Gold Coast Suicide Prevention Community Action Plan

2020-2025

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). However, 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 or go to an emergency department.

National 24/7 Crisis Services

Lifeline (24 hours)
13 11 14 | www.lifeline.org.au/Get-Help

Suicide Call Back Service (24 hours)
1300 659 467 | www.suicidecallbackservice.org.au

Mensline Australia
1300 78 99 78 | www.mensline.org.au

Kids Helpline (24 hours)
1800 55 1800 | www.kidshelp.com.au

Mental Health Acute Care Team
1300 MH CALL (1300 64 2255)

National Indigenous Critical Response Service (NICRS)
1800 805 801

Counselling and support services

beyondblue
1300 22 4636 | www.beyondblue.org.au

SANE Australia Helpline
1800 18 SANE (7263) | www.sane.org

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

COVID – 19 recovery service

COVID-19 Recovery Service
07 5625 1949
www.wmq.org.au/mental-health-services/covid-19-recovery-service

Gold Coast Suicide Prevention Community Action Plan

2020-2025

Contents

Acknowledgements 3

How can I be involved? 4

Foreword 4

Abbreviations 7

Introduction 8

Suicide prevention in the Gold Coast region 17

Gold Coast Suicide Prevention Community Action Plan (CAP and implementation approach) 20

Current response: Gold Coast suicide prevention activity 2019-20 21

Working together 22

1 Improving emergency and follow up care for suicidal crisis 23

2 Using evidence-based treatment for suicidality 26

3 Equipping primary care to identify and support people in distress 28

4 Improving the competency and confidence of frontline workers to deal with suicidal crisis 30

5 Promoting help-seeking, mental health and resilience in schools 33

6 Training the community to respond to suicidality/Gatekeeper training 36

7 Engaging the community and providing opportunities to be part of the change 38

8 Encouraging safe and purposeful media reporting 41

9 Improving safety and reducing access to means of suicide 43

References 45

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 (CAP) 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 Community Action 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 Community Action 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 Community Action 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.

Suicide Prevention Leadership Group

- Dr Kathryn Turner, Clinical Director, Mental Health & Specialist Services – Gold Coast Health
- Philip Williams, Program Manager (Commissioning) – Gold Coast Primary Health Network
- Sara Dixon, Senior Project Officer Suicide Prevention – Gold Coast Primary Health Network
- Cindy Heddle, Lived Experience Committee Member, Suicide Prevention Research Advisory Group
- Leila Farahani, Lived Experience Representative
- Toni Eachus, Operations Manager/Assistant CEO – Goldbridge Rehabilitation Services
- Pauline Coffey, Suicide Prevention Services Manager – Wesley Mission Queensland
- Dr Susie Radford, General Practitioner
- Amanda Smith, Nurse Unit Manager, School Based Youth Health Program – Gold Coast Health
- Rose Spencer, Executive Committee Member, Care for Life Suicide Prevention Network
- Natalie Mudge, Lived Experience Representative
- Heidi Rix, Sergeant, Vulnerable Persons Co-ordinator, Gold Coast Mental Health Intervention Co-ordinator,
- Domestic and Family Violence Task Force – Gold Coast District Queensland Police
- Ricky Smith, Critical Care Paramedic, Queensland Ambulance Service

Acknowledgement of Funding

The development of this Community Action Plan has been funded by 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.

How can I be involved?

Everyone has a role to play in suicide prevention. If you would like to be involved in this plan, please share how your vision or interest aligns and express your interest in contributing to or leading actions contained in this plan, by contacting:

Suicide Prevention Officer
Gold Coast Primary Health Network
mentalhealthaod@gcphn.com.au

Clinical Director
Mental Health and Specialist Services
Gold Coast Health
GCDSOMHSS-CD@health.qld.gov.au

Matt Carrodus
CEO, Gold Coast Primary Health Network

Kathryn Turner
Clinical Director Mental Health and Specialist Services

Foreword

Joint statement Gold Coast Health/Gold Coast Primary Health Network

Suicide is a complex issue and effects people of all ages and walks of life. Multiple factors are recognised as contributing to suicidal behaviour or someone being at risk of suicide. To reduce suicide rates in our community, there needs to be a holistic approach from all stakeholders involved 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 a sense of purpose and control.

On the Gold Coast we are fortunate to have the opportunity to build on the collaborative journey started by Gold Coast Health with its 2016-2018 Suicide prevention strategy. Based on the Zero Suicide framework, the strategy incorporates a systems approach to suicide prevention, with an aspiration of reaching zero suicides in the health system.

The LifeSpan integrated framework developed by the Black Dog institute 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. In combination, these frameworks provide an ideal basis for this Community Action Plan 2020-2025.

This plan has been made possible by the generous contributions from people with lived experience, clinicians, service providers and the broader community. We acknowledge the critical role communities play in suicide prevention and sincerely thank the contributors not only to this plan but also those who have built the solid foundations of suicide prevention already transpiring on the Gold Coast.

We recognise this as a foundational Community Action Plan that is ambitious. We believe it helps us set a clear vision that over time will achieve integrated service planning and co-commissioning for our region. It is anticipated this plan will continue to grow and change over time through an ongoing and interactive process which will also continue to strengthen partnerships to enable a shared response to suicide prevention in our region.

Foreword

Continued...

KALWUN Health Service

Suicide has a disproportionate impact on Aboriginal and or Torres Strait Islander peoples and their families, who are experiencing suicide at approximately twice the rate of the rest of the population. Therefore, it is important we take an early intervention and holistic view that focuses on building strong communities which support Aboriginal and/or Torres Strait Islander peoples' mental health, physical, cultural, and spiritual connections. Emphasis is placed on the holistic viewpoint of these individual components as being very important to the Aboriginal and or Torres Strait Islander community.

In enabling a holistic approach, at Kalwun we ensure cultural strengths, knowledge and practices support community around social and emotional wellbeing. Relevant to the development of a stronger community and sitting within the delivery of service, is ensuring staff are available who have training in the delivery of Aboriginal and Torres Strait Islander Mental Health First Aid. In turn, this training has a 'train the trainer' approach that supports other workers and community members to utilise this training to deliver Mental Health First Aid within the community.

This community action plan complements the work Kalwun is undertaking to improve the social and emotional wellbeing of Aboriginal and/or Torres Strait Islander peoples and reduce the harm associated with suicidal ideation and attempts. In particular, the objectives of the Community Action Plan align with Kalwun's recognition and emphasis placed on working towards a community action on suicide prevention.

Martie Wighton
Social Health Manager
KALWUN Health Services

Care For Life Suicide Prevention Network

Care For Life firmly believe that the only way forward is for all organisations on the Gold Coast with an investment in the health and welfare of our community to work together in the prevention of suicide. Care for Life has been operating on Gold Coast since 1995 with an emphasis on providing training and resources. We have been working with all organisations in developing resources to fill gaps. Gold Coast Primary Health Network has provided the vehicle to enable this to take place with input from all key parties. A comprehensive plan has been developed and the implementation of this plan will go a long way to ensuring that we are able to educate, protect and care for our community.

Raylee Taylor
Chair, Care For Life Suicide Prevention Network

Krurungal

While suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander peoples of Australia in pre-colonial times, it has become increasingly prevalent over recent decades. The interconnected issues of cultural disconnection, personal/intergenerational trauma and the ongoing stresses of disadvantage, racism, alienation, and exclusion are all acknowledged as contributing to the heightened risk of suicide.

Krurungal recognises these interconnected issues and has supported its local community in the Gold Coast region for nearly 30 years. Krurungal has contributed to and supports this Community Action Plan, which aids Krurungal's ongoing work with community and local services to address this important issue.

