SUMMARY OF OUTCOMES: TOWARDS ZERO SUICIDE PREVENTION FORUM

National Suicide Prevention Taskforce

November 2019

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About this report

On 13 November 2019, the *Towards Zero Suicide Prevention Forum* (the Forum) was held in Canberra with over 100 people in attendance. Through a series of workshops, participants considered better responses to the needs of specific target groups, ways to address social determinants through policy and program levers and enhanced coordination across multiple agencies at all levels of government. Both the Prime Minister and Minister for Health attended and presented at the Forum and affirmed the importance of this work.

The following report was prepared by Yellow Edge, who provided facilitation support at the Forum. It provides a summary of workshop discussions help across the day, using the written contributions from participants at all three workshops, including post-its and easel comments, as well as the template used in workshop 1b.

For further information on this report, email: SPTaskforce@health.gov.au

Summary of key themes

Throughout the day, participants were urged to find common ground and a unified voice that would speak to the solutions that most people agree on.

Participants were also encouraged to focus on solutions that could be implemented *now* to save lives, build momentum and create a foundation for future growth.

A few key themes emerged from the common ground that was found at the forum, all of which point to practical, implementable solutions that leverage existing resources and goodwill.

1.	Further leverage lived experience and peer and community networks to reach people who may not be engaging with health services.
2.	Create tools and resources to enable and upskill non-health sectors of the community.
3.	Go local through outreach into existing community organisations and locally tailored solutions.
4.	Harness existing bipartisan support to embed a long-term strategic direction.
5.	Create tools, resources and supports that enable families and communities to support the people around them.
6.	Invest in local solutions informed by local data.
7.	Elevate the response to social determinants of suicide, considering a prevention in all policies approach.
8.	Prioritise care-coordination for all people in suicidal distress to ensure they get the right service at the right time with alternatives to Emergency Departments urgently needed.

Summary of outputs from workshop 1a and 1b

The focus of workshop 1a was coordination. Each table focused on either a particular target group, system design and coordination, whole-of-government approaches or whole-of-community approaches. Participants were provided context about their topic and a targeted question, then asked to think of solutions individually and then discuss and prioritise them as a group. Overall the questions asked how can we build coordinated actions/approaches [for the topic] to create better-connected journeys and supports for people at risk of or impacted by suicide.

In workshop 1b participants were then asked as a table to build upon the top 3 solutions/opportunities from workshop 1a. To fully understand the solutions and prompt practical implementation descriptions, tables completed a template asking for a description of the solution, who the key stakeholders are, steps in the process, key enablers and potential barriers.

Below are summaries of the outputs from workshops 1a and 1b for the topics:

- Men
- Young people
- Social determinants
- Integration of health and non-health approaches
- Workforce development
- Regional approaches
- Rural and remote approaches
- Cross-government approaches

Workshop 1a: Men

Participants noted that men are less likely to seek clinical help, less likely to discuss their problems with peers or friends and less likely to seek support after a suicide attempt. Enhanced social connectivity was identified as a means through which risk could be reduced. A need to tackle stigma in this group was discussed, shifting culture towards a stronger focus on wellbeing and help-seeking behaviour. Participants agreed that it is important to meet men 'where they are'.

Key Points

- There needs to be better support for men in distress.
- Men going through divorce and needing clinical help may be hesitant to seek it as it may be used against them and can affect access to their children.
- Government/Legal/Financial services need to have an understanding of the pathway of support for men in distress.
- Across all suicide attempts, we need to change the 'they're just seeking attention' type of attitude.
- We need to 'get in young' to change attitudes and stigma – start at school.
- Communities need to be supported to help men who won't seek professional help.
- More focus/analysis on income and social determinants – men feel like they have failed if they can't support their families, turn to Alcohol and Other Drugs (AOD), gambling etc.

Suggestions

- Access men where they are in the community, through workplaces, schools, education establishments, sporting and social clubs, when accessing health services, and when accessing other government services such as housing or employment support.
- Enable non-health sectors e.g. a divorce lawyer could provide brochures and other resources.
- Raise awareness through health and wellbeing promotions.
- Provide gatekeeper training for leaders in community, social and sporting groups, and for service providers in government and business. Use gatekeepers to create a one-door approach to help-seeking. The tension would come through the need for national consistency to ensure standardisation of training, support for peers / gatekeepers, funding, and evaluation. This would need non-traditional methods of evaluation and Key Performance Indicators (KPIs) for funding services as the activities would be supporting social connectivity rather than clinically-based services. Similar to the discussion going on now in the Primary Health Network (PHN) / Aboriginal Controlled Community Health Organisations(ACCHO) space.
- Create a model of community-based peer mentors with lived experience, employed through local councils to create and sustain community activities / clubs that could be accessed by males to increase social connectivity and improve wellbeing. Peer mentors would have an assertive outreach presence in the community and could be directly accessed by individuals, or would support facilitated access through community requests, primary health referrals or local government services.

Workshop 1b: Men

Solution: Finding men at crisis points and upskilling workers/peers to deliver an appropriate response	
Description	**Key Stakeholders**
• Identify mechanisms to improve systems/touchpoints – collect data • Improve proactive and reaction responses to men at risk • Peers need to be genuine and identified • Centrelink staff need to be trained • Safer spaces for talking about wellbeing (health, financial, family etc.) • Peer support type planning sessions with men to reduce stigma	• State and commonwealth government agencies • Judicial system • Community organisations (sporting clubs, men's sheds, employers)
Immediate next steps/short-term actions	
Facilitate men with lived experience of situational factors – housing, legal, M.H. Develop an Activation Strategy for men at work similar to Mates in Construction Activate communities – similar to men's sheds	
Key Enablers	**Key Barriers**
• Existing communities of support (e.g. Mates in Construction) • Men support other men • Activate 'help offering' approaches • Harness existing knowledge • PM priority • NSW Premier priority • Vic Royal Commission • Qld Suicide Prevention Plan • SA Premier's Advocate • More holistic wellbeing approach • Public awareness of suicide and desire to do something	• Gender neutral gate-keeper training • Lack of national suicide prevention plan for men • Lack of Minister for Men • Dominance of clinical approach • Issues around accessing/connecting data • Attitudes – perceptions/beliefs we can't do anything about suicide • Funding not gender-specific

Workshop 1a: Young People

Participants noted that co-design is critical when thinking about suicide prevention and youth. Young people and communities need input into the services that are provided for them to ensure that they are fit-for-purpose and tailored to their needs. They also agreed that systemic issues and siloed approaches are currently a barrier to optimal care. Participants agreed that it is currently challenging to 'navigate the system' and that a more holistic, integrated approach would lead to better outcomes.

Key Points

- Systemic issues need attention: the siloed nature of the current system is impacting on support.
- Trauma-informed primary prevention is crucial.
- We need a coordinated approach that blends traditional and non-traditional approaches.
- We want a strategy that acknowledges the role of community and young people themselves in creating change. Ask young people what they want then help them with that – self-determination.
- We need a common strategy across federal and state jurisdictions.
- Safe places that allow disclosure look different to young people.
- Don't put the burden on young people to reach out in a system that isn't built for them.
- Relationships must be developed before crisis points are reached.
- Change the conversation from 'what's the matter with you?' to 'what matters to you?'
- The focus for young people should be on prevention rather than just looking at those already impacted by suicide. We need to be looking at parents, families, community, support and leisure. Things that can keep children strong, engaged and resilient.

Suggestions

- Re-establish national youth representative bodies.
- Utilise peers and lived experience workers in delivery. However, it was also noted that there are risks in this approach; it needs careful management.
- There was strong consensus that system reform is crucial to promote collaboration rather than siloed approaches: data sharing, unified communication infrastructure, linking new services to established services, ensuring that policy aligns with real on-the-ground needs, make services visible and easy to navigate through a clear information channel.
- Hospital and aftercare need a holistic strategy so people are not returning to their communities unsupported.
- Mental Health First Aid focuses on identification but doesn't provide enough information on how to respond, what people should do and say.
- We need to re-think data collection strategies. We currently measure outcomes rather than protective factors.
- Policy design across whole of government needs to screen for impact on risk of suicide. Co-design processes that allow youth and community self-determination are also important.

