September 2023

Strategic suicide prevention workshop in the New England region: Summary report

About this report

This report has been prepared for suicide prevention stakeholders in the New England 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 Mercure Hotel on September 13, 2023. A total of 45 participants were involved, including local service providers, people with lived and living experience, community members, families and friends, academics and sector leaders. The outcomes of the workshop have been integrated into this summary report.

Acknowledgements

Everymind and our partners would like to acknowledge the Kamilaroi and Gomeroi people of the Kamilaroi Nation 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 Kamilaroi and Gomeroi 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 New England region who shared their experiences and expertise at the workshop.

What we heard

The workshop participants in the New England region were connected to their community and able to identify the local strengths and gaps in the current suicide prevention approach. Participants identified existing local services, particularly the local Safe Haven and other Aboriginal-run support, as a key strength. Staff across the region were identified as critical to local responses, and participants emphasised the important role of local Aboriginal mental health workers in the community. Participants also noted that the connectivity of the local community and the recent advances in lived experience involvement contributed to the overall strength of the local suicide prevention approach.

Despite local strength and connections with the local community, participants identified gaps in community knowledge about how to access and navigate services. They also identified issues impacting service delivery, such as staff shortages, long wait lists, unstable funding models, gaps in outreach to remote areas and limited services that would meet the needs of people with mild to moderate concerns, young people, older people and tailored support for family and friends.

Across the workshop, participants identified many priorities to improve the local suicide prevention approach with a practical and solution-focused approach across the workshop activities.

Emerging priorities

- Improve communication across services and community settings to support service access, including readily available service maps for community members and improved communication of data and case management between services.
- Support and expand the peer workforce and availability of non-clinical support services (such as the Safe Haven model), particularly in areas outside of major regional hubs.
- Start early and support parents and young people through social and emotional wellbeing education in early learning centres and primary schools as well as increasing opportunities for youth mentoring programs.
- Increase the availability of community ‘touchpoints’ that can support people experiencing concerns by partnering with local groups such as sporting clubs or Men's Sheds and proactively share stories of hope and resilience in the local media.
- Improve service accessibility and support staff retention through thoughtful funding and resource distribution across the region.
- Continue to improve access to culturally specific services for Aboriginal and Torres Strait Islander people.

Next steps

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

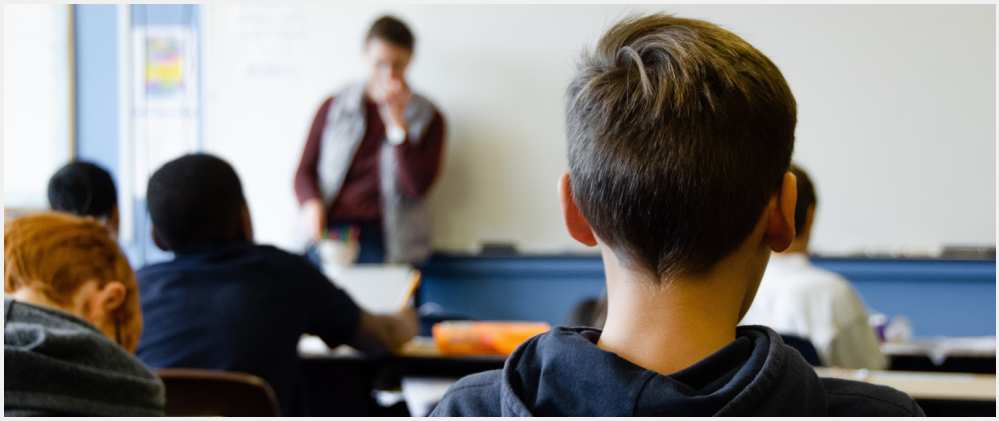
Current strengths, gaps and priorities

Workshop activity 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
• Existing services that have a community focus such as headspace, BackTrack, Billabong Club House, the local Safe Haven, One Door and other Aboriginal-run support • The recent establishment of the Tamworth suicide prevention collaborative • Increasing opportunities for training and awareness raising across the community.	• There is no strategic approach to addressing socioeconomic barriers to support, such as housing issues, transport, access to bulk billing GPs and session limits for psychology • Access to culturally safe services for people needing support, as well as culturally safe staff working within the services • Lack of service capacity and staff shortages, particularly for outreach outside of Tamworth or Armidale.	• Increase youth-focused initiatives, including support and education for teachers about trauma and early distress, improve collaboration between child protection and health services, and increase youth peer support • Improve community capacity through education and clear referral mapping to services and support • Provide staff with training opportunities that are evidence-based.



Current strengths, gaps and priorities

Intervention

Suicide intervention refers to early, safe and effective support 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
• Community socially orientated services such as the Safe Haven, Billabong clubhouse and headspace • Services such as BackTrack provide a safe place for young people • Local schools have increased engagement with wellbeing programs and access to psychologists	• Staff shortages, particularly outside of the major hubs of Tamworth and Armidale • Lack of support for addressing socioeconomic barriers – Medicare bulk billing limits and the need for more subsidised psychology sessions • Lack of opportunities for local clinicians, emergency departments and first responders to upskill in new approaches.	• Increase the lived experience workforce and support lived experience workers to complete qualifications. • Address staffing shortages, retention rates and training and resources available to the workforce • Build community capacity through education, resources, and clear referral mapping.