Alfred Summers
Service Coordinator/AOD
Krurungal Aboriginal & Torres Strait Islander Welfare Corporation.

Foreword

Continued...

Lived Experience Perspective

“I believe suicide prevention starts by supporting people to hold hope”

How we achieve this is by sharing our stories, helping people to understand the different ways they can learn to cope better and to hold hope even in the most difficult times.

We can all help to instil hope by talking about the challenges we have endured in our every day life, and in doing so, shine a light on the darkness. We should never underestimate the power of sharing our own recovery journey. History has taught us the value of passing on our knowledge, experiences and wisdom - Peoples stories have spanned generations and become the bedrock for our lives today. The lived experience voice echoes hope. It carries empathy and an understanding that only life can impart.

By valuing and utilising the wisdom of lived experience within our community and health services, we can best support vulnerable people in crisis and help our over burdened system. Lived experience peer support is now recognised as an important addition to other therapies and clinical support. It helps people to overcome fear, anger, shame and hopelessness. While offering them comfort, compassion, knowledge, and understanding.

Although a long time coming, peer workers have finally been acknowledged as essential in helping people in crisis to feel safe, supported and genuinely heard. I believe the path we are on is evolutionary, and together we are paving a new way forward for suicide prevention through the empathy of lived experience.

To those of you who have been touched by suicide and now use your experiences to support others, this is written with respect and appreciation of your courage and dedication in the work you do for suicide prevention.

Cindy Heddle and Penny Eccleston
Lived Experience Representatives

Abbreviations

Abbreviation	Meaning
AISRAP	Australian Institute for Suicide Research & Prevention
CAP	Community Action Plan
CALD	Culturally and Linguistically Diverse
CFLSPN	Care For Life Suicide Prevention Network
CYMHS	Child and Youth Mental Health Service
ED	Emergency Department
ED-LinQ	Queensland Ed-LinQ Initiative
ECEC	Early Childhood Education Centres
GCMHPN	Gold Coast Mental Health Professional Network
GCPHN	Gold Coast Primary Health Network
GO	Guidance Officer (School based)
GP	General Practitioner
JRP	Joint Regional Plan
KPI	Key Performance Indicator
MBS	Medicare Benefits Schedule
MHACT	Mental Health Acute Care Team (Gold Coast Hospital and Health Service)
MHFA	Mental Health First Aid
NGO	Non-government organisation
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer / Questioning (the + represents other identities not captured in the letters of the acronym)
MOU	Memorandum of Understanding
PSP	Psychological Service Providers
QAS	Queensland Ambulance Service
QMHC	Queensland Mental Health Commission
QPS	Queensland Police Service
RAG	Red, Amber, Green (reporting)
SBYHN	School Based Youth Health Nurse
SPLG	Suicide Prevention Leadership Group
TWBSS	The Way Back Support Service
WMQ	Wesley Mission Queensland

1. Introduction

1.1 The problem of suicide

Every year over 65,000 Australians make a suicide attempt and in 2018 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 on 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].

1.2 Purpose of the CAP

Using the LifeSpan framework, this plan aims to bring together lived experience, health services and community efforts to support a holistic approach to suicide prevention on the Gold Coast. The CAP seeks to strengthen relationships and collaboration in the planning, coordination, and implementation of suicide prevention activities and is intended to foster supportive social relationships, encourage effective help-seeking and positive connections to good health services, and support family harmony as well as a sense of purpose and control. As this plan is ambitious and wide-reaching people are encouraged to use it to guide all suicide prevention activities that are planned to increase the coordination and collective impact of our efforts.

This plan is intended to be iterative and ongoing and reflects the importance of a coordinated and continual approach to suicide prevention for our region.

1.3 Context and scope of the CAP

Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services in the Gold Coast

The development of the Community Action Plan (CAP) was undertaken as part of the joint initiative between Gold Coast Primary Health Network (GCPHN) and Gold Coast Health to develop a Joint Regional Plan for Mental Health, Suicide Prevention, and Alcohol and Other Drugs (the Joint Regional Plan) in response to the new Suicide Prevention Strategy outlined by the Australian Government.

The Joint Regional Plan aims to lay the foundations for improved collaboration and integration between mental health, suicide prevention, alcohol and other drugs services in the Gold Coast region. This Plan forms a significant part of our response to the commitment made by the Commonwealth and State Governments in the Fifth National Mental and Suicide Prevention Plan[1].

It was developed as a foundational plan through a process that we intend to be an ongoing and iterative process that will enable us, over time, to achieve integrated service planning and co-commissioning for our region.

The Joint Regional Plan includes a strategic road map for suicide prevention which includes prioritised action from the CAP that Gold Coast Health and Gold Coast Primary Health Network have jointly committed to progressing, as shown in Figure 1.

Suicide prevention: Strategic Roadmap

Current state and identified gaps	Desired state	Headline measures	Long term outcomes
People with a lived experience of suicide have the potential to inform, influence and enhance local suicide prevention solutions but may lack the confidence, skills and readiness to participate. Suicide is often a highly stigmatised topic that is not discussed or can be highly sensationalised by the media. People with lived experience frequently feel that their voice and experience is censored and is not valued.	**1. People with lived experience are supported to share and contribute their knowledge and experience in a safe and meaningful way at every level.**	• Number of identified people trained to safely share their lived experience story • Deliverable: Endorsed Black Dog Institute's LifeSpan Lived Experience Framework	Regional focus on collaborative suicide prevention with the intention of reduction in suicide rates in the region.
Currently we don't know enough about what evidence-based treatments are being delivered, by whom or what the quality of these services is. Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified. Due to fear, stigma or time pressures, these people do not receive the care or follow up support they need at this critical time. Limited supports are available for people in distress who end up in ED by default or on a mental health trajectory, but many times their distress is related to a situational crisis in their lives.	**2. Support people in distress in the community through:** • Evidence based treatments for suicidality are available within the community and public health system. • Primary Care providers are skilled at identifying and responding to individuals in distress or at risk of suicide including the use of compassion. • People in distress are able to access supports in the community without having to be referred via ED or have a mental health care plan.	• 100% of suicide prevention activity includes representation of the lived experience voice • See client within 7 days for referrals to commissioned services identified for suicide risk (PMHC) in HHS - 100% with a tolerance of 90% • See client within 7-days for referrals to HHS - 100% with a tolerance of 90%	
Carers are at the frontline of suicide prevention and many sit daily with this risk and responsibility but may not have any training or skills to equip them for this. In addition, they may not know where to go for help or how to access the unique supports they require at this time. Caring for someone with a suicidal ideation can also be a demanding and often isolating experience which may impact employment, social connection and the physical, mental and emotional health of the carer.	**3. Improve support for carers and families impacted by suicide through:** • Information and connection to supports including online. • Prioritisation for care and support alongside people who have attempted suicide or have suicidal ideation.	• Contact within 24-48 hours for referrals to suicide prevention services • Clearly identified services for carers and families (resources/ referral pathways developed) • Deliverable: evaluation report for Carers Support Program	

Suicide prevention: Strategic Roadmap (continued)

