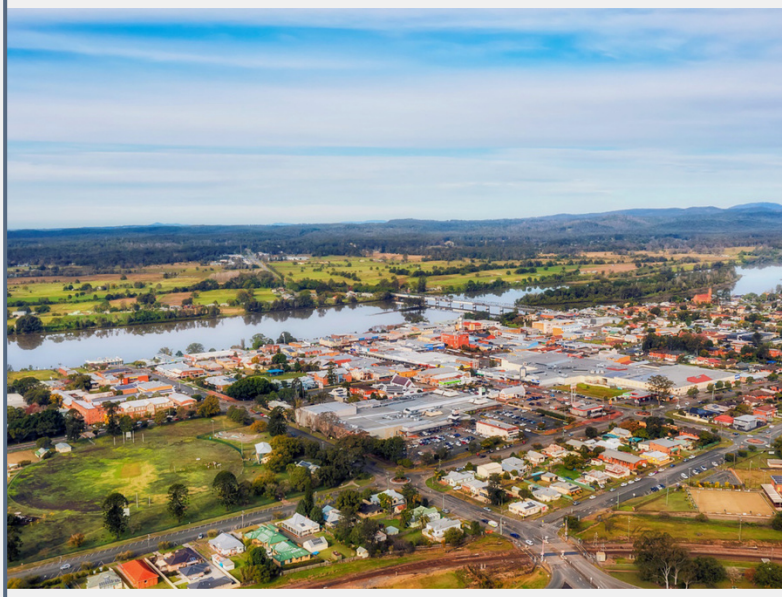
August 2023

Strategic suicide prevention workshop in the Manning River region summary report



About this report

This report has been prepared for suicide prevention stakeholders in the Manning region and was developed by Everymind in partnership with Hunter New England Local Health District (Towards Zero Suicides team), HMRI Healthy Minds Research Program and Hunter New England Central Coast Primary Health Network.

The report summarises the outcomes of a workshop held at the Manning River Rowing Club on August 3, 2023. In total, 29 attendees contributed to the workshop over five hours. Various sector stakeholders were represented, including local service providers, people with lived and living experience, community members, families and friends, academics and sector leaders.

A separate consultation was also conducted with Biripi Aboriginal Corporation Medical Centre staff, with 11 people attending to share their experiences and expertise. The outcomes of both workshops have been integrated into this summary report.

Acknowledgements

Everymind and our partners would like to acknowledge the Biripi people as the traditional owners of the land where this work was conducted and pay respects to Elders past, present and emerging. We also acknowledge the current and continuing contributions of the Biripi people to social and emotional wellbeing and suicide prevention. We would also like to recognise the contribution of people with lived and living experience of suicide and the knowledge and expertise they have provided to this project and suicide prevention initiatives.

Thank you to the many organisations, service providers and community members in the Manning River region who shared their experiences and expertise at the workshop.

What we heard

Workshop participants identified that a strength of local suicide prevention approaches was the passion and commitment of the Manning community to collaborate to deliver lasting changes. While many conversations occurred across workshop activities, key themes and ideas were repeated.

Firstly, local service providers were seen as passionate and hardworking, and the Manning River Suicide Prevention Network was considered a key community strength. Despite this, gaps within service provision and workforce shortages were seen as a challenge.

With regard to service provision, common gaps included support for children and young people (particularly those in primary school and Aboriginal young people), access to non-clinical supports, culturally safe supports and safe spaces outside the Emergency Department. Long waiting lists, lack of bulk billing services, access to allied health staff, and access to non-clinical workers and support groups were also discussed as common gaps.

Some identified priorities included increasing education to build community capacity, improving resources to support service navigation and facilitating interagency collaboration. Establishing a Safe Haven or "safe space" outside of the Emergency Department was also a key priority that emerged across workshop activities. Participants also identified the importance of co-designing these services with people who have lived and living experience of suicide and with community members, including the local Aboriginal community. Some participants also shared a vision of establishing a 'community wellbeing hub' to co-locate services and provide holistic support to the whole community.

