The Greater Whitsunday Council of Mayors Suicide Prevention Taskforce Consultation Report

September 2021

Further information

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Acknowledgements

The Greater Whitsunday Council of Mayors Taskforce respectfully acknowledges those who have died or have been affected by suicide or intentional self-harm. The Taskforce collective is committed to ensuring our work continues to inform improvements in both community awareness and prevention of suicide and self-harm.

The Greater Whitsunday Council of Mayors Taskforce acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued cultural and spiritual connection to country, waters, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore. We are committed to making a valued contribution to the wellbeing of all Aboriginal and Torres Strait Islander peoples.

This report has been developed by Northern Queensland Primary Health Network (NQPHN) on behalf of the Mackay, Isaac and Whitsunday Regional Councils, in collaboration with the Whitsunday, Isaac and Mackay Suicide Prevention Community Action Planning Group, and the Mackay Hospital and Health Service.

The Greater Whitsunday Council of Mayors Taskforce acknowledges the Taskforce Members.
See Appendix A for a list of the members.

The Greater Whitsunday Council of Mayors Taskforce acknowledges and thanks the Taskforce Working Group:

- Mackay Regional Council - Deputy Mayor Karen May
- Isaac Regional Council – Jeff Stewart- Harris
- Whitsunday Regional Council – Cr. Al Grundy
- Mackay Whitsunday Isaac Suicide Prevention Community Action Planning Group – Deb Rae
- Mackay Hospital and Health Service – Cara McCormack
- Northern Queensland Primary Health Network – Karin Barron and Jennifer Corbett
- Community/Lived Experience Advisors: Sonia Oliver Scoble and Emma Rix

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Disclaimer:
Given the limited sample size for each of the surveys and focus group discussions, it is difficult to find significant relationships to ensure an even distribution/representation of the larger population cohort. The limitations also include the measures used to collect data and the data collection process along with selection bias in terms of participants. The data summary was completed by three individual NQPHN staff members.

Executive summary

Suicide in Australia persists as a complex issue, with interventions to reduce the current statistics and to prevent suicide often fragmented and difficult to access for community. With approximately 3,000 deaths occurring by suicide nationally each year, many local communities are calling for action. One such approach has been the establishment of the Greater Whitsunday Council of Mayors Suicide Prevention Taskforce across the Mackay and Greater Whitsunday regions.

The Taskforce was precipitated by a call to action from the local Whitsunday, Isaac, and Mackay Suicide Prevention Community Action Planning (SPCAP) Group. Mackay Mayor Greg Williamson called on his regional counterparts including Isaac Mayor Anne Baker and Whitsunday Mayor Andrew Wilcox to officially form the Taskforce in late 2020.

The Taskforce formed a working group to design and deliver a range of community engagement co-design interventions. The aim of these interventions was to collect and analyse community and provider intel to inform planning and ultimately deliver targeted action to reduce and prevent suicide in the region. The intel gleaned from the multipronged consultations has provided comprehensive feedback from people with lived experience, providers, and non-providers to inform this consultation report. Six areas for improvement were identified, including:

- access
- improving and diversifying workforce development
- navigation support
- services and providers capacity and capability enhancement
- community capacity and capability enhancement
- funding and planning approaches.

The six areas for improvement provide a foundation for action that encompasses local, place-based interventions as well as longer term service system change approaches. It must be noted that the six areas for improvement should be developed for action in alignment with relevant suicide prevention plans and is informed by local data. The North Queensland Joint Wellbeing Plan, mandated by State and Federal governments, provides a robust framework to facilitate local activity.

This report also highlights the increased complexity of suicide rates in relation to rurality and recommends consideration of geographical location when developing and resourcing interventions.

With the provision of preliminary funding confirmed for the Greater Whitsunday Council of Mayors Suicide Prevention Taskforce, the Greater Whitsundays Communities - the regional peak for social development - will progress action-planning activities that leverage the findings of this report and local intel. It is envisaged that as a community collective, the taskforce with initial funding will deliver interventions to reduce and prevent suicide in the greater Whitsunday region.

1. Introduction

Suicide prevention in Australia is a complex area of policy, with governments, policymakers, and service providers all having a role in reducing suicides and cases of intentional self-harm[1]. The reasons for suicide are also complex and are different for each individual. Prevalence, characteristics, and methods of suicidal behaviour vary between different communities, demographic groups, and over time. These complexities have made developing and delivering responses to address the issue difficult to define and fragmented in approaches.

Consequently, the suicide rate in Australia remains relatively static , however trends have changed with some cohorts. For example, females have increasing presentation in the statistics than previous cohorts, and First Nations People and younger males remain disproportionately represented[1].

- Approximately 3,000 deaths occur by suicide each year.
- The highest number of deaths by suicide are in mid-life.
- Males are 3 to 4 times more likely to take their own lives than females.
- Suicide is the leading cause of death in youth people.
- Females are more likely to be hospitalised for intentional self-harm[1].

2. About the Greater Whitsundays Council of Mayors Suicide Prevention Taskforce

The Council of Mayors Suicide Prevention Taskforce was established in response to industry and community concerns in relation to local suicide rates, which was raised by the Whitsunday, Isaac and Mackay Suicide Prevention Community Action Planning group (SPCAP). These key stakeholders were concerned that residents of the Mackay region were experiencing significant mental health distress, could be at risk of suicide, and experienced difficulties in navigating and accessing appropriate services and health care. In 2020, this already fragile situation was adversely impacted by the COVID-19 pandemic, with the toll of uncertainty of the situation, the restrictions (including social isolation), and the heightened demand on an already stretched health workforce.

Consequently, Mackay Mayor Mr Greg Williamson made a call to action to the Greater Whitsunday Region Mayors of Mackay, Isaac, and Whitsunday to form the Council of Mayors Suicide Prevention Taskforce. The taskforce was a collective of local industry, regional councils, lived experience residents, First Nations People, and the local health sector. The taskforce hypothesised that as a collective, they were better placed to understand the issues and develop evidence informed, place-based solutions.