Current state and identified gaps	Desired state	Headline measures	Long term outcomes
Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated. Service providers do not always know what the best evidence - based treatments are for people experiencing suicidal thoughts and behaviours or how to access local services and supports. 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 receiving the care they need. People living with mental illness are up to 30 times more likely to die by suicide than the general population. However, many mental health clinicians do not have specific training in suicide prevention or know what the best evidence based treatments are for people experiencing suicidal thoughts and behaviours. Many people lack the confidence and skills to address people in suicidal distress or crisis.	**4. Develop a responsive workforce and community where:** • Regional agreement about what suicide prevention training is appropriate for different components of the workforce across the region. • Workforce has shared knowledge and understanding of local suicide prevention services, interventions and approach. • Workforce and community is supported to feel safe with risk and responsibility. • Sector wide knowledge and understanding of the regional suicide prevention approach and evidence-based treatment options. • General Practitioners are skilled at identifying and responding to individuals in distress or at risk of suicide including the use of compassionate language. • Frontline workers (e.g. police, ambulance) have access to training programs and support required to be competent and confident when dealing with suicide crisis. • People in the community have the confidence and skills to support people in suicidal crisis.		
Representations and portrayals of suicide in the media can be sensationalised and can increase the risk of suicide for vulnerable people and can perpetuate stigmatising attitudes towards people experiencing suicidal thoughts or behaviours, or towards people who have died by suicide. Suicide prevention activities are frequently fragmented. Individuals who naturally have the influence to drive suicide prevention activities in their communities may not be connected with or aware of regional suicide prevention initiatives and how they could contribute.	**5. Develop a regional communication strategy/plan to build awareness and maintain momentum** • The Gold Coast region has shared leadership and commitment to clear, consistent and safe messaging around the topic of suicide and suicide prevention. • Partner with community champions to promote and market suicide prevention activities.	• Deliverable: communications strategy • Engagements (events attended, communiques out)	

1. Introduction

Continued...

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 LifeSpan 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 it must be acknowledged 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 be 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 CAP

This Gold Coast Suicide Prevention CAP is a five-year plan. Actions shaded in grey (see the roadmap on previous pages) indicate actions that are aspirational and will require the active contribution of the whole of community to provide additional resourcing, information and/or leadership to drive these actions. As this becomes available these actions can be added or revisited and shading can be removed to indicate their active status.

In addition, the SPLG used a prioritisation matrix to assess each action according to the difficulty of implementation and the degree of impact. 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.

Based on available resources, funding, partnerships and feasibility

DIFFICULTY OF IMPLEMENTATION	IMPACT: LOW	IMPACT: MEDIUM	IMPACT: HIGH
LOW	3 Low Impact/Low Difficulty	2 Medium Impact/Low Difficulty	1 High Impact/Low Difficulty
MODERATE	4 Low Impact/Moderate Difficulty	3 Medium Impact/Moderate difficulty	2 High Impact/Moderate difficulty
HIGH	5 Low Impact/High Difficult	4 Medium Impact/High Difficult	3 High Impact/High Difficult

Based on evidence and assessment of needs

Figure 2: Prioritisation matrix

1. Introduction

Continued...

1.4 How we developed this plan

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 and was adopted to guide and underpin this work.

Gold Coast Suicide Prevention Leadership G roup

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 Primary Health Network, Gold Coast emergency services, suicide prevention service providers, Care for Life Suicide Prevention Network, Aboriginal and Torres Strait Islander service community, LGBTIQ+ 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.

Governance

The CAP was developed under the governance structures of the Joint Regional Plan, the Joint Regional Steering Committee, Clinical Leaders Advising on Wellbeing (CLAW) and a Group of Lived Experience Experts (GLEE) provided leadership and advice on the development of the CAP. For more information about these governance structures, refer to the Joint Regional Plan (p7).

Consultation

The development of the CAP builds on knowledge and feedback gathered from previous consultation activities, which 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. This consultation took place through existing groups and governance structures, local events and workshops, targeted consultation with key stakeholders, and applying learnings from National and State consultation.

1.5 Planning and policy context

Suicide prevention activity in Australia is underpinned by several layers of policy, strategy and plans. The Gold Coast Suicide Prevention Community Action Plan 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 The 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 Community Action Plan will be implemented in alignment with this strategy.

- Suicide prevention breakfast (March 2016)
- Mental Health and AOD Community Briefing (June 2016)
- Stakeholder Validation Survey (August 2016)
- World Café (September 2016)
- Care for Life Network Consultation (2016)

Past consultation

- 8 monthly meetings between August 2019 and June 2020
- Participants worked together to co-design outcomes, actions and priorities using the Black Dog Institute LifeSpan framework.

Suicide Prevention Leadership Group

- Care For Life Suicide Prevention Network
- GCPHN Consumer Advisory Council
- Joint Regional Plan Steering Committee
- Group of Lived Experience Experts (GLEE)
- Clinical Leaders Advising on Wellbeing (CLAW)

Existing groups/Joint Regional Plan governance groups

- Gold Coast Youth Wellbeing Conference
- World Suicide Prevention Day
- Mental Health and Suicide in Culturally and Linguistically Diverse communities (Multicultural Queensland Advisory Council)
- Crisis Now/reform consultation

Local events/workshops

- Indigenous Suicide Prevention services (Kalwun and Kurungal)
- Wesley Lifeforce
- QAS mental health co-responder state representative
- Pathways Gold Coast Response Service
- Child and Youth Mental Health Service
- Roses in the Ocean
- Brisbane North PHN

Key stakeholder consultation

- Beyond blue collaborative design workshops X 2
- Black Dog Institute LifeSpan Symposium
- National Suicide Prevention Australia Queensland Suicide Prevention Plan Consultation Workshop
- National Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

National/State consultation

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

1. Introduction

Continued...

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:

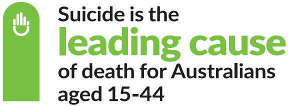
- The inclusion of the nine evidence-based strategies, targeting population to individual - level risk
- Simultaneous implementation of all nine strategies within a localised region
- Use of best evidence-based programs and interventions within each of the nine strategy areas, as suitable for the local 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)

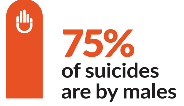
Recognising that multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of its parts, the model is data driven and evidence-based, helping to raise the bar in suicide prevention.

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

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

The LifeSpan framework (Figure 4) 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.





The trial of a new approach has the potential to turn some of this around.

WHAT IS LIFESPAN?

LifeSpan is a new, evidence-based, integrated approach to suicide prevention.
It combines nine strategies that have strong evidence for suicide prevention into one community-led approach.
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.

Data-driven decision-making

Workforce information and development

Lived experience inclusion at every level

Cultural governance and inclusion

Community engagement

Local ownership and adaptation

Improving **emergency and follow-up care** for suicidal crisis

Using **evidence-based treatment** for suicidality

Equipping primary care to **identify and support people** in distress

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

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

Training the community to **recognise and respond** to suicidality

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

Encouraging **safe and purposeful media** reporting

Improving safety and reducing access to means of suicide

Building a community safety net that helps prevent suicide

Estimated to REDUCE SUICIDE DEATHS BY 20%

Estimated to REDUCE SUICIDE ATTEMPTS BY 30%

GET INVOLVED

- Undertake suicide prevention training
- Familiarise yourself with the services and support available in the community
- Look after yourself and support others when they need help

Figure 4: LifeSpan framework developed by Black Dog Institute

Zero Suicide framework

The Zero Suicide framework is a commitment to suicide prevention in healthcare with an aspirational challenge. It is based on a flexible set of evidence based interventions, strategies and customisable tools including an open access website. It comprises of the elements of lead, train, identify, engage, treat, transition and improve . Gold Coast Health adopted the Zero Suicide framework for its 2016-2018 Suicide prevention strategy.

These elements aim to overcome pessimism / nihilism, shift from focus on risk assessment and containment, promote overall systems and culture change rather than stand alone training and tools and be suicide specific not just as a symptom of underlying disorder.

1 Leadership

- Create a leadership-driven, safety oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

2 Train

- Develop a competent, confident and caring workforce.

3 Identify/Engage/Treat

- Systematically identify and asses suicide risk among people receiving care. Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and **restriction of lethal means**. Use effective, **evidence-based treatments** that directly target suicidality.

