Illawarra Shoalhaven Suicide Prevention Collaborative

Breakfast Meeting Minutes – 6 October 2016
8:00am – 9:00am, room 3.301, IHMRI

1. Attendees

WOLLONGONG:

VIDA BLIOKAS	(VB)	ISSPC Executive; ISLHD
FRANK DEANE	(FD)	Director, Illawarra Institute of Mental Health; UOW
LYNN LANGHORN	(LLa)	Mental Health Operations Manager, ISLHD (in place of Paula Hakesley)
NICK GUGGISBERG	(NG)	Kiama Council
RON DE JONGH	(RdJ)	CEO, GPH
PAUL MCCANN	(PMc)	Catholic Education
CYNTHIA MCCAMMON	(CMc)	Catholic Education
GRAHAME GOULD	(GG)	Lifeline South Coast
GREG HAND	(GH)	Department of Education
ADAM MCRAE	(AM)	Suicide Prevention Team Leader, GPH (in place of Erin Hiesley)
ERIN FRASER	(EF)	IAMS (in place of Leanne Lawrence)
LEANNE WOODLEY	(LW)	Association of Independent Schools
ROB MURRAY	(RM)	Health Relationships Manager, Ambulance Services
ARMANDO REVIGLIO	(AR)	Wollongong City Council (in place of Kerry Hunt)

NOWRA:

WENDI HOBBS	(WH)	Shoalhaven Suicide Prevention Awareness Network
TIM HUDMAN	(THu)	Shoalhaven Suicide Prevention Awareness Network
ALEX HAINS	(AH)	Regional Manager, ISSPC
LINDA LIVINGSTONE	(LL)	ISSPC Executive; COORDINARE
GLENN WILLIAMS	(GW)	Project Manager, MIND the GaP

APOLOGIES:

PAULA HAKESLY	(PH)	Director Mental Health Services, ISLHD
BRIN GRENYER	(BG)	ISSPC Executive; IHMRI
WADE LONGBOTTOM	(WL)	South Coast Medical Service Aboriginal Corporation
TIM HEFFERNAN	(TH)	ISSPC Executive; Lived Experience
HEATHER TAFERNER	(HT)	Shellharbour City Council
ERIN HIESLEY	(EH)	Youth Health Manager, GPH
MARILYN DUNN	(MD)	First Floor Program Coordinator, Salvation Army
LEANNE LAWRENCE	(LL)	Illawarra AMS
KIMBERLY CHISWELL	(KC)	Senior Social Worker, Waminda
JUDITH SIMONS	(JS)	Schizophrenia Fellowship
DEBRA MURPHY	(DM)	CEO, Regional Development Australia Illawarra
DARREN BROWN	(DB)	Wollongong LAC, NSW Police
PETER BROWN	(PB)	Illawarra SPAN
EMMA RODRIGUES	(ER)	LGBTI advocate
KERRY HUNT	(KH)	Manager Community Cultural and Economic Development, Wollongong City Council

2. Welcome and introduction

VB welcomed attendees.

3. LifeSpan project

LL noted that she and AH attended the National LifeSpan Advisory Committee meeting on 30 Sep at the BDI. Each of the pilot sites attended and provided presentation on what support we'd like from the BDI for effective implementation of the 9 strategies.

Key information from the meeting of interest to members is the following:

- A strong emphasis of the initiative will be maintaining fidelity to the evidence (i.e. making sure we are implementing the strategies as the evidence suggests they should)
- BDI are currently engaging a number of experts to help with the rollout of the initiative, including:
    - The Centre for Evidence and Implementation
    - Michelle Banfield from ANU re effective Consumer Engagement
    - How to undertake successful community campaigns
    - Aust. Institute of Health and Welfare (AIHW) and SASS will be working together to collect good measure on a regular basis, which will be provided to each site (e.g. they are hoping to be able to identify where private providers are located and which professionals have undertaken particular training in relation to suicide prevention)
    - Geo spatial mapping of sites that are relevant to the means restriction strategy (i.e. hotspots)
- BDI will be developing an intranet that Collaborative members will be able to access through a portal, it will include collaborative tools and links to a research engine that will be capturing relevant data
- Protocols for each strategy are currently being developed. For example, with regards to school-based programs, BDI are currently meeting with the Dept Education (and will subsequently be meeting with Independent and Catholic Schools) about the rollout of the YAM and Sources of Strength programs

LL reminded all that representatives from the Black Dog Institute (BDI) will be attending the Nov meeting to answer any questions we have about how the LifeSpan project will be rolled out locally.

