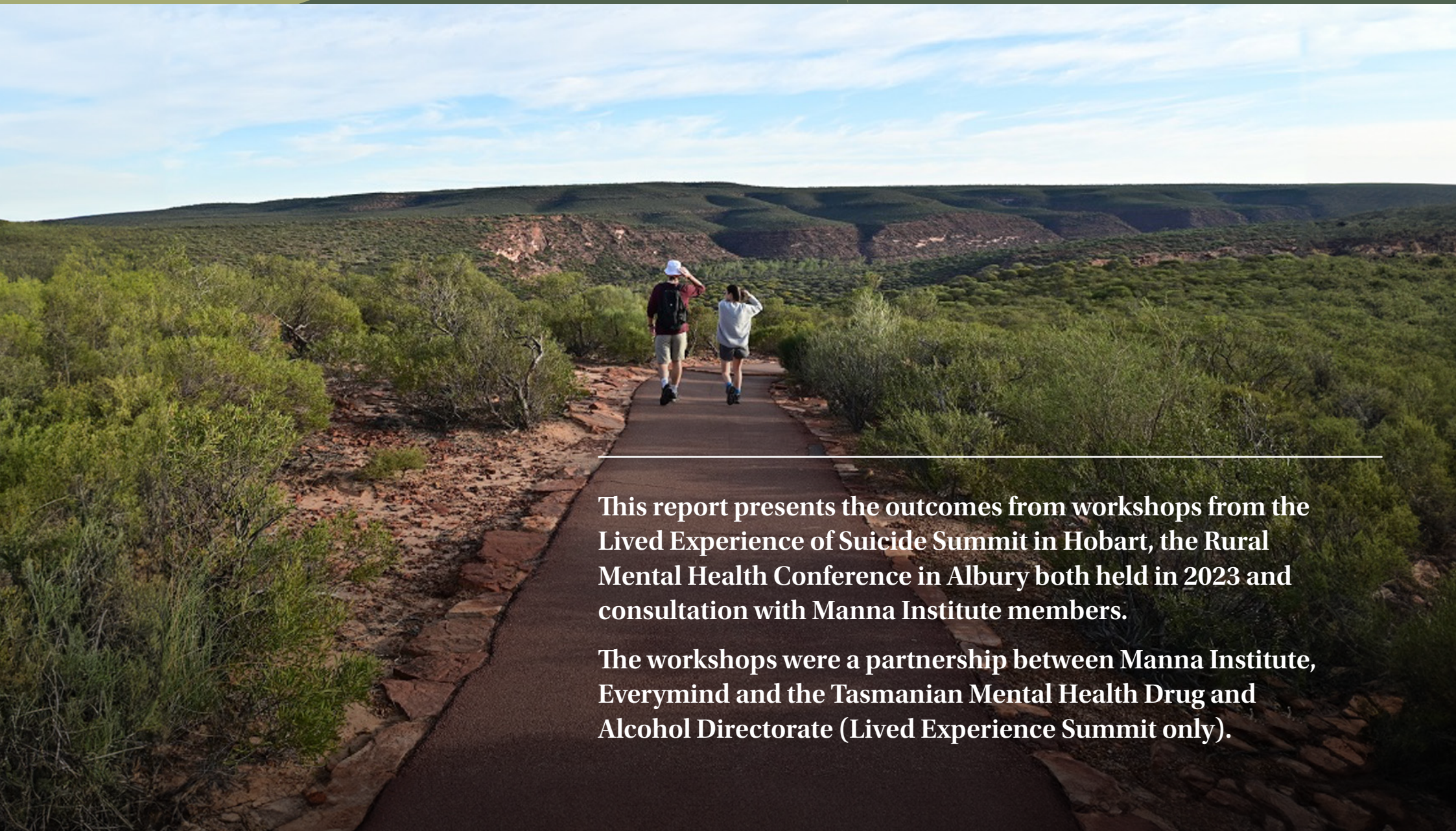
manna
INSTITUTE

Outside the city:

Designing suicide prevention for regional, rural, and remote communities.

Workshop findings and forward thinking



This report presents the outcomes from workshops from the Lived Experience of Suicide Summit in Hobart, the Rural Mental Health Conference in Albury both held in 2023 and consultation with Manna Institute members.

The workshops were a partnership between Manna Institute, Everymind and the Tasmanian Mental Health Drug and Alcohol Directorate (Lived Experience Summit only).

Acknowledgements

The workshop facilitators acknowledge and thank all the participants who participated in the workshops and provided insights from their learnt, lived and living experiences of suicide. The activities provided scope to engage in the breadth of knowledge about suicide and its prevention in regional, rural and remote areas. The knowledge will assist with how to best plan and deliver initiatives. The report was developed in partnership with those who participated in the workshops. We appreciate the opportunity to host the workshops and extend our thanks to the organisers of the 2023 Lived Experience of Suicide Summit and the 2023 Rural and Remote Mental Health Conference.

Terminology used

This report utilises the term 'lived or living experience of suicide'. The Roses in the Ocean [1] definition of 'lived or living experience' refers to a person who has experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or who has lost a loved one by suicide. The term 'living' is important to acknowledge, where experiences of suicide and suicidality may be current and/or ongoing.

In addition, the term 'rural' is used throughout the report. This term refers to all areas outside major cities, including regional and remote areas [2, 3].

