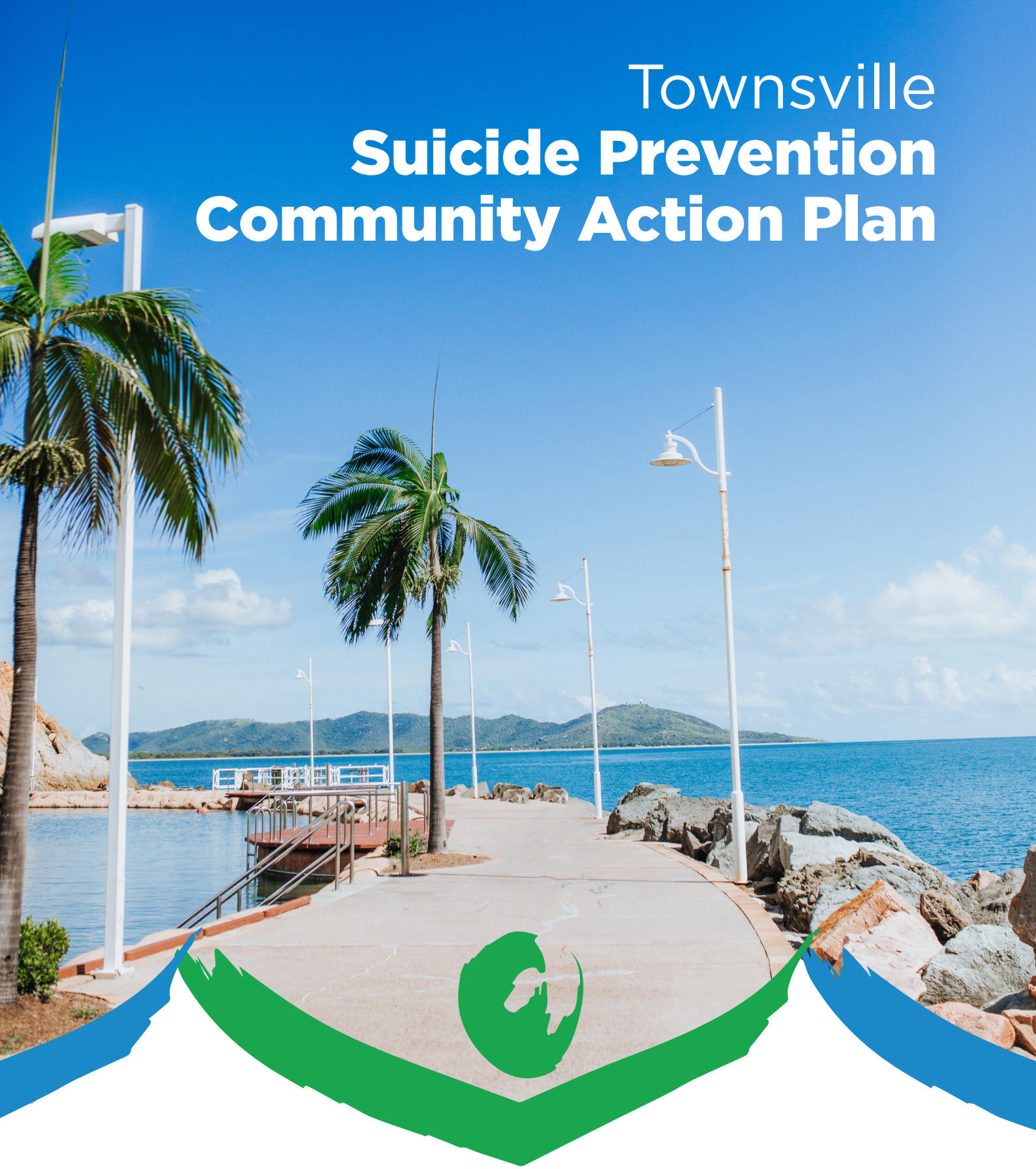
Townsville
Suicide Prevention Community Action Plan



Townsville
SUICIDE PREVENTION NETWORK

whole of region
strategy 2022-23

Acknowledgements

We acknowledge the Traditional Owners of the Townsville region, the Nywaigi, Bindal and Wulgurukaba and Gujal people. We further acknowledge the Traditional Owners of Palm Island, the Manbarra people and the Historical Custodians, the Bwgcolman people (Many Tribes). We pay our respects to Elders past, present and emerging. We also extend that respect to all the other Aboriginal and Torres Strait Islander people from other regions who are a vital part of our community.

Lived experience

We acknowledge all people who have had any direct experience of suicide, including those who have attempted suicide or those that have been impacted or bereaved by suicide. We acknowledge their courage and tenacity to carry and move through the immense pain. The voice of people with lived experience is essential in the development of the work that we do.

Black Dog Institute

We acknowledge the Black Dog Institute as the only medical research institute in Australia to investigate mental health and suicide prevention across the lifespan. By providing suicide prevention specific expertise in relation to the LifeSpan model as well as a compelling Suicide Data Analysis Report, we will ensure that the Townsville SPCAP is data-driven and informed by leading practice.

Participants

We would like to acknowledge the many community members, government, non-government organisations and service providers who shared their knowledge, expertise, and stories to help develop this and future Community Action Plans. We further acknowledge the work and efforts made by previous selectability employees and members of the Townsville Suicide Prevention Network (TSPN) on past Community Action Plans. We also thank those courageous people who work and/or volunteer in this field, making a difference in the lives of others.

Northern Queensland Primary Health Network

We would like to thank Northern Queensland Primary Health Network (NQPHN) for funding the development of the SPCAP as well as supporting the direct involvement of the passionate and committed NQPHN team in developing the SPCAP along the way.

phn
NORTHERN QUEENSLAND
An Australian Government Initiative

Contents

"The Townsville Suicide Prevention Network is driven to deliver on this plan, and build a strong basis for ongoing support, funding and collective initiatives into the future."

Danielle Hornsby
TSPN Chair
B.Speech Therapy, MBA (Marketing and Info Systems), AICD

Foreword

Welcome to the third edition of the Suicide Prevention Community Action Plan (SPCAP) for the Townsville Region.

In preparing this action plan, we have taken the time to consult with agencies and communities to listen to the needs of those across our region. The response, input and feedback has been incredibly important in shaping the 2022 Townsville SPCAP.

Of course, people in our regions have had their individual struggles over the past couple of years, with the threat of COVID-19 and the anxiety, isolation, and social disruption it has caused in our region.

It has presented different challenges for agencies who have an increasing demand for their services, on the backdrop of organisational, workforce and logistical interruptions.

Our network brings those groups together to lean into the challenges of the future, to combine our perspectives, knowledge and leadership to build stronger and more resilient systems.

Our footprint of services, communities and people are as diverse as they are unique... and whilst this could divide us, instead it unites us to find new and innovative ways to bring people together to achieve our vision.

We are well placed to build on our foundations, because of the people and groups who have come before us, we have a strong network of likeminded agencies working together.

Especially pleasing is the way that local groups have realised their own aspirations to take local action, for their community.

Particularly, we acknowledge the leadership in the Burdekin Suicide Prevention Network who have developed a solid base for gearing and supporting localised plans for local results.

