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<td>AIHW:</td>
<td>Australian Institute of Health and Welfare.</td>
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<td>CALD:</td>
<td>Culturally and linguistically diverse.</td>
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<td>CAMS:</td>
<td>Collaborative Assessment and Management of Suicidality is a therapeutic framework to assess and treat patients identified as being at risk of suicide.</td>
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<td>CBPATSISP:</td>
<td>Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.</td>
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<td>CLO:</td>
<td>Community liaison officer.</td>
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<td>Fifth Plan:</td>
<td>The Fifth National Mental Health and Suicide Prevention Plan is a national approach to suicide prevention that spans eight target areas. It covers the period from 2017–2022.</td>
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<td>Gatekeeper:</td>
<td>Central people within a community who are trained to recognise, respond to and support people at potential risk of suicide or who have been impacted by suicide, including those with lived experience.</td>
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<td>LifeSpan:</td>
<td>A nine-strategy systems approach to suicide prevention developed by the Black Dog Institute in partnership with the NHMRC Centre for Research Excellence in Suicide (CRESP).</td>
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<td>National Suicide Prevention Implementation Strategy:</td>
<td>A roadmap for implementation of the Fifth Plan.</td>
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<td>PHN:</td>
<td>Primary health network.</td>
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<td>Suicide prevention trials:</td>
<td>The Black Dog Institute currently supports the implementation of systems approaches to suicide prevention in 29 trial sites across Australia, comprised of:</td>
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<td>YAM:</td>
<td>Youth Aware of Mental Health is an evidence-based suicide prevention and mental health awareness program for young people.</td>
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Introduction

“We are getting stronger and stronger as a sector... I have great hope.”

Tegan Cotterill, Newcastle

In May 2019, the Black Dog Institute hosted a two-day Suicide Prevention Symposium in Canberra. The symposium sought to bring together for the first time the interim learnings from 29 suicide prevention trials that are currently in progress across Australia – 12 national suicide prevention trials, 12 Victorian place-based trials, four NSW LifeSpan research trials and one ACT LifeSpan research trial.

More than 100 trial staff, policymakers, researchers and other sector and community partners travelled to Canberra to share their experiences of working in suicide prevention. The presence of coordinators from all 29 sites helped focus the event on effective, on-the-ground approaches and ‘how to do’ systems, leading to two days of in-depth discussion about the opportunities, limitations and outcomes of systemic suicide prevention activities and the link between suicide prevention activities and policy processes at all levels of government.

Eight sessions, facilitated by Jono Nicholas and Lisa Ryan, combined presentations, panel discussions and group work, supplemented by real-time questions and feedback using the SLIDO online Q&A and polling platform. These sessions make up the chapters in this report.

Discussions spanned priority populations, with a particular emphasis on Aboriginal and Torres Strait Islander experiences; policy and evaluation, including the importance of effective data collection and dissemination; and sustainability, with a particular emphasis on building longevity into suicide prevention workforces.

A number of key themes emerged over the course of the symposium, including:

• the challenges facing Aboriginal and Torres Strait Islander communities, whose need for culturally safe, community-oriented and community-led initiatives isn’t reflected within the constraints of one-size-fits-all government-funded programs

• policy and funding issues, including short-term funding cycles; the emphasis on longer-term, outcomes-driven data as a prerequisite for ongoing funding, despite the fact that site-level findings often provide strong indications of program success; and the challenges of securing financial support for programs with hard-to-measure outcomes

• workforce needs, including the pressures that trial teams, community champions and other suicide prevention workers face in trying to deliver meaningful services amidst budget and time constraints

• barriers to collaboration, including difficulties working effectively with local health services like GPs and emergency departments

• the need for faster, more effective and more responsive data collection processes that recognise the importance of narrative data and prioritise the dissemination of meaningful information for people at the coalface of suicide prevention.

Despite the many challenges that these discussions highlighted, one of the most critical messages to emerge over the two-day period was that of hope – hope for communities impacted by suicide that help was at hand, and hope for people working in suicide prevention that their work was truly making a difference.
The 29 trials that informed the symposium respond to a growing body of evidence that supports a systems approach as best practice in suicide prevention; as such, the trial sites are implementing a range of systems-based frameworks and approaches that have been tailored to meet the needs of their local communities and priority populations.

Among these is the LifeSpan model, a world-class, multi-faceted, systems approach to suicide prevention developed by the Black Dog Institute in partnership with the NHMRC Centre for Research Excellence in Suicide Prevention (CRESP). Today, LifeSpan sits at the forefront of suicide prevention activity in Australia; Black Dog Institute is trialling and evaluating the LifeSpan approach at five trial sites in NSW and the ACT. As an internationally recognised research organisation in the field of suicide prevention, the Black Dog Institute is well positioned to transform the symposium outcomes into a structured, strategic course of action. From here, the Black Dog team will compile the findings of the symposium and prepare a Communique containing the call-to-action and recommendations to be disseminated to government and policymakers in suicide prevention and mental health.
Navigating a systems approach to suicide prevention
Ray Martin (Townsville), Merryl White (Mildura), Tegan Cotterill (Newcastle)

Overview
This session was split into three presentations – one from each site – followed by a discussion on the use of the LifeSpan wheel as a tool for guiding the implementation of a systems approach to suicide prevention. The presentations highlighted the diversity of methodologies among each of the suicide prevention sites, the result of differing geographic areas, priority populations and trial criteria.

