Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2016-2018:

National Suicide Prevention Trial - Midwest (WA)

Country WA PHN

Approved to publish 22/12/17

NATIONAL SUICIDE PREVENTION TRIAL – Midwest (WA)
Work plan covering activities up to June 2018

This work plan focuses on trial activities up until 30 June 2018 as follows:

- **Planning and development activities beginning in 2016-17**
- **Identification of service areas and target populations**
- **Activities to be undertaken in 2017-18, including implementation in all focus areas**
- **Indicative timelines and expenditure.**

All sites participating in the National Suicide Prevention Trial are required to:

- Promote the development and trialling of strategies in communities with higher risk of suicide due to economic hardship or other circumstances.
- Focus on activities at a local level.
- Develop a systems-based approach to the delivery of suicide prevention services.
- Provide enhanced services for people who have attempted or are considered at higher risk of suicide, which builds upon base activities being undertaken by Primary Health Networks where appropriate.
- Trial strategies for preventing suicide attempts and deaths among one or more of four high risk populations:
  - Aboriginal and Torres Strait Islander peoples
  - Men, particularly in the very high-risk age range of 25 to 54 years
  - Young people
  - Veterans.
- Gather evidence and participate in a comprehensive evaluation of their activity.

Work plans are to identify all major activities relating to these objectives that have been undertaken or are planned in the period covered by the work plan, irrespective of whether these were for part of the year only or they will continue beyond the period.

It is acknowledged that sites are at different points in planning and implementation, and may adapt or change activities as the trial progresses, including in response to further consultations and/or to better meet local needs.
Should there be substantive change in the focus or type of activities identified in the work plan, the Department is to be advised in writing and the changes reflected in the next performance report.

All work plans are to be assessed to ensure that activities are in line with the parameters of the National Suicide Prevention Trial as specified in the *National Suicide Prevention Trial: Background and overview.*

PLANNING AND DEVELOPMENT	INFORMATION REQUIRED
Summary of main activities	The Midwest National Suicide Prevention Trial will be trialling the implementation of the Alliance Against Depression (AAD) framework for WA Primary Health Alliance (WAPHA) to work in partnership with communities to co-ordinate and integrate approaches to the prevention of suicide and the treatment of depression. The implementation will be aligned with the 'Success Factors' findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Report. The AAD strategy comprises a four-part community-based intervention including; co-operation with general practitioners from primary care and specialised mental health professionals, public relation activities destigmatising depression and talking about suicide, co-operation with community facilitators and stakeholders, and, support for high-risk patients and their relatives. The initial analysis suggests that the local populations of the following towns in the Midwest will be: • Gascoyne region – working with CMSAC with a focus on Aboriginal people • Murchison region – working with GRAMS with a focus on Aboriginal people • Geraldton – with a focus on farmers and fishermen • Morawa – with a focus on farmers and fishermen Following the methods of AAD Framework, extensive stakeholder engagement and partnerships will be key features of the trial. The trial will involve the formation of a network of cooperation partners, community members and stakeholders to work as local advisory committees/reference groups to the project. This community reference working groups (CRWGs), known as the Midwest Alliance is to provide: • Advice on the planning phase of the project (defining and developing comprehensive community action plans); • Instruction on activities to be commissioned; and • Data to formulate a baseline report on activities to be evaluated against over the life of the project. This Midwest trial commenced in May 2017. The main activities to date have been preparatory in nature, and have included: • Mapping services in the trial site region (Midwest) that prevent suicide and influence mental health and well-being