Workshop 1b: Young People

<table>
<tr><th colspan="2">Solution: Building social connection</th></tr>
<tr><td>Description</td><td>Key Stakeholders</td></tr>
<tr><td>Embed practice/principles in schools, sport/recreation and community organisations where young people are to build social connections, respect, kindness and resilience
Will allow young people to feel accepted, worthy, connected, and that they belong
The lack of these things is a risk factor in young people</td><td>Youth peers
Teachers/schools
Community organisations/leaders
Parents</td></tr>
<tr><td colspan="2">Immediate next steps/short-term actions</td></tr>
<tr><td colspan="2">Review existing evidence-based programs that have proven outcomes and/or explore innovative solutions

Consider suitability for sustained support and scaling out

Focus on options with a whole of community approach and those that can be embedded in a school curriculum

Recognise and invest in the role that young people can plan in designing, delivering and governing initiatives</td></tr>
<tr><td>Key Enablers</td><td>Key Barriers</td></tr>
<tr><td>Peer-led initiatives, especially peers with lived experience
Principles of inclusion and human rights
Implementing where young people already are
Starting early and before young people are in crisis
Collective impact approach
Youth work skills</td><td>‘Otherisation’ of certain cohorts in politics and the media e.g. LGBTIQ+, refugee/migrant, Indigenous
Resources to run youth-led, community-led initiatives over extended time horizons
Preference for new and shiny approaches</td></tr>
</table>

Workshop 1b: Young people continued

<table>
<tr><th colspan="2">Solution: Strengthening youth services through affordability and broader peer support</th></tr>
<tr><th>Description</th><th>Key Stakeholders</th></tr>
<tr><td>Increased access to low cost coordinated services
Increased support post-discharge
Community facilitated programs led by a peer leader that hosts a space for young people to freely communicate</td><td>PHNs
Housing services
Employment services
Education services
Health services
Family services
Consumer groups
Community leaders and groups</td></tr>
<tr><th colspan="2">Immediate next steps/short-term actions</th></tr>
<tr><td colspan="2">Systems modelling of PHN level already occurring haphazardly to coordinate and leverage existing activities
Search for best practice in peer support youth services
Increase psychological supports
Digital platform for client-centred care (Innowell)
Identification of community-based leaders who can facilitate peer-to-peer programs
Communication with Department of Education to program peer-teachers with mental health and youth training</td></tr>
<tr><th>Key Enablers</th><th>Key Barriers</th></tr>
<tr><td>Workforce training
Participatory systems modelling to test improvements before implementation
Compiling data ecosystems
Funding
Co-design with young people
Regional focus
Continuity of care</td><td>Funding
Siloed approach and lack of coordination
Waiting lists
Affordability
Transition from youth to adult services</td></tr>
</table>

Workshop 1b: Young people continued

Solution: Strengthening protective factors for prevention	
Description	**Key Stakeholders**
• Strengthening social fabric so we have strong, resilient kids, families and communities • Involves parents, schools and communities at large seeking to strengthen known protective factors including social determinants • Also weakens risk factors • Taking a holistic view of a young person's life	• Parents • Schools and teachers • Children • Police • Local government • Health services • Community groups – sport clubs, spiritual groups • State/federal government • Justice/courts • Non-Government Organisations (NGOs)
Immediate next steps/short-term actions	
Review government policies for impact on protective factors and risks COAG agreement to share data Whole of Government approach to data collection and assessment Educate relevant stakeholders, parents and teachers in particular Fund community programs Evidence-based peer support and leadership in the community – make sure peers are educated and supported Address referral restrictions and lack of coordination	
Key Enablers	**Key Barriers**
• Data that is attuned to the questions about protective and risk factors. Data should be culturally appropriate, accessible and usable at a local level to drive change. It needs to be reported quickly and cover the community population, including those at risk • Data-sharing appetite within government • Central role for schools and parents • Focus on wellbeing for everybody • Local councils • Investment in early life prevention	• Affordability of things that strengthen protective factors • Privacy concerns • Data access/fragmentation/duplication • Focus on treatment rather than prevention • Requirement for 'opt in' parental consent for surveys means the most disadvantaged young people are often not contributing data. This skews our understanding of what is happening and what is needed • Geography • Heavy reporting requirements for funding

Workshop 1b: Young people continued

<table>
<tr><th colspan="2">Solution: Youth representation and data ownership</th></tr>
<tr><th>Description</th><th>Key Stakeholders</th></tr>
<tr><td>Fund national youth representative bodies to ensure that youth voices and interests are systematically built into strategies and programs
Create a platform that allows young people to own their own data, share their story just once, and have control over the information that is shared</td><td>Young people
Governments
Service providers
Representative bodies
Health and other services
Information systems</td></tr>
<tr><th colspan="2">Immediate next steps/short-term actions</th></tr>
<tr><td colspan="2">Look at examples where data ownership is working
Seek clinical governance and support
Trial this in one jurisdiction
Fix bugs
Scale up</td></tr>
<tr><th>Key Enablers</th><th>Key Barriers</th></tr>
<tr><td>Ongoing funding
Structural pathways to facilitate representative involvement
Young people use digital tools all the time</td><td>Stigma around the capacity of young people
Governance</td></tr>
</table>

Workshop 1a: Social Determinants

There were diverse perspectives regarding the social determinants of suicide, with more debate on the issues and best ways forward compared to other groups. A number of participants suggested that it would be helpful to position suicide in a broader context rather than within narrow mental health confines. There was a focus on the impact of factors such as poverty, and discussion of heightened risk among particular social groups.

Key Points

- We know a lot already about risk factors for suicide: LGBTIQ+, poverty, child sexual abuse, neglect and isolation, intimate partner violence, risks in Indigenous communities, gender, and the link between homicide and suicide in men.
- Ensuring basic needs are met lowers risk: community connectedness, safe, stable and appropriate housing, food security and relationships.
- We need to meet people where they are rather than relying on them to seek help. We need to better reach people who do not come into contact with the mental health sector.
- We need to upskill people who come into contact with vulnerable people to be able to identify and confidently provide support or connect people to supports.
- Access to therapy has many barriers e.g. cost and geography.
- Preventative strategies are under-utilised e.g. equipping people to be better parents, reducing trauma, enhancing rehabilitation, looking at family court approaches and outcomes to ensure that a preference to keep families together doesn't place children at risk.
- We need a greater focus on intergenerational trauma and other factors that lead to feelings of hopelessness.

Suggestions

- Better understanding of the 12 months prior to a suicide crisis would allow us to identify flags/issues then look at ways to address these, like upskilling people at touchpoints in the suicidal person's journey. This could be a soft-touch intervention.
- There is a pressing need to better integrate and connect data and identify gaps. Linking other data sets e.g. housing data, abuse, sexual orientation etc. may lead to better risk management.
- Non-health options such as the Scottish Distress Brief Intervention could be explored.
- We need more person-centred design. Policy currently focuses on the existing system.
- We need to train the non-health people who may come into contact with people at risk of suicide.

