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

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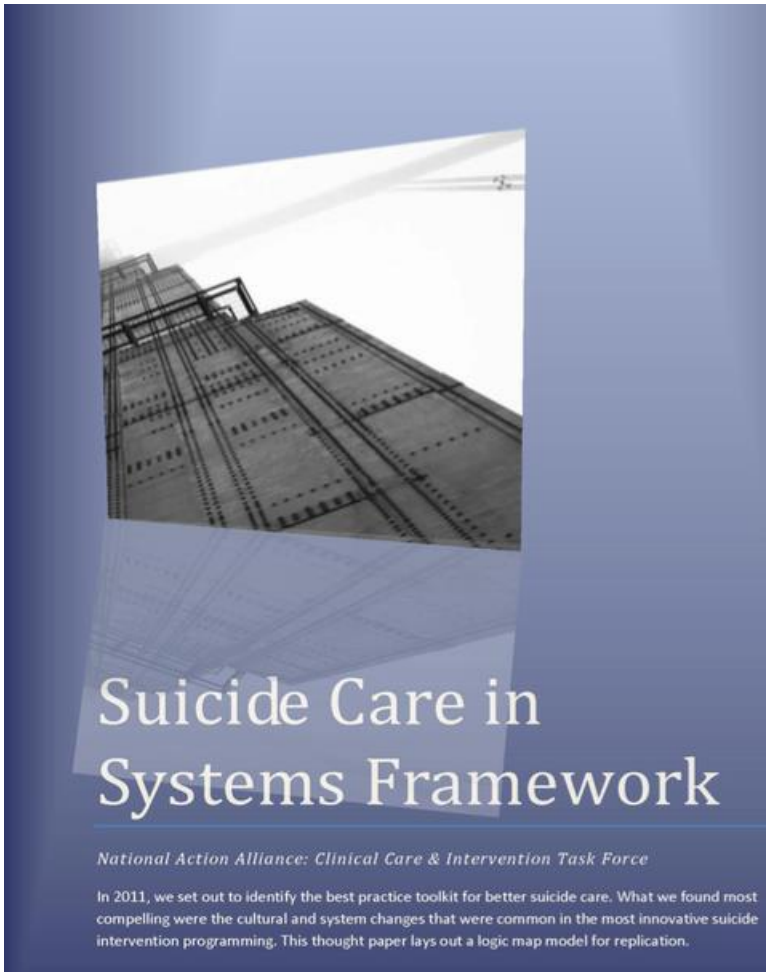
"There has to be a better way than this."

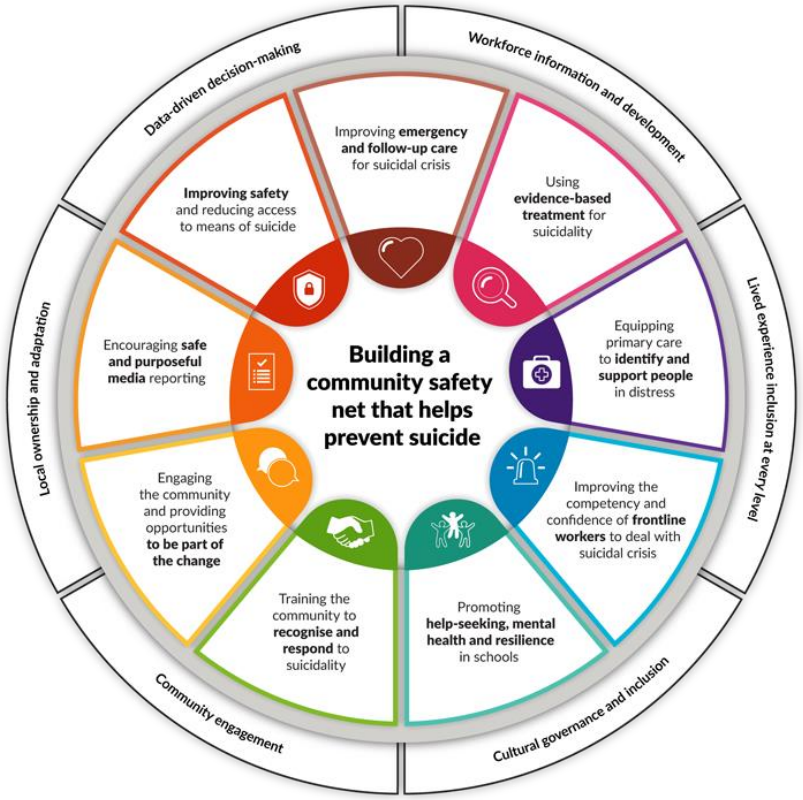
- Opportunity to review following critical incident.
- Paradigm Shift Required:
- Preoccupation with Risk Assessments and Categorical Risk Prediction
  - Embedded in practice, training and documentation (and yet literature says: Don't use screening and risk categorization to predict risk or allocated 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)

