Gold Coast Suicide Prevention Community Action Plan 2020-2022

Gold Coast Health
Building a healthier community

Queensland Government

phn GOLD COAST
An Australian Government Initiative

Need help?

If you are having thoughts of suicide or supporting someone with thoughts of suicide please seek help.

- In the first instance you should contact your General Practitioner (GP),
- If this is not possible or if you think the matter is more urgent, please contact one of the services below
- In an emergency call 000

National 24/7 Crisis Services

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

Mensline Australia 1300 78 99 78

Kids Helpline 1800 55 1800 (24/7 crisis support) 5-25 year olds or www.kidshelp.com.au

National Support Services

Beyondblue 1300 22 4636 or email/chat at www.beyondblue.org.au

Lifeline www.lifeline.org.au/Get-Help/

Suicide Call Back Service www.suicidecallbackservice.org.au

SANE Australia Helpline

1800 18 SANE (7263) www.sane.org

e-headspace for 12-25 year olds www.eheadspace.org.au

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Acknowledgements

Acknowledgement of Country

We acknowledge and pay our respects to the traditional custodians of the Gold Coast region, the Yugambeh speaking people and all their descendants both past and present. We also acknowledge the many Aboriginal people from other regions as well as Torres Strait and South Sea Islander people who now live in the local area and have made an important contribution to the community.

Acknowledgement of Lived Experience

We acknowledge all people who have direct experience of suicide, including those who have attempted suicide and those bereaved by suicide.

The Gold Coast Suicide Prevention Community Action Plan is dedicated to the memory of those who have been lost to suicide and the suffering that suicide brings to our lives. The voice of people with a lived experience of suicide has been essential in the development of the plan. These voices are a valued contribution to the ongoing body of work in suicide prevention.

Acknowledgement of community

We acknowledge and thank the many community members, government and non-government organisations and service providers across the Gold Coast region who have shared their views, their knowledge and expertise, and stories to help shape the plan.

Thank you also to the members of the Gold Coast Suicide Prevention Leadership Group who met regularly between August 2019 and June 2020 to inform and shape the development of the Plan. We feel confident that the dedication and commitment of these passionate members will continue to influence and support the ongoing implementation of this Plan in the Gold Coast region.

Acknowledgement of funding

The development of this Community Action Plan has been funded by the Gold Coast Primary Health Network as part of the Australian Government's response to the National Mental Health Commission's Review of Mental Health Programs and Services.

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How can I be involved?

Everyone has a role to play in suicide prevention. For more information about how you can be involved in the Gold Coast Suicide Prevention Community Action Plan, please contact:

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Foreword

[To be developed]

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Glossary

ACT – Acute Care Team (Gold Coast Hospital and Health Service)

AISRAP – Australian Institute for Suicide Research & Prevention

CAP – Community Action Plan

ED – Emergency Department

ED LinQ – Queensland Ed-LInQ Initiative

GCHHS – Gold Coast Hospital and Health Service

GCPHN – Gold Coast Primary Health Network

GO – Guidance Officer (School based)

NGO – non-government organisation

QAS – Queensland Ambulance Service

QPS – Queensland Police Service

SBYHN – School Based Youth Health Nurse

WMQ – Wesley Mission Queensland

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Introduction

The problem of suicide

Every year over 65,000 Australians make a suicide attempt and in 2017 more than 3,000 Australians died by suicide. Suicide is the leading cause of death for Australians between 15 and 55 years of age and young Australians are more likely to take their own life than die in motor vehicle accidents.[1]

Suicide is a complex issue. Multiple factors are recognised as contributing to suicidal behaviour or someone being at risk of suicide. These include personal hardship, difficult life events, trauma, poor physical and mental health, harmful substance use, poor living circumstances and previous self-harm or suicide attempts. The stigma associated with suicide and mental illness may also discourage many people from seeking the help they need.[2]

The devastating impacts of suicide are immediate, far-reaching and long-lasting. This creates a ripple effect resulting in many people being impacted by or exposed to suicide and the pain it brings. The impacts are felt by families, friends, work colleagues and the broader community, who may struggle to support a person experiencing suicidal behaviour or to cope with the aftermath of a suicide. Suicide attempts and deaths also have a significant impact family and friends, service providers, and first responders such as police and ambulance officers. It has been estimated that as many as 135 people may be impacted by each suicide.[3]

To reduce suicide rates in our community, there has to be a holistic approach from all stakeholders involved including the community in the planning, coordination and implementation of suicide prevention activities that foster supportive social relationships, encourage effective help-seeking and positive connections to good health services available and support family harmony as well sense of purpose and control.

Policy and strategy

Suicide prevention activity in Australia is underpinned by several layers of policy, strategy and plans. The Gold Coast Suicide Prevention CAP has been developed in the context of, and in alignment with the following key global, national and state documents:

- *Preventing suicide: a global imperative*
- *The Fifth National Mental Health and Suicide Prevention Plan*
- *Living is for Everyone (LIFE) Framework*
- *Every Life: The Queensland Suicide Prevention Plan 2019-2029*
- *Suicide Prevention Health Taskforce: Phase 1 Action Plan*

In response to T*he National Mental Health Commission's Review of Mental Health Programs and Services,* the Australian Government outlined a renewed approach to suicide prevention to be implemented through a new National Suicide Prevention Strategy.[4] The Strategy is focused on person-centred care, funded on the basis of need, using a regional approach to service planning and integration, early intervention across the lifespan and strengthening national leadership. In implementing the Strategy, the Government recognises that people at risk of suicide are better supported through the implementation of evidence based and community focussed approaches to suicide prevention. The Gold Coast Suicide Prevention CAP will be implemented in alignment with this strategy.

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The Gold Coast region

The Gold Coast region extends from Coolangatta in the south to Logan and Albert Rivers in the north/north west; and to Tambourine, Mt Tambourine, Canungra and Beechmont to the west, see Figure 1. As of 2018 the Gold Coast is home to an estimated 622,048 people.[5] The population is growing at a slightly faster rate than Queensland and by 2041, the population of the Gold Coast is expected to reach nearly a million people (961,076).[6]

Nearly 10,000 people in the region identify as Aboriginal and Torres Strait Islander (1.7% of the population). The proportion of Aboriginal and Torres Strait Islander people in the region is lower compared to Queensland. However, within the region Coolangatta has the largest percentage of Aboriginal and Torres Strait Islander persons (2.3%) and Ormeau-Oxenford has the highest number of Aboriginal and Torres Strait Islander residents, a population that has almost doubled since 2011.

The Gold Coast region is characterised by high tourist numbers drawn to the beaches and attractions. Additionally, the Gold Coast resident population is slightly more transitory compared to Queensland attracting residents from interstate as well as overseas. 28% of Gold Coast residents were born overseas and more than half of these residents come from English speaking backgrounds.[7]

Figure 1: Map of the Gold Coast region

Suicide in the Gold Coast Region

Queensland context

Suicide is a leading cause of death for Queenslanders age 15-44. In 2017 804 people died by suicide. Men are more than three times likely to die from suicide than women and suicide rates for Aboriginal and Torres Strait Islanders are double the rate of the general population. Over the past decade, suicide age standardised death rates in Queensland have remained higher than the national rate. In 2017 the standardised death rate by suicide was **16.3** deaths per 100,000 people in Queensland, compared to a national average of **12.6** deaths per 100,000 people.[8]

Prevalence of Life events

Data from the Queensland Suicide Register identified the prevalence of life events among people who died by suicide (2011-13). Relationship separation was the most frequently recorded life event (27%) among all ages and for both women and men. This was followed by relationship conflict (15.5%), financial problems (14.9%) and bereavement (13.9%).[9]

Services that support people struggling with relationship and family breakdowns, financial problems and bereavement are therefore essential elements of the suicide prevention system.