Workshop Facilitators

Lived Experience of Suicide Summit, Hobart, March 2023

- **Jaelea Skehan** (Everymind and Manna Institute)
- **Laura Grattidge** (Manna Institute and Centre for Rural Health, University of Tasmania)
- **Lynette Pearce** (Mental Health Alcohol and Drug Directorate, Department of Health Tasmania)
- **Myfanwy Maple** (Manna Institute and University of New England)

Rural Mental Health Conference, Albury, November 2023

- **Sally Fitzpatrick** (Everymind and Manna Institute)
- Everymind and Manna Institute members

Suggested citation

Grattidge, L., Maple, M., Fitzpatrick, S, Pearce, L., and Skehan, J. Outside the City: Designing suicide prevention for rural and remote communities. Workshop findings and forward thinking. February 2024.

Executive summary

Outside the city is a Manna Institute led, collaborative research project, engaging with Everymind, the Tasmanian Mental Health Drug and Alcohol Directorate as well as community members in Tasmania and NSW.

The report proposes a call to action that seeks change in the way suicide prevention in regional, rural, and remote communities, can be enhanced by place based intervention, postvention, involvement of people and communities. The report highlights the need for whole of government approaches.

Using a co-design methodology, the project used a community-led approach seeking insights from two regional locations. Facilitated focus groups yielded data that demonstrated how increasing accessibility of services, peer-led supports, and addressing social determinants of suicide outside of a metro centric focus is necessary. The report provides practical actions that identify how community-based supports, outreach, training, and collaboration, can take the lived experience of what is needed 'out of the city' to allow for enhanced engagement with community, for solutions tailored to respond to specific regional and rural needs. What the report proposes is a focus on improving community awareness, reducing stigma, and supporting marginalized groups, noting that what occurs in the city is not replicated across the country.

The report offers recommendations, as a call to action, compelling funders, policy makers, services and community members to ensure authentic involvement of people with lived experience in suicide prevention efforts and designing outcome measures that allow for success of suicide prevention initiatives in community for community.

Background to the Workshop

A complex interplay of personal, social, and situational factors contribute to suicide in rural areas. Data identifies that suicide in rural areas is 60% higher than in urban counterparts.

In rural areas, risk is higher for males compared with females [4, 5], for younger (15-24 years) and older (75-84 years) age groups and people experiencing a mental health challenge or concern (including substance use disorders) [6]. Common themes contributing to this vulnerability include social and geographic isolation, rural values and associated stereotypes associated with stoicism, and conservative values and attitudes that uphold traditional structures and social values. These factors, although contributing to personal and community strengths and resilience, have also contributed to a reluctance to discuss problems and seek support. Additional factors increasing vulnerability include exposure to natural disasters and adversity and lack of healthcare options, including mental health specialists [7-9].

When planning suicide prevention in rural areas, there needs to be consideration of the unique characteristics of communities, accounting for cultures and histories, to understand risk and protective factors. These factors need to be considered when implementing programs, while simultaneously tailoring programs to suit the needs of demographic groups that are disproportionately affected by suicide [10, 11]. In rural areas, where formal supports and services may not always be readily available, it is crucial to tap into existing resources and community strengths. This should be done in conjunction with the valuable insight and leadership of individuals who have lived or are living through experiences with suicide [9, 10].

This report describes outputs from two workshops conducted in 2023. The first was held at the Roses in the Ocean Lived Experience of Suicide Summit in March 2023, and the second was held at the Rural Mental Health Conference in Albury in November 2023. Both workshops used a consistent framework to explore opportunities and strategies to facilitate coordinated suicide prevention action in regional, rural and remote areas, drawing on the expertise of people in the workshop, including people with a lived experience as well as professionals working in the space. Current practices and future solutions were explored, and emerging recommendations were identified for designing and delivering suicide prevention action in regional, rural and remote communities.

The findings were then considered by Manna Institute researchers and affiliates with lived and living experiences.

About the Workshops

Rural communities

Each interactive workshop was delivered in 90-minutes, with a consistent approach utilised across both events (see Table 1).

A total of 109 people participated in the Hobart (*n=55*) and Albury (*n=54*) workshops.

The following principles were considered when engaging participants in the workshop:

- Responsiveness, setting clear expectations, and open and transparent communication processes
- Fostering a learning environment to build capacity
- Respecting the traditional owners of the land and people with a lived experience of suicide.

Recommendations

From the workshop activities and discussion, some emerging recommendations for suicide prevention action, led by and delivered in regional, rural, and remote communities, were noted and synthesised.

Upskill and build the capacity of local communities to be decision makers and implementation partners.

Recommendation 1

That community members, including people with lived and living experiences, champions, leaders and community-based organisations, be supported with capacity building opportunities and funding to implement suicide prevention programs.

Recommendation 2

That stigma be reduced, awareness raised, and training provided to community members and community organisations, health and frontline services.

Recommendation 3

That peer workers be trained, supported and employed across a range of clinical and non-clinical community settings, including within standalone safe spaces to support people in distress and provide holistic approaches.

Recommendation 4

That communities, including First Nations people, people with lived and living experiences and other population groups that are disproportionately impacted by suicide, be engaged in consultation and co-design of suicide prevention activities, and across all levels of program governance, planning, implementation, and evaluation.

All levels of government to play a supportive and active role in suicide prevention

Recommendation 5

That collaboration between governments, organisations, community members, and networks is facilitated and prioritised with reach into rural communities.