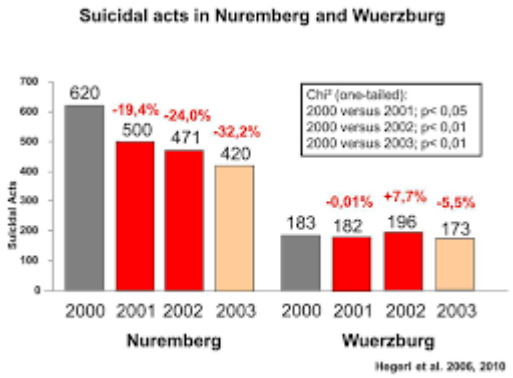
	• Mapping service supply in relation to population health needs, especially services for those who are disadvantaged or vulnerable, including Aboriginal and Torres Strait Islander people • Liaison with data analytics personnel and external health, justice and coronial data stakeholders to understand patterns of suicide and self-harm risk (demand) • Consultation with local communities to provide contextual analysis • The preparation of key findings for the region, to inform this workplan, premised on the findings and evidence based approaches to suicide prevention, particularly the Alliance Against Depression • Liaison with Midwest WA Country Health Service (WACHS) for a collaborative approach, with respect to WACHS' suicide prevention coordination in the Midwest • Liaison with the Mental Health Commission of WA, with respect to this State Government's commissioning of suicide prevention projects and suicide prevention coordination in the Midwest region.
Systems-based approach	The AAD is a multilevel approach to the prevention of suicidal behavior developed and evaluated in the region of Nuremberg, Germany (The Nuremberg Alliance Against Depression) which resulted in a reduction of suicidal acts (-24% in two years) by implementing the four-part approach. Formed as the European Alliance Against Depression (EAAD), this strategy comprises a four-part community-based intervention including: co-operation with general practitioners from primary care and specialised mental health professionals, public relation activities destigmatising depression and talking about suicide, co-operation with community facilitators and stakeholders, and, support for high-risk patients and their relatives. 

	Fig. 1: Suicidal acts in Nuremberg compared to Wuerzburg[1] The Midwest trail site will give full consideration to the recommendations identified in the ATSISPEP (Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project) Report within the trial. Factors contributing to suicidality are complex, interrelated and different for each suicidal act. Gusmão et al[2] found, the best predictor for reduction in suicide rates in 29 European countries through implementation of the European Alliance Against Depression (AAD) was not unemployment, gross domestic product (GDP) or alcohol consumption, but a change in antidepressant prescription rates. The Alliance places a focus on the treatment of depression and suicidality simultaneously across the 4 different intervention levels. This has been found to have generalising positive effects (in particular destigmatisation) for other mental health issues including anxiety. Rutter et al[3] suggest most evidence to date regarding prevention strategies has largely been developed to answer specifics around the effectivenss of inidividual clincial interventions. These approaches are grounded in a linear, cause and effect model which effectively restricts a wider focus on the complexity of the system as a whole. Furthermore previous interventions and frameworks have focussed too heavily on 'fixing a problem through a particular intervention, rather than asking how to contribute to reshaping the system in favourable ways'. 'The development of robust tools, by use of a broad, multidisciplinary suite of methods for both intervention research and evidence synthesis, is needed to support effective policy responses' (Rutter et al, 2017, p.2).[4] In this light, the Alliance provides the opportunity to trial activities that are 'place-based' in nature and context yet are integrated to the broader system approach to reducing suicidality. The strength of The Alliance framework

[1] Hegerl U, Wittmann M, Arensman E, Van Audenhove C, Bouleau JH, Van Der Feltz-Cornelis C, Gusmão R, Kopp M, Löhr C, Maxwell M, Meise U, Mirjanic M, Oskarsson H, Sola VP, Pull C, Pycha R, Ricka R, Tuulari J, Värnik A, Pfeiffer-Gerschel T. Antidepressant Utilization and Suicide in Europe: An Ecological Multi-National Study. 2008; 9(1):51-58.

[2] Gusmão R, Quintão S, McDaid D, Arensman E, Van Audenhove C, Coffey C, Värnik A, Värnik P, Coyne J, Hegerl U. The 'European Alliance Against Depression (EAAD)': a multifaceted, community-based action programme against depression and suicidality. PLOS ONE. June 2013; 8 (6):1-15. Accessed from https://doi.org/10.1371/journal.pone.0066455.

[3] Rutter H, Chira M, Savona N, Glonti K, Bibby J, Cummins S, Finegood D, Greaves F, Harper L, Hawe P, Moore L, Petticrew M, Rehfuess E, Shiell A, Thomas J, White M. The need for a complex systems model of evidence for public health. The Lancet. June 2017.