Workshop 1b: Social Determinants

Solution: Connecting for wellbeing	
Description	**Key Stakeholders**
• Peer support workers in the community • Lived experience support to reduce stigma and improve the culture of wellbeing • Training • Employed peer support workers • Linkages/pathways • National model -> community needs • Wellbeing focused • Online – e-space	• Communities • Clubs, workplaces, councils, sport, RSL, social • Industry groups • Schools/educational institutions • Peer organisations • NGOs
Immediate next steps/short-term actions	
Create a national scheme with an evaluation framework, guiding principles, co-design with communities and local council support Build a peer workforce Create a national policy/funding model Create a core model that can be adapted to suit communities and groups	
Key Enablers	**Key Barriers**
• Peers within communities • Non-health organisations • Lived experience mentors • Extended outreach	• Understanding of male needs • Sense of community • Funding models • Evidence re. peer support • Crisis model • Too many options • Coordination • Evaluation framework

Workshop 1b: Social Determinants continued

Solution: Roll out Victorian Coronial Data System	
Description	**Key Stakeholders**
• Consistency/homogenisation of data across the country • Insight into last year of life of people who die by suicide to identify patterns • Include LGBTIQ+, presentation to emergency, transition points in life course e.g. loss of job, qualitative analysis of touch points around health	• Coronial bodies/registers • Australian Bureau of Statistics (ABS) • State data collection • Hospitals • Council of Australian Governments (COAG)
Immediate next steps/short-term actions	
Consultation and collaboration across jurisdictions on how to collate data and which data to collate Streamline IT systems	
Key Enablers	**Key Barriers**
• Inclusion of minority groups • Funding • Workforce	• Different systems • Funding • Time to collate, analyse and disseminate data

Workshop 1b: Social Determinants continued

<table>
<tr><th colspan="2">Solution: Address and prevent trauma</th></tr>
<tr><td>Description</td><td>Key Stakeholders</td></tr>
<tr><td>• Trauma lasts a lifetime unless it is addressed
• Childhood trauma is often a reason for suicide
• We need to stop the intergenerational trauma cycle
• People in highly marginalised and stigmatised groups experience trauma and exclusion</td><td>• Health services including midwifery
• Early childhood
• Education
• Children’s advocates
• Child protection services
• Parents and children</td></tr>
<tr><td colspan="2">Immediate next steps/short-term actions</td></tr>
<tr><td colspan="2">Use existing systems which connect with babies and families e.g. extend baby checks to include mental, emotional and social wellbeing checks with extra support available for child, family and community
Promote inclusivity
Services need to be culturally safe and operate from a trauma informed approach</td></tr>
<tr><td>Key Enablers</td><td>Key Barriers</td></tr>
<tr><td>• There are multiple touchpoints in existence which allow government services to connect with parents and kids
• Connection, contribution, belonging, being valued</td><td>• Poverty and family difficulty in meeting basic needs</td></tr>
</table>

Workshop 1a: Integration – health and non-health

Participants discussed the merit and risks of a case management system that would provide a single-contact pathway, along with the value of lived experience companions, pre-, during and postvention. They agreed that enhanced communication, standardised training, outreach into other sectors of the community and universal awareness would improve outcomes. They recommended a single point of contact approach and better integration of lived experience into prevention, intervention and aftercare.

Key Points

- People get sick of having to repeatedly share their stories. We need a contact point and way of sharing/coordinating information.
- We need to build understanding that suicide prevention is everyone's business.
- Digital capability to allow a more effective case management model across areas, sharing risk information across services and better communication may lead to better outcomes.
- We need to integrate services e.g. health positions in schools in Queensland.
- We need shared goals, values and suicide prevention leadership in all jurisdictions.
- We need an interface between acute care and regular GP/health providers and we need to re-think the involvement of police and emergency departments.
- The question for discussion assumes that the health system is working while participants expressed the view that the health system needs to be improved. Sometimes the system fails people, and this contributes to subsequent outcomes.
- We underestimate how hard it is to navigate services when you can't even meet your basic needs.

Suggestions

- We could create lived experience companions to assist with crisis intervention and postvention. Further goals would be to emphasise the difference between ideation and completion, to prevent relapse, and to integrate cultural elements and build community.
- We need a care management model and a communication protocol to bring all areas together.
- We recommend a case management system with a population health approach, collaborative leadership and information sharing across networks to bring services together and convene all relevant agencies.
- If we move towards one central case coordinator, we must make sure this person is not overburdened, and that there is the capacity to scale up and escalate resources during a crisis. We also need to make sure that individual agency is maintained to ensure people don't experience disempowerment through this process. The case manager should be an expert in navigating and accessing resources.
- We need consistent training across services. While most do some training now, there is no consistency. A standard model and approach would be helpful.
- We recommend universal awareness in workplaces e.g. QPR (Question Persuade Refer) training. You don't have to be an expert to be able to help someone.

Workshop 1b: Integration – health and non-health

Solution: Lived experience companions	
Description	**Key Stakeholders**
• A person with a lived experience of suicidality is engaged as a companion to support a person in suicidal distress through their journey across and between support services. • Align the peer support (i.e.. the type of lived experience) with the lived experience of the person receiving support	• People with lived experience
Immediate next steps/short-term actions	
Key Enablers	**Key Barriers**
• Emphasis on common humanity • Support structures for lived experience companions • Engagement of a broad range of lived experience to match the experience of the person receiving support • Co-design • Professional network of training, support and supervision	

Workshop 1b: Integration – health and non-health continued

Solution: Service collaboration – learning from postvention collaboration	
Description	**Key Stakeholders**
• Organisational protocol in place • Working group to oversee operations • Contact roles in each agency • Agencies respond in a coordinated way • Broaden across health and human service and support sectors	
Immediate next steps/short-term actions	
Collate existing postvention service collaboration activities to determine better practice model	
Key Enablers	**Key Barriers**
• Having an organising principle (PHNs) • Agency reps with the authority to make decisions e.g. allocate resources, triage action • Lived experience at all levels of planning, design and delivery • Disciplined system design up-front	• Legislative boundaries • Service catchments – these need to align and have a workable footprint on the ground

Workshop 1b: Integration – health and non-health continued

<table>
<tr><th colspan="2">Solution: Care coordinators for people in distress</th></tr>
<tr><th>Description</th><th>Key Stakeholders</th></tr>
<tr><td>A dedicated person to assist with navigation of the system across health and non-health
Individual care coordinators would allow the person to navigate the system already in place for best outcome in relation to education, housing, employment as well as health care needs. It will fill a gap when people do not have anyone else in their lives to help with this role.
Multiple access points e.g. GPs, community centres, libraries, Centrelink, out-patient services, youth services, schools, family services, employment providers, drug and alcohol services</td><td>Co-design of services to include lived experience
Commonwealth, state and local government organisations
Private health services
Local NGOs
Education and training providers</td></tr>
<tr><th colspan="2">Immediate next steps/short-term actions</th></tr>
<tr><td colspan="2">Multi-modal commitment to collaborate across government
Co-design of the nature of the role
Training/professional development
Mapping of resources and services in local communities</td></tr>
<tr><th>Key Enablers</th><th>Key Barriers</th></tr>
<tr><td>No intake process or qualifying criteria
A tele-health platform, real-time, to health services so a response plan can be created across health and non-health services</td><td>Not completed during the Forum.</td></tr>
</table>

Workshop 1a: Workforce development

Participants agreed that there is much that can be done to engage workplaces with suicide prevention. They spoke about the leadership that peak and industry bodies could provide, and they agreed that a shared understanding of what emotional distress 'looks like', a common language to enable discussion, and a comprehensive education strategy – starting in tertiary institutions – would develop awareness and skill in identifying and mitigating risk.

Key Points

- Workforces need a shared understanding of emotional distress and a common language to discuss and engage. People need to know what it looks like. Signage about acceptance and who to contact would be helpful, and industry education would underpin awareness.
- Steer conversation towards wellbeing and suicide prevention rather than mental health.
- Ensure that programs are evidence-based and not 'pop' psychology. Focus on distress rather than 'suicide' language.
- Workforce burnout may be a contributing factor.
- Is EAP working as well as it could?

Suggestions

- There is an opportunity to create a comprehensive suicide prevention and mental health curriculum informed, perhaps, by lived experience.
- Training needs to start with tertiary education across all disciplines.
- Develop training that focuses on preventative factors.
- Peak bodies could be engaged to assist and drive capability.
- Workforce champions (potentially with lived experience) could provide support.
- Mandatory reporting in workplaces.
- Online platforms to build capability and share resources may be helpful.
- Organisational governance structures to build understanding of the 'why' and elicit buy-in might assist in building a culture of awareness.