3. The Greater Whitsunday Council of Mayors Suicide Prevention Taskforce Working Group

The Council of Mayors Suicide Prevention Taskforce Working Group was formed to progress scoping of the issue, planning, and actioning the intention of the taskforce. The Working Group consisted of:

- Mackay Regional Council
- Isaac Regional Council
- Whitsunday Regional Council
- Mackay Hospital and Health Service
- Northern Queensland Primary Health Network
- Whitsunday, Isaac, and Mackay Suicide Prevention Community Action Planning (SPCAP) Group
- community/lived experience representative/s.

1 Australian Institute of health and Welfare, 2020, Suicide & self-harm monitoring, Suicide & self-harm monitoring data - Australian Institute of Health and Welfare (aihw.gov.au)

The Working Group further defined the issues by exploring local and national data, including:

- the Whitsunday, Isaac, and Mackay SPCAP consultation data
- the Australian Institute of Health and Welfare (AIHW) 2020 Suicide and Self Harm Monitoring Data Report
- Queensland Chief Health Officers Report 2020
- North Queensland Joint Wellbeing Plan 2020
- National Health Reform Agreement – Addendum 2020-25 - Released November 2020
- Productivity Commission: Mental Health Inquiry: Mental Health Australia Briefing - Released 18 November 2020
- NQPHN Health Needs Assessment 2019-2022: Mental Health Suicide Prevention and Alcohol and Other Drugs Extract

The Working Group then set about defining how the Council of Mayors Suicide Prevention Taskforce should best define the issues and identify the needs of the community. Ultimately, it was decided that the Working Group should take a multipronged approach to gleaning local health and community information, which included:

- the design, development, and delivery of a co-design workshop
- the design and dissemination of three surveys:
  - Lived Experience Survey
  - Providers Survey
  - Non-Provider Survey
- primary care provider focus groups.

4. Council of Mayors Suicide Prevention Taskforce Co-Design Workshop

The Council of Mayors Suicide Prevention Taskforce Co-Design Workshop was undertaken with people with lived experience, service providers, and government and industry representatives on Thursday 6 May 2021 in Mackay. Invitations to attend were offered to regional community members who could inform and contribute to this stakeholder engagement process. They were selected using purposive and snowball techniques and established guidelines for qualitative methods[2] (Daly 2009).

The opportunity to participate was made available to community members through dissemination of an expression of interest flyer, emails, and face to face invitations.

4.1 Participation

The eighty-seven participants who accepted this invitation and attended the workshop included representatives from:

- Whitsunday, Isaac, and Mackay Regional Councils
- community organisations
- children's organisations
- private providers
- politicians
- Hospital and Health Service
- Primary Health Network
- Suicide Prevention Community Action Plan Group
- Chaplaincy groups
- General practice
- First Nations Peoples
- Education Queensland
- Youth agency
- Queensland Police Service
- Queensland Ambulance Service
- Legal agencies
- Non-health industry representatives (mining/agribusiness)

See Appendix B: Workshop flyer

2 Daly, J., 2009, Qualitative method and the curse the illustrative quotation, doi:10.1111/j.1753-6405.2009.00419. x.

4.2 Method

Prior to the workshop, the Working Group identified attendees who could proficiently facilitate a group discussion at the event. These semi-structured group discussions explored the views of participants on three broad themes. The three questions that participants were asked included:

- Question one – Please tell us about your experience navigating and accessing services and support in the context of suicide prevention.
- Question two – Can you identify what has worked well for you when you have had to navigate and access services and support in the context of suicide prevention?
- Question three – What would timely and effective navigation and access support look like in the context of suicide prevention?

4.3 Evaluation report

Eighty-four per cent of the participants cited that the co-design workshop was relevant to them, with the remaining 16 per cent citing the event was partially relevant. The participants rated the co-design workshop sessions as follows:

Co-design workshop session	Partially beneficial	Beneficial	Entirely beneficial
Suicidology – guest presentation	9%	38%	53%
Data and evidence of need session	13%	30%	57%
Lived experience panel	7%	29%	64%
Co-design working session 1	5%	14%	81%
Co-design working session 2	7%	19%	73%

4.4 Data collection

Comprehensive data was collected from participants who actively engaged in activities during this one-day, co-design workshop. A content analysis process was applied, with data consisting of small group discussion notes. The transcripts were imported into NVivo 12 software and analysed. All statements were reviewed and aligned (where relevant/possible) with existing initial themes. This refined data was then reviewed by the facilitation team to ensure themes were collectively agreed.

4.5 Codesign session one Q1. Please tell us about your experience navigating and accessing services and support in the context of suicide prevention

Recurring themes

- Access barriers – timeliness /centralised
- Services – availability / appropriateness / directories of /operating hours
- Support – for prevention / clinical / peer/ afterhours / crisis
- Culturally - safety / appropriateness
- Crisis and risk – Crisis intervention /poor crisis support / increased risk

Graphic 1.1 Codesign Session one: Q1 Word Cloud

4.6 Codesign session one
Q2. Can you identify what has worked well for you when you have had to navigate and access services and support in the context of suicide prevention?

Recurring themes

- Services – criteria / access / coordination / timeliness / directories
- Support – workforce / community increase needs / peer
- Access – referral / timely / directories – navigation / central point of access
- Continuity of care – including patient information sharing / referrals / service coordination
- Community – central point / support / vulnerable / Family carer friend's support

Graphic 1.2 Codesign Session one: Q2 Word Cloud

4.7 Codesign session one
Q3. What would timely and effective navigation and access support look like in the context of suicide prevention?

