Illawarra Shoalhaven Suicide Prevention Collaborative

Breakfast Meeting Minutes – 10 March 2016
8:00am – 9:00am

Venue: IHMRI Level 3.301

Attendees:

Dr Vida Bliokas	(VB)	MHAB Clinical Theme Leader, IHMRI; ISLHD
Prof Brin Grenyer	(BG)	MHAB Academic Theme Leader, IHMRI; UOW
Prof David Adams	(DA)	Executive Director, IHMRI
Frank Deane	(FD)	Director, Illawarra Institute of Mental Health; UOW
Mr Grahame Gould	(GG)	Director, Lifeline South Coast
Mr Tim Heffernan	(TH)	Peer Support Worker, ISLHD
Ms Wendi Hobbs	(WH)	Shoalhaven Suicide Prevention Awareness Network (SSPAN)
Mr Tim Hudman	(Thu)	Shoalhaven Suicide Prevention Awareness Network (SSPAN)
Ms Linda Livingstone	(LL)	Regional Director, Coordinare
Ms Cynthia McCammon	(CM)	Senior Professional Officer, Catholic Education Office
Ms Bethany Pye-Respondek	(BPR)	Research Development Administrator, IHMRI
Mr Alan Woodward	(AW)	Research Director, Lifeline Foundation

1. Preliminary Business

1.1 Apologies:

Prof Leonard Arnolda	Clinical Director, IHMRI
Ms Sue Baker-Finch	COO, IHMRI
Mr Peter Brown	Chair, Illawarra Suicide Prevention Awareness Network (ISPAN)
Dr Mitch Byrne	School of Psychology, UOW; Mind the Gap Planning Group
Dr Alex Hains	Mental Health Manager, Grand Pacific Health
Mr Greg Hand	Learning and Wellbeing Coordinator, Dept of Education
Ms Erin Hiesley	Manager, Partners in Recovery
Ms Dianne Kitcher	CEO, Coordinaire
Ms Sally McNeill	Research Development Officer, IHMRI
Prof Lorna Moxham	Mental Health Nursing, School of Medicine UOW
Mr Phil O'Neil	Duty Officer, Wollongong LAC, NSW Police Force
Dr Coralie Wilson	UOW, School of Medicine; Mind the Gap Planning Group

2. General Business

2.1 Welcome and Introduction

BG welcomed attendees and noted the new data on cause of death from the Australian Bureau of Statistics (ABS) had been released in the last week. GG will update later in meeting. Keen to set up a video-conference with Shoalhaven members if possible. BPR and LL to discuss options.

VB noted LL has joined Collaborative Exec. Would also like to include a consumer/lived experience rep – nominated TH and requested comment.

TH: Happy to join if all members are in agreement

All members agreed

2.2 ISSPC Regional Coordinator recruitment update

VB: Regional Coordinator position has been advertised. ISLHD and Coordinare have managed recruitment, interviews will be held shortly.

BG: Great opportunity for the collaborative – very grateful to ISLHD and Coordinare for this opportunity to move the Collaborative's agenda forward.

LL (phone): 17 or 18 applications received, and plenty of interest.

VB: Reflection of the hard work the group has done thus far. Hope to know more by next meeting.

2.3 Executive Update

BG requested support of group to submit a presentation to the National Suicide Prevention Forum in July. Would like to see a poster and presentation put together.

GG: Great opportunity to share knowledge with other groups

AW: As a member for the forum program committee, highly encourage the group to submit

FD: Possibility of working with others in the Illawarra to coordinate something? Is Life Line South Coast planning to present?

GG: No plans, but it's possible. Suggest plenty of communication and working together to prepare.

VB: Collab can circulate an expression of interest for those interested in participating or presenting.

2.4 National Innovative PHN Mental Health & Suicide Prevention Forum

LL: Sunday and Monday (March 6 and 7, 2016) attended a forum of suicide prevention for Primary Health Networks in Brisbane. PHN still not received guidelines or contracts from the Department of Health regarding their role and/or remit. Others from PHNs, Headspace, the Brain and Mind Institute discussed what the opportunity may look like in the future.

A presentation was heard from David Butt, National Mental Health Commission. Regarding the national reforms, he emphasized that this isn't about fixing individual programs, this is about looking more broadly to improve the system. The Prime Minister recognizes the economic impact of poor mental health for children and youth, including suicide prevention. Very aware of children in this situation. Wants to turn the focus beyond diagnosis to cognitive impairment. Need to expand research and evidence base to improve consumer experience.