[4] Rutter H, Chira M, Savona N, Glonti K, Bibby J, Cummins S, Finegood D, Greaves F, Harper L, Hawe P, Moore L, Petticrew M, Rehfuess E, Shiell A, Thomas J, White M. The need for a complex systems model of evidence for public health. The Lancet. June 2017.

	focuses on collective interventions contextualised to community; with the integration of the four elements through a coordinated approach. Intervention activities will be co-designed by the local Alliance and linked to each component of the Alliance framework. This is a critical element to effectively reducing suicide. Many recent multi-level programmes have failed to link the 'strategy' being implemented to the needs and requirements of the community. Often the focus of these strategies is only on one or two priority areas and fails to adequately address the whole system. The strength of the Alliance requires 'integration' between all four elements through the role of a coordinator within community. As mentioned above, the Midwest trial will have a focus on implementation of The Alliance framework, providing a synergistic contextualised and system approach focus to reduced suicidality. The Alliance provides the macro framework and guiding principles for WAPHA to work in partnership with communities to coordinate and integrate approaches to the prevention of suicide and treatment of depression. Operationalising the strategies will consider recommendations from reports such as the ATSISPEP Report, *Solutions that Work: What the Evidence and Our People Tell Us.* The strength of this approach is the design and implementation of a collective intervention formed by and grounded in local community needs and aspirations, with an integration of the four Alliance intervention levels through a coordinated approach. Strong synergistic effects can be expected from taking such a cooperative and comprehensive system based-approach. A better-informed public, being consulted by more qualified and equipped GPs alongside accessible and well-equipped community services can form a synergistic and effective alliance against depression and suicide. Informing the work plan and project plan will be recommendations from the Midwest community action plans. These localised community action plans are a legacy of the WA Suicide Prevention Strategy, 2009-2013[5] and therefore provide a foundation for the trial. These plans will be revised based on current needs of community, political and financial climate. Findings from previous Alliances include: • Improved attitudes and knowledge about depression in the general public which produced synergistic effects; in particular when the dissemination of awareness campaign materials was simultaneously reinforced by other intervention levels of the multi-level intervention programme

[5] Department of Health. Western Australian Suicide Prevention Strategy 2009 – 2013. 2009. http://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3911639c69927819f990b3cb48257d03002045f8/$file/tp-1639.pdf

	• Targeting both suicidal behaviour and depression works • Intervention concept with focus on general practitioners alone does not meet local needs and professional structures in all contexts • Clinical psychologists, General Practitioners and other mental health staff can and should equally be incorporated in suicide prevention interventions • Raising awareness can intensify the problem for depressed people who are trying to get access to specialised and evidence based care, therefore further support and reform is required in place To achieve a reduction in suicide, all elements of The Alliance need to be in place and integrated for example, where only two or three areas had been addressed, there has not been a significant reduction in suicide. Failure has also occurred when some other suicide prevention programmes have failed to link the strategy being implemented to the needs and requirements of the community.

Key partners; community engagement	**European Alliance Against Depression (EAAD)** Membership to the European Alliance Against Depression (EAAD) – WAPHA has become the National Chapter of EAAD within Australia. Perth South PHN to be the first site to trial the Nuremberg model in Australia. Membership has been granted to WAPHA by the Board of Directors of EAAD on 17th Jan 2017. **WA Primary Health Alliance** WAPHA will be the Coordinating organisation of the Western Australian Alliance Against Depression & Suicide. Regional Alliances will be established in line with funding of suicide prevention trial sites: • Rockingham Kwinana Peel Alliance • Midwest Alliance • Kimberley Suicide Prevention Working Group. **Key WA Partners** • **Mental Health Commission WA**: Mental Health Commission (MHC) and WAPHA together form a conduit for a whole systems approach to suicide prevention using an evidence based systems model. The Commission and WAPHA have formed an agreement of understanding supporting the implementation of the AAD. The MHC has a State suicide prevention strategy, under which they have commissioned Suicide Prevention Coordinators for each WA health region. This position in the Midwest, which commenced in May 2017 and is employed by the WA Country Health Service (WACHS), is a critical player in the suicide prevention arena in the region. In the Midwest, the Suicide Prevention Coordinator role is referred to as the Mental Health Promotion Coordinator. • **Community reference working groups (CRWGs)**, known as the Midwest Alliance – the CRWG will form the community based network for this activity. • **Other partners** - Other partners of the Alliance will include a broad range of health, social service, education and justice stakeholders, and lived experience groups and other grass roots groups, including but not limited to: - Consumers/community groups - GPs - WA Country Health Service (WACHS) - GRAMS - CMSAC - Justice - Community and mental health NGO providers

