Illawarra Shoalhaven Suicide Prevention Collaborative

Breakfast Meeting Minutes – 9 December 2015
8:00am – 9:30am

Venue: IHMRI Level 3.301

Attendees:

Prof Brin Grenyer	(BG)	MHAB Academic Theme Leader , IHMRI; UOW
Dr Alex Hains	(AH)	Grand Pacific Health, Mental Health Manager
Prof Frank Deane	(FD)	Director, Illawarra Institute of Mental Health
Prof Lorna Moxham	(LM)	Mental Health Nursing, School of Medicine UOW
Lord Mayor Gordon Bradbury (present for agenda items 2 & 3)	(GB)	Chair, Illawarra Joint Organisation of Councils
Mr Grahame Gould	(GG)	Director, Lifeline South Coast
Mr Greg Hand	(GH)	Learning and Wellbeing Coordinator, Dept of Education
Mr Tim Heffernan	(TH)	Peer Support Worker, ISLHD
Ms Erin Hiesley	(EH)	Manager, Partners in Recovery
Ms Wendi Hobbs	(WH)	Secretary, Shoalhaven Suicide Prevention Awareness Network (SSPAN)
Ms Dianne Kitcher	(DK)	CEO, Coordinaire
Ms Lynn Langhorn	(Lynn L)	Operations Manager Mental Health, ISLHD
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
Ms Carla Rutherford	(CR)	CNC Shoalhaven ED, ISLHD
Mr Alan Woodward	(AW)	Research Director, Lifeline Foundation
Ms Leanne Woodley	(LW)	Special Education Consultant, Association of Independent Schools

1. Preliminary Business

1.1 Apologies:

Ms Sue Baker-Finch	COO, IHMRI
Dr Vida Bliokas	MHAB Clinical Theme Leader, IHMRI; ISLHD
Dr Mitch Byrne	School of Psychology, UOW; Mind the Gap Planning Group
Dr Tim Coombes	Director of Nursing Mental Health, ISHLD
Ms Marilyn Dunn	Program Coordinator, Salvation Army
Ms Margot Mains	Chief Executive, ISLD
Ms Sally McNeill	Research Development Officer, IHMRI
Mr Phil O'Neil	Duty Officer, Wollongong LAC, NSW Police Force
Ms Leeanne Simpson	Health Relationship Manager, NSW Ambulance
Dr Coralie Wilson	UOW, School of Medicine; Mind the Gap Planning Group

2. General Business

2.1 Welcome and Introduction

Brin Grenyer welcomed the members. Apologies expressed for those who could not attend.

2.2 Update and discussion on Data Audit

BG expressed thanks to Alex and Abhijeet for the data collection.
BG: Any Updates/outcomes raised?
AH: Feedback received from people with Lived Experience: 6 written responses and 1 interview. Will discuss further at agenda item 5.

2.2.1 Turning Point

AH: Approach local Ambulance?
LL: Difficult to engage. Meeting scheduled in January, can raise interest and engagement?
Lyn L: MH MOU later this morning with Ambulance service, can take items from ISSPC meeting and weave into MOU for discussion.

2.3 National Mental Health Reform

Agenda item moved forward

DK advised that the recent meetings in Canberra have not resulted in elaboration of further details or information. PHN will work with local providers and consumers to support MH more appropriately with allocated flexible pool of funds. 12 pilot sites not continuing a previous tender stated, however PHN is to address SP as core aspect. Key message of PHN to continue to support ISSPC consortia to address issues, and no intention of working differently.

BG: What about complex clients with long term support needs?
DK: Pilots in 'innovative step care' across the country will be raised, addressing the 'missing middle'.
BG: Will there be a change in headspace (HS) operation?
DK: Could be. HS is currently protected short-term with the centre-based model to continue until 2018.
BG: Update enforces positive news

2.4 ISSPC proposed Terms of Reference and Statement of Purpose

AH presented a draft of the proposed TOR and SOP (see attachment)

AH raised the catchment area to be revised. Model open to be discussed.
GG: Same borders as PHN?
AH: Easier to include same catchment (core group that feeds into two catchment regions)
Lyn L: Larger area could minimize commitment to Illawarra/Shoalhaven
WH: Support received dilutes as spread further south. Mindful of how far we can stretch before dilution spreads. Prevention could be lost with larger area.
BG: SPN in Southern NSW?
WH: Previously in Batemans Bay, unsure if still operational.
AH: Data shows rates higher than average in Illawarra/Shoalhaven, Southern NSW rates second highest in State.
TH: Frustration shown in Bega with lack of resources. Peer Support utilised as layer of support in isolated areas. Challenge to implement but willingness shown in communities for involvement.
BG: Communication aspect is the largest challenge between large catchment region.