Presentations

Ray Martin, Townsville
Priority population: Ex-ADF personnel
The Townsville team is focused on delivering suicide prevention activities for a priority population of ex-Australian Defence Force (ADF) personnel and their families. Called Operation Compass, the trial aims to reduce suicide rates by building connections with ex-veterans and their families who experience social isolation after leaving the ADF. Initiatives include the Check Your Mates campaign, which encourages people to check in with five mates using three simple steps: connect to others, yarn to listen, and motivate to act; as well as a series of community grants-funded projects such as a cycling group, a farming program, and a newsletter for veterans aged 85+. Guided by LifeSpan, Operation Compass will roll out approximately 20 campaigns. Community connection, leadership and communication have been the foundations of success to date.

Merryl Whyte, Mildura
Priority population: CALD community
Mildura is a culturally diverse community comprised of more than 65 nationalities, including a high proportion of Aboriginal Australians, in Victoria. Despite living in a largely harmonious community, Mildura residents report significant levels of social distress and the town has the state’s highest proportion of emergency department admissions for suicide and self-harm. One of the key challenges of trial activity to date has been the lack of available data on suicidality and its impacts in the CALD community, the result of ethnicity not being represented in existing datasets. Broad community consultation has been key to understanding need, particularly within this priority population, as has developing an active postvention protocol. Extensive lived experience expertise remains a fundamental feature of the work, with the team placing trained lived experience volunteers at the heart of decision making, leadership and implementation. Engaging with the media to reinforce available resources for responsible reporting on suicide has increased opportunities for positive public discourse.

“The only way we can identify these individuals is through relationships.”
Merryl White, Mildura.

“The community development aspects (of this work) don’t sit as cleanly with PHNs as we had imagined.”
Merryl White, Mildura
Tegan Cotterill, Newcastle

Priority population: General population

The Newcastle site is the first – and smallest – of the four NSW trial sites taking part in Black Dog Institute’s LifeSpan systems approach to suicide prevention research trial. This trial involves a complete implementation of the integrated LifeSpan model in order to assess the effectiveness of the systems approach. The Newcastle team is delivering suicide prevention activities for the general population; however, with a high proportion of Aboriginal and Torres Strait Islander people located in Newcastle and the surrounding Hunter region, an Aboriginal and Torres Strait Islander Suicide Prevention advisory group has also been established in this and other LifeSpan trial sites to provide input and expertise. Areas of focus include Youth Aware of Mental Health (YAM), gatekeeper training, and supporting the provision of best practice care by health professionals through approaches such as Collaborative Assessment and Management of Suicidality (CAMS). As this trial nears its end, key recommendations include the need for extensive stakeholder engagement and ownership, as well as a need to listen to the community in order to deliver programs that reflect the local context. Mapping out interventions can assist in ensuring that adequate resources are in place before the work starts and keeping aspirations realistic – aiming to be effective rather than ambitious – can help get early wins on the board.

Key themes of discussion

The LifeSpan Model

Discussion around the use of the nine-strategy LifeSpan model highlighted a range of approaches. The Townsville team used the wheel as a modifiable framework, reconstructing it to produce an eight-point version that corresponds to the Operation Compass initiative (detailed previously). In Mildura, the LifeSpan approach provides a map for developing suicide prevention activities, as well as an evidence base that has been critical in securing sector and community engagement. In Newcastle, the model and its evidence base has been a useful tool for communicating critical information to stakeholders and getting everyone speaking the same language.

Money well spent

Panellists were asked where they’d achieved their best return on investment in the trial thus far. In Mildura and Newcastle, lived experience was identified as most critical investment shaping suicide prevention activities. In Townsville, investing in professional communications support was key to creating better access to a target demographic (ex-ADF personnel), whose tendency to reject the system could make them difficult to reach.

Barriers to clinical service interaction

All three speakers identified a need for more streamlined interaction with clinical services, with each site reporting varying degrees of success thus far. The Townsville team have established a close relationship with the local hospital, but high turnover on the steering committee, coupled with challenges in working closely with the emergency department, has resulted in slow progress. The Mildura team has received extensive support from the local hospital but is struggling to gain traction in the general practice setting. In part, this is because of an existing GP shortage in the region that has left current GPs overstretched. In Newcastle, building relationships with emergency departments has been slow going, but local mental health services have been quick to respond to changing suicide prevention approaches. Suicide prevention training for clinicians offered as part of the Newcastle trial has had significant uptake.
Aboriginal and Torres Strait Islander suicide prevention

Presenters: Leilani Darwin (Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention), Chez Curnow (Country South Australia PHN), Vicki McKenna and Rowena Cox (Kimberley Aboriginal Medical Service)

“Throughout the Kimberley region, we continue to hear an echo, a question that’s asked ... so what’s becoming [of], or happening to, our children?”

Vicki McKenna, Kimberley

“This is the first time we’ve ever been given an opportunity as Aboriginal people to do what we know is right. In the past we’ve had projects shoved down our throats and it never works, because there are so many elements missing that should be in place.”

Vicki McKenna, Kimberley

“Strong spirit, healthy people, healthy country. We can’t have one without the other.”