This is the platform we seek to leverage in the coming period of our plan, and we hope that new groups can be supported to deliver in other regions.

Finally, without the financial support of the NQPHN, the development of this plan would not have been possible. We thank selectability for supporting this plan as part of the PHN funding. Our network is driven to deliver on this plan, and build a strong basis for ongoing support, funding and collective initiatives into the future.

Yours sincerely,

Danielle Hornsby
Townsville Suicide Prevention Network Chair

Seek help

Some people may find the content of the SPCAP to be confronting and/or distressing. If this is the case, please contact any of the services listed below.

1 000 EMERGENCY

In an emergency please call 000

2 1800RESPECT NATIONAL SEXUAL ASSAULT, DOMESTIC FAMILY VIOLENCE COUNSELLING SERVICE

1800 737 732 | 1800respect.org.au

3 Lifeline

13 11 14 | lifelineqld.org.au

4 Beyond Blue

1300 224 636 | beyondblue.org.au

5 MensLine Australia

1300 789 978 | mensline.org.au

6 DVCONNECT Be heard. Be safe.

1800 600 636 | dvconnect.org

7 Suicide Call Back Service

1300 659 467 | suicidecallbackservice.org.au

8 13 HEALTH (13 43 25 84)

13 43 25 84

9 13 YARN

13 92 76 | 13yarn.org.au

10 ALCOHOL & DRUG Counselling ONLINE a TURNING POINT service

1800 177 833 | counsellingonline.org.au

11 selectability mental wellbeing and suicide prevention

1800 133 123 | selectability.com.au

12 Townsville Hospital and Health Service

Acute Care Team | 1300 642 255

Disclaimer: The information provided in the **Townsville Suicide Prevention Community Action Plan 2022** *is not intended to be a substitute for professional medical advice, diagnosis or treatment. Always seek the best advice of your qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read/seen/heard here.*

Background

About the SPCAP

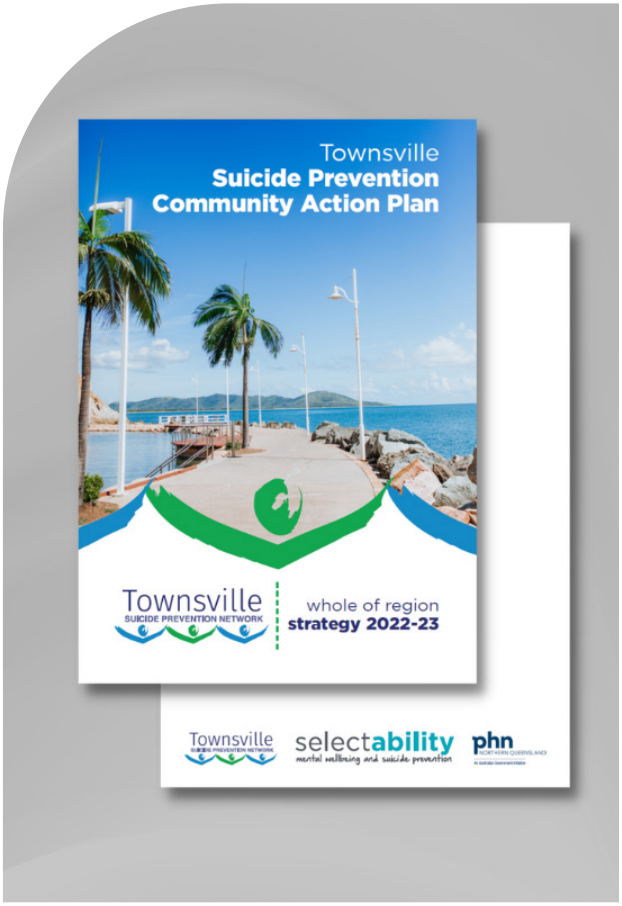
The purpose of the Townsville Suicide Prevention Community Action Plan (SPCAP) initiative is to lead the collaborative development of a community and sector endorsed path forward for coordinated suicide prevention activities across the Townsville region.

This SPCAP further includes Charters Towers, Ingham and Palm Island, which we recognise as key regional areas with their own unique communities that require suicide prevention initiatives.

The project will be delivered through a partnership led by selectability, one of regional Queensland's largest and leading providers of mental health services, supported by the Black Dog Institute, funded by NQPHN and guided by our communities, and particularly those with a lived experience of suicide.

About this document

The SPCAP comprises of two main sections:



Whole of region strategy
The purpose of this document is to set out the background, rationale and strategic drivers aligned to the Black Dog Institute's **LifeSpan framework.**

Actions register
This lists detailed actions, including a description, implementation steps, key stakeholders, and timeframes.

It contains actions which may be implemented at a whole-of-region level or locally.

It is not intended that all actions will be implemented simultaneously, but rather this document will assist local teams to prioritise actions for implementation.

Strategic directions

Vision

There will be significantly fewer people dying by or contemplating suicide in our communities.

Mission

The Townsville Suicide Prevention Network work together to raise awareness, listen to our communities and take combined action to reduce suicide in our region.

Outcomes

Our focus is on increasing community capacity and awareness, to recognise and respond to people in distress, better coordination of suicide prevention efforts and a reduction of suicide attempts and deaths.

Principles

The key principles supporting the LifeSpan framework and adopted by the SPCAP are:

- **Data-driven decision making**
Planning of suicide prevention activities is evidence-based, informed by collecting, analysing, interpreting, and mapping available data that is locally relevant.

- **Workforce development**
Health and community services professionals and frontline workers play a critical role in suicide prevention. Training and knowledge sharing is key to supporting workers in preventing suicide.

- **Lived experience recognition and inclusion**
We acknowledge the invaluable contribution of those with a lived experience of suicide who must be included at all stages of decision making, implementation, and evaluation of the SPCAP.

- **Local ownership and adaptation**
Local communities must own the implementation of the SPCAP. Actions have intentionally been left high-level so that localised implementation teams may adapt them to suit the region.

- **Community engagement**
The community all have a role to play in suicide prevention. As much as possible, the plan's implementation should be community led and should be designed to meet community needs.

- **Cultural governance and inclusion**
Any initiative must be led and owned by the community to ensure that they are done in their best interest and in the most appropriate manner.

Our communities of interest

The Townsville Suicide Prevention Community Action Plan (SPCAP) covers the following areas of the Townsville Hospital and Health Service.

- **Hinchinbrook Shire Council**
- **Palm Island Aboriginal Shire Council**
- **Townsville City Council**
- **Charters Towers Regional Council**
- **Flinders Shire Council**
- **Richmond Shire Council**

It does not cover Ayr and Home Hill which are covered in the Burdekin Suicide Prevention Comunity Action Plan.

Regional **need**

Townsville

Population

Outside the southeast corner, Townsville is the largest city in regional Queensland.

The current population count is 196,800 people *(ABS estimated resident population, 30 June 2020).* By 2041, Townsville's population is estimated to be at 282,281 people *(Queensland Population Projections, 2018 edition).*

Economy

Townsville has a diverse economy that features retail trade, health and education services, government administration, defence, construction, mining, manufacturing, property and business services.

It is a major service centre, and the main centre for government administration outside of Brisbane.

