OUTSIDE THE CITY: DESIGNING SUICIDE PREVENTION FOR REGIONAL, RURAL, AND REMOTE COMMUNITIES

– Workshop findings

This report summarises the outcomes from a workshop delivered at the Roses in the Ocean Lived Experience of Suicide Summit on 10 March 2023. The workshop was a partnership between the Tasmanian Mental Health Drug and Alcohol Directorate, the Manna Institute and Everymind.

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ACKNOWLEDGEMENTS

We acknowledge and thank all the participants who took part in the workshop. Each participant provided insights from their learnt, lived, and living experiences of suicide. Through the workshop activities, we learned from this breadth of knowledge about suicide and its prevention in regional, rural, and remote areas and how we can all best plan and deliver initiatives to reach those most needing support. The workshop facilitators have developed this report in partnership with those who participated in the workshop. We appreciate the opportunity to host the workshop and extend our thanks to Roses in the Ocean and all the organisers who made the 2023 Lived Experience Summit a memorable experience for all.

TERMINOLOGY USED

The Roses in the Ocean [1] definition of Lived Experience is used in this report referring 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 broader term “rural” will be used interchangeably, referring to all areas outside of major cities and including regional and remote areas [2, 3].

WORKSHOP FACILITATORS

- 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)

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BACKGROUND TO THE WORKSHOP

A complex interplay of personal, social, and situational factors contribute to rates of suicide in rural areas being around 60% higher than urban counterparts, with risk higher for males compared with females [4, 5], younger (15-24 years) and older (75-84 years) age groups and people experiencing mental ill health (including substance use disorders) [6]. Common themes contributing to this increased vulnerability centre on social and geographic isolation, the rural stereotypes associated with stoicism and traditional values, conservative values and attitudes, and a reluctance to discuss problems and seek support, exposure to natural disasters and adversity, and lack of healthcare options including mental health specialists [7-9].

When planning and implementing 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, and tailoring programs to suit the needs of demographic groups that are disproportionately affected by suicide [10, 11]. Where formal supports and services are not always accessible in rural areas, there is a need to utilise existing resources and community strengths along with the insight and leadership of people with lived experience of suicide [9, 10].

This report provides an overview of outcomes from a workshop held at the Roses in the Ocean Lived Experience Summit, delivered as a partnership between the Tasmanian Department of Health (Mental Health Alcohol and Drug Directorate), Everymind, and the Manna Institute. The workshop aimed to explore opportunities and strategies to facilitate coordinated suicide prevention action in regional, rural, and remote areas, drawing on the expertise of people with lived experience of suicide. Current practices and future solutions relevant to the Tasmanian and broader national context were explored with emerging recommendations for designing and delivering suicide prevention action in regional, rural, and remote communities.

ABOUT THE WORKSHOP

The 90-minute interactive workshop was held on Friday, 10 March 2023, during Day 2 of the Lived Experience of Suicide Summit. A total of 55 people participated in three workshop activities, summarised in Table 1 below.

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.

Table 1: Workshop activities – an overview

Activity	Purpose	Details
Activity 1: Three words	To connect people with each other and get people ready for workshop participation.	Each person writes down three (3) words that connect with: 1. Rural communities 2. Suicide prevention in rural communities 3. Lived Experience in rural communities.
Activity 2: Opportunities for change	To record what people see as some of the key opportunities for change when thinking about suicide prevention in rural communities.	People to move around the room add their "opportunities" against the type of intervention or type of enabler it best relates to, with the following options provided: • 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	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 butchers paper. 1. What CHANGE do you want to see to planning and delivery of suicide prevention in rural and remote communities? 2. What practical ACTIONS would help communities achieve these changes? 3. WHO should lead on the actions? 4. What are some ways in which people with lived experience could be involved to ensure those actions and changes reflect the needs of those within the community? 5. How will we know if the actions, if implemented, have been successful? 6. Are there any members of your community whose needs are being missed?

FINDINGS

ACTIVITY 1: THREE WORDS

Rural communities

When asked to write down three words that come to mind when thinking of '*Rural communities'*, out of a total of 175 words noted, the most common responses noted were *isolated* (*n*=17), *isolation* (*n*=14), followed by *community* (*n*=4) and *strong* (*n*=4) (Figure 1).

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

Suicide prevention in rural communities

When thinking of '*Suicide prevention in rural communities'*, the most common responses noted out of a total of 177 were *stigma* (*n*=11), *community* (*n*=6), followed by *under-funded* (*n*=5) and *isolation* (*n*=5) (Figure 2).