Vicki McKenna, Kimberley

Overview

This session identified the significant challenges of implementing an effective systems approach to suicide prevention for Aboriginal and Torres Strait Islander people. The overarching challenge is the critical intersection of Aboriginal and Torres Strait Islander culture and healing practices with mainstream service models. Cultural considerations, such as language barriers, distrust of government, kinship and tribal protocols, are not embedded in mainstream models. In rural and remote areas, these cultural issues are exacerbated by logistical problems, such as lack of services to support suicide prevention activities, the need to travel substantial distances to implement programs, and small populations that make it difficult to establish a robust and locally led and driven suicide prevention workforce. Further, developing these workforces requires time and funding that isn’t accounted for in mainstream program timeframes.

The session also highlighted the fact that these challenges have long been known to those working in community, and while work has been done to adapt and deliver culturally-responsive models of suicide prevention – work that has been pioneered by the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention - more time and resourcing needs to be committed to the implementation and delivery of these models by Aboriginal and Torres Strait Islander people from the community who have the local knowledge and networks necessary to ensure community buy-in and sustainability.

Further to this, the personal stories shared by Leilani Darwin, Vicki McKenna and Rowena Cox painted an emotionally poignant picture of the human impacts of suicide and related trauma in Aboriginal and Torres Strait Islander communities and the barriers these communities face in making their voices heard. They also highlighted the far-reaching implications of government-run interventions that don’t embed Aboriginal and Torres Strait Islander cultural knowledge or agency at the heart of prevention activities.

The impact and resonance of this session was felt across the Symposium, with 70 per cent of participants who responded to a post-event survey identifying the session as the highlight of Symposium presentations over the two days. Further, the key themes highlighted during these discussions continued to emerge across a range of conversations for the remainder of the two days, demonstrating their far-reaching impacts and implications for suicide prevention activity in communities across Australia.
Presentations

Leilani Darwin, Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Leilani Darwin opened the session with a minute's silence to honour those with lived experience of suicide and those lost too soon. She provided a brief overview of work done by the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) and reiterated that integrated suicide prevention approaches must be community-led and owned. Information was shared with participants on the many and varied key policy documents and frameworks relevant in the mental health and suicide prevention for Aboriginal and Torres Strait Islander communities. In describing CBPATSISP's “true and genuine” partnership with the Black Dog Institute, Leilani provided an overview of the three key documents produced through the partnership that provide a framework for culturally appropriate, safe and informed suicide prevention activities: Indigenous Governance for Suicide Prevention for Aboriginal and Torres Strait Islander Communities (PDF); We are not the problem, we’re part of the solution – Indigenous Lived Experience Project Report (PDF); and Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities (PDF), a companion guide to the Black Dog Institute's LifeSpan Implementation Framework.

Chez Curnow, Country South Australia PHN

Chez Curnow delivered a presentation on the development of an Aboriginal-led after-care service, including coordinated discharge planning, that was integrated into the local emergency department in Port Augusta. This service was developed after early community engagement activities identified a lack of culturally appropriate services for Aboriginal people in the region. Service development was locally led by an Aboriginal reference group with people who had skills in mental health, community and culture, and the service itself is now being delivered by Pika Wiya, an Aboriginal community-controlled health organisation. The inclusion of narrative therapies and trauma-informed care, as well as an understanding of kinship and family models, was critical to the success of this initiative. While the service is now up and running, it required careful and considered consultation over a period of 12 months to bring it to life. Service representatives have asked for additional time to ensure that this work is successful and responsive to community needs and, as such, were happy for Chez to present at the Symposium on their behalf.

Vicki McKenna and Rowena Cox, the Kimberley

Vicki McKenna and Rowena Cox shared their experience of implementing the ATSISPEP suicide prevention model across the vast Western Kimberley in WA, as part of the National Suicide Prevention trial site. These included heartfelt discussions about the extensive challenges, both cultural and logistical, of delivering culturally appropriate, community-led suicide prevention services in the Kimberley. This trial site spans an area of 421 square kilometres across nine locations, with a population of 45,000 people; driving from one end of the site boundary to the other can take up to 12 hours. Vicki described the differences in local cultural groups and languages spoken between locations which adds to the complexity of the work. With genuine consideration of gender and kinship roles, it is culturally inappropriate or impermissible in some circumstances to have one person in a trial site engage with the entire community. Gender poses significant barriers under certain cultural protocols, and the lack of trained male Community Liaison Officers (CLOs) for each language group means that there is a service gap in this population.

Upskilling local community members to build a local suicide prevention workforce has been critical to the success of the Kimberley trial and further ensures the region will have access to relevant expertise beyond the trial period. This was a key outcome and expectation of hiring local CLOs from the trial site communities and providing substantial opportunities for training, development and personal growth. However, local staff also face several challenges to their own wellbeing as a direct result of their involvement, including being the
recipients of community anger towards government-led programs and being on call 24/7. Vicarious trauma of those trained to deliver services may also be induced by the tight-knit personal nature of community, and the proximity to someone who has been lost to suicide. Additional support for Trial Coordinators and CLOs is therefore also an important need in Aboriginal and Torres Strait Islander suicide prevention activities.

Rowena Cox shared with the Symposium delegates her Lived Experience of suicide, and her powerful story of resilience and recovery that led her to work in suicide prevention as a CLO in Halls Creek in the East Kimberley region. Her depth of knowledge, experience and insights into what is needed to address suicide rates in the Kimberley, speaks to the need to further fund and support training of a local Aboriginal and Torres Strait Islander suicide prevention workforce.