Emerging priorities

- Provide education and training to build knowledge and skills across the community, especially for school teachers, first responders, Emergency Department staff, support staff and family and friends.
- Increase the availability of community-based supports such as safe spaces and ensure they are accessible and safe to people who need them.
- Extend and support a diversified workforce in the region, including an increased availability of peer and Aboriginal health workers in health and community settings.
- Improve information and education provided in the Emergency Department to people in distress and provide resources and support for families, friends and carers.
- Provide more outreach and proactive support – including case managers, mental health response teams, Aboriginal health services, and alternative school pathways.
- Build on the strengths of the local service providers and the Manning River Suicide Prevention Network to plan and monitor local suicide prevention action.

Next steps

This workshop is one of three conducted across the Hunter New England region. Once all workshops are complete, a report synthesizing priorities across all three sites will be prepared to inform regional suicide prevention planning.

Current strengths, gaps and priorities

Workshop one identified the key strengths, gaps and priorities across three broad domains of suicide prevention action - prevention, intervention and postvention.

Prevention

Suicide prevention refers to actions focused on preventing the onset of suicidal thoughts and behaviours. Prevention may include enhancing social and emotional wellbeing, reducing risk factors for suicide or responding early to signs of distress.

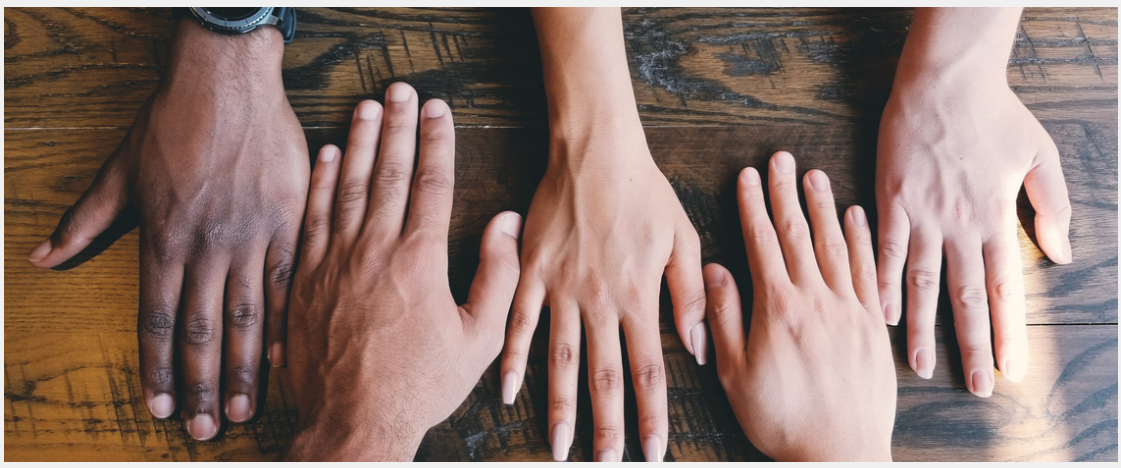
Strengths	Gaps	Priorities
• A strong suicide prevention network • A growth in the number of health and social services in the region • An enhanced focus on wellbeing in schools.	• Long wait times and out-of-pocket costs for many local services, including General Practitioners • Availability of proactive and early support for children and young people, especially those experiencing adversity • Services that address the social determinants of wellbeing - e.g. housing, transport, safety and social connection.	• Mental health and suicide prevention training for health and other workforces – e.g. school teachers, First Responders, Emergency Department staff, support staff and community members • Targeted prevention programs for children and young people with a focus on schools, families and communities (including Aboriginal communities) • Increased availability of non-clinical supports for people experiencing distress, including community safe spaces and support for families and friends.

Current strengths, gaps and priorities

Intervention

Suicide intervention refers to early, safe and effective supports for someone experiencing suicidal thoughts or behaviours. Interventions are compassionate and support people experiencing suicidal distress, suicidal crisis and following a suicide attempt.