	- Department of Communities - Department of the Prime Minister & Cabinet - Local government authorities - Community Aboriginal Reference Groups - Schools.
Community engagement	To date the Midwest Suicide Prevention Trial Project Coordinator has commenced consultations with existing community service reference groups and Aboriginal groups in all of the main towns in the Midwest including Geraldton Suicide Prevention Action Group. The next phase of the work will include the establishment of CRWG for suicide prevention (as adjunct to existing groups or as stand-alone groups, as determined locally). Following on from this, the review of community (suicide prevention) action plans (CAPS) will commence for the following: the Gascoyne and Murchison regions, Geraldton and Morawa. WA Country Health (State) Suicide Prevention staff have been engaged as part of the planning process and the Project Coordinator is also engaging with surrounding towns. Communities in the Midwest will have the opportunity to be informed and to be involved, and a comprehensive community engagement (CE) strategy will be developed to ensure initiatives are embedded within and supported by communities rather than being imposed. CRWG are going to be one component of the CE strategy. Local communities in the Midwest will have the opportunity to contribute. A comprehensive community engagement strategy has been designed in accordance with the International Principles for Public Participation (IAP2) and will be implemented to ensure initiatives are grounded within and supported by communities rather than being imposed. **Community Champion** The AAD framework suggests it is important to identify a local person, preferably someone with influence and status within the community, to drive Alliance activity and coordination. The Midwest trial will work to identify, resource and build capacity within a 'community champion' for each trial area, or as is known in the Alliance framework - Local Coordinators.
Input from people with lived experience	The community engagement framework mentioned above will include a range of opportunities for input from people with lived experience, feedback to services and co-design and production. WAPHA has engaged Roses in the Ocean to provide expertise around utilisation of a lived experience framework for residents within the Perth South PHN's trial site community and this is also an option for the Midwest. Further work

	with people with lived experience will be developed depending on the community's readiness. Options include utilisation of the Black Dog Lived Experience Framework, and the Consumers of Mental Health WA's position on the value of peer support in suicide prevention.
State/Territory engagement	WAPHA is committed to developing a robust and integrated primary mental health care system providing equity of access to care for patients with mental health issues. WAPHA has commenced the process of aligning The Alliance Against Depression framework with current State, Commonwealth and community-based policies and programmes including: • ***WAPHA Mental Health and Suicide Prevention Regional Plan.*** WAPHA is committed to aligning all commissioning and reform activities undertaken to the AAD framework and Mental Health and Suicide Prevention Regional Plan. • ***Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report (ATSISPEP).*** Indigenous suicide rates in Australia are a cause great suffering in communities and families. Suicide has emerged in the past half century as a major cause of Indigenous premature mortality and is a contributor to the overall Indigenous health and life expectancy gap. WAPHA is working closely with Aboriginal and Torres Strait Islander people to ensure that the AAD is adapted in Australia with a full consideration of the findings of the ATSISPEP, and with ways for genuine engagement with communities, and in a way, that allows for a co-creation of culturally right solutions. As an international network for change, the AAD also has information and resources about effective strategies carried out in other Indigenous communities to prevent suicide, such as those in Canada, which Australian Indigenous communities can also draw from - in their partnerships with primary health, in the implementation of an alliance against depression (for suicide prevention) approach, such as the AAD, in a way that would be full consideration to the 'success factors' findings of the ATSISPEP Report, *Solutions that Work: What the Evidence and Our People Tell Us*[6].