Age standardised suicide rates per 100,000 (2017)

Prevalence of life events in Queensland suicide cases (2011-2013) [10]

Relationship seperation (27%)

Relationship conflict (15.5%)

Financial problems (14.9%)

Bereavement (13.9%)

Familial conflict (10.3%)

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Gold Coast data

A significant challenge for suicide prevention work is access and availabiltiy of current regional suicide data. The last comprehensive report *Suicides in Queensland: Mortality Rates and Related Data 2011-2013*, was published in 2016. According to this report:

- The Gold Coast age-standardised suicide rate (13.7%) is consistent with Queensland rate (14.0%) but is greater than the national rate (10.7%)
- Males were more than twice as likely to suicide then women and accounted for over 70% of suicides
- People aged 35-54 years accounted for almost 50% of all suicides
- Women aged 35-44 and 65-74 had some of the highest rates of suicide in all regions of Queensland.
- Hanging (46.7%) and poisoning (19.1%) are the most common methods of suicide.[11]

In 2019, 2,050 people presented to Gold Coast public Hospitals Emergency Departments for suicidal ideation. This number has slightly increased from the 2018 figure of 2,025.[12]

Mental Health and Alcohol and other drugs

Underlying mental health and alcohol and other drugs issues are frequently associated with suicide attempts**.**

Compared to national and state rates, the Gold Coast region had higher rates of people accessing MBS GP mental health-related services. In 2018, there was a total of 7,847 mental health-related ED presentations to Gold Coast Public Hospitals with 51% being Males and 49% Females. This is an average of 150 presentations per week.[13]

In 2017-2018, 5,088 people on the Gold Coast sought treatment for alcohol and other drug issues.[14] While drug and alcohol hospitalisation rates are lower than national rates, Coolangatta, Gold Coast-North, Southport and Surfers Paradise were above the national rate. Alcohol intoxication was the leading mental health related ED presentations in 2018 to Gold Coast Public Hospitals.[15]

Impact of COVID-19

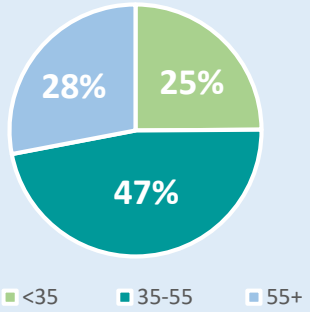
During the drafting of this Plan, the global coronavirus pandemic has significantly changed the world as we know it. We anticipate that the significant social and economic impacts of Covid-19 will contribute to an increase in demand for crisis and mental health services and an increase in numbers of suicidal presentations. More than ever, while we are all practicing social distancing and isolated in our homes, we need to continue to work together, maintain connection and build a strong community safety net that is ready to embrace new ways of working together.

GOLD COAST DATA 2011-2013

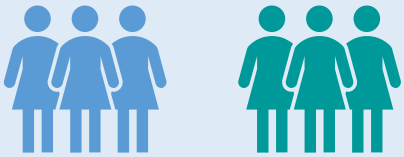
Age standardised rate of suicide 2011-2013

Men are twice as likely to die by suicide than women

Most suicides are in the 35-55 year age group



Gold Coast women have some of the highest rates of suicide in all regions of Queensland.



35-44 years (14.4)

65-74 years (15.9)

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Background and development of the Community Action Plan (CAP)

The development of the CAP was undertaken as part of the joint initiative between Gold Coast PHN and Gold Coast Health to develop a Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and other drugs in response to the new Suicide Prevention Strategy outlined by the Australian Government.

In approaching the development of the CAP, we wanted to ensure that our actions were evidence-based and built on an evidence-based framework. The **LifeSpan Framework** developed by the Black Dog Institute sets out actions across nine evidence-strategies was adopted to guide and underpin this work.

Gold Coast Suicide prevention leadership group

In August 2019 a Suicide Prevention Leadership Group was formed to provide advice and leadership for the development of a regional suicide prevention plan. The group included people with a lived experience of suicide, and representatives from Gold Coast Health, Gold Coast PHN, Gold Coast emergency services, suicide prevention service providers, Care for Life Suicide Prevention Network, Aboriginal and Torres Strait Islander service community, LGBTI community services, Alcohol and Other Drug services, and General Practice.

Between August 2019 and June 2020 the group met together eight times to determine local needs, outcomes, actions and priorities.

Mapping the current response

The CAP identifies key pieces of work that are currently happening or already planned for in the Gold Coast region across each of the nine life Span strategies, these actions are also included in the CAP as current and ongoing actions. The current response table provides a snapshot overview of this work and helps us to identify development opportunities. It is important to note however that the evidence supporting each LifeSpan strategies is not equal and that we should continue to return to the evidence base when planning and prioritising new activities.

A living, breathing document

From the outset in must be acknowledge that the list of actions identified within this CAP are aspirational but not exhaustive. We acknowledge that many of the actions and suggestions that have been put forward in this CAP are not able to actioned at this time. Suicide is a complex issue and therefore requires a complex all of community response united in purpose and vision. We recognise the need to continue to actively engage community and other sectors in this work in order to further progress these actions. As resourcing and leadership emerges and develops, we will be able to revisit these actions. This means that the CAP will grow and change in response to community need, resourcing and leadership. The CAP is a **foundational plan** and our starting point but it is very much a living breathing document.

Prioritisation and scope of the plan

This Gold Coast Suicide Prevention CAP is a **two-year plan**. Actions shaded in grey indicate all actions that are currently outside the scope of this plan and require additional resourcing, information and/or leadership. As this becomes available these actions can be added or revisited.

In addition, the SPLG used a prioritisation matrix to assess each action according to the difficulty of implementation and the degree of impact, see Figure 2. While we acknowledge that there are limitations in the application of this matrix, this prioritisation may be useful when considering new actions to include when the plan is being reviewed and updated.

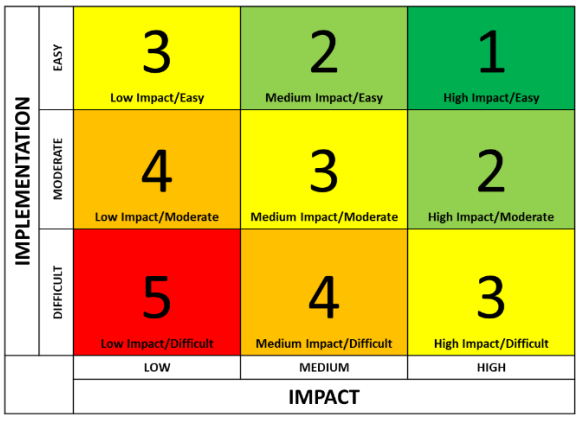

Figure 2: Prioritisation matrix

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Community input into this Action Plan

The development of the Gold Coast Suicide Prevention Community Action Plan builds on knowledge and feedback gathered from previous consultation activities including identified local health needs, service issues and priorities. From April 2019-June 2020, consultation and engagement activities have included ongoing face to face co-design, consultation and email communication as well as attendance at meetings and workshops through existing groups and governance structures, local events and workshops, targeted consultation with key stakeholder, and applying learnings from National and State consultation, see Figure 3.