Strengths	Gaps	Priorities
• An increasing number of local services and programs to support people experiencing distress or following a suicide attempt • Community collaboration, communication, and a commitment to working together to support people in distress.	• The costs of primary care and the wait times for some mental health services can be considerable barriers to accessing the right care at the right time • A lack of information and support for families and friends who are the key supports for people experiencing suicidal distress • Community safe spaces for people at risk of suicide that are outside of, and an alternative to, the Emergency Department.	• Establish community safe spaces and increase the availability of non-clinical support options • Improved workforce diversity in health and community settings, including more Aboriginal staff and more peer workers • Improved collaboration between health and community-based services so that people receive joint care.



Current strengths, gaps and priorities

Postvention

Postvention is focused on supporting individuals, families and communities affected by a suicide death.

Strengths	Gaps	Priorities
• Existing local services who are willing to work together • A strong suicide prevention network who has skills and knowledge • The community's willingness to support each other.	• Knowledge of services and service navigation • Supports in schools for students impacted by suicide • Support for community members, including immediate support, bereavement support groups, and grief support for the extended family.	• Community knowledge about the range of services that can provide support following a suicide • Availability of support in schools for students impacted by suicide • Availability of support for community members, including immediate support, bereavement support groups, and grief support for the extended family.

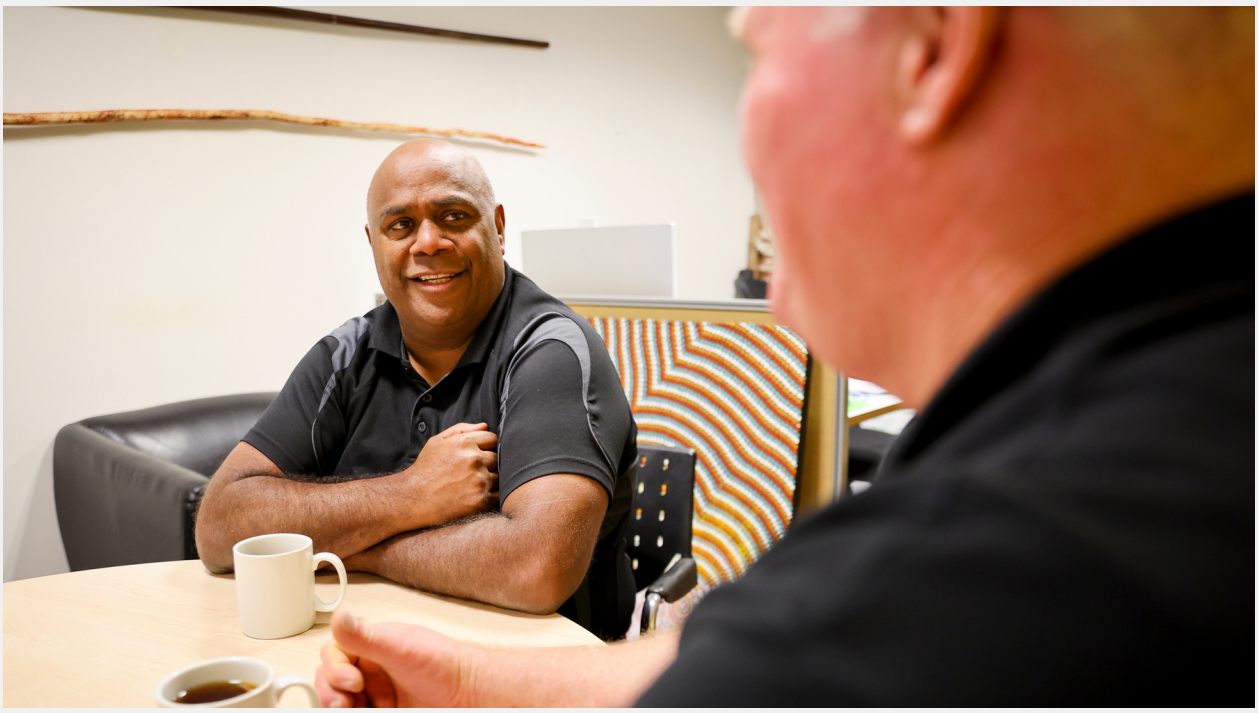
What we need

Workshop two used five common experiences of people with a lived or living experience of suicide to identify what is needed, who needs to be involved and the local priorities. People worked on their particular experience type in small groups.

