICIDE INTERVENTION. THIS IS THE APPROACH ADOPTED BY FIRST NATIONS PEOPLE IN CANADA.

IT IS THE BASIS OF THE PEER TO PEER SUICIDE INTERVENTION APPROACHED DEVELOPED BY THE WESTERN MASSACHUSETTS RECOVERY LEARNING COMMUNITY WHICH WE ARE INTRODUCING TO AUSTRALIA.

## **SLIDE 15– WHY PEER SUPPORT**

WE HAVE MENTIONED PEER SUPPORT THROUGHOUT THIS PRESENTATION AS THOUGH IT IS A RELATIVELY RECENT PHENOMENON. HOWEVER, IT HAS A LONGER HISTORY BUT HAS BEEN OVERRIDDEN BY THE ACTIVITIES OF THE PROFESSIONS.

AS FAR BACK AS 1793 THE GOVERNOR OF THE BICENTRE ASYLUM IN FRANCE WAS HIRING PAST PATIENTS TO WORK IN THE ASYLUM. PHILLIPPE PINEL, LATER TO BE KNOWN AS THE FATHER OF PSYCHIATRY, WROTE AT THE TIME:

“AS MUCH AS POSSIBLE, ALL SERVANTS ARE CHOSEN FROM THE CATEGORY OF MENTAL PATIENTS. THEY ARE AT ANY RATE BETTER SUITED TO THIS DEMANDING WORK BECAUSE THEY ARE USUALLY MORE GENTLE, HONEST, AND HUMANE.”

THERE IS A GROWING BODY OF LITERATURE IN MENTAL HEALTH WHICH DEMONSTRATES THE VALUE OF PEER SUPPORT.

FOR EXAMPLE, WE KNOW THAT IN AUSTRALIA THE VIETNAM VETERANS COUNSELLING SERVICE WAS STARTED AS A PEER SUPPORT GROUP OF VETERANS WHO MET TO HELP EACH OTHER DEAL WITH THEIR TRAUMA OF WAR. THIS LATER BECAME A FULLY FUNDED SERVICE OFTEN STAFFED BY PAST VETERANS WHO TRAINED AS SOCIAL WORKERS AND PSYCHOLOGISTS.

## **SLIDE 16– WHY PEER SUPPORT**

PAUL PFEIFER FROM THE US VETERAN’S HEALTH ADMINISTRATION RESEARCH DEVELOPMENT, IN A PRESENTATION IN 2015, OBSERVES THERE IS LITTLE RESEARCH SPECIFIC TO THE VALUE OF PEER ENGAGEMENT IN SUICIDE PREVENTION. HE TALKS ABOUT THE GROWING MOVEMENT TOWARDS PEER SUPPORT IN SUICIDE PREVENTION BEING DRIVEN BY

EXISTING SERVICES WHICH ARE SEEN BY MANY INDIVIDUALS AS TRAUMATIC, HUMILIATING AND DISEMPOWERING DUE TO:

- INVOLUNTARY COMMITMENT
- POLICE INVOLVEMENT
- RESTRAINTS
- FORCED MEDICATION
- REMOVAL OF CLOTHING/BELONGINGS
- STERILE COLD SURROUNDINGS
- ISOLATION FROM FRIENDS AND FAMILY
- EXCESSIVE WAIT/"BOARDING" TIMES
- DISCOURTEOUS STAFF

YOU WILL RECOGNISE SOME OF THESE THEMES FROM INFORMATION I HAVE PRESENTED EARLIER IN THIS TALK.

ANECDOTAL EVIDENCE IN AUSTRALIA SUGGESTS SIMILAR EXPERIENCES.

HE DESCRIBES ROSE HOUSE WHICH IS A SERVICE THAT IS AN ALTERNATIVE TO PSYCHIATRIC ADMISSION AND PROVIDES A RESPONSE THAT COSTS ONE QUARTER OF THE COST OF PSYCHIATRIC ADMISSION BUT OF WHICH 97% OF THE RESIDENTS REPORTED FEELING BETTER AND MORE SOCIALLY CONNECTED.

HE IS CURRENTLY CONDUCTING RESEARCH ON A 12 WEEK OF 1:1 PEER MENTORSHIP TO REDUCE THE RISK OF SUICIDE AFTER A PSYCHIATRIC HOSPITALISATION USING A CO-DESIGNED PEER TRAINING PROGRAM.