ACTION 1: Questions for the BDI to be sent to AH prior to Nov meeting to help shape the discussions.	all

ACTION 2: Questions from members to be collated to feed into agenda for Nov meeting.	AH

4. SP Collaborative website

LL advised members that work is commencing on development of website for SP Collaborative. A small working group of 2-3 members is needed to assist with this. This should not involve much time, but just 1-2 short meetings.

ACTION 3: Members able to help with development of SP Collaborative branding and website to contact LL asap.	all

5. Revised Terms of Reference

AH thanked members for feedback received on the revised Terms of Reference (ToR). All of these have been incorporated. No further comments from other members. All agreed for these revisions to be accepted. See attached for updated ToR.

6. Executive vacancy

Executive position for an identified Aboriginal representative was put out to Expression of Interest (EoI) shortly after the Sep meeting. One EoI received from GW. All members agreed for this to be accepted and GW to join the executive as the Aboriginal or Torres Strait Islander representative.

7. Membership

New member applications received (as per revised ToR):

- Flourish (formerly RichmondPRA)
- ACON (New South Wales based health promotion organisation specialising in HIV prevention, HIV support and lesbian, gay, bisexual, transgender and intersex (LGBTI) health)
- West Street Counselling Centre (for people with complex trauma)

All these applications were accepted unanimously.

AH noted need to continue working on engaging other members:

- Community-based services for older people
- Multicultural services
- Justice Health (related to expanding prison population)

All agreed for AH to pursue these representatives. NG recommended Legal Aid or Illawarra Legal Services as an option too.

ACTION 4: AH to distribute updated list of Collaborative members with contact details for representatives shortly.	AH

8. NSW Suicide Prevention Funding

All members were made aware of this funding as soon as it was announced (after the Sep meeting). Invited members to share their ideas for proposals with the Collaborative.

- AM stated that GPH was considering submitting proposal aimed at psychosocial treatments for adults at risk of suicide in Nowra, building on their existing SP program for young people.
- AH noted that he understood other agencies (e.g. South Coast AMS, Waminda) were considering submitting proposals as well, but their representatives weren't in attendance to clarify.
- GG noted that Lifeline Australia has told Lifeline South Coast that it cannot submit an independent proposal but can support others in local proposal.
- SSPAN said they would like to put in a proposal but don't have the resources to put something together in time.

AH encouraged all those who were considering submitting applications to ensure they focused on the 3 priority areas for funding: psycho-social treatment, GP Capacity Building and Aftercare.

AH raised possibility of joint proposal by multiple Collaborative members with focus on aftercare. Given this will be a key strategy for reducing suicide attempts in the region, it was agreed for a small working group to be established.

ACTION 5: All those interested were invited to contact AH asap, with a likely meeting next week.	All

9. beyondblue Way Back Support Service

A copy of the proposal was tabled (see attached), with a request that organisations who are interested in discussing further with beyondblue let LL know. RdJ noted that GPH would be interested in talking further with beyondblue in relation to this proposal.

The Dept Education and Independent Schools also were interested in finding out more about any program that would assist with support following a suicide attempt. LL will pass information on to beyondblue.

10. Regional Suicide Report Card

AH spoke about the concept of the Collaborative developing a 'Report Card' that would collate relevant performance measures and help the group to keep focused on making progress on key priority areas. More to follow in future meetings. All were supportive.

11. Cause of death statistics

GG provided summary of updated cause of death statistics from the Australian Bureau of Statistics (ABS). See attached for summary handout.

These stats are provided 6 months earlier than usual due to improved processes by the ABS and coroner.

Findings of note:

- Increase in both the number and rate of suicides – 3,027 suicides in 2015 (at a rate of 12.7 per 100,000)
- Now over 8 suicides per day, with 6 of these being men
- 85+ year old men have the highest rate (39.3 per 100,000)
- 40-55 year old men have highest number of deaths
- 47% increase in suicides for 15-19 year old females (38 deaths in 2014 to 56 deaths in 2015)
- Northern Territory has double the suicide rate of NSW
- 21% increase in years of potential life lost (YPLL) from 2013 to 2015, partly due to average age of suicide getting younger

12. Other business

SSPAN advised that they were recently successful in receiving a $1400 grant from Bluescope. This will go towards the purchase of some resources that support people who have attempted suicide. The *Safe Journey Home* initiative has also had a 6 month extension of funding.