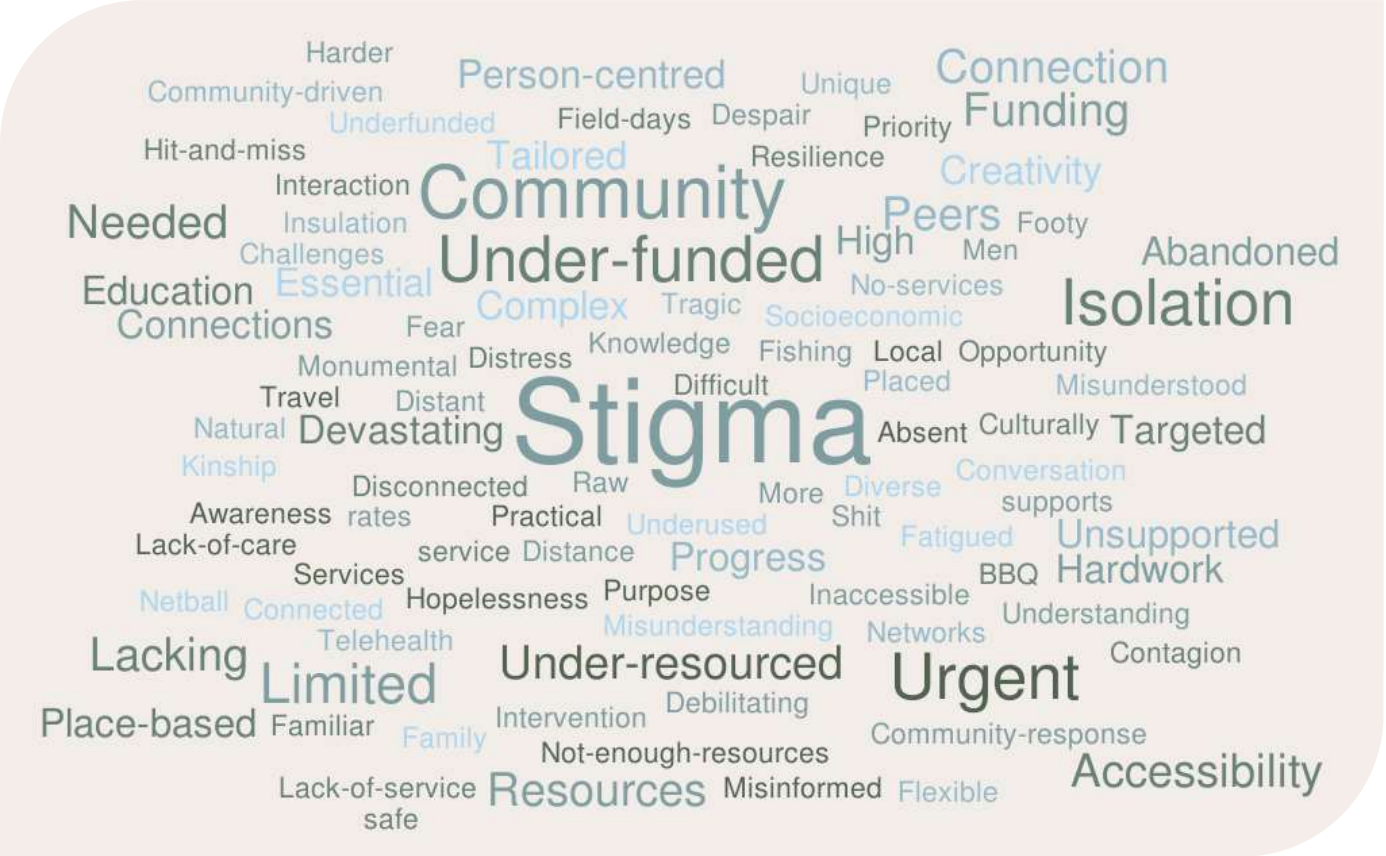

Figure 2: Responses when thinking of *'suicide prevention in rural communities'*

Lived Experience in rural communities

When thinking of '*Lived experience in rural communities'*, out of 197 words noted, the most common responses were *stigma* (*n*=10), *needed* (*n*=8), followed by *connection* (*n*=7), *shame* (*n*=7), and *isolated* (*n*=7) (Figure 3).