Recommendation 6

That the role of local government be considered when planning and implementing rural suicide prevention.

Recommendation 7

That government funding be available across the spectrum of suicide prevention action in formats that best suit rural communities, for example, flexible, long-term, seed-funding and scholarships.

Recommendations

Programs to address local, real-world needs and issues in rural communities

Recommendation 8

That community strengths and programs need to be identified by communities themselves, based on local resources as well as specific risk factors and determinants of suicidality.

Recommendation 9

That services, supports and resources in communities be mapped and communicated, and efforts coordinated to reduce duplication of efforts whilst also ensuring a sufficient choice in service offerings.

Recommendation 10

That program efforts be tailored to meet the needs of priority populations within communities, taking into account cultural diversity and inclusion, including holistic and alternative views of wellbeing, suicide and its prevention.

Recommendation 11

That connection to the community and other protective factors within community are prioritised, including early intervention programs to reduce isolation and increase opportunities for connection.

Recommendation 12

That disasters and traumatic events, including suicides and longer-term impacts of natural disasters and interpersonal traumas, within rural communities be accounted for in the planning and implementation of suicide prevention programs.

Program monitoring, data, and evaluation to guide decisions

Recommendation 13

That qualitative perspectives from people with lived and living experiences of suicide are used alongside service data and suicide statistics, including in program evaluations.

Recommendation 14

That local-level data be available for communities to plan suicide prevention programs and to enable them to respond to emerging concerns.

Recommendation 15

That funded services and programs in rural areas be accountable to the funding body and the community, detailing key performance indicators, how resources are being used and where they fit within the service and community ecosystem.

Recommendation 16

That long-term, government-funded program evaluation be included in government policies and priorities to build the evidence base for regional, rural and remote areas.

Table 1: Workshop activities – an overview

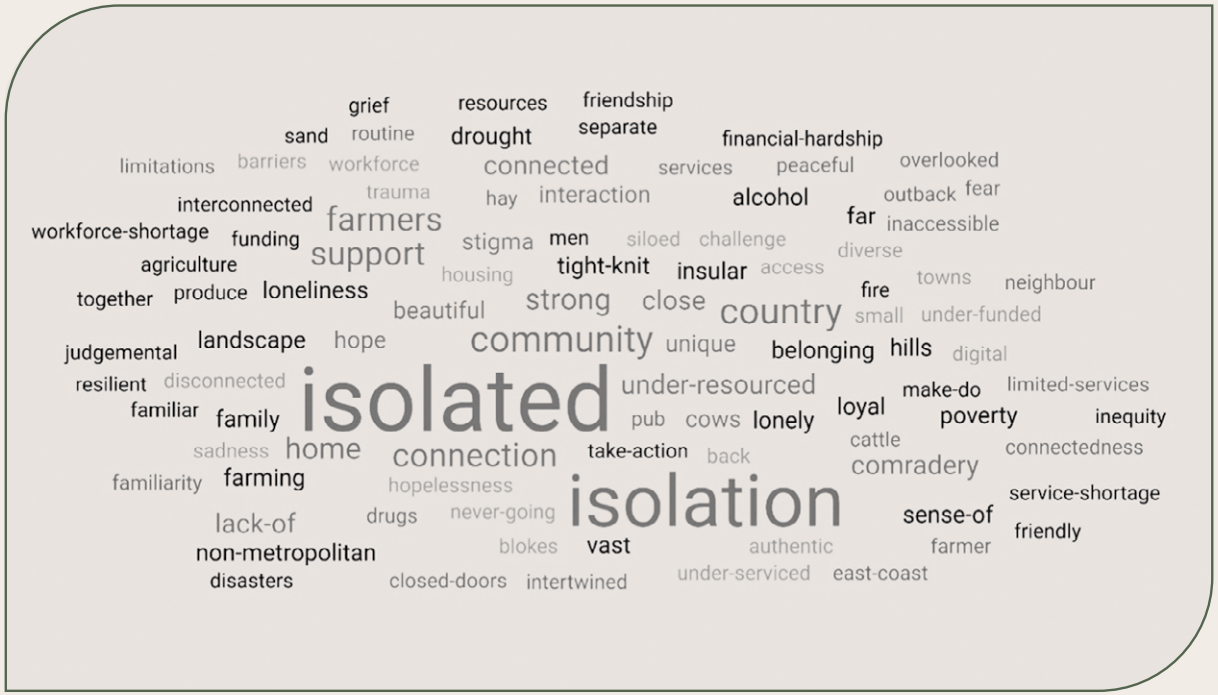
Activity	Purpose	Details
Activity 1: **Initial reflections** (Hobart and Albury)	To connect people with each other and prepare for workshop participation.	Each person writes down one to three words to describe: 1. Rural communities 2. Suicide prevention in rural communities 3. Lived experience in rural communities.
Activity 2: **Opportunities for change** (Hobart and Albury)	To record what participants identified as some of the key opportunities for change when thinking about suicide prevention in rural communities.	Participants moved around the room, adding their 'opportunities' against the type of intervention or type of enabler it best relates to, with the following options: • Wellbeing • Prevention • Intervention • Postvention • Enabler: People and communities • Enabler: Evidence and whole of government.
Activity 3: **Defining the change we need and how we will get there** (Hobart and Albury)	To get people to identify one action area or enabler from Activity 2 to discuss further as a small group.	Each table worked together to answer the following questions and recorded their discussion on butcher's paper. • What CHANGE do you want to see to planning and delivery of suicide prevention in rural communities? • What practical ACTIONS would help communities achieve these changes? • WHO should lead on the actions? • What are some ways in which people with lived experience could be involved? • How will we know if the actions have been successful? • Are there community members whose needs are missed?
Activity 4: **Initial reflections** (Albury only)	To provide people with an opportunity to contribute to and identify research and workforce priorities.	Each participant was invited to contribute ideas about research that they would like to see as a focus for Manna Institute and to describe what they feel are the most pressing rural workforce issues that need to be addressed in policy and research.