Recurring themes

- Support – support person / service access – navigation / accessible / peer
- Services – referral pathways / navigation / specialist services
- Access – after hours / central point / centralised
- Community – grassroots / central access (for community) / peer /Family, carer and friends
- Pathways and navigation – referral pathways / criteria / navigation of referral service

Graphic 1.3 Codesign Session one: Q3 Word Cloud

4.8 Codesign Session two
Q4. Blue sky thinking: what would enhance navigation and support in the context of suicide prevention?

Recurring themes

- Services - available / outreach / rural / silo / integrated / holistic / transparent
- Providers – culturally skilled / accessible / education and training / networks of
- Support – Indigenous / appropriate / male / people / peer
- Community – centres / van / events / awareness / rural / connection / community groups
- Connections – cultural / social / local / providers / people

Graphic 1.4 Codesign Session two: Q4 Word Cloud

Co-design workshop summary

Co-design workshop participants identified perceived service knowledge gaps of both people with lived experience and health professionals, resulting in “dead ends and wrong turns”. Participants also raised a perceived lack of support for people with lived experience encountering non-crisis events (“no support for intermediate crisis”).

Relatedly, participants identified barriers to non-crisis care, including the time from booking to the appointment, (“services aren’t always available when you need them”), financial barriers, communication barriers, stigma, and fear (consumer and health professional), and lack of a clear follow up pathway (“being bumped from one agency to another” and “handballing back and forth”).

A lack of equity was also raised by participants, specifically stating that Indigenous and people who are culturally and linguistically diverse experience decreased access. When service access is achieved, the environment can then be culturally unsafe due to a “lack of culturally based programs and clinicians” and “no consultation with culturally lived people”.

Participants described having one person to “walk alongside them”, a “dedicated worker” or “non-clinical support”, and the benefit of “connection with real people” throughout the process of navigating and accessing services. They also raised the need for “central touch points” which are local, appropriate and free from stigma. Relatedly, participants highlighted the value of cross-sector coordination, particularly for at-risk cohorts. Providing culturally safe environments, including staff with an “understanding of other cultures” or an “Indigenous counsellor” was also specified by workshop participants.

When asked what timely and effective navigation and access to support looks like in the context of suicide prevention, participants identified “timely access to services” with “no waitlist” as key factors, along with support for families and carers. One participant raised the potential benefit of dedicated “peer support programs” and another suggested an “information tablet in hubs”.

Participants further identified the necessity of culturally safe environments and a skilled workforce. “Early intervention” and recognition of the “social determinants” of health were identified as important, including “wellbeing programs implemented in school/day care curriculums” and resilience building and “mental health literacy” “commencing at an early age”. Participants indicated that local services are very important (identified eight times), including “ensur[ing] the service remains local” and highlighted the importance of “grassroots community programs”.

5. About the primary care provider focus groups

Since participation in the workshop by primary care providers was very low, separate focus groups were planned in an attempt to capture feedback from this vital cohort. However, due to the continuing COVID-19 pandemic and vaccine rollout creating unprecedented demand on primary care, it was difficult to access these providers, in particular general practitioners. As a result, only two sessions were delivered of the three planned focus groups. As the COVID pandemic and vaccine roll out continued unabated, it was decided to move forward with the data already gleaned.

5.1 Method

Mackay and Isaac primary care focus groups were delivered on 27 May 2021 and 15 June 2021. Attendees were provided with an overview of local suicide prevention data from community, primary care, and public sector perspectives. The participants were then asked the following three questions, which are consistent with the co-design workshop:

- Question one – Please tell us about your experience navigating and accessing services and support in the context of suicide prevention.
- Question two – Can you identify what has worked well for you when you have had to navigate and access services and support in the context of suicide prevention?
- Question three – What would timely and effective navigation and access support look like in the context of suicide prevention?

A content analysis process was used for analysis of the data collected in the focus groups, which consisted of roundtable discussion notes. The transcripts were imported into NVivo 12 software and analysed, with all statements reviewed and aligned with existing initial themes. This data was then reviewed by the facilitation team to ensure themes were redefined and collectively agreed.

5.2 Participation

Mackay primary care focus groups participants:

- 1 x GP
- 2 x Primary Care Mental Health Nurses
- 1 x Psychologist
- 1 x Primary Care Nurse
- 1 x General Practice Liaison Officer

Isaac primary care focus group participants:

- 1 x GP
- 1 x Psychiatrist
- 1 x MHHS Mental Health – Moranbah

5.3 Evaluation report

One hundred per cent of the participants cited that the primary health provider focus group was relevant to them.

Commentary

The primary care focus group held within the Mackay region raised concerns regarding difficulty in accessing services due to a limited workforce, poor service navigation, and consumer financial constraints. Participants from the primary care providers focus group also discussed the need for greater collaboration, coordination, and continuity of care between services as well as greater training for the suicide prevention sector. Participants also discussed increasing consumer ability to navigate available services.

The primary care provider focus groups also identified a lack of flexibility and responsiveness in the service model as a key concern within the suicide prevention sector. Similarly, feedback from stakeholder/community consultations and an online survey conducted as part of the NQPHN Health Needs Assessment (HNA)[3] identified a lack of sector coordination, lack of awareness of evidence-based interventions, difficulty accessing services, and the need to develop greater capacity within services. Feedback from the focus groups also identified that there can be delays between seeing a GP and the psychologist receiving the referral. In addition, the Joint Regional Wellbeing Plan 2020-2025 identifies coordinated access to services across primary to tertiary level care as a priority for suicide prevention[4].

Both participants of the primary care service provider focus groups and respondents to the lived experience survey, discussed the need for cultural safety within services. Additionally, respondents to the non-health industry survey recommended incorporating lived experience points of view in service design as well as developing messaging to decrease possible stigma associated with suicide prevention services.