13. Next meeting

8-10am (NOTE: 2 hours) on Thurs 3 Nov, with BDI representatives also attending.

It was agreed for organisations to bring more staff to the Nov meeting as it will be a good opportunity for a broader range of people to have exposure to how the LifeSpan project will roll out locally.

ACTION 6: Members to email AH to advise of numbers attending Nov meeting.	All

ACTION 7: Organise venue suitable to the increased numbers.	AH

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 and their family, carers and friends, and 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*. To access this, please email Alex Hains (Regional Manager) on ahains@coordinare.org.au.

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
- ensuring suicide prevention activities are aligned with the evidence-base
- supporting relevant organisations to implement agreed suicide prevention activities
- identify and monitor potential risks
- 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

Membership of the Collaborative will include representatives from different sectors, including but not limited to: primary health, academia/research, public health, non-Government organisations and service providers, emergency services, Aboriginal communities, LGBTI communities, people with a lived experience of suicide and/or mental health issues, education, media, local Councils, business and community groups.

3.1. Roles and responsibilities of members

By joining the Collaborative, all members commit to:

- work collaboratively with other agencies and individuals towards the common goals outlined in the *Statement of Purpose*;
- actively contribute to a range of evidence-informed suicide prevention activities;

- learn from others and share their own information when relevant;
- prioritise the interests of the community ahead of personal or organisational interests; and
- act as advocates for the Collaborative and its outcomes.

It is the responsibility of all Collaborative members to ensure their networks are suitably informed of the Collaborative's activities and, where members are representing an organisation, report back to senior management within their organisation.

3.2. Organisational representatives

Members representing an organisation should hold appropriately senior positions so as to actively contribute to decisions made without needing to confer with other management or executive staff. Collaborative members who are representing an organisation or service should remain constant as much as possible. In the event that the usual representative cannot attend a Collaborative event or meeting, the organisation should send a suitable alternative representative.

3.3. Executive members

The executive members are responsible for the oversight and progress of the Collaborative and are required to provide additional contributions to the progress of activities. Executive membership is based on the skills, knowledge and experience of the individual person and the nature of the organisation or community group they represent.

The executive members include representatives from the following sectors:
- Public health (i.e. Illawarra Shoalhaven Local Health District)
- Primary health (i.e. COORDINARE – South Eastern NSW Primary Health Network)
- Lived Experience of suicide and/or mental health issues
- Academia/Research
- Illawarra-based non-Government service provider
- Shoalhaven-based non-Government service provider
- Aboriginal person working within (or with strong links to) Aboriginal Community Controlled Organisations

When an executive role is vacant, an expression of interest process is to be undertaken and all Collaborative members are invited to vote on the most suitable nominee. Should a person in such a role leave their organisation, the executive role is to be filled via a new expression of interest process open to all relevant organisations (unless there is no alternative organisation to represent that sector, e.g. public health representative can only be fulfilled by the Illawarra Shoalhaven Local Health District).

Executive members are responsible for ensuring there is a Chair for the monthly Collaborative meetings.

3.4. Becoming a member

Organisations or individuals wanting to become a member of the Collaborative should email their expression of interest to the Regional Manager (ahains@coordinare.org.au). Expressions of interest should outline what the applicant will contribute to the Collaborative and describe how their actions have aligned with the principles of the systems approach to suicide prevention. Applications received will be presented to the Collaborative with the outcome decided by majority vote. The applicant will be advised of the outcome and required to co-sign the Collaborative's *Statement of Purpose* to indicate their commitment to actively support the activities of the Collaborative.

3.5. 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;
- act in a way that is considered inconsistent with the principles of the Collaborative or counter to what the Collaborative is working to achieve; or
- their organisation fails to deliver on their obligations, as determined by the executive via discussion at the regular executive meetings.

The executive are responsible for advising a member should it be decided that their membership be ceased.

3.6. 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 majority vote. When a majority cannot be established amongst the Collaborative members, the executive will make a decision on behalf of the Collaborative.

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.

Executive members may submit a vote when reaching decisions, but those employed by the Collaborative cannot vote.

From time to time, members may wish to invite other colleagues from their organisation or community group to attend a meeting. The same conditions of membership apply to these additional representatives, even when they only attend one meeting. However, it should be noted that, when decisions are made, these additional representatives do not necessarily have an additional vote. Only one vote per member organisation or community group will be counted.