Despite what could easily be seen as an unsurmountable challenge, the Kimberley trial site team have been rolling out suicide prevention activities that are based on extensive community consultation and respond directly to community need. These are entirely community led and demonstrate that the trial is, according to Vicki, “the first time we’ve ever been given the opportunity as Aboriginal people to do what we know is right and what will work in our community.”

Key themes of discussion

Timeframes

‘Planning to plan’ – an acknowledgement that the process of building relationships and designing and resourcing interventions is a lengthy process that needs to sit outside existing timeframes – was a recurring theme across all streams of the Symposium and was particularly prevalent in Aboriginal and Torres Strait Islander communities. Providing time for community members to express what is often complex and extensive grief and mistrust of previous failed engagement is a necessary part of the process. For both the Port Augusta and Kimberley teams, building trust as the faces of a government initiative was a slow-going process; ‘growling’, finger-pointing and anger towards the government had to be dealt with before the work could begin, while staff turnover also pushed out existing timelines. Speakers agreed that project timeframes need to be adapted to recognise these challenges. Further, funding should reflect the work involved in building community relationships as these will ultimately enable effective suicide prevention work.

Workforce

An emphasis on community-led programs at the Kimberley site resulted in the establishment of a workforce of CLOs staffed by local language speakers. The benefits of engaging local CLOs included upskilling of local workers, thereby creating a sustainable skillset that will remain in the local community beyond the initial trial timeframe; and an existing rapport within the community – in general, CLOs are already known and respected, although they still face difficulties when promoting government programs in communities that have had negative past experiences.

Challenges include the risk of burnout – despite the fact that they’re paid for 10 hours of work a week, CLOs living in small communities often work around the clock, because “as a local, everyone knows where you live.” In Port Augusta, recruitment of staff for the aftercare service was a drawn-out challenge; community members were wary of getting involved because of the weight of expectation and potential for blame if things didn’t go well. These pressures reinforced one of the recurring messages of the Symposium: that self-care remains vital for everyone involved in suicide prevention service delivery.

Cultural considerations

The Kimberley is home to 28 language groups. In many of these languages, words like ‘suicide’, ‘suicide prevention’ and ‘mental health’ often have very little meaning; instead, the Kimberley team uses the phrase ‘life promotion’, which also emphasises a more positive outlook. Resources and activities that are culturally appropriate and responsive to local languages are needed. Beyond these language barriers, complex kinship and tribal protocols govern communication and interaction within community groups – for example, kinship ties may prevent some men and women...
from speaking to one another. For CLOs who are prevented from speaking to particular people within the community, these protocols can make establishing relationships, building trust and implementing programs a challenging prospect, and may result in an uneven delivery of services that doesn’t always reach the people who are most in need. Funding to increase staff numbers could allow male and female CLOs to provide services across the breadth of the trial site population.

“In our language, the word suicide doesn’t exist. Never has.”

Vicki McKenna, the Kimberley.

Suicide prevention versus crisis support

Identifying a scope of service was critical in Port Augusta to ensure that the after-care service remained focused on fulfilling its remit. Socialising the service and communicating its skills both within the health care sector and the general community was an important step in ensuring that it wasn’t flooded with referrals for general crisis support. In the Kimberley, however, the boundaries were less distinct – CLOs are frequently viewed by community as available to provide support in any crisis. As well as impeding the progress of suicide prevention program implementation, this also places significant pressure on CLOs, who are repeatedly called on to respond to community pain. Engaging with CLOs, services and communities themselves to better draw boundaries around the scope of work could help alleviate some of these challenges.

“As a culture, we’re collectivists, not individual. If something’s not working well then other things won’t work well.”

Leilani Darwin, Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
Embedding activity in the policy context

Lucy Brogden (Chair, National Mental Health Commission Advisory Board), Matthew James (Deputy Director, AIHW), Alison Morehead (First Assistant Secretary, Australian Government Department of Health), Margaret Grigg (Executive Director, Victorian Department of Health and Human Services), Elizabeth Moore (Coordinator General, ACT Office for Mental Health and Wellbeing)

“We all have to get behind a shift to prevention and early intervention.” – Lucy Brogden, National Mental Health Commission Advisory Board

Overview

In this session, panellists provided a brief overview of their roles and organisations as they relate to suicide prevention in Australia. Discussion focused on data, funding and the social determinants of health as they relate to suicide prevention policy.

Presentations

Lucy Brogden talked about the role of the National Mental Health Commission in monitoring and reporting, driving change and ensuring that consumers and carers are well represented in policy development.

Matthew James discussed AIHW’s data collection and management role in the context of supporting national suicide prevention efforts. Current areas of interest include exploring the utility of integrating ambulance data into existing datasets related to suicide, understanding the intersection between suicide data and other demographic factors, and looking at service patterns over the last 12 months for people who die by suicide. AIHW has received funding to create a national suicide surveillance system under the National Suicide Information Initiative.

Alison Morehead broke down government spending on mental health, which includes $4.9 billion from the Federal Government and $5 billion more from the states; $48 million has been allocated to boost to front-line services for suicide prevention and directly address a growing community need. 2020 The Department of Health has since appointed a National Suicide Prevention Adviser role to work between government departments.

Margaret Grigg believes that state and federal governments are all concerned about suicide and that these suicide prevention trials are a symbol of their willingness to work collaboratively towards a solution. A bipartisan approach remains crucial to success. Establishing the National Suicide Prevention Implementation Strategy has been one of the most significant products to emerge from the Fifth Plan and should enable people with lived experience of suicide to have meaningful input into planning processes.

