Stakeholder Consultation Forums Outcomes Report

Key issues and priorities when discussing suicide

Outcomes Report:
Stakeholder Consultation Forums Outcomes Report

June 2012

Developed by:
Hunter Institute of Mental Health

An initiative of the NSW Ministry of Health

NSW GOVERNMENT Health

hunter institute of mental health

Mental Health Commission of New South Wales

This report was developed under a project originally called 'Community guidelines for discussing suicide' funded by the NSW Ministry of Health (Mental Health Drug and Alcohol Office). The project and resources are now called 'Conversations Matter: Resources for Discussing Suicide' and are supported by the Mental Health Commission of New South Wales. The report was produced by the Hunter Institute of Mental Health (HIMH) to inform development of 'Conversations Matter' and is available at www.conversationsmatter.com.au

Preferred citation:

Hunter Institute of Mental Health. (2012). ***Key issues and priorities when discussing suicide: Stakeholder forums.*** **Newcastle, Australia.**

Acknowledgments:

This report was principally written by Aimee Stazak and Jaelea Skehan from the Hunter Institute of Mental Health (HIMH). The HIMH would like to acknowledge the support of the state-wide steering committee in the planning of this project. In particular, HIMH would like to express sincere gratitude to the 109 participants who represented the four identified settings of Education, Community and online, Workplaces and Family.

Contact:

Hunter Institute of Mental Health

PO Box 833 Newcastle NSW 2300

+61 2 4924 6900

HNELHD-HIMH@hnehealth.nsw.gov.au

www.himh.org.au

ISBN: 978-0-9875688-7-8

This report and other research and evaluation reports for the program are available online at www.himh.org.au

Contents

Chapter 1: About the Forums

1.1 Background

In 2010, The NSW Ministry of Health released the NSW Suicide Prevention Strategy 2010-2015. The aim of the planning document is to work with the community to reduce the rate of suicide and suicidal behaviour in NSW by strengthening the capacity of individuals, families, schools, workplaces and the local community to work together and share responsibility in supporting each other and the whole community. One strategic direction under the NSW Suicide Prevention Strategy is the development and dissemination of community guidelines for discussing suicide.

The Hunter Institute of Mental Health has been contracted by the NSW Ministry of Health (Mental Health and Drug and Alcohol Office) to work with a state-wide steering committee to review the evidence, consult with various stakeholders and develop the community guidelines. The aim of the guidelines is to provide support for schools, workplaces, families and communities to strengthen their capacity to participate in suicide prevention action.

The guidelines should be developed in a way to be relevant to a range of groups including, but not limited to: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; gay, lesbian, bisexual, transgender and intersex people; young people; older people; and males.

The first phase of the project included a search, critical review and synthesis of the research evidence, as well as existing resources and program approaches to identify and provide evidence based recommendations on the proposed content and format for the guidelines.

The second phase of the project has been designed to ensure consultation and engagement with key stakeholders within: (a) target settings; and (b) target groups; that may benefit from the final guidelines.

This report outlines key outcomes of four forums held in Sydney in May 2012 to engage key informants from identified settings, including educational settings, workplaces, families, communities and online.

1.2 About the Forums

The aim of the consultation forums was to engage relevant stakeholders within four identified settings, and to identify key issue and priorities to be considered within each setting and other implications for project planning and delivery.

Four half-day consultation forums were held on 9 and 10 May 2012 at the ACON Meeting Centre, Sydney (as outlined below).

9 May 2012: Educational settings (morning); Workplaces (afternoon)

10 May 2012: Communities and Online (morning); Families (afternoon)

The forums were planned by the Hunter Institute of Mental Health in consultation with the steering committee, and facilitated by the program Manager, Jaelea Skehan. Each forum followed the same basic structure, using small group activities to obtain key information and input from all invited participants. Table 1 below provides a basic structure of the sessions. Morning and afternoon sessions were invited to stay (or arrive early) for a combined lunch.

Table 1: Summary of Forum Structure

FORUM STRUCTURE	
Welcome and overview of the day	10 minutes
PRESENTATION & DISCUSSION: Project overview, key considerations and outcomes from the literature review	30 minutes
SMALL GROUP ACTIVITY 1: Identification of key issues, priority target groups, key influencers within the setting	55 minutes
MORNING/AFTERNOON TEA BREAK	
SMALL GROUP ACTIVITY 2: Identification of barriers and opportunities and key partners for each setting	55 minutes
SMALL GROUP ACTIVITY 3: Key considerations for the format and dissemination of the guidelines.	35 minutes
Final comments and evaluation	10 minutes
COMBINED AM & PM SESSION LUNCH	1 hour

1.3 Participation

Stakeholders were selected because of their experience working with or within each of the identified settings. They included both national and state representatives from government and non-government agencies, key mental health and suicide prevention organisations and programs, other organisations or networks with key roles within each setting.

An attempt was made to ensure representation from urban, rural and remote settings and covered specific population groups, including Aboriginal people, culturally and linguistically diverse communities, young people, older people, gay, lesbian, bisexual and transgender people.

The forums were attended by 109 participants across the four settings: Education (n=26), Workplaces (n=22), Communities and Online (n=39) and family (n=22). A full list of participants is provided as Appendix 1.

1.4 Data collection

Participants were allocated to a small group for each of the forums. Some of these small groups were specifically targeted (e.g. a dedicated group looking at online considerations in the communities forum and a dedicated TAFE group at the education forum) while others were formed to ensure a diversity of views (e.g. ensuring a mix of workplace and suicide prevention representatives in the workplace forum, ensuring a mix of rural and urban representatives in the families forum).

Small group facilitators were identified and briefed by the project team prior to the forums to ensure the flow of conversation and the recording of key discussions. Each group was provided with

instructions for each activity and A3 feedback forms for the collection of group conversations. Each participant was also provided with an individual participant feedback form to ensure that those who were less comfortable sharing in a group discussion could still submit their views for consideration.

Key discussions from each group were shared by a nominated spokesperson and summarised by the facilitator on butcher's paper. These summaries were pinned up for the reference of participants throughout each forum.

Small Group Activity One (setting priorities) was followed by voting process to further refine the priority list. Each small group could nominate 3-4 key priorities from their discussion to be listed on butcher's paper. Each participant was then invited to vote for only two priorities listed (using colour dots provided to each person) during the break.

This report represents a summary of key outcomes obtained from both group and individual feedback forms. The outcomes from each forum are discussed separately.

Chapter 2: Outcomes for Educational Settings

A face-to-face consultation forum which focused on the discussion of suicide in educational settings was conducted in Sydney on Tuesday 9 May 2012 (9:00am to 12:30pm). The forum included 26 participants working in four small groups.

The following section outlines a summary of the discussions and priorities set during the consultation forum.

2.1 Priorities

Each group was asked to brainstorm some priority target groups, types of conversations and/or areas for action directly applicable to the education setting.

Following the small group activity, key priorities were presented to the larger group and all participants were invited to vote (with an allocation of two points per person). The results of the large group discussion and priority rankings are outlined in Table 1 below.

Table 1: Priorities for Educational Settings.