Regional health services are provided by the Townsville Hospital & Health Service.

Queensland Rail and the Port of Townsville provide a transport hub for the region's mining and agricultural industries, as well as for locally-based Xstrata Copper Refinery, Sun Metals Zinc Refinery and the Queensland Sugar Corporation Distribution Centre.

There are a number of research institutions such as James Cook University, the Australian Institute of Marine Science, the Great Barrier Reef Marine Park Authority, Department of Agriculture, Fisheries and Forestry, and the CSIRO.

Furthermore, Townsville has a significant Australian Defence Force community due to the presence of army and air force bases.

NQPHN health needs assessment 2019-22

The NQPHN Health Needs Assessment 2019-2022 *(hereinafter referred to as HNA)* has identified a need for increased suicide prevention activities in the region.

The overall age-standardised rate for suicide nationally is 10.9/100,000 rates. However, the suicide rates in Townsville were reported as 30 per cent higher *(14.2/100,000)* than the national average, marked by a high percentage of male, as well as Aboriginal and Torres Strait Islander suicides.

Regarding hospitalisations for self-harm and various mental conditions, Townsville fared higher than the NQPHN regional averages:

For schizophrenia and delusional disorders
• 28/10,000 compared to the NQPHN regional average of 22/10,000 in 2015-16 reporting period.

For anxiety and stress episodes
• 14/10,000 compared to the NQPHN regional average of 12/10,000 in 2015-16 reporting period.

For the three years 2011 to 2013, data prepared by the Australian Institute for Suicide Research and Prevention (AISRAP) for NQPHN provides analysis of 328 suicides in the region, of which 225 (69 per cent) were male, and 49 of 321 (15 per cent). Of these deaths, 98 (30 per cent) occurred within the Townsville Hospital & Health Service region.

NQPHN has identified several barriers to effective suicide prevention activities throughout the region, including:
• Lack of coordination between primary health care service and related mental health and suicide prevention services.
• Lack of suicide prevention programs and response protocols in rural areas.
• Issues with current suicide prevention activities including:
    • suicide prevention models being culturally ineffective
    • limited number of services
    • lack of sector coordination
    • lack of awareness of evidence-based interventions
    • difficulty accessing services
    • a need to develop greater capacity within services.

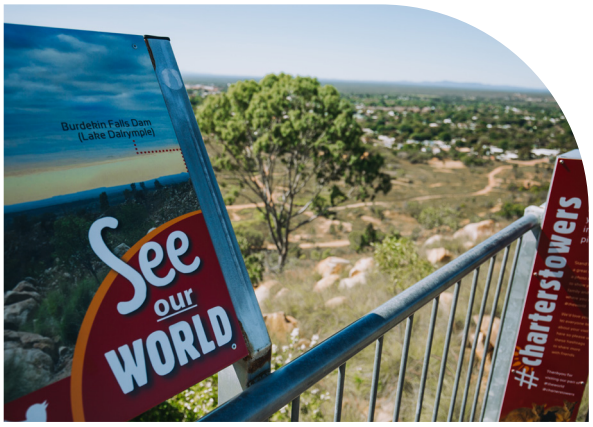
Furthermore, the HNA advocates for a regional approach to suicide prevention that should target these barriers and provide region-wide solutions to identified needs.

Charters Towers

Population

Charters Towers is situated 136 km south-west from Townsville.

In the 2016 census, Charters Towers had a population of 8,120 people. By 2041, its population is estimated to reach 8,365 *(Queensland Population Projections, 2018 edition).*



Economy

Charters Towers is a productive agricultural and mining region with a rich gold mining history, beautiful heritage buildings, natural attractions, and a strong community.

The Burdekin River provides the region with a strong supply of water, and the region has a wealth of mineral deposits, fertile soils, and solar energy opportunity.

The Agriculture, Forestry and Fishing industry had the largest number of total registered businesses in Charters Towers Regional Council, comprising 40.4 per cent of all total registered businesses, compared to 8.9 per cent in Queensland.

Primary research

Our primary research in collaboration with the Charters Towers Community Advisory Network further underlines similar issues with current suicide prevention activities, including:

- limited mental health services
- lack of awareness of available interventions
- service accessibility and staffing issues

We have additionally identified that:

- Stigma around mental health and illness is a troublesome barrier.
- Long distances to service appointments cause rural property owners to miss work to seek support, which is not an ideal long-term arrangement.
- The highest rates of suicide are found in men aged 18 to 35 from low socio-economic backgrounds.

NQPHN health needs assessment 2019-22

The HNA has identified a need for increased suicide prevention activities in the region.

Regarding hospitalisations for self-harm and various mental conditions, the Charters regions fared higher than the NQPHN regional averages:

For schizophrenia and delusional disorders
• 31/10,000 compared to the NQPHN regional average of 22/10,000 in 2015-16 reporting period.

For anxiety and stress episodes
• 14/10,000 compared to the NQPHN regional average of 12/10,000 in 2015-16 reporting period.

For depressive episodes
• 17/10,000 compared to the NQPHN regional average of 12/10,000 in 2015-16 reporting period.

The NQPHN HNA 2022-2024 further emphasises the significance of psychologists as a core professional group that is essential for the delivery of primary and community mental health services. However, psychologist workforce availability varies significantly between different regions in the catchment.

The Charters region is the most underserved among all NQPHN SA3 regions with only 0.1 FTE psychologists per 1,000 population *(compared with 0.6 for Townsville and 0.8 for Cairns).*

NQPHN has identified several barriers to effective suicide prevention activities throughout the region, including:
• Lack of coordination between primary health care service and related mental health and suicide prevention services.
• Lack of suicide prevention programs and response protocols in rural areas.
• Issues with current suicide prevention activities including:
    • suicide prevention models being culturally ineffective
    • limited number of services
    • lack of sector coordination
    • lack of awareness of evidence-based interventions
    • difficulty accessing services
    • a need to develop greater capacity within services

Charters Towers SPCAP

It is envisaged that with the assistance of the TSPN the Charters Towers region will have its own SPCAP in the near future.

Ingham

Population

Ingham is located in the Shire of Hinchinbrook, which is situated approximately 110 km north of Townsville.

In the 2016 census, the locality of Ingham had a population of 4,426 people. By 2041, Ingham's population is estimated to reduce to 3,514 people *(Queensland Population Projections, 2018 edition).*

Economy

Ingham is the service centre for many sugarcane plantations, which are serviced by the two sugar mills located in the Ingham district: Victoria Sugar Mill, which is the largest sugar mill in Australia, and Macknade Mill, which is the oldest operating sugar mill in Queensland.

Sugar comprises 97 per cent of the value of agricultural production in Ingham *(ABS, 2010/2011).*

Other industries in the Ingham area include cattle, watermelons, rice, horticulture, fishing, timber and tourism. Ingham is also the administrative centre for the Shire of Hinchinbrook.

Primary research

Our primary research in collaboration with the Hinchinbrook Community Support Centre also underlines similar issues with current suicide prevention activities, including:

- limited mental health services
- lack of awareness of available interventions
- service accessibility and staffing issues

In addition, we have also identified that:

- Stigma around mental health and illness is a troublesome barrier.
- The highest rates of suicide are found in middle aged men with a farming background.