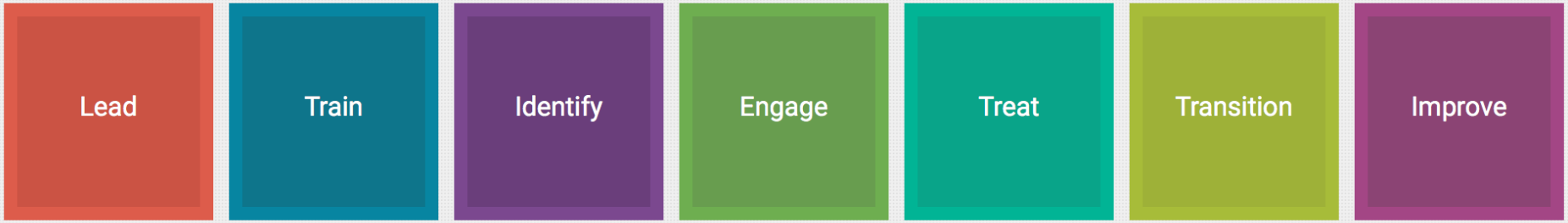


ZERO Suicide

Zero Suicide is:

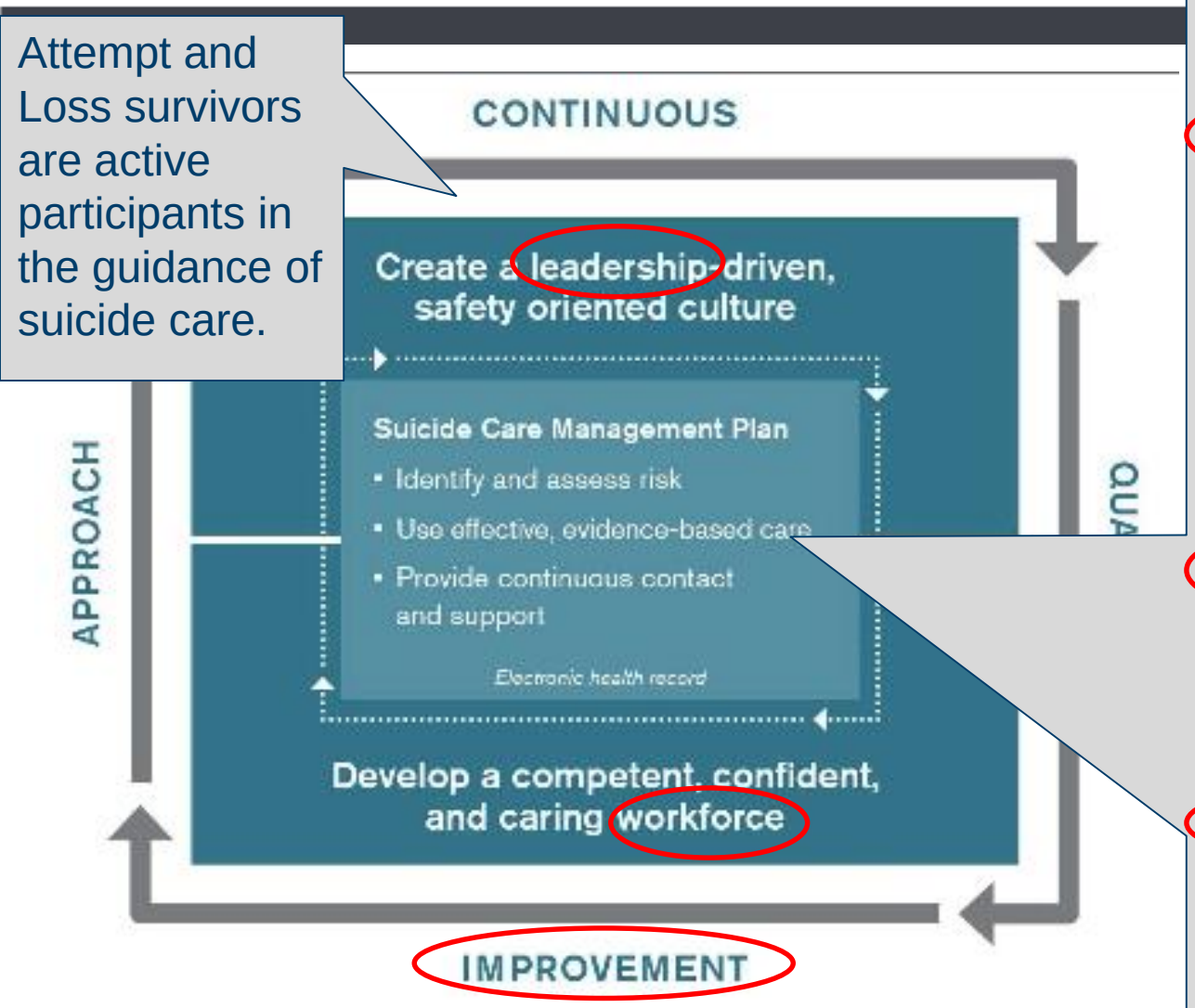
- ***a commitment to suicide prevention in healthcare***
- ***a specific set of strategies and tools.***
- ***It presents both a bold goal and an aspirational challenge.***

7 Essential Elements:



Elements of Zero Suicide

Attempt and Loss survivors are active participants in the guidance of suicide care.



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.

A Shift in Mindset?

From?	To:
Pessimism: Seeing suicide as inevitable.	A Systems Approach can lead to prevention of suicides.