Workshop 1b: Workforce development

Solution: Enhancing capability through workplace programs	
Description	**Key Stakeholders**
• Within workforce on-boarding, induction KPIs, suicide awareness • Shared language, awareness, acceptance/normalisation, skills	• Universities • TAFEs • Professional bodies/registration boards • Unions • Industries • Small and Medium Enterprises and sole traders • Businesses
Immediate next steps/short-term actions	
Define and align capability with other initiatives Identify a capability suite – create tools and resources Identify leverage points Educated as to why it's important	
Key Enablers	**Key Barriers**
• Mandated for organisations • Work, Health and Safety (WHS) Legislation • Workforce strategy • Resources for implementation • Clear pathways for support	• Buy-in • Concerns about WHS legislation • Disconnected services

Workshop 1a: Regional approaches

Participants agreed that community-led approaches to suicide prevention at the regional level require coordinated systemic approaches, co-design with community stakeholders, leadership at the local level, co-commissioning architecture between commonwealth, state and local government, and culturally safe services for LGBTIQ+ people.

Key Points

- Australia's mental health sector is siloed and needs reform to unify it. Competition for commissioning impedes collaboration in the provider market.
- There needs to be a cohesive approach to mental health commissioning through PHNs but each community is different and co-design from within the community is important.
- Stronger partnerships at local, state and commonwealth government levels are critical to regional readiness strategies.
- We need to listen to grass root community ideas: What do the people on the ground really want and how can we develop this into practical solutions? We need to consider how governance structures, practical solutions and trial/error evaluations support this co-design.
- Discussed examples of genuine engagement with community and stakeholders in the commissioning of mental health services in SA:
    - The reformed *SA Mental Health Commission and Wellbeing SA* both have a stronger focus on bringing the voices of people with lived experience and the wider community to mental health strategy, policy and service improvement.
    - They have established a *model for engagement with communities* that involves the community in shaping into commissioning agreements a single vision/mission statement – together with an agreement/lines of accountability/indicators etc to optimise the partnership.
    - This not only improves the effectiveness and quality of service delivery – within the agreement, we can bring MH *education to communities*, in particular, linking in an understanding of SP especially.
- There needs to be a commitment to collaborate and share best practice experiences of local and regional mental health and suicide prevention services - we do see examples of community leaders being empowered in PHN processes and the huge different this can make.
- Community controlled MH services need to be empowered (including with an increased education and awareness) to respond to the very specific and particular needs of LGBTIQ+ groups in order to provide culturally safe care.

Suggestions

- Implementation approaches must include sustained coordination and resourcing to communities to include information/data, infrastructure, education, research/evaluation and workforce development in the long term.

Workshop 1a: Rural and Remote

Participants in the Rural and Remote working group spoke about the risk factors and societal factors that impact people in these communities, in ways that may differ from urban impact. They spoke about the local tailoring that was needed in these environments and the potential value of upskilling community members rather than providing visiting services that were based on urban models. They emphasised the need for coordination between service providers.

Key Points

- We need to focus on children and families, targeting early development, however access to services can be a problem in rural and remote areas. While there may be mental health services available in these communities, they are unlikely to be services for children.
- Coordination of services is a big issue everywhere, including in rural and remote areas. How do we make sure all those involved communicate?
- There is a need to consider how the workforce can be better supported. When people move to cities for professional training, they may not return or they may feel disconnected when they do. Similarly, the practice of sending inexperienced graduates into rural and remote communities doesn't always lead to the best outcomes.
- We need local leadership and champions and this may work better if these positions are remunerated. Consider possible links with the Community Development Program (National Indigenous Australians Agency - NIAA).
- Suicide prevention plans need to be based on an understanding of trauma.
- First responders are a whole range of people, not just emergency services. They can be family, community leaders, teachers etc.
- We need to do more in prevention and early intervention rather than waiting for an event that acts as a trigger for action.
- Resource rural and remote communities properly - underserviced because of geography.
    - Engage the sector to facilitate local action - we have 145 Aboriginal Medical Services across the country we need to use them properly/more effectively.
    - Funding people properly to service communities and using organisations there.
    - They don't want Sydney/Canberra based organisations delivering services in their communities. They often don't understand the issues.
    - National vs local debate (There can be value in doing things at a national level but sometimes the value is lost at a local level).
- We need an alternative to emergency departments and police, particularly in areas where these services may not be available outside of regular working hours.
- We need to improve our use of data and technology.

Suggestions

- Shared commissioning of services and joint plans in rural and remote areas may lead to better communication between service providers and better outcomes.
- Train community members to provide services.
- Invest in young leaders and connect them with older mentors and peer-to-peer support.

Workshop 1b: for Regional approaches/Rural and remote[1]

Solution: Connected communities	
Description	**Key Stakeholders**
• 'Community watch' connectors • Flexible funding models to support community-based initiatives • Local communities that are empowered to make decisions • High level of government representation • Shared commissioning of services and accountability	• Government organisations – federal, state, local • Community bodies and service providers • Schools • Local leaders • Online • Individuals with lived experience and families
Immediate next steps/short-term actions	
Identify existing community resources and establish shared interests Identify local connectors and grass-roots organisations who can provide support and connect people to the service best suited to their circumstances Develop community messaging around risk identification and suicide prevention Bring together interested parties Build capacity in regional connectors Examine funding models to create the flexibility to support community-based initiatives Enable information sharing Create a system for standardised mapping of community capacity Develop resources for community connectors Develop a national campaign encouraging people to reach out within their local communities Create a website/app to link people with services and resources at a local level Have the PM consider writing a letter to every household talking about mental wellbeing as a priority in this term of government. This would elevate the project and give it momentum.	
Key Enablers	**Key Barriers**
• Strengths-based approach • Builds on existing capacity • National strategy/plan with long-term objectives • Community-led, ground-up support • Balance between evidence-based approach and local flexibility • Community readiness • Self-determination • Support early intervention for people who feel lonely or isolated • Paid roles for community connectors • High level governance and oversight	• Disjoined policy landscape and services • Sustainability • Disconnected services • Consultation fatigue • Managing expectations of 'towards zero' target • Challenges navigating between government systems • The most vulnerable people may need encouragement to reach out • The needs of minority communities need to be factored in

[1] These two categories have been merged because of the similarity in the recommended solutions

Workshop 1b: for Regional approaches/Rural and remote continued

Solution: Funding models for community needs and outcomes	
Description	**Key Stakeholders**
• Governments need to demonstrate value for the funding they expend and ensure that people receive quality, outcome-focused services • Inflexible contracts can sometimes inhibit the inclusion of small-scale community programs in regional service responses • Smaller, local organisations do not always have the administrative capacity or expertise to meet government tendering requirements • New models that lower the barrier to participation could promote more equitable and relevant service provision • If governments gave commissioning agencies more flexibility to deliver outcomes (not focused on outputs or compliance) they could engage more effectively in needs of communities	• Government organisations – federal, state and local • PHNs • Department of Social Services • Department of Human Services • Department of Health • Health and social service providers • Individuals with lived experience and their families
Immediate next steps/short-term actions	
Develop trials of new contracting models based on community outcomes rather than rigid input and performance measures. This will require new approaches to evaluation, including community ratings and narrative evaluation. Higher level values and principles which spell out what all programs in this area are collectively endeavouring to achieve will ensure some alignment with policy frameworks and should be supported by agreed data collection and metrics for success. The Productivity Commission has mentioned the need for a “drastic overhaul”. This would represent a drastic overhaul of the current standard way of doing business in our sector, while protecting the unique services communities value most.	
Key Enablers	**Key Barriers**
• A strengths-based approach is needed to support this work, supported by strong governance and a focus on measurable outcomes for those who need them most. • A national suicide prevention strategy would be an important anchor for such a radical change.	• Disjoined policy landscape and service provision • Government concern about visibility/accountability for funding.