RANKING	VOTES (%)	PRIORITY GROUP OR AREA
Priority 1	10 (24%)	Training for gatekeepers in education settings
Priority 2	6 (15%)	Ensuring appropriate integration and dissemination within existing resources, programs and policies
Priority 3	5 (12%)	Ensuring a strong evidence base so that the guidelines can be applied with confidence.
	5 (12%)	Language to be used, especially for diverse groups
Priority 5	4 (10%)	Overcoming teacher and staff fear in using the word suicide
Priority 6	3 (7%)	Addressing the underlying stigma associated with suicide
	3 (7%)	Target resources to the appropriate level and type of discussion – i.e. education department, school, classroom, and individual
	3 (7%)	Ensure the discussions occur as part of a broader social and emotional wellbeing context
Priority 9	2 (5%)	Postvention conversations (including reintegration into school following a suicide attempt)

Other	0	Age appropriate discussions – i.e. include both a primary and high school focus
	0	Online conversations that happen within the school context or school community
	0	Families as part of the school community
	0	Young people talking to each other

Reviewing all of the small group and individual participant forums, a number of other target groups were identified, but not listed as key priorities from the groups. These target groups included: At risk youth; TAFE Students; Children of parents with a mental illness; Young people living with domestic violence and sexual assault; Young people recently released from prison; Young people with intellectual, physical or learning disability; Gay, Lesbian, Bisexual and Transgendered youth; Youth who drop out of school; and Teachers.

In addition, there were a range of other target areas identified from group and individual feedback forms: Assisting youth to express their feelings; Health and PE curriculum; Exam processes, self-harm and distress; Exam disability provisions; HUG day; Referral pathways to help; Training for non-mental health staff; Sitting with distress; Differences between government and non-government schools; Mandatory reporting and confidentiality; Target information to different year levels; Assembly vs. school room conversations; Risk of liability for staff.

2.2 Opportunities, Risks and Barriers

Activity two asked each small group to work through two small activities:

- Activity 2A: Identification of opportunities and strengths to build on as well as potential or known risks to be considered or managed;
- Activity 2B: Outline of key barriers to uptake in educational settings and potential solutions to overcome those barriers.

Opportunities and strengths

1. Build on existing programs

The overwhelming response was for the guidelines to compliment and add value to existing evidence-based programs being rolled out within educational institutions. There were a number of programs and organisations identified. Some of these were specific school based programs or interventions, while others were organisations or services targeting young people or more general training available to staff or students.

- Specific school-based programs included: School- Link; MindMatters; Kids Matter, Got IT; Head Start (Black Dog Institute); Sense Ability (beyondblue); RUOK? Day in schools; Headspace School Support Program; and Response Ability for Teacher Education (for training of teachers).
- More general services and training identified included: Inspire Foundation; Applied Suicide Intervention Skills Training (ASIST); Justice Health; Westmead Hospital Mental Health and Intellectual Delay program.

2. Health and wellbeing focus of educational settings

Participants noted that educational institutions generally aim to build the capacity of students by focusing on health and wellbeing. This is often implemented through the health and physical education curriculum (in schools). Participants suggested that the guidelines could build upon this curriculum by incorporating material about discussing suicide into school policies and mental health guidelines. The employment of mental health teaching consultants could also add value to this process.

3. Build on current interest

The participants recognised that conversations were already occurring in educational settings. This is an opportunity to be built on. It was noted, however, that there is no evidence to support that these conversations are safe. Suggestions to influence safe conversations included:

- Increase the visibility of help and support and further build connections between people using social media e.g. Facebook, twitter;
- Building prevention planning into conversations on postvention and attempted suicide.

4. Build on health policies

Participants identified an opportunity to impact strategically on policy making at a state level by integrating the guidelines with:

- The NSW State Plan 2012;
- Commonwealth priority for gatekeeper training;
- National standards for maintain student safety now part of teachers training.

Risks

1. Reluctance to talk about suicide

There was a general agreement that some education professionals may feel reluctant to talk about suicide. The fear of inadvertently 'glamourizing' suicide as an option in dealing with emotional pain; 'scaring off' students who were not ready to have the conversation; the risk of 'opening a can of worms' and the current lack of support given to education staff to safely have a discussion about suicide.

2. Evidence-base for conversations in schools

Participants documented concern about the evidence base for talking about suicide in schools, with current conflicting evidence. Participants noted other areas, for example post traumatic counselling that has shown negative evaluations in a school setting.

Participants stated that the guidelines for an educational focus need to be evidence based, define clear priorities, be reinforced by curriculums, focus on mental health and wellbeing and overall be safe. However participants also stated that the current lack of evidence about discussing suicide with young people ought not to soften the message conveyed. If the message is too 'soft' people may be left with a small piece of the puzzle rather than a comprehensive overview.

3. Impact of conversations on students

Identifying who should lead the discussion was debated under risk. Participants identified that there may be some risk in students talking to friends about suicide. The question was also asked about who protects the student if a suicide does occur following a conversation they had with a peer.

4. Impact on health services

The potential impact on local mental health services was noted. If conversations occur in education settings and difficulties or risk is uncovered, then this will have an impact on local services. In some areas, such as rural and remote areas, there may not been enough services to meet the potential demand.

5. Confidentiality and duty of care

A number of concerns were raised in relation to duty of care and confidentiality. There were questions about the limits of responsibility for teachers and other services. Given teachers and other staff have mandatory reporting obligations; it is unknown how this will impact on their willingness and ability to hold conversations with students. There was also concern about independent and catholic schools which may not allow these themes to be explored.

6. Involvement of the target group

Not involving consumers or students in the project was seen as a risk to the overall buy in to the guidelines. There is also the need to address all students across the spectrum from 'dropouts' to 'high achievers'. Appreciating the role of social media (including Facebook) as a conduit to conversations in the education setting was seen as vital to the project.

Barriers and solutions

Participants also identified a number of barriers to the development or uptake of the guidelines in educational settings. In summary, the key barriers included:

- The lack of research evidence to guide the content and dissemination of the guidelines;
- Structural barriers such as constant movement of staff
- Lack of training and education for teaching and other staff;
- A perceived risk of liability and the reluctance of staff to enter this sphere;
- The lack of relationships between teachers and students due to the constant movement of staff, tight time scheduling and online delivery methods (in TAFE and Universities);
- Understanding the transition points between school, TAFE, university and work;
- A lack of clarity about whose responsibility it would be to have these conversations within an educational setting;
- A lack of transparency between government agencies and educational settings in relation to potential students 'at risk'.

Within small groups, participants considered possible solutions to address these barriers in educational settings. In summary, these solutions included:

- There needs to be a culture change within educational institutions. The stigma associated with suicide needs to be addressed;
- In order for change to be successful, institutions should consider having school principals and role models (e.g. football players) as change agents;
- The focus needs to be on the promotion of mental health and wellbeing and the implementation of resilience building programs in the context of each community.
- Close collaboration with research institutions to ensure the 'evidence base' of the guidelines is built;

- The final guidelines should encompass wider discussions by not focusing exclusively on intervention conversations and asking the question 'are you feeling suicidal'. The message needs to be relevant to the types of discussion including prevention, intervention and postvention.
- The guidelines should recognise the need to encourage help-seeking, as well as support for the individuals having the conversations;
- Improvement in the referral pathways via clear policies, practices, training for staff, clinical supervision for school counsellors and open access to information through shared data collections;
- Pathways to partnerships with local youth services should also be encouraged to ensure that the message is relevant, current and encourages young people to link to other support outside the education sphere;
- There should also be a focus on incorporating mental health training into teaching degrees and training.