Common experience one

Adverse experiences in childhood, psychological and social challenges as a young person and co-occurring stressors in adulthood.

What is needed?	Priorities
• A no-wrong-door approach across the lifespan • An increase in non-clinical support options at the point of distress • Improved care coordination and continuity of care when someone is not in crisis.	• Increase information about and accessibility of services. This might include a centralised point of information about available services and supports, ideally a hub of co-located services • Training 'job ready' clinicians and peer workers to work in suicide prevention and provide them with ongoing support and supervision • Improve information and education provided in the Emergency Department to people in distress and their families and friends.



What we need

Common experience two

Co-occurring psychological, financial and relational stressors in adulthood.

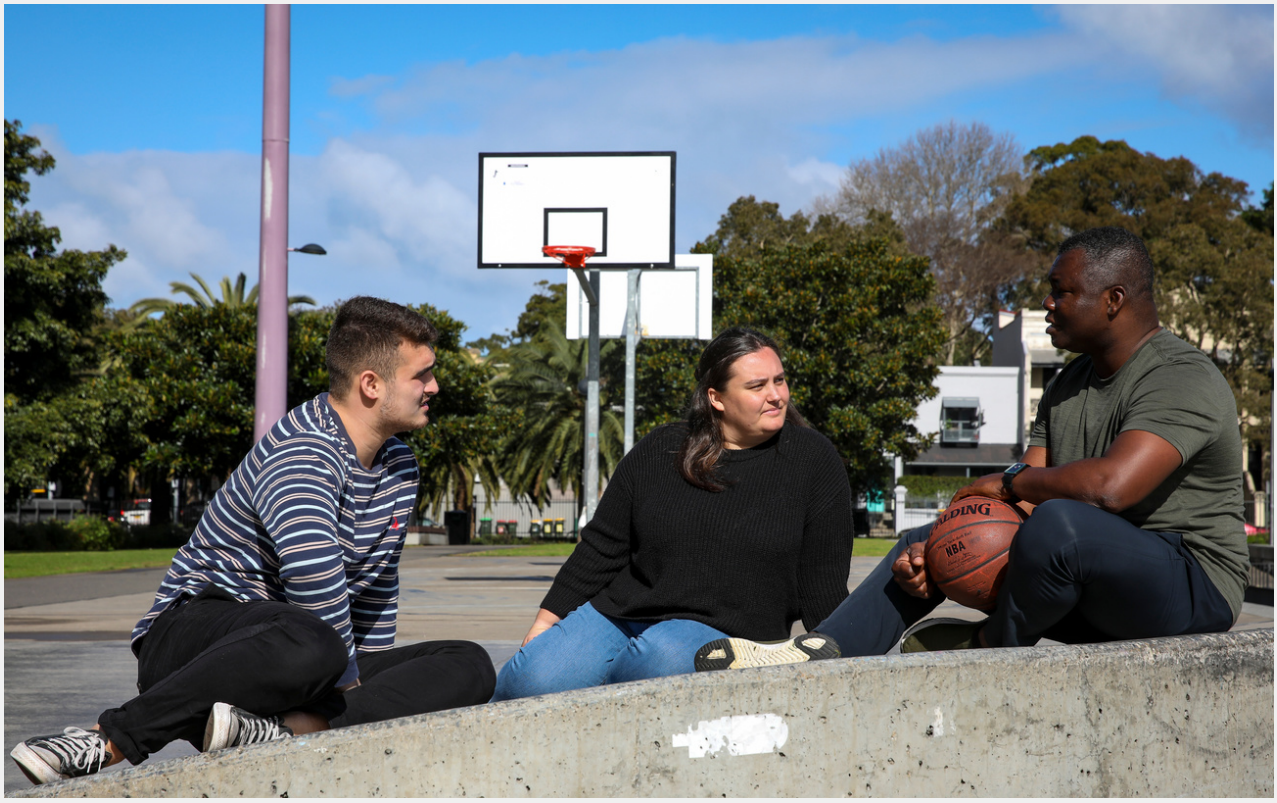
What is needed?	Priorities
• Centralised information (e.g. a community directory) and co-located health and wellbeing services (e.g. a 'hub') for clinical and non-clinical services • Providing education and training for General Practitioners • Soft referral touchpoints in other settings (e.g. workplaces, schools, social services) and provide training to people in those settings to identify and respond to distress.	• A health and wellbeing multi-disciplinary hub locally to bring together services and supports • Grassroots awareness, promotion and prevention approaches to build community capacity • Free access to early support services and transportation to get there.