INITIAL RESEARCH RESULTS PUBLISHED IN NOVEMBER 2018 WERE HIGHLY POSITIVE REGARDING PEER SPECIALISTS' ABILITY TO RELATE, LISTEN, AND ADVISE AND TO PROVIDE SUPPORT SPECIFICALLY DURING DISCUSSIONS ABOUT SUICIDE. FINDINGS DEMONSTRATE THAT A PEER SUPPORT SPECIALIST SUICIDE PREVENTION INTERVENTION IS FEASIBLE AND ACCEPTABLE FOR PATIENTS AT HIGH RISK FOR SUICIDE.

PFEIFER ET AL NOVEMBER 2018.

## **SLIDE 17– WHY PEER SUPPORT**

IN 2015, LEAH HARRIS A TRAUMA INFORMED CARE SPECIALIST FROM THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS DESCRIBED THE VALUE OF PEER TO PEER SUPPORT: IN ZERO SUICIDE AND PEER SUPPORT (USA)

- PEER TO PEER SUPPORT IS AN EVIDENCE-BASED PRACTICE
- PROMOTES CRUCIAL PROTECTIVE FACTORS SUCH AS CONNECTEDNESS AND HOPE
- PROMOTES RECOVERY AND RESILIENCE
- PROMOTES CHOICE AND VOICE IN TREATMENT
- CHALLENGES NEGATIVE STEREOTYPES

## **SLIDE 18– THE GAP IN OUR SUICIDE PREVENTION SYSTEM**

WE HAVE SEEN FROM THE DIRECTION IN THE USA, BRITAIN AND THE BEGINNINGS HERE IN AUSTRALIA THAT THE LIVED

EXPERIENCE IS INFORMING THE APPROACH TO SUICIDE PREVENTION. IN PARTICULAR THE GROWING INFLUENCE OF PEER SUPPORT IS STARTING TO RESHAPE SOME APPROACHES.

HOWEVER, IN SPITE OF THE GROWING INFLUENCE OF PEER SUPPORT THERE IS STILL A GAP IN AUSTRALIA. THE PRESENCE OF PEER SUPPORT IN AUSTRALIA IS STILL INFLUENCED PRIMARILY BY THE DECISIONS OF PROFESSIONALS.

THE GAP IN AUSTRALIA LIES IN THE LACK OF GENUINE PEER TO PEER ACTIVITIES THAT ARE NOT DETERMINED BY PROFESSIONAL ENGAGEMENT. THAT IS GENUINE SELF HELP GROUPS THAT ARE RUN ONLY BY PEERS.

THIS IS THE GAP WHICH WHEN FILLED WILL HELP RESHAPE OUR SUICIDE PREVENTION SECTOR AND WHICH WILL ADD VALUE TO THE CURRENT APPROACH IN AUSTRALIA. IT WILL ALSO CONTRIBUTE TO THE OVERALL STRENGTHENING OF THE LIVED EXPERIENCE VOICE IN AUSTRALIA

THIS APPROACH OFFERS ONE OF THE SEVERAL EMERGING NON CLINICAL ALTERNATIVES THAT ARE BEING EXPLORED IN AUSTRALIA BUT IS THE ONLY ONE THAT DOES NOT ULTIMATELY HAVE CLINICIANS AS THE ULTIMATE DETERMINER OF HOW OR WHEN TO INTERVENE.

THE PEER TO PEER APPROACH RESTS ON LISTENING, SUPPORTING, HELPING TO SOLVE, RATHER THAN ASSESSING, AND RECOGNISES WHAT SHNEIDMAN DESCRIBED AS PSYCHACHE. DUBBED THE FATHER OF SUICIDOLOGY, HE SAID:

“...AS I NEAR THE END OF MY CAREER IN SUICIDOLOGY, I THINK I CAN NOW SAY WHAT HAS BEEN ON MY MIND IN AS FEW AS FIVE WORDS: SUICIDE IS CAUSED BY PSYCHACHE (SIK-AK; TWO SYLLABLES). PSYCHACHE REFERS TO THE HURT, ANGUISH, SORENESS, ACHING, PSYCHOLOGICAL PAIN IN THE PSYCHE, THE MIND. IT IS INTRINSICALLY PSYCHOLOGICAL – THE PAIN OF EXCESSIVELY FELT SHAME, OR GUILT, OR HUMILIATION, OR WHATEVER. WHEN IT OCCURS, ITS REALITY IS INTROSPECTIVELY UNDENIABLE. SUICIDE OCCURS WHEN THE PSYCHACHE IS DEEMED BY THAT PERSON TO BE UNBEARABLE. THIS MEANS THAT SUICIDE ALSO HAS TO DO WITH DIFFERENT INDIVIDUAL THRESHOLDS FOR ENDURING PSYCHOLOGICAL PAIN ...”(SHNEIDMAN, 1985,