Workshop 1a: Cross-government

Participants in the Cross-government working group spoke about the importance of a whole-of-government suicide prevention strategy. They talked about the issues associated with data sharing and debated the merits of a centralised versus de-centralised approach. They also spoke about the challenges arising from separate buckets of funding. There were differing views on the best way forward, but most participants appear to believe in the value of an accountable body with shared responsibility across all agencies.

Key Points

- Central agencies have a role to play in holding all agencies to account.
- How do you stop free riding in a pooled funding model?
- We need a solution to the problems with access to data.
- Risk assessment is a problem and people who are high risk are sometimes turned away.
- There is a difference between safety planning and suicide prevention. Everyone should have a suicide safety plan.
- How do we use the information we have at a cross-portfolio level? Responding to data trends is always reactive. We need a plan for what we might find.
- It is appropriate for the target to remain the responsibility of the Minister for Health.

Workshop 1b: Cross-government

<table>
<tr><th colspan="2">Solution: Joint investment and commissioning</th></tr>
<tr><th>Description</th><th>Key Stakeholders</th></tr>
<tr><td>• New national agreement for suicide prevention that specifies funding, service types, roles, responsibilities, outcomes, reform, accountabilities, timelines
• Single approach to commissioning</td><td>• Government organisations – federal, state and local
• Service providers</td></tr>
<tr><th colspan="2">Immediate next steps/short-term actions</th></tr>
<tr><td colspan="2">Agreement between government officials – bilateral agreement to share data
Mapping and a gap analysis to understand the current state
Build community capacity and advocacy</td></tr>
<tr><th>Key Enablers</th><th>Key Barriers</th></tr>
<tr><td>• Unparalleled level of political commitment
• Strong relationships at all levels of government
• Protecting community funding
• Everyone using the same language and approach
• Community-led – led from the ground up to inform construction</td><td>• Status quo bias
• Vested interests
• Initial set-up investment
• Concerns about accountability
• The assumption that solutions need to be technical and complicated
• Coordination of information at the local level</td></tr>
</table>

Summary of Outputs from the World Café

A world café format was used for the afternoon workshops, with eight areas of focus. Summaries from each station are tabled below. At the end of each of station, participants were asked to identify priorities. Items in bold font in the tables below indicate priorities shared by more than one person.

World Café Station 1: Aboriginal and Torres Strait Islander Peoples

What are immediate opportunities or actions to reduce suicide and the impacts of suicide for Aboriginal and Torres Strait Islander People?

Stop	Build On	Start
• Stop racism in our systems and processes • Stop prescribing solutions • Stop "unconnected to local" national programs • Stop importing solutions and allow for community and cultural solutions to be developed • **Stop funding non-indigenous organisations without evaluations and cultural safety** • Stop prioritising non Aboriginal Organisations to deliver services to Aboriginal people • Stop mental health funding to PHN's/mainstream organisations where there is capacity for Aboriginal Community Controlled Health Organisations to deliver services • Stop national roll outs of programs to regions unless there has been local consultation and partnerships • **Stop pilots and fund services – "offer protection services for programs shown to work"** • Stop short-term funding • Stop framing the issue as suicide – needs to be strengths-based and focus on overall wellbeing of communities • Stop children being charged with offences	• Build on staff support systems and self-care • Build understanding of crisis in Aboriginal communities • Work of trials – whole of system approaches to improving the wellbeing of communities • Build on housing • Build on improving evidence of what works in Aboriginal communities • Fund programs flexibly to meet Aboriginal priorities – i.e. Don't expect them to look like mainstream "health" programs • Build on community connection training • Build on men's business: build on the existing strengths of men's groups • Support Aboriginal and Torres Strait Islander communities to govern health services to key communities • Develop KPIs, evaluation consistent with Aboriginal people's priorities • Mental health literacy training for families and communities • Strengthen educational opportunities for Aboriginal and Torres Strait Islander people • **Respect culture as a protective and healing factor** • **Build Aboriginal Community Controlled Health Organisations – integrated – culturally safe and trusted – community led/identified solutions** • Sharing good practice • Evaluating what works and sharing across the sector • Need more dedicated funding services for Social and Emotional Wellbeing (SEWB) teams • Need greater investment in regional/hub-spoke models of care with multidisciplinary teams • **Community controlled health organisations are preferred providers of suicide prevention activities** • More allied health in schools • Strengthen processes and support Aboriginal and Torres Strait Islander young people to become health workers, doctors, psychologists etc. • Increase healing activities in local communities • **Listening to local community priorities** • **Local/community governance infrastructure** • Community led responses to suicide prevention • Local decision making – self-determination and principles of empowerment • **Youth mentor/leadership programs/ peer-education models** • Yarning and true talk • Co-design with community in developing responses • Stronger cultural underpinning of services • Build on "5th plan" in terms of priority. ATS priority needs to remain • Mentor programs including elders in remote schools • Whole of Government and Services approach – policy – practice – training –PD • Build on Indigenous parenting skills from a cultural perspective • Support community truth telling and healing • Build sustainable funding models • Start building cultural programs for healing more broadly and address intergenerational trauma • Build services delivery in rural and remote regions • Build on culturally competent and trauma response mental health services • Build on mental health workforce • Strengthening of social determinants	• Appropriate training for communities • Start a serious program of workforce development for Aboriginal young people in health and social support • Start properly investing in early childhood and families • Support/counselling for the "undiagnosed" • Research in successful "SEWB" programs explored to expand • Mentors for new parents or families in crisis • Start giving aboriginal young people hope for the future through equal opportunities • Start prioritising the issue of trauma and the need for whole of community healing • Funding Indigenous staffing, training, etc. • Heat/risk mapping for Indigenous Australians • **Start stand-alone but integrated "Aboriginal and Torres Strait Islander SP Plan" with funding plan** • **Start providing MIT/SEWB funding to "ACCHO's" as preferred providers for Aboriginal people** • Start empowering communities to make decisions • **Community peer champions that can support/aid/call in on those at risk** • Address social determinants: health, housing, education, in a culturally-specific way • Information in language e.g. mind frame • Ensure regional/state plans exist • 24/7 support services • Mental health and suicide prevention focussed on Indigenous community needs • Incorporate cultural love and tradition into "how to respond"; act, support, who has the authority to say, respect • Educating elders and leaders • Community resilience • **Supporting community-led solutions** • Taking a human rights-based approach • Task communities to find out what they think works; respect them as experts in their own lives/communities • **Aboriginal and Torres Strait Islander Crisis support text service with paid ATSI crisis counsellors** • Culturally appropriate relationship support/healing • **Prepare Aboriginal and Torres Strait Islander Strategy and Implementation plan through COAG** • Develop culturally-specific services • Providing counselling, not just crisis support • Include cultural and community leadership work in work participation requirements

World Café Station 2: Support After Suicide (Postvention)

What are immediate opportunities or actions to effectively respond in a coordinated way to individuals and communities impacted by suicide?