2.3 Format and Dissemination

The final small group activity asked participants to generate some ideas about the best format for the guidelines as well as key considerations for the promotion and dissemination of the guidelines in educational settings.

The participants identified the following possible formats for the final version of the guidelines:

- Podcast/vodcast;
- Information sheets;
- Stories;
- Flow charts;
- Story and visual;
- Internet site with open access for children and staff;
- Web-based with database attached;
- Hardcopies;
- Social theatre for young people
- Interactive workshops;
- Download PDF (TIPS);
- Factsheets (targeted to specific settings)
- Toolkit
- Posters; and
- Practice conversations and referrals.

Key considerations in relation to the format of the guidelines were documented. It was stated that the guidelines need be developed using a combination of formats which complement each other and are targeted to identified groups. The language needs to be 'simple, to the point and punchy' and they need to be formatted so that they are not text heavy, use colour and pictorials thereby capturing the audience's attention. The title should be broader to include mental health or wellbeing

without losing the intent of talking about suicide. The final product should also be accessible in different languages.

Participants also identified possible setting based dissemination and promotional ideas for the guidelines. Overall, the participants believed that the guidelines should be integrating into existing curriculum programs, rather than being 'something extra'. Traditional dissemination methods were seen as part of this approach with face to face training discussed as a key strategy. The training should also occur through the university curriculum and through school induction processes.

Promotion online was seen as a way to 'hook them in' via non-traditional high access sites. This should include cross integration with other websites and organisations such as Headspace, Inspire, Kids Helpline and GLBTI youth programs. Media strategies should include links to the NSW Community Awareness Campaign. Local promotional methods were also discussed including school forums, workshops, newsletters, conferences, and networks such as Parents and Community (P&C).

Promotion should initially be encouraged through senior management (including the NSW Department of Education and Communities) and appropriately trained staff. Could possibly use peer support programs as an effective tool, but this approach would have to be effectively evaluated and monitored.

There were sentiments of caution expressed from participants where campaigns have gone 'very wrong' especially where emotions come into play. Any campaigns should be pre and post market tested to ensure the key message does not have any unforeseen adverse effect. The guidelines should be an interagency governmental approach with all sectors 'owning' the material.

Chapter 3: Outcomes for Workplace Settings

A face-to-face consultation forum which focused on the discussion of suicide in a workplace settings was conducted in Sydney on Tuesday 9 May 2012 (1:30to 5:00pm). The forum included 22 participants working in three small groups.

The following report outlines a summary of the discussions and priorities set during the consultation forum.

3.1 Priorities

Each group was asked to brainstorm some priority target groups, types of conversations and/or areas for action directly applicable to workplaces.

Following the small group activity, key priorities were presented to the larger group and all participants were invited to vote (with an allocation of two points per person). The results of the large group discussion and priority rankings are outlined in Table 2 below.

Table 2: Priorities for Workplaces.

RANKING	VOTES (%)	PRIORITY GROUP OR AREA
Priority 1	10 (29%)	Peer based programs, including peer delivery/peer support and a train-the-trainer model
Priority 2	7 (21%)	Integration into policies, including suicide prevention policies and policies about responding to crises
Priority 3	4 (12%)	Tailored to specific occupations and/or workplaces
Priority 4	3 (9%)	Emergency workers (including former workers)
	3 (9%)	Considerations within job design and human resources
	3 (9%)	Targeting each level of an organisation (from managers through to staff)
Priority 7	2 (6%)	Identify referral pathways
Priority 8	1 (3%)	Prevention conversations, including a focus on risk and protective factors
	1 (3%)	Managers
Priority 10	0	Isolated workers

Reviewing all of the small group and individual participant forums, a number of other **target groups** were identified, but not listed as key priorities from the groups. These target groups included: Leaders, senior managers and chief executive officers; Vulnerable and marginalised youth; Aboriginal and Torres Strait Islanders; Farmers; Recent migrant workers; Refugees; and Individuals with families experiencing mental illness and suicide.

In addition, there were a range of other target areas identified from group and individual feedback forms: Life promotion; Patriarchal structures and the effects on identify and masculinity; Develop training program for non-mental health workers; Social committee within organisations; Supported conversations.

3.2 Opportunities, Risks and Barriers

Activity two asked each small group to work through two small activities:

- Activity 2A: Identification of opportunities and strengths to build on as well as potential or known risks to be considered or managed;
- Activity 2B: Outline of key barriers to uptake in educational settings and potential solutions to overcome those barriers.

Opportunities and Strengths

1. Build on existing programs

Participants stated that the guidelines should not be seen as something else that sits in isolation, but rather be integrated into already established programs. Programs identified included:

- R U OK? Day
- Stress Management and Resilience
- Support Your Buddy
- Promoting Employer Wellbeing for Managers
- Managing Stress: for all staff (1 Day)
- Beyondblue workplace program
- Black Dog Institute programs
- Mental Health First Aid
- Youth Mental Health First Aid
- Susan Rose Education Workshop on Suicide Awareness Prevention
- Oz Help
- Mates in Construction
- Workplace Health and Safety training
- The Square Project: videos for how bosses can talk to staff

2. Build on existing workplace practices

Within the workplace setting, many of the participants identified that in many occupations, work has already been undertaken in suicide intervention training and management. Many workplaces also have access to in house psychologists e.g. police, military. Any guidelines developed, should build further upon this work.

3. Accreditation and training

If a new program was going to be developed as part of the guidelines, participants identified that they should consider:

- Using trained practitioners to conduct the training, similar to the Partners in Depression program;

- Ensuring that the program is accredited;
- Has a flexible delivery system i.e. ½ day, 1 day and 2 day.

1. Work with industry standards about mental health at work

The guidelines should align with changes in industry standards which now include wellbeing as part of occupational health and safety. The guidelines could engage the industry (such as unions) to promote key messages (in the same way that OzHelp and Mates in Construction have with some industries).

2. Evidence-based practice

Participants identified that employers are generally fond of implementing approaches which have demonstrated effectiveness in the workplace. Therefore the guidelines should provide an evidence base which supports the efficiency of the intervention in order to gain industry leverage.

3. National and state policies

There are also a number of structural foundations which the guidelines can build upon including the newly established NSW Mental Health Commission, National Mental Health Commission, LIFE Framework (national Suicide Prevention Strategy) and *Mindframe* national media guidelines.

Risks

1. Perceived usefulness

General risks for the project as a whole were identified including that the guidelines will be too general, duplicate work already in use, are not relevant to local or individual workplaces and do not recognise the low literacy levels in some target groups. Participants identified that the guidelines should be tailored and relevant to target audiences and be inclusive of cultural and religious taboos.