NQPHN health needs assessment 2019-22

The HNA has identified a need for increased suicide prevention activities in the region.

Regarding hospitalisations for self-harm and various mental conditions, the Ingham regions fared higher than the NQPHN regional averages:

For schizophrenia and delusional disorders
• 31/10,000 compared to the NQPHN regional average of 22/10,000 in 2015-16 reporting period.

For anxiety and stress episodes
• 14/10,000 compared to the NQPHN regional average of 12/10,000 in 2015-16 reporting period.

For depressive episodes
• 17/10,000 compared to the NQPHN regional average of 12/10,000 in 2015-16 reporting period.

The NQPHN HNA 2022-2024 further emphasises the significance of psychologists as a core professional group that is essential for the delivery of primary and community mental health services. However, psychologist workforce availability varies significantly between different regions in the catchment.

The Ingham region is the most underserved among all NQPHN SA3 regions with only 0.1 FTE Psychologists per 1,000 population *(compared with 0.6 for Townsville and 0.8 for Cairns).*

NQPHN has identified several barriers to effective suicide prevention activities throughout the region, including:
• Lack of coordination between primary health care service and related mental health and suicide prevention services.
• Lack of suicide prevention programs and response protocols in rural areas.
• Issues with current suicide prevention activities including:
    • suicide prevention models being culturally ineffective
    • limited number of services
    • lack of sector coordination
    • lack of awareness of evidence-based interventions
    • difficulty accessing services
    • a need to develop greater capacity within services.

Ingham SPCAP

It is envisaged that with the assistance of the TSPN the Ingham region will have its own SPCAP in the near future.

Palm Island

Population

Palm Island constitutes a group of 16 islands, split between the Shire of Hinchinbrook and the Aboriginal Shire of Palm Island. Per the 2016 census, Palm Island had a population of 2,455, of whom 74.5 per cent identified as Aboriginal and 12.8 per cent identified as Torres Strait Islander. By 2041, Palm Island's population is estimated to increase to 3,544 *(Queensland Population Projections, 2018 edition).*

Economy

Due to its history of personal, social and cultural disadvantage, and the absence of usual land tenure and property rights, the economy of Palm Island is highly constrained.

Palm Island experiences very high unemployment *(52.8 per cent vs 6.2 per cent average for Queensland. Australian Govt Dept of Employment, 2016)* and high rates of reported crime.

With 100 percent of Palm Island residents falling within the most disadvantaged quintile, Palm Island is considered highly disadvantaged in socio-economic terms. The community has a significant deficit of imports over exports, another clear measure that Palm Island consumes significantly more than it produces.

The biggest contributing industry sector to the local economy is public administration and safety followed by rental, hiring and real estate services and health care and social assistance.

Primary research

Our primary research in Palm Island has identified key issues, including:

- limited mental health services
- lack of awareness of available interventions
- service accessibility and staffing issues

In addition, we have also identified that:

- Stigma around mental health and illness is more severe due to cultural reasons. While women may occasionally speak about their mental health, men rarely do so.
- Multiple cultural barriers make it difficult for community members to seek support.
- Privacy concerns are paramount as community members do not feel conformable opening up to professionals about their mental ill health due to possible disclosure of their condition to the community.
- Five people have already lost their lives to suicide in 2022. They were all in their mid-30s with complex issues, including illicit drug and alcohol misuse.

NQPHN health needs assessment 2019-22

The following observations from the HNA highlight areas of significant concern for Palm Island communities, particularly in relation to mental wellbeing and suicidality:

- 100 per cent of the population is in the most disadvantaged quintile.
- Children in the region are developmentally vulnerable to social competence, communication skills and emotional maturity, possibly due to family conditions and quality of parenting.
- 72.9 per cent of primary and secondary school students surveyed reported high levels of psychological distress and high exposure to high risk factors for self-harm.
- Disproportionately high levels of alcohol consumption were reported, with people aged 18 years and over consuming more than two standard alcoholic drinks per day at 20.2 per cent, which compares to 17.2 per cent for Queensland.

Palm Island SPCAP

It is envisaged that with the assistance of the TSPN the Palm Island region will have its own SPCAP in the near future.

Systems approach

Suicide prevention is a complex health and social policy area with responsibility shared across both health and non-health systems.

The SPCAP has been developed in direct alignment with **Black Dog Institute's LifeSpan framework.**

LifeSpan is an integrated framework for suicide prevention. It combines nine strategies that have evidence for suicide prevention into one community led approach incorporating health, education, frontline services, business and the community.

The LifeSpan framework 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.

LifeSpan involves the implementation of evidence-based strategies simultaneously within a localised area.

These strategies are based on the most up-to-date evidence drawn from similar, large-scale suicide prevention programs overseas that have shown positive results.

The **nine evidence-based strategies** are implemented from whole of population level to the individual level, simultaneously within a localised region.

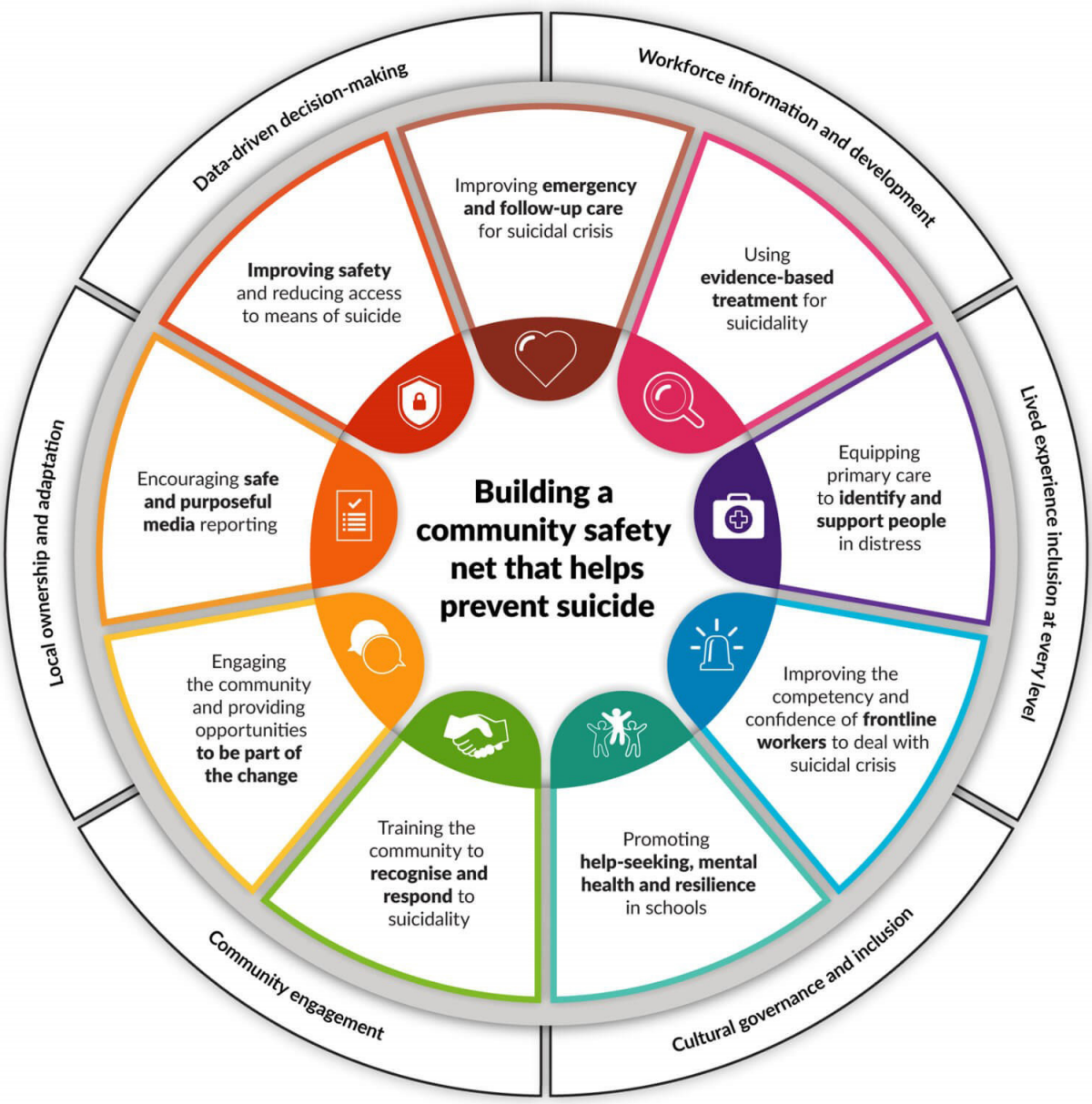
For effective delivery, all strategies require a thorough consultation and review process to ensure their relevance and tailoring to the local context and community.