Findings

Rural communities

When asked to write down one to three words that come to mind when thinking of *'Rural communities'* (Figure 1), the most common words noted across the responses were *isolated (n=22), isolation (n=18), and country (n=6)*. While many words used have negative connotations (e.g. trauma, grief, hardship), many were also positively worded (e.g. familiar, family, comradery).

Figure 1: Responses when thinking of *'rural communities'*

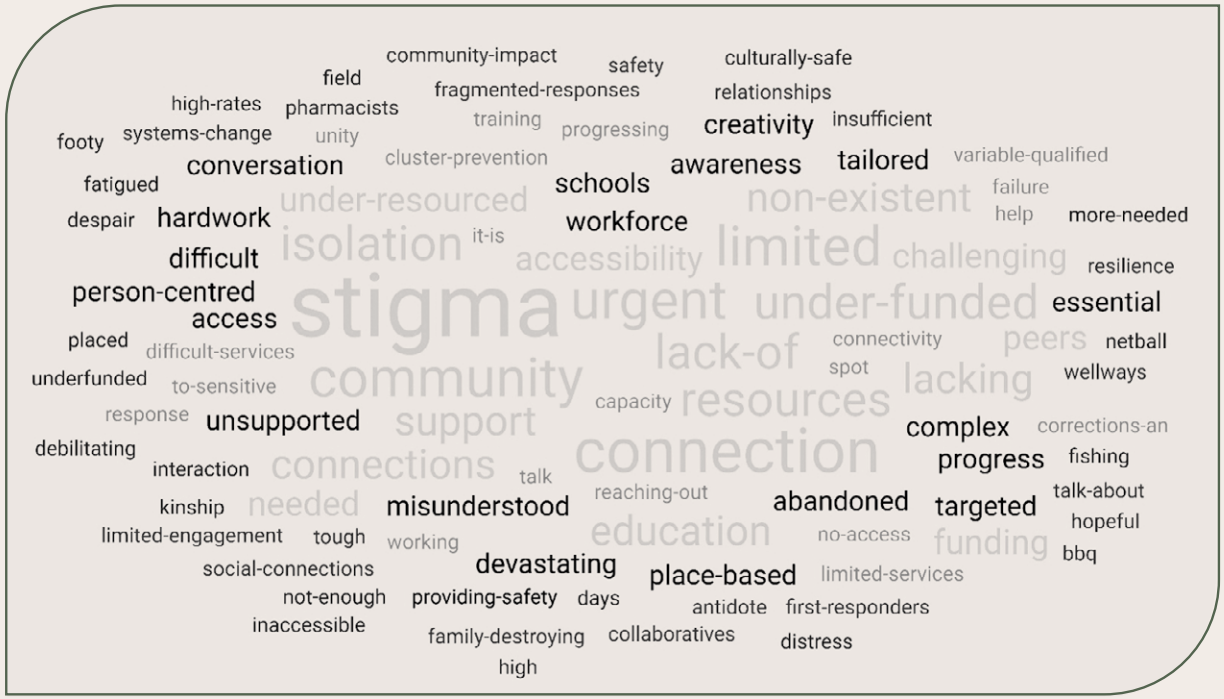


Findings

Suicide prevention in rural communities

When asked to write down words that come to mind when thinking of *'suicide prevention in rural communities'* (Figure 2), the most common words noted across the 233 responses were *connection/s (n=11), stigma (n=11), community and under-funded (both n=6)*.

Figure 2: Responses when thinking of *'suicide prevention in rural communities'*



Findings

Lived Experience in rural communities

As shown in Figure 3, when asked to write down words that come to mind when thinking of '*lived experience in rural communities*', the most common of the 248 words recorded were *stigma (n=10), needed (n=8), connection (n=7), Important (n=7), isolated (n=7) and shame (n=7)*.

Responses when thinking of '*lived experience in rural communities*'.

Findings

Wellbeing

When asked about opportunities for change in the action area of wellbeing, participants highlighted person-level factors and factors at a community and environmental level (Figure 4). Person-level factors included employment, financial, education, and housing support, as well as access to health and support services and the development of personal and coping skills. Community and environmental factors included activities to increase connection and purposeful association, improved awareness and literacy, and community-driven and peer-led approaches.

Figure 4: Opportunities for Change: Wellbeing Themes

Person-level factors (Hobart=28; Albury=11)

- Personal and coping, skills, emotion regulation, cultural awareness, identity, sense of purpose.
- Employment and education support.
- Access to appropriate health and support services, inc. cultural, alternative options.
- Food access, housing and financial support.

Community and environmental-level factors (Hobart=44; Albury=37)

- Natural environment and disaster recovery
- Options for peer and lived experience safe spaces, networks, groups and connections.
- Role models, mentors and Community Champions.
- Funding for community-driven wellbeing services and activities.
- Inclusive and appropriate wellbeing activities and services inc. supporting infrastructure.
- Opportunities for connection and purposeful association.
- Community building activities inc. community groups and networks.
- Government roles in wellbeing promotion.
- Addressing stigma in communities.
- Diversity and trauma awareness and improved literacy.