Ian Hickie discussed the challenges for many organisations. Funds previously to be distributed nationally through the Department of Health, but now to be distributed through 31 PHNs. There is no central contact point. He argues that there needs o be a regional approach, and a regional focus. Groups should take advantage of the regional focus around how services are designed and delivered.

Regarding technology, the Government's Digital Mental Health Gateway is still a few years off. Progressive leadership in the community and service leadership very important. Consider the role of users and families? Engage evaluation – academic opportunities? – how to make continuous improvements?

Representatives from Headspace discussed clinical staging in Headspace. Clients presenting can be identified if they are likely to develop serious mental health issues.

ConNetica representative spoke about concern that 20-30% of people who complete suicide have contacted services previously. Note there is plenty of room for improvement, especially on discharge from emergency departments.

LL will type up her notes from the forum for distribution.

3. Other Business

3.1 Digital Mental Health Gateway

AW: Regarding the Digital Mental Health Gateway – Lifeline hosted a round table in the ACT on Feb 25. Minister for Health indicated initial steps should be complete by mid-2016. Those in attendance representing consumers warned against moving too quickly and potentially creating long-term problems. Very real opportunities in Australia around digital connection, even providing treatment. How does the existing digital group relate to health services currently?

TH: Significant social media communities and initiatives that consumers have developed for themselves – important to acknowledge these.

BG: What is the digital gateway? How does it differ to current model?

AW: Still being shaped and created. Will be an interface for the community to find services and be connected more clearly, use technology to facilitate this. It's about responding to the reality of an online world. Issues around suicidality can be expressed – it creates a space for people to disclose and connect. However, that raises questions of what pathways are created? How do you support after disclosure?

THu: 80-90% of online apps don't get picked up. Planning with consumers groups to design apps is needed. Real opportunities within social media – data collection, geo locations, services can be promoted through ad-words, more integrated services in social media, more accessible when needed – less passive.

3.2 Update on funding from The Black Dog Institute

VB queried if there was any mention of research funding opportunities through The Black Dog Institute at the PHN forum

LL: No. Black Dog presented on Tuesday 8 March, but did not discuss funding. Dianne Kitcher has been invited to a breakfast meeting with Black Dog. Not sure of the purpose of this meeting, but communication is still open. Nicole Cocayne, Head of Research at Black Dog, said she hoped to clarify the application process by the end of February. LL and DK will chase up.

3.3 2014 ABS Cause of Death statistics

GG: Tabled pages from recent ABS data release – 2014 data (Attachment 1).

Note suicide numbers vary due to coding differences.

13% increase in death by suicide and self-harm from last round of data. Over a long period, the rate of suicide among women has increased, but in the last 12 months of data, the rate among men has increased more than that of women. Notably higher.

Heart disease is recorded as the number 1 cause of death, however in terms of years of potential life lost (YPLL), suicide and self-harm are at number 1. There has been a 14% increase from 2013 to 2014 data.

Note people dying from suicide are younger in the 2014 data than the 2013 data. Increased opportunity to move into an economic argument. The economic burden of suicide has increased more than the rates of suicide itself.

Looking at the implications of this data for the Collaborative – businesses cannot ignore the economic arguments here. Look for opportunities to bring them into the conversation in a deliberate way, connect with the core business community of the Illawarra-Shoalhaven. In terms of direction for the Collaborative it's important to engage business, as business brings people together and connects them.

AW: Note the impact of suicide on communities 10 to 12 people are affected per suicide. There is research underway, and that figure is likely to be higher. Some impact dissipates early, but some lingers for years and significantly impactions on population and public health.

GG: Very clear argument to move forward.

VB: Consider the University as an industry body/business

WH: Australian Defence also

TH: Recovery Network Learning, led by Sue Sumskis – looking at deaths in faculty and etc, could speak to her regarding potential involvement?