A culture of Blame	A Just Culture that supports staff.
Risk Assessment and Containment	Collaborative safety, treatment, recovery.
Stand alone training and tools	Overall Systems and culture change
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care.
Consider suicidality only a symptom of an underlying disorder	Treat suicidality directly with specific interventions.

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

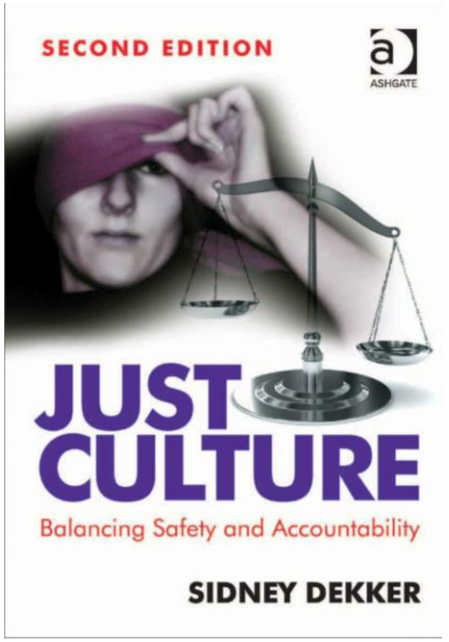
"Unachievable goal… 20% is more realistic; community is given unrealistic expectations; Potential to lead to therapeutic nihilism when the inevitable suicide occurs." Goldney 2018

Why Zero?