4 Transition

- Provide continuous contact and support, especially after acute care.

5 Improve

- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

2. Suicide prevention in the Gold Coast region

2.1 The Gold Coast region and people

The Gold Coast region extends from Coolangatta in the south to Logan and Albert Rivers in the north/north west; and to Tamborine, Mt Tamborine, Canungra and Beechmont to the west, see Figure 5. As of 2019 the Gold Coast is home to an estimated 636,117 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[7]. However, within the region Coolangatta has the largest percentage of Aboriginal and Torres Strait Islander persons (2.3%) alongside Nerang (1.9%), and Ormeau-Oxenford (1.9%) a population that has almost doubled since 2011[8].

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. Twenty-eight (28%) of Gold Coast residents were born overseas and more than half of these residents come from English speaking backgrounds[9].

Figure 5: Map of the Gold Coast region

2.2 Queensland suicide data

Suicide is a leading cause of death for Queenslanders with 757 suspected suicides in 2019. Rates of suspected suicide have increased from 2011 onwards, however overall, the rates from 2017 have been found to show a decrease (2.8%) by 2019[10]. During that same year, Queensland showed the second highest number of deaths following New South Wales as the highest[11].

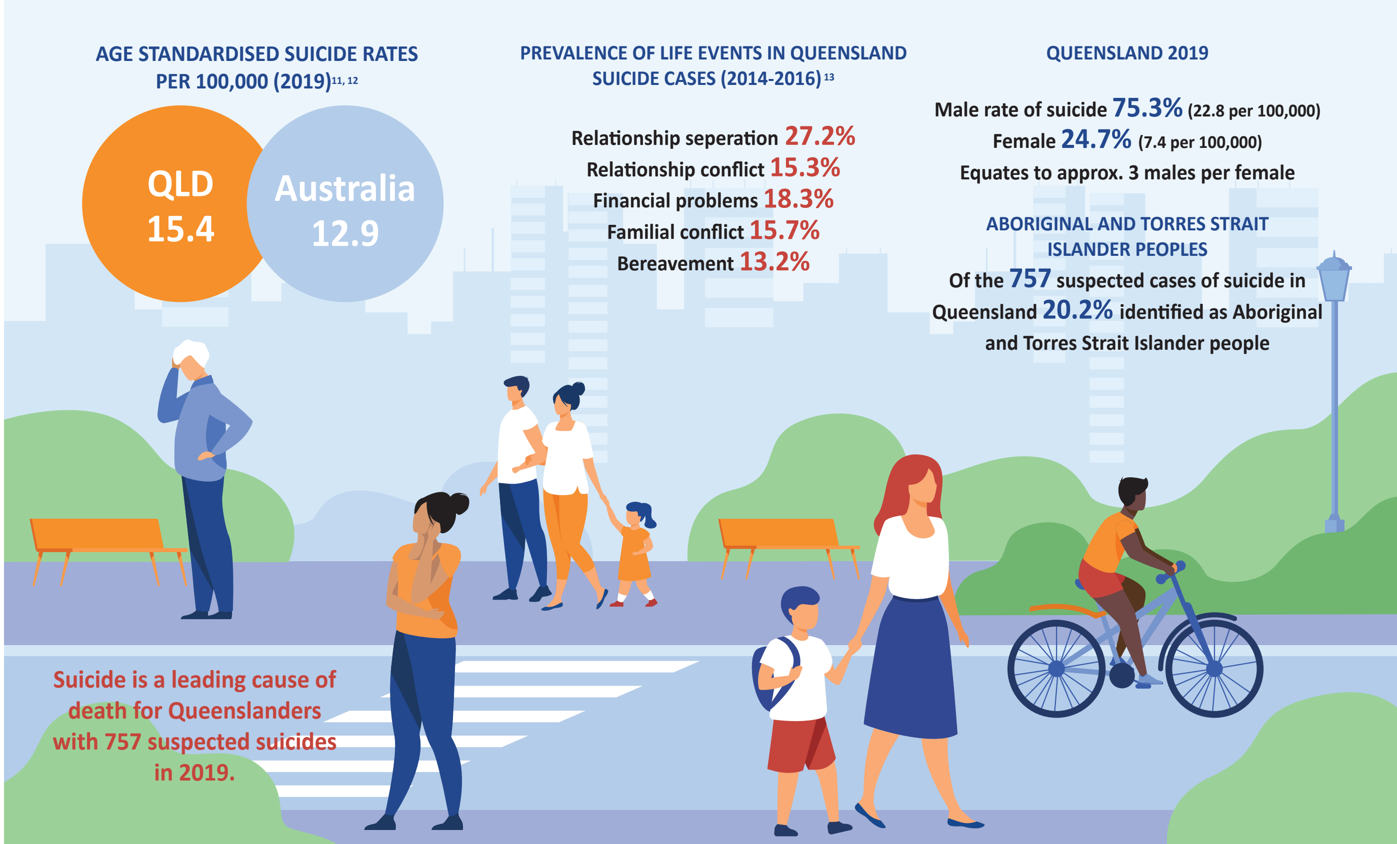
Age-standardised death rates in Queensland for 2019 are higher than the national rate, with Queensland standardised death rate by suicide being 15.4 deaths per 100,000 people, compared to a national average of 12.9 deaths per 100,000 people[12].

Researchers have suggested that prevention interventions targeting males are imperative, as men have been found to be more than three times likely to die from suicide than women (males 75.3%, females 24.7%)[13]. The highest rates in males are aged 40-49yrs[14].

2.3 Gold Coast suicide data

A significant challenge for suicide prevention work is access and availability of current regional suicide data. However, a number of sources have recently increased the frequency of interim reporting including, Suicides in Queensland: Annual Report 2020 and Suicide and self-harm monitoring data provided by Australian Institute of Health and Welfare. These sources report:

- The Gold Coast age-standardised suicide rates over the last three years (17.8 in 2017, 15.3 in 2019 and 12.3 in 2018)15 have been relatively consistent with the Queensland rates (16.5, 15.8, 15.4)16 and predominately greater than the National rate (13.2, 12.4, 12.9)[15].



- In 2019, males were more than twice as likely to suicide than women and accounted for over 65.5% of suicides[16].
- Gold Coast data for 2018 indicated male rate of death by suicide as higher (59.4%) than female (40.6%), however since 2013, male suicide rate has decreased (2013:76.1%) whereas female suicide rate has increased (2013:23.9%)[17].
- The predominant age cohort of people dying by suicide in Gold Coast Hospital and Health Service has increased since 2013, from 40-44yrs to 50-54yrs during 2018[17].

Aboriginal and Torres Strait Islander peoples

Overall, 2019 National data explain that of suspected suicides in all Australians, the Indigenous population ranged from 1.4 to 2.3 times that of non-Indigenous Australians[16]. Of the 757 suspected cases of suicide in Queensland in 2019, 20.2% identified as Aboriginal and Torres Strait Islander people. This was made up of 11.9% males and 8.3% females[17].

In 2018 there were 50 suspected suicides (33 male, 17 female) of people who identified as Aboriginal and Torres Strait Islander People in Queensland. This overall number was less than 2017, in which there were 52 suspected suicides of people who identified as Aboriginal and Torres Strait Islander People in Queensland[17].

Prevalence of life events

Data from the Queensland Suicide Register identified the prevalence of life events among people who died by suicide (2014-2016). Relationship difficulties including separation (27.2%) and conflict (15.3%) were the most frequently recorded life events when combined[18].

This was the case for all ages and for both women and men. This was followed by financial problems (18.3%), interpersonal or familial conflict (15.7%), and bereavement (13.2%); recent or pending unemployment (12.7%), pending legal matters (11.6%); and work or school problems (8.9%)[18].