4.2. Conflict resolution and disputes

In the event of a dispute or perceived conflict, members should follow the process outlined below:

- Members should attempt to address the dispute or conflict directly with the other member outside of the Collaborative meetings.
- If the above does not resolve the dispute satisfactorily, members should approach the executive for support to resolve the dispute.

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, there may be situations where their own personal or organisational interests conflict with the interests of the Collaborative. This would be considered a conflict of interest.

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 either within the meeting prior to a vote being cast or directly with an executive member prior to the meeting. In this instance, the above steps will again be followed and similarly be noted in the minutes.

4.4. Frequency and duration of meetings

The Collaborative will meet every month for approximately 1-2 hours. A review of these arrangements will be conducted every six months.

All members commit to regularly attending the monthly meeting. However, when attendance is not possible and a suitable alternate representative also cannot attend, members are required to send their apologies to the Regional Manager (ahains@coordinare.org.au) prior to the meeting.

4.5. Quorum

At least two (2) executive members and a further eight (8) members of the Collaborative must be present for a quorum. Refer to Section 4.1 with regards to decision making.

4.6. Absentee voting

Members who are not able to attend a meeting are still able to vote by sending an alternative representative from their organisation or community group to vote on their behalf. They should advise the executive prior to the meeting.

These alternative representatives should be employed by the same organisation (or participate in the same community group, e.g. Suicide Prevention Awareness Network) as the member for whom they are representing.

4.7. Chair arrangements

Responsibility for facilitation of the Collaborative meetings will be the shared responsibility of the executive members. The Chair is responsible for ensuring the meeting run on time, that discussions are productive, and that outcomes or further action required are clarified.

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

The executive is also responsible for distributing the minutes from Collaborative meetings.

5. Communication

The meeting agenda will be prepared and distributed by the executive members (or representative organisation) in the week prior to the scheduled meeting. Any additions or changes to the agenda must be submitted via email to the Regional Manager (ahains@coordinare.org.au) 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 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.

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.

5.1. Media

Communications regarding Collaborative activities should be directed to Kristine Laird (Communications Manager, COORDINARE).

Members are not to speak publically on behalf of the Collaborative without prior approval. Members must ensure all communications that identify them as a member of the Collaborative align with the principles of the Collaborative and are supportive of its activities.

5.2. 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 have 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.

6. 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.

The Way Back Support Service

Take Action after a Suicide Attempt

A New Suicide Prevention Model

The Way Back Support Service draws on evidence of 'what works' to prevent suicide, targeting one of the most at-risk population groups – those who have attempted suicide - and improving continuity of care in the days, weeks or months after a suicide attempt.

The service is delivered to people who have been admitted to a hospital following a suicide attempt. Partnering hospitals assess and refer people to the Service. Support Coordinators then contact the person within 24 hours, and work with them to develop a safety plan. The plan includes setting goals tailored to the individual which encourages them to re-engage safely in everyday life. It also reduces barriers to accessing follow-up care, such as assisting with transport, and tracks appointments with health and other social support services.

The Support Coordinators keep in touch with people regularly, either face to face, by phone and/or email. Support levels vary, based on individual client needs – from a one-off contact providing essential information, to multiple communications over several months. This support helps people to manage the most critical, at-risk time for suicide: three months following their suicide attempt.

If suicidal behaviour escalates, Support Coordinators facilitate access to Crisis Assessment Teams, emergency departments and/or admission to mental health inpatient units. By using a stepped-care model, the Service reduces the reliance on hospital and emergency-based care, freeing up resources and ensuring that problems are managed before they reach crisis point.

The model also includes an auxiliary service component aimed at the support networks of individuals at risk of repeated suicide attempt. The Guiding Their Way Back Support Groups deliver face-to-face support and information to the families, friends and other supporters of people participating in The Way Back Support Service, to help them to better understand the experiences of their loved one and provide ongoing care and support in their recovery.

Trialling the Model: The Way Back Support Service, New South Wales

The Way Back Support Service is currently being trialled in Newcastle, NSW. A consortium of five agencies are collaborating in its delivery: Hunter Primary Care, Calvary Mater Newcastle, Hunter New England Local Health District, Hunter Institute of Mental Health and Relationships Australia.