Feedback from stakeholder/community consultations and online survey conducted as part of the NQPHN HNA3 identified a need for programs that address stigma, target those most at risk, and - for holistic programs of early intervention and prevention (including within schools) - appropriate intervention and postvention. Specifically, it was identified that suicide prevention needs to consider regional approaches that take the needs of at-risk populations into account. Similarly, the Joint Regional Wellbeing Plan[4] also identified developing appropriate responses following suicide attempts and suicides as a priority area.

6. Surveys

Three surveys were co-developed by the Working Group, with clinical review and leverage off the 'Mental Health and Suicide Survey[5]'. Surveys were developed for three key groups:

- people with a lived experience
- providers
- non-providers, including funders and local, state, and federal government agencies.

6.1 Method

The three surveys were promoted and disseminated across the Mackay, Isaac, and Whitsunday regions via email, networks, providers, and community. The response rate was poor, with a total of 20 surveys completed and returned:

- 5 lived experience surveys
- 12 provider surveys
- 3 non-providers surveys.

6.2 Survey results

6.2.1 Lived experience survey

Q.1

Eighty per cent of respondents stated that they have had a lived experience of suicide.

Q.2

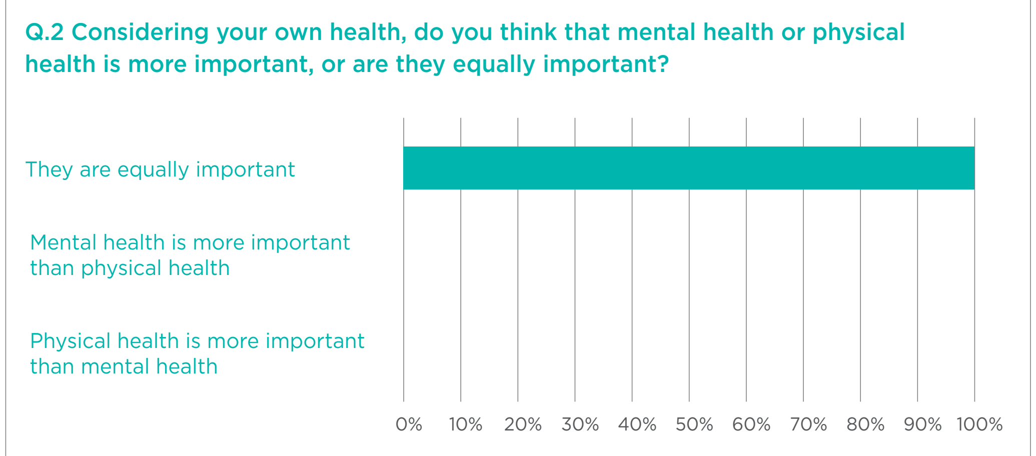
One hundred percent of respondents considered mental and physical health as equally important (refer to Graph 1.1).

3 NQPHN., (2020). Health Needs Assessment 2019-2022. www.nqphn.com.au/about-us/reports-and-plans/health-needs-assessment

4 NQPHN., (2020). Joint Regional Wellbeing Plan 2020-2025. www.nqphn.com.au/about-us/reports-and-plans/joint-regional-wellbeing-plan-northern-queensland

5 Harris Poll, 2015, The mental health and suicide survey, Anxiety and Depression Association of America, the American Foundation for Suicide Prevention, and the National Action Alliance for Suicide Prevention, USA College-Aged_Adults_Survey_Summary-1.14.16.pdf (adaa.org)

Graph 1.1



Q.3

Sixty per cent of respondents felt that physical health is treated as more important in the current health care system.

Q.4

Respondents identified multiple barriers to accessing support, including (in order of significance):

significant waiting times	100%
only eligible for limited services/limited sessions	100%
limited continuity of service/changes in workers	80%
no follow up after referral or receiving service	80%
unable to access services when urgent	80%
financially unable to pay service fee	80%
the process to access services was too complicated	40%
didn't know where to start	40%
service provider did not have relevant expertise	20%
did not meet specific criteria to access services	20%

Q.5

Respondents indicated that what works well for them in navigating and accessing services and support in the context of suicide includes:

- Beyondblue App
- continuity (of service) across the region
- having support of GP and/or service provider

Q.6

For respondents, timely and effective navigation and access support in the context of suicide prevention was considered to be:

responsive to urgent care needs	100%
a localised response	100%
navigation support that is locally based	100%

follow up after receiving service	100%
one stop shop, where residents can access advice	80%
one stop shop, where residents can access support	80%
crisis hotline	40%

Q.7

Respondents specified the following attributes of improved navigation and support:

client focused	100%
one stop shop locally	100%
follow up by service provider	100%
reduced red tape to access	80%
fast tracked urgent care	80%

Q.8

Respondents identified the following health care providers as being most important in preventing suicide:

family doctor	100%
mental health nurse	80%
Queensland Ambulance	80%
general counsellor	60%
psychologist	60%
Public Mental Health Unit staff	60%
Emergency Department doctors and staff	60%
Employee Assistance Programs (EAP)	60%
nurse	40%
psychiatrist	40%

Q.9

Other support considered most relevant to respondents' mental health care was:

partner/family	100%
support from workplace	100%
support from family and friends to attend appointments	100%
support group	80%
sporting clubs, community groups, or social/hobby groups	60%
church community	20%

Q.10

Respondents indicated that seeing a mental health professional is perceived to be:

a sign of strength	100%
something people do not know where to find	80%
something most people cannot afford	60%

Q.11

Respondents described their opinion of suicide as:

a way to escape pain	100%
an impulsive act	40%
a person's right	20%

Commentary: Survey 3: Lived experience survey

- A total of five respondents completed this survey that addressed questions around navigation and access of services specific to suicide prevention.
- All five respondents agreed that mental health and physical health were equally important.
- Three respondents agreed that in our current health care system, physical health was more important than mental health.
- Four of the respondents ranked limited client sessions and significant waiting times high, followed by financially incapability, inability to access service for a client in urgent need, the process to access services being complicated, and inability to follow up with a client.
- Two respondents identified individually that the BeyondNow app and GP support have worked well in terms of navigation and access to services.
- For timely and effective navigation and access support, respondents ranked responsiveness to urgent care needs as high, followed by responses being localised, along with localised navigation support and follow up services being crucial.
- Respondents ranked fast tracked urgent care, having a local one stop shop and follow up services high in terms of attributes that would improve navigation and access to services.
- Respondents chose partner/family support and family/friends support to attend appointments as the most relevant to mental health care.