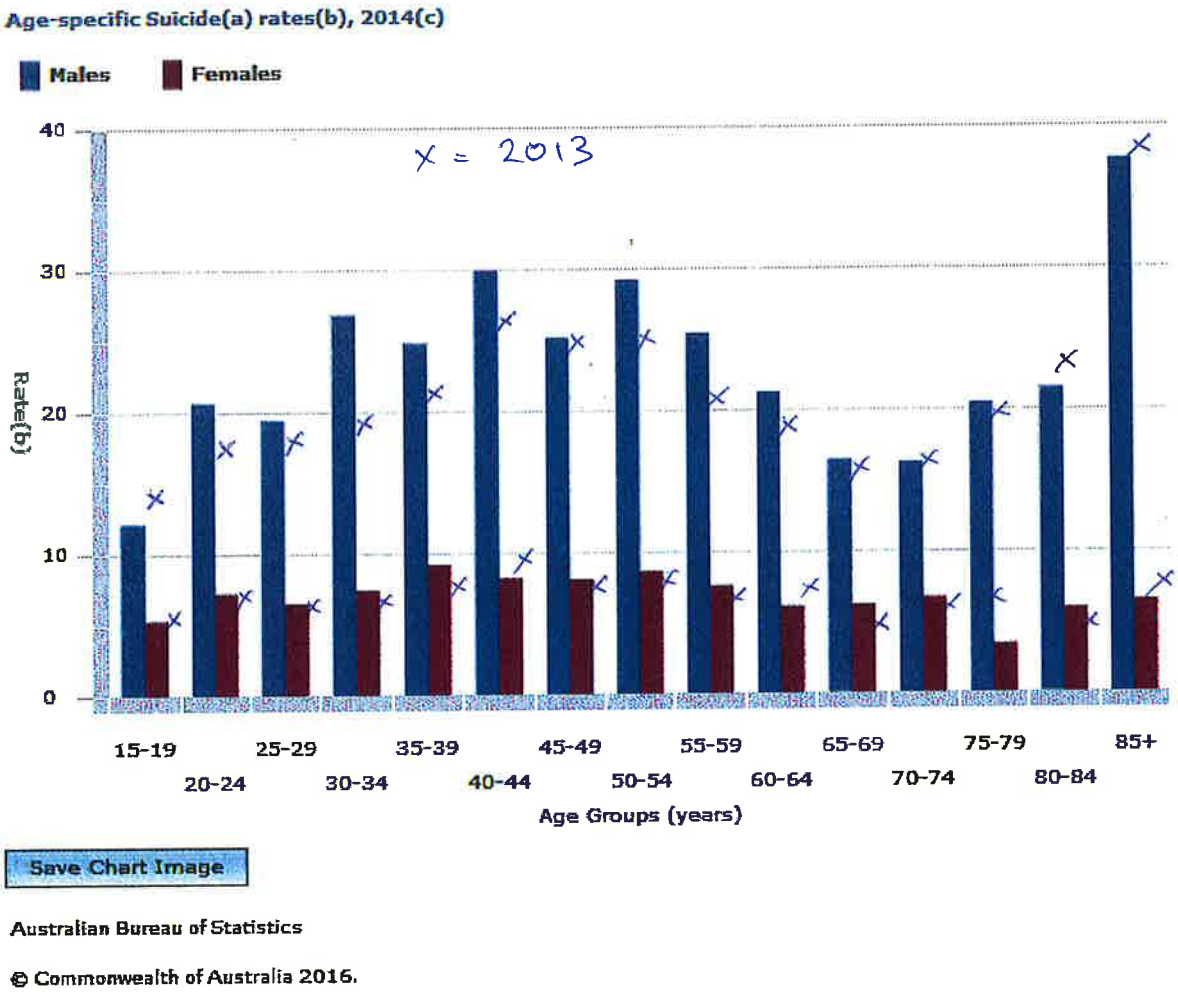
VB: Regional Coordinator will progress this further.

3.4 ISSPC Forum date

Group agreed on Thursday, 21 April. Executive to go ahead with planning, will update at next meeting and circulate a save-the-date to members.

Meeting close

Attachment 1



Footnote(s): (a) Includes ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 85-92. (b) Rate per 100,000 estimated mid-year resident population for each age group and sex. (c) Causes of death data for 2014 are preliminary and subject to a revisions process. See Explanatory Notes 68-94 and the Causes of Death Revisions 2012 and 2013 Technical Note in this publication.