Elizabeth Moore talked about the challenges and opportunities of the new Office for Mental Health and wellbeing in the ACT and its role in driving a whole of government and community approach to health and wellbeing, including suicide prevention. The work is divided into three areas: mentally healthy workplaces and communities; support for individuals, families and carers; and workforce issues.
Key themes of discussion

Data

Access to data remains an ongoing challenge for people working in the field of suicide prevention, as does better use of existing data to better inform activity on the ground. AIHW plans to improve data accessibility with initiatives like secure login portals for PHNs, as well as limited public access; however, future work is required to understand how to use this data for operational purposes. Participants also made reference to Black Dog's existing success in supporting PHNs and communities to harness data for means restriction and planning, through Suicide Audit Reports, and providing ongoing analysis and support to trial sites in how the data can be utilised.

Time lags on data were another critical issue; panellists suggested that spending more on data collection and analysis could assist in removing the time lag currently hampering the dissemination of formal suicide prevention outcomes data. Driving better development and use of dynamic data, improving data monitoring processes and enabling access for localised use could help overcome this gap.

Further, reframing existing approaches to data collection would enable a broader and deeper understanding of suicide and suicide prevention. AIHW is looking to integrate ambulance data with existing datasets and to improve coding for suicidality in emergency department datasets. Narrative data, such as lived experience and case study data, is currently overlooked; combining this rich data with 'clean' datasets could provide a more complete picture of suicide trends and prevention activity outcomes.

Funding

Discussions around funding focused on the extent to which suicide prevention is a priority for government investment. Current funding models are seen to unresponsive to real-world community need and there has been no increase in government funding for suicide prevention since 2014, despite the Mental Health Commission recommending additional investment in this area. Further, there's no clear plan in place for ongoing funding for suicide prevention, although the 5th Implementation Plan will provide a framework that responds to this gap. Investment earlier in the pipeline, rather than in the "ambulance at the bottom of the cliff", is crucial.

Stop-start trial funding remains an ongoing issue – participants want a better understanding of the criteria for ongoing funding and why evidence of success in suicide prevention doesn't guarantee continuing financial support, while social policy initiatives face ongoing funding challenges compared to physical health programs. A strong evidence base combined with an understanding of what works – and why – is crucial in helping government departments to justify their funding decisions; however, this approach puts efforts focused on less measurable areas, such as pre-determinants of health, community connection and development work, at a significant disadvantage.

Participants also expressed frustration about the need to constantly justify programs that are working and the requirement to frame their work in government terms in order to communicate need and success. There was general consensus that governments need to be more accountable for managing the risks that arise during transition and end-of-funding periods.

Social determinants of health

The social determinants of health are increasingly seen to be a driving force of suicide and suicidal behaviour. More than $60 billion a year is spent on mental health and related issues, according to the CSIRO; as such, the underpinning economic and social determinants of poor mental health must be examined. AIHW is conducting a program of work to better understand links between suicide data and demographic factors like income and education, which increasingly appear to play a role in suicide risk. However, understanding social determinants is a challenging proposition to trial, as detailed above.
Key issues in suicide prevention

Group Discussion

Overview

At the end of day 1, participants identified four key issues in suicide prevention to be tabled for discussion. For this session, the first of day 2, they broke into small teams, reporting key findings back to the group.

Key themes of discussion

**Topic 1: Embedding youth-targeted strategies in broader prevention activities**

Participants identified the following approaches to better target youth-related suicide prevention: relationship building in the community as key to building support for program development, providing young people with opportunities for autonomy and leadership that give them scope to bring their friends and peers to the table, and creating opportunities for young people to get involved with the co-design of programs and services that go beyond community consultation. While support is strong in schools, discussions revealed that additional research and support is needed for the 18–25 age group.

**Topic 2: Role of community leaders and champions**

Participants described community leaders and champions as a critically important component of suicide prevention activities, regardless of priority population. Taking time to plan these roles was considered an important first step, followed by careful consideration of how to build sustainability into these roles. Burnout remains one of the key challenges that champions face; establishing a large pool of prospective champions and distributing the work between them could provide some measure of protection. This could further be achieved by moving away from traditional champion ‘types’ to consider who else in the community might be critically engaged – a bank manager, a mayor, a police officer – and by understanding that champions may need different types of support depending on the communities and challenges they’re working with. Having champions at different levels, including some who can sign off on key decisions, could bring greater autonomy to the role.

**Topic 3: Engaging GPs**

Incentivising GPs to increase their engagement with suicide prevention was a recurring theme of this discussion, with governance and systemic issues highlighted as potential barriers. On a day-to-day level, GPs are often stretched and have multiple competing interests; offering funding, continuing professional development points or other training/skill-building opportunities could help build better connections between the suicide prevention sites and local GP practices. Pre-engagement – that is, communicating plans for suicide prevention activity and starting to build relationships before trial activity begins – was also seen to be useful, as was calling on the expertise of the local GP community to provide advisory input into trial activities. Establishing connections within the broader general practice ecosystem, such as with practice managers and other gatekeepers, could provide new opportunities for engagement in this sector.