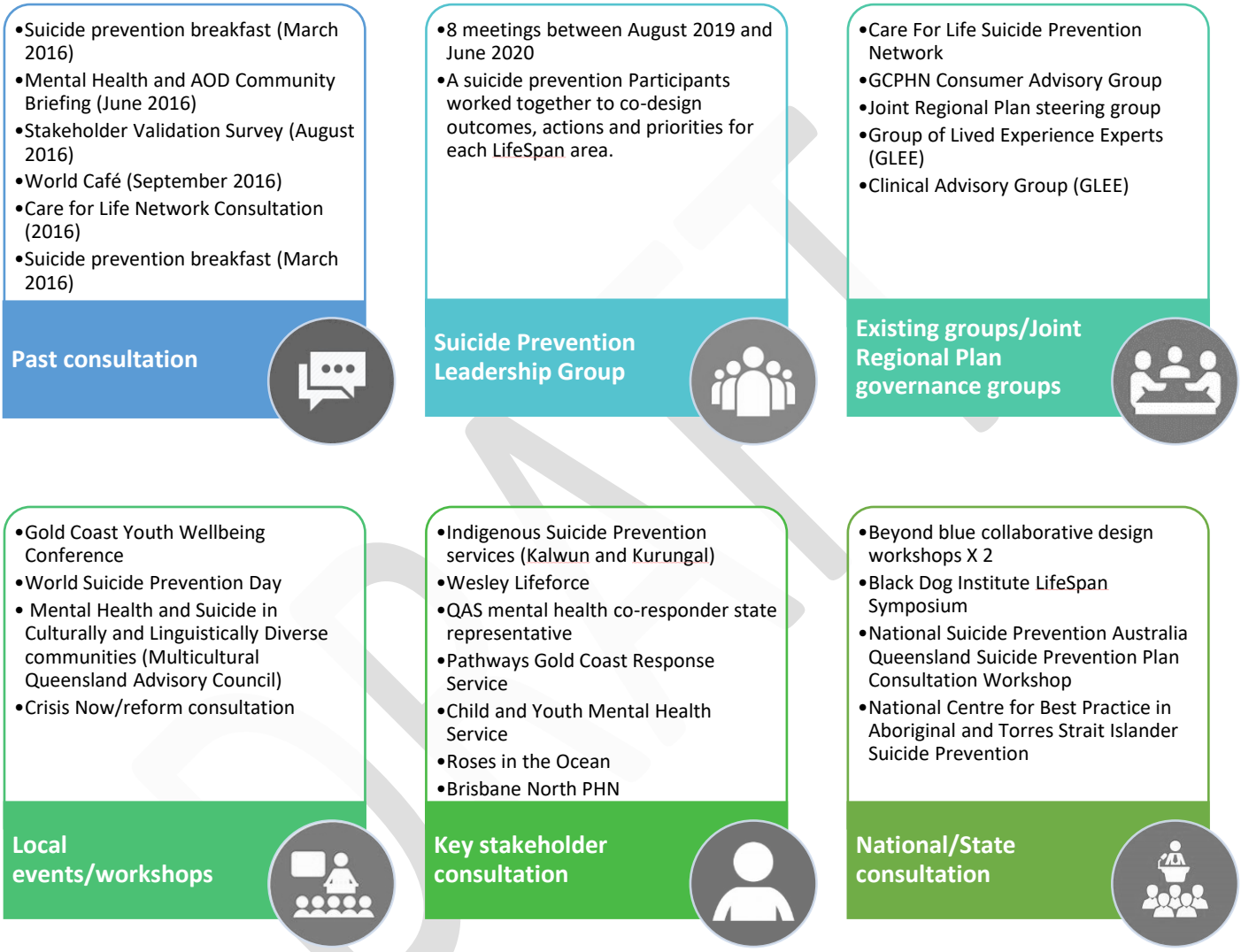


Figure 3: Suicide prevention consultation and engagement activities from 2016 as undertaken by Gold Coast PHN and Gold Coast Health

How will implementation and progress of the CAP be monitored?

A suicide prevention implementation group will be formed to lead actions prioritised as part of the Gold Coast Joint Regional Plan. In the short term, this implementation group will also provide governance of the Gold Coast Suicide Prevention CAP.

Approach: LifeSpan Framework for Suicide Prevention

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) commits all governments to a system-based approach which focuses on the 11 elements of the *WHO Preventing suicide: A global imperative*. The LifeSpan framework aligns well to these elements and provides a new approach for integrated, regional suicide prevention in Australia and compliments the Zero Suicide framework that is being implemented within the Gold Coast Health system.

Lifespan involves several key components:

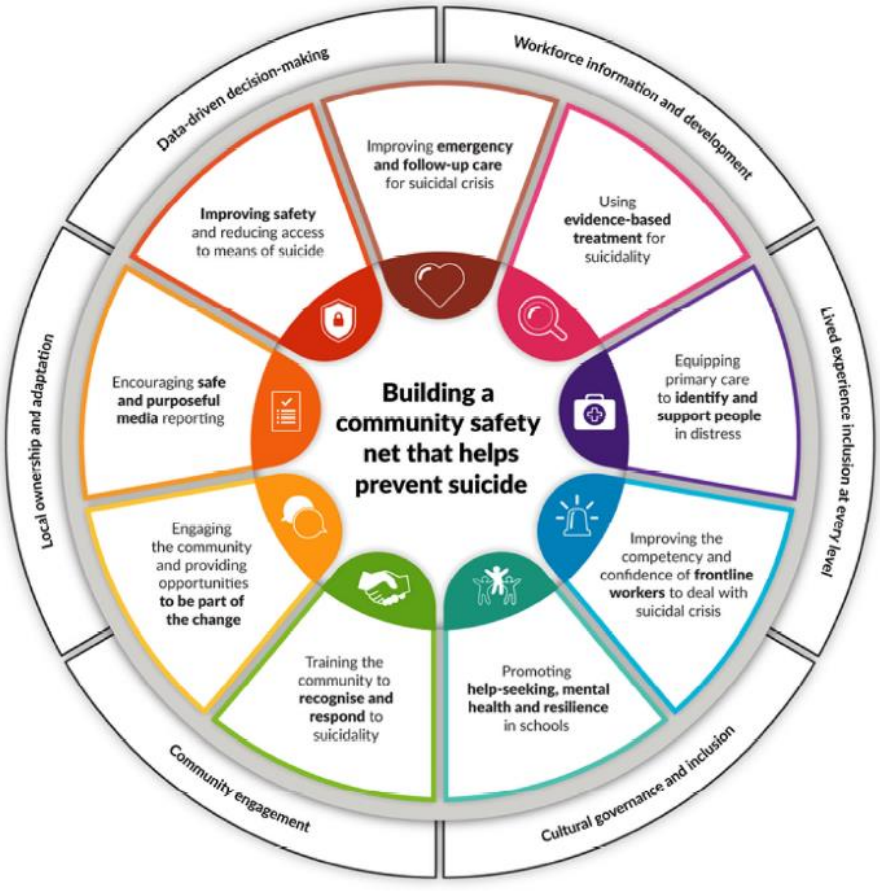
- The inclusion of the nine evidence-based strategies, targeting population to individual- level risk
- Simultaneous implementation of all nine strategies within a localised region
- Use of best evidence-based programs and interventions within each of the nine strategy areas, as suitable for the local region and adapted or suited to the target population
- Governance at a local level (integration of non- government organisations (NGOs), primary health care networks, local health districts, education, police and community groups to coordinate action)

Recognising that multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of its parts, the model is data driven and evidence-based, helping to raise the bar in suicide prevention.

Using the LifeSpan systems approach, estimates suggest it may be possible to prevent 20% of suicide deaths, and 30% of suicide attempts**.**

In addition, the Life Span framework compliments the Zero Suicide framework that is being implemented at Gold Coast Health as part of the regional health system's reform to suicide prevention.

For more information about LifeSpan and each of the strategies go to:
https://www.blackdoginstitute.org.au/research/lifespan



Current response: Gold Coast Suicide Prevention Activity 2019-2020

	Strategy	GCHHS	GCPHN	Gold Coast Community
	Improving emergency and follow up care for suicidal crisis	MH Acute Care Team, Suicide Prevention Pathway Mental Health Co-responder model with QPS and QAS SBYHN, Ed-LinQ Crisis reform initiative	LOTUS The Way Back Service	Crisis lines: Lifeline, Beyond Blue, Suicide Call Back Service, Bereavement support: Pathways Gold Coast Response Service, Bereavement support group and Bereavement resource Student Support Services in Schools Carer Support Program
	Using evidence-based treatment for suicidality	Brief interventions e.g. safety planning and Pisani Model Research trials (Dr Chris Stapleberg) Comprehensive mental health service and treatment for co-morbidities	Psychological Service Providers (PSP) – Suicide Prevention stream PSP training with GCHHS	Private Psychologists, Mental Health Professional Network (GCMHPN), University partnerships - Bond University & Griffith Uni
	Equipping primary care to identify and support people in distress			Wesley Lifeforce, Assist training, Mental Health First Aid Training (MHFA) Mental health skills training for GP Focussed Psychological strategy training for GPs
	Improving the competency and confidence of frontline workers to deal with suicidal crisis	Zero Suicide Mental Health Co-responder model (QPS, Gold Coast Health, QAS)	PSP training with GCHHS	Wesley Lifeforce, Assist training, Mental Health First Aid, Youth Mental Health First Aid Carer's Mental Health First Aid, Queensland Centre for Mental health Learning training
	Promoting help-seeking, mental health and resilience in schools	SBYHN, Ed-LinQ, CYMHS		HeadSpace in schools, Youth Info Card and App, Ohana for Youth, BeYou, Curriculum/HP programs, Social & Emotional Learning packages (Respectful Relationships)
	Training the community to recognise and respond to suicidality			Wesley Lifeforce Training, SafeTalk, Assist Mental Health First Aid, Indigenous Mental Health First Aid, Marcus Mission (Men)
	Engaging the community and providing opportunities to be part of the change			World Suicide Prevention Day, Candlelight Vigil/Out of the Shadows, GC Suicide Prevention Service Finder Card, Youth Info Card and App, MH week, GC Youth Wellbeing Conference, Headspace Youth Advisory Group, Marcus Mission
	Encouraging safe and purposeful media reporting			MindFrame website (national)
	Improving safety and reducing access to means of suicide			

Gold Coast Suicide Prevention Community Action Plan (CAP)

Our Vision

The people of the Gold Coast live life with meaning and purpose within a compassionate, connected, and diverse community. (JRP Vision)

Our Mission

Working together, using the Life Span framework, to prevent and respond to suicide in the Gold Coast community.