“OUR BEST ROUTE TO UNDERSTANDING SUICIDE IS ... DIRECTLY THROUGH THE STUDY OF HUMAN EMOTIONS DESCRIBED IN PLAIN ENGLISH, IN THE WORDS OF THE SUICIDAL PERSON.” – ED SHNEIDMAN, THE SUICIDAL MIND

SHNEIDMAN PRESENTS A BOLD AND SIMPLE PREMISE: THE MAIN CAUSE OF SUICIDE IS PSYCHOLOGICAL PAIN OR "PSYCHACHE." THUS THE KEY TO PREVENTING SUICIDE IS NOT SO MUCH THE STUDY OF THE STRUCTURE OF THE BRAIN, OR THE STUDY OF

SOCIAL STATISTICS, OR THE STUDY OF MENTAL “DISEASES” (*MY USE OF INVERTED COMMAS*), AS IT IS THE DIRECT STUDY OF HUMAN EMOTIONS. TO “TREAT” (*MY USE OF INVERTED COMMAS*) A SUICIDAL INDIVIDUAL, WE NEED TO IDENTIFY, ADDRESS, AND REDUCE THE INDIVIDUAL'S PSYCHACHE.

REFLECTING ON HIS WORDS I AM LEFT WONDERING HOW WE AS PROFESSIONALS HAVE MANAGED TO CREATE A SYSTEM THAT APPEARS TO HAVE BLURRED THE FOCUS ON THE ACTUAL PAIN BEING EXPERIENCED, INSTEAD DEVELOPING ASSESSMENTS AND INTERVENTIONS WHICH ACTUALLY DISTRACT US FROM RECOGNISING THE PAIN.

THIS BRINGS US TO EXPLORING THE PEER TO PEER APPROACH THAT IS GROWING IN THE USA CALLED THE ALTERNATIVES TO SUICIDE PEER SUPPORT GROUP.

## **SLIDE 19 – ORIGINS OF THE “ALTERNATIVES TO SUICIDE” PEER TO PEER SUPPORT APPROACH**

THE ALTERNATIVES TO SUICIDE APPROACH GIVES VOICE TO THE LIVED EXPERIENCE OF SUICIDE. IT IS A PEER TO PEER SUPPORT GROUP COMPRISED OF PEOPLE WHO HAVE ATTEMPTED TO TAKE THEIR LIFE OR WHO HAVE THOUGHTS ABOUT SUICIDE.

- THIS PEER SUPPORT APPROACH HAS ITS ORIGINS IN THE HEARING VOICES APPROACH I OUTLINED AT THE BEGINNING

OF THIS TALK, WHICH WAS ESTABLISHED BY PROFESSOR MARIUS ROMME AND OTHERS IN 1987 IN RESPONSE TO MANAGING PSYCHOSIS.

- THE ALTERNATIVES TO SUICIDE PEER SUPPORT GROUP PROVIDES A SAFE SPACE FOR PEOPLE TO TALK ABOUT THEIR FEELINGS AND EXPERIENCES IN A SAFE, NON-JUDGEMENTAL SETTING, WITH THE SUPPORT OF TWO TRAINED FACILITATORS WHO ALSO HAVE A LIVED EXPERIENCE
- NO CLINICIANS ARE INVOLVED
- IT PROVIDES AN OPPORTUNITY FOR INDIVIDUALS TO SHARE WITH OTHERS IN A WAY WHICH DOES NOT INVOLVE RISK ASSESSMENT OR INTERVENTION, INSTEAD HAVING OTHER SIMPLY LISTENING TO THEIR DISTRESS AND WALKING ALONG SIDE THEM
- MANY PEOPLE WHO HAVE EXPERIENCED THE SUICIDE INTERVENTION SYSTEM - WHICH WAS MEANT TO ASSIST THEM - OFTEN DESCRIBE THE ACTUAL INTERVENTION AS BEING WORSE THAN THE DISTRESS THAT LED TO THEIR ATTEMPT
- THEY SAY THE INTERVENTION HAS CAUSED THEM TO STOP TALKING ABOUT THEIR SUICIDAL IDEATION, BUT IT HAS NOT STOPPED THEM THINKING ABOUT SUICIDE

THE STRENGTH OF THE ALTERNATIVES TO SUICIDE APPROACH LIES IN THE PEER NATURE OF THE SUPPORT. THE RESEARCH PREVIOUSLY REFERRED TO IN THIS TALK HAS OUTLINED THE BENEFIT OF PEER SUPPORT AND PEER WORK.

