Embarking on Our Journey to Zero: Implementing the Zero Suicide Framework

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“There has to be a better way than this.”

- Opportunity to review following critical incident.
- Paradigm Shift Required:
  - Preoccupation with Risk Assessments and Categorical Risk Prediction
    - Embedded in practice, training and documentation (and yet literature says: Don’t use screening and risk categorization to predict risk or allocated resources)
  - Critical Incident Reviews looking through the lens of Risk Prediction.
  - Assessing but little focus on interventions
- Diagnosis as a gateway to help.
The review of these programs identified three distinct and critical attributes contributing to the success:

I. “Suicide-specific, evidence-based practices;
II. Reliably delivered by well-managed whole systems of care that are continuously improving service access, quality and safety; and that are,
III. Firmly rooted in core values reflecting a service culture that no longer accepts suicide as an outcome.” — Mokkenstorm et al (2017)
In Conjunction with All of Community Approach (eg. Lifespan)
ZERO Suicide

Zero Suicide is:
- a commitment to suicide prevention in healthcare
- a specific set of strategies and tools.
- It presents both a bold goal and an aspirational challenge.

7 Essential Elements:
**Elements of Zero Suicide**

**Identify** – Systematically identify and assess suicide risk among people receiving care.

**Engage** – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.

**Treat** – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

**Transition** – Provide continuous contact and support, especially after acute care.

Attempt and Loss survivors are active participants in the guidance of suicide care.
# A Shift in Mindset?

<table>
<thead>
<tr>
<th>From?</th>
<th>To:</th>
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<tr>
<td>Pessimism: Seeing suicide as inevitable.</td>
<td>A Systems Approach can lead to prevention of suicides.</td>
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<td>A culture of Blame</td>
<td>A Just Culture that supports staff.</td>
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<td>Risk Assessment and Containment</td>
<td>Collaborative safety, treatment, recovery.</td>
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<td>Stand alone training and tools</td>
<td>Overall Systems and culture change</td>
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<td>Hospitalization during episodes of crisis</td>
<td>Productive interactions throughout ongoing continuity of care.</td>
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<td>Consider suicidality only a symptom of an underlying disorder</td>
<td>Treat suicidality directly with specific interventions.</td>
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Adapted from the National Action Alliance for Suicide Prevention.
Risks

“Introduced in various forms without a clear underlying strategy and it has become a question of using the label rather than implementing a comprehensive suicide prevention programme.” Hawton 2016

“Unintended consequences of …. a culture of blame will emerge and pressures to distort easily manipulated statistics” Coyne 2016

“Unachievable goal… 20% is more realistic; community is given unrealistic expectations; Potential to lead to therapeutic nihilism when the inevitable suicide occurs.” Goldney 2018
Why Zero?


- In keeping with this rationale and aiming to create a culture shift, some organizations have set ambitious targets of dramatically reducing suicide deaths within their populations.

- Links to other organizations.

- What other target is acceptable?
Caveat - Just Culture

- Does NOT mean that if there is a suicide that someone must be to blame.

- Just Culture is:
  - “Getting to an account of failure that can do two things at the same time:
    - satisfy demands for accountability;
    - contribute to learning and improvement.”
Restorative Just Culture

- Accountability can be seen as backward-looking or forward-looking, focusing either on assigning blame for what has already happened, or agreeing on responsibilities for what needs to happen going forward (Sharpe, 2003).

- Its not about Blame – but it is all about Accountability.
Review of Just Culture Principles

The Three Behaviors

- Human Error
  - Product of Our Current System Design and Behaviors Choices
  - Manage through
    - Chances
    - Processes
    - Procedures
    - Training
    - Environment

- All-Risk Behavior
  - A Choice: Risk Believed Insignificant or Justified
  - Manage through
    - Remaining incentives for risk behavior
    - Changing incentives
    - Increasing situational awareness

- Reckless (In tolerable) Behavior
  - Consciously Disregard of Substantial and Justifiable Risk
  - Manage through
    - Remedial action
    - Disciplinary action

Coach

Discipline

Engagement of all Stakeholders

Who has been Hurt?