AW: Wesley Life-Force provides community support community based action eg. Communities Matter/Conversations Matter
AH: Need to clarify broadening catchment, remain core member group, and feed shared skill set to southern Collaborative.
BG: Model of 'Hub and Spokes' – ISSPC remains as centralized hub, with spokes outreaching to broader community.
LL: Agreement needed on backbone of Collaborative, regional details can be transferable.
TH: Bega SP currently strong.
AH: Feedback needed on TOR and SOP to progress into concrete action.
GG: Question raised with Quorum: currently two executives and five members, suggested one executive and three or four members due to patterns of member number lowering over time.
Lyn L: set benchmark as minimum seven members for quorum to ensure consistency of membership.
LM: Raised UOW and IHMRI as two separate executives in membership.
AH: Create fourth position for organisations such as PHN?
LL: Difficult to include PHN as executive as role in Collaborative is currently undefined, and conflict of interests may occur as major funder. Expressed the need to review TOR and SOP quarterly. Signing members on to the purpose is currently key priority.
BG: Comments? There is a strong sense to move forward with improvements along the way.

Action/s:

- TH to approach Bega SP to gauge level of involvement.
- Acknowledge UOW and IHMRI as separate members
- TOR and SOP accepted

2.5 Lived Experience Input

AH provided a brief overview of received feedback. Six currently received from people of risk, and carers. Feedback provides an insight of:

- Access
- Interperson interaction
- Role of carers
- Communication with carers

Themes will be addressed once further information is collected and collated.

AH has copies of survey for distribution, or link to survey if required.

3. Other Business

FD asked if details of Model regarding Blackdog announcement are available?
BG: Model is available on Blackdog website. Model is quite broad.

AH asked the group if any further questions regarding the Data Audit Update? Feedback/thoughts/comments?
GG: Trends by gender by age? Is there a group of women of a certain age accelerating?
AH: Age by generation. Rates by number increasing. Younger generations reach a later peak.
LL: Data is worth exploring.
AH: was there a significant event that impacted 2011's numbers?
WH: Not sure, could research media archives?
PB: Look at police data?

WH: Look at Shoalhaven ED data/stats? Was it the GFC?
GG: Revised dates/backdated data?
AH: Revised dates/backdated data was in 2006.

The next meeting will be held on Wednesday 3 February 2015 at 8.00am.

Illawarra-Shoalhaven Suicide Prevention Collaborative

Terms of Reference

1. Background

The Illawarra-Shoalhaven Suicide Prevention Collaborative (the Collaborative) formed in September 2015 following the expressed commitment from multiple government and non-government agencies to reduce the impact of suicide in the Illawarra-Shoalhaven region.

The Collaborative aims to achieve this by:

- improving the supports available to people at risk of suicide as well as improving people's experience of these supports;
- encouraging systems change through collaboration; and
- ensuring that suicide prevention efforts are effective.

The Collaborative's vision and guiding principles are further outlined in the Collaborative's *Statement of Purpose*.

Priorities are to be reviewed regularly and as prompted by research, funding announcements and political decisions likely to impact the Collaborative's activities.

2. Role of Collaborative

The Collaborative has responsibility for:

- influencing strategic directions and outcomes
- overseeing of allocated budget (regardless of the organisation(s) responsible for auspicing any associated funds)
- governing and implementing agreed suicide prevention activities
- monitoring and management of risks
- developing necessary policies and protocols
- taking responsibility for the activities, their implementation and achievement of outcomes
- ensuring the activities align with stakeholder interests and relevant requirements
- communicating and addressing any issues that may have implications for the Collaborative
- promoting the achievements of the Collaborative.

3. Membership

Ongoing membership of the Collaborative will include representatives from the key stakeholders as required to contribute to the activities of the Collaborative. Members may come from multiple different sectors and industries including but not limited to: Coordinare, University of Wollongong, Illawarra-Shoalhaven Local Health District, Non-Government organisations and service providers, people with a lived experience, and community groups.

Membership consists of executive members and optional members as outlined below.

The Collaborative will select three executive members responsible for the oversight and progress of the Collaborative. The executive members will be comprised by representative from the following three sectors:

- Academia/Research (e.g. University of Wollongong, Illawarra Health and Medical Research Institute)
- Public health system (i.e. Illawarra-Shoalhaven Local Health District)
- Non-government service provider (e.g. Lifeline, Grand Pacific Health, headspace)

The Collaborative is also committed to involving representatives from key organisations and community groups, including but not limited to:

- Primary Health Network
- Aboriginal and Torres Strait Islander organisations
- Lived Experience (including carer) groups
- Community groups
- Mental health service providers
- Phone support providers
- Education
- Emergency service providers (e.g. Police, Ambulance)
- Non-Government organisations (who support people at risk of suicide and those who care for them)
- Media
- Railways
- Local government and council

All members of the Collaborative are required to actively support the Collaborative activities and act as advocates for its outcomes.