Our Values – The way we will work together

The outer wheel of the LifeSpan wheel contains key six values. The Gold Coast Suicide Prevention CAP recognises key outcomes for each of these values, recognising that that are the foundations that support successful implementation of the Plan.

Data driven decision making	•Better picture of how we are responding, what's working and what's not
Workforce information and development	•Consensus on miniumum training requirements for different industries/levels of workforce •A capable, responsive, confident, compasssionate workforce
Lived Experience at every level	•Incusion of lived experience at every level from individual throught to policy and throughout the project cycle from planning to evaluation
Cultural governance and inclusion	•Culturally safe services for everyone •Groups impacted will be involved in decision making
Community engagement	•Community voice is heard and included •All diverse members coming along on the journe with us and empowered
Local ownership and adaptation	•Motivated individuals and sustainable momentum •Agreed community resonse responding to changing needs (i.e. a Community Action Plan)

Understanding the timeline and prioritisation of actions in this CAP

The timeline for actions are categorised as follows:

- **Current and ongoing –** work/activity that is already planned or underway
- **ST** – Short term (within 1-2 years)
- **MT** – Medium term (within 3-4 years)
- **LT** – Long term (in the next 5+ years)

Priorisation of actions are categorised on a scale as follows:

0 – current and ongoing work
1 – Highest priority (High Impact/Easy to Implement)
5 – Lowest priority (Low Impact/Difficult to Implement)

For more detail, please refer to the prioritisation matrix on page 10.

0 Working together

LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis.

Successful implementation of this CAP requires a shared vision and understanding of the issues we are trying to address, building trust with key stakeholders, supportive infrastructure and governance to oversee, drive and monitor the plan, and to ensure that actions are coordinated to contribute to outcomes outlined in the plan.

❖*Indicates JRP priority actions*

Working together

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*
W.1. Oversight, coordination and governance of the Community Action Plan	**W.1.1** A Suicide Prevention implementation group is developed that is sustainable financially and structurally, with strong regional relationships and demonstrated commitment to regional suicide prevention goals in the CAP and Joint Regional Plan.	• Identify appropriate governance structure • Develop and maintain terms of reference • Develop role descriptions • Frequency and feedback/reporting mechanisms are agreed and scheduled • KPIs for RAG status reporting developed.	ST	TBD
W.2 Progress of the plan is tracked and reported	**W.2.1** The CAP implementation group will meet four times per year to monitor progress and implementation of the CAP actions.	• CAP implementation group meets quarterly	ST Quarterly	TBD
	W.2.2 Responsible officers will report four times per year on the implementation of CAP actions to the Suicide prevention Implementation group.	• RAG status reporting on implementation of CAP actions.	ST Quarterly	TBD
	W.2.3 Monitor and report on progress of CAP actions to funding/commissioning bodies.	• An annual progress report is developed and distributed.	ST Annually	TBD
	W.2.4 Explore local research capability for future in-depth analysis and evaluation of the CAP.	• TBD	MT	TBD
W.3 Lived Experience inclusion at every level	**W.3.1** Endorse and apply the Black Dog Institutes Lived Experience Framework to Framework to guide regional engagement of Lived Experience against each LifeSpan strategy.	• Activity register and type of engagement	ST	GCPHN/GCHHS

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1 Improving emergency and follow up care for suicidal crisis

A suicide attempt is the strongest risk factor for subsequent suicide. To reduce the risk of a repeat attempt, a coordinated approach to improving the care of people after a suicide attempt is required.

Coordination of care is highly complex and emergency departments are high-pressure environments with staff that are time and resource poor. Unfortunately, current protocols are often not implemented and people who are treated in emergency departments for suicide attempt often don't receive the care and support they need to recover. Additionally, evidence shows that it is the experience rather than strict adherence to a protocol that can make the difference between good and poor care. When vulnerable people seek help, services need to make them feel welcome.

Current state
Issues that you told us about

- *People who present in ED for suicidal thinking or attempts don't receive the care and support they need. This may be related to staff experience and skills to deal with suicide crisis.*
- *Suicide risk is greatest immediately after discharge from an emergency department or psychiatric ward and remains high for up to 12 months following the attempt*
- *Those who are bereaved by suicide have an increased risk of suicide.*
- *People who present in ED for suicidal thinking or attempts don't receive the care and support they need. The ED environment can be fast paced and traumatising environment.*
- *Service eligibility criteria/thresholds often limits access to services. In addition, many services do not provide afterhours support.*
- *Police and ambulance may not have the level of experience/skills or time to deal with mental health related call outs effectively.*
- *Current resource material is outdated to changes in the sector*
- *Provide training to workforce and carers/family*

❖ *Indicates JRP priority actions*

1 Improving emergency and follow up care for suicidal crisis

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
1.1 People in crisis receive timely and appropriate care and support.	**1.1.1** Support the crisis reform initiative and relevant actions where appropriate including options to: → Improve prioritisation of suicidal presentation through ED – R U OK triage? → Provide safer spaces within ED to respond to people in distress e.g. Living Edge at Redcliff Hospital	• Participation in crisis reform consultation • Attendance and contribution at meetings as required	Current and ongoing	SP Implementation group.	0
	1.1.2 Continue to progress crisis reform initiative	• Quarterly progress reports indicate	Current and ongoing	GCHHS	0

1 Improving emergency and follow up care for suicidal crisis					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
		project is on track			
1.2 Zero Suicide guidelines are implemented, and suicide prevention training is provided to emergency department (ED), hospital staff and frontline workers within GCHHS, including peer support workers.	**1.2.1** Continue to implement Zero Suicide at GCHHS	• GCHHS to advise (e.g. evaluation report)	Current and ongoing	GCHHS	0
1.3 Mental health expertise is included to respond to mental health related call outs with first responders.	**1.3.1** Continue to implement and trial a Mental Health Co-responder model	• Progress reports and learnings are shared • Diversions from ED • Connections/linkages to other supports/services	Current and ongoing	GCHHS/QPS/QAS	0
1.4 A dedicated aftercare service is accessible across the region to provide follow-up care for those who have made a suicide attempt and includes continuity and coordination of care.	**1.4.1** Continue to implement the Lotus program.	• Program level data • Client satisfaction	Current and ongoing until The Way Back funding has been approved.	GCPHN/Wesley Mission Queensland	0
	1.4.2 Implement The Way Back Support Service (TWBSS) in partnership with Queensland Health and Beyond Blue.	• Program level data • Client satisfaction • Partnership feedback	ST July 2020 - June 2022	GCPHN and NGO service provider	0
1.5 People affected or bereaved by suicide (particularly families and carers) are provided with supports.	**1.5.1** Continue to implement the Pathways Gold Coast Response Service (for bereavement)	• Program level data • Annual service report and update.	Current and ongoing	Lifeline/QPS	0
	1.5.2 Maintain and promote a suicide bereavement resource that is updated annually.	• Resource is reviewed and updated annually • A register is developed that includes where these resources are distributed/available and	Current and ongoing	CFLSPN	0

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1 Improving emergency and follow up care for suicidal crisis					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
		who is responsible.			
	1.5.3 Continue to provide a suicide bereavement support group	• Program level data (frequency, attendance, satisfaction)	Current and ongoing	Lifeline (Uniting Care)	0
	1.5.4 Co-design, trial and evaluate a Carer's Support Program for carers of individuals who have made a suicide attempt or are in suicidal crisis. ❖	• Quarterly progress reports • Evaluation findings	ST 18-month trial commencing January 2020 and to be completed by	WMQ/Roses in the Ocean/Beacon Strategies with funding from Queensland Health	0
	1.5.5 Identify and map services that could offer relevant support/service offerings for families and carers and explore referral pathways to/from these services. ❖	• Resource is developed for carers	ST	GCPHN in partnership with WMC Carer Support Program?	3
1.6 People and services who are supporting others in crisis have access to up to date and relevant information.	**1.6.1** Update current resource packs at GCHHS and review annually. ❖	• Updated resource packs are distributed to Carers • Resource packs are reviewed and updated annually	ST 2020 and reviewed annually	GCHHS Carers and Consumers?	0
1.7 Service providers and community are aware of crisis support services to the Gold Coast community (see 7.6)	**1.7.1** Maintain a Gold Coast Suicide Prevention Service Finder which includes 24 hour crisis support, counselling and support services	• A resource is maintained and distributed • Distribution register is maintained	Current and ongoing (updated every 2-3 years) last updated in	CFLSPN	0
1.8. People in distress are supported in the community without the need to go to ED/ACT	**1.8.1** Co-design and commission a model of care to address distress in the community. ❖	• Service is designed and implemented • Program level data • Quarterly progress reports	ST 2020-2022	GCPHN	0

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2 Using evidence-based treatment for suicidality

Mental illness, including depression, is associated with a large portion of suicide attempts. Providing accessible and appropriate mental health care is essential to suicide prevention.