2. Impacts of promoting conversations

There were also concerns that the guidelines will encourage people to have conversations without providing the necessary tools to respond effectively in an emergency. The conversations may also lead to 'labeling' of individuals and further perpetrate the stigma associated with suicide in the workplace. Guidelines should also avoid the term 'warning signs' as there is no evidence of predictability in suicide.

3. Support from senior management

The ongoing support of senior management was seen as a risk to the project as a whole. This support was linked to project funding specifically funding for implementation of the guidelines at an organisational level. If organisations are expected to implement the guidelines using funds from their own budget, the project will need to undertake quantitative analysis and research into the benefits to the organization in the long term.

Barriers and Solutions

A number of **barriers** to the development and uptake of the Guidelines were identified at the workplace forum and included:

- Potential lack of buy-in from senior management due to time commitments, perceived return on investment, program purchase, implementation costs and ongoing monitoring of the program's effectiveness;

- Dissemination process will need to be multi-leveled and therefore very complex and time consuming;
- Workplace structures (such as job and work design issues) and the pressure and diversity of workplaces may also impede implementation;
- The fear of contagion if colleagues try to assist another colleague who afterwards takes their own life;
- Employees in occupationally smaller workplaces may find it too difficult to raise the topic of suicide.

The identification of **possible solutions** to assist effective implementation was considered by the group and suggestions included:

- Learn about the end user in developing best practice models for workplaces. The guidelines need to draw upon existing workplace structures and integrate the guidelines as part of core business;
- Developing clear guidelines, education programs, debriefing resources and working with human resources to develop flexible work options. However the involvement of human resources was cautioned by one group who stated that the project needs to '*move beyond human resources*' as the best option;
- The guidelines should not rely on individual employers to deliver implementation of the guidelines;
- Liaison with worker based unions, introducing an employer levy (via workers compensation) and quantitative research in relation to employer benefits.

3.3 Format and Dissemination

The final small group activity asked participants to generate some ideas about the best format for the guidelines as well as key considerations for the promotion and dissemination of the guidelines in workplaces.

The participants identified the following possible **formats** for the final version of the guidelines:

- Templates which demonstrate how to have conversations and use the lived experience: consumers; carers/families; employers;
- Presentations which employers can access easily and are relevant to their individual industry;
- Develop as part of a '*mental health first aid'* kit;
- Induction pack for new staff and deliver as part of staff orientation;
- A tool box talk handout;
- Role play of situations with specialised actors;
- Web based learning tool (similar to *Beyondblue*) that is appropriate to age, and using tools like comics, podcasts, vodcasts, mobile friendly with possible phone application;
- Develop a DVD where staff can see people having conversations;
- A training aspect for staff to learn how to ask, question and hold the conversation with the person at risk.

Key considerations in relation to the format of the guidelines were documented. The guidelines should be informal, quick, short, and consider the literacy levels of the end user. They also need to be culturally appropriate across multicultural workplaces and possibly employee a different style across different industries.

Participants also identified possible setting based **dissemination and promotional** ideas. Although highlighted as a potential risk, participants identified that the dissemination should be multileveled through various channels including:

- Suicide prevention NGOs who have experience in the field;
- Workers compensation authorities;
- Employer associations, unions and industry organisations;
- Social media.

However, it was identified that the dissemination should be corporate initiated with the Chief Executives of organisations taking the lead and building the guidelines into organisational structures. The most appropriate day and time of the week for employees should also be considered as part of dissemination. Potential dissemination tools could include: Face-to-face dissemination; Tool box talks; Staff booklets; Handouts; Staff newsletters; Noticeboard; and Bulletin boards.

Workplace representatives identified that promotional activities should be a mix of small and large scale activities. Small scale activities ranged from local based activities such as holding a special awareness morning tea or adopting a mental health at work week, to drama and role plays in the workplace.

Large scale promotion included developing a campaign with advertisement on the radio, TV, internet and you tube. The campaign could use the methodologies used by the Anti-Homophobia Project which conducted a segment on the Channel 9, Footy Show or RU OK? Day. There was caution that the campaign should not be generalist but focus rather on certain high-risk industries. There should also be pre and post market testing of the campaign to ensure the safety of the message.

Chapter 4: Outcomes for Communities and Online

A face-to-face consultation forum which focused on the discussion of suicide in communities and online settings was conducted in Sydney on Wednesday 10 May 2012 (9:00am to 12:30pm). The forum included 39 participants working in six small groups. One of the six small groups was made up of organisations working online.

The following report outlines a summary of the discussions and priorities set during the consultation forum.

4.1 Priorities

Each group was asked to brainstorm some priority target groups, types of conversations and/or areas for action directly applicable to the broad target setting of communities, including online communities.

Following the small group activity, key priorities were presented to the larger group and all participants were invited to vote (with an allocation of two points per person). The results of the large group discussion and priority rankings are outlined in Table 3 below.

Table 3: Priorities for the Communities and Online.

RANKINGS	VOTES (%)	PRIORITY GROUP OR AREA
Priority 1	7 (15%)	Rural communities
Priority 2	5 (11%)	Education settings i.e. teachers, communities and families
	5 (11%)	Isolated, homeless and disconnected people
Priority 4	4 (9%)	Targeted information for different age spans (repeated at critical stages of life)
	4 (9%)	Aboriginal (high risk) remote and urban communities
	4 (9%)	Young people aged 15-25
Priority 7	3 (7%)	Young men who demonstrate impulsive and reckless behaviour
	3 (7%)	CALD and refugee populations
Priority 9	2 (4%)	Service providers operating online (duty of care & self-care)
	2 (4%)	People telling personal stories
	2 (4%)	Young people online (peer to peer targeting, including peer leaders)

	2 (4%)	High risk settings/formats online (e.g. suicide forums)
Priority 13	1 (2%)	Rural men
	1 (2%)	Support networks
	1 (2%)	People aged 65 and over (especially men and CALD)
Other	0	Access to information
	0	General users online
	0	Organisations online (non-health)
	0	Government financial support

Reviewing

Reviewing all of the small group and individual participant forums, a number of other target groups were identified, but not listed as key priorities from the groups. These target groups included: Culturally and linguistically diverse communities; Men; and Children.

In addition, there were a range of other target areas identified from group and individual feedback forms: Drug and alcohol rehabilitation; Cross cultural divide within families; Postvention conversations within families; Social media; Public campaigns; and Online generally.

4.2 Opportunities, Risks and Barriers

Activity two asked each small group to work through two small activities:

- Activity 2A: Identification of opportunities and strengths to build on as well as potential or known risks to be considered or managed;
- Activity 2B: Outline of key barriers to uptake in educational settings and potential solutions to overcome those barriers.