Figure 3: Responses when thinking of *'lived experience in rural communities'*

ACTIVITY 2: OPPORTUNITIES FOR CHANGE

Wellbeing

When asked about opportunities for change in the action area of wellbeing, participants highlighted person-level factors and factors at a community, interpersonal, and environmental level (Figure 4). Under person-level, the commonly mentioned sub-themes were '*Employment and education support'*. Under community, interpersonal, and environmental, '*Opportunities for connection and purposeful association'* was the most common sub-theme.

Person-level factors (*n*=28)

- Personal, coping and interpersonal factors inc. skills, emotion regulation, cultural awareness, identity, sense of purpose.
- Employment and education support.
- Access to appropriate health and support services, inc. cultural, alternative.
- Housing and financial support.

Community, interpersonal and environmental-level factors (*n*=44)

- Natural environment.
- Peer and lived experience, safe spaces, networks, groups, connections.
- Role models, mentors, 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.

Figure 4: Themes identified from data: Opportunities for Change: Wellbeing

Prevention

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

Under the theme of Community and environmental factors, '*Consideration of natural disasters', 'Inclusivity and diversity considerations',* and *'The role of suicide prevention networks'* were equally most mentioned as opportunities for change. Under Services, systems, and workforce factors, the '*Appropriateness and availability of services'* was most commonly mentioned. Under the types of prevention initiatives*, 'Social supports and opportunities for connection'* was most commonly mentioned.

Table 2: Themes identified from data: Opportunities to Change: Prevention

Themes	Sub-themes
Community and environmental factors (*n*=7)	Consideration of natural disasters
	Cultural factors
	Inclusivity and diversity considerations
	The role of suicide prevention networks
Services, systems and workforce factors (*n*=23)	Appropriateness and availability of services
	Lived experience and peer workers
	System level factors
	Workforce supports and training
Types of prevention initiatives (*n*=24)	Early intervention
	School-based
	Social and sports clubs
	Social media and bullying
	Social support and opportunities for connection
	Training and awareness raising

Intervention

When noting opportunities for change in the action area of intervention, 12 themes were identified, with '*Available, accessible and appropriate supports and services including addressing risk factors'* (*n*=16) the most commonly mentioned theme, followed by *'Community-led and capacity building interventions including champions, gatekeeper training*' (*n*=9) (Figure 5).