- "Zero defect" / "perfect process" approaches- common in aviation, automobile, manufacturing industries. "High Reliability" organizations.
- 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."*



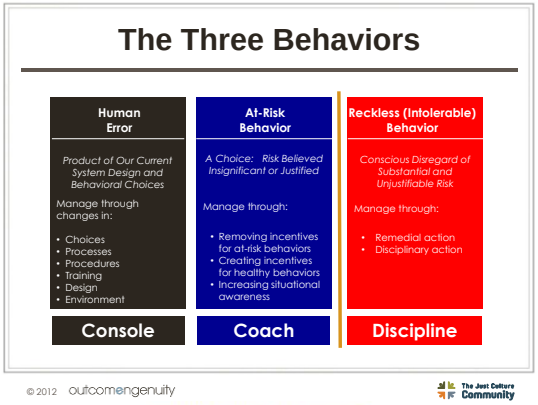
Restorative Just Culture

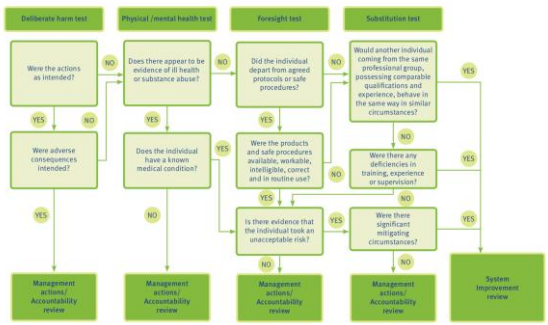
- Accountability can be seen as backward-looking or forward-looking, focusing either on assigning blame for what has already happened, or **agreeing on responsibilities for what needs to happen going forward** (Sharpe, 2003).

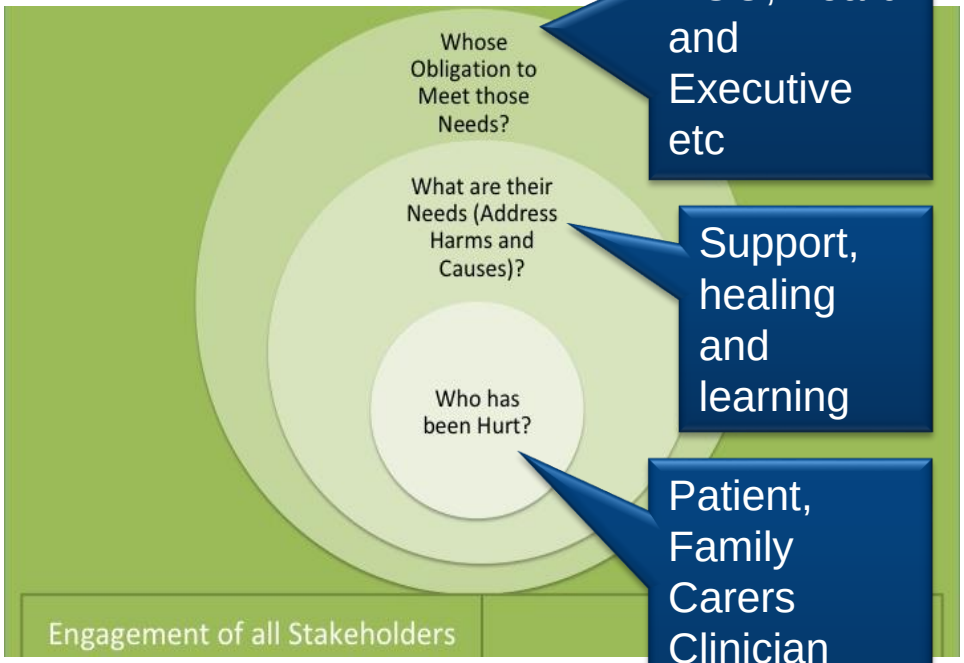
- Its not about Blame – but it is all about Accountability.