6.2.2 Provider survey

Q.1

One hundred per cent of respondents considered mental and physical health as equally important.

Q.2

Eighty-three per cent of respondents felt that physical health is treated as more important in the current health care system.

Q.3

Respondents identified multiple barriers to accessing support for clients, including (from most significant):

unable to access services when urgent	100%
significant waiting times	100%
client did not meet specific criteria to access services	91%
financially unable to pay service fee	91%
the process to access services was too complicated	91%
client only eligible for limited services/limited sessions	91%

limited continuity of service/changes in workers	91%
unable to follow up with client and unsure of whether they continued to receive service	91%
inconsistent service to client who missed appointments due to lack of transport, poor mental health, etc.	82%
service providers did not have relevant expertise	27%

Q.4

Respondents indicated that what works well for them in navigating and accessing services and support in the context of suicide includes:

- good communication between services and prior knowledge and information about available services
- referring directly to the Aboriginal and Torres Strait Islander Community Controlled Health Service's Social Emotional Wellbeing Service Workers
- culturally appropriate workers and approach
- knowing people personally in certain services, to short cut processes and enable warm referrals
- information on the range of services available and being able to select the most appropriate service
- Connect to Wellbeing to prioritise suicide prevention clients
- talking with a person, not a voice recording
- connecting with some services

Q.5

Respondents indicated that, in the context of suicide prevention, timely and effective navigation and access to support would be:

responsive to urgent care needs	100%
a localised response	100%
navigation support that is locally based	91%
follow up after receiving service	91%
one stop shop, where residents can access advice	82%
one stop shop, where residents can access support	82%
crisis hotline	82%

Q.6

Respondents specified the following attributes of improved navigation and support:

client focused	100%
fast tracked urgent care	91%
reduced red tape to access	91%
navigation support that is locally based	91%
localised one stop shop	73%

Q.7

Respondents identified the following health care providers as being the most important to preventing suicide:

mental health nurse	91%
Public Mental Health Unit staff	82%
Queensland Ambulance	73%
family doctor	73%
Emergency Department doctors and staff	73%
general counsellor	64%
psychologist	64%
psychiatrist	64%
Employee Assistance Programs (EAP)	64%
nurse	55%

Q.8

Respondents considered the following supports as most relevant to mental health care:

partner/family	100%
support from family and friends to attend appointments	100%
support from workplace	91%
support group	91%
church community	82%
sporting clubs, community groups, or social/hobby groups	64%

Q.9

Respondents indicated that seeing a mental health professional is perceived to be:

something most people cannot afford	64%
sign of strength	64%
something people do not know where to find	64%
ineffective	18%
a last resort	9%
a sign of weakness	9%

Q.10

Respondents described their opinion of suicide as:

a way to escape pain	73%
an impulsive act	36%
a person's right	9%
a selfish act	9%

Q.11

Respondents indicated their interested in working collaboratively or as a consortium to address the needs identified as follows:

yes	73%	no	27%

Commentary: Survey 2: Service Provider Survey

- A total of 12 respondents completed this survey that addressed questions around navigation and access of services specific to suicide prevention.
- All 12 respondents agreed that mental health and physical health were equally important.
- Ten respondents agreed that in our current health care system, physical health is treated as more important than mental health.
- Eleven of the respondents ranked inability to access service for a client in urgent need and significant waiting times high, followed by financial incapability, process to access services being complicated, limited client sessions and inability to follow up with a client.
- For timely and effective navigation and access support, respondents ranked responsive to urgent care needs as high, followed by response being localised, along with localised navigation support and follow up services being crucial.
- When asked about attributes that would improve navigation and support, 10 respondents ranked fast tracking of urgent care, reduced red tape access, and navigation support that is locally based high.
- Respondents chose partner/family support, family/friends support to attend appointments, support groups, and workplace support as the most relevant to mental health care.

Graphic 1.5 Provider Survey Word Cloud

6.2.3 Non-provider survey

Q.1

There were three respondents to the non-provider survey.

Q.2

Seventy-five percent of respondents felt that their physical and mental health is treated equally in the current health care system.

Q.3

Which of the following best describes how you think the importance of mental health and physical health are treated in our current health care system.

Physical health is more important than mental health	50%
Mental health is more important than physical health	25%

Q.4

Respondents identified multiple barriers to accessing support for clients, including (from most significant):

significant waiting times	100%
unable to access services when urgent	100%
the process to access services is too complicated	75%
client only eligible for limited services/limited sessions	75%
client did not meet specific criteria to access services	50%
financially unable to pay service fee	50%
limited continuity of service/changes in workers	50%
service provider did not have relevant expertise	50%
no follow up after referral or receiving services	50%

Q.5

Can you identify what has worked well for you when you have had to navigate and access services and support in the context of suicide?

- Lack of qualified staff, extensive travel required to access services, locally in Clermont there is no one to assist in crisis situations without having to travel to Mackay where people are left with no support, no clothes etc., and no way to get home.
- Who to see? Doctor and psychologist appropriately trained to deal with mental health concern in question. What will the waiting period be?
- Access - not enough services, pathways convoluted, frontline health services not set up to support suicidal/mental health at risk patients. Stigma - people don't want to be seen accessing services as they feel vulnerable and like they will be judged. Ignorance - not aware of services available.