Findings

Activity 2: Opportunities for Change

Prevention

Under the action area of Prevention, three overarching themes were identified relating to opportunities for change: 1. Community and environmental factors; 2. Services, systems and workforce factors, and 3. Types of prevention initiatives (Table 2).

Table 2: Opportunities for Change: Prevention Themes

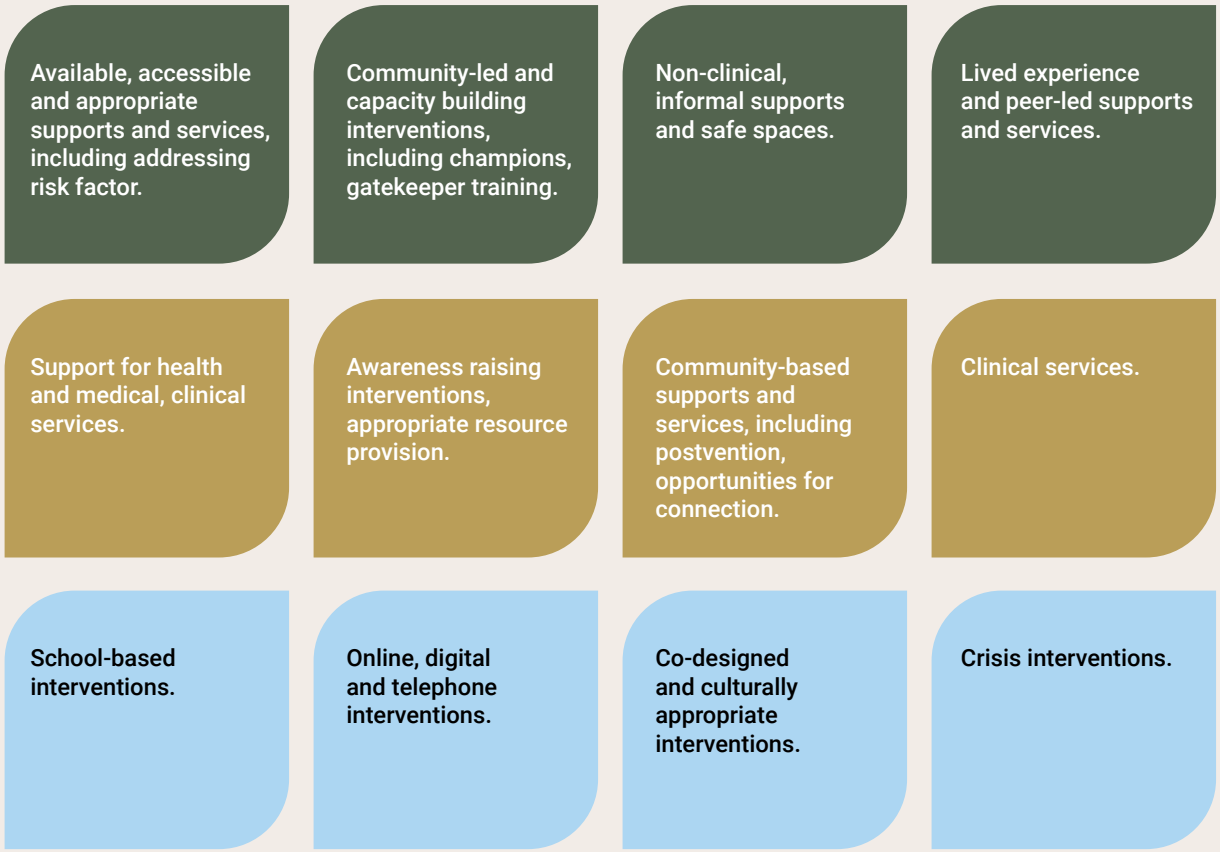
Themes	Sub-themes
Community and environmental factors *(n=15)*	Community involvement, including co-design and community networks Consideration of natural disasters Cultural, diversity and inclusivity
Services, systems and workforce factors (*n=44*)	Appropriateness and availability of services Lived experience and peer workers System level factors Workforce supports and training
Types of prevention initiatives (*n=88*)	Community-based programs Early intervention programs Family-focused programs and services Peer-worker roles School-based interventions Targeting social media, including online bullying Social support, opportunities for connection and sporting clubs Training and awareness raising

Activity 2: Opportunities for Change

Intervention

When noting opportunities for change in the action area of intervention, 12 themes were identified, with workshop participants commonly discussing opportunities relating to increasing the availability, accessibility and appropriateness of supports and services, as well as efforts focusing on addressing risk factors. Other commonly reported themes for addressing programs at the intervention level included ensuring community-led and capacity building interventions (see Figure 5).

Figure 5: Opportunities for Change: Intervention Themes



Activity 2: Opportunities for Change

Postvention

Under the action area of postvention, 12 themes were identified, with accessible services and supports and peer and lived experience-led services the most commonly mentioned (see Figure 6).

Figure 6: Opportunities for Change: Postvention Themes

Enabler: People and communities

When looking at the enabler focused on people and communities, nine themes were identified across the workshops. Recognising and building the lived experience and peer workforce were most commonly mentioned, followed by partnerships, collaboration and coordination (see Table 3).