[6] Dudgeon P, Milroy J, Calma T, Luxford Y, Ring I, Walker R, Cox A, Georgatos G, and Holland C. Solutions That Work: What The Evidence And Our People Tell Us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report (ATSISPEP). http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

	• ***Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services***. The EAAD model provides communities with the framework and tools to achieve integration. The aim being to reduce current fragmentation, inefficiency, duplication and lack of coordinated planning within the mental health system. • ***Mental Health 2020: Making it personal and everybody's business.*** The following policy and practice principles of this WA mental health policy are consistent with the fundamental principles of the AAD model: - A system that is person centred supports people with mental health problems and/or mental illness to increase choice, flexibility and control of the services they receive. More emphasis will be placed on the important role of family, carers and friends in supporting people. - Better connections between; public and private mental health services, the range of formal and informal supports, services, and community organisations will help ensure better support for people. - A more balanced and equitable investment across the mental health system providing a full range of support and services from promotion, prevention and early intervention to treatment and recovery. ***Suicide Prevention 2020: Together we can save lives.*** This policy framework of the WA government is also consistent with the AAD model, as it also has a focus on: greater public awareness, united action across the community, coordinated and targeted responses for high risk groups, increased suicide prevention training and improved service responses.
Local Government involvement	The local community action plans for suicide prevention will involve local government stakeholders. The AAD framework provides extensive analysis and information on civic engagement throughout the trial. A focus of this stakeholder relationship is on building collaboration and involvement as an Alliance partner.
Primary care involvement	The primary care sector, particularly GPs, will be a key component of the systems approach to be implemented in the Midwest. The community action plans in each area including locally tailored strategies for engagement with primary health services in the treatment of depression, and service provision in the realms of suicide prevention, intervention and postvention. The Midwest trial is starting to proactively seek engagement with local GPs, and will continue to do this to: • Investigate the capacity of GPs to be involved in the CRWG, and suicide prevention and postvention strategies • Find GPs who would like to further identify and engage with patients suffering depression, and/or at risk of suicide within their practice • Identify practices with the capacity for practice nurses • Explore options for data gathering amongst practices

	• Provide opportunities for training: training videos, specific depression and suicide prevention content • enhancing Mental health care skills, better facilitating pathways • Link GP practices up with public awareness campaigns.
Other	N/A

IMPLEMENTATION	INFORMATION REQUIRED
Summary of main trial activities and approach	The following will underpin trial activities under four categories within the AAD framework. **1. Primary care and mental health care** • Cooperation with primary and mental health care, focussing on training for general practitioners to identify and treat depression. • The aim is to improve the identification and treatment of depressed and suicidal persons. This is achieved through forming connections with primary care physicians in the local community and by offering advanced training to improve the quality of treatment to be provided. • Consultation with GPs (face to face) to: - Explore GPs' current practice perceived skills, attitudes and confidence plus their perceived needs (e.g. tools, training, reminders) regarding assessing suicide/self-harm risk in young people - Challenges faced - Knowledge and use of assessment measures - Barriers to care - Perceived needs in terms of education and training.

	2. Public awareness campaign • A broad media campaign will be undertaken to educate the public through a coordinated depression awareness campaign, de-stigmatising depression and challenging commonly held misconceptions around suicidality. This has commenced with a media release and follow up activity with local print and radio media. • These campaigns will be informed by community engagement, regionally based and tailored to meet the need of the community and target groups within the trial region. **3. High risk groups and relatives** • Training for stakeholders who are engaged with high-risk groups and vulnerable populations. Developing strategies to ensure high-risk groups have equitable access to primary care and receive the right treatment at the right time. • Forming better health pathways between primary care, community stakeholders and high-risk groups. • Country WA PHN (Midwest) will be implementing a 'community leadership program', aimed at equipping a diversity of community facilitators with tools, skills and knowledge to assist them within their own communities to identify depressive symptoms and reduce suicide and self-harm. • People identifying as LGBTIQ will be part of the Alliance with champions being recruited and trained. It is acknowledged that in the larger towns of Geraldton and Carnarvon it may be easier to recruit interested people, rather than in the smaller communities where stigma may be an issue. • Postvention services are being mapped to identify gaps and to re-establish the Midwest postvention group. • Funding of Carnarvon Medical Services Aboriginal Corporation (CMSAC) to review the Community Action Plans for Aboriginal communities within the Gascoyne region to June 2018. • Funding of Geraldton Regional Aboriginal Medical Service (GRAMS) to review Community Action Plans for Aboriginal communities in the Murchison region to June 2018. • Commissioning will occur to meet Action Plan priorities in the Gascoyne and Murchison regions as the plans are completed. **4. Community facilitators and stakeholder** Coordinating a community intervention response including community facilitators and stakeholders, focussing on training and resourcing to recognise and refer persons with depression or suicidal intent into the correct treatment path.
Service areas	Based on initial consultation and data analysis and anecdotal evidence, it is indicated that men, including Aboriginal men, should be the target population. This cohort is expected to include farmers, fishers and Fly In/ Fly Out (FIFO) workers, who are situated in numerous towns within the Midwest region.