AS MENTIONED, THE ALTERNATIVES TO SUICIDE OR PEER TO PEER APPROACH IS

- PURELY PEER BASED,
- NON JUDGEMENTAL,
- A SAFE SPACE AND
- INVOLVES WALKING ALONG SIDE INDIVIDUALS.

THIS APPROACH TO SUICIDE RESPONSE AROSE FROM RECOVERY AND HEARING VOICES TRAINING RUN AT THE WESTERN MASSACHUSETTS RECOVERY LEARNING COMMUNITY, OR WESTERN MASS RLC FOR SHORT.

THE WESTERN MASS RLC IS A PEER RUN ORGANISATION : THE BOARD AND STAFF ARE ALL MENTAL HEALTH OR SUICIDE INTERVENTION PEERS.

PARTICIPANTS IN THEIR RECOVERY TRAINING BEGAN TO TALK ABOUT THEIR THOUGHTS OF SUICIDE BECAUSE IT WAS SAFE TO DO SO. THEY TALKED ABOUT THEIR DESTRUCTIVE EXPERIENCES WHEN SEEKING HELP FROM THE SYSTEM AND HOW THIS LED THEM TO STOP TALKING ABOUT THEIR THOUGHTS AND FEELINGS OF SUICIDE, BUT IT DIDN'T STOP THEM THINKING ABOUT SUICIDE.

THE WESTERN MASS TRAINERS DECIDED TO SET UP GROUPS TO SUPPORT PEOPLE IN THEIR PROGRAMS WHO HAD SUICIDAL FEELINGS AND THOUGHTS AS THEY CLEARLY HAD NOWHERE ELSE TO TURN BECAUSE OF THEIR REJECTION OF EXISTING SERVICES AND SUPPORTS HAVING PREVIOUSLY FELT DAMAGED BY THOSE RESPONSES.

THE WESTERN MASS STAFF ESTABLISHED A GROUP SIMILAR TO THE HEARING VOICES GROUPS BUT WHICH FOCUSED ONLY ON SUICIDE. THEY TRAINED FACILITATORS TO COFACILITATE THE GROUPS AND ALL MEMBERS, INCLUDING THE FACILITATORS, WOULD BE PEOPLE WITH IDEATION OR WHO HAD MADE ATTEMPTS.

THE VALUE OF THE PEER TO PEER SUPPORT REMAINS THE STRONGEST FACTOR IN THE CONTINUATION OF THESE GROUPS. THESE GROUPS ARE BEING ESTABLISHED IN OTHER PARTS OF THE US AS PEOPLE HEAR ABOUT THEM AND THE WESTERN MASS RLC WERE RECOGNISED BY THE STATE OF MASSACHUSETTS FOR THEIR CONTRIBUTION TO SUYICIDE PREVENTION IN RESPONSE TO HAVING ESTABLISHED THESE GROUPS. THEY ARE ALSO A RESOURCE REFERRED TO IN THE ZERO SUICIDE PROGRAM I REFERRED TO EARLIER IN THIS TALK.

## **SLIDE 20 – WHY DOES THE ALTERNATIVES TO SUICIDE PEER TO PEER APPROACH WORK?**

THE WESTERN MASS RLC DEVELOPED THE 'ALTERNATIVES TO SUICIDE' APPROACH BECAUSE THE OPPORTUNITY TO TALK OPENLY ABOUT SUICIDE AND FEELINGS OF DEEP EMOTIONAL DISTRESS WITH OTHERS WHO HAVE OR ARE EXPERIENCING SIMILAR STRUGGLES CAN BE A POWERFUL WAY TO SUPPORT PEOPLE TO MOVE THROUGH THOSE DARKEST PLACES.

HOWEVER, PEOPLE WERE BEING DENIED THAT OPPORTUNITY IN TRADITIONAL RES[PONSE SETTINGS. THESE GROUPS PROVIDED A SETTING IN WHICH THOSE DISCUSSIONS COULD TAKE PLACE WITHOUT FEAR.