Collaborative members who are representative of an organisation or service should remain constant. All people participating in meetings should hold appropriate positions within their organisations so as to actively contribute to decisions made without needing to confer with other management or executive staff.

3.1. Cessation of membership

A Collaborative member will cease to be a member if they:

- resign from the Collaborative;
- do not attend 3 consecutive meetings without providing apologies;
- resign from employment at the represented organisation/service;
- breach confidentiality; or
- their organisation fails to deliver on their contracted obligations as determined by annual review.

3.2. Chair arrangements

Responsibility for facilitation of the Collaborative meetings will be the shared responsibility of the executive members.

The executive will also ensure that issues raised within the meeting are tracked, reported and resolved in a timely manner.

Executive members may submit a vote when reaching decisions.

3.3. Invitees

From time to time, the Collaborative may wish to invite external persons to provide advice and assistance. This can be done by the executive at the request of any member of the Collaborative.

4. Operations

4.1. Decision making

Decisions are made by consensus. However, when consensus cannot be reached by the Collaborative, the executive will make a decision on behalf of the Collaborative. For a decision to be made within a Collaborative meeting, a majority of members present and a majority of executive members must be in agreement.

To support activity progress and meet deadlines, the executive are able to make decisions external to meetings where unanimous agreement is reached. Decisions made between meetings will be communicated to Collaborative members and recorded in the minutes of the next scheduled meeting.

4.2. Conflict resolution and disputes

In the event of a dispute, the executive members will be called upon to assist in the resolution of the disputes. Disputes which are unable to be resolved within the meeting may be deferred to a process external to the meeting.

4.3. Conflict of interests

The Collaborative acknowledges that when discussing and deciding upon some elements of the development and implementation of the Collaborative's activities, members may possess a conflict of interest relating to their own personal or organisation's interests.

When discussing and deciding upon topics where Collaborative members may have a conflict of interest, the steps below will be followed:

- The Collaborative member declares their conflict to the meeting and it will be noted in the minutes.
- Depending on the point for discussion, the Collaborative member may or may not be permitted to participate in the discussion. This decision will be made by majority agreement of the other members and led by the executive members.
- The Collaborative member with the conflict will not be able to participate in voting for the decision.

If other members believe another person has a possible conflict of interest that has not been declared, they are required to raise this with the meeting prior to a vote being cast. In this instance, the above steps will be followed and similarly be noted in the minutes.

4.4. Frequency and duration of meetings

The Collaborative will meet every month for approximately 2 hours. A review of these arrangements will be conducted every six months.

4.5. Quorum

At least two executive members and a further five members of the Collaborative must be present for any decisions to be made.

4.6. Proxies

Proxies shall have voting rights at the meeting and can act on behalf of executive or optional members. Proxies are also able to provide relevant comments/feedback to the Collaborative and report back to the member for whom they are representing.

A proxy must be employed by the same organisation (or participate in the same community group) as the member for whom they are representing.

4.7. Communication

The meeting agenda will be prepared and distributed by the executive members (or representative organisation) in the week prior to the next scheduled meeting. Any additions or changes to the agenda must be submitted to the executive or designated officer no less than two days prior to the next scheduled meeting.

The executive are responsible for the quality of the minutes, ensuring they are an accurate record of proceedings. Executive members will arrange for an appropriate person to attend each meeting for the purpose of taking and typing the minutes and distributing to all members.

Full copies of the minutes, including any related attachments, will be forwarded to all Collaborative members prior to the next meeting.

All Collaborative members will report to the management of the organisation that they represent.

As outlined in the *Statement of Purpose*, the Collaborative commits to actively creating opportunities for people with lived experience contributing to the activities of the Collaborative. The Collaborative also commits to providing timely feedback to those who have provided such input.

4.8. Confidentiality and intellectual property

Each member or member organisation shall keep confidential any information that it receives from another member or member organisation that is marked confidential or that another member has stated is confidential.

Intellectual property owned by a member or member organisation remains vested in that member or member organisation. Participating in Collaborative activities does not transfer ownership of any intellectual property rights or constitute consent for anyone else to use that intellectual property in a manner that suggests they has any ownership, unless agreed in writing.