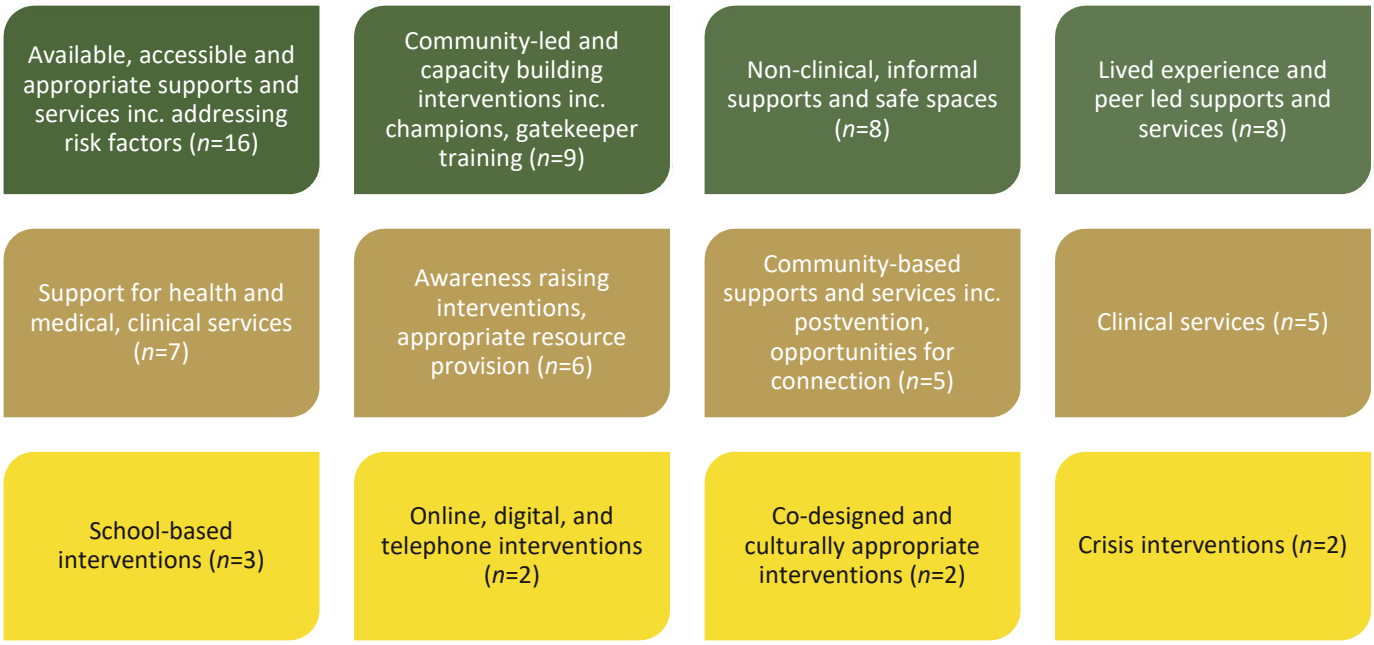

Figure 5: Themes identified from data: Opportunities to Change: Intervention (*n*=12)

Postvention

Under the action area of postvention, 14 themes were identified relating to opportunities for change, with '*Peer and lived experience led services and supports'* the most commonly mentioned (*n*=14) (Table 3).

Table 3: Themes identified from data: Opportunities to Change: Postvention (*n*=14)

Themes	
• Peer and lived experience led services and supports (*n*=14) • Accessible services and support, including practical supports and outreach (*n*=7) • Awareness raising, training and provision of resources, including for family (*n*=6) • Funding and employment support for postvention (*n*=6) • Long-term and follow-up bereavement supports and services (*n*=5) • Building the capacity of existing services (*n*=3)	• Non-clinical services, alternatives to bio-medical model (*n*=3) • Safe spaces (*n*=3) • Whole community engagement, community-led (*n*=2) • Holistic models of support (*n*=2) • Clinical services (*n*=2) • Targeted support for at-risk groups (*n*=2) • Consideration of impacts of suicide to wider community (*n*=2) • School-based postvention (*n*=2)

Enabler: People and communities

When looking at the enabler focused on people and communities, nine themes were identified, with *'Recognising, understanding, utilising and building lived experience and peer workforce'* (*n*=12) and *'Community involvement, support, and leadership including community champions and networks'* (*n*=9) the most commonly mentioned opportunities for change (Table 4).

Table 4: Themes identified from data: Enablers of change - People and communities (*n*=9)

Themes	*n*
Awareness raising, education and training including for services, local touchpoints and gatekeepers.	*n*=7
Collaboration and coordination of services and responses inc. mapping.	*n*=3
Community involvement, support and leadership inc. community champions and networks.	*n*=9
Funding inc. scholarships.	*n*=7
Importance of government inc. local, state and federal.	*n*=4
Incorporating cultural awareness, diversity and inclusion and trauma-informed practices in services and practices.	*n*=6
Place-based, community specific initiatives.	*n*=3
Recognising, understanding, utilising and building lived experience and peer workforce.	*n*=12
Safe spaces and building connections.	*n*=2

Enabler: Whole of government

Under the enabler concerning the whole of government approaches, nine themes were identified relating to opportunities for change, with '*Lived experience inclusion, representation, and employment at all levels including advisory, evaluation'* the most commonly mentioned (*n*=10) (Figure 5).

Enablers of Change: Whole of Government	Provision, appropriateness and inclusivity of data, i.e., surveillance, cluster monitoring, linkage, qualitative (*n*=9)
	Lived experience inclusion, representation and employment at all levels inc. advisory, evaluation (*n*=10)
	Coordination, communication and resource sharing across governments (*n*=5)
	Whole of systems approaches and addressing the determinants of suicidality (*n*=4)
	Recognising and supporting community-level and led action inc. co-design and consultation (*n*=3)
	Local workforce recruitment, upskilling, and incentives inc. peer workforce (*n*=2)
	Accessibility and diversity of service options inc. suicide prevention specific (*n*=2)
	Ensuring accountability of funded services and initiatives (*n*=2)
	Addressing needs and ensuring inclusion of minority communities and priority populations inc. First Nations (*n*=2)
	Ensuring sufficient infrastructure to support programs i.e., internet, opportunities to share learnings (*n*=2)

Figure 5: Themes identified from data: Enablers of Change – Whole of Government (n=9)

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.