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

2. Suicide prevention in the Gold Coast region

Continued...

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 emergency department presentations to Gold Coast Public Hospitals with 51% being males and 49% females. This is an average of 150 presentations per week[19].

In 2017-2018, 5,088 people on the Gold Coast sought treatment for alcohol and other drug issues[20]. 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 emergency department presentations in 2018 to Gold Coast public hospitals[21].

Extrinsic influences/Contextual factors e.g. Covid-19

Suicide is a complex interaction of individual, social and other factors, with no single factor solely responsible for suicidal behaviour. Social isolation, stigma, discrimination, employment, financial hardship, housing and homelessness and adverse life events can all influence vulnerability to suicide.

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.

3. Gold Coast Suicide Prevention Community Action Plan (CAP) and implementation approach

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

Value	Outcomes
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)

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. This implementation group will also provide oversight of the Gold Coast Suicide Prevention CAP and will report progress to the JRP Strategic Oversight Committee. Progress of the CAP will also be included in the broader JRP annual progress report to community.

Understanding the timeline and prioritisation of actions in this CAP

The timeline for actions are categorised as follows:

- **CO** 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)

Prioritisation of actions are categorised on a scale as follows:

- **CO** Current and ongoing work
- **1** Highest priority (High impact/Low difficulty)
- **5** Lowest priority (Low impact/Difficult to implement

Current response: Gold Coast Suicide Prevention Activity 2019-2020

STRATEGY	GOLD COAST HEALTH	GCPHN	COMMUNITY
Improving emergency and follow up care for suicidal crisis	Mental Health Acute Care Team, Suicide Prevention Pathway, Mental Health Co-responder model with QPS and QAS, School Based Youth Health Nurse (SBYHN), Ed-LinQ, Crisis reform initiative	The Way Back Support 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 Crossing Paths, Northern Gold Coast Suicide Prevention Service WMQ
Using evidence-based treatment for suicidality	Brief interventions (e.g. safety planning and Pisani Model), Research trials Research trial SPA grant AISRAP Prof Chris Stapleberg with interim progress published June 2021, Comprehensive mental health service and treatment for co-morbidities	Psychological Service Providers (PSP) – Suicide Prevention stream, PSP training with Gold Coast Health	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 training, ASIST training, Mental Health First Aid Training (MHFA), Mental health skills training for GPs, Focused 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 Gold Coast Health	Wesley Lifeforce training, ASIST 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	School Based Youth Health Nurse (SBYHN), Ed-LinQEdlinkb, Child and Youth Mental Health Service (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	MHFA LE Training for Consumers Carers and Community Members	Question, Persuade, Refer (QPR) training	Wesley Lifeforce Training, SafeTalk, ASIST training, 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, Mental Health week, Gold Coast 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			

For more information about these initiatives, please see Appendix A

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 CAP.

Working Together

❖Indicates JRP priority actions

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	GCPHN and Wesley Mission Queensland
W.2. Progress of the plan is tracked and reported	W.2.1 The Suicide Prevention Iimplementation group will meet to monitor progress and implementation of the CAP actions.	• Attendance and minutes of Suicide Prevention Implementation Group	ST As per Terms of Reference	GCPHN and Wesley Mission Queensland
	W.2.2 Responsible officers will report on the implementation of CAP actions to the suicide prevention Implementation group.	• RAG status reporting on implementation of CAP actions.	ST As per Terms of Reference	Express interest - mentalhealthaod@gcphn.com.au
	W.2.3 Monitor and report on progress of CAP actions to funding/commissioning bodies.	• An progress report is developed and distributed.	ST As agreed Suicide prevention Implementa-tion Group	GCPHN and Wesley Mission Queensland
	W.2.4 Explore local research capability for future in-depth analysis and evaluation of the CAP.	• To be determined by lead	MT	Express interest - mentalhealthaod@gcphn.com.au
W.3. Lived Experience inclusion at every level	W.3.1 Endorse and apply the Black Dog Institutes Lived Experience Framework to guide regional engagement of Lived Experience against each LifeSpan strategy.	• Activity register and type of engagement	ST	GCPHN /Gold Coast Health

1. Improving emergency and follow up care for suicidal crisis

A suicide attempt is the strongest risk factor for subsequent suicide[1]. To reduce the risk of a repeat attempt, a coordinated approach to improving the care of people after a suicide attempt is required[3].

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[2,3]. When vulnerable people seek help, services need to make them feel welcome.

Current state
Issues that you told us about

- *"People who present in emergency department 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."*
- *"The emergency department 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"*

Improving emergency and follow up care for suicidal crisis

❖Indicates JRP priority actions

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 development of Gold Coast crisis reform initiative Strategy 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 strategy consultation • Attendance and contribution at meetings as required • Gold Coast Crisis Reform strategy completed	December 2020	Gold Coast Health	CO

[1] Christiansen E, Jensen BF. Risk of repetition of suicide attempt, suicide or all deaths after and episode of attempted suicide: a register-based survival analysis. Australian and New Zealand Journal of Psychiatry. 2007;41:257-265.
[2] Krysinska K, Batterham PJ, Tye M, et al. Best strategies for reducing the suicide rate in Australia. Australian and New Zealand Journal of Psychiatry. 2016;50(2):115-118.
[3] Hunter C, Chantler K, Kapur N, Cooper J. Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: A qualitative study. Journal of Affective Disorders. 2013;145:315-323.
[4] NHMRC Centre of Research Excellence in Suicide Prevention (C.R.E.S.P). Care after a suicide attempt. 2015.

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**
	1.1.2 Continue to progress crisis reform initiatives	• Quarterly progress reports indicate project is on track	Current and ongoing	Gold Coast Health	CO
	1.1.3 Develop and implement a Stabilisation unit at the Robina Hospital Site	• Quarterly progress reports indicate project is on track	Opens July 2021	Gold Coast Health	ST
1.2 Zero Suicide guidelines are implemented, and suicide prevention training is provided to emergency department (ED), hospital staff and frontline workers within Gold Coast Health, including peer support workers.	1.2.1 Continue to implement Zero Suicide at Gold Coast Health	• Gold Coast Health to advise (e.g. evaluation report)	Current and ongoing	Gold Coast Health	CO
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	Gold Coast Health /QPS/QAS	CO
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 Implement The Way Back Support Service (TWBSS) in partnership with Queensland Health and Beyond Blue	• Program level data • Client satisfaction • Partnership feedback • Connections/ linkages to other supports/services	ST July 2020 - June 2022	GCPHN and Wesley Mission Queensland	CO
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	CO
	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 who is responsible.	Current and ongoing	CFLSPN (until September 2021)	CO

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**
	1.5.3 Continue to provide a suicide bereavement support group	• Program level data (frequency, attendance, satisfaction)	Current and ongoing	Lifeline (Uniting Care)	CO
	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 18m trial starts Jan 2020	WMQ/Roses in the Ocean/ Beacon Strategies with funding from Queensland Health	CO
	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	WMQ via implementation of the Carers Support (Crossing Paths) Program - currently until September 2021)	CO
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 GOld Coast Health and review annually. ❖	• Updated resource packs are distributed to Carers • Resource packs are reviewed and updated annually	ST 2020 and reviewed annually	Gold Coast Health Carers and consumers?	CO
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 card 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 2020	CFLSPN (until September 2021)	CO
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. ❖ (see also 3.1.1)	• Service is designed and implemented • Program level data • Quarterly progress reports .	ST 2020-2022	GCPHN	CO

2. Using evidence-based treatment for suicidality

Mental illness, including depression, is associated with a large portion of suicide attempts[5]. Providing accessible and appropriate mental health care is essential to suicide prevention[6,7]. 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[8,9].

