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National Suicide Prevention Office
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Delivered by email to **nspo@nspo.gov.au**

Dear Review Team

Advice on the National Suicide Prevention Strategy

People with Disability Australia (PWDA) welcomes the opportunity to provide this submission in response to the **consultation draft** of Advice on the National Suicide Prevention Strategy ('consultation draft') and thank the members of the National Suicide Prevention Office's (NSPO) Lived Experience Partnership Group and the Advisory Board for their work in developing the strategy.

PWDA is Australia's peak cross-disability Disability Representative Organisations (DRO) and Disabled People's Organisation (DPO) and is funded by the Australian Government to represent the 1 in 6 Australians with disability nationally, including LGBTIQA+ people with disability.

This submission is also endorsed by the following organisations:

- Community Mental Health Australia, and
- Down Syndrome Australia.

A voice of our own

Suicidal distress of people with disability

As noted in the consultation draft, people with disability are three times more likely to die by suicide than those without disability, with a suicide rate of 33.5 per 100,000 people compared to 11.4 per 100,000 people without disability, with a higher likelihood for LGBTIQA+ people with disability.[1] In addition, mental health conditions can be both a cause and an effect of disability, so PWDA views people with mental health conditions as people with psychosocial disability, thus the suicide rate of people with disability is higher than that noted in the consultation draft.

Considering the higher risk of suicide for people with disability, we welcome the consultation draft's identification and focus on key social determinants (safety, good health, economic security, social inclusion and ability to navigate key life transitions) of suicidal distress, as well as the identification and focus on mutually reinforcing critical enablers for meaningful system reform.

However, as noted in the consultation draft, much more work is needed to understand the lived and living experience of population groups who are disproportionately impacted by suicide but not routinely identified in data, such as LGBTIQA+ people and people with disability.[2] Further, much more work is needed on how social determinants of suicidal distress impacts multi-marginalised of people with disability, for example those with intellectual disability and those from First Nations backgrounds. Additionally, we note the importance of understanding the additional inherited trauma impacts for First Nations peoples.

Key recommendations

Therefore, our key recommendation is to include and improve the representation of people with disability, including LGBTIQA+ people with disability and First Nations people with disability, in the implementation and monitoring of the strategy, including but not limited to the following activities:

[1] *Advice on the National Suicide Prevention Strategy (consultation draft),* National Suicide Prevention Office, 2024, p. 7.
[2] *Advice on the National Suicide Prevention Strategy (consultation draft),* National Suicide Prevention Office, 2024, p.67.

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1. Development of both the 2024-2029 and 2030-2034 implementation plans for the strategy
2. Development of any data improvement plans, to improve the data visibility of people with disability, First Nations peoples, and LGBTQIA+ people
3. Development of any monitoring and evaluation framework/s of the National Suicide Prevention Strategy model, and
4. Participation of Disability Representative Organisations in the NSPO Lived Experience Partnership Group, Advisory Board and any other relevant working group.

Further, we note that the first critical enabler in the consultation draft is improved governance. We welcome the focus on this critical enabler, but we emphasise that the inclusivity and accessibility of government services, systems and programs that will influence the strategy's focus on social determinants of suicidal distress (safety, good health, economic security, social inclusion and ability to navigate key life transitions) is shared by all levels of Australian government. Additionally, ***Australia's Disability Strategy 2021-2031*** ('ADS'), outlines key outcome areas and actions that will overlap with the strategy's focus on social determinants of suicidal distress.

Therefore, we further recommend that the strategy directly links with all outcome areas of the ADS (not just the safety, rights and justice outcome area), as well as include and improve the representation of people with disability, including First Nations and LGBTIQA+ people with disability, in the following:

- Identifying governance priorities
- Developing the roles and responsibilities of each level of government, to reduce the social determinants of suicidal distress for people with disability
- Participation in the authorising and/or governing mechanism that promotes whole-of-government action to improve the governance of the strategy
- Improving transparency and accountability measures and approaches to ensure whole-of-government actions are inclusive and accessible to people with disability, and
- Ensuring accessibility-first approaches to governance and engagement.

The representation of disability in the improved governance of the strategy is key, especially with the expected uplift in community and mainstream mental health supports that will come online with the roll-out of 'foundational supports' across Australia, as **agreed** to by the National Cabinet in December 2023 following the final report of the ***Independent Review of the National Disability Insurance Scheme***.

Response to survey questions

Lastly, we also would like to take this opportunity to respond directly to the following **survey** questions:

How well does the advice on the strategy articulate what is required for long-term change in suicide prevention?