Table 3: Opportunities for Change: People and Communities Themes

Themes	*n*
Recognising, understanding, utilising, and building the lived experience and peer workforce	***n=16***
Partnerships, collaboration and coordination of services and responses	***n=13***
Awareness raising, education and training including for services, local touchpoints and gatekeepers	***n=10***
Incorporating cultural awareness, diversity and inclusion and trauma-informed practices in services and practices	***n=10***
Community involvement, support and leadership, including champions and networks	***n=9***
Government involvement, including local, state and federal	***n=9***
Place-based, community-specific initiatives	***n=9***
Funding, including scholarships	***n=8***
Safe spaces and building connections	***n=2***

Enabler: Whole of government

Under the enabler concerning whole of government approaches, 10 themes were identified with lived experience inclusion, representation, and employment at all levels the most commonly mentioned, followed by coordination, communication and resource sharing across governments (see Table 4).

Table 4: Opportunities for Change: Whole of Government Themes

Enablers of Change: Whole of government	Lived experience inclusion, representation and employment at all levels	***n=12***
	Coordination, communication and resource sharing across governments	***n=11***
	Provision, appropriateness and inclusivity of data, i.e. surveillance, cluster monitoring, data linkage and qualitative data	***n=10***
	Ensuring sufficient infrastructure to support programs i.e. internet, opportunities to share learnings	***n=7***
	Whole of system approaches and addressing the social and economic determinants of suicide	***n=6***
	Accessibility and diversity of service options, including suicide prevention specific	***n=6***
	Ensuring accountability of funded services and initiatives	***n=5***
	Local workforce recruitment, upskilling and incentives across the workforce spectrum, clinical/non-clinical, multidisciplinary, psychosocial, peer workforce, lived experience	***n=4***
	Whole of systems approaches and addressing the determinants of suicidality	***n=4***
	Recognising and supporting community-level and led action, including co-design and consultation	***n=4***
	Addressing community issues and needs and ensuring inclusion of priority populations, including First Nations communities	***n=4***

Activity 3 – The change we need and how to get there

Workshop participants chose one action area or enabler from Activity 2 to explore further as a small group. Findings are presented in Table 5. Across the two workshops, at least two groups focused on each topic area (Wellbeing = 2; Prevention = 3; Intervention = 2 groups; Postvention = 2 groups; People and Communities = 4; Whole of government = 3).

Table 5: The change we need and how we get there – themes identified

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Wellbeing *(groups n=2)*	• Opportunities for connection • Wellbeing incorporated into work • People recognised as a resource • Local councils having a role • Diverse delivery methods for programs • Breaking down silos/stigmas • Programs focusing on individual-level factors • More early intervention and primary prevention • Programs that are culturally correct and tailored for each community • Greater access to basic community services • Address Maslow's hierarchy of needs - self-actualisation, meaning, purpose, (spirituality) is on top of Maslow's hierarchy [12]	• Opportunities to showcase community strengths, share resources • Programs building individual level skills • Start small with community engagement • Respectful of community, first nations, farmers etc. • Use of universal, common languages • Understand history of the country, what is currently happening in community • Alignment/coordination between services • Sustainable frameworks/ longer term view • Global 'healthy communities' movement • Measure economic success in happiness • Whole community approach	• People trained to hold space • Lived experience • Local health services • Local fire brigades • Schools • Government e.g. councils, Minister for Wellbeing • A holistic team • Content experts on panels, committees	• Community champions • Women in leadership • TAS Premiers Lived Experience advisory group • Regional leaders and establish regional bodies and • Ensure lived experience inclusion • Reduce stigma • Community suicide prevention supporters i.e. touchpoints • Partnerships with traditional custodians • Resourcing for land councils and rangers and First Nations groups • Engagement with people with disability, neuro-divergent people, other critical voices	• Community feedback • Measuring community support • Social connections • Strategies included to reach the quiet, softer voices	N/A

Activity 3 – The change we need and how to get there

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Prevention *(n=3)*	• Place-based approaches - even if the idea, program or initiative originated outside the community. • Alternatives to ED • Funded, peer-led, long-term community hub/safe spaces • Increase awareness and reduce stigma • Overcome confidentiality barriers • Support for family and friends • Mental health for youth • Inclusivity and accessibility of programs and services • Linking services and referral pathways • Education, incentives for locals and youth to upskill and train • Parental education • Broaden issue – not a health issue. • Programs addressing social determinants • Early distress/support (any initiative that promotes mental health and wellbeing (e.g. sport and recreation, social prescribing etc.) and 'keeps' people well or catches someone prior to an escalation of distress is more effective and cheaper (in the long run)	• Improve transport access • Streamline approaches to grants/funding • Community control over funding • Peer workers across services • Lived experience recognition • Local collaborations i.e. community/schools • Services to meet local needs • Community co-design/ consultation • Digital services • Incentives for services • Resource packs for new community members • Community Champions • Outreach/promotions • No wrong door • Referral program including doctors • Support before distress • Mental health literacy • Service accountability • De-stigmatise • Primary School Education	• Local people with local knowledge • Telehealth • Local councils • Community as a whole • Community champions • Community and government collaboration • Networks • GPs	• Local knowledge and experiences, sharing knowledge • As support • Connect community, build relationships • Cultural and religious groups • Community co-design • CALD groups	• Have conversations with community • Collect feedback six months post intervention • Capture voices through a variety of means • Multiple consultations • Lived Experience involvement in evaluation • Measure in 'real time' to allow for changes/ improvements • Improved community awareness • Increased ED presentations • Use KPIs with outcomes built in • Implementation science • Basic quality satisfaction of services	• Elderly • People under 12 years • Geographically isolated people • Disengaged people • Minority groups • Missing middle (low-moderate and mod-severe/ people without diagnosis