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 the quality of these services."*
- *"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."*

Using evidence-based treatment for suicidality

❖Indicates JRP priority actions

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	CO
	2.1.2 Review the Psychological Services Program Suicide Prevention Stream to ensure evidence-based treatments are being delivered and targeted to the right individuals. ❖	• Evaluation report	ST By June 2021	GCPHN	CO
	2.1.3 Continue to provide a comprehensive mental health service and treatment for co-morbidities at Gold Coast Health which includes brief interventions	• Gold Coast Health data • Client satisfaction • Client experience • Initial mapping to NMHSPF tool • JRP progress updates	Current and ongoing	Gold Coast Health	CO

5 Pompili M, Innamorati M, Raja M, et al. Suicide risk in depression and bipolar disorder: Do impulsivenessaggressiveness and pharmacotherapy predict suicidal intent? Neuropsychiatric Disease and Treatment. 2008;4(1):247-255.
6 Hawton K, Witt KG, Salisbury TLT, et al. Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis. The Lancet Psychiatry. 2016;3(8):740-750.
7 Calati R, Courtet P. Is psychotherapy effective for reducing suicide attempt and non-suicidal self-injury rates? Meta-analysis and meta-regression of literature data. Journal of psychiatric research. 2016;79:8-20.
8 Dixon L, McFarlane WR, Lefley H, et al. Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatric services (Washington, DC). 2001;52(7):903-910.
9 Fuller JD, Perkins D, Parker S, et al. Effectiveness of service linkages in primary mental health care: a narrative review part 1. BMC Health Serv Res. 2011;11:72.

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 shared learning opportunities for Psychological Service Providers and other service providers about evidence-based interventions and the Gold Coast Health Suicide Prevention Pathway including Just Culture. ❖	• Frequency, attendance • Training feedback	Current and ongoing	GCPHN/Gold Coast Health	CO
	2.2.2 Identify and promote shared learning opportunities suitable for members of other sectors to participate and promote as appropriate. ❖	• Number of activities • Attendance • Participant feedback	ST	GCPHN/Gold Coast Health	CO
	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/Gold Coast Health	CO
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	Gold Coast Health/ Bond University	CO
2.4 Cross sector understanding of the urgency for suicide prevention and evidence-based treatment options.	2.4.1 Cross sector training on basis for suicide prevention in the region including: Just culture, shared language, principles, current approaches to suicide prevention and treatment, pathways for referral.	• Frequency • Attendance • Training feedback	MT	GCPHN/Gold Coast Health	2
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/Gold Coast Health and Governing bodies	5
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.	• To be determined by lead	• TBD	Express interest mentalhealthaod@gcphn.com.au	5

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[10,11]. 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[12,13,14].

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 Mental Health Care Plan e.g. Psychological Service Providers."*
- *"When describing their experience of care, consumers frequently express a lack of empathy and compassion from primary care providers."*

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 Explore models of care to address distress in the community ❖	• Recommendations from review	ST	GCPHN	3
	3.1.2 Continue to implement GP 6-month Mental Health training rotations for trainees in Gold Coast Health and explore opportunities to further promote. ❖	• Increase in number of GP trainees in MH rotation.	ST	Gold Coast Health/ University	1
	3.1.3 Maintain awareness of approaches and relevant GP training packages in other regions and develop recommendations for GPs in the Gold Coast region. ❖	• Recommendations developed and hosted on GCPHN website	MT	GCPHN	3
	3.1.4 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	Express interest mentalhealthaod@gcphn.com.au	3

10 De Leo D, Draper BM, Snowdon J, Kolves K. Contacts with health professionals before suicide: missed opportunities for prevention? Compr Psychiatry. 2013;54(7):1117-1123.
11 Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159(6):909-916.
12 Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. JAMA. 2005;294(16):2064-2074.
13 Zalsman G, Hawton K, Wasserman D, et al. Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry. 2016;3(7):646-659.
14 Page A, Atkinson JA, Heffernan M, McDonnell G, Hickie I. A decision-support tool to inform Australian strategies for preventing suicide and suicidal behaviour. Public Health Res Pract. 2017;27(2).

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**
3.2 Primary Care providers can recommend a range of supports and know where to refer individuals in distress.	3.1.5 Explore barriers to participation and potential incentives/opportunities to support GP training.	• TBD	MT	Express interest mentalhealthaod@gcphn.com.au	3
	3.2.1 Promote use of eMHPrac and appropriate digital health resources. ❖	• Number of communications to Primary Care that include eMHPrac	ST	GCPHN	2
	3.2.2 .Create simple referral pathways. ❖	• To be determined by lead	TBD	Suicide Prevention Implementation Group	3
3.3 There is a more consistent approach to intake, assessment, and referrals.	3.2.3 Support clear/warm referral pathways to non-clinical options (e.g. Active and Healthy, employment, housing etc.) ❖	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	2
3.4 Primary Care providers are supported to follow up with people who have presented in distress	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
3.5 Mental Health leaders in Primary Care can be easily identified by the community.	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
3.6 People in distress have a positive experience in Primary Care settings.	3.5.1 Identify and mark GPs who are mental health friendly or who have a special interest in mental health.	• To be determined by lead	TBD	Express interest mentalhealthaod@gcphn.com.au	5
	3.6.1 Train primary care workers in compassionate care and safe language.	• To be determined by lead	TBD	Express interest mentalhealthaod@gcphn.com.au	5
	3.6.2 Explore MH Nurses embedded in Practices or Team based care coordinators.	• To be determined by lead	TBD	Express interest mentalhealthaod@gcphn.com.au	3

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[15]. However, existing training may not include the latest emerging research and skills that 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[16].

In addition, workers exposed to stressful situations and trauma can themselves become vulnerable to suicide[17]. 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."*

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

❖Indicates JRP priority actions

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 activit	ST	GCPHN/Gold Coast Health (TBC by Suicide Prevention Implementation Group)	3
	4.1.2 Promote shared learning opportunities attended with leaders of Frontline workers.	• Number of shared learning opportunities attended by High- level Frontline workers.	MT	GCPHN/Gold Coast Health(TBC by Suicide Prevention Implementation Group)	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/Gold Coast Health (TBC by Suicide Prevention Implementation Group)	3

[15] WHO. Preventing Suicide: a resource for police, firefighters and other first line responders. Geneva, Switzerland: World Health Organization;2009. 3.
[16] Smith AR, Silva C, Covington DW, Joiner Jr TE. An assessment of suicide-related knowledge and skills among health professionals. Health Psychology. 2014;33(2):110.
[17] NCIS. Intentional Self-Harm Fact Sheet: Emergency Services Personnel. http://www.ncis.org.au/mortalitydata-from-the-ncis/mortality-data-statistics-and-internal-reports/: National Coronial Information System;2015.

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**
	4.2.2 Better understand the relationship and potential role of QAS in suicide prevention. ❖	• Recommendations	ST	GCPHN/Gold Coast Health (TBC by Suicide Prevention Implementation Group)	3
	4.2.3 Identify which front line workers require prioritised training and support.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	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.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	2
	4.2.5 Regional agreement on preferred evidence-based training and skills development packages.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3
	4.2.6 Promotion and coordination of training and skills development opportunities for a more standardised approach across the region.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3
	4.2.7 Evaluate application of training.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	2
	4.2.8 Explore philanthropic grants/funding to remove barriers to training.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3
4.3 Frontline workers are supported to feel safe with risk and responsibility.	4.3.1 Restorative Just culture Principles are highlighted in shared learning and training opportunities. ❖	• Number of Gold Coast based trainings where Just Culture is included.	ST	Express interest - mentalhealthaod@gcphn.com.au	3
	4.3.2 Explore effective ways to embed Restorative Just Culture principles into service models for suicide prevention. ❖	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3

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**
4.4 Frontline workers have access to appropriate supervision and support to ensure that they do not also become vulnerable to suicidal thinking e.g. Blue Hope	4.4.1 Provide training about self-care and where to get help.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3
	4.4.2 Look for opportunities to support Frontline Workers following losing a patient to suicide.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	2
	4.4.3 Explore the possibility of a local 'Helpline' dedicated to workers e.g. Blue Hope.	• To be determined by lead	TBD	Express interest - mentalhealthaod@gcphn.com.au	3

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

Young people can be particularly vulnerable to mental health problems, self-harm and 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-based school programs reviewed, including the best outcomes specific to suicidal behaviour, with flexibility to be integrated into any school environment[18].