IT IS THE VERY RESPONSE THE CURRENT SYSTEM IN AUSTRALIA DOES NOT ENCOURAGE.

DURING GROUPS, PEOPLE SHARE THEIR SUCCESSES AND THEIR CHALLENGES, PROVIDE SUPPORT FOR ONE ANOTHER AND STRATEGIZE AND SHARE IDEAS FOR COPING WITH DIFFICULT LIFE CIRCUMSTANCES.

PEOPLE ARE ENCOURAGED TO COME BOTH IN TIMES OF STRENGTH AND CHALLENGE. INDIVIDUALS NEED NOT IDENTIFY AS BEING IN 'CRISIS' IN ORDER TO ATTEND.

PEOPLE ARE SUPPORTED BY STAYING IN THE DIALOGUE:



- ASKING WHY DO THEY WANT TO END THEIR LIFE?
- WHY DON'T THEY WANT TO END THEIR LIFE?

THE ENGAGEMENT IN GROUPS ENABLE PEOPLE TO CONNECT WITH A PERSON IN DISTRESS :

- THEY VALIDATE THE EXPERIENCE (OF PAIN AND DISTRESS - *THAT SOUNDS REALLY HARD, I CAN SEE WHY YOU FEEL THAT WAY*)
- THEY ENABLE OTHERS TO BE CURIOUS/EXPLORE – *HOW LONG HAVE YOU FELT THAT WAY?WHAT GIVES YOUR LIFE MEANING? WHAT KEEPS YOU GOING/*
- *THEY ALLOW VULNERABILITY – SHARING SOME OF ONE'S OWN EXPERIENCE*
- *THE HELP A PERSON FIND COMMUNITY – BEING A BRIDGE TO OTHERS. FINDING MEANING AND PURPOSE IN RELATIONSHIPS BEYOND THE ROLE OF “SERVICE RECIPIENT”, READING GROUPS ETC*

## **SLIDE 21: THE ATS PHILOSOPHY**

- RESPONSIBILITY TO – NOT FOR, OR OVER
- HONOURING EVERYONE'S UNIQUE JOURNEY
- EMPOWERING THROUGH SHARED EXPERIENCE
- COMMUNITY BUILDING
- MEANING MAKING
- SOCIAL JUSTICE FOCUS
- CHALLENGING PRECONCEIVED JUDGEMENTS

THE GROUPS ARE LIFE PROMOTING.

## **SLIDE 22 - INTRODUCING THE APPROACH TO AUSTRALIA**

I FIRST CAME ACROSS THE ALTERNATIVE TO SUICIDE APPROACH IN NOVEMBER 2015 AT THE WORLD HEARING VOICES CONGRESS IN MADRID, SPAIN.

I WAS STRUCK BY ITS SIMPLICITY YET TRANSFORMATIONAL APPROACH TO SUICIDE INTERVENTION, VERY MUCH IN THE SAME WAY THE HEARING VOICES APPROACH HAS EMPOWERED INDIVIDUALS IN RESPONSE TO PSYCHOSIS.

AFTER I LEFT RICHMOND WELLBEING IN 2016 I APPROACHED MERCYCARE TO SEE IF THEY WOULD TAKE THIS ON AS A PROJECT.

THEY ARE A LARGE CATHOLIC SOCIAL SERVICES ORGANISATION THEIR MISSION IS TO BREAK CYCLES OF DISADVANTAGE AND THEY SAW THE IMPORTANCE OF THIS IN THE SUICIDE INTERVENTION SECTOR.

MERCYCARE WAS NOT INVOLVED IN SUICIDE PREVENTION AND WERE CONCERNED ABOUT REPUTATIONAL RISK IN EXPLORING THE ALTERNATIVES TO SUICIDE APPROACH, SO THEY DECIDED THEY WOULD SHOWCASE THE APPROACH TO ENABLE KEY STAKEHOLDERS TO CONSIDER ITS MERITS RATHER THAN INTRODUCE THE APPROACH OUTRIGHT.