Opportunities and Strengths

1. Build on existing resources, programs and services

The following programs and organisations working in suicide prevention were identified as potential conduits to guidelines targeting communities and online

- Lifeline
- Mindframe
- Inspire Foundation
- Mental Health First Aid
- Young and Well Cooperative Research Centre
- Headspace
- Wesley Life Force
- Crisis Support Services
- Kids Helpline
- Orygen Youth Health Service
- Suicide Prevention Australia

- Men's Shed
- Partners in Depression
- Salvation Army: Hope for Life
- Save a Mate
- SANE Australia
- Stepping out of the Shadows walk
- Living works (ASIST)
- Beyondblue
- R U OK? Day

2. Capitalise on government interest in mental health and suicide prevention

The current positive climate focusing on mental health within the government policy and priorities was outlined as an important strength. Work continues at a national level, which can support the guidelines, including the following:

- Department of Health and Aging Suicide Hot Spots and Managing Clusters Project;
- Realignment and Coordination of Services e.g. Medicare Locals, Allied Health Network;
- Department of Veteran Affairs training and development packages;
- Establishment of the Mental Health Commission;
- Evolution of E-Mental Health.

1. Partnerships with the media

The guidelines can build on positive relationships with Australian mainstream, multilingual and Indigenous media, for example the partnership between Australia's multicultural and multilingual broadcaster, SBS (Special Broadcasting Service), other mainstream media and the *Mindframe National Media Initiative* (Mindframe). Media codes of practice have been updated to include information on the portrayal of suicide with some updates in progress. Partnerships with Indigenous and multicultural media organisations may lead to dissemination opportunities for hard to reach communities.

2. Partnerships with NGOs

Participants identified that closer collaboration with the Non-Government Sector (e.g. *Beyondblue*, Lifeline and The Blackdog Institute) who are also conducting community programs would be strategic. The R U OK? Day organisation is also undertaking a number of programs aimed at the community. This project may be supported by research R U OK? Organisation are currently undertaking on stigma and suicide, their strong online presence and broad social media strategy. There was also a general discussion on how the NGO sector has successfully engaged community champions, leaders, celebrities and community based networks to highlight work across the broader community.

3. Corporate funding

There may also be an opportunity to attract corporate funding for suicide prevention programs from industries which constitute '*high risk groups'* including the motor, mining, construction and defense industries.

4. Opportunities for CALD partnerships

Guidelines which focus on Culturally and Linguistically Diverse (CALD) communities was a strong theme in the communities and online setting. The Transcultural Mental Health Centre (TMHC) and Mental Health First Aid have a number of prevention and promotion resources translated into community languages. There is also international research being undertaken at present into suicide in second generation immigrant groups which may be useful to the guideline development. The DART Centre for Journalism and Trauma might be able to assist with work with refugees and suicide.

5. Community readiness

It was identified that there is a growing community readiness to talk about mental illness and suicide and the guidelines can assist by reinforcing and aligning messages. The participants identified a number of potential high risk groups including: people who have attempted suicide, GLBTI, high schools students, people with drug and alcohol problems and carers.

Risks

1. Lack of consensus

A number of participants identified the lack of consensus on tone, format and style of the guidelines amongst key stakeholders as possibly endangering the uptake of the resource. The risk of not involving people with a mental illness in the guideline design was also considered.

2. Perceived duplication of existing resources

There was also concern that the guidelines will be replicating guidelines already in circulation such as the Mental Health First Aid guidelines. The project should also ensure that the guidelines are not too clinically focused even though the majority of evidence about 'talking about suicide' is generally found within the clinical field.

3. Impact on mental health services

The project should also consider the relationship between the guidelines and the availability of mental health services. A balance needs to be drawn between not clearly identifying help seeking pathways and providing too much information on services and helplines. It can often be difficult for the community to make referrals to the correct place and when they do, information can get lost in the system i.e. between Medicare Locals, NGOs, Health and other government departments.

4. Lack of sustainability

Participant's identified that if the guidelines are currently being funded as a time limited project this may lead to a lack of sustainability. Long term engagement would ensure that the message is delivered to the audience appropriately. The project should also ensure that it does not develop the guidelines in isolation from other projects occurring at the NSW Ministry of Health, thereby ensuring that there is appropriate resource allocation across the sector.

Barriers and Solutions

A number of **barriers** to the development and uptake of the guidelines were identified at the communities and online forum and included:

- Individual beliefs may affect individuals' ability to have a conversation, whether face to face, in groups or across communities;
- Stigma, taboo, ignorance and fear all relate to the complexity of having a discussion about suicide. It may impact on the readiness of the target groups to hear messages;

- Cultural and language barriers and the lack of buy in (potentially from rural men) need to be considered to ensure that the guidelines are inclusive of the entire community;
- Lack of awareness about the issue of suicide and its perceived low prevalence within the community;
- Distilling the important messages to the community and ensuring it does not get lost in the plethora of other messages;
- Messages should not be fused with mental health messages as they can each have their own differences.

Participants were asked to identify **possible solutions** to barriers in order to progress the guidelines effectively. Suggestions included:

- Having a broad consultation plan which engages the right experts, at the right time, for the right advice. This should also include targeted engagement with schools, teachers, workplaces and male leaders;
- The guidelines should be customised to individual target groups;
- Ensuring cultural competence , including translation of the guidelines into community languages and training specific community leaders in the dissemination of the guidelines;
- The guidelines should highlight the benefits, tackle myths and common misconceptions and include pathways to support;
- A focus on positive, strength based protective strategies that address multiple concerns would be beneficial to the community;
- The message should be clear and focus on coping, resilience, strengths and agency to act. Helping people to understand the importance of social connections and sense of agency about suicide is an issue for the whole community;
- The program should identify champions and networks which can assist with the process;
- The NSW Ministry of Health could consider buy in from the other states and territories to assist with dissemination, education and training costs.

4.3 Format and Dissemination

The final small group activity asked participants to generate some ideas about the best format for the guidelines as well as key considerations for the promotion and dissemination of the guidelines in communities and online.

The participants identified the following possible formats for the final version of the guidelines:

- Interactive phone application
- Literature review
- Executive summary
- Hardcopy
- Online
- Downloadable PDF
- Case studies
- Story telling

- Presentations
- Narrative/storytelling with summary points
- Written material
- Facilitated discussion
- Play theatre
- Film and video
- You Tube
- Video
- Role plays

Key considerations were also raised by participants in relation to the format of the guidelines. Participants also stated that the guidelines should be clear, simple, translate easily, be designed for people with low literacy, and not be too prescriptive as to deter people from using their own communication styles. The Guideline should not be seen as a 'one size fits all' but rather have targeted messages for specific groups. The guidelines should also be flexible in their format so they can be incorporated into curriculums e.g. schools, Employee Assistance Programs.

The guidelines need to be delivered in a simple format (visual and pictorial) which allows the target to take away the key message easily. The guidelines could learn from other sectors and issues that have tried approaches with a simple concise messages e.g. CPR, Slip/Slop/Slap. The guidelines need to contain credible information to assist with implementation.

Appropriate setting based dissemination and promotional concepts were identified by participants on the day. Overall, participants believed that online was the best space for dissemination and promotion of the guidelines. This included the development of a centralised online information source. This site should be linked to other organisations to act as a 'one stop shop' for suicide information. An online application, webinar, Facebook and strategically sent electronic newsletters were all considered as part of this information source.