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."*

Promoting help-seeking, mental health and resilience in schools

❖Indicates JRP priority actions

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 • A GC Youth Working group is established or identified to lead this work	ST (priority)	Express interest mentalhealthaod@gcphn.com.au	4
	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 • A GC Youth Working group is established or identified to lead this work.	MT	GC Youth Working group?	3

[18] Wasserman, D., Hoven, C. W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G.,…Carli, V. (2015). School-based suicide prevention programmes: the SEYLE cluster randomised, controlled trial. The Lancet, 385(9977), 1536-1544.

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**
5.2 Schools implement appropriate suicide prevention training, supports and resources for students, staff and parents including culturally appropriate options for diverse communities. (Training)	5.2.1 Promote uptake of Be You at schools and Early Childhood Education Centres (ECEC).	• Number of schools and ECECs whose staff report active use of Be You as a percentage of all Gold Coast State schools.	ST	Be You coordinators and Education Queensland	2
	5.2.2 Utilise recommended referral pathways between schools and local support services.	• Percentage of referrals from local schools	MT	Express interest mentalhealthaod@gcphn.com.au	4
	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	Express interest mentalhealthaod@gcphn.com.au	4
	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	Express interest mentalhealthaod@gcphn.com.au	4
	5.2.5 Evaluate training programs	• Cochrane style review regularly (3-5yrly)	MT	Express interest mentalhealthaod@gcphn.com.au	4
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	1
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 health & wellbeing framework) SafeMinds in Victoria is another example to look at-need to ensure that facilitated discussions with students about suicide or suicide related behaviours occurs	• Whole of School Approach-Health & Wellbeing Framework (not mandatory)-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	2

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**
5.5 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	3
	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 Ed-LinQ programs. • A GC Youth Working group is established or identified to lead this work	Current and ongoing	Express interest mentalhealthaod@gcphn.com.au	2
	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) • A GC Youth Working group is established or identified to lead this work	ST/MT	Express interest mentalhealthaod@gcphn.com.au	3
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/frameworks 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	• Number of events • Attendance • Representation/participating schools • Participant satisfaction	MT	Express interest mentalhealthaod@gcphn.com.au	4
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 • A GC Youth Working group is established or identified to lead this work	MT	Express interest mentalhealthaod@gcphn.com.au	1

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[19,20]. This is often referred to as 'Gatekeeper training'.

While there are many training programs that deliver skills in mental health awareness, Question, Perusade, Refer (QPR) has the most and strongest evidence for building skills to help with a suicidal crisis[21].

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."*

Training the community to respond to suicidality/Gatekeeper training

❖Indicates JRP priority actions

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

19 Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. Jama. 2005;294(16):2064-2074.
20 Krysinska K, Batterham PJ, Tye M, et al. Best strategies for reducing the suicide rate in Australia. Australian & New Zealand Journal of Psychiatry. 2016;50(2):115-11.
21 Lancaster PG, Moore JT, Putter SE, et al. Feasibility of a web-based gatekeeper training: Implications for suicide prevention. Suicide and life-threatening behavior. 2014;44(5):510-523.

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**
6.2 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	Express interest mentalhealthaod@gcphn.com.au	3
	6.2.2 Desktop review of evidence, including review of approaches in other regions, mapping of relevant training packages and develop recommendations.	• Resource of recommended training is developed and accessible to the public	MT	Express interest mentalhealthaod@gcphn.com.au	4
	6.2.3 Regional agreement on preferred evidence-based training and skills development packages.	• Endorsement of training and skills packages	MT	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	4
	6.4.3 Gather data from training providers	• Pre/post training and follow-up surveys	TBD	Express interest mentalhealthaod@gcphn.com.au	3
6.5 Compassionate care is promoted in all suicide prevention training.	6.5.1 Explore existing training for compassionate care	• To be determined by lead	TBD	Express interest mentalhealthaod@gcphn.com.au	3
	6.5.2 Provide compassionate care training	• To be determined by lead	TBD	Express interest mentalhealthaod@gcphn.com.au	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[22].

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."*

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

❖Indicates JRP priority actions

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 Gold Coast Health 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	Express interest mentalhealthaod@gcphn.com.au	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 Support opportunities for people with lived experience to speak and present and to share stories of hope and recovery. ❖ (see also 8.2.1 below)	• Case studies: Good news stories	MT	TBD	4

[22] Torok, M., Calear, A., Shand, F., Christensen, H. (2016). A systematic review of mass media campaigns for suicide prevention: understanding their efficacy and the mechanisms needed for successful behavioral and literacy change. Suicide and life-threatening behavior.

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**
7.2 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 Sept	CFLSPN (until September 2021)	CO
	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 (until September 2021) GCPHN,Gold Coast Health, Suicide Prevention Implementation Group	2
	7.2.3 Explore opportunities to actively engage other sectors who create connection e.g. engagement with awards nights, neighbourly initiatives, social programs etc.		MT	CFLSPN / GCPHN	3
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	Express interest mentalhealthaod@gcphn.com.au	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. ❖	• Number of engagement activities with diverse groups (consultation, events, etc)	ST	Express interest mentalhealthaod@gcphn.com.au	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 21	ST	CFLSPN	4
7.6 Service providers and community are aware of crisis support services to the Gold Coast community.	7.6.1 Maintain and promote Gold Coast Suicide Prevention Service Finder which includes 24 hour crisis support and counselling and support services.	• A resource is maintained and distributed • Distribution register is maintained	Current and ongoing (updated every 2-3 years)	CFLSPN (until September 2021)	CO

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**
	7.6.2 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 (until September 2021)	CO
	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 (until September 2021)	CO
7.7 People with a lived experience of suicide are acknowledged and supported to be involved in suicide prevention activities.	7.7.1 Candlelight Vigil/Out of the Shadows walk	• Number of people registered/attending • Participant feedback	Current	Lifeline	CO
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 mental health and suicide prevention training as part of Workplace Health and Safety	MT	Express interest mentalhealthaod@gcphn.com.au	3
	7.8.2 Explore Train the Trainer models to identify champions of support e.g. Mates in Construction	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	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 factors and referral pathways.	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	3

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[23], 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[24].