What we need

Common experience three

Onset of complex mental illness in youth followed by social disadvantage or contact with the justice system.

What is needed?	Priorities
• Service and community collaboration that can support complexity – between the person, their family, employers, housing services, financial support services, mental health teams, technology providers, Department of Communities and Justice, educators, Police, Aboriginal Health and Community Services, peer groups and community clubs.	• A focus on getting in early and setting children and young people up for life • Better access to youth alcohol and other drug services in the region • Education and support for the family and others in the community providing support • A Safe Haven or safe spaces that are accessible, available and safe for all people • More outreach and proactive support – including case managers, mental health response teams, Aboriginal Health Services, and alternative school pathways.



What we need

Common experience four

Adverse experiences in childhood followed by co-occurring mental health challenges and other stressors as a young person.

What is needed?	Priorities
• Increased mental health education in primary schools • More research is needed to understand the impact of technology and social media on young people and its influence on thoughts and behaviours • Access to school counsellors as well as psychologists.	• Start mental health education in primary school and support educators to identify and respond to concerns early. • Build a central place where community-based settings (e.g. schools, sports clubs) can access available resources • Interagency approaches at schools for children and young people with services they can easily access.

Common experience five

Impacts on families and friends (including those bereaved by suicide).

What is needed?	Priorities
• Training for the community on how to talk to and support families and friends • Increase access to local support groups, peer workers and counsellors for families, friends and carers • Better access to primary care (e.g. bulk billing General Practitioners) and cultural support to meet the holistic needs of families and friends • Utilise the Standby support after the suicide program.	• Increase the capability of primary care (e.g. General Practitioners) to work with families, friends and carers • Increase the availability of peer and social workers in primary care settings - to act as a contact point for families and friends needing support • Provide information to family and friends about accessing existing support groups and other services.

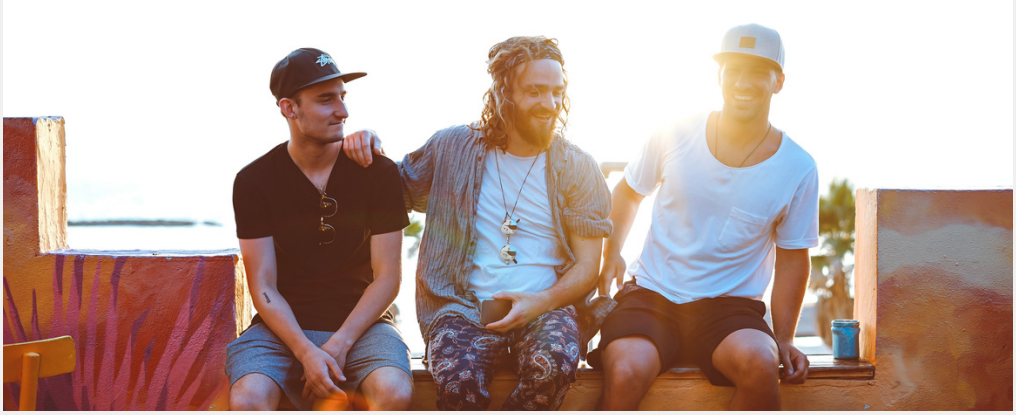
Enablers for action

Workshop three focused on identifying the current approach, future approach and priority actions for three key suicide prevention enablers: lived experience, data and evidence and whole-of-community approaches. Participants were given the opportunity to contribute to two of the three key areas.