It was suggested that the guidelines be promoted via a national media campaign (using high profile people) as part of a public relations launch. Recommended opportunities included: working with SBS; Community Radio (Aboriginal and CALD) and developing a national media communication policy able to be integrated with existing communication policies and guidelines within companies and organisations.

More traditional forms of dissemination were also suggested including through professional bodies and incorporating into stakeholder key messages. The development of a self-sufficient training kit, staff induction training and the provision of non-branded PowerPoint templates to enable easy uptake of the guidelines was also suggested.

Chapter 5: Outcomes for Family Settings

A face-to-face consultation forum which focused on the discussion of suicide in family settings was conducted in Sydney on Wednesday 10 May 2012 (1:30 – 5:00pm). The forum included 22 participants working in three small groups.

The following report outlines a summary of the discussions and priorities set during the consultation forum.

5.1 Priorities

Each group was asked to brainstorm some priority target groups, types of conversations and/or areas for action directly applicable families.

Following the small group activity, key priorities were presented to the larger group and all participants were invited to vote (with an allocation of two points per person). The results of the large group discussion and priority rankings are outlined in Table 3 below.

Table 4: Priorities for Family Settings.

RANKINGS	VOTES (%)	PRIORITY GROUP OR AREA
Priority 1	5 (19%)	Communication skills
Priority 2	4 (15%)	Children and siblings
Priority 3	3 (12%)	GLBT families (particularly where the child identifies as GLBT)
	3 (12%)	Impact on self of having conversation
Priority 5	2 (8%)	Veterans
	2 (8%)	Rural families (especially areas where there is adversity)
	2 (8%)	Aboriginal (prevention and postvention conversations)
	2 (8%)	Intergenerational connections (e.g. child/grandparent relationships)
Priority 9	1 (4%)	CALD (prevention and postvention conversations)
	1 (4%)	Families where there is separation or conflict
	1 (4%)	Carers (broadly)
Other	0	Family and carers (especially after discharge)
	0	Single person families
	0	Age appropriate resources (e.g. for children)

	0	Vested interest/buy-in
	0	Balancing desensitising vs. normalising behaviour
	0	Understanding of the 'death' process

Reviewing all of the small group and individual participant forums, a number of other target groups were identified, but not listed as key priorities from the groups. These target groups included: People who identify as gay, lesbian, bisexual, transgender or Intersex; Refugees; Youth; and the aged.

In addition, there were a range of other target areas identified from group and individual feedback forms: Step by step process for conversations; and identifying safe spaces.

5.2 Opportunities, Risks and Barriers

Activity two asked each small group to work through two small activities:

- Activity 2A: Identification of opportunities and strengths to build on as well as potential or known risks to be considered or managed;
- Activity 2B: Outline of key barriers to uptake in educational settings and potential solutions to overcome those barriers.

Opportunities and Strengths

1. Build on existing programs and initiatives

A number of programs, training and initiatives were identified, including:

- ASIST
- Mental Health First Aid
- Partners in Depression
- School-Link
- Family and Carers Mental Health Program
- CoPMI (Children of Parents with a Mental Illness)

The involvement of Medicare Locals as part of project planning would also be valuable as often General Practitioners are the first point of contact for families. The Mental Health Act is also a good platform in which to raise the individual involvement of families as long as they are supported.

2. Engage key gatekeepers

Opportunities to involve family specific services or gatekeepers such as the Country Women's Association, Universal Early Intervention Support Services and Grass Roots E-Sustained Home Visiting Services in the development of the guidelines could ensure that they are matched well with the target group. Consideration of 'health by stealth' tactics employed by programs such as Men's Shed should be factored into project planning.

3. Interest from families and the wider community

The participants identified that families are already having these conversations, however need some guidance on how to do this safely. There is currently strong support from the media on the role of families in caring for people with a mental illness. Whilst health has the infrastructure to develop the guidelines, it should be recognised that suicide is 'bigger than health' and needs the coordination of a range of government and non-government services.

Risks

1. Interpretation of messages

It is well known that messages can be perceived differently due to the complexity of the issue and that stories from one person may be different to the stories from others. The project needs to ensure that the message is consistent and correct.

2. Lack of linkages with other services or programs

If individual projects at a state level are not linked or are not linked to grassroots organisations that people may 'fall through the gaps'. The guidelines need to acknowledge the importance, value and support, grassroots organisations give to families in navigating through the issues and services.

3. Lack of flexibility and sustainability

There is also the risk that the guidelines are not sustained or flexible enough to respond to changes families will become overburdened with resources or there is a general lack of awareness about the guidelines at a family level.

Barriers and Solutions

A number of barriers to the development and uptake of the guidelines were identified at the families forum and included:

- Families can be overburdened by the impact of suicide including shame, guilt and anger. These emotions can pressure families into remaining silent on the issue;
- People may not want to (or not know how to) engage with the families for privacy concerns after a suicide has occurred;
- Cultural barriers, especially for inter-cultural conversations;
- It can be difficult for families to have conversations about suicide as the person at risk may have a history of non-engagement, services may not be available in their area or the person may seek support from another trusted person outside the family;
- When conversations occur the services may not be able to meet demands;
- Underestimating the capacity of individuals and giving families agency in dealing with suicide would be a good platform on which to launch the guidelines. However not every family will be able to use the guidelines successfully, and this should be a consideration ;
- Lack of funding for evaluation and appropriate dissemination should be considered at an early stage.
- Participants were asked to identify possible solutions to barriers listed. Suggestions included:
- The guidelines need to find the right mix between research and practice;
- Understanding the conversation in the context of the family dynamic and strengthening existing frameworks was suggested as a way of delivering the guidelines;
- The impact that the conversation has on the individual trying to help the person at risk also should be considered and included in the guidelines;
- Ensuring that the messages can be 'slipped in' to daily practice or conversations (similar to the Domestic and Family Violence screening tool) would ensure that the guidelines are useable;

- Funding arrangements which allow programs to be flexible and creative could increase uptake of the guidelines;
- Consultations should continue after the implementation to ensure the guidelines are embedded into practice.

5.3 Format and Dissemination

The final small group activity asked participants to generate some ideas about the best format for the guidelines as well as key considerations for the promotion and dissemination of the guidelines in family settings.

The participants identified the following possible formats for the final version of the guidelines:

- Educational teaching aids for kids;
- DVD with a storyline which prompts conversation;
- Coasters;
- An educational video-game;
- Comic (Marvel has just released a suicide prevention comic for Captain America);
- Online application.

Key considerations for the guidelines included the use of a number of formats targeted at different levels including: young children, young people, adults and people over the age of 65. The format should be 'accessible, acceptable and cool'. It was generally understood that the final format would be dependent on time and budget. Participants stated that the format should be simple with a catchy title.

Participants also identified possible family based dissemination and promotional concepts. Participants identified that the guidelines should be 'heavily publicised' without sensationalising the content. Participants identified that a campaign which included media dissemination and education about the resources would be a good option. Some suggested titles for the campaign included 'Not in our Family' and 'Creating Conversations Before it is too Late'. Facebook and other social media dissemination and promotion were also strongly suggested as part of the campaign.