Central to this is ensuring mental health professionals are aware of the latest evidence and best practice care and treatment options. Information sharing between care providers also needs to be enhanced.

Current state
Issues that you told us about

- Mental illness, including depression, and trauma are associated with a large portion of suicide attempts
- Currently we don't know enough about what evidence-based treatments are being delivered, by whom or what the quality of these services is
- Mental health professionals are not aware of the latest evidence and best practice care and treatment options for suicide.
- The Gold Coast has some of the highest use of MBS billings in the country for the private sector but we don't know much about who is accessing services or what services are available and the quality of these services.
- The Gold Coast has one of the busiest EDs in Queensland, a large percentage of these are people presenting with mental health issues.
- There is a lack of urgency for evidence-based treatment options to address suicide within the mental health sector.
- For the 2017-18 period, 36% of all referrals to GCPHN's Psychological Services Program were made through the suicide prevention stream accounting for 54% of all sessions delivered.

❖ *Indicates JRP priority actions*

2 Using evidence-based treatment for suicidality

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
2.1 Evidence based treatments for suicidality are available within publicly funded health services.	**2.1.1** Continue to provide a specific suicide prevention stream within GCPHN's Psychological Service Providers	• Program level data • Client satisfaction • Client experience	Current and ongoing	GCPHN	0
	2.1.2 Review the Psychological Services Program Suicide Prevention Stream to ensure evidence-based treatments are delivered and targeted to the right individuals. ❖	• Evaluation report	ST By June 2021	GCPHN	0
	2.1.3 Continue to provide a comprehensive mental health service and treatment for co-morbidities at GCHHS which includes brief interventions	• GCHHS data • Client satisfaction • Client experience • Initial mapping to NMHSPF tool • JRP progress updates	Current and ongoing	GCHHS	0

2 Using evidence-based treatment for suicidality					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
2.2 Shared knowledge and increased awareness of evidence-based treatments and effective supports for suicidality amongst service providers.	**2.2.1** Provide training to GCPHN's Psychological Service Providers to increase knowledge and understanding of the GCHHS Suicide Prevention Pathway	• Frequency, Attendance • Training feedback	Current and ongoing	GCCPHN/GCHHS	0
	2.2.2 Identify and promote shared learning opportunities to: • Increase knowledge of suicide prevention research • Share about effective interventions including from the perspectives of lived experience; and • Create awareness about local services, supports and referral pathways.	• Number of activities • Attendance • Participant feedback	ST	GCPHN/GCHHS	0
	2.2.3 Provide or commission training on specific evidence-based interventions to address local needs.	• Frequency • Attendance • Training feedback (Pre-Post tests)	MT	GCPHN/GCHHS	3
2.3 Gold Coast region actively contributes to the knowledge and evidence base for treatment of suicidality.	**2.3.1** Undertake a randomised control trial to assess effectiveness of brief interventions for suicidality.	• Updates are provided • Early findings are shared • Research is published • Presentations at conferences etc.	Current and ongoing?	GCHHS/Bond University	0
2.4 Cross sector understanding of the urgency for suicide prevention and evidence-	**2.4.1** Cross sector training on basis for suicide prevention in the region including: Just culture, shared	• Frequency • Attendance • Training feedback	MT	GCPHN/GCHHS	2

DRAFT

2 Using evidence-based treatment for suicidality					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
based treatment options.	language, principles, current approaches to suicide prevention and treatment, pathways for referral.				
2.5 Better understanding of the private sector capacity and response to suicidality.	**2.5.1** Conduct a regional review of interventions delivered in the private sector to address suicidality.	• Outcomes of review	MT/LT	GCPHN/GCHHS and Governing bodies.	TBD
2.6 Consumers/ family are presented with options so that clients can make informed choices about their own care.	**2.6.1** A resource is created to inform clients about evidence based options and supports available to them, eligibility criteria etc.	• TBD	TBD	TBD	TBD

DRAFT

3 Equipping primary care to identify and support people in distress

Suicidal individuals often visit primary care providers in the weeks or days before suicide yet many do not mention their suicidal thoughts to their doctor or if they do, they often don't receive the care and support they need. There are many reasons for this including fear, stigma and time pressures. Many GPs are unaware of referral points and current best practice care and treatment. Encouraging evidence-based practice and greater integration with other services is critical. Capacity building and education for GPs is one of the most promising interventions for reducing suicide.

Current state

Issues that you told us about

- GPs encounter numerous barriers and competing priorities which impacts GP uptake and access to suicide prevention training.
- Traditional GP training does not necessarily equip GPs with the skills and confidence to address mental health concerns and suicidal ideation.
- Many GPs are unaware of referral points and current best practice care and treatment.
- Issues with GPs being able to access forms for referral pathways other than MHCP e.g. Psychological Service Providers.
- When describing their experience of care, consumers frequently express a lack of empathy and compassion from primary care providers.

❖ *Indicates JRP priority actions*

3 Equipping primary care to identify and support people in distress					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
3.1 Primary Care providers are supported to identify and respond to individuals in distress or at risk of suicide.	**3.1.1** Review application of learnings from the Distress Brief Intervention model being implemented in Scotland. ❖	• Recommendations from review	ST	GCPHN	3
	3.1.2 Continue to implement GP 6-month Mental Health training rotations for trainees and explore opportunities to further promote.	• Increase in number of GP trainees in MH rotation.	ST	GCHHS/University	1
	3.1.3 Identify most appropriate evidence-based training for suicide prevention that promotes a shared understanding and a more standardised approach across the region.	• Training recommendations are developed and accessible to GPs and the general public	MT	TBD	3
	3.1.4 Explore barriers to participation and potential incentives/opportunities to support GP training.	• TBD	MT	TBD	3
3.2 Primary Care providers can recommend a	**3.2.1** Promote use of e-MHprac. ❖	• Number of communications to Primary Care	ST	GCPHN	2

DRAFT

3 Equipping primary care to identify and support people in distress					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
range of supports and know where to refer individuals in distress.		that include e-MHprac			
	3.2.2 Referral pathways for suicide support services will be minimised to increase accessibility. ❖	• TBD	TBD	TBD	3
	3.2.3 Support clear/warm referral pathways to non-clinical options (e.g. Active and Healthy, employment, housing etc.) ❖	• TBD	MT	TBD	2
3.3 There is a more consistent approach to intake, assessment, and referrals.	**3.3.1** Contribute suicide prevention perspective to develop a shared understanding and vision for central intake for the region as part of the Joint Regional Plan.	• Participation in consultation processes	MT	Suicide prevention Implementation Group.	3
3.4 Primary Care providers are supported to follow up with people who have presented in distress	**3.4.1** Explore use of Primary Sense data to provide timely follow-up with individuals who have presented in distress. ❖	• Use cases and feasibility	MT	GCPHN	3
3.5 Mental Health leaders in Primary Care can be easily identified by the community.	**3.5.1** Identify and mark GPs who are mental health friendly or who have a special interest in mental health.	• TBD	TBD	TBD	5
3.6 People in distress have a positive experience in Primary Care settings.	**3.6.1** Train primary care workers in compassionate care and safe language.	• TBD	TBD	TBD	5
	3.6.2 Explore MH Nurses embedded in Practices or Team based care coordinators.	• TBD	TBD	TBD	3

DRAFT

4 Improving the competency and confidence of frontline workers to deal with suicidal crisis

The interactions a suicidal person has with frontline workers such as Police, paramedics and emergency department staff, can influence their decision to access and engage with care. Frontline workers can play a key role in de-escalating a crisis and improving safety. However, existing training may not include the latest emerging research and skills require periodic refreshing.