LYN MILLETT, EXECUTIVE DIRECTOR FAMILY AND COMMUNITY SERVICES, AND I MET WITH SEVERAL KEY STAKEHOLDERS

INCLUDING THE MENTAL HEALTH COMMISSION, CHIEF PSYCHIATRIST. MENTAL HEALTH ADVOCATE, MENTAL HEALTH ADVISORY COUNCIL, MINISTERIAL COUNCIL ON SUICIDE PREVENTION, SUICIDE PREVENTION AUSTRALIA AND OTHERS TO TEST THEIR REACTION TO SHOWCASING THIS APPROACH IN WESTERN AUSTRALIA. THEY ALL EXPRESSED INTEREST IN FINDING OUT MORE.

IN FEBRUARY 2017 MERCYCARE FUNDED TWO TRAINERS FROM WESTERN MASS RLC TO COME TO PERTH FOR FOUR DAYS TO RUN A SERIES OF ACTIVITIES INCLUDING A HALF DAY FORUM ATTENDED BY 400 PEOPLE WHICH WAS OPENED BY THE MINISTER FOR MENTAL HEALTH.

GIVEN THE CONSIDERABLE INTEREST EXPRESSED IN THIS APPROACH, A STEERING GROUP WAS FORMED LED BY MERCYCARE AND INCLUDING CONSUMERS OF MENTAL HEALTH WA, CONNECTGROUPS, HELPINGMINDS AND SUICIDE PREVENTION AUSTRALIA. IT WAS LATER EXPANDED TO INCLUDE THREE INDIVIDUALS WITH A LIVED EXPERIENCE OF SUICIDE TWO OF WHOM ARE YOUNG PEOPLE AND THE THIRD IS A MOTHER WHO HAS LOST TWO CHILDREN TO SUICIDE.

TWO TRAINERS WERE BROUGHT BACK TO PERTH IN MARCH 2018 FOR TWO WEEKS TO RUN A MIXTURE OF PROGRAMS INCLUDING THE THREE DAY FACILITATORS PROGRAM. SHORT EVENTS WERE ALSO RUN IN MELBOURNE AND SYDNEY ON THE BACK OF THE PERTH VISIT. ONE GROUP HAS EMERGED AS A RESULT OF THE

FACILITATOR TRAINING AND THERE ARE SEVERAL OTHER PEOPLE WHO ARE TRAINED AS FACILITATORS BUT WHO MIGHT NOT BE IN A STATE OF READINESS TO START GROUPS. ISSUES OF SUPPORT FOR FACILITATORS ARE BEING EXPLORED WITH THE STEERING GROUP.

## **SLIDE 23 - INTRODUCING THE APPROACH TO AUSTRALIA**

THE EVALUATIONS FROM THESE TWO VISITS IN 2017 AND 2018 REVEALED STRONG SUPPORT FOR ITS INTRODUCTION IN AUSTRALIA.

SINCE THEIR LAST VISIT TO AUSTRALIA WE HAVE KEPT IN CONTACT WITH THE TRAINERS AND ARE PLANNING THEIR RETURN TO AUSTRALIA. WE INTEND TO HAVE THEM DELIVER A TRAIN THE TRAINER PROGRAM AS THIS WILL ENABLE US TO GROW THE APPROACH BY HAVING LOCAL PEOPLE TRAINED IN RUNNING FACILITATION PROGRAMS.

WE HAVE OBTAINED THE SUPPORT OF THE CITY ROTARY CLUB OF PERTH WHICH HAS ADOPTED THIS APPROACH AS ONE OF ITS PROJECTS.

WE ARE IN DISCUSSIONS WITH LOTTERYWEST FOR FUNDING SOME OF OUR ACTIVITIES, INCLUDING POSSIBLY HOSTING A CONFERENCE ON THIS APPROACH.

CONNECTGROUPS, WHICH IS AN UMBRELLA BODY FOR A RANGE OF PEER SUPPORT GROUPS ACROSS THE BROAD HEALTH SECTOR, HAS OFFERED TO PROVIDE SUPERVISION AND SUPPORT FOR EMERGING GROUPS.

CONNECTGROUPS HAS ALSO FACILITATED A SMALL GRANT TO DISCHARGE THE TRANSFOLK GROUP, WHICH I WILL OUTLINE FURTHER SHORTLY, TO ENABLE SOME UNIVERSITY MANAGED

EVALUATION TO BE UNDERTAKEN THAT WILL FORM THE FIRST FORMALISED EVIDENCE BASE IN AUSTRALIA FOR THIS APPROACH. THIS WILL BE A FULLY CO-PRODUCED EVALUATION.

THERE ARE TWO ADDITIONAL GROUPS EMERGING IN PERTH WHICH MEANS THIS EVALUATION MAY BE ABLE TO BE CONDUCTED ACROSS THREE GROUPS.