**Topic 4: The needs of priority populations**

Topic 4 was the most passionately debated topic of the day. Each table group self-selected 1–2 priority population groups to work on, drawing out urgent areas of need to better guide suicide prevention activities within these demographics. Participants identified specific issues for each group, but also teased out some overarching themes that were relevant to all. Key among these were the need for patience; specifically, allowing adequate time for champions to be identified, relationships to be built, and the structures and resources to be identified and embedded before suicide prevention activity can begin. Targeted and inclusive language, as well as data that is both inclusive and reflective of priority populations, was also important in ensuring community buy-in.
Based on individual populations, the following themes emerged:

Aboriginal and Torres Strait Islander populations

Community leadership remains essential to the success of suicide prevention activities in Aboriginal and Torres Strait Islander communities. Resources, programs and other initiatives need to be informed and driven by local knowledge-holders, including elders, and delivered by community members, keeping in mind that the gender of facilitators should respond to cultural and kinship rules. The implementation of activities also needs to be within the recommended Cultural Governance Framework. The input of knowledge-holders with extensive expertise should be appropriately acknowledged and remunerated. Conversations/programs should be taken to community, rather than community being required to travel in order to participate, and language should be an ongoing consideration in all forms of communication with community members. Care must be taken when asking people to repeat personal stories, which can be painful for those with lived experience of suicide and other traumatic events. In the context of Aboriginal and Torres Strait Islander people engaging with clinical services to support their mental health, an existing relationship with the clinician and the gender of the clinician may inform how much individuals disclose in this setting. Continuity of care – that is, the same clinician being available at each appointment – can assist with this.

Rural communities

Meeting the needs of rural communities includes understanding the data and the demographic to engage in population-specific communications; the use of targeted and inclusive language; and identifying champions, attending community groups and engaging with community events. However, additional support is needed to better link suicide prevention into other areas of WHS, to develop resources and rural support information in language that reaches intended audiences, to ensure that services responses are warm and accessible, and to provide more targeted gatekeeper training and education.

Systems structures need to foster partnerships, not competition, between people and organisations involved in suicide prevention and should include funding to build workforce and community capacity, support gatekeepers, deliver community education toolkits and contribute to disaster recovery. More broadly, investments in communications infrastructure would enable better connectivity via mobile phones and internet.

Men

Male outreach workers are critical to successful communication with men and should be considered when identifying champions to reach this priority population; a focus on mateship and peer support between men could be useful tools for facilitating communication. Resources should be developed based on an understanding of how men seek information; for example, the use of high-profile public figures, such as sporting identities, in communications collateral could be as a tool to start conversations, as could programs and events that encourage men to gather socially, such as Mates in Construction or barbeque events. Given that men are often reluctant to accept help, ‘making’ them do so implicitly, such as by embedding information on suicide prevention and help-seeking behaviours into workplace training sessions, particularly in industries that remain largely staffed by men, could enable the communication of critical information.

CALD populations

The role of community is very important for CALD communities, with relationships and champions/leaders identified as essential to ongoing community buy-in. In many cases, the community need will be an unknown; starting these conversations is an important first step. Further, community leaders can drive opportunities for peer support, facilitate introductions to postvention services, and broker connections with relevant organisations, as well as help to frame a culturally appropriate response to service and resource development. Translation and its associated cost should be considered part of the process when working with this demographic.
Evaluating and expanding the evidence base

Dr Fiona Shand (Senior Research Fellow and Research Director for LifeSpan, Black Dog Institute), Dr Sallie Newell (Evaluation Fellow, Sax Institute), Dr Kylie King (Research Fellow, University of Melbourne), Alan Woodward (Strategic Advisor, Quality and Innovation, Suicide Prevention Australia)

“As we go in and ask these questions, we’re going to learn a lot more about the phenomenon of suicide and what and why we’re going to do in response to it.”

Alan Woodward, Suicide Prevention Australia

Overview

This session was focused on the various evaluation processes underpinning the suicide prevention trials.

Presentations

Fiona Shand described the randomised, stepped-wedge approach supporting the LifeSpan NSW and ACT trial design and the importance of evaluation in understanding the efficacy of an integrated approach to suicide prevention. The primary outcome is a reduction in suicide attempts and deaths, and secondary outcomes associated with each of the nine strategies will be assessed. The Black Dog Institute will also conduct an implementation evaluation to compare outcomes across the five trial sites, as well as assess the integration of interventions in the health system. A health economic evaluation is being conducted by Macquarie University. Two key challenges have emerged in the trial process: the time lag in making project data available to the trial site teams so that they can engage their key stakeholders in tracking progress, and not commencing an evaluation of the implementation process early enough. These two issues are now being addressed; outcomes are shared with the sites, stakeholders and collaborators on a regular basis.

Kylie King is involved with the evaluation of the national suicide prevention trials and is also working with the Sax Institute to model the projected impacts of the trial. The process, which began in 2018, has been co-designed with community, including with specific priority populations at each site. The focus on Aboriginal and Torres Strait Islander populations has been much larger than originally anticipated; as such, the research process has been adapted to be culturally relevant, with findings reported back to community.

Alan Woodward is passionate about evaluation. While Alan and his team at Suicide Prevention Australia (SPA) are not leading any of the trial evaluations, they have a vested interest in the trial outcomes on behalf of SPA’s members. Good evaluation is about knowledge creation and purposeful enquiry; in the context of suicide prevention, the focus is on measuring and monitoring change. SPA is funded to deliver an online suicide prevention hub that will include resources around evaluation.