When vulnerable people seek help, frontline staff need to make them feel safe and heard. Evidence shows that it is the experience, rather than strict adherence to a protocol, that can make the difference.

In addition, workers exposed to stressful situations and trauma can themselves become vulnerable to suicide. By offering training to those on the frontline can build their capacity to respond to those in need – both members of the community and their colleagues who may be vulnerable due to trauma and PTSD.

Current state
Issues that you told us about

- Existing training for frontline workers (mental health services, police, paramedics and hospital staff) may not include specific suicide prevention skills
- Barriers to training such as funding, time of day, endorsement and approval by workplaces can limit uptake and participation in training

❖ *Indicates JRP priority actions*

4 Improving the competency and confidence of frontline workers to deal with suicidal crisis					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
4.1 Frontline workers are active partners in suicide prevention initiatives in the Gold Coast region.	**4.1.1** Identify and build relationships with key sector decision makers to better understand policy drivers and how we can work together.	• Formal frontline worker representation in suicide prevention activity	ST	GCPHN/GCHHS?	3
	4.1.2 Promote shared learning opportunities with leaders of Frontline workers.	• Number of shared learning opportunities attended by High-level Frontline workers.	MT	GCHHS/GCPHN?	3
4.2 Frontline workers have access to training programs and support required to be competent and confident when dealing with suicidal crisis.	**4.2.1** Review state initiatives for training frontline workers in MH and suicide prevention e.g. Partners in Prevention resource development for frontline workers.	• Summary of scheduled state activities	ST	GCPHN/GCHHS?	3
	4.2.2 Explore opportunities to supplement QAS training activities in the Gold Coast region with information about local suicide prevention services	• Recommendations	ST	GCHHS/GCPHN?	3

4 Improving the competency and confidence of frontline workers to deal with suicidal crisis					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
	and approach to suicide.				
	4.2.3 Identify which front line workers require prioritised training and support.	• TBD	TBD	TBD	1
	4.2.4 Desktop review, including review of approaches in other regions, mapping of most appropriate evidenced-based training packages and develop recommendations for training frontline workers in the Gold Coast region.	• TBD	TBD	TBD	2
	4.2.5 Regional agreement on preferred evidence-based training and skills development packages.	• TBD	TBD	TBD	3
	4.2.6 Promotion and coordination of training and skills development opportunities for a more standardised approach across the region.	• TBD	TBD	TBD	3
	4.2.7 Evaluate application of training.	• TBD	TBD	TBD	2
	4.2.8 Explore philanthropic grants/funding to remove barriers to training.	• TBD	TBD	TBD	3
4.3 Frontline workers are supported to feel safe with risk and responsibility.	**4.3.1** Ensure Just culture Principles are highlighted in shared learning opportunities and training. ❖	• Number of Gold Coast based trainings where Just Culture is included.	ST	TBD	3
	4.3.2 Just culture principles are embedded into Queensland Health funding tenders and contracts.. ❖	• TBD	TBD	QLD Health/Gold Coast Health?	3
4.4 Frontline workers have access to	**4.4.1** Provide training about self-care and where to get help.	• TBD	TBD	TBD	3

4 Improving the competency and confidence of frontline workers to deal with suicidal crisis					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
appropriate supervision and support to ensure that they do not also become vulnerable to suicidal thinking e.g. Blue Hope.	**4.4.2** Look for opportunities to support Frontline Workers following losing a patient to suicide.	• TBD	TBD	TBD	2
	4.4.3 Explore the possibility of a local 'Helpline' dedicated to workers e.g. Blue Hope.	• TBD	TBD	TBD	3

DRAFT

5 Promoting help-seeking, mental health and resilience in schools

Young people can be particularly vulnerable to mental health problems, self-harm or suicide. Schools are keen to support their students but often don't know how to choose quality programs or integrate programs with other student wellbeing activities and referral pathways.

Youth Aware of Mental Health (YAM) is designed to raise awareness about suicidality and the factors that protect against it. It works by improving mental health literacy and explicitly teaching the skills necessary for coping with adverse life events and stress, so that young people get help before reaching crisis point.

YAM has the strongest evidence-base of school programs reviewed including the best outcomes specific to suicidal behaviour, and the flexibility to be integrated into any school environment.

Current state
Issues that you told us about

- Schools are overwhelmed with options and pressure from multiple bodies/sectors to include additional stuff in their curriculum and programs.
- Schools are keen to support their students but often don't know how to choose quality programs or integrate programs with other student wellbeing activities and referral pathways.
- A focus on preventing or intervening early in the progression of mental health difficulties not only benefits infants and children, but also creates a solid foundation for health outcomes later in life.
- Training initiatives are often fragmented, parents, teachers, and young people may all receive different training, resources and information about how to respond to mental health issues and suicidal crisis resulting in fragmentation and diffusion of responsibility.
- Currently the communication between hospitals and schools to is not being optimised to support young post discharge and in the recovery process or to help children and youth remain engaged with school
- Clinicians in schools often operate in silos and at the discretion of school principals. Involvement in the planning of school activities could facilitate and enhance coordination of activities.
- Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without getting the care they need.

❖ *Indicates JRP priority actions*

5 Promoting help-seeking, mental health and resilience in schools					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
5.1 Schools and services providers are aligned in their knowledge, resources and strategies to support children and young people's mental health and wellbeing. (Referrals and supports)	**5.1.1** Identify, establish and maintain up to date resource on referral pathways between schools and local support services. ❖	• Resource is developed and reviewed annually	ST (priority)	GC Youth Working group?	
	5.1.2 Develop a resource that provides information, resources and training options for school-based prevention/intervention programs	• Resource is developed and reviewed annually	MT	GC Youth Working group?	
5.2 Schools implement	**5.2.1** Promote uptake of BeYou at	• Number of schools and ECECs whose staff	ST	Be You coordinators and	

5 Promoting help-seeking, mental health and resilience in schools					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
appropriate suicide prevention training, supports and resources for students, staff and parents including culturally appropriate options for diverse communities. (Training)	schools and Early Childhood Education Centres(ECEC).	report active use of Be You as a percentage of all Gold Coast State schools.		Education Queensland	
	5.2.2 Utilise recommended referral pathways between schools and local support services.	• Percentage of referrals from local schools	MT	TBD	
	5.2.3 Use evidence to recommend and promote appropriate training, programs, resources and referral pathways for the Gold Coast region.	• Number of trainings from recommended resource	LT	TBD	
	5.2.4 Maintain data about training being provided in the region	• Numbers/percentage attending training • Pre-post training surveys • Measure output of resources	MT	TBD	
	5.2.5 Evaluate training programs	• Cochrane style review regularly (3-5yrly)	MT	TBD	
5.3 School based supports/clinicians have the required training and skills to respond to suicidal crisis.	**5.3.1** Implement mandatory suicide prevention training and supervision for all Mental Health Nurses and School Based Youth Health Nurses in the Gold Coast region.	• Number of SBYHNs trained in QC31- • Number of school-based clinicians/supports trained in STORM (being explored currently) • Occasions of Clinical Supervision	ST	SBYHN Nurse Unit Manager, CYMHS	
5.4 Students, parents and teachers have a shared language and consistent messaging around help-seeking, mental health and resilience.	**5.4.1** Identify and support shared learning opportunities. e.g. Safe Talk in schools for parents and youth, partner with school P&C committees (Student Wellbeing Policies-Learning & Wellbeing Frameworks-schools individual	• Whole of School Approach-Health & Wellbeing Framework (not manadatory)-there is a Reflection and Implement Tool (I have attached to email) • Creating safe, supportive & inclusive environments • Building the capacity of staff, students and the school community • Developing strong systems for early intervention	ST	EQ-Regional Office and Principals	

DRAFT

5 Promoting help-seeking, mental health and resilience in schools					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
	health & wellbeing framework) SafeMinds in Victoria is another example to look at- need to ensure that facilitated discussions with student about suicide or suicide related behaviours occurs				
5.5 Strong relationships and trust between service providers and schools facilitate information sharing and integrated support.	**5.5.1** Establish a working group or subgroup to provide ongoing oversight and coordination to promote help-seeking, mental health and resilience in schools.	Group is established and meets regularly. • Number and frequency of meetings • Representation of stakeholders is diverse	ST	CYMHS, SBYHN, Headspace Be You Coordinators, GCPHN, school representatives	
	5.5.2 Monitor and support linkages between schools and public mental health services (CYMHS) through the use of Ed-LinQ positions and other partnerships.	Annual review shows all schools have access to linkages with EdLinQ programs.	Current and ongoing	GC Youth Working group?	
	5.5.3 Explore pathways to communicate feedback to all the people/services involved in the care, not just GPs. ❖	• Stakeholder satisfaction measures for effective communication with schools (GO's, SBYHNs)	ST/MT	GC Youth Working group?	
5.6 Schools and organisations are supported to feel safe with risk.	**5.6.1** Coordinate and promote shared learning/networking opportunities with the education sector and community to embed Restorative Just Culture principles and provide consistent information and guidance/framewor	• No of events • Attendance • Representation/participating schools • Participant satisfaction	MT	TBD	