Stop	Build on	Start
• Postvention needs separate understanding and support • Stop discrimination, stigma, isolation, excluding postvention from suicide prevention • Stop calling it postvention • Unsafe funerals • Move away from ad hoc, reactive approaches • Emergency Department (ED) only access to postvention services	• Postvention support should be ongoing for those that need it regardless of the proximity of the bereavement e.g. 20 years later • Build stronger communication about postvention and its importance as prevention for the community • Build on awareness of postvention and impacts • Support communities and individuals • Broaden education • Training – MIT first-aid training including postvention • Build on male peer support groups (see Jesuits Melbourne) • National program with local solutions/community led – harnessing existing resources • **National funding of a postvention service so we don't have a "postcode" lottery – equality** • Current investment – continue to fund WICRS and Standby • Suicide prevention community grants – starting the community conversation • Build on existing programs – continuum, prevention, intervention, postvention all interlinked. E.g. M.C • Build on/fund community integrated approaches – standby, focus on long term integrated (sustainable in place) approaches • **Services from the right person, place, service** • **Build on school-based programs – broader community responses** • Suicide Prevention Australia's (SPA) focus on postvention • Postvention guidelines – are they visible? - is use of guidelines known? • What should coverage of postvention services be? How do we do this? • Does suicide date inform what coverage should be?	• Start calling it "bereaved by suicide' • A separate stand-alone Federal Ministry for Mental Health • Postvention helpline • Evolve community focussed postvention to work in different types of communities (e.g. industry, workplace, sporting clubs) • Better integration with state police – referrals • **Case manager post-attempt to individualise care** • Peer support training, upskilling, implementing – utilise our lived experience • Whole of government (bilateral and bipartisan) support and investment into support after suicide • **National funding to meet demand and equitability** • Postvention referral mechanism activated by police for families and those impacted across all states and territories • Accreditation (national) • Inventory of service providers • To identify peer-body for postvention • Publish evaluation of services • **Translate school postvention into workplace postvention** • **Workforce development: specific training, capacity building, preparedness** • Communication and knowing who is involved and what they are doing • Continue recognising postvention as a ball point of prevention • Workplace too kits: how to respond after suicide, targeted to specific industries e.g. doctors, veterans etc. • **Peer mentor lived experience support as a part of workforce and strategy**

World Café Station 3: Digital Approaches

What are immediate opportunities or actions to integrate digital approaches into suicide prevention in Australia?

Stop	Build On	Start
• Stop creating ugly interventions without consumers or users in mind • Stop reinventing the wheel • Stop assuming that e-services work for all people: lack of digital literacy, need for connection • Stop duplication: confusing, inefficient use of funds • Stop building digital solutions without "inter-operability" standards • **Neglecting to remedy the abundance of poor-quality data sets** • Stop thinking e-health + poor health • Stop trying to move consumers across platforms – their preference • Stop seeing tech as a cheap and quick fix for the health system • Stop creating silver and disconnected data sets/digital initiatives that don't connect/build on existing resources • **Stop pilots with no funding continuity** • Seeing telehealth as a remote-only solution	• Appropriate and qualified social media moderation after hours • E-safety commissioner resources: promote • **Build on existing infrastructure/capability** • **Social environments: build on the spaces where young people are** • Young people's preference for digital communication: build on/introduce new channels that help seekers can utilise • Artificial Intelligence (AI), CCTV and anomaly detection – digital phenotyping and suicide detection – target population specific interventions to delve into tailored diversity • **Build a playbook for social media users on how to support someone online and develop a national standard around digital governance 24/7 risk/need** • Build on existing broader health digital initiatives and leverage on early life focus (e.g. National children digital health collaborative) • **Research/evidence – build on and use** • **Start collaboration** • Systems/apps on social connection • Accreditation/quality and safety standards of e-mental health apps/support • www.Headtohealth.org.au • Online peer support/ peer-to-peer and support groups = revolutionise reddit • Tapping into lived experience for design and addressing barriers • Utilise guided digital support – thereby transitioning personal connection with digital solutions • Building better navigation of existing digital resources • **Build on digital mental health tools that are demonstrating effectiveness in other markets/settings and repurpose for appropriate context – scale up successful interventions** • **Care coordination platforms that put clients in charge of their care – "Innowell"** • Start implementing what works at scale and with proper funding • Start/better looking at developing partnerships with tech companies and make existing platforms safer and better for wellbeing • Build on and complement on-the-ground services	• **Making e-therapy/help-seeking economically viable and structured** • **Prioritise e-health access – web/broadband/NBN** • National standardisers for patient consumers, cater for health and wellbeing • **Health commissioner cross collaboration** • Investing in mental health like we do in cancer prevention, research and cure • Start better education around options and opportunities available • Export our innovations • **Innovation driven Medical Research Future Fund (MRFF) projects** • Extend key agency funding cycles to allow for meaningful long-term strategic decision maturity • Tapping of "World Economic Forum (WEF)" international institutions to develop exemplary local solutions • Start "servicing"/identifying virtual communities virtually • Start doing a better job of signposting effective interventions – it will build credibility and engagement • Industry and government • Better understanding of impact of social media on all of us • **Educating clinicians and community about best methods of digital care for specific situations** • Invest in effective digital interventions to allow free and open source access • Looking at gender-specific tools – what works for men?

World Café Station 4: Workplaces

What are immediate opportunities or actions to ensure an effective approach to suicide prevention and postvention across all workplaces, from small to large?

Stop	Build On	Start
• Stop ticking boxes – "KPI's" • Stop forgetting people in informal/insecure work • **Stop blaming/"fixing the individual"** • Stop being response-oriented/reactive • Stop "fixing broken people" and start fixing organisations • **Stop hot desking**	• Build on best practices for workplace separation and **transition into retirement** • **Build on thrive at work** • **Build on tool kits** • Support of family • Peer support; i.e.. Champions • Language knowledge • **Skills development** • Safe culture • **Knowledge development > awareness** • Insurances; role • **Strategic approaches: building on wellbeing or pathway in** • Evaluation and selection criteria • **Industry approach** • Case-study: good models	• **Start postvention for workplaces** • Professionalise HR • **Sharing facts in the industry** • **Myth busting** • **Workplace champions: trained and supported, peer support** • Trauma informed approach

World Café Station 5: Crisis Response and Aftercare

What are immediate opportunities or actions to ensure all people who are in crisis or have attempted suicide get immediate and ongoing, person-centred and evidence-based support?

Stop	Build On	Start
• **Stop taking people to the ED if they don't need or want to go** • Stop putting the onus on the individual to seek help • **Stop stigmatising people who are suicidal** • **Stop discrimination against people in crisis or who have attempted suicide** • Stop assuming what's going on with someone when they present to hospital and are suicidal (e.g. "just want benzos" • Services which are underpinned by arse-covering mentality • EDs are often not the best, most therapeutic places for people in crisis • Don't put suicidal people in paddy wagons • Sending people home with nothing different and no follow up • Don't require people to be critically suicidal to get help • **Stop police responding to mental health/crisis and suicidal crisis** • Treating visible self-harm only from a physical perspective • Telling people they're taking up a bed that could be used up by someone who wants to live • Stop assuming one size fits all – whatever that is • Stop ignoring people in distress • Stop sending people back to the very environments that exacerbate their distress • Stop sending people home from the ED without a discharge plan • No discharge from impatient care without supports organised • No police • Stop having social determinants ignored • Stop putting up barriers (criteria) to people accessing help • Stop ignoring families and support people • Stop blaming people with mental health/suicide issues for "clogging the system" • Stop focussing on only risk management • Stop the neat target • Do not force them through ED • Stop delayed responses to crisis (Crisis Assessment and Treatment Team – CATT cores 3-5 days later) • Stop eligibility criteria for programs to limit to "attempts only" • Discharge to homelessness • Stop saying "they do that" or "they are known to us" • Stop having to wait until Monday for assessment • Stop funding mental health as if it is a 9-5 • Stop stigma	• Learn and expand on aftercare • **Community capacity and confidence building** • **Access to telehealth specialists** • Working with suicidal distress • **Build on, evaluate, scale non-clinical safe spaces and integrate** • **Engage health services and emergency response services** • **Build and combine clinical, peer and family peer support** • **Making Mental Health Care Plans available to all via telehealth and not just remote and rural individuals** • Culturally appropriate aftercare services for Aboriginal and Torres Strait Islander individuals • Distress outreach services • **Services which we tailor around the needs of the individual** • **Shared approach to risk formulation – prevention not prediction** • Pilots of safe haven cafes • **Extend peer workers in ED's** • Build on co-response models and trial others (e.g. peers and police) • **Crisis teams 24/7** • Prompt trial (ambulances and mental health professionals in VIC) and similar First responder alternatives to ED • Scale up police/ mental health workers co-response pilots • **Build alternatives to the ED e.g. stabilisation units and haven café** • Looking at successful models. E.g. Crisis Now RI International USA • Peer workforce - develop training and career pathway and integrate into services • Transitional housing models • **Hospital in the home for mental health** • Triage skills for staff • Successful housing programs like Housing and Accommodation Support Initiative (HASI) in NSW • Soft entry points to hospitals: "hubs/cafes" • Education and support for carers in crisis • Only leave hospital with care plan, need a follow-up appointment • Online peer support spaces	• Trauma informed care (language) • **Start giving the workforce time to engage and support** • Fully educate the workforce • Peer support, social support workers to support people's recovery • Peer support well matched • Peer support via trained lived experience • Learning from lived experience and those who have attempted suicide to identify gaps • **Support/funding practitioners to live/work in rural and remote areas** • **Investing funds into postvention** • **Frank Campbell's model USA: peers and paramedics** • Peer outreach • Don't forget men, most aftercare reaches women, find other ways to reach men who have attempted • Peer support in child and adolescent services • Start funding to meet demand • Looking for an effective way to connect services with people in country e.g. iPads • Have staffing so that there is someone to talk "24 hrs" • **Starting having a co-response – peers and police** • Responding in a human-to-human way • Enabling people to use their lived experience in helping people • Safety planning for everyone • **Having people home with a proper safety plan** • Providing alternative places to ED to get help • Publish evaluations • **Start funding evidence-based programs e.g. BAU** • Funding for partners in recovery again • **Fund community care help - safe place 24hr, bed for 3 days** • One crisis hotline • **Do what they did in New Zealand - one crisis hotline** • **Look at successful models internationally: DBI Scotland, Crisis Now USA** • Being compassionate • Start a peer workforce career pathway and accredited training infrastructure etc. • Do a properly tailored assessment