Core responsibilities are as follows:

Hunter Primary Care Limited

- Lead consortium member and Service Provider for the Project and engages Service/Management Team

Calvary Mater Newcastle, Department of Clinical Toxicology

- Referrers to the Service for patients admitted to hospital or presenting to the Emergency Department, and provide expertise in clinical toxicology
- Facilitate access to patient data for evaluation studies

Calvary Mater Newcastle, Department of Consultation-Liaison Psychiatry

- Referrers to the Service, and provide expertise in Consultation-Liaison Psychiatry and in area of suicide prevention and intervention

Hunter New England Local Health District

- Referrers to the Service from hospital Mental Health Services, and provide expertise in acute mental health services
- Liaise with Community Mental Health Teams about the Project

Hunter Institute of Mental Health

- Develop the family/carer support group concept and provide Project staff orientation training

Relationships Australia NSW

- Deliver The Guiding Their Way Back Support Groups for family, friends and carers who have experienced a suicide attempt by someone close to them

Duration of the Trial

The Way Back NSW project began in January 2016 and is scheduled to end in March 2018.

Evaluating Service Effectiveness

A suite of evaluation studies to investigate the effectiveness of the Service is currently being developed. The primary outcomes being measured are:

- Reduced rates of repeated suicide attempts
- Sustained client engagement with the Service and reduced client distress levels
- Cost effectiveness of the Service

The exact research methodology of the evaluation has yet to be confirmed but tentative research components include:

A process and summative evaluation using service and patient level data to examine who is using the Support Service, the types of services and supports they are receiving and changes over time in patients' needs and levels of psychological distress.

Service level data include patterns of service activity, and will measure:

- Number of service users;
- Number, type and location of services provided by Support Coordinators;
- Referrals made to other services and their uptake.

Patient level data include pre- and post-intervention changes in client outcomes for those clients who access higher intensity support coordination services. This will include assessing changes in psychological distress and proportion of met versus unmet needs and clients' concern ratings relating to unmet need.

- The Kessler 10 (K10) will be used to measure psychological distress.

Changes in pre-post scores on these measures will be combined with service use information to examine if the pattern of service use or mode of service influences any changes in the key impact measures among service users.

An effectiveness evaluation will investigate whether rates of re-presentation and admission to Calvary Mater Newcastle for deliberate self-poisoning, within 12 months of discharge, changed after the introduction of the Support Service compared to historical controls. Measures are, specifically:

- Proportion and total number of general hospital re-presentations and/ or readmissions for an episode of hospital treated deliberate self-poisoning occurring within 12 months of discharge from hospital for the index episode;
- The length of stay for any general hospital readmissions for an episode of hospital treated deliberate self-poisoning within 12 months of discharge from hospital for the index episode;
- Any psychiatric hospital presentations and/ or admissions for any reason within 12 months of discharge from hospital for the index episode; and
- The length of stay for any psychiatric hospital admissions for any reason within 12 months of discharge from hospital for the index episode.

Lastly, an economic evaluation will:

- estimate the economic costs and benefits of the Support Service; and

- establish the cost-effectiveness of the Support Service.

Aligning Approaches to Suicide Prevention

The Black Dog Institute has referenced The Way Back as aligning directly with the 'After-care and crisis care' component of the LifeSpan Systems approach to suicide prevention. The scope of the Service is provided by the following:

- It is offered to people who have attempted suicide[1] - one of the most significant risk factors for suicide, and the primary intake criterion for the trial. A secondary intake criterion, suicidal crisis[2], is being applied in other sites where capacity permits;
- It is provided for up to three months immediately following a suicide attempt, the period of highest risk;
- It is focussed on empowering people to connect with informal and formal supports following a suicide attempt by providing assertive and non-clinical guidance, encouragement, motivation and follow-up;
- It provides continuity of care by acting as a conduit between primary points of contact following a suicide attempt to community based supports and services that are able to address the issues contributing to a person's distress.

Further, The Way Back service model aligns with the Systems Approach in that:

- *It is multisectorial.* The Way Back is a collaborative initiative, with government, non-government, health, research and community agencies liaising closely to develop, deliver, oversee, and evaluate the Service.
- *It is localised.* The Service operates in the client's local community. The Service is based on rigorous assessment of individual client needs and circumstances, and accordingly supports clients to access services to redress client-specific issues and concerns.
- *It offers a sustainable approach to crisis care and suicide prevention.* The Service implements a stepped-care model that ensures that people who need higher levels of care are 'stepped-up' to specialised services as needed. This model is more effective, sustainable and efficient, as it reduces the reliance on expensive, acute hospital-based care and emergency services.
- In addition, people with Lived Experience with attempted suicide attempt are engaged throughout the Project via consultations with a Community Reference Group sub-committee including representatives from high risk groups such as Aboriginal and Torres Strait Islander people, LGBT, other people of diverse sexualities and gender identities, men, and family/carers/friends of people who have attempted suicide, and others.