One group focused on the area of wellbeing, with nine participants exploring the change needed in this area and how to get there. When asked about one key consideration the group would like to highlight for the area of Wellbeing, '*Acknowledging connect to land and environment*' was mentioned. Two groups focused on prevention (*n*=10). When asked about one key consideration the group would like to highlight for the area of prevention, '*Communities leading action, including Lived Experience'* was mentioned. One group focused on the area of intervention (*n*=12), noting that '*Rural areas don't need telehealth or time specific programs*…', '*Programs need to recognise and utilise intersectionality*…', and '*We want equal access, tailored to the needs of demographic groups, at any time, including peer-led programs/services and crisis care'.*

One group focused on the area of postvention, with 10 participants exploring a need to include suicide attempt aftercare, which is seen to be not covered in the intervention space. Additionally, when asked to highlight key areas of postvention that need to be considered, the group mentioned that *'There are different definitions of postvention that need to be considered and communities need to be able to tell government what they define it as', 'There needs to be key performance indicators on what works',* and *'Ongoing funding'.*

Two groups focused on the enabler focused on people and communities (*n*=10), highlighting that '*There needs to be consideration for what is already in the community', 'Program efforts need to be tailored to different communities', 'A need to identify and support champions in training and with remuneration,* and '*People with Lived Experience and Champions need to lead [efforts]'.*

Two groups focused on the enabler of whole of government action (*n*= 4), mentioning that *'There needs to be key performance indicators and assessment of what and how things worked'*, and *'Community needs access to, and visibility of data'.*

Table 5: The change we need and how we get there

Discussion points	Wellbeing (groups *n*=1)	Prevention (*n*=2)	Intervention (*n*=1)	Postvention (*n*=1)	Enabler - People and communities (*n*=2)	Enabler – Whole of Gov (*n*=2)
CHANGES to planning and delivery of suicide prevention in rural and remote communities	• More opportunities for connection (as a protective factor) • More integrated community who know each other. • Wellbeing not seen as separate from work. • People recognised as a resource • The role of local Councils • Prevention using diverse delivery methods • Breaking down silos/stigmas	• "Place-based" approaches • Alternatives to ED • 'Safe space' • Funded, peer-led, long-term community hub/safe space • Reduce stigma • Increase conversation inc. in education. • Confidentiality barriers • Support for family and friends • Disengagement due to limited access to services (fly in/out) • Mental health for youth • Be inclusive • Education, incentives for locals and youth to upskill and train • Parental education	• Community-based supports • Local community outreach • Local services • Services not limited based on timeframe, age, gender, culture • Inclusive eligibility criteria & services • Minimum timeframes for rural placements • Upskilling local people and workforce • Reducing stigma as a barrier to access	• More 'seed funding' direct to community • Organised, planned efforts • Clear roles • Contentment as a target, not happiness. • Strategies for: – mental/emotional / physical/social/ spiritual/financial – 'safety plan' style – 'holistic navigator' approach • Meet people where they are – outreach	• Bottom-up approach. • Embedding support in communities. • Long term plans. • Strategic collaboration between services. • Cross cultural/ culturally aware services inc. Lived Experience • Organisations like Manna, Mates etc. • Modelling of success stories from other communities. • Meet people where they are – outreach.	• Not just whole of government, include GPs/ health professionals • Cross-sharing of data • Support communities to understand their data • Delivery – upstream – improve connection with community • Account for health literacy • Digital models (if accessible) • Early intervention services • Remove GPs as gatekeepers • Using/developing/ making accessible social media

Practical ACTIONS to help communities achieve these changes	• Opportunities to showcase strengths, share resources and talents (inc. local markets, council engagement) • Build on human skills (inc. parenting, trauma-informed, communications, interpersonal) • Start small with community engagement (i.e., community markets, gardens, groups to engage with)	• Improve transport and access • Streamlined approach to grants/funding • Community control over funding • Peer workers across multiple/emergency services • Lived Experience recognition • Collaboration between community & schools • Services that meet local needs • Community co-design and consultation • Digital services • Incentives for services. • Resource packs inc., for new community members (Councils) • Community Champions	• Lived Experience training i.e., peer workers • Community-led strategies e.g., Facebook group • Community safe spaces • Workforce development • Training for first responders • Physical location (safe, discrete, visibility)	• Supporting first responders/witnesses/ community • Suicide notifications • Central supports register • Subsidise and make widely available, awareness training i.e., MHFA	• See what the community wants/needs • 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	• Well-equipped professionals • Collaborative approach • GP systems as anecdotal data • Use AI to centralise information to identify signs/analysis (i.e., SafeWork Victoria) • Whole of Government linkage/monitor trends i.e., presentations, socio-economic risk factors • Use stories to articulate performance i.e., indigenous story-based evaluation/methods