Recognising that multiple strategies implemented at the same time are likely to generate bigger effects than just the sum of its parts, LifeSpan offers a data driven, evidence-based approach, setting it apart from current practice and raising the bar in suicide prevention *(Source: Black Dog Institute's LifeSpan Framework).*

In addition to the nine LifeSpan Framework strategies, a tenth strategy was included to the SPCAP approach in consultation with the community in 2017. This is explained further in the document.

LifeSpan Framework

The SPCAP is aligned with **Black Dog Institute's LifeSpan Framework**. High-level actions have been developed to allow prioritisation and refinement of key actions, and for local implementation teams to tailor their responses to the needs of their communities.



SPCAP **focus areas**

Actions register key

- Hinchinbrook Shire Council **(HSC)**
- Palm Island Aboriginal Shire Council **(PIASC)**
- Townsville City Council **(TCC)**
- Charters Towers Regional Council **(CTRC)**
- Flinders Shire Council **(FSC)**
- Richmond Shire Council **(RSC)**

Strategy **one**

Improving emergency and follow-up care for suicidal crisis

Strategy one

A suicide attempt is the strongest risk factor for subsequent suicide. To reduce the risk of future attempts, a coordinated approach to care for people after a suicide attempt is essential. Coordination of care is complex and emergency departments are high-pressure environments where staff are often time poor.

Often people who present in emergency departments (EDs) for suicidal ideation or attempts don't receive the care and support they need. Evidence shows that it is the experience rather than strict adherence to a protocol that makes the difference between good and poor care.

When people seek help, services need to make them feel validated, welcome, and heard *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

- There is a need for upskilling for crisis, support, suicide risk and follow up care after an attempt.
- Wait times and impersonal triage processes are barriers to effective crisis care.
- Key government stakeholders need accountability to provide a consistent and coordinated care pathway.
- There is a clear and identified need for support services to deliver care outside of normal business hours and alternate options for people to present when feeling suicidal or at risk of harm to self, including safe haven cafés or safe houses.
- The community does generally not understand pathways through the system.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Community survey: ED • HSC • PIASC • TCC • CTRC • FSC • RSC	**Conduct a survey to determine the community's perceptions towards the quality of delivery of suicide prevention crisis care and aftercare in THHS ED and other acute settings.** • Develop online community survey questionnaire. • Implement across Townsville region post codes. • Collate and analyse information to determine improvement areas.	• Townsville Hospital & Health Service (THHS)	• 2-3 months
Suicide prevention training for Emergency Department (ED) staff • TCC	**Provide education and training in suicide prevention to ED and other crisis staff. This needs to be an ongoing action.** • Evaluate existing suicide prevention training being delivered to relevant staff. • Determine training opportunities to improve and strengthen ED staff capability to respond to crisis situations. • Implement training to negotiate gaps.	• THHS • ED staff	• Ongoing

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Review and improve existing peer-led support models within ED • TCC	**Evaluate the efficacy of existing peer-led support models to meet the needs of people in crisis within the ED setting to determine improvement areas and their implementation.** • Evaluate existing peer-led support models in effect within the ED setting. • Identify gaps. • Implement improvements.	• THHS • ED staff • NQPHN • Peer workforce	• >6 months to fully scope and evaluate; and • >6 months for implementation
Improve community awareness around alternatives to ED • HSC • PIASC • TCC • CTRC • FSC • RSC	**Aggressively promote existing Mental Health Hubs, Safe Havens and other such ED alternatives to improve community awareness and reduce dependency on ED for those experiencing crisis or distress.** • Evaluate and assess existing ED alternatives available within the region and their catchment area(s). • Promote existing alternatives to target communities. • Explore opportunities to scale up and replicate alternatives. • Monitor and assess effectiveness.	• THHS • Townsville Suicide Prevention Network (TSPN)	• Ongoing
Enhance effectiveness and reach of follow-up care services • HSC • PIASC • TCC • CTRC • FSC • RSC	**Ensure consistent follow-up protocols for those who have attempted suicide. Leverage local follow-up services following an interaction with ED.** • Evaluate existing follow-up protocols. • Assess available follow-up care programs. • Develop consistent region-wide follow-up protocol.	• THHS • NQPHN • Regional follow-up with service providers	• >6 months to fully evaluate existing protocols/ regional provider availability; and • >6 months to develop consistent regional protocols and roll out.
Develop response model for communities lacking access (rural and remote) • HSC • PIASC • TCC • CTRC • FSC • RSC	**Design appropriate response models that can be implemented locally across communities lacking access to ensure people in crisis can be cared for locally.** • Scope crisis care requirements for rural and remote communities. • Assess available supports for rural and remote communities for adequacy and responsiveness. • Develop localised crisis control models in consultation with community. • Implement localised model.	• THHS • NQPHN • Regional and rural suicide prevention service providers • Community based organisations and groups	• >6 months to fully evaluate existing requirements and service adequacy/ responsiveness; • >6 months to develop localised response models and their roll out.

Strategy **two**

Using evidence-based treatment for suicidality

Strategy two

Ensuring that accessible and appropriate mental health care is available to those who need it the most. Mental illness, including depression, is associated with a large portion of suicide attempts. Providing accessible and appropriate mental health care is essential to suicide prevention.