DRAFT

5 Promoting help-seeking, mental health and resilience in schools					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
	ks about supporting young people with suicidality, such as: Return to school safety and support plan • Restoring wellbeing in school community (Guidelines) • Identifying students for referral guidance • BE You • Headspace Postvention support				
5.7 Schools with a commitment to mental health and resilience are recognised in their communities/region.	**5.7.1** Implement Gold standard achievement awards for Prevention (Wellbeing and Resilience Training for whole student body), Intervention (Gatekeeper training for parents, staff, auxiliary staff), Postvention (school support).	• Annual Review of: - Health & Wellbeing Framework - Curriculum delivery - Implementation of Be You • Nominations and awards	MT	GC Youth Working group?	

6 Training the community to respond to suicidality/Gatekeeper training

Many people who are experiencing suicidal thoughts communicate distress through their words or actions but these warning signs may be missed or misinterpreted. Training can provide people with the knowledge and skills to identify warning signs that someone may be suicidal, talk to them about suicidal thoughts and connect them with professional care.

By building a network of 'helpers' in our community we will strengthen our local safety net. Some people are natural helpers in the community while others provide help through the work they do. Everyone in the community has the potential to be a helper but the best way to reach a large number of helpers is by delivering training programs with good evidence, designed for suicide prevention outcomes directly to target workplaces. This is often referred to as '**Gatekeeper training'**.

While there are many training programs that deliver skills in mental health awareness, QPR has the most and strongest evidence for building skills to help with a suicidal crisis.

Current state
Issues that you told us about

- Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated.
- Inconsistent approaches to increasing Mental Health and Suicide Prevention literacy across the community through workplaces.
- Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without getting the care they need.
- Many gatekeepers are in roles that might encounter people in suicidal crisis, however since this is not their primary role, they may lack skills and confidence to respond to suicidality.
- There is a lot of training available, but people are not always aware of what is available and relevant to them, this may result in duplication and inefficiency.
- There is limited evidence around which programs are most effective and relevant to local stakeholders.

❖ *Indicates JRP priority actions*

6 Training the community to respond to suicidality/Gatekeeper training

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
6.1 People in the community have the confidence and skills to respond to people in suicidal distress or crisis.	**6.1.1** Fund and promote evidence-based training (e.g. QPR or similar) to the general public.	• Training completion/uptake through website • Number of organisations/workplaces promoting free suicide prevention training	ST	GCPHN/CFLSPN?	3
6.2 Regional agreement on preferred suicide prevention training for key gatekeeper individuals/groups across the region.	**6.2.1** Identify which community gatekeepers require prioritised training and support.	• Priority gatekeepers are identified.	ST	TBD	3
	6.2.2 Desktop review of evidence, including review of approaches in other regions, mapping of relevant training packages and	• Resource of recommended training is developed and accessible to the public	MT	TBD	4

6 Training the community to respond to suicidality/Gatekeeper training					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
	develop recommendations.				
	6.2.3 Regional agreement on preferred evidence-based training and skills development packages.	• Endorsement of training and skills packages	MT	TBD	2
	6.2.4 Promotion and coordination of training and skills development opportunities for the identified core skills.	• Uptake/Attendance • Number of training events completed/planned	MT	TBD	4
6.3 Community is supported to feel safe with risk and responsibility.	**6.3.1** Ensure Just Culture principles are included in shared learning opportunities and training	• Number of trainings/shared learning opportunities where Just Culture is included.	TBD	TBD	4
6.4 Knowledge and skills of identified gatekeepers is up-to date and maintained	**6.4.1** Develop and maintain a publicly available calendar of current suicide prevention training/courses provided across the region.	• Calendar is developed and regularly updated.	TBD	TBD	3
	6.4.2 Develop a process to gather and maintain data about suicide prevention training being provided across the region.	• Training audit template is developed • Partner and identified targets. • Training provider data • Pre/post training and follow up surveys	TBD	TBD	4
	6.4.3 Gather data from training providers	• Pre/post training and follow-up surveys	TBD	TBD	3
6.5 Compassionate care is promoted in all suicide prevention training.	**6.5.1** Explore existing training for compassionate care	• TBD	TBD	TBD	3
	6.5.2 Provide compassionate care training	• TBD	TBD	TBD	2

7 Engaging the community and providing opportunities to be part of the change

Community engagement and communication delivered in conjunction with other evidence-based suicide prevention strategies can improve local awareness of services and resources and drive increased participation in prevention efforts across the community.

Engagement in campaigns and activities such as R U OK? Day can provide an important first step for many community members. Some people may wish to take the next step: undertake training so they can recognise risk and connect others with professional support.

Current state
Issues that you told us about

- Suicide prevention activity is frequently fragmented and
- People do not know how to be actively involved in suicide prevention and are not always aware of opportunities or ways they can contribute.
- Service eligibility criteria/thresholds often limits access to services. In addition, many services do not provide afterhours support.
- Stigma associated with suicide and help-seeking is a significant barrier to prevention. Greater acknowledgment and recognition of community suicide prevention activity is required to raise the profile of suicide prevention and postvention in a positive way.
- Some people don't identify with the mental health label and will not access support for conditions that they don't relate to.
- Suicide prevention services and approaches need to be more culturally inclusive and responsive to diversity.

❖ *Indicates JRP priority actions*

7 Engaging the community and providing opportunities to be part of the change

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
7.1 People with lived experience are supported to share and contribute their knowledge and experience in a safe and meaningful way	**7.1.1** Endorse the Black Dog's institute lived experience framework for regional suicide prevention activity	• JRP Steering Committee endorses Black Dog LifeSPan Framework • 100% of suicide prevention activity includes representation of the lived experience voice	ST	JRP Steering group GCHHS and all GCPHN commissioned services	3
	7.1.2 Review the QMHC Lived Experience framework and alignment to LifeSpan. ❖	• Review is completed and recommendations are provided to the JRP steering group	ST	TBD	3
	7.1.3 Invest in Lived Experience training for all Lived Experience members participating in advisory and governance roles. ❖	• Number of lived experience people trained • Participant feedback	ST	GCPHN	3
	7.1.4 Provide opportunities for people with lived experience to speak and present and to	• Case studies: Good news stories	MT	TBD	4

	share stories of hope and recovery. ❖ (see also 8.2.1 below)				
7.2 Instil hope, connection and collaboration for suicide prevention in the Gold Coast community.	**7.2.1** We will host an annual World Suicide Prevention Day event.	• Number of people registered • Stakeholder feedback (Evaluation form)	Annually in September	CFLSPN	0
	7.2.2 Identify and promote community action at community events that can be linked with community events cost effectively (e.g. QPR training).	• Register of event and community action • Uptake of actions	ST	CFLSPN GCPHN,GCHHS, SP governance group	2
	7.2.3 Explore opportunities to actively engage other sectors in suicide prevention e.g. leverage other sectors awards nights and have a suicide prevention award	• TBD	MT	TBD	TBD
7.3 Partner with community leaders to promote and market suicide prevention activities.	**7.3.1** Identify and train leaders champions and explore how they can contribute. e.g. community leaders, elders, role models, sports stars, etc. ❖	• Partnership agreements • Actions register.	ST	TBD	3
7.4 Suicide prevention activities engage diverse communities in the Gold Coast region.	**7.4.1** Explore partnership or build relationships with QLD transcultural mental health or GCCG to explore how to engage more effectively with the CALD community. ❖	• No of engagement activities with diverse groups (consultation, events, etc)	ST	TBD	4
7.5 A network/ working group is in place to coordinate community events and to promote safe, targeted and consistent messaging.	**7.5.1** Review the ongoing sustainability, role and function of the Care For Life Suicide Prevention Network. (CFLSPN)	• CFLSPN strategic plan • Outcomes of AGM March 20	ST	CFLSPN	4
7.6 Service providers and community are aware of crisis support services	**7.6.1** Maintain and promote Gold Coast Suicide Prevention Service Finder which includes 24 hour	• A resource is maintained and distributed • Distribution register is maintained	Current and ongoing (updated every 2-3 years)	CFLSPN	0