World Café Station 6: Support for families, friends and carers

What are immediate opportunities or actions to better support the family, friends and carers of people living with suicidal distress.

Stop	Build On	Start
• Family = broad and not just immediate • Stop assuming that all families can successfully navigate the system, and support when they can't • Stop varied interpretation of privacy principles etc. – think broader than client… sense shift. • Stop funding services without adequate support for families/carers etc	• **Extra support following suicide attempts – make sure before sent home** • **When the person is in acute care, establish family meetings as a priority to support the discharge process** • Opportunity to connect aftercare models • Early intervention across community • Community: home, school, agencies, networks • Peer-led, community-led responses (e.g. done in the past for HIV) • Build on community led initiatives to connect LGBTIQ+ young people, especially in rural and remote communities • Self-care/respite/support for carers – link to flexible workplace practices • Need to ensure carers know that to provide care they need to seek care themselves • Respite • Flexible work arrangements and workplace attitude • **Workforce development: understand what the family is going through: mental health staff need upskilling/training** • **Positive narrative: what works? Strengths?** • Peer enhancement model under "wan" back model – include families • **Grant/ funding options/services to better support families/carers/children** • Existing services to include carer/family • "Children of Parents with Mental Illness (Copmi)" successful model = how to scale and include suicidal distress • Carer navigators/peer-support: **GPs/schools need information to pair on** • Start outreach support/peer mentor "early intervention" • Family peer support • Opportunity to connect models from mental suicide to Suicide Distress • Carer navigators hosted by carer NGO's • Follow up and respond to families that had a bad experience of services (HS) • Listening to "friends and family (F&F) who have had lived experiences • Involving F&F in service design • Action plans for family carers • Anticipate potential needs and plans • Campaign, messaging, where next locally • **Create healthy wellbeing literacy program for national suicide awareness – referrals – risks screen – self-care** • Promotions: PM to write to Australians with key messages and where to look - messaging campaign with family "you are not alone" • Support communities that also support carers • Carer consultants in mental health units help with discharge planning and supports	• Start making it clear what you can say to families/carers – contracting and commissioning as an opportunity • Holistic view of family support to parents of grown "children' • Workforce (health) – collate for inclusion • Develop a much more sophisticated understanding of mental health not privacy provisions: develop a common-sense approach – adapted in policies and producers • **Parents** • Provide tools, resources, access – gate keepers • Support with skills and techniques to manage • Start programs for families of transgender/diverse young people to understand and respond to suicidality • Recognise the family as quite frequently the key support team and utilise their knowledge a lot more • **Peers networks and supports between people in similar situations** • Start peer support and peer outreach programs for LGBTIQ+ young people for mental health • Families together locally to help make sense and not feel so alone • Peer navigators to support • Where do we connect with and find people? Where do they go to interact? – coordinate information and access to support/support groups • **Proactive outreach/ check-in for families to support them, manage risk/navigate** • GAP = Culturally and Linguistically Divers (CALD) communities and families • New trials/peer warm line – matched to type of care (ROSES) • "Peer warm line" trial • Peer workers lived experience as family members • Package/skills for carers • **Carers at risk – self-care/care burden** • Relationship counselling and financial counselling • Self-care • (Awareness) understanding by carers etc that they are important in the health of the person at risk • **Workforce to include working with families** • Information sharing; clear fact sheets about legislation for GPs as well as carers • **Peer outreach (including veteran families)** • **Educate families and friends about how to support** • Support suicide lived experience resources for different carers • **Young people supporting peers** • Giving family and children a voice • **Connection to community support** • Family education – all involved not just spouse • Develop a health pathway (GP's for family/friend support) • Pharmacy as opportunity to navigation

World Café Station 7: data and Evidence

What are immediate opportunities or actions that we can take to ensure suicide prevention policy and practice is informed by data and evidence?

Stop	Build On	Start
• Stop excluding groups • Excluding LGBTIQ+ data indicators in standard pop data • Stop excluding young people in some GPs through opt-out parent consent • Stop dismissing approaches without data • Stop dismissing approaches or interventions that have no data or evidence because they are innovations • Relying on academic tested data/evidence over reliance on "evidence-based" – the best approaches may not have the best evidence • **Short-term funding** • Stop short-term funding evaluation perspectives (results in poor data and evaluation) • Data provided to independent non-government organisations • Build on evaluation around bio/psycho/social models – integration/allied systems • Limited/poor systemic approach to data/evaluation • Stop trial and error approach to system reform – we have the tools to simulate • Stop assuming trust • Stop assuming the public trusts in governing bodies to make decision about individual data • Duplication • Asking everything – narrow and get to the meat • Stop duplicating data through multiple data collection processes • Delay/transparency • Slow turnaround to analysis and dissemination	• **Data linkage** • What evidence we have and improve national coordination • National comprehensive linkage data • Better linkage across agencies/systems layers of government • Build on data assets already in place through ABS, etc. with data linkage and research access • Data quality • Collect comprehensive and high-quality data • Consent processes – streamline • Collecting better quality data on SA and nationally – ED/ISR responders national survey • Data psychosocial/place-based • Risk factors: health links, government departments, identify people who may need help • **Abs data on psychosocial factors … are directly targeting higher risk groups e.g. men going through relationship breakup** • Reviewing place-based grass root/evidence • Understand from stories key risk factors for community cohorts • Data through life stages in education to understand changing risks and inform intervention • **System modelling** • Strengthen regional decision analytic capability – systems modelling and situation to test policies, strategies and intervention scaling up before implementing them in the real world – leverages existing research data and expert knowledge • Evaluate programs (Continuous Quality Improvement - CQI) not-set and for-set • Funding to generate evidence • Decision support tools embedded in ongoing monitoring and evaluation cycle • Existing to include LGBTIQ+ • MDS/Data consistency (gender) • Keep gender segregating data and evidence • Translation • **Communicate (international) research findings to practitioners in the field in an understandable manner** • Trust and awareness • Collect data and feedback locally and nationally • Research/evaluation • Evidence we already have test-stretch • Big data and combing to look at big picture (data repository) • More funding for data analysis and researchers	• Start coordinating approach to collection of data with schools and linkages to other data sets • **Collecting LGBTIQ+ data census, all other data sets** • **Start collecting better data on suicide deaths i.e.. more detail doing health contracts after/other risk factors** • Collecting better data – new mechanism for police, coroners to collect better data • Engage with funded providers of community and social services to understand risks and etiquette • Start on a system that allows people to air and carry their own data • Start insisting that funding requests are supported by a commitment and quarantine of resources for measurement and evaluation • **Information sharing between clinical and psycho-social service providers** • Individual data systems that follow and monitor people • Clarify type of data that is required • Reliable attempt data • Data that helps patients and clinicians in real time • Users own their data • Build a social license for the use of data in health • Outcomes • **Start measuring longer-term patient outcomes for mental health treatment and interventions so we know what's working** • **Understand what effective early intervention looks like at community** • Measure outcomes not services delivered – designed in new programs • Data and timelines • **Access to current live data for tertiary/hospital sector/Emergency Service Organisations** • Real-time monitoring of suicide methods • Website with suicidal events on local level • Start using data to inform real time responses – SA and deaths • **Non-traditional evaluation/data** • **Last year of life data – broader than health** • Start looking for approaches or interventions that sit outside traditional health/academic settings and therefore might not have established evidence • Start partnerships with tech companies to allow data sharing/responses • Data consistency • Aligning LGBTIQ+ indicators so data can be compiled • Consistency of coronial data • **Suicide registers in all states** • Updated meta-analysis on current programs. E.g. Men's Shed etc. • User requirements – make it meaningful • Start looking across the lifespan to identify opportunities to reduce/ break intergenerational cycles of trauma etc. • Legislation and policy • Legislative framework to bring together cross-sectoral data • Trust and standards of data • A service of data to communities • Data feedback to communities • Providing data on predictive/risk factors to communities to inform their local platforms for change