An arts health movement for dissemination and promotion through theatre companies was also suggested as an option. Evaluating familiar access points and being available where families are, or frequently access, would be important to the overall success of the guidelines.

Chapter 6: Forum Evaluation

6.1 Method

A total of 67 responses were collected from participants who attended the consultation forums held on 9 and 10 May 2012. Participants were asked to rate how interesting and relevant they found the forums on a scale from one to five, with high scores indicating a positive response and low scores indicating a negative response. An opportunity to provide qualitative data was available via open-ended questions, which invited the participants to comment on the aspects of the consultation that worked well, how the consultation could be improved, and further comments or concerns related to the project as a whole.

6.2 Results

Interest in the Consultation

Results (outlined below in Table 5) indicate that the consultation was interesting to all participants, with 97% of respondents rating the consultation as 'quite a bit interesting' or better. The average rating of the forums was 4.5 out of 5.

Table 5: Rating of Interest in the Consultation

Description	Frequency	Percentage
Not interesting at all	0	0%
A little interesting	0	0%
Moderately interesting	2	3%
Quite a bit interesting	29	43%
Extremely interesting	36	54%

Rating of the Forum Venue

Overall, participants were happy with ACON Meeting Centre as the location for the forums with 88% of respondents indicating that the forum venue was 'more than satisfactory' or 'good'. The average rating of the forums was 4.5 out of 5.

Table 6: Rating of forum venue

Description	Frequency	Percentage
Poor	0	0%
Less than satisfactory	0	0%
Satisfactory	8	12%
More than satisfactory	23	34%
Good	36	54%

Relevance of Small Group One – Setting Priorities

As can be seen in the Table 7 below, the majority of respondents (88%) described small group one as either 'quite a bit relevant' or 'extremely relevant' with a total mean rating for that item of 4.4 out of 5. The rest of the participants rated the consultation as 'moderately relevant', with none of the participants indicated the consultation as 'a little relevant' and 'not relevant at all'.

Table 7: Rating of Relevance of the Group One

Description	Frequency	Percentage
Not relevant at all	0	0%
A Little Relevant	0	0%
Moderately relevant	6	9%
Quite a bit relevant	25	37%
Extremely relevant	34	51%
No Response	2	3%

Relevance of Small Group Two – Opportunities, Risks and Barriers

Table 8 demonstrates that 94% of respondents thought that small group activity two was either 'quite a bit relevant' or 'extremely relevant' to the development of the community guidelines. The mean score rating of small group two was 4.5 out of 5.

Table 8: Rating of Relevance of Small Group Two

Description	Frequency	Percentage
Not relevant at all	0	0%
A Little Relevant	0	0%
Moderately relevant	3	4%
Quite a bit relevant	25	37%
Extremely relevant	38	57%
No Response	1	1%

Relevance of Small Group Three – Format and Dissemination

On average, participants rated small group three 4.4 out of 5. As can be seen in Table 9 below, 85% of participants rated small group activity three as quite a bit relevant or above. There were no results indicating that this activity was not relevant to the guideline development.

Table 9: Rating of Relevance of Small Group Three

Description	Frequency	Percentage
Not relevant at all	0	0

A Little Relevant	0	0
Moderately relevant	7	10%
Quite a bit relevant	25	37%
Extremely relevant	32	48%
No Response	3	4%

Aspects of the forum that worked well

Participants were asked to describe, in their own words, the aspects of the consultation that worked well. This question had a response rate of 80%. Participants indicated that the overall structure and facilitation of the forum was appropriate and encouraged discussion and capacity for input. The opportunity to workshop ideas with a diverse range of services and people were reported to work well. There were a small number of participants who stated that it would have been more valuable with a larger group size and that the small group discussions limited time for formal presentations.

How the forum could be improved

Participants were asked to suggest ways to improve the consultation forums. Almost half of the responders answered this question, with half of this sample indicating that the forum was run well. One participant would have liked more clarity relating to the guidelines and four would have liked a pre workshop discussion paper. Three participants suggested that forums could have been improved by opening participation to a broader representation, inviting higher numbers, videoconferencing to other sites and possibly integrating consumers. Longer time to explore some of the concepts within the larger group and keeping the conversation confined within the parameters of the discussion topic was suggested by three responders. Two participants mentioned they would have liked an opportunity to network by mixing up the small groups after each activity. This would have made the forum less repetitive and would have allowed the participants a better understanding of the people in the room.

Further comments or concerns relating to the project as a whole

There were 34 participants that provided additional comments. Ten participants expressed a 'thank you' for the opportunity to participate in the forum and wished the project luck. Three respondents cautioned that the project does not duplicate existing resources and two indicated that the Guideline should be extended and applied nationally.

There was a general concern amongst participants about the lack of ongoing funding and how this may impact of the project's sustainability and scope. Overall there were a small number of comments in relation to: Drafting the guidelines within a mental health and wellness framework; Ensuring the guideline settings are not seen in isolation; Ensuring the guidelines to do not burden those they are trying to assist; and ensuring people released from custody are considered in the project scope

Appendix 1: Lists of Participants

Education Settings: Wednesday 9 May (9:00am-12:30pm)

Participant Attending	Position	Organisation
Carlton Quartly	Associate Director	MH-Kids
Gabriel Baldwin	Stakeholder Consultant	Headspace
Jane Fisher	Coordinator NSW Alcohol and Other Drugs Unit	TAFE NSW
Jill Pearman	National Co-ordinator	MindMatters, Principals Australia Institute
Jo Robinson	Research Officer	Headspace
John Dalgleish	Manager Strategy and Research	BoysTown
Julie Carter	Service Director	Adolescent Health Justice and Forensic Mental Health
Karen Price	Associate Director, Mental Health Clinical Policy	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Kathy McKay	Post-doctoral Fellow	University of New England, School of Health
Kerry Sheehan	Senior Project Officer, Student Engagement and Achievement	NSW Board of Studies
Kylie Wilson	Teacher, Community Services	Aboriginal Education and Training (TAFE)
Libby Gledhill	Principal	NSW Primary Principals Association
Lori Schell	HSS Snr Clinician	Headspace
Lucy Brogden	Individual PHD Student	
Lynne Paisley	Counselling & Career Development	TAFE NSW
Megan Mitchell	Commissioner, CCYP	NSW Commission for Children and Young People
Melissa Wolfshoerndl	Youth Advisory Council	
Myf Maple	Associate Professor	UNE School of Health
Noel Grannall	R/Leader Student Attendance	NSW Department of Education and Communities State Student Representative Council
Peter Bazzana	Mental Health Educator	NSW Institute of Psychiatry

Phil Foreman	Emeritus Professor/Chair	NSW Institute of Teachers
Ron Balderston	Principal Psychologist	NSW Department of Education and Communities
Rosemary Houghton	District Guidance Officer	Student Welfare and Counselling - Sydney Region
Sara Maxwell	Coordinator, Research and Policy Development coordinator	Suicide Prevention Australia
Vicky Coumbe	Project Manager, Peace of Mind Project	ACON