Review of Just Culture Principles

Restorative Just Cu



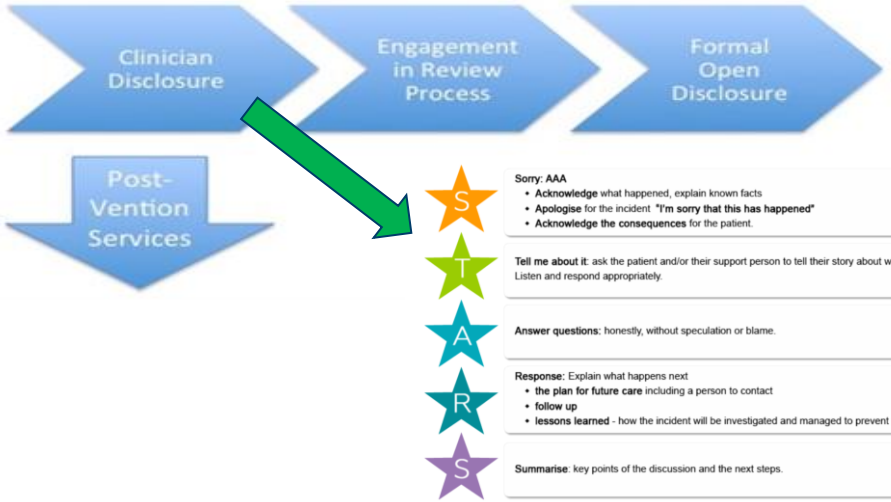


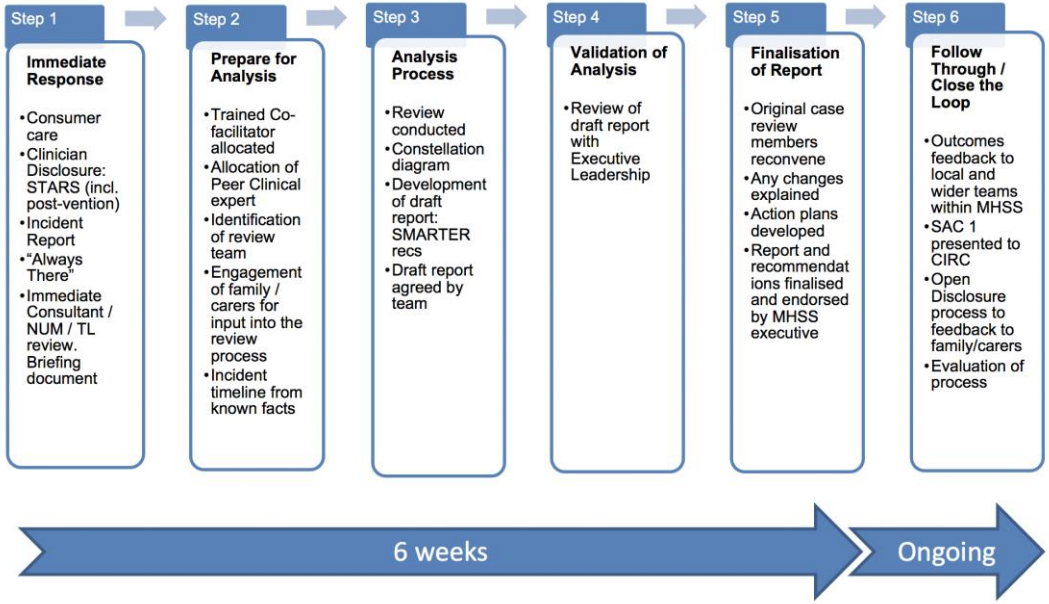


Clinicians, Leaders, Peer Supporters, Post Vention NGO, Board and Executive etc

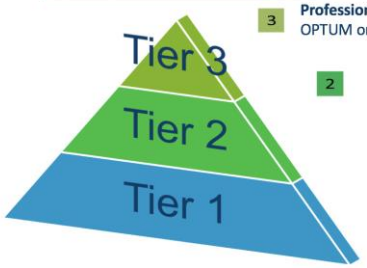
Support, healing and learning

Patient, Family Carers Clinician Organization Community





SCOTT'S THREE –TIERED STAFF SUPPORT MODEL



3 **Professional Resources**- Referral to professional assistance e.g. GP, OPTUM or other non government services.