Central to this is ensuring mental health professionals are aware of the latest evidence and best practice care and treatment options. Information sharing between care providers also needs to be enhanced *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

- The bereaved become particularly vulnerable once mourning processes are over.
- There are delays in 'real-time' data being made available, which creates a gap of when and where services and referral pathway responses are needed.
- There are many services, but people do not know what is available, how to access them and whether they are available after hours.
- Promotion of service providers who are most appropriate and responsive to identified risk-groups is needed.
- System navigation is required for when a person requires help but is not in crisis.
- A central location or 'one-stop-shop' for supports *(i.e. Oasis for ex-ADF)* would assist greatly in improving mental health access to the community.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Enhance coordination between existing mental health and suicide prevention services • HSC • PIASC • TCC • CTRC • FSC • RSC	**Develop information sharing and informed consent protocols that allow key services (hospitals, support services, other services) to share information to facilitate provision of appropriate care.** • Develop online community survey questionnaire. • Implement across Townsville region postcodes. • Collate and analyse information to determine improvement areas.	• THHS • Service providers	• >3 months to map services across region. • >6 months to organise consultations and develop protocols for implementation. • Beyond this period, mapping and consultations are envisaged as periodic activities.
Suicide prevention training for mental health professionals	**Identify and provide training opportunities to mental health professionals to improve their understanding of the context of suicide and judgment.**	• Service providers • Training providers • THHS	• Ongoing

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
(continued) • HSC • PIASC • TCC • CTRC • FSC • RSC	• Identify and map training opportunities available to practitioners in the region. • Develop a regional training portal *(online resource)* for practitioners and providers to undertake training.		
Develop and promote localised suicide prevention resources • HSC • PIASC • TCC • CTRC • FSC • RSC	**Increase awareness of and access to existing suicide prevention resources. This may include development of a central information portal from where localised information is easily accessible to relevant communities.** • Evaluate existing suicide prevention resources and services, particularly from a localisation perspective. • Develop and implement a communications plan to promote services to the community.	• THHS • Service providers • Community-based organisations and groups	• 6-12 months.
Enhance community based outreach • HSC • PIASC • TCC • CTRC • FSC • RSC	**Utilise existing mental health and suicide prevention programs throughout the region to provide outreach services and expand their geographic reach into hard to reach communities.** • Conducting mapping assessment for existing services. • Consult with community to identify community need for increased outreach services. • Develop outreach model to deliver within existing services.	• THHS • NQPHN • Service providers	• 6-12 months.
Organise local support groups • HSC • PIASC • TCC • CTRC • FSC • RSC	**Establish local community support groups for people with a lived experience of suicide based on community needs. This includes training people with a lived experience of suicide to lead localised support groups.** • Organise community consultations to understand local needs. • Identify people with a lived experience of suicide who are willing to lead groups. • Provide peer facilitation training. • Establish support groups.	• Lived experience peers • Community-based organisations or groups • Service providers	• 6-12 months.
Provide support and debriefing opportunities for workers • HSC • PIASC • TCC • CTRC • FSC • RSC	**Burnout amongst support workers is real. It is important to ensure adequate support is offered to workers whose roles touch on suicide prevention and the support is culturally appropriate.** • Consult with support workers to understand their emotional and wellbeing needs. • Determine appropriate support requirements and develop model of support.	• Service providers • Community-based organisations or groups	• Ongoing. The model is currently being implemented at selectability with potential to scale across region.

Strategy **three**

Equipping primary care to identify and support people in distress

Strategy three

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. There are many reasons for this including fear, stigma, and time pressures. GPs are often unaware of referral pathways and current best practice care and treatment. Encouraging evidence-based practice and integration with other services is critical.

Capacity building and education for GPs is one of the most promising interventions for reducing suicide *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

• Buy-in from professionals within respective fields is required for this strategy to be successful.
• Wellbeing screening can occur from the moment a patient enters the GP clinic. This will assist the GP to gain a better understanding of a patient's mental health.
• GPs have limitations due to time and the number of patients they must see.
• Upskilling is necessary *(i.e. implementation of the Screening Tool for Assessing Risk of Suicide [STARS])* to strengthen understanding and cues from a person at risk.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Suicide prevention training for GPs • HSC • PIASC • TCC • CTRC • FSC • RSC	**Offer ongoing suicide prevention training that has been informed by lived experience to primary care health professionals.** • Identify and evaluate training available to primary care staff from a suicide prevention perspective. • Map additional training opportunities and assess suitability for local role out.	• General practices and other primary care providers	• 6-12 months.
Develop clear referral pathways for GPs • HSC • PIASC • TCC • CTRC • FSC • RSC	**Develop clear referral pathways for GPs to provide information about available and appropriate services.** • Organise up to date service mapping. • Monitor and update HealthPathways to ensure accurate information. • Promote HealthPathways to GPs.	• General practices • Primary care providers • Service providers	• 6-12 months.
Provide cultural training for GPs • HSC • PIASC • TCC • CTRC • FSC • RSC	**Upskill GPs in how to provide appropriate care for culturally diverse paitients.** • Evaluate cultural training currently being provided to GPs. • Identify gaps and opportunities to strengthen cultural training and capability of GPs.	• General practices	• 6-12 months.

Strategy **four**

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

Strategy four

The interactions a suicidal person has with frontline staff *(i.e. police, paramedics, and ED staff)* can influence their decision to access and engage with care. Frontline staff can play a key role in de-escalating a crisis and improving safety. Existing training may not include the latest emerging research and skills require periodic refreshing.

When vulnerable people seek help, frontline staff need to make them feel safe and heard. Evidence shows that it is the experience, rather than strict adherence to protocol, that can make the difference. Staff exposed to stressful situations and trauma can themselves become vulnerable to suicide.

Offering training to those on the frontline can build their capacity to respond to those in need – both members of the community and colleagues who may be vulnerable due to trauma *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

- There is a need to overcome negative stigma around seeking help.
- A peer-support system is vital for frontline personnel working in these areas.
- Many organisations are proactive in providing training in crisis intervention and vicarious trauma.
- Former and retired frontline staff can provide incredible support for active workers; however, it is essential to note that they may be vulnerable to vicarious trauma.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Plan and deliver suicide prevention specific training to first responder organisations • HSC • PIASC • TCC • CTRC • FSC • RSC	**Establish connections with local representatives from first responder organisations to identify local training needs and delivery systematic training across the region.** • Consult with local first responder organisations to identify training needs. • Assess existing suicide prevention training provided to first responders. • Develop training to address any local gaps in knowledge or response strategies. • Implement localised training throughout region. **Training may include:** • Application of listening skills when working with someone experiencing suicidality. • Awareness of referral options. • Awareness of connected services to respond to immediate needs *(housing, nourishment, DV, etc).*	• Queensland Police Service (QPS) • Queensland Ambulance Service (QAS) • Queensland Fire and Emergency Service (QFES) • State Emergency Service (SES)	• 6-12 months.

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Establish and expand a mental health and suicide prevention co-responder model • HSC • PIASC • TCC • CTRC • FSC • RSC	**Evaluate any existing mental health co-responder model that provides a trained suicide prevention peer worker or mental health professional to co-respond with first responder calls throughout the region. The objective is to establish and expand throughout the region.** • Assess existing co-responder model to understand utilisation/implementation challenges and outcomes. • Utilise findings to either establish a model or inform the expansion of the co-responder model throughout the region.	• QPS • QAS • QFES • SES	• 6-12 months.
Establish a lived experience advisory mechanism in partnership with first responders • HSC • PIASC • TCC • CTRC • FSC • RSC	**Identify opportunities to embed a lived experience perspective into frontline services. This can include lived experience-led training, service review/evaluation and peer worker roles.** • Organise a joint consultation with people with a lived experience of suicide and first responders to identify opportunities to embed a lived experience perspective into frontline services.	• QPS • QAS • QFES • SES	• 6-12 months.