Lived experience

Active involvement and leadership from people with a lived and living experience of suicide.

Current approach	Future approach	Priorities
• Peer support workers in mental health inpatient units • A lived experience participation unit through HNELHD • Local peer workers in the NDIS space • Lived experience with consumer and carer a committee or committees • A lived experience workforce that does not always feel respected by clinicians • Clinicians with lived experience of suicide.	• An increased peer workforce who have appropriate training, supervision and support • Lived experience workers at a managerial level within services and organisations • More peer workers in community settings • A Safe Haven that is lived experience-designed and peer-led • Clinicians feeling safe to share their lived experience • Improved processes around co-design and clinical governance.	• Incorporate lived experience knowledge into education, training and service planning in community settings e.g. schools, Emergency Services, primary care • Increase the peer workforce across the region and support their career progression • Increase opportunities for clinicians and researchers to understand how they can share and apply their lived experience.

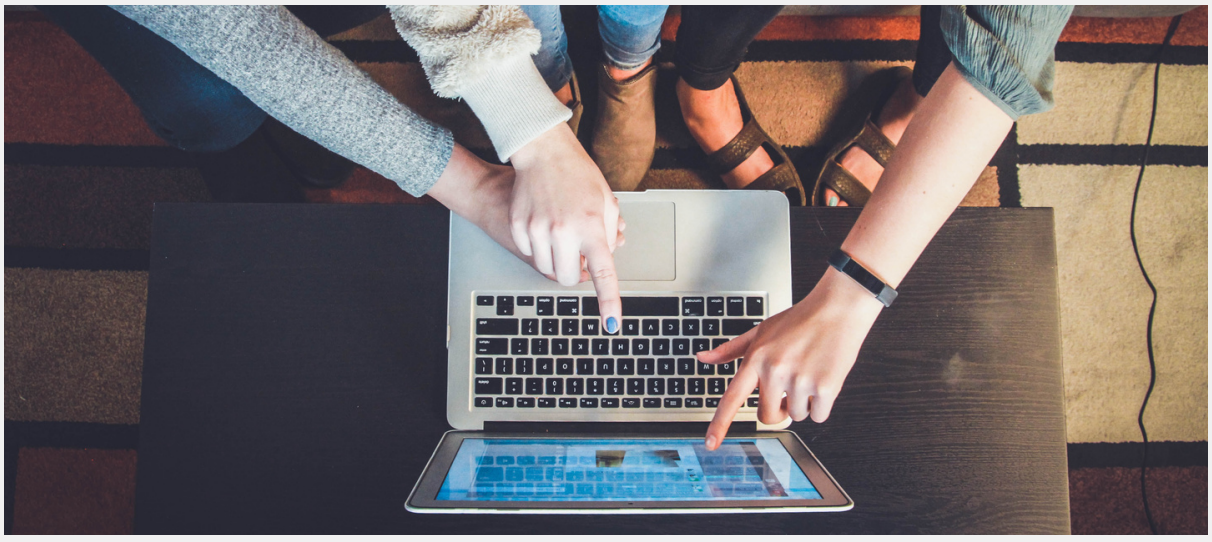


Enablers for action

Data and evidence

Availability and use of local data to support planning and responses to suicide.