As a guiding principle, intellectual property that is newly developed during the course of the Collaborative's activities would be jointly owned in such proportions relative to member contributions to its development. It is also the intention that members or member organisations would be freely able to use such newly developed intellectual property for their own purposes and at no cost.

4.9. Reimbursement

Members will not be reimbursed for their participation in the Collaborative. Attendance and involvement in Collaborative activities is considered part of the members' current roles for their employer (or community group). All contributions are considered to be in kind given the goal of reducing the impact of suicide in the Illawarra-Shoalhaven is important for all organisations and community groups involved.

Illawarra-Shoalhaven Suicide Prevention Collaborative

Statement of Purpose

1. Background

Suicide is the leading cause of death for Australians aged 15-44 years of age, accounting for more deaths than motor vehicle accidents, assaults and substance use combined. Put another way, every day in Australia, 7 people die by suicide and another 170 attempt to suicide.

The Illawarra-Shoalhaven is far from immune, with suicide rates for this region higher than State and national averages. Despite a number of services being available to help those at risk of suicide, suicide rates have remained relatively stable over the past 10 years. Therefore, a more systematic and coordinated approach is warranted.

2. Vision

The Illawarra-Shoalhaven Suicide Prevention Collaborative (the Collaborative) was founded on the common ambition of multiple government and non-government agencies to reduce the impact of suicide in the Illawarra-Shoalhaven region. This incorporates reducing the number of people who die by suicide, and improving the service experience of those at risk of suicide and those who care for them.

The Collaborative aims to reduce the impact of suicide by:

2.1. Improving the supports available to people at risk of suicide as well as improving people's experience of those supports

The Collaborative aims to improve the efficiency and effectiveness of suicide prevention services available in the Illawarra-Shoalhaven. In acknowledgement that there are many people at risk of suicide who do not engage with traditional health services, the Collaborative will not be restricted to clinical interventions when considering suicide prevention activities.

The Collaborative is committed to learning from those with lived experience so as to improve the supports and services available to people at risk of suicide as well as those who care for them.

2.2. Encouraging systems change through collaboration

The Collaborative understands that when a person's care is transferred from one service/sector to another can be a particularly high risk time for suicide. Therefore, a significant and sustainable reduction in the number of suicide deaths will only be achieved by working together in a systematic and coordinated way. This will be achieved through encouraging innovative solutions, cross-sectorial collaboration, and whole-of-community involvement.

2.3. Ensuring that suicide prevention efforts are effective

It is crucial that we focus our suicide prevention efforts on strategies that are evidence-based. Furthermore, suicide prevention activity should continue to be subject to thoughtful and well-designed evaluation to ensure such activity effectively addresses local needs. Any innovations

should also be evaluated, and the findings be made available to the community to contribute the emerging evidence-base. The Collaborative commits to systematic evaluation of all suicide prevention activities it undertakes, and actively creating opportunities to build upon the evidence-base in the literature.

3. Guiding Principles

The Collaborative believes that suicide prevention is everyone's business, and not exclusive to any one service or sector. People at risk of suicide and those who care for them often access support from various services and sectors, and so any successful approach will require a collaborative cross-sectorial approach.

The Collaborative values those with lived experience, and is committed to actively ensuring that thse people are encouraged to contribute to the development, evaluation and governance of suicide prevention activities in the region.

4. Membership

Membership of the Collaborative includes key representatives from all the major services involved in supporting those at risk of suicide, including health, education, academia, emergency services, community groups, Aboriginal & Torres Strait Islander community organisations, media, council, and lived experience representatives.

Current membership includes:

Coordinare
(South Eastern NSW Primary Health Network)
Dianne Kitcher

_____ CEO

_____ date

Illawarra-Shoalhaven Local Health District
Margo Mains

_____ CEO

_____ date

Illawarra Health & Medical Research Institute
XX

_____ XX

_____ date

Grand Pacific Health
Ron de Jongh

_____ CEO

_____ date

Lived Experience advocate
Tim Heffernan

_____

_____ date

University of Wollongong
XX

XX | date

headspace
(Wollongong & Nowra Centres)
Erin Hiesley

Youth Health Manager | date

Lifeline South Coast
Grahame Gould

Director | date

Illawarra-Shoalhaven Partners in Recovery
Erin Hiesley

Manager | date

Illawarra Suicide Prevention & Awareness Network
Peter Brown

Chair | date

Shoalhaven Suicide Prevention & Awareness Network
XX

Chair | date

Department of Education & Communities
Greg Hand

Learning & Engagement Coordinator | date

NSW Police
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XX | date

NSW Ambulance
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XX | date

Illawarra Aboriginal Medical Service
Julie Booker

CEO | date

Salvation Army

Marilyn Dunn

First Floor Program Coordinator

date