Strategy **five**

Promoting help-seeking, mental health and resilience in schools

Strategy five

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

Youth Aware of Mental Health (YAM) is designed to raise awareness about suicidality and the factors that protect against it.

YAM has the strongest evidence-base of school programs reviewed including the best outcomes specific to suicidal behaviour, and the flexibility to be integrated into any school environment *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

• School curriculum has limited capacity to include programs on resilience.
• According to headspace data, there is high complex trauma among young people in the Townsville region.
• There is a vast difference in the resilience, mental health and wellbeing needs between various school catchments.
• There are groups within the community carrying a higher risk of trauma *(First Nations, LGBTQIA+, ADF families, etc).*
• Floods, global disasters and economic factors have an impact on young people's resilience.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Suicide prevention training for school staff • HSC • PIASC • TCC • CTRC • FSC • RSC	**Establish structured training in suicide prevention for school staff. This should be made available to all school staff who interact with students, and not just counsellors and psychologists.** • Assess any existing suicide prevention training provided to local school staff. • Consult with schools to understand needs and/or gaps. • Identify or develop training programs that address local school requirements. • Implement training based on community needs.	• Schools	• >12 months.
Suicide prevention programs for students	**Deliver programs at school that build resilience and de-stigmatise mental health and suicide prevention. The aim is for students to be more likely to identify early signs of mental health issues or distress and be more comfortable speaking to someone about it.**	• Schools	• >12 months.

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
(continued) • HSC • PIASC • TCC • CTRC • FSC • RSC	• Assess any existing suicide prevention training provided to local students. • Consult with schools to understand needs and/or gaps. • Identify or develop training programs that address local requirements. • Implement training based on community needs.		
Integrate mental health service providers in the school environment • HSC • PIASC • TCC • CTRC • FSC • RSC	**The integration proposition could include school-based psychologists, counsellors and other support persons.** • Organise consultations with schools to understand student mental health needs. • Identify appropriate services to implement within the school environment.	• Parents • Schools	• 12-24 months.
Mental wellbeing and suicide prevention programs for parents • HSC • PIASC • TCC • CTRC • FSC • RSC	**Offer capacity building programs through schools for parents to improve their mental health and suicide prevention knowledge.** • Organise local community consultations to understand needs of parents. • Identify or develop appropriate programs to implement via schools to maximise outreach to parents.	• Parents • Schools	• 6-12 months.
Establish school-based referral pathways and ensure their currency • HSC • PIASC • TCC • CTRC • FSC • RSC	**Develop up-to-date referral pathways and information for school staff, students and parents to ensure everyone is aware of available support services and resources.** • Organise up to date service mapping with particular consideration towards services for children and young people. • Develop simple guides that explain different services, when it is appropriate to refer, and how to refer into them.	• Schools • Service providers • General practices	• 6-12 months.
Establish whole of school mental health and suicide prevention initiatives • HSC • PIASC • TCC • CTRC • FSC • RSC	**Leverage initiatives listed above to create a suicide prevention campaign. Showcase how being a 'suicide prevention promoting school' leads to positive outcomes for students.** • Determine need and appetite at local level for actions to be implemented. • Identify and enrol schools who are willing to become a suicide prevention promoting school. • Deliver comprehensive suicide prevention strategies within enrolled schools and measure outcomes. • Showcase outcomes.	• Schools • Parents • Service providers	• 12-24 months.

Strategy **six**

Training the community to recognise and respond to suicidality

Strategy six

Many people who are experiencing suicidal thoughts communicate distress through both words and 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 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 many helpers is via workplaces.

While there are many training programs that deliver skills in mental health awareness, QPR has the most and strongest evidence for building skills to help with a suicidal crisis *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

• Affordable 'train the trainer' programs are required on an ongoing basis due to the transient nature of Townsville's population.
• There is limited suicide prevention training coordination across organisations, communities and the greater region.
• Engagement of community stakeholders is required to continue providing training.
• Regular training is needed to enable support workers from various sectors *(including volunteers)* with self-care skills.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Deliver effective suicide prevention gatekeeper training across the region, with focus on high-risk workplaces	**Most people at risk of suicide do not consult with health care professionals on time. However, friends, family, co-workers, and others can help if they know how to recognise and respond to suicide risk. Gatekeeper training helps with identifying individuals who are demonstrating warning signs so that they can be supported in a timely manner.** Audiences for gatekeeper training include those who have regular contact with people who may be at increased risk for suicide, such as: • high school teachers and students • first responders • faith community leaders • people who work with older adults, LGBTIQA+, youth etc • staff in the criminal justice system • staff in health care settings • high-risk industries and workplaces, particularly those who employ men	• Local Council • Community-based organisations • Sports clubs • Other local groups • Suicide prevention training providers • Industry specific suicide prevention training providers	• 12-24 months.

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
(continued) • HSC • PIASC • TCC • CTRC • FSC • RSC	• Engage with local communities regarding their community gatekeeper training needs. • Map all suicide prevention gatekeeper training offerings and providers. • Develop community gatekeeper training strategy. • Deliver activities in line with strategy. For high-risk workplaces: • Develop project plan based on leading research of high-risk industries. • Develop industry gatekeeper training strategy. • Map industry specific training offerings and providers. • Deliver activities in line with industry specific gatekeeper training strategy **Training could take variable forms** • Mental Health First Aid • Applied Suicide Intervention Skills Training		
Develop local suicide prevention gatekeeper networks and protocols	**The local gatekeeper network would leverage members of the community who have undertaken gatekeeper training to provide a network of informal support which could be readily accessed by the community.** • Design support structure to maintain gatekeeper network over an extended period. • Provide a supportive environment. • Recruit community members who have received gatekeeper training into the network. • Recruit community members who have a lived experience of suicide into the network. • Provide immediate access to emergency and support services through readily available mobile apps such as the selectability Well Man app.	• General community and community-based organisations • Trained gatekeepers	• >12 months.

Strategy **seven**

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

Strategy seven

Community engagement and communication delivered in conjunction with other evidence-based suicide prevention strategies can improve local awareness of services and resources, and drive increased participation in prevention efforts across the community. Engagement in campaigns and activities such as R U OK? Day can provide an important first step for many community members.