- The strategy overemphasises recovery and does not sufficiently acknowledge that some individuals, particularly those with complex psychosocial disability, will never recover. Especially considering the significant trauma experienced by survivors of psychiatric harm and institutions, those who have had their dignity and rights abrogated through legally permissible substitute decision-making and denial of personhood, those who have been indefinitely detained, and those who experience legally permissible involuntary treatment and medical interventions.
- Given this history of institutional and systemic harm, it is paramount that long-term changes in suicide prevention also seriously consider lived experience-led restorative justice and repair approaches and actions, to acknowledge the long history of harm and to pave the way for a suicide prevention system co-designed by those who have experienced previous and significant harm.[3]
- To facilitate lived experience-led restorative justice and repair approaches for long-term change, the strategy must also consider and contend with necessary legal and policy reform of the laws and policies that have driven the institutional and systemic harm described above.
- In a disability context, key legal drivers of institutional and systemic harm have been the Australian Government's interpretive declarations on Articles 12 (equal recognition

[3] See Katterl, S. et al, *Not Before Time – Lived experience-led justice and repair: Advice to the Minister for Mental Health on Acknowledging Harm in the Mental Health System* [**report**], 2023 for more information.

before the law) and 17 (protecting the integrity of the person) to the United Nations *Convention on the Rights of Persons with Disabilities*, which have respectively provided the legal basis for Australian laws to abrogate the rights of people with disability through substitution decision-making systems, and forced medical interventions and restrictive practice regimes.

- We note that the recent Royal Commission into Violence, Abuse, Neglect and Exploitation of recommended the withdrawal of Australia's interpretive declaration on Article 12 in their **final report** (see recommendation 6.20).
- The strategy also lacks a focus on suicide prevention through the framework of suicidism (viewing suicide as an outcome of social inequality and discrimination, and invites thinking on how systems influence the experience of suicidal distress). Viewing suicide through this framework is crucial for long-term change and incorporates human rights approaches, by addressing how responses to systemic drivers of suicidal distress disproportionately impacts people who are experience multiple marginalisation and exclusion.
- While we welcome the focus on social determinants of suicidal distress in the strategy, we also note that long-term change in suicide prevention requires multi-sectoral collaboration and partnerships, to facilitate society-wide ownership over suicide prevention. This level of collaboration and partnership needs investment and leadership across all levels of government and is not sufficiently addressed in the consultation draft.
- Lastly, while we acknowledge the strategy has referenced the *National Agreement on Closing the Gap,* the strategy needs stronger reference and interface with the agreement's **Disability Sector Strengthening Plan**, to ensure long-term change is inclusive of First Nations people with disability by developing culturally safe, viable and First Nations-led suicide prevention actions.

Is there anything critical to preventing suicide in Australia that the Advice on the Strategy does not address

- Consistent with our comments on suicidism and that the strategy does not sufficiently acknowledge that some individuals, particularly those with complex psychosocial disability, will never meet biomedical standards of recovery, the advice does not address the important role of peer support and networks as an alternative to clinical care.

- Peer support approaches, particularly those led by people with living experience, need to be promoted and integrated into the broader suicide prevention system. This could lead to more effective, person-centred approaches that move beyond clinical settings, and support individuals to reconnect with their communities.
- Additionally, the strategy did not address the cost of diagnosis to access supports. Noting the strategy's focus on economic security, the income instability of many people with disability who experience suicidal distress makes receiving diagnoses incredibly difficult. Access to support should not be reliant on receiving formal diagnoses, as many people in need of support will be left behind.
- Finally, while we welcome the focus on social inclusion and a culture of compassion in the strategy, the strategy does not explicitly address strategies to remove attitudinal barriers that drive social exclusion and 'othering'. People who experience suicidal distress often feel like a 'burden' due to attitudinal barriers, and this compounds the suicidal distress a person can experience.
- Therefore, the strategy should further consider how to address attitudinal barriers, consistent with our comments above recommending for investment and leadership in driving multi-sectoral collaboration and partnerships, to facilitate society-wide ownership over suicide prevention.

Which actions do you think are the highest priority? (Please list up to 5 actions and include action numbers)

The following five actions are the highest priority (in no order) for PWDA:

- Action ko4.2a: Address loneliness and social exclusion in Australia, particularly for people with disability and other marginalised groups
- Action k03.2e: 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.
- Action ko1.2h: Improving the safety and security of people with disability by implementing *Australia's Disability Strategy 2021-2031*, aligned with joint Australian, State and Territory response to the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability
- Action ko2.2a: Expanding mental health services with a focus on addressing the needs of people with severe and enduring mental illness, and

- Action k03.2c: Provide adequate income support to minimise the financial stress experienced by people with income instability.

Thank you for the opportunity to provide this response. If you would like to discuss our submission further, please contact my Senior Manager of Policy, Mx Giancarlo de Vera via email at **giancarlod@pwd.org.au** or on 0413 135 731.

Yours sincerely

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People with Disability Australia

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