Current strengths, gaps and priorities

Postvention

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

Strengths	Gaps	Priorities
• Existing services, such as Suicide Call Back Service, Standby, Tamworth I.AM aftercare for youth • Suicide prevention collaborations and recognition of lived experience knowledge and skills • Department of Education postvention protocols and support from initiatives such as Be You and headspace.	• Lack of local support groups for people who are bereaved by suicide • There are gaps in the communication between services after critical incidents occur and the protocols to link families and friends to support services • Lack of access to bulk billing psychology and counselling services for family and friends bereaved by suicide.	• Establish an aftercare service that includes support for families and friends impacted by suicide attempts • Increase support for those bereaved by suicide, including group sessions and free grief counselling • Improve follow-up from services for families who are impacted by suicide deaths, particularly in more remote areas • Improve the availability of culturally safe supports for Aboriginal and Torres Strait Islander communities and families impacted by suicide.

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

• Childhood
  ◦ Focus on wellbeing and social and emotional education with parents from birth
  ◦ Expand wellness teams in schools, e.g. include social workers
  ◦ Support the teaching workforce with education and resources about how to support the mental health and wellbeing of children and young people and how to respond to concerns
  ◦ Enhance youth drug and alcohol support and JobLink services.
• Adulthood
  ◦ Create opportunities for community connection
  ◦ Affordable 10 + psychology sessions with access to transport to get to appointments
  ◦ Consistency in service providers to build connection
	• Include attachment education and emotional wellbeing education for parental visits
	• Parenting and child support in primary school, e.g. parent-peer support, big brother and big sister programs
	• Affordable and accessible General Practitioner (GP) appointments
	• Increase in peer support and non-clinical support
	• Opportunities for community connection with consistent programs and initiatives over time.

What we need

Common experience two

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

What is needed?	Priorities
• Increase community knowledge of services and support people to navigate services • Increase availability of General Practitioners (GPs) • Increase availability of informal networks for support, e.g., sporting groups, Men's Sheds, parent groups • Move messaging from 'mental health' to 'distress' in order to destigmatise support and reach groups who may not identify with the 'mental health' label.	• Run a focused campaign on distress and wellbeing rather than mental health in the regions • Local area mapping of service providers and identifying ways to communicate that to the community • Increase availability of Safe Haven or similar non-clinical services in more communities in the New England area • Service 'expo' available through schools and sporting clubs to increase community awareness of available supports.

Common experience three

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

What is needed?	Priorities
• Local community decision makers that support people through complex experiences • Flexible funding arrangements and more efficient use of limited funds • A proactive approach to justice release handover with all necessary community supports and a guarantee of access to services, e.g. AMS, CAMHS, financial counselling, JobLink services, housing, etc • Recognise the role of Aboriginal staff in patient assessments and support of community members.	• Flexible funding, e.g. increasing time and sessions available in services to meet needs • Shared case management approach to complex care • Recognise the key role of the Aboriginal mental health workforce • Pre and post-release services and holistic support • Guarantee acceptance into CAHMS and AMHS following release from justice or corrections.

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
• Clear referral pathways to support • Youth Mental health services, including more acute service options • Aftercare services to support people following a suicidal crisis or attempt • Community collaboration and access to safe community spaces, e.g. sports facilities • 'One-stop-shop' so that people can access multiple services and supports together • Support for teachers about mental health and wellbeing through education and resources.	• Increase the regional workforce and the diversity of the workforce to meet community needs • A 'One-stop-shop' with the capacity to be mobile for rural areas • 'My education record' – interagency collaboration and data storage between schools • Positive role modelling and mentoring programs that draw on the strengths of the community • Supportive parenting programs that start from infancy.

Common experience five

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

What is needed?	Priorities
• GPs and psychiatrists – issues with shortage and costs in the region • More Safe Havens or similar service models in rural and remote areas, including Aborignal-run support services • Waitlist service options so people are not left without support • Knowledge of programs that are available for families, friends and carers.	• Reduction in stigma and shame experienced by those impacted by suicide • Increase counselling and support options for families and friends • Build family and friends into safety planning and discharge planning.

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
• The level of respect and clarity of the peer work role varies across services • Improvements in acknowledging the role of lived experience • The ongoing power imbalance between lived experience workers and clinicians • Shortage of workforce and workforce support across the board, including peer workforce • We need to improve the recognition of lived experience in all staff, including those in non-peer work roles.	• Increase the peer workforce and the sector areas where peer workers are based, e.g. emergency departments and police stations • Removal of the power imbalance between lived experience and clinical work and improve the recognition of lived experience • Recognition of lived experience in a variety of roles.	• Create a standardised peer work award (including salary) • Funded peer workers in all services, including emergency departments • Expand the peer workforce and create pathways for people with lived experience to move into a variety of mental health roles.

Enablers for action

Data and evidence

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

Current approach	Future approach	Priorities
• Available data is not timely and irregularly shared with and between services • Issues with health service coding reliability • Issues with diversity and contextual information within the data sets collected • Data is typically not localised and it is less helpful to services.	• Localised, relevant and timely data that can inform service planning • Standard data coding processes to improve the capture of data • Community ownership of data • Nuanced data (e.g. gender, cultural identity, age) and data with stories that contextualise the numbers • Evidence of what works and meaningful evaluation • Capturing what matters to the community.	• Distribute data to the services that need it and help them to use it • Use real-time data to identify areas of need and evidence-based interventions • Collect and use data with an equity lens • Improve access to localised data and the understanding of available data, and develop ways to contextualise data.

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
• Barriers to engaging, such as distance and socioeconomic status • Mental Health interagency • Turnover in staff, decreasing trust • Suicide prevention collaboratives (Tamworth, Gunnedah and Narrabri) • Communication breakdown between services can cause duplication or issues in evidence-based practice.	• Better accountability for funding • No wrong door approaches • Increase choices to access services and more flexibility in service scope • Increase lived experience voices and stories • Break down barriers to support, such as cost and transport.	• A portion of funding is allocated to innovation and connection and creating a 'story of change' focus • Share stories of hope and safe media reporting around suicide through Mindframe • Stigma reduction through sharing power with peer workers, Aboriginal workers and culturally and linguistically diverse communities.

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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