Current approach	Future approach	Priorities
• Inconsistent use of data, data that is hard to access, and data that is not available in 'real-time' • Need to use data for funding proposals, but data not always used for proactive service planning purposes • Predominant outcome measures used include HONOS/K10/ASK • Local Health District uses CES/YES surveys • Data is not adequately used as a tool, and data use can be "tokenistic" to prove a point rather than for guidance.	• Quicker turnaround of data and increased data access for those who need it • Use of data in real-time to inform priority setting, actions and responses • Identification of meaningful indicators of what outcomes matter to people • A data orientation and recommended tools package for organisations and groups new to suicide prevention data.	• Co-design of service indicators- "measuring what matters" • Tip sheet for evidence of "what works" and how it can be used in practice (including for grant writing) • Increase collaboration between researchers, community and lived experience for data-driven action.

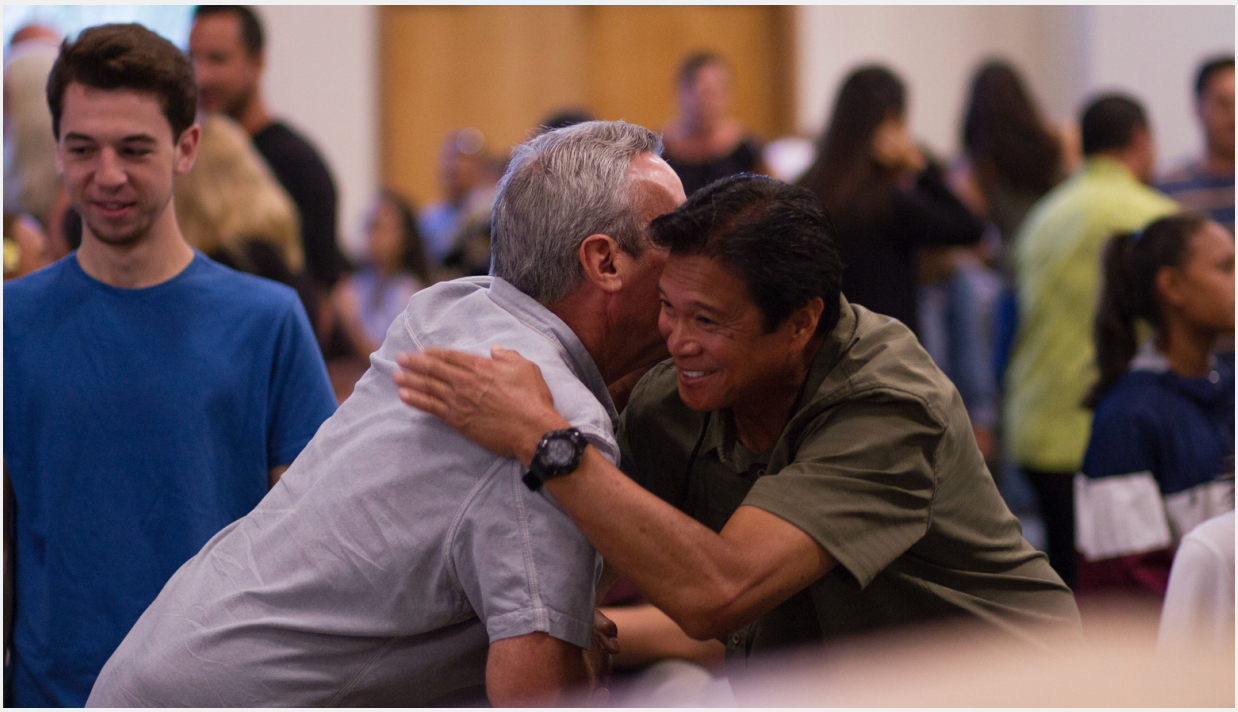


Enablers for action

Whole-of-community action

Collective action across agencies, sectors and community groups to contribute to suicide prevention.

Current approach	Future approach	Priorities
• Networks and services are siloed and can be disconnected from each other • Some shared training across services, e.g. Safetalk • National campaigns that may or may not be relevant to local communities • Access to cultural programs • Youth interagency – including Headspace/RHYME/ CAMHS • Collaboration between mental health services and the primary health network.	• No wrong door approach with community-based entry points for a range of services • Improved coordination between services, including those outside of health • Culturally appropriate care and stronger links to Biripi AMS • Person-centred approaches that provide a choice of services and partnerships.	• Establish a Community Hub and collective collaboration • Establish a Safe Haven developed and led by the local Aboriginal community • Develop an easy-to-understand toolkit to inform the community about suicide and related issues.