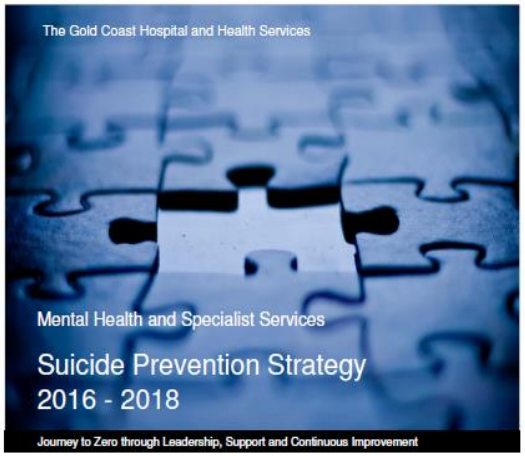
2 **ALWAYS THERE team responders** – provides psychological first aid to staff where more support is needed than provided at tier 1 e.g. one on one emotional support, or small group; **formal support**. This is short term support and then referral to professional services.

1 **Formal support**– support team leaders, NUM's, senior clinicians when there is a traumatic event.
Informal support - ongoing awareness of staff who are potentially experiencing difficulties.

Scott (2010)

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

Change



Implementing a new approach to Suicide Prevention.....

Gold Coast Health
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Queensland Government

The Suicide Prevention Pathway

Mandatory Components	Definition
Screening	Identifies the best way we can engage our consumers and detect suicide risk.
Assessment	Identifies techniques and approaches that will enhance the identification of suicide risk.
Risk Formulation	Synthesis the suicide risk information and articulates a consumers immediate distress and resources at a specific time and place.
Initial Intervention	Safety Planning Counselling on Access to Lethal Means Brief Patient & Carer Education Rapid Referral
Structured Follow Up	Identifies components of follow up which aims to address drivers of suicidality, resolve crisis and identify resolution
Transition of care	Identifies a process for the safe transition of care between service providers.

Suicide Prevention Pathway GCMHSS KT,MW ,2016

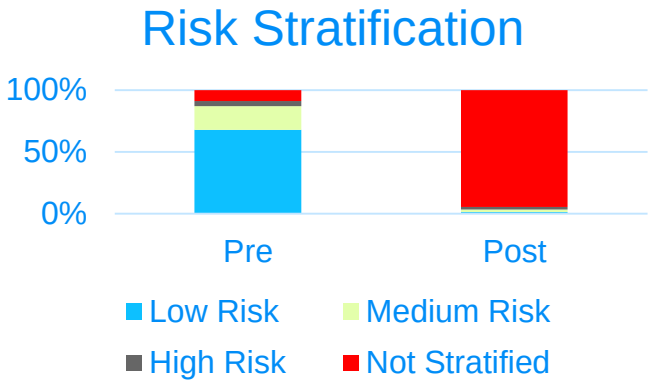
Training

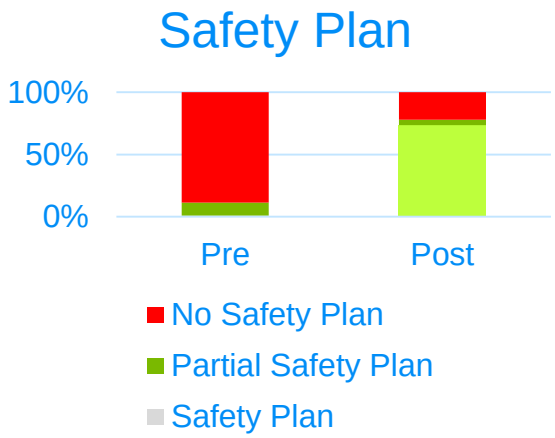
Queensland Centre for Mental Health Learning