Sallie Newell is part of the collective impact evaluation of the Victorian place-based trial. This process has been split into three phases that were developed in collaboration with the 12 trial sites and guided by an external advisory group; reporting is about to begin on phase 1. As well as collecting quantitative data, the Victorian sites are also bringing together narrative information at both site and state level.
Key themes of discussion

Questions were tabled via SLIDO for the panel to respond to, with two key themes emerging:

Qualitative data provides valuable insights into people who are suicidal or in crisis and has a significant role to play in informing how we understand the impact of suicide on loved ones and carers. Further, qualitative data is an important component of understanding the impacts of services, programs or community/regional approaches.

Case study methods are being used to collect data as part of the evaluation of the National Trial sites, particularly sites with priority Aboriginal and Torres Strait Islander populations. For the Victorian trial sites, the Sax Institute is exploring a Most Significant Change evaluation approach at both site and state level; this process is a structured way of collecting stories to reveal the drivers of change in a community.

Evaluation of the ACT and NSW sites will include a qualitative component of the implementation process that seeks to understand what has changed over time and how that change has come about. Further, a current LifeSpan study of emergency department presentations will include interviews with patients, carers, families and health service providers to help researchers to understand barriers and enablers in accessing high quality care in the emergency department.

Outcome versus activity

Outcomes were identified as a crucial component of ongoing suicide prevention work, but despite this, many PHNs still rely on activity measures in order to progress their work. In Victoria, sites complete quarterly reports that reflect on their progress towards an optimal suicide prevention system, the characteristics of which – locally tailored and partnered, evidenced informed, capably led and governed with community support – have been developed using a collaborative process.

The health and cohesiveness of the regional network or collaborative was discussed as a factor that is likely to have an impact on trial activity implementation and effectiveness. The Illawarra site is using a collaborative health assessment tool (CHAT) that measures how effectively they’re working towards their goals. For the national sites, the evaluation is focus on a Department of Health evaluation framework that describes a number of outcomes and data sources for the evaluation including a suicide ideation scale. The team is also working with the community to understand the outcomes that are important to them.

“We’re very aware of the need to tell the story; the numbers don’t [paint] the complete picture.”

Kylie King, University of Melbourne
Considering sustainability

Alex Hains (Illawarra Shoalhaven Suicide Prevention Collaborative), Vicki McKenna (the Kimberley)

Overview

Sustainability, or the process of building longevity into systems and processes, ensures that suicide prevention expertise remains in communities beyond the trial period. This session combined presentations on sustainability with group discussions on how best to embed sustainability into current trial activity.

Presentations

Alex Hains set the scene for this session with a presentation that described the need for a ‘long game’ mentality for suicide prevention and the importance of continuing to deliver hope in our communities, regardless of the length of the current funding contract.

He also outlined four counterintuitive principles of successful collaboration networks – mission, not organisation; node, not hub; humility, not brand; trust, not control – and encouraged participants to have honest conversations about how these principles might play out in their own collaborative networks.

In reflecting on the work being done in the Shoalhaven, Alex further identified a series of key learnings underpinning his team’s success:

- Focus on the mission, not the contract
- Cultivate and reinforce trust in relationships
- Help people see how they’re contributing to a bigger story
- Translate relationships into systemic practice
- When in doubt, look to the evidence rather than to locally-held truths
- The need for ongoing funding commitments for backbone staffing.

Vicki McKenna provided an Aboriginal perspective on sustainability, reminding participants that suicide prevention remains a long-term challenge for Aboriginal and Torres Strait Islander communities and that long-term responses must be community led. She highlighted the need for a national response to suicide prevention that sits beyond political persuasion and funding cycles and that doesn’t segregate the needs of Aboriginal and Torres Strait Islander people.

“We’re Aboriginal and Torres Strait Islander people, but we’re Australians and this is an Australian crisis.”

Vicki McKenna, the Kimberley

Key themes of discussion

The discussion began with SLIDO responses to questions about sustainability. Collaboration, community, ongoing, funded, shared and commitment emerged as keyword responses to a question about the sustainability of suicide prevention trial activity at a local level, while funding, data time, evidence of outcomes, local evaluations, community champions and commitment, buy-in, and increased Aboriginal and Torres Strait Islander and lived experience workforces were considered critical support and resources to get there.

The policy and planning frameworks that inform suicide prevention activity were variously described as unfolding, siloed and disjointed; too numerous and lacking in cross sectoral focus; and rife with implementation plans that don’t deliver. Participants emphasised that policy should be informed by the work that’s being done on the ground.

Table work

Participants next broke into groups to identify key insights that should inform sustainability in suicide prevention. Each table delivered five key insights back to the group.

Recurring themes included:

**Funding**

Transition phases are needed to support communities as funding cycles end remains critical. Consideration should be given to long-term funding of coordinator roles in order to deliver ongoing support. Lived experience expertise should be remunerated, and coordination and communication around government processes, such as funding timelines, need to be improved.

**Community**

Community engagement should sit at the heart of suicide prevention activity, with tools and resources made available to maintain, upskill and empower community workforces. Evidence-informed, grassroots approaches are crucial, as are initiatives to engage community and support community advocacy, buy-in and ownership.

**Collaboration**

Successful suicide prevention depends on genuine collaboration, including working with local governments and establishing ongoing coordination at both local and regional levels. Building strong relationships and advocacy channels remains an important goal, as does building relationships with other individuals and professions who should be involved with a ‘business as usual’ approach to suicide prevention – these include pharmacists, educators and first responders; PHNs, local health districts and state and federal health departments; and NGOs like Black Dog Institute. Cross-sectoral commitments should be established to enhance partnerships rather than feed competition over funding.
Reflections and learnings

Overview

Ros Garrity from ACT Health provided an overview of the ACT trial, which is currently focused on delivering youth awareness of mental health services to 2000 students over two years, before providing a summary of the key symposium findings over the last two days.