A focus on Aboriginal communities

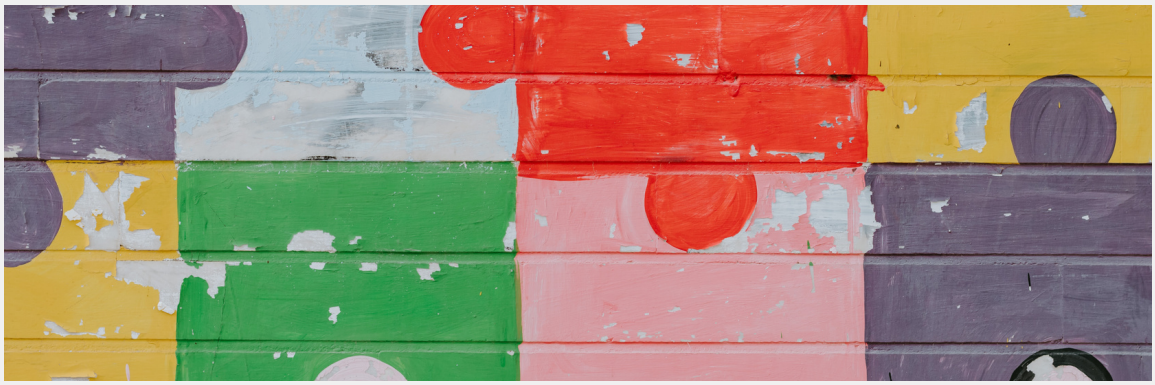
This section of the report summarises the outcomes of a semi-structured discussion with 11 people working at the Biripi Aboriginal Medical Service.

Current strengths

- Early intervention programs for Aboriginal children and families
- Biripi is seen as somewhere Aboriginal people can go to connect with staff who are trusted and safe
- Women's groups and men's groups provide an opportunity for connection
- Staff work hard to meet needs – but that often means going outside of funded or core business
- Community support each other as best they can, with Aboriginal services working together to provide practical support.

Current Gaps

- People turn to family and friends for support before formal services, but there is limited education and support for family and friends to know what to say, what to do, and how to support their wellbeing
- Wait times for any mainstream or mental health services are too long to be preventative, and people often get worse while waiting, particularly young people
- There are major gaps in services and early intervention supports for young people – the available funding is targeted at children and families but not young people
- Schools aren't safe places or able to support all young people – some young people are not in school either
- Funding is a gap for culturally-led services, with small funding for programs and no specific funding for suicide prevention
- A limited number of Aboriginal staff in the health services means there are limited 'safe places and safe faces'
- There is limited support for people after hours and limited non-acute support such as safe spaces or havens.



A focus on Aboriginal communities

Priorities

- Families and friends are a priority – they are where people turn, but they need education and support that is accessible, safe and appropriate so they know what to do for others and what to do for themselves
- Increased clinical and non-clinical support for young people (up to 25). These services need to be available in the local area so that families do not need to travel and preferably delivered by or with Aboriginal staff
- There is a need for local services that can support complexity – when people have co-occurring challenges or complexity, it is a reason to 'bounce' them to other services or back to the community
- More flexible funding options so that community-controlled organisations can work with communities to meet their needs and join up approaches across mental health, AOD, family and domestic violence and suicide prevention
- More Aboriginal staff in the health service and across community settings, with increased support – especially for small teams often holding significant community concerns
- Cultural awareness training (ongoing) for all mainstream services in the region and increase the availability of culturally safe suicide prevention training and resources.

Future action

This workshop is one of three conducted across the Hunter New England region. A report detailing immediate and future priorities across the region will be prepared to inform regional suicide prevention planning**.**

If you have further questions, please visit everymind.org.au or contact:
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