What are their Needs (Address Harms and Causes)?

Whose Obligation to Meet those Needs?

Support, healing and learning

- Patient, Family Carers
- Clinician
- Organization Community

Clinicians, Leaders, Peer Supporters, Post Vention NGO, Board and Executive etc
Change

1. CREATE Sense of Urgency
2. BUILD Guiding Coalition
3. FORM Strategic Vision & Initiatives
4. ENLIST Volunteer Army
5. ENABLE Accept & Embrace Change
6. GENERATE Short-Term Win
7. SUSTAIN Acceleration
8. INSTITUTE Change

The Big Opportunity

Gold Coast Hospital and Health Services
Mental Health and Specialist Services
Suicide Prevention Strategy 2016 - 2018
Journey to Zero through Leadership, Support and Continuous Improvement

Implementing a new approach to Suicide Prevention....

Gold Coast Health
www.goldcoast.health.qld.gov.au

Queensland Government
### The Suicide Prevention Pathway

<table>
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<tr>
<th>Mandatory Components</th>
<th>Definition</th>
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<tr>
<td><strong>Screening</strong></td>
<td>Identifies the best way we can engage our consumers and detect suicide risk.</td>
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<tr>
<td><strong>Assessment</strong></td>
<td>Identifies techniques and approaches that will enhance the identification of suicide risk.</td>
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<td><strong>Risk Formulation</strong></td>
<td>Synthesis the suicide risk information and articulates a consumers immediate distress and resources at a specific time and place.</td>
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<td><strong>Initial Intervention</strong></td>
<td>Safety Planning: Identifies components of follow up which aims to address drivers of suicidality, resolve crisis and identify resolution.</td>
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<td>Counselling on Access to Lethal Means: Identifies a process for the safe transition of care between service providers.</td>
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<td>Brief Patient &amp; Carer Education: Identifies a process for the safe transition of care between service providers.</td>
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<td>Rapid Referral: Identifies a process for the safe transition of care between service providers.</td>
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Suicide Prevention Pathway GCMHSS KT,MW ,2016
Training

• 3 SRAM-ED Modules (QCMHL)
• 1 GCMHSS Module
• 1 day face to face training.
• Support post training (first 2 weeks, then ongoing)
• Initial target community
• Now all inpatient
• Over 690 staff so far.
• Sustainable: Booked in as part of Orientation.
Outputs:
- Trained > 690 Staff;
- Trained 100 Private Practitioners
- Over 2800 patients through the SPP
- PHN “Lotus” Program – non-clinical support
- Staff Survey
- Restorative Just Culture principles embedded into practice.
Organization Wide Staff Survey: Significant improvement noted in:

- Feeling that have received the necessary training.
- Confidence and Skills – particularly in terms of specific interventions to deal with suicidality.
SA Representations following SA Event (July – Dec 2017)

- 7 day (6 on SPP, 17 not on SPP)
- 14 days (10 on SPP, 23 not on SPP)
- 30 days (25 on SPP, 45 not on SPP)
- At 90 days (45 on SPP, 76 not on SPP)
Next Steps — Suicide Prevention Strategy

• Updating training.

• Specific Interventions — Caring Contacts; Consider CBT for Suicide Prevention or ASSIP (Attempted Suicide Short Intervention Program)

• Project Air

• continuing quality improvement approach — feedback to teams, and support to improve, addressing barriers.

• Addressing the challenges of Data.

• Tackling the issue of Screening in non mental health settings.

• Issues:
  • Capacity — Resources if all people went onto the pathway?
  • Connection with NGO / Community Resources — co-location / Shared Training / Shared Attitudes and Beliefs / Fidelity to evidence based suicide specific care?