to the Gold Coast community.	crisis support and counselling and support services.				
	7.6.2 Maintain and promote a Youth Info Card and App which includes 24 hour crisis support and counselling and support services.	• A resource is maintained that is relevant and accessible to the Gold Coast community. • Distribution register	Current and ongoing (updated every 2-3 years) last updated in 2019	Headspace/CFLSPN	0
	7.6.3 Maintain and promote suicide postvention bereavement resource with crisis support, counselling and support services. Available in hard copy and in PDF version	• A resource is maintained that is relevant and accessible to the Gold Coast community. • Distribution register	Current and ongoing	CFLSPN	0
7.7 People with a lived experience of suicide are acknowledged and supported to be involved in suicide prevention activities.	**7.7.1** Candlight Vigil/Out of the Shadows walk	• Number of people registered/attending • Participant feedback	Current	Lifeline	0
7.8 Mental Health is included as part of workplace health and safety culture in the region.	**7.8.1** Provide Mental Health and Suicide Prevention training in workplaces	• Number of workplaces who implement MH and SP training as part of WHS	MT	TBD	3
	7.8.2 Explore Train the Trainer models to identify champions of support e.g. Mates in Construction	• TBD	MT	TBD	3
7.9 Recognition for workers/champions committed to Suicide Prevention/Postvention Cross over with 8.5	**7.9.1** Implement a community award to celebrate and recognise community champions and their dedication to suicide prevention.	• Number of people/organisations who nominate and attend event	ST	TBD Approach Rotary?	3
7.10 Help seeking options are inclusive	**7.10.1** Explore help-seeking options language around mental health, suicide etc as e.g. Life Review App/tool to identify life stressors, situational	• TBD	MT	TBD	3

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	factors and referral pathways.				

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8. Encouraging safe and purposeful media reporting

Suicidal behaviour can be learned through the media. Media guidelines supporting the responsible reporting of suicide by the media can reduce suicide rates, and in providing safe, quality media coverage, improve awareness and help seeking. Australia leads the world in application of the evidence around media and suicide yet there can be a misunderstanding and 'fear' of media guidelines.

What is said (or not said) about suicide is important. The community needs to drive the conversation about what is working locally, what people can do to help and where more attention is required. We are supporting local organisations to take a more proactive and coordinated approach to engaging with the media and managing this conversation.

Current state
Issues that you told us about

- Representations of suicide in the media can be sensationalised and unsafe leading to copycat behaviour
- The graphic nature of news can be traumatising and cause fear and anxiety.
- Suicide is frequently sensationalised and/or stigmatised in the media.
- People with a lived experience of suicide are often not empowered or provided with opportunities to become agents of system change or to share messages of hope and recovery with others.
- Suicide prevention activities and campaigns could be better coordinated to maximise impact.

❖ *Indicates JRP priority actions*

8. Encouraging safe and purposeful media reporting

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
8.1 The Gold Coast region has shared leadership and commitment to clear, consistent and safe messaging around the topic of suicide and suicide prevention.	**8.1.1** Develop a regional communication strategy for portrayal of suicide events in the region and connecting people to supports. ❖	• TBD	ST	TBD	4
	8.1.2 Hold an annual event for local services, organisations, business, community groups etc to sign the National Communications Charter. ❖	• Attendance • Number of new organisations signing up	ST Annual/Biannual	GCPHN/GCHHS and local media	1
	8.1.3 Promote awareness of Mindframe guidelines and training and SANE stigma watch. ❖	• No of events or publications where training/collateral was promoted	ST Annually/Biannually?	TBD	2
	8.1.4 Provide Mindframe media plus training to local media outlets and service providers. ❖	• TBD	MT	TBD	4
	8.1.5 Explore what can be done locally to contain social media	• TBD		Explore partnership with headspace in schools.	1

8. Encouraging safe and purposeful media reporting					
Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** *Who will lead this work?*	**Priority**
	sensationalisation of local suicides.				
	8.1.6 Promote awareness of Chatsafe guidelines for young people. ❖	• TBD	ST	TBD	3
	8.1.7 Lobby to move news to a later hour.	• TBD	MT	TBD	5
8.2 People with a lived experience are supported with training and opportunities to share their story in a safe and appropriate way.	**8.2.1** Provide opportunities for people with lived experience to share stories of hope and recovery. ❖ (see also 7.1.4 above)	• Case studies: Good news stories	MT	TBD	4
8.3 There is a positive mental health focus through local media that share stories of hope.	Explore partnering with known community champions/ambassadors to speak to support a shared action for suicide prevention.	• TBD	ST	TBD	TBD
	Partner with local media to promote stories of hope to the community through local campaigns/initiatives. ❖	• TBD	ST	TBD	4

9 Improving safety and reducing access to means of suicide

Local suicide trends and common means are not well understood. There is a lack of timely data, which is important, as implementation of any interventions must be informed by what is actually happening in the local community.

Restricting access to the means of suicide is one of the most effective suicide prevention strategies. With better data and a regional approach, communities can develop a long-term, strategic approach and drive local efforts in safety and prevention.

Current state
Issues that you told us about

- Currently timely (up to date) regional data is not available which limits our ability to use data to drive decision making.
- Hangings and poisoning are the most common methods of suicide in Queensland.
- Safety plans are held by providers and individuals have to develop new safety plans with multiple providers.
- Carers are often not aware of/informed of details of safety plans and how they can support people to implement their safety plans.

❖ *Indicates JRP priority actions*

9 Improving safety and reducing access to means of suicide

Outcome *What do we want to achieve?*	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** Who will lead this work?	**Priority**
1 Know the patterns and trends of suicide in the Gold Coast region and use this data to better target suicide prevention activities. (including hotspots/sites, means of suicide, age trends, gender, cultural backgrounds etc).	**1.1** Undertake an annual needs assessment to inform the community of regional patterns and trends in suicide.	• Needs assessment is updated annually and publicly available on the PHN website	Current and ongoing annually	GCPHN	0
	1.2 Explore options for ongoing access to current data and regular updates from the Queensland Suicide Register.	• MOU or collaboration agreement is signed with AISRAP/MHC	Current and ongoing	GCPHN/GCHHS	0
	1.3 Identify and explore access to other sources of relevant regional data e.g. police referrals, ambulance data, local service providers.	• A register is developed to identify most current sources of information, key contacts, frequency of data updates etc	ST	GCPHN/GCHHS	3
	1.4 Prepare an annual suicide audit template/report to share regional data and highlight	• Template/report is developed and updated annually	MT	TBD	3

9 Improving safety and reducing access to means of suicide					
Outcome *What do we want to achieve*?	**Action** *How will we do it?*	**Measure** *How will we know when it has been achieved?*	**Timeline** *When will we do it?*	**Lead** Who will lead this work?	**Priority**
	potential responses to improve safety and reduce access.				
	1.5 Use regional data to help promote good prescribing behaviours in GPs.	• TBD	MT	TBD	4
2 Establish strategic partnerships and planning with other services and sectors that could reduce access to means e.g. AOD.	**2.1** Explore cost and funding for Suicide Prevention training for Gold Coast Pharmacists.	• Attendance • Satisfaction survey	ST	GCPHN/GCHHS	3
	2.2 Actively Promote suicide prevention training delivered by the AOD sector to other providers.	• Frequency and number of suicide prevention training sessions • Attendance	Current and ongoing)	QUIHN and Goldbridge?	1
	2.3 Promote clear/warm referral pathways to AOD services	• TBD	TBD	TBD	2
3 Initiatives are in place for known periods/seasons of high risk e.g. schoolies.	**3.1** Review what are initiatives that already exist at schoolies e.g. Red frogs.	• TBD	ST	TBD	2
4 People in suicidal crisis are supported to develop and share individual safety plans to improve their safety and reduce access to means.	**4.1** Provide safety planning training for service providers, family and carers.	• TBD	ST	TBD	3
	4.2 Explore pathways to share safety plans with other providers, family and friends. ❖	• TBD	MT	TBD	2
	4.3 Promote use and uptake of Beyond Now Safety planning app.	• TBD	ST	TBD	3

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