Source(s): Age-specific Suicide(a) rates(b), 2014(c)-Age-specific_suicide_rates_2014

The highest age-specific suicide death rate for males in 2014 was observed in the 85 years and over age group (37.6 per 100,000 males). As a proportion of total male deaths in this age group, suicide deaths represented 0.3%. The second highest age-specific suicide rate was observed in the 40-44 year age groups, with 29.9 suicide deaths per 100,000 males. Suicide as a proportion of total male deaths for this age group was 18.3%. Excluding the 0-14 year age group, the age-specific suicide rate for males was lowest in the 15-19 year age group (12.1 deaths per 100,000). However, suicide accounted for over a third of all deaths in this age group (35.9%).

For females, the highest age-specific suicide death rate in 2014 was observed in the 35-39 year age group, with 9.2 deaths per 100,000. Outside of the 0-14 year age group, the lowest age-specific death rate for female deaths was in the 75-79 year age group (3.4 deaths per 100,000).

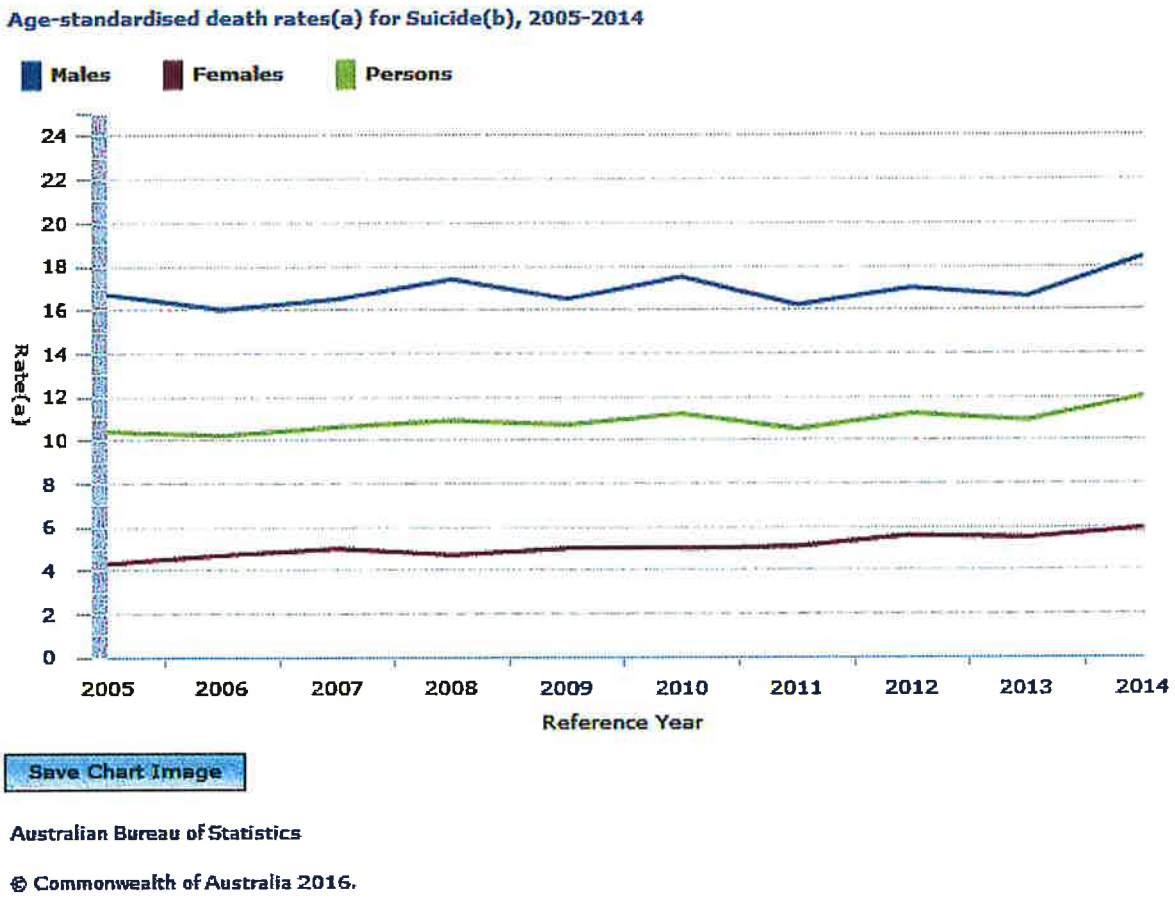
Age-standardised rates

2013 2014
2520 → 2861

Attachment 1

Age standardisation is used to compare death rates over time, as it accounts for any changes in the age structure of a population. The age-standardised suicide rate for persons in 2014 was 12.0 per 100,000.