Among these findings, she identified seven recurring themes:

- **Sustainability and the need for ongoing funding**, the use of language that reflects our long-term aspirations in this space, and responsibility to communities and partners to better protect them from short-term nature of funding cycles.

- **Funding approaches** that are realistic and based on the extent of the work that’s required, as well as the orientation of funding towards a prevention approach that’s proactive rather than reactive.

- **Data and data collection activities** that are more dynamic, responsive and effective, coupled with a more purposeful translation of that data into a language that frontline workers can understand.

- **Workforce and the needs and limitations in the context of suicide prevention**. This includes protecting workers who are impacted by the gruelling nature of the job and being realistic about the input we can expect from clinical colleagues – how can we make it easy for them to engage?

- **Collaboration as a crucial ingredient of successful implementation**, including building effective collaborative, system-wide networks that include community engagement.

- **National prioritisation** that positions suicide prevention as everyone’s business.

- **Curiosity and embracing opportunities to do things differently** by looking outward rather than inward – creating supportive environments, building personal skills, shaping public policy and constantly evaluating, as well as looking at other public health models in order to drive change.
Communicating outcomes of the symposium

“The biggest impediment is the access to the ears that will listen to the voices and also our measure of time. How can you put a defined time on building relationships and respect in the community?”

Dwayne Mallard, RUOK? representative and Wajarri-Nunda Yamatji man from Western Australia

Overview

The final session was focused on audience feedback, with a view to shaping a policy response informed by the symposium outcomes. This session highlighted one of the clear themes that emerged over the two-day event: the need to influence, communicate and build understanding among a broad range of audiences and to use that knowledge to shape the long-term funding and policy agenda.

Informing our stakeholders

Participants were asked to respond to a series of questions via SLIDO with a view to informing future stakeholder activity in the suicide prevention space as a result of Symposium discussions.

- Who are the key audiences?
- What do we want to communicate to policymakers?
- What do we want to communicate to funders?
- What do we want to communicate to our communities?
- What do we want to communicate to our researchers?
- What do we want to communicate to sector partners?
- What do we want to communicate to PHNs?
- What do we want to communicate to GPs?

Key themes of discussion

Community was identified as the critical key audience, followed by families, Commonwealth and state governments and departments of health.

Key points for policymakers included the need for adequate timelines for suicide prevention activities, including time to fully understand outcomes. Taking a long-term view beyond the initial trial period was also considered crucial. The work itself, not just the issue of suicide, should be seen as important, and suicide prevention should be understood in the context of the social determinants of health rather than solely as a mental health issue. All levels of government need to get – and stay – involved with suicide prevention, with an emphasis on cross-departmental and cross-sectoral collaboration and backbone support. Place-based approaches are essential, as are community-led approaches in Aboriginal and Torres Strait Islander populations. Learnings and evidence from the current trials should inform future policy in this space.

Funders should be aware that short-term funding does not work in the suicide prevention space. Timeframes for funded trial activities need to be expanded. Explicit, long-term funding of a systems approach to suicide prevention is the way forward. This funding should support a transition period at the end of trial activities, as well as engagement, sustainability and ongoing implementation activities; flexible models are required to achieve this. Funders need to actively listen to community voices and commit to suicide as a national emergency.

The idea of hope was a recurring theme throughout the Symposium and was a resounding message that participants wanted to communicate to communities. Suicide can be prevented, communities can be part of the solution, and those working in the field are in it for the long haul.

Researcher expertise is needed at the local level and PHNs and local collectives require evaluations expertise and to improve their data collection and synthesis processes, as well as their capacity to understand the data and what it says about the trial outcomes in order to put it into action. Further, an
emphasis on evaluation and capacity-building for PHNs would deliver outcomes-based frameworks and activities. Timely data collection and regular feedback is key, as is a focus on outcomes rather than outputs. More collaboration between researchers would be useful to consolidate data and get a better understanding of the scope in which different organisations are working.

Sector partners need to focus on shared suicide prevention outcomes and goals. Collaboration and information sharing remains important, as is integration and co-design of solutions.

PHNs should consider funding grassroots initiatives and to influence, empower and build capacity at an all-important community level – one participant identified community development as ‘a frontier of opportunity’. By embracing creativity and different ways of working, supporting staff and continuing to provide valuable feedback, PHNs can push boundaries in order to work flexibly and embed sustainability in what they do.

GPs should recognise their role in suicide prevention and their capacity to save lives.

Where to from here?

Black Dog Institute’s Director of Discovery and Innovation Nicole Cockayne congratulated participants on the passion, support and progress that defined the last 3–4 years, assuring them their voices had been heard. She then committed to capturing the key messages from the event to share with key government stakeholders in suicide prevention. This approach has borne fruit for Black Dog Institute in the past; findings from the 2015 CRESP Suicide Prevention Summit – specifically, that investment was required in both regional approaches and a systems-based approach to suicide prevention – led to the $15 million in funding from the Paul Ramsey Foundation that enabled LifeSpan’s development – the largest single philanthropic donation for suicide prevention in Australia.

“You are a workforce to be reckoned with.”

Nicole Cockayne, Black Dog Institute