Activity 3 – The change we need and how to get there

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Intervention *(n=2)*	• Community-based supports • Outreach • Services not limited on timeframe, age, gender, culture • Inclusive eligibility criteria/services • Minimum timeframes for rural placements • Upskilling local people/ workforces • Reducing stigma • Qualified, skilled staff • Consistent, standardised programs • Consideration of geography/isolation • Community members trained in mental health first aid	• Lived experience training i.e. peer workers • Community-led strategies • Community safe spaces • Workforce development i.e. training for first responders • Means restriction • Upper primary school, education, health literacy • Mental health first aid training • Long term relationships based outreach • Easier access to health, safe spaces • More trained clinicians to do assessments	• Community • Community champions/ leaders • Community collaboration • Policy leaders • Community working groups • Councils • GPs	• Insight on real life experiences • Representative of the whole community	• Story boards • Feedback • Statistics • ED presentations • First responder callouts • Development of skills • Less interventions • Change in language used	• Farmers • Older men • Isolated people • People with lifelong mental illness • Refugees and people with English as second language • Adolescents • First Nations people

Activity 3 – The change we need and how to get there

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Postvention *(n=2)*	• More 'seed funding' direct to community • Organised, planned efforts • Clearer roles • Contentment as a target, not happiness • Strategies for mental/emotional/ physical/social/ spiritual/financial factors • Safety plan • Holistic approaches • Outreach • Early distress service linkage • Collaboration of local organisations	• Support first responders/ witnesses/ community • Suicide notifications • Central supports register • Subsidised and accessible mental health awareness training • Services provided to those at low risk – not just moderate/high distress. • Remove exclusion criteria. • Provide services without referral form/ gatekeeping • Increase mental health literacy of consumers	• All agencies/services working together e.g., police, local area district, StandBy, Department of Education/Emergency Departments, provider, Aboriginal Community Controlled Health Organisations • Family • Community networks • Community centres • Everyone • Government inc., Councils	• Community co-design • Supporting people at risk to access help • Postvention • Empower communities and build capacity • Community peer support groups • In suicide prevention networks • Peer workforce • Hospital peer workers or supports	• Community set up hubs/ centres, safe spaces • Outreach/in-reach with hard to reach people • Community Action Plan funding • Volunteers trained • Evaluation • Program logic • Asking communities feedback • E-tools • Patient experiences • Conversations with mental health professionals/ communities/those trained in accidental counselling	• Those with stress without mental health diagnosis—missing middle • Lower socioeconomic groups

Activity 3 – The change we need and how to get there

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Enabler – People and communities ***(n=4)***	• Bottom-up approaches • Embedding support • Long term planning • Strategic collaboration across communities/services • Cross cultural/ culturally aware programs and services • Modelling community success stories • Outreach • Community-based activities/ consultation • Enhanced connection • Community development • Mapping strengths • Program evaluation • Ongoing conversations • Accountability of programs/funding • Community input into program design • Evidence-based programs • Sustainable approaches/funding • Representation across sectors • Holistic programs Embedded community beliefs	• See what the community wants/needs are • Tap into what's working • Identify/build capacity of natural leaders/ champions/influencers • Work with local hubs/ community houses/ schools/councils/ workplaces • Creating resource pack/ DIY for community-led suicide prevention • Long term planning • Strategic collaboration between services • Mentoring system • Relationships building • Program evaluation • Consultation with community • Partnerships • Community-based programs • Dissemination of evidence based information • Social connectedness • Long-term funding • Community awareness training/education	• Lived experience • Whole of community • People who speak the local 'language' • Local leaders/champions • University researchers • Experts • Local government • Industry • Local media	• Creative initiatives • Reduce stigma • Young people friendly initiatives • Involve and engage diverse groups • Use traditional models • Dedicated roles, positions, and career pathways at all levels • Financial remuneration • Leadership and decisions making • Co-design • Story telling • Translating • Lived experience networks	• Reduced suicide rates • Improved wellbeing • Increased accessibility • Decreased poverty • Increased community spirit • Increased school attendance • Engagement of diverse community members • Reduced ED presentations • Data captured • Retention of staff • Reduction in isolation/ increased levels of participation • Shared purpose • Local community attendance at community events • The networks and activities are self-sustaining	• Young men/people • Diverse community members, including LGBTIQ+ • First Nations peoples • CALD communities • Primary school aged children • Elderly population • Lived experience • Transient populations