Q.6

What would timely and effective navigation and access support look like in the context of suicide prevention?

Responsive to urgent care needs/fast track	100%
Localised response	100%
Navigation support - locally based	100%
Follow up after receiving service	100%
One stop shop, where residents can access support	100%
Local crisis hot line	75%
One stop shop, where residents can access advice	50%

Q.7

What attributes would improved navigation and support have?

Fast tracked urgent care	100%
Reduced red tape to access	100%
Follow up by service provider	100%
Navigation support - locally based	91%
Client-focused	75%
One stop shop - locally	73%

Q.8

Which of the following health care providers do you feel are most important to preventing suicide?

Mental health nurse	100%
Public Mental Health Unit staff	100%
Employee Assistance Programs (EAP)	100%
Psychologist	100%
Queensland Ambulance	75%
Family doctor	75%
General counsellor	75%
Emergency Department doctors and staff	73%
Psychiatrist	50%
Nurse	50%

Q.9

What other support do you consider most relevant to your mental health care?

Partner/family	100%
Support from workplace	100%
Support group	75%
Sporting clubs, community groups, or social/hobby groups	75%
Support from family and friends to attend appointments	50%
Church community	25%

Q.10

Which of the following best reflects your opinion? Seeing a mental health professional is...

a sign of strength	100%
something most people cannot afford	75%
something people do not know where to find	75%
not accessible for most people	50%

Q.11

Which of the following describes your opinion of suicide? Please select all that apply.

A way to escape pain	75%	Decline to answer	25%

Q.12

Is your organisation interested in working collaboratively or as a consortium to address the needs identified?

yes	73%	no	25%

Commentary: Survey 3: Non provider

- A total of four respondents completed this survey that addressed questions around navigation and access of services specific to suicide prevention.
- Of the four respondents, three agreed that mental health and physical health were equally important, while one stated that mental health was more important than physical health.
- Two respondents agreed that in our current health care system, physical health was perceived to be more important than mental health.
- All four respondents ranked significant waiting times as a primary experience for them in navigating and/or accessing services and support, followed by inability to access services when in urgent need, the process to access services being complicated and only being eligible for a limited service or sessions.
- For the question around greatest concerns about navigating and accessing services that assist with suicide prevention, respondents stated that access to services is a major concern, followed by lack of qualified staff in the region. Additional concerns raised were stigma and poor awareness of services available.
- For timely and effective navigation and access to support, respondents ranked responsive to urgent care needs as high, followed by response needing to be localised, and localised navigation support and follow up services being crucial.
- Respondents ranked fast tracking of urgent care and follow up services high in terms of attributes that would improve navigation and access to services.
- Respondents chose partner/family support and workplace support as the most relevant to mental health care.

Overall survey feedback

From the three surveys, it was observed that although the respondents represented different cohorts, the feedback to certain questions were similar. For example, when it came to experiences of accessing services in the context of suicide prevention, respondent from all three groups identified inability to access services, financial limitations, and the process of access to services being complicated. Similarly, in relation to timely and effective navigation and support, respondents in all three surveys ranked responsiveness to urgent care needs and localised navigation as a high priority.

Graphic 1.6 Non-Provider Survey Word Cloud

Alignment with other regional consultations and research

These concerns are supported by findings from the NQPHN Health Needs Assessment (HNA)[3] which identified a lack of suicide prevention programs and services across the region as well as a need for increased advanced suicide prevention training within the workforce. Analysis of local service planning reports and initial service mapping activities highlighted very limited availability of suicide prevention activities, particularly in rural and remote areas.

Graphic 1.7 Overarching Survey Word Cloud

3 NQPHN., (2020). Health Needs Assessment 2019-2022. www.nqphn.com.au/about-us/reports-and-plans/health-needs-assessment

7. Alignment with the North Queensland Joint Regional Wellbeing Plan

The state and federal governments mandated Northern Queensland Joint Regional Wellbeing Plan[4] encompasses joint planning and action for mental health, alcohol and other drugs, and suicide prevention. The plan was developed by North Queensland service providers, community members with lived experience, Northern Queensland Primary Health Network (NQPHN), and the four Health and Hospital Services (HHSs) within the NQPHN region, including Torres and Cape, Cairns, Townsville, and Mackay HHSs. The Plan has identified six priority focus areas:

1. workforce, including peer workforce
2. Aboriginal and Torres Strait Islander partnership in healing
3. service access and coordination
4. alcohol and other drugs harm reduction
5. physical health of people living with mental illness
6. suicide prevention.

The Joint Regional Wellbeing Plan consultation identified similar needs as the Greater Whitsunday Council of Mayor Suicide Prevention Taskforce consultation process. Contributors to the Plan cited capacity and capability enhancement of the trained peer workforce who could be recruited to share their knowledge and experience with people experiencing mental distress as a priority. The Plan further acknowledges:

- the need to explore and understand barriers to help-seeking
- the need to improve visibility of the mental health landscape for primary care professionals
- that strategies to improve coordination and communication around consumer care to support continuity of care require improvement
- the need for barrier free pathways to care, including optimal transition of care across and within and sectors
- the need for programs that address stigma, and target those most at risk.

With significant areas of alignment between the Joint Regional Wellbeing Plan and this report, it is highly recommended that future work be conducted in collaboration with the drivers of the Joint Regional Wellbeing Plan, which is hosted by the Better Health North Queensland collective. By working in collaboration, greater reach and impact of investment and activity could be achieved.

Graphic 1.7 North Queensland Joint Wellbeing Plan priority areas

The priorities

This deliberation has resulted in the following six priority focus areas:

4 NQPHN., (2020). Joint Regional Wellbeing Plan 2020-2025. www.nqphn.com.au/about-us/reports-and-plans/joint-regional-wellbeing-plan-northern-queensland

8. Opportunities for improvement

Key areas for improvement

Key areas for improvement have been gleaned from the Greater Whitsunday Council of Mayors Suicide Prevention Taskforce consultations. These areas for improvement will subsequently inform the Taskforce's recommendations to develop place-based, community led solutions for suicide prevention interventions.