THE STEERING COMMITTEE HAS RECONFIGURED TO INCLUDE THE SMALL GROUP OF ACTIVE FACILITATORS OF THIS APPROACH IN FUTURE DECISION-MAKING TO GROW THE APPROACH IN WESTERN AUSTRALIA.

THE PEER TO PEER SUPPORT APPROACH IS COMPLEMENTARY BUT ALSO FUNDAMENTALLY DIFFERENT FROM EXISTING RESPONSES TO SUICIDE INTERVENTION. WE BELIEVE THIS CAN HELP TRANSFORM THE SUICIDE PREVENTION SYSTEM IN AUSTRALIA. IT IS A COMPLEMENTARY APPROACH WHICH FILLS AN IMPORTANT GAP IN THE CURRENT SYSTEM. IT WILL HELP ENHANCE THE LEARNING THAT IS EMANATING FROM THE TRIAL SITES AND WILL START WHERE THE LEARNING NEEDS TO START – AT THE BEGINNING WITH THE LIVED EXPERIENCE.

THERE ARE MOVES AFOOT TO BRING THE TRAINERS BACK TO AUSTRALIA IN 2019 AND THIS INCLUDES FOR PROGRAMS TO BE DELIVERED IN NEW ZEALAND.

## **SLIDE 24– CURRENT GROUPS IN AUSTRALIA**

IN MAY 2018 THE DISCHARGE GROUP WAS FORMED IN PERTH. THIS GROUP IS ENGAGED WITH THE TRANS COMMUNITY AND IS HOSTED THROUGH TRANSFOLK IN PERTH.

THERE ARE OTHER GROUPS ABOUT TO EMERGE IN PERTH WHICH WILL HAVE DIFFERENT MEMBER BASES.

THERE IS ALSO A GROUP THAT WAS ESTABLISHED IN SEPTEMBER 2018 INNER WEST SYSDNEY.

THESE GROUPS ARE UNFUNDED BUT ARE SUPPORTED BY A LOOSE NETWORK OF AGENCIES OR PROFESSIONALS WHO ARE COMMITTED TO THE EXPANSION OF THE PEER TO PEER APPROACH IN RESPONSE TO SUICIDE.



## **SLIDE 25– FURTHER INFORMATION**

THE MERCYCARE WEBSITE CONTAINS THE TWO VIDEO RECORDINGS OF THE PRESENTATIONS MADE BY THE TRAINERS IN FEBRUARY 2017 IN PERTH. THE COMBINED RECORDINGS COVER ALL OF THE ISSUES WE TOUCH ON TODAY BUT IN MORE DETAIL AND INCLUDE RESPONSES TO QUESTIONS RAISED AT THE FORUM.

THE MERCYCARE EMAIL ADDRESS IS THE LINK TO THE DATABASE OF PEOPLE WHO WANT MORE INFORMATION. IF YOU WRITE TO THAT ADDRESS AND ASK TO BE INCLUDED YOU WILL RECEIVE REGULAR UPDATES.

THE WESTERN MASSACHUSETTS WEB LINK TAKES YOU DIRECTLY TO THEIR TRAINING PROGRAMS. IF YOU EXPLORE THE BROADER WEBSITE YOU CAN ACCESS OTHER INFORMATION ON THE APPROACH INCLUDING WEBINARS.

### **CONCLUSION**

I HOPE THIS PRESENTATION HAS RAISED AWARENESS FOR YOU OF THE IMPORTANCE OF ENGAGING WITH THE LIVED EXPERIENCE IN OUR APPROACH TO SUICIDE PREVENTION IN AUSTRALIA.

MORE SPECIFICALLY, I HOPE THIS PRESENTATION HAS INFORMED YOUR UNDERSTANDING OF THE IMPORTANCE THAT PEER SUPPORT CAN PLAY IN SUICIDE PREVENTION AND MORE IMPORTANTLY THE ROLE THAT CAN BE PLAYED BETWEEN PEERS IN THIS SPACE.

I HOPE YOU WILL JOIN ME AND OTHERS IN SEEKING TO INTRODUCE SOME OF THE IMPORTANT CHANGES REQUIRED IN OUR SUICIDE PREVENTION SYSTEM TO HELP ENHANCE THE GOOD WORK THAT IS ALREADY BEING UNDERTAKEN.

THANK YOU