Activity 3 – The change we need and how to get there

Theme area	Changes required	Practical actions	Who to lead actions	Ways people with lived experience could be involved	How we will know if the actions implemented have been successful	Members of your community whose needs are being missed
Enabler – Whole of Government *(n=4)*	• Including GPs/health professionals • Cross-sharing of data • Communities understanding their data • Upstream program delivery • Community connection • Account for health literacy • Digital models • Early intervention • GPs as gatekeepers • Using social media • Sustained funding • Federal/State Minister for Mental Health • Legislation informed by data and evidence • Lived experience input/consultation	• Training and support for professionals • Collaborative approach • GP systems as anecdotal data • Use AI to identify signs/ analysis • Whole of government linkage/monitor trends • Indigenous story-based evaluation/methods • Communication with National Mental Health Commission • Improve communication and understanding of government policy/actions/ processes in regional, rural and remote communities • Improve reciprocal communication	• LGAs • Councils • Public/private hospitals • Community members • National suicide prevention office research team	• Voices of lived experience in data i.e. corrections, homelessness • Representatives in government governance structures • Perspectives in evaluations	• Communities have access/ visibility over their own data, are empowered to use it (by governments) • Lived experience leadership and membership on community panels in service systems e.g. PHNs • Government suicide prevention co-ordinators consult, engage and map out regional service systems • Track data related to relevant legislative changes • Regular interagency consultation	• Farmers • First Nations peoples • CALD communities • People on parole • Elderly • Children and young people • Migrants • People with alcohol and drug dependence • People with no data available • Men/young men

Activity 4 – research and workforce priorities

Participants in the Albury workshops identified a range of research and rural workforce priorities for consideration in future policy and planning, as summarised in Table 6.

Table 6: Research and workforce priorities

Research priorities	Workforce priorities
• Efficacy of outdoor health in suicide prevention • Role of Adverse Childhood Experiences • Consultation with First Nations Elders • Aboriginal and Torres Strait Islander-led research, including yarning approaches • What does a self-determining mentally healthy town (or LGA) look like? • Consultation and co-design with rural communities • The role and impact of peer work • Telehealth outcomes for mental health concerns • Barriers to support in rural communities • Understanding protective or success factors in communities with suicide rates • Establish lived and living experience think tank to guide research priorities • Build the lived experience research discipline • Use a relational approach to suicide • Family wellbeing • Research to practice initiatives	• Invest in and grow the workforce • Support staff wellbeing • Build capability in all current workforces, including GP, clinical and non-clinical • Manageable caseloads and quality supervision • Reflective practice and training in strength-based and trauma-aware practices • Specific rural mental health vocational pathways, e.g. rural psychologists and counsellors • More outreach workers (clinical and non-clinical) • Increase connection with other organisations and access to communities of practice • Bring in lived experience, Elders and traditional healers to the workforce • How to staff a systems approach in rural areas with limited staff and volunteers • Increasing understanding of the community • Talent pool in regional areas to provide skilled, qualified and experienced workers • Partnerships with universities, TAFEs • Paradigm shift so that the workforce and community accept blended care, including telehealth and online modalities • Increase support for families, friends and carers • Increase community connectors and navigators

Next Steps

This report will be distributed by Manna Institute and Everymind and used as a technical report to inform the research direction of the 'Suicide Prevention and Distress' stream within Manna Institute.

It is anticipated that the findings will inform policy planning, as well as the planning and development of future suicide prevention in regional, rural and remote communities. Additional research to explore the suitability of suicide prevention for rural communities is needed, with a focus on community and lived experience direction and leadership and building on the protective factors, strengths and connections already within rural communities.

For any enquiries, please contact mannainstitute@une.edu.au

References

1. Roses in the Ocean. *Lived experience of suicide*. 2023; Available from: https://rosesintheocean.com.au/lived-experience-suicide/.
2. Australian Institute of Health and Welfare. *Rural and remote Australians*. 2020 18 October 2023]; Available from: https://www.aihw.gov.au/rural-health-rrma-classification. .
3. Centre for Rural and Remote Mental Health, *Suicide and Suicide Prevention in Rural Areas of Australia: Briefing Paper*. 2017, The University of Newcastle Australia.
4. National Rural Health Alliance, *Suicide in Rural and Remote Australia. Fact sheet, July 2021*. 2021.
5. Australian Institute of Health and Welfare. *Deaths by suicide by remoteness areas*. 2022 18th August 2023]; Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring.
6. Fitzpatrick, S.J., et al., *Suicide in rural Australia: A retrospective study of mental health problems, health-seeking and service utilisation.* PLoS One, 2021. 16(7): p. e0245271.
7. Kaukiainen, A. and K. Kõlves, *Too tough to ask for help? Stoicism and attitudes to mental health professionals in rural Australia*. Rural and Remote Health, 2020. 20(2).
8. Handley, T.E., et al., *Contributors to suicidality in rural communities: beyond the effects of depression*. BMC psychiatry, 2012. 12(1): p. 1-10.
9. Hazell, T., et al., *Rural Suicide and its Prevention: A CRRMH position paper*. 2017, Centre for Rural and Remote Mental Health: University of Newcastle.
10. Grattidge, L., et al., *Exploring Community-Based Suicide Prevention in the Context of Rural Australia: A Qualitative Study*. International Journal of Environmental Research and Public Health, 2023. 20(3): p. 2644.
11. Handley, T.E., et al., *Lessons from the development and delivery of a rural suicide prevention program*. Australian Journal of Rural Health, 2021. 29(6): p. 993-998.
12. Maslow, A.H., *Lessons from the Peak-Experiences*. Journal of Humanistic Psychology, 1962. 2(1): p. 9-18.

“We are cultivating connections, projects and opportunities to improve mental health and wellbeing in rural, regional and remote Australia. We are growing meaningful research and professional workforces, and engaging industry to translate research findings into much-needed initiatives.”

Contact us:

mannainstitute@une.edu.au
www.mannainstitute.au

manna
INSTITUTE