WHO to lead actions	• Local council • People trained to hold space • Lived experience • Local health • local fire brigades • Schools	• Community-driven – local people with local knowledge • Face-to-face • Telehealth • Local Council • Community, as a whole, not just the minority with opinions • Community champions. • Collaboration between community and government	• Community-led strategies • Community champions/leaders • Community collaboration	• All agencies/services working together e.g., police, local area district, StandBy, DoE/ED, provider, ACCHOs • Family support • Community support networks • Community centres • Everyone, from the front desk to clinical spaces	• Lived Experience/ community-led • Speak the local 'language' – if you do bring in an 'expert' make them secondary to LE person or local leader • Resources from university researchers	• Collaborative approach: – national suicide prevention office research team – LGAs – councils – public/private hospital data sharing – community members • Shared data – national suicide prevention office • National location, but localised use and accessible options
Ways PEOPLE WITH LIVED EXPERIENCE could be involved to ensure actions and changes reflect the needs of communities	• Community champions • Women in leadership • TAS premiers Lived Experience advisory group • Regional leaders • Reducing stigma • Community suicide prevention supporters i.e., (hairdressers,	• Local knowledge and experiences to offer supports • Connect community, build relationships and share information • Educate on suicide prevention/postvention/ intervention/wellbeing in community, i.e., local BBQs, functions, schools,	N/A	• Lead people at risk to help • Postvention – covering attempts and people bereaved • Empower communities and build capacity • Community peer support groups – people trained in MHFA/other ASIST	• Creative initiatives e.g., community projects • Reduce stigma • Young people friendly communities and initiatives • Involve and engage diverse groups and use traditional models • Dedicated roles, positions and career	• Capture voices of lived experience in data i.e., correctional facilities, homelessness • Governments to have lived experience representatives in governance structures • Lived Experience perspectives in evaluations (paid, valued)

	people who won't avoid) • 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	clubs, churches, youth programs		• People in suicide prevention networks as having the skills and being in the community—should be utilised as an access point • Hospital peer workers or supports who are trained to connect and listen • Peer workforce as experts of their own community and context	pathways at all levels of community • Financial remuneration • Leadership and decisions making ability	• Better uses of digital technologies to monitor and evaluate suicide
HOW WE WILL KNOW if the actions implemented, have been successful	N/A	• Talk to us! Have conversations • Capture voices through a variety of means – meetings, surveys, online platforms, SMS • Multiple consultations • Lived Experience to be involved in evaluation • Measure in 'real time' to allow for changes/ improvements • Improved community awareness	• Story boards • Feedback • Statistics • People presenting to ED – decrease or increase • Police callouts, first responders	• Community set up their own hubs/centres, safe space for people to come and chat • Outreach/in-reach, too hard to reach people in the community • CAP funding • Volunteers trained to support	• Reduced suicide rates • Improvement in wellbeing • Increased accessibility • Decreased poverty • Community spirit increase • Increased school attendance • Engagement of diverse community members • Reduced ED presentations	• Communities have access/visibility over their own data and are empowered to use it (enabled 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

		• Increased ED presentations			• Data captured • Retention of staff	
MEMBERS OF YOUR COMMUNITY whose needs are being missed	N/A	• Elderly • School-aged kids • People under 12 years • Vulnerable groups. • Geographically isolated people • Disengaged people i.e., groups/cultures/sub-cultures	• Stigma reducing access to interventions	N/A	• Young men/people • Diverse community members inc., LGBTIQ+ • First Nations peoples • Place-based • Seek to understand cultural nuances • Empowered communities making change • CALD communities • Elderly	• Farmers • First Nations peoples • CALD communities • People on parole • Elderly • Children and young people • Migrants (no Medicare) • People with Alcohol and Drug Dependence • Data not provided

EMERGING 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 experience, champions, leaders and community-based organisations, be supported with capacity building opportunities and funding to implement suicide prevention programs.

Recommendation 2

That stigma reduction, awareness raising, and training be 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.

Recommendation 4

That communities, including First Nations people, people with lived experience 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.

PROGRAMS TO ADDRESS LOCAL, REAL-WORLD NEEDS AND ISSUES IN RURAL COMMUNITIES

Recommendation 8

That community strengths and program needs 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.

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 suicide and its prevention.

Recommendation 11

That connection to the community be recognised as a protective factor, and programs should seek to reduce isolation and increase opportunities for connection.

Recommendation 12

That disasters and traumatic events, including suicides, 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 experience 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.

NEXT STEPS

This report will be distributed through the Tasmanian Directorate, Manna Institute, Everymind, and Roses in the Ocean. An additional workshop will be held at the Rural Mental Health Conference in Albury, November 2023. It is anticipated 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.

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