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[1] A suicide attempt is defined as: "A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury". Centers for Disease Control: http://www.cdc.gov/violenceprevention/suicide/definitions.html

[2] A suicidal crisis is defined as: "Distressed, having suicidal thoughts and articulating an intent to die and who in the absence of assertive follow-up to assist them and engage with other community based services/agencies would be vulnerable to their risk of suicide potentially increasing".

Piloting the Service: The Way Back Support Service, Northern Territory

A pilot service was initially trialled in the Northern Territory from June 2014 through December 2016. This pilot provided *beyondblue* with a wealth of learnings which have allowed the model to be further refined and tested in the current NSW trial site.

In the pilot trial in NT, there were:

- 122 referrals, with 87 people successfully engaged in the service - a 71% conversion rate
- 60% of clients were women and 40% were men
- 78% were under 45 years of age
- 14% identified as Aboriginal and/or Torres Strait Islander
- 74% of clients received services for a period of 1 months or more.

Results and feedback

Feedback was positive and showed that the trial met a real need. Clients indicated that the Support Service was extremely important and had helped them after their suicide attempt or their suicidal crisis, citing improvements in social and emotional wellbeing. To date, of the people engaged, no-one has died by suicide. Anecdotal evidence also indicated that the trial has reduced attendances at Royal Darwin Hospital for repeat suicide attempts.

Stakeholder held highly skilled Support Coordinators to be integral to the Project's success. Partnering agencies reported that having highly experienced Support Coordinators proved essential for risk mitigation, and clients reported that the Coordinators had contributed strongly to a perceived reduction in stigma.

Learnings

The pilot provided highly useful learnings for subsequent iterations of the trial service primarily with respect to data collection. Developing a range of more varied and nuanced data measures will greatly improve the prospects of obtaining the necessary data to adequately gauge the success of the Project:

- Standardising clinician data collection practices within hospitals regarding suicide attempt will yield more robust data on suicidal behaviour
- Ensuring a sufficient degree of client participation in service evaluation will facilitate more robust quantitative analyses, as statistically significant results are required for scientific validity and thus a sound evidence base to support the service model
- Embedding measurement tools for gauging client distress levels naturally into client interactions as a standard case work process will yield greater measures of service impact on client wellbeing.

A Promising Service Model

The Northern Territory pilot test demonstrated positive indications of the viability and efficacy of the service model in preventing suicide:

- The Way Back Support Service offers a service model with high potential. The pilot showed that it was feasible to expand the service to additional sites.
- Further trials and testing should yield strong evidence of the utility of the service model in reducing suicide.
- Testing the Service in other jurisdictions should be undertaken to test model adaption in the face of increasing activities or referrals.
- Risk was well managed. Manuals and materials developed for the NT pilot are applicable to other services who may also trial or implement this model.

Looking Forward

Limitations and nuances of the NT pilot trial were recognised early and have informed the development and implementation of the second trial site in NSW. The NSW trial site will test the service model in a densely populated metropolitan area with a complex service system. Learnings from the NT pilot have also informed development of evaluation studies proposed for the site, with more extensive data measures being tabled.

Due to the recognised successes of the initial NT trial, the Way Back Support Service has entered a Second Phase in the NT. Another trial site, in the ACT, has also been contracted to deliver the Service. Both sites are scheduled to commence client intake in the near future. These are liable to yield further insights on the nuances of service implementation and monitoring.

The participation of other sites can only strengthen the service model. Continued trialling and testing of the model across varied local contexts will provide a conclusive evidence base for the efficacy of The Way Back service model in reducing suicidal behaviour. The Way Back Support Service is set to contribute strongly to best practices in suicide prevention at the national level.