Access

- Support for help seeking.
- Financial barriers.
- Fast track / urgent access for crisis care.
- Capacity of the workforce (numbers of appropriate clinicians - shortages).
- Referral pathways – timeliness/ support/facilitated.

Workforce

- Provider training in suicide prevention.
- Provider training in suicide postvention.
- Peer workforce development and utilisation.
- General workforce development in mental health, suicide prevention, and cultural safety.
- Capacity of the workforce (numbers of appropriate clinicians – shortages).

Navigations

- Care navigation support - care coordination.
- Service navigation.
- Navigation directories/platforms.
- Service knowledge.
- Criteria/inflexible.

Services and providers

- Coordination and integration.
- Collaboration.
- Communication enhancement.
- Continuity of care.

Community

- Education and training in suicide prevention.
- Awareness raising.
- Stigma reduction activities.
- Central touch point.
- Enablement and capability enhancement of family, carers, and friends to table.
- Self-management tools – apps.

Funders and planners

- Policy change advocacy.
- Evidence informed intervention.
- Flexible service funding.
- Lived experience included in planning and design phase.
- Target at risk groups.
- Early intervention and preventions models.

Priority area mapping table

The priority mapping table will remain as a 'Living Document' to support ongoing work of the Greater Whitsunday Council of Mayors Taskforce.

Key areas for improvement	Sub areas for improvement	Current	Change area	Priority for action rating
Access	Support for help seeking	General Practice / SPCAP/ Apps	Awareness	Moderate
	Financial barriers	NQPHN and MHHS funded services	Funding	High
	Fast track / urgent access for crisis care	Emergency Department	Service models	High
	Capacity of the workforce (numbers of appropriate clinicians - shortages)	MHHS/NGOs/ NQPHN Rural ONLY	Systems / Service models	Moderate
	Referral pathways – timeliness / support/ facilitated	HealthPathways	Systems / Service models	Moderate
Workforce	Provider training in suicide prevention	NQPHN / MHHS	Policy	High
	Provider training in suicide postvention	SP CAP / NGOs	Policy	Moderate
	Peer workforce development and utilisation	MHHS / NGOs	Policy / Service models	High
	General workforce development in mental health, suicide prevention and cultural safety	NQPHN / MHHS /SP CAP/NGOs	Policy / Service models	Moderate
	Capacity of the workforce (numbers of appropriate clinicians – shortages)	MHHS/NGOs/ NQPHN Rural ONLY	Policy	Moderate
Navigations	Care navigation support - care coordination	Limited	Systems - Clinical info / Service models	High
	Service navigation	Limited	Systems	High
	Navigation directories / platforms	MCD	Systems	Moderate
	Service knowledge	Limited / HealthPathways	Systems	Moderate
	Criteria / inflexible	HealthPathways details	Systems	High
Services and providers	Coordination and integration	Mental Networks/ SP CAP	Systems	Moderate
	Collaboration	Mental Networks/ SP CAP	Systems / Policy	Moderate
	Communication enhancement	SP CAP/ NGOs/ MHHS/NQPHN	Systems	Moderate
	Continuity of care	Fragmented	Systems	High
Community	Education and training in suicide prevention	SP CAP	Policy / Systems	High
	Awareness raising	SP CAP/ NGOs/ MHHS/NQPHN	Systems	High
	Stigma reduction activities	SP CAP/ NGOs/ MHHS/NQPHN	Systems – Communication	High
	Central touch point	Nil	Policy - System change / Service models	High
	Enablement and capability enhancement of family, carers and friends	MHHS/ SP CAP/ NGOS	Systems / Service models	High
	Self-management tools – i.e. Apps	Peaks	Systems	Moderate
Funders and planners	Policy change advocacy	NQPHN	Policy	Moderate
	Evidence informed intervention	SP CAP/ NGOs/ MHHS/NQPHN	Policy - Models of care	High
	Flexible service funding	Fragmented	Systems Issues	Moderate
	Live experience included in planning and design phase	SP CAP/ NGOs/ MHHS/NQPHN	Policy	High
	Target at risk groups	Fragmented	Policy - Models of care	High
	Early intervention and interventions models	SP CAP/ NGOs/ MHHS/NQPHN	Funding / systems issues	High

Note: Rural and Remote context is generally less resourced and would priority rate higher that in the above table .

9. Concluding comments

The Council of Mayors Suicide Prevention Taskforce Consultation Report demonstrates that suicide remains a persistent, complex, challenging, and whole of community issue. The report findings demonstrate the need for a call to action for suicide prevention activities using a collective and cross sectorial approach. Action on this issue needs to acknowledge and promote that all suicides are potentially preventable. Action also needs to foster a philosophy of prevention, access, awareness, and skill enhancement, delivered by locally informed interventions, and that are supported at every level of service design, development, and provision as well as at local, state, and federal government levels.

It should be noted that the areas for improvement outlined in the report are made more complex by rurality. This results in a greater need for a collective and responsive approach to suicide prevention planning and implementation that addresses and acknowledges the barrier of distance.

The report and areas for improvement will be reviewed by the Council of Mayors who will make the final recommendations for actions. To ensure that this crucial action-planning continues, NQPHN has provided investment funding for the Greater Whitsunday Council of Mayors Suicide Prevention Taskforce of $100,000. This investment will be used to progress the report findings into opportunities for improvement through locally developed, place-based suicide prevention interventions.