	With the target audiences in mind, the local populations of the following towns in the Midwest is expected to be the focus of trial activity: • Gascoyne region – working with CMSAC with a focus on Aboriginal people • Murchison region – working with GRAMS with a focus on Aboriginal people • Geraldton – with a focus on farmers and fishermen • Morawa – with a focus on farmers and fishermen
Enhanced services for people who have attempted or are at higher risk of suicide	• A study is currently underway to identify service supply and referral pathways, with a consideration of what the data says, and what anecdotal evidence there is, of suicide and self-harm risk, coupled with the findings of the forthcoming community consultations, to identify targets for service delivery and outcomes. • It is anticipated that the delivery and evaluation of a targeted small grants program, for community (suicide prevention) action plan initiatives in the above-mentioned main towns in the Midwest, will enhance PHN activity in the Midwest. • It is hoped that collaboration with the Suicide Prevention Coordinator funded by the WA Mental Health Commission will contribute to a joined-up approach to suicide and self-harm prevention in the region.
Areas for focussed activity	☒ Aboriginal and Torres Strait Islander peoples ☒ Men ☐ Youth ☐ Veterans A preliminary analysis of the data and anecdotal evidence, suggests that the target focus for the trial in the Midwest will primarily be men aged 25 to 54 years. This cohort will include Aboriginal men, farmers, fishers and Fly In/Fly Out workers located in the Midwest region. However, a whole of population approach will be taken for the Suicide Prevention trial, as per the AAD framework, as community/peer support and education around depression will be available for everyone in each community. Evidence about the needs of local target populations will be gathered at a local level, as each nominated town has a different target population. The CRWG and other community engagement will provide information about local population needs. Data about suicide and self-harm in the Midwest has recently been obtained and is currently being analysed. The data has been provided by the Department of Health WA (Health Tracks) under a strict confidentiality agreement. Further data from hospitals has also been requested.

	A meeting has been held with the Midwest police to ascertain the availability of data and to listen to anecdotal information to gain a rich picture of suicide and self-harm behaviours in the Midwest. Utilisation of the expertise of the Black Dog Institute will be sought to access further data. The following will inform strategies for service activities to be undertaken in relation to prevention, intervention and postvention services: • Service mapping – assessment of services conducted by Curtin University on behalf of the PHN. • Information being gathered about services available, referral pathways, and service strengths, gaps and deficits. Referral pathways for relevant suicide prevention, intervention and postvention services - process and data collation template drafted. Services and interventions to be delivered for each target area/population will be informed by community consultations and the community action plans and will therefore be identified once the current data collection phase is complete. The four main areas of activity will include: co-operation with general practitioners from primary care and specialised mental health professionals, public relation activities destigmatising depression and talking about suicide, co-operation with community facilitators and stakeholders, and, support for high-risk patients and their relatives. Recommendations identified in the ATSISPEP (Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project) report provide guidance on the cultural appropriateness of intervention activities within the trial.
Distinguishing activities in focus areas from PHN base activity	Other enhancements to the PHN mental health and suicide prevention activities are not planned at present, but an alignment of them with trial activities has commenced. The activities will be distinguished from one another by their project plans, associated budget delineation, and evaluation.
Related suicide prevention activity	The suicide prevention position under WACHS will be introducing suicide prevention initiatives to the region, and the Mental Health Commission has also commissioned suicide prevention projects in the region. The latter information has only recently been made available, and WAPHA is starting to find out who has responsibility for each funded project. Discussions, to inform a collaboration agreement with the Mental Health Commission of WA, have also been held about sharing information about: commissioning (funded projects), evaluation methods, data collection and, data sharing.