Some people may wish to take the next step: undertake training so they can recognise risk and connect others with professional support *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

• It can be challenging to engage network and community members to drive and attend these events.
• Continued support across government, not for profit and private organisations is essential.
• It is difficult to have campaigns gain momentum where there are fewer volunteers.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Deliver whole of region community awareness and engagement campaigns • HSC • PIASC • TCC • CTRC • FSC • RSC	**Community awareness campaigns can help start the conversation around suicide and promote help-seeking behaviour from those impacted. Campaigns should be reflective of local community needs and designed in a way that is culturally appropriate.** • Identify key stakeholders. • Evaluate scope for a whole-of-region awareness campaign with stakeholders. • Develop referral pathways and/or resources to enable call to action. • Secure commitment for the delivery of the campaign.	• Community-based organisations • Service providers • THHS	• 12 to 24 months.
Coordinate and deliver localised community awareness events and programs	**Coordinate and fund community awareness events and programs targeted at priority populations and tailored to the needs of local communities.** • Engage with suicide prevention networks with regards to community awareness event. • Deliver events specific to the needs of the local community.	• Suicide prevention networks • Service providers • Community-based organisations • Local council	• >12 months.

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Establish localised Suicide Prevention Networks • HSC • PIASC • TCC • CTRC • FSC • RSC	**Local networks aim to raise awareness, provide resources and make information sharing and referrals a simpler process.** • Map existing suicide prevention networks available across the region. • Engage with suicide prevention networks to identify current needs. • Establish suicide prevention networks in locations where there are none.	• Suicide Prevention Networks • Local council • Community-based organisations • Healthcare workers • Service providers	• 12-24 months.
Design and implement a community based safe spaces program • HSC • PIASC • TCC • CTRC • FSC • RSC	**Develop a community based safe space network (community centres, mental health and other services) where individuals experiencing crisis can reach out for help or support.** • Assess community based safe space initiatives that are available in other regions to provide advice to local model. • Develop a localised safe spaces model any training materials. • Develop scheme to onboard local organisations to be apart of the program. • Deliver and monitor localised safe spaces model.	• Community-based organisations • Local council • Local business owners • Not-for-profits • THHS	• 12-24 months.
Build a network of local program ambassadors • HSC • PIASC • TCC • CTRC • FSC • RSC	**Ambassadors would speak publicly from a position of lived experience on suicide prevention and mental health (raising awareness and reducing stigma). Ambassadors would require training and support for the network to be effective.** • Assess existing Real Mates Talk ambassador model and develop a comprehensive ambassadorship program that can be localised and implemented across the region. • Recruit and train local ambassadors. • Advocate for opportunities where ambassadors can speak.	• Community-based organisations • Local council • Local businesses • General community	• >12 months.
Determine the needs of local communities to develop future programs and initiatives • HSC • PIASC • TCC • CTRC • FSC • RSC	**The community needs to remain active in the implementation of suicide prevention programs. This requires a planned engagement approach.** • Design a regional community engagement campaign. • Organise engagement activities to better gauge needs. This information will inform future programs. • Utilise feedback from engagement campaigns to streamline activities.	• Service providers • Community-based organisations • Local council	• >12 months

Strategy **eight**

Encouraging safe and purposeful media reporting

Strategy eight

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

We are supporting local organisations to take a more proactive and coordinated approach to engaging with the media and managing this conversation *(Source: Black Dog Institute's LifeSpan Framework).*

What we know

- Through consultation with community groups, local media outlets and Mindframe representatives, it was identified that Townsville is a hotspot for journalism cadets.
- A high turnover in journalists requires ongoing training around appropriate language and safe messaging around both mental health and suicide.
- Messaging must be clear and factual, reducing sensationalism especially for youth and First Nations populations.
- There is little to no peer support for vicarious trauma that journalists receive when dealing with tragic circumstances in the community.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Develop local media partnerships • HSC • PIASC • TCC • CTRC • FSC • RSC	**Work with the local media to develop campaigns that inform about suicide and its prevention, promote mental health and reduce stigma. Deliver training to media outlets across the region to ensure suicides are reported in a manner that is safe and meaningful.** • Identify arrangement(s) with local media outlets to roll out suicide prevention media training. • Deliver training and monitor outcomes over time.	• Local media outlets • Training organisations	• >12 months.
Engage and partner with prominent social media groups • HSC • PIASC • TCC • CTRC • FSC • RSC	**Provide training to community based social media groups and provide guidance on best practice communication regarding suicide.** • Identify and map prominent social media groups within region. • Identify relevant suicide prevention training program(s). • Develop campaign to engage and train moderators. • Implement training and other engagement programs with social media groups.	• Community-based social media groups • Training organisations	• >12 months.

Strategy **nine**

Improving safety and reducing access to means of suicide

Strategy nine

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 happening in the local community.

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

What we know

- Community consultation has indicated a strong focus on Alcohol and Other Drugs community education.
- Community consultation has shown providing Mental Health First Aid, including the First Nations version to public-facing service providers *(i.e. taxi drivers, hairdressers, café staff)* would be a significant, sustainable contribution to this strategy.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Monitor local suicide data • HSC • PIASC • TCC • CTRC • FSC • RSC	**Continuously collect and monitor suicide data across the region. Data and findings will inform future restriction activities.** • Agree on regularity of reporting. • Use data to inform the direction of activities within the plan.	• Research institutions with access to current suicide data • ABS • QGSO	• >12 months.
Implement a regional safety planning initiative • HSC • PIASC • TCC • CTRC • FSC • RSC	**Develop and implement a region-wide safety planning initiative. This can make use of publicly available safety planning tools and apps.** • Conduct a safety planning needs assessment and organise a project plan. • Implement the initiative with support from key stakeholders to achieve an all-of-region impact.	• THHS • NQPHN • Service providers • Community-based organisations • Not for profits • Social services	• >12 months.

Strategy **ten**

Inclusion, healing, and transition

Strategy ten

Everyone should expect the same rights, opportunities, physical and mental health outcomes as the wider community, free from stigma and discrimination. Strategy 10 is unique to Townsville because of our diverse population and a desire to support the whole of community ensuring equality for all.

What we know

• Townsville has a high proportion of First Nations peoples with unique culture and language. Cultural safety and sensitivity must be provided to promote inclusion. Those from regional and remote communities may have very different needs and will be less likely to attend mainstream public events and services.
• Townsville has a large population of current and ex-Australian Defence Force personnel.
• Townsville has a fly-in/fly-out mining community that expands with contracts based on mines opening and closing.
• Townsville is a nominated centre to receive refugees/CALD, and thus there is increasing presence and need for inclusion for many different cultures and languages to receive adequate support.
• Rural and remote communities in the region have very different needs, and yet their healthcare and medical support is often centred on Townsville; they have specific needs and require inclusion.

Actions register

ACTION	DELIVERABLES	STAKEHOLDERS	TIMEFRAME
Establish a Townsville SPCAP inclusion and equity committee • TCC	**Organise a committee comprising members who represent the diverse Townsville region. This would involve mandating equal representation from groups. These may include First Nations, CALD, LGBTIQA+, post retirement age men, amongst others.** • Organise community consultations to understand and appreciate the diversity in groups that comprise the region. • Draft a Terms of Reference (ToR) for the TSV SPCAP inclusion and equity committee. • Engage with local community and organisations/businesses to enrol committee members. • Organise quarterly committee meetings, with the aim to inform existing programs about service gaps or improvements required to specifically address the needs of diverse groups.	• Community-based organisations • Local businesses • Not-for-profits • Service providers	• >12 months.


Townsville
SUICIDE PREVENTION NETWORK


selectability
mental wellbeing and suicide prevention


phn
NORTHERN QUEENSLAND
An Australian Government Initiative