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."*

Encouraging safe and purposeful media reporting

❖Indicates JRP priority actions

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. ❖	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	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/Gold Coast Health and local media	1
	8.1.3 Promote awareness of Mindframe guidelines and training and SANE stigma watch. ❖	• Number of events or publications where training/collateral was promoted	ST	Express interest mentalhealthaod@gcphn.com.au	2
	8.1.4 Provide Mindframe media plus training to local media outlets and service providers. ❖	• To be determined by lead		Express interest mentalhealthaod@gcphn.com.au	4

23 Etzersdorfer E, Sonneck G. Preventing suicide by influencing mass-media reporting. The Viennese experience 1980–1996. Archives of Suicide Research. 1998;4(1):67-74.
24 Wang X. Media guidelines for the responsible reporting of suicide: a review of effectiveness. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2012;33(4):190

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**
	8.1.5 Explore what can be done locally to contain social media sensationalisation of local suicides.	• To be determined by lead		To be determined by lead	1
	8.1.6 Promote awareness of Chatsafe guidelines for young people. ❖	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	3
	8.1.7 Lobby to move news to a later hour.	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	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	Express interest mentalhealthaod@gcphn.com.au	4
8.3 There is a positive mental health focus through local media that share stories of hope.	8.3.1 Explore partnering with known community champions/ambassadors to speak to support a shared action for suicide prevention.	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	TBD
	8.3.2 Partner with local media to promote stories of hope to the community through local campaigns/initiatives. ❖	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	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[25,26,27]. 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."*

Improving safety and reducing access to means of suicide

❖Indicates JRP priority actions

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**
9.1 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).	9.1.1 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	CO
	9.1.2 Explore options for ongoing access to current data and regular updates from the Queensland Suicide Register.	• MOU or collaboration agreement is signed with AISRAP/QMHC	Current and ongoing	GCPHN/Gold Coast Health	CO
	9.1.3 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/Gold Coast Health	3
	9.1.4 Prepare an annual suicide audit template/report to share regional data and highlight potential responses to improve safety and reduce access.	• Template/report is developed and updated annually	MT	Express interest mentalhealthaod@gcphn.com.au	3
	9.1.5 Use regional data to help promote good prescribing behaviours in GPs.	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	4

25 Mann, J. J., Apter, A., Bertolote, J., Beatrais, A., Currier, D., Haas, A., Hendin, H. (2005). Suicide prevention strategies: a systematic review. Journal of the American Medical Association, 294, 2064-2074.1 Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., & Roy, A. (2011). Controlling access to suicide means. International Journal of Environmental Research and Public Health, 8, 4550-4562.

26 Krysinska, K., Batterham, P.J., Tye, M., Shand, F., Calear, A.L., Cockayne, N., & Christensen, H. (2016). Best strategies for reducing the suicide rate in Australia. Australian & New Zealand Journal of Psychiatry, 50, 115-118.

27 Klieve, H., Barnes, M., & De Leo, D. (2009). Controlling firearms use in Australia: has the 1996 gun law reform produced the decrease in rates of suicide with this method? Social Psychiatry and Psychiatric Epidemiology, 44, 285-92.

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**
9.2 Establish strategic partnerships and planning with other services and sectors that could reduce access to means e.g. AOD.	9.2.1 Explore cost and funding for Suicide Prevention training for Gold Coast Pharmacists.	• Attendance • Satisfaction survey	ST	GCPHN/Gold Coast Health	3
	9.2.2 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
	9.2.3 Promote clear/warm referral pathways to AOD services	• To be determined by lead	GCPHN	Express interest mentalhealthaod@gcphn.com.au	2
9.3 Initiatives are in place for known periods/ seasons of high risk e.g. schoolies.	9.3.1 Review what are initiatives that already exist at schoolies e.g. Red frogs.	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	2
9.4 People in suicidal crisis are supported to develop and share individual safety plans to improve their safety and reduce access to means.	9.4.1 Provide safety planning training for service providers, family and carers.	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	3
	9.4.2 Explore pathways to share safety plans with other providers, family and friends.❖	• To be determined by lead	MT	Express interest mentalhealthaod@gcphn.com.au	2
	9.4.3 Promote use and uptake of Beyond Now Safety planning app.	• To be determined by lead	ST	Express interest mentalhealthaod@gcphn.com.au	3

References

1 Commonwealth Department of Health. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: DOH, 2017.
2 WHO (2014). Preventing suicide: A global imperative. Available at https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
3 Cerel. J., Brown, M., Maple, M., Singleton, M. van deVenne, J., Moore, M., Flaherty, C. (2018). How many people are exposed to suicide: Not six. Suicide and Life-Threatening Behavior 49 (2)
4 Commonwealth of Australia (2016). National suicide prevention strategy. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps
5 ABS 3218.0, Regional Population Growth, Australia, released 25 March 2020
6 Queensland Government population projections, 2018 edition; Australian Bureau of Statistics, Population by age and sex, regions of Australia, 2016 (Cat no. 3235.0).
7 ABS, 2016 Census Community Profiles – Gold Coast https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/communityprofile
8 Census of population and Housing, 2016, Aboriginal and Torres Strait Islander Peoples Profile-102 Indigenous Status by SA3ABS,
9 ABS, Census of Population and Housing, 2016, General Community Profile - G01 and G09
10 Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020 - https://www.griffith.edu.au/__data/assets/pdf_file/0035/1196855/QSR_Annual_Report_2020.pdf. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University. Suicide rates were calculated using the June 2001 Australian standard population and the estimated resident Queensland population numbers for June 2019. Australian Bureau of Statistics (2019). Australian Demographic Statistics, December 2019. ABS Catalogue number: 3101.0. Estimated Resident Population by Single Year of Age, Queensland. Released 18 June 2020
11 AIHW National Mortality Database and ABS Causes of Death, Australia 2020, supplementary table: NMD S4, NMDS5 2019 (annual release) accessed from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories last accessed 20 November 2020
12 AIHW National Mortality Database and ABS Causes of Death, Australia 2020, supplementary table: NMD S4, NMDS5 2019 (annual release) accessed from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories last accessed 20 November 2020
13 Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. https://www.griffith.edu.au/__data/assets/pdf_file/0035/1196855/QSR_Annual_Report_2020.pdf Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University. - Suicide rates were calculated using the June 2001 Australian standard population and the estimated resident Queensland population numbers for June 2019. Australian Bureau of Statistics (2019). Australian Demographic Statistics, December 2019. ABS Catalogue number: 3101.0. Estimated Resident Population by Single Year of Age, Queensland. Released 18 June 2020
14 AIHW National Mortality Database and ABS causes of Death, Australia 2020, Supplementary table NMD S9, accessed from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/suicide-by-phn-areas, last accessed 20 November 2020.
15 AIHW, National Mortality Database and ABS Causes of Death, Australia 2020, supplementary table: NMD S4, NMDS5 2019 (annual release) accessed from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories last accessed 20 November 2020
16 AIHW National Mortality Database and ABS causes of Death, Australia 2020, Supplementary table NMD S1, accessed from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time last accessed 20 November 2020.
17 Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: Annual Report 2019. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, Griffith University. https://www.griffith.edu.au/__data/assets/pdf_file/0029/848063/Suicide_in_QLD_2019_ANNUAL_REPORT_ACESSIBLE.pdf
18 Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). Suicide in Queensland: Annual Report 2020. https://www.griffith.edu.au/__data/assets/pdf_file/0035/1196855/QSR_Annual_Report_2020.pdf Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University
19 Gold Coast Health Emergency Department data, 2018-2019
20 Source: AIHW, Mental Health services provided in emergency departments 2017/18
21 Alcohol and Other Drug treatment Services (AODTS) National Minimum Data Set (NMDS), https://data.qld.gov.au/dataset/alcohol-and-other-drug-treatment-services-aodts-national-minimum-data-set-nmds

Level 1, 14 Edgewater Court Robina QLD 4226 | PO Box 3576, Robina Town Centre QLD 4230
P 07 5635 2455 | E info@gcphn.com.au | W www.gcphn.org.au

Copyright 2020. Primary Care Gold Coast Limited (ABN 47 152 953 092), trading as Gold Coast Primary Health Network.
All rights reserved. Content is correct at time of publication - Print date 13/08/21.

Gold Coast Primary Health Network (GCPHN) gratefully acknowledges the financial and other support from the Australian Government Department of Health. While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use or reliance on the information provided herein.