The Greater Whitsundays Communities, as the peak regional body for social development, has been engaged by NQPHN through the aforementioned $100,000 investment funding. The Greater Whitsundays Communities role will be to leverage the momentum and sector buy-in as a result of the Council of Mayors Suicide Prevention Taskforce consultation and engagement. The Greater Whitsundays Communities will develop an implementation plan, including marketing and communication strategies based on the findings of the report and the recommendation of the Council of Mayors. The investment contract with the Greater Whitsundays Communities places a high priority on community facing care navigation social enterprises that align and complement local and social initiatives to facilitate seamless connections for community across sectors.

Appendix A: Taskforce members

	Name	Position / organisation
1	Mayor Greg Williamson	Mackay Regional Council
2	Cr Karen May	Mackay Regional Council
3	Cr Michelle Green	Mackay Regional Council
4	Cr Belinda Hassan	Mackay Regional Council
5	Deb Rae	SPCAP facilitator, Mackay
6	Mayor Anne Baker	Isaac Regional Council
7	Mayor Andrew Wilcox	Whitsunday Regional Council
8	Cara McCormack	MHAODS, Queensland Health
9	Dr Aaron Kennedy (proxy) via Teams Toni Simmons (not attending)	GP Clinical Editor, Mackay HealthPathways Health Pathways, Qld Health/NQPHN
10	Karin Barron	NQPHN
11	Rhyann Luck	Admin Officer, NQPHN
12	Ian Gray	G & S Engineering
13	Dave Hackett	DGH Engineering
14	Chris Attard	General Manager Mackay, Selectability
15	Peter Tait	RSDC
16	Dean Kirkwood	RIN
17	Sonia Anderson	RIN
18	Tonia Wilson (attending)	GW3
19	Kylie Porter	CEO, Greater Whitsunday Alliance
20	Stephen Cutting	Aurecon

	Name	Position / organisation
21	Justin Harris	Aurecon
22	Steve Rae	CEO, Dalrymple Bay Coal Terminal
23	Karen Beckham	Dalrymple Bay Coal Terminal
24	Allison Williams	Senior Health & Wellbeing Advisor, DBCT
25	Nicolas Fertin	NQBP
26	Jannik Olejas – via Teams	Mackay Sugar
27	Craig Muddle	Wilmar
28	Ed McKeiver	Aurizon
29	Sharon Hoops	Adani
30	Tony Caruso	Mastermyne
31	Peter Kane	QCoal
32	Margarita Escartin	Manager Social Performance QCoal Bne
33	Amanda Walker	Principal Corporate Affairs – Community, BHP
34	Jasmine Cadd	Manager Corporate Affairs – Community, BHP
35	Dawid Pretorius	Glencore
36	Pierre Viljoen	CQU

Appendix B: Workshop flyer

A copy of The Mayor's Suicide Prevention Taskforce co-design workshop flyer is below:

The Mayor's Suicide Prevention Taskforce co-design workshop

Date claimer and invitation for expressions of interest

Stakeholders and community members from the greater Mackay, Whitsunday, and Isaac regions are invited to a co-design workshop on improving residents' access to mental health and suicide prevention services.

The one-day workshop will explore community-based solutions in response to industry and community concerns for residents who are experiencing mental health distress, may be at risk of suicide, and have difficulties navigating and accessing appropriate services and health care.

Collective representation from the three local governments, health sector, First Nations community, private health sector, not-for-profit organisations, local businesses, and industry will assist in defining problems and developing place-based solutions.

To attend, please complete the online expression of interest (EOI) registration form.

DATE

Thursday 6 May 2021

TIME

Registration: 7.30am
Program: 8am–4pm

WHERE

Mackay Entertainment and Convention Centre (MECC) Foyer
258 Alfred Street, Mackay

EOI REGISTRATION

www.surveymonkey.com/r/FJRC7XJ

For more information, contact:
Kayla Vella
p: (07) 4963 4455
e: kayla.vella@nqphn.com.au
w: nqphn.com.au/events/

Appendix C: Population profile

Population profile

It is observed that for the year 2018-19, the intentional self-harm hospitalisations for NQPHN region were 208.6 per 100,000 population. The breakdown age and sex wise has been presented in Table 1.

Table 1: Intentional self-harm hospitalisations by age and sex, 2018-2019

	Sex	0-24	25-44	45-64	65+	Total	Measure
Northern Queensland Primary Health Network	Males	127.1	231.0	168.2	59.0	155.5	Rate (per 100,000)
	Females	368.8	279.2	230.3	46.6	262.5	Rate (per 100,000)
	Persons	244.3	255.4	199.2	52.8	208.6	Rate (per 100,000)

Table 2: Deaths due to suicide and self-inflicted injuries by HHS type, 2016-2018

Measure	CHHS	MHHS	TCHHS	THHS	NQPHN	Qld	Qld Indigenous
Deaths due to Suicide and self-inflicted injuries, 0-85+ years, 2016-2018	20	19	n/a	16	18	15	24

For the indicator, deaths due to Suicide and self-inflicted injuries, Cairns HHS has a higher rate (20 per 100,000 persons) than our State (15 per 100,000 persons) followed by MHHS (19 per 100,000 persons) for 2016-2018 as per the Queensland Health Chief Health Officer Report, 2020. Consequently, these values are not meant to equal 100.

Data references:

- Queensland Health., (2020). The health of Queenslanders – Chief Health Officer Report 2020. www.health.qld.gov.au/research-reports/reports/public-health/cho-report/current/data
- AIHW., (2020). National Suicide and Self-harm Monitoring Project. www.aihw.gov.au/suicide-self-harm-monitoring/data
- NQPHN., (2020). Joint Regional Wellbeing Plan for Northern Queensland. www.nqphn.com.au/about-us/reports-and-plans/joint-regional-wellbeing-plan-northern-queensland
- NQPHN., (2020). Health Needs Assessment 2019-2022. www.nqphn.com.au/about-us/reports-and-plans/health-needs-assessment

The Greater Whitsunday Council of Mayors
Suicide Prevention Taskforce Consultation Report

September 2021