	WAPHA recently commissioned the Poche Centre for Indigenous Health, University of WA, to plan a Country WA PHN roll out of ATSISPEP 'success factors' framework. This question about the differentiation of these activities from the trial activities, underpin some of the discussions with the Mental Health Commission of WA. However, the Alliance provides the opportunity to trial activities that are 'place-based' in nature and context yet are integrated to the broader system approach to reducing suicidality. The strength of The Alliance framework focuses on collective interventions contextualised to community; with the integration of the four elements through a coordinated approach.
Recruitment and workforce	Personnel requirements for community engagement, stakeholder consultation and partnerships have been addressed to an extent by the employment of a project coordinator for the Midwest and appointment of the Suicide Prevention Program Manager who has leadership and accountability for the three WA Suicide Prevention trial sites. A budget based on the specific plan for the Midwest trial site is attached. The project coordinator in based in the Midwest and has qualifications and experience in community nursing, stakeholder and community engagement. The program manager has state-wide and place-based experience in mental health and community service management. **Services to be commissioned** CMSAC have been commissioned to review the Community Action Plans for Aboriginal people within the Gascoyne region, to June 2018. GRAMS have been commissioned to review Community Action Plans for Aboriginal people in the Murchison region, to June 2018. Further commissioning will occur to meet Action Plan priorities in the Gascoyne and Murchison areas as the plans are completed.
Other	N/A
REPORTING AND DATA COLLECTION	**INFORMATION REQUIRED**
Current data collection	None of the commissioned services are applicable for collection of the Primary Mental Health Care Data Minimum Data Set (PMHC MDS) data set. For services that may be commissioned throughout the trial period, if face to face service delivery is required and provided, then PMCH MDS will be collected.

Provisions for trial-specific data	WAPHA, through partnership with Curtin University, are establishing parameters for evaluation to test the efficacy and success of trial activities. Alliance partners and commissioned services will be asked, if appropriate, to provide data through the PMHC MDS. A crucial element of the AAD framework is coordinating the four parts and integrating a systems approach to provide greater access to care and treatment for people with depression or suicidal intent. WAPHA are working closely with Curtin University and our Alliance partners to establish research protocols and questions to measure integration.
Reporting responsibility	Sharleen Delane, Program Manager, Suicide Prevention – sharleen.delane@wapha.org.au
Site specific contact(s)	Jacki Ward, Project Coordinator, Suicide Prevention Trial (Midwest) – jacki.ward@wapha.org.au
TIMELINE FOR MAIN TRIAL RELATED ACTIVITIES	
Completed in 2016-17	• Data collection • Service mapping • Community consultations • Liaison, partnership development – WACHS and Mental Health Commission of WA. • Planning for community action plans and commissioning (in progress).
Timeline for 2017-18	• WAPHA personnel trained in The Alliance Against Depression, August 2017 • Community Champions for each community identified, September 2017 • Memorandum of Understanding between WAPHA and the WA Country Health Service (WACHS) to ensure collaboration between the two suicide prevention projects, completed October 2017 • Formation of Reference group and Steering Committee for joint WAPHA/WACHS trials, November 2017 • Meetings held with Black Dog Institute (BDI) to ascertain assistance available to the Midwest trial, November 2017 • Commencement of The Midwest Alliances: - Formation of CRWGs, November 2017 to February 2018 • Consultation with Black Dog Institute (BDI), November 2017 - assistance with collection of data to support the choice of target group and to assist with education around depression of GPs, other health professionals, Police, ambulance and other first responders

	• Funding of CMSAC to review the Community Action Plans for Aboriginal communities within the Gascoyne region, to June 2018 • Funding of GRAMS to review Community Action Plans for Aboriginal communities in the Murchison region, to June 2018 • Gascoyne, Murchison, Geraldton and Morawa Community Action Plans reviewed, October 2017 to June 2018 • Commissioning of Action Plan priorities in the Gascoyne and Murchison areas will occur as the plans are completed.

EXPENDITURE		
Planned expenditure to 30 June 2018	2016/2017	$ 46,118
	2017/2018	$1,745,000
	Total (GST exclusive)	**$1,791,118**