The age-standardised suicide rate in 2014 for males was 18.4 per 100,000 while the corresponding rate for females was 5.9 per 100,000.



Footnote(s): (a) Age-standardised rate per 100,000. (b) Includes ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 87-93. (c) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2012 (final), 2013 (revised), 2014 (preliminary). See Explanatory Notes 52-54 and Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (cat. 3303.0) and Causes of Death Revisions, 2012 and 2013 in this publication.

Source(s): Age-standardised death rates(a) for Suicide(b), 2005-2014-Age-Standardised Death Rates for Suicide, 2005-2014

The following two tables present the number of deaths from suicide by age group for the combined 2010-2014 reference period. Table 3.1 shows the number of deaths from suicide and age-specific death rates by age group and sex. Table 3.2 shows the number of deaths from suicide by age group and state or territory of usual residence.

Attachment 1

leading cause of death, had the second highest YPLL, with a total of 77,584 years of potential life lost. Trachea, bronchus and lung cancer (C33-C34) was the fourth leading cause of death and had the third highest YPLL with 57,660 years of potential life lost. Although Dementia, including Alzheimer's disease (F01, F30, G30) was the second leading cause of death, the YPLL ranking of the disease was 17, with 6,710 years of potential life lost.

2.2 LEADING CAUSES OF DEATH(a) AND YEARS OF POTENTIAL LIFE LOST, Australia - Persons - 2014(b)

Cause of death and ICD code	2014 no.	Rank	YPLL	Rank(d)
Ischaemic heart diseases (I20-I25)	20 173	1	77 584	2
Dementia, including Alzheimer disease (F01, F03, G30)	11 965	2	6 710	17
Cerebrovascular diseases (I60-I69)	10 765	3	25 933	9
Trachea, bronchus and lung cancer (C33-C34)	8 251	4	57 660	3
Chronic lower respiratory diseases (J40-J47)	7 810	5	28 897	6
Diabetes (E10-E14)	4 348	6	19 171	10
Blood and lymph cancer (including leukaemia) (C81-C96)	4 275	7	27 469	7
Colon, sigmoid, rectum and anus cancer (C18-C21)	4 169	8	30 065	5
Heart failure (I50-I51)	3 447	9	7 902	14
Diseases of the urinary system (N00-N39)	3 136	10	7 438	16
Prostate cancer (C61)	3 102	11	7 562	15
Influenza and pneumonia (J09-J18)	2 873	12	8 754 *	13
Intentional self-harm (X60-X84)(c)	2 861	13	97 066	1
Breast cancer (C50)	2 844	14	30 145	4
Pancreatic cancer (C25)	2 547	15	16 967	11
Accidental falls (W00-W19)	2 301	16	6 526	18
Hypertensive diseases (I10-I15)	2 225	17	3 985	19
Cardiac arrhythmias (I47-I49)	2 131	18	3 205	20
Skin cancers (C43-C44)	2 067	19	16 542	12
Cirrhosis and other diseases of liver (K70-K76)	1 754	20	26 875	8

(a) Causes listed are the top 20 leading causes of death for 2014, based on the WHO recommended tabulation of leading causes. See Explanatory Notes 34-35 in this publication for further information. Groupings of deaths coded to Chapter XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) are not included in analysis, due to the unspecific nature of these causes. Furthermore, many deaths coded to this chapter are likely to be affected by revisions, and hence recoded to more specific causes of death as they progress through the revisions process.
(b) See Explanatory Notes 68-94 for further information on specific issues relating to 2014 data.
(c) Excludes Sequelae of intentional self-harm (Y87.0) as per the WHO recommended tabulation of leading causes. Care needs to be taken in interpreting figures relating to intentional self-harm. See Explanatory Notes 86-92.

(d) The ranking of YPLL data presented in this table is based only on the 20 causes listed. When considering the full listing of leading causes of death, including those not in the top 20, the YPLL ranking would be different. See Explanatory Notes 36-39 for further information on YPLL.

From * 85 032 in 2013 = 14% increase

This page last updated 7 March 2016