3303.0 - Causes of Death, Australia, 2015 Quality Declaration

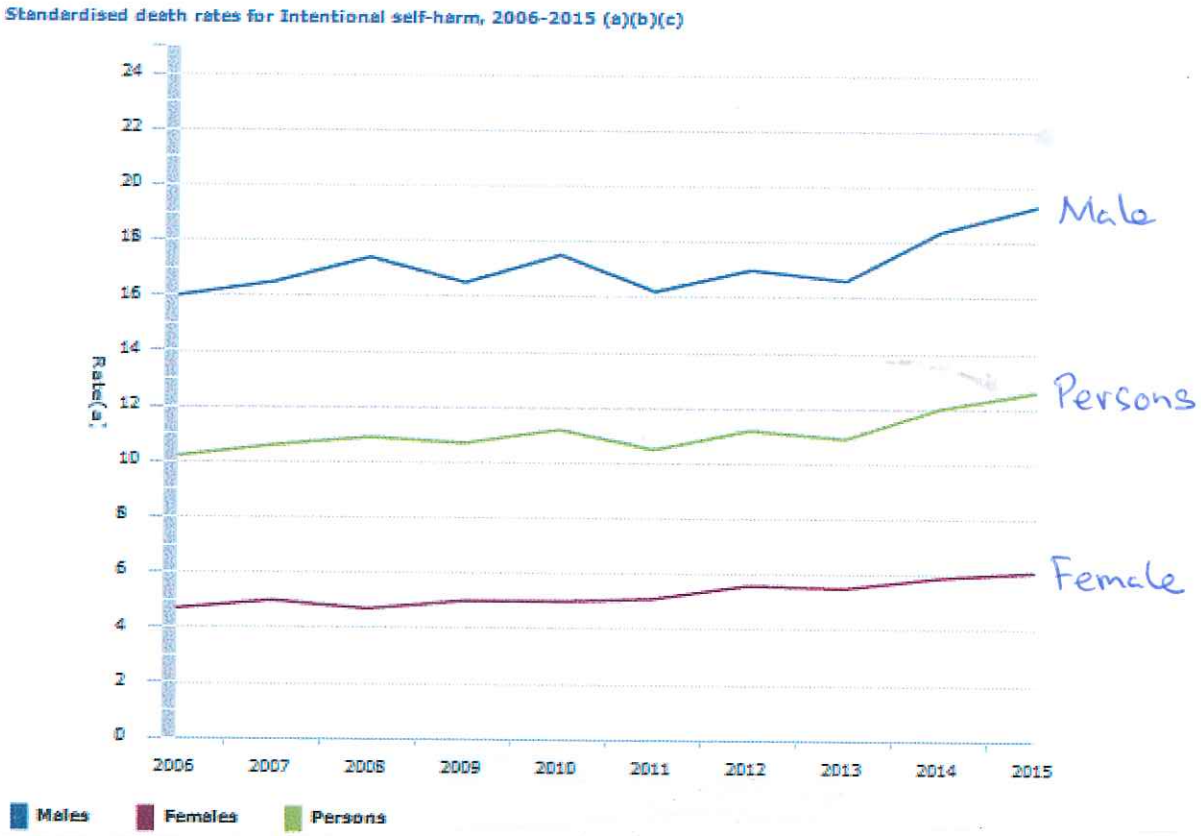
Latest ISSUE Released at 11:30 AM (CANBERRA TIME) 28/09/2016

SUICIDE IN AUSTRALIA

2014 = 2,864

In 2015, 3,027 people died from intentional self-harm (X60-X84, Y87.0) in Australia. To understand how the number of deaths due to suicide has changed in Australia over time, standardised death rates are used, as they enable the comparison of death rates between populations with different age structures. In 2015, the standardised death rate was 12.6 deaths per 100,000 people (see graph below). This compares with a rate of 10.2 suicide deaths per 100,000 persons in 2006. The ranking of suicide as a leading cause of death has also changed over time; it is now the 13th leading cause of death in Australia, compared to the 14th leading cause in 2006.

Deaths from intentional self-harm occur among males at a rate three times greater than that for females. In 2015, the standardised death rate for males was 19.3 deaths per 100,000 people, while for females it was 6.1 deaths per 100,000 people.