World Café Station 8: Loneliness and Disconnection

What are the immediate opportunities or actions to address loneliness and isolation as risk factors of suicide?

Stop	Build On	Start
• **Stop making public statements that are homophobic or transphobic in nature: they only serve to marginalise and exclude LGBTIQ+** • Underemployment • Nursing homes for the elderly – more home care and community support • Stop ignoring childhood adversity and trauma • Stop letting the onus fall on child to nominate trauma • Not devaluing people e.g. older people • Stop building new communities/densifying existing communities without providing spaces and places that allow for community connection and gathering places, e.g. parks, plazas, community halls – lack of these spaces reinforces isolation and reduces community cohesion • **Stop our LGBTIQ+ kids killing themselves because of stigma, shame and being hidden** • Government policy that excludes LGBTIQ+ people • **Stop building physical environments that facilitate isolation. E.g. big homes, outdoor areas out back (not front)** • Sexual abuse. Including clergy • Funerals that eulogise those who died by suicide • Stop poverty – the unaffordability to live an engaged life • Messages from the government that shut down the voices of young people • Building large high-rise developments with no informal community/neighbourhood engagement • Political and media rhetoric that "otherises" certain cohorts • Stop LGBTIQ+ stigma, school based for both LGBTIQ+ community and not	• **Build on community connections through local/neighbourhood programs especially in areas if distress (e.g. Natural disasters, drought etc)** • **Community men's groups e.g. Men's Sheds, Son of the West – encourage and facilitate membership** • **Increase involvement of LE across all aspects of suicide prevention – 750,000 attempt survivors** • Stigma reduction, education about differences, tolerance for diversity • Engagement at an individual level with services to connect to other people that connect and engage • Build on existing initiatives at community level to develop connections among LGBTIQ+ young people – especially in new digital environments • Carers/friends – more of them in varied groups • Online community resources for youth – chat rooms (safe) • **Existing community cohesion/social wellbeing programs – ensuring that they are holistic and funded – community cohesion is broader than counter-terrorism** • **Programs that leverage community anchor and engagement (e.g. COAT) to build community connections** • Address AOD (D and A) in mental health and suicide prevention. Those with AOD issues to auto receive suicide assessment and know where they can get help from etc. • Building string regional identities, "sense of community" – how? Regional approaches • **Older people well enough to live at home but socially disconnected – as a part of community audit – have a lens program (non-religious)** • **Our common humanity** • New dad community groups (Central Coast Blokes with Bubs) • Local govt. requirements housing developed informed design • More home care • On trials/pilots e.g. Collocating childcare and old aged centres- gives value to the experience of older people • Men's Shed, Mr Perfect, Dads group inc, the man walk, average joes, banksia men's table, men in flight, men's circle, complete men, "toment", mentoring men, dads in distress, fathering project, indigenous men's group, camping on country, grab life by the balls, Dad's I'd Like to Friend (DILF) • **Intergenerational play groups** • **Promote and value volunteering e.g. In my workplace we give everyone 2 days (paid)/year for community connectedness** • Build on alternatives to ED for distress • Youth services that support youth without family support • Social groups, settings for young adults in local communities – increase clubs, sports, volunteering, opportunities in youth run	• Start equality in all policy approaches – include LGBTIQ+ in the census and data collection • **Start peer to peer interventions responding to burden-ness (feeling like a burden on others)** • Young peers in evidence-based programs • **Assistance with transition from working life to retirement – e.g. Still in-service groups** • **Facilitating ages care incursions and excursion** • Measuring impacts and outcomes of efforts • Connecting community efforts – reduce duplication and increase impact • Start: developing leadership and advocacy training for LGBTIQ+ people so they can talk openly about mental health and reduce the isolation associated with the experience • Funding local governments to deliver more community cohesion and wellbeing programs • Connection of Men's Sheds mentoring with disengaged or at-risk youth in trades like activities – reduce loneliness in volunteers and increase connection for youth • Providing communities with evidence programmes/resources/tools to use • Social inclusion – look at root causes across cases/cycles for exclusion, discrimination, isolation, disconnection, disadvantage • Create programs which connect people of all ages, abilities, cultural backgrounds to link and connect • **Start facilitating connection in streets/neighbourhoods – how? national street party day** • **Transitional stages in life – leaving school, leaving home, aged care homes leaving work – include as a focus in the development of programs and policies** • City dwellers – surrounded by people who are lonely, time poor – how to address? • Lived experience across community and life cycle • Teaching about personality and emotional intelligence at school at work, in prisons • Media/more responsibility in broadening the ideas of "successful people" • Face-to-face from digital requires buddy/mentor to facilitate • Identifying significant-significant others of high risk 2+ = lower risk, gatekeeper onus • Start investing in early childhood comprehensively – supports, geography • Emotional wellbeing taught in curriculum/safe space provided in schools nationally. • Youth peer support post hospital discharge with the community • Invest seriously in social connection for marginalised cohorts • Have safe urban/community spaces people can enjoy

	• Identifying priority groups – young, old, CALD • Creating more community spaces/investing in activities • **Prioritise respect, kindness, and facilitated social connection in schools** • Look at how communities support each other and seed that into other communities • **Involve local government more in policy and practice in this area – they do a lot already** • Build on community connections, family centres, youth support, adult, elderly • School based projects/programs – build inclusions for LGBTIQ+ students • Existing community, LGBTIQ+ social inclusion programs that work • Events like "mardi gras" – HAY (small rural town) • Community capacity building programs like Thrive NY – building a trauma informed community • How kids can participate in after school activities (without barriers, e.g. cost, transport etc) • CVS/CSN ageing programs • Build on safe schools starting point. It helps. Don't politicise LGBTIQ+ kids and young people • Being explicit about this being a major health and wellbeing issue and start funding prevention and postvention • Investing in strengthening families to support each other	• Have in reach of city groups to aged care facilities • Community hubs and safe spaces • A national PR awareness campaign similar to neighbourhood watch – a community buy-in • Respect and invest in youth participation to build purpose and belonging • Start immediate personal letter to all Australians to ensure they are not alone – "hope is on its way" signed by Prime Minister • Increase role models for LGBTIQ+ people • Working with developers to ensure community connection spaces are included • Promoting intergenerational connection, and support • Services for young teen dads • Consider emerging cultural and social changes and how that affects community