Workplace Setting: Wednesday 9 May (1:30pm to 5:00pm)

Participant Attending	Position	Organisation
Anthony Holland	Chief Executive Officer	OzHelp Foundation
Bernie Brown	Counsellor	Veterans and Veterans Family Counselling Service
Di Pritchard	NSW Department of Trade and Investment (Primary Industries)	Rural Support worker
Francessca Zucchini	Job Service Manager, Campbelltown	BoysTown
Frankie Motilal	Employment Case Worker, Mental Health	BoysTown
Jane Fisher	Coordinator NSW Alcohol and Other Drugs Unit	TAFE NSW
Jenn Caine	Coordinator	Rural Adversity Mental Health Program
Joel Murchie	Inspector – Commander Mental Health Intervention Team	NSW Police
Jorgen Gullestrup	CEO	Mates in Construction
Katrina Davis	Mental Health Promotion Manager	Mental Health Association NSW/ Workplace Health Promotion Network
Linda Allaway	Senior Organisational Psychologist, Psychology Unit, Workplace Safety	NSW Police
Louise Ashelford	Manager, Healthy Workplace Strategies	Ambulance Service of NSW

Lucy Brogden	Individual PHD Student	
Margo Lydon	Executive Officer	SuperFriend
Martin Collis	Senior Clinical Advisor, Mental Health Intervention Team	NSW Police
Matt Ireland	Project Coordinator for Mental Health Intervention team	NSW Police
Myf Maple	Associate Professor	University of New England School of Health
Nick Arvanitis	Project Manager	*beyondblue*
Rodney Cole	Senior Coordinator training, Lifeforce	Lifeline
Vaughan Parsons	Senior Project Officer, Employee Wellbeing and Mental Health	Ambulance Service of NSW
Veronica Eulate	Manager, Planning, Evaluation and Knowledge Management	ACON

Communities and Online: Thursday 10 May (9:00am-12:30pm)

Participant Attending	Position	Organisation
Alan Woodward	Executive Director	Lifeline Foundation for Suicide Prevention
Bill Clifford	President	Men's Sheds NSW
Chris Williams	Acting Manager, Primary Health and Community Partnerships	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Clarissa Mulas	Multicultural Health Coordinators (NSW Health) Representative	
Deb Masani	Director of Digital Productivity Coordination Unit	Australian Commonwealth Department Broadband, Communications and Digital Economy
Di Pritchard	Rural Support Worker	Rural Support Workers (NSW DPI)
Dr Kathy McKay	Post-doctoral Fellow, School of Health	University of New England
Dr Roderick Bain	RSL NSW State Vice President	Returned Services League of Australia
Eamon Waterford	Policy and Advocacy	Youth Action and Policy Association
Jane Ryan	Senior Policy Officer	Clinical Governance MHDAO

Participant Attending	Position	Organisation
Jill Fisher	National Coordinator	National StandBy Response Service
Jo Riley	ReachOut.com Manager	Inspire Foundation
Joe Gormley	Project Officer, Community Drug Action Teams	Drug Health Services, Sydney and South West Sydney Local Health District
Joel Murchie	Inspector Commander Mental Health Intervention Team	NSW Police Mental Health Intervention Team
Josiy Butson	Community, Health and Wellbeing	RedCross
Julie Edwards	Senior Project Officer, Prevention and Community Partnerships Team	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Karen Burns	Chief Executive Officer	Uniting Care Mental Health
Kate Hille	Project Manager Community Education	Black Dog Institute
Katrina Hasleton	Senior Project Officer	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Kerry Saloner	Manager, Wellbeing Programs	ACON
Kristine Bajuk	Psychological Services Officer	NSW Department of Education and Communities
Linda Carroll	Senior Project Officer, Prevention and Community Partnerships Team	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Marc Bryant	Projects Manager	Hunter Institute of Mental Health
Maria Cassaniti	Centre Manager	Transcultural Mental Health Centre, Mental Health Promotion and Prevention Team
Nick Arvanitis	Project Manager	*beyondblue*
Patrick Livermore	Mental Health Promotion and Prevention Coordinator	Elderly Suicide Prevention Network
Peter Rogers	Senior Project Officer	Information and Education MHDAO
Rebecca Lewis	Foundation Project Manager	RUOK? Foundation
Robert Stirling	Program Manager	Network of Alcohol and Other Drug Agencies

Participant Attending	Position	Organisation
Rodney Cole	Senior Coordinator of Training, Lifeforce Suicide Prevention Program	NSW Farmers
Sam Hartland	Client Services Coordinator	Twenty10
Susan Beaton	Psychologist and Suicide Prevention Specialist	Susan Beaton Consulting
Susan Horsley	Policy Assistant	NSW Consumer Advisory Group Mental Health
Susan Rosenthal	Program Leader, Suicide and Veterans Services	Crisis Support Services
Terry Kirkpatrick	Manager	Mental Health Association NSW
Vikki Ryall	E-Headspace Manager	Headspace
Alan Woodward	Executive Director	Lifeline Foundation for Suicide Prevention

Families: Thursday 10 May (1:30pm to 5:00pm)

Participant Attending	Position	Organisation
Adam Leahy	Practice Support Team Leader	General Practice Australia
Angela Milce	Manager	Carer Assist
Bill Clifford	President	Men's Sheds NSW
Cathy Davis	Director National Operations	Defence Community Organisation
Chris Smith	Coordinator Personal Helpers and Mentor Program	Aftercare
Darren Mitchell	Director	Office for Veterans' Affairs
Eamon Waterford	Policy and Advocacy	Youth Action and Policy Association
Emma Cother	Acting Program Manager	Hunter Institute of Mental Health
Felicity Cocuzzoli	Manager of Projects	Interrelate Family Centres
Jeff Johnstone	ACON Volunteer, Counselling Program, Hunter Region	ACON
Jill Fisher	National Coordinator	Stand by Support Services
Julie Edwards	Senior Project Officer, Prevention and Community Partnerships and Aboriginal Mental Health	Mental Health Drug and Alcohol Office, NSW Ministry of Health

Participant Attending	Position	Organisation
Karen Burns	CEO	Uniting Care Mental Health
Kathy McKay	Post-doctoral Fellow, School of Health	University of New England
Leonie Green	NSW State Director	Mission Australia
Linda Carroll	Senior Project Officer, Prevention and Community Partnerships and Aboriginal Mental Health	Mental Health Drug and Alcohol Office, NSW Ministry of Health
Maria Cassaniti	Centre Manager	Transcultural Mental Health Centre
Nadia Garan		Transcultural Mental Health Centre
Noha Sutton	Parenting Program Manager, COPMI	MH-Kids, NSW Ministry of Health
Patrick Livermore	Mental Health Promotion Prevention Coordinator	Elderly Suicide Prevention Network
Robert Stirling	Program Manager	Network of Alcohol and Other Drug Agencies
Susan Horsley	Policy Assistant	NSW Consumer Advisory Group

CONVERSATIONS MATTER
resources for discussing suicide

hunter institute of mental health

NSW GOVERNMENT Health

Mental Health Commission of New South Wales