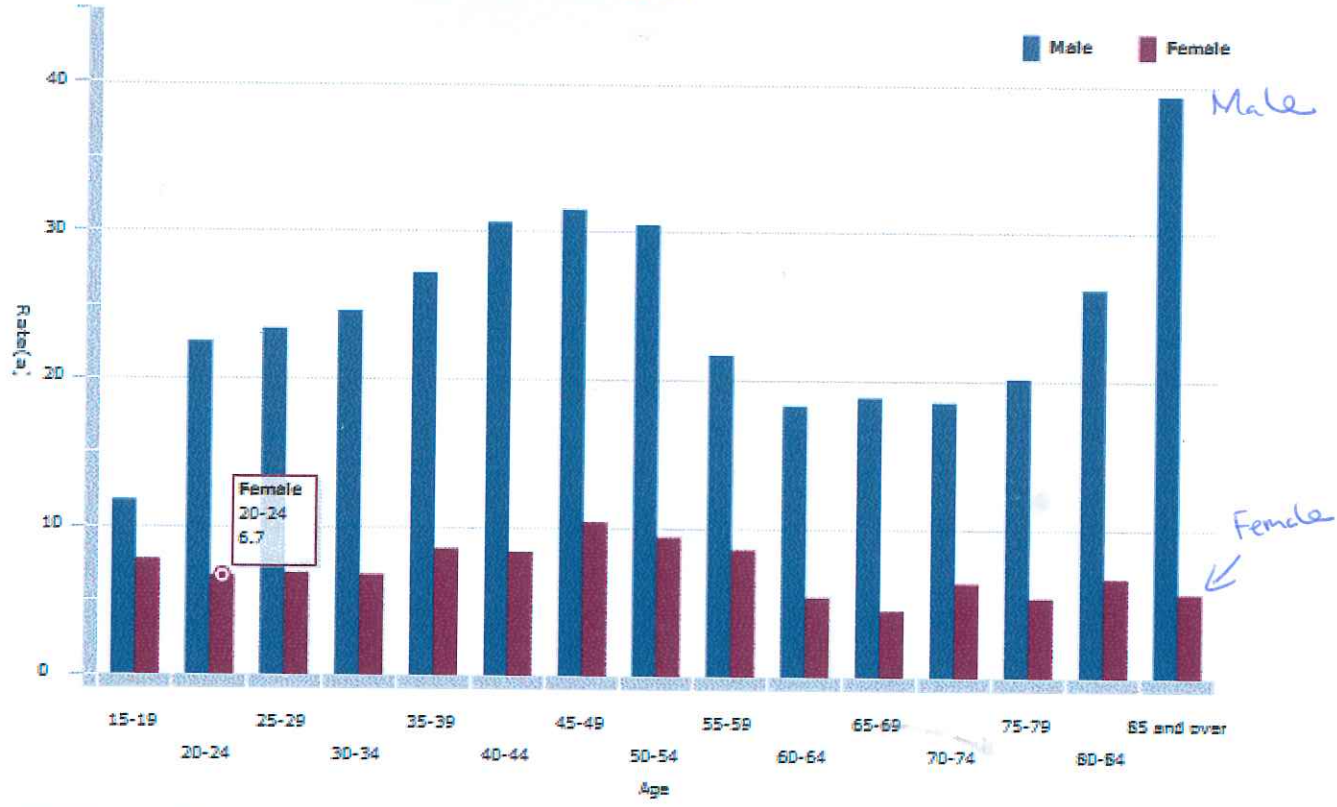


3.1 STANDARDISED DEATH RATES FOR SUICIDE, State/territory of usual residence, 2006-2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)	Rate(c)
NSW	8.4	8.9	8.8	8.7	9.3	8.4	9.8	9.4	10.3	10.6
Vic	9.4	9.0	10.2	10.5	10.1	9.2	9.0	8.7	10.8	10.8
Qld	12.3	12.7	13.2	12.1	13.4	12.9	13.9	14.4	13.7	15.7
SA	11.4	12.8	11.0	11.5	11.8	12.9	11.7	11.6	14.2	13.4
WA	11.9	12.5	13.8	12.3	13.6	12.9	14.9	13.2	14.4	15.0
Tas.	14.6	13.5	15.0	15.4	13.0	14.1	13.7	13.8	12.7	16.3
NT	15.2	29.8	17.5	17.4	18.8	18.5	19.2	14.3	20.8	21.0
ACT	9.4	9.5	10.1	8.9	11.3	9.3	6.2	9.6	9.8	11.6
Australia	**10.2**	**10.6**	**10.9**	**10.7**	**11.2**	**10.5**	**11.2**	**10.9**	**12.0**	**12.6**

2

Age-specific death rates for Intentional self-harm, by sex, 2015 (a)(b)(c)



Leading causes of death & Years of Potential Life Lost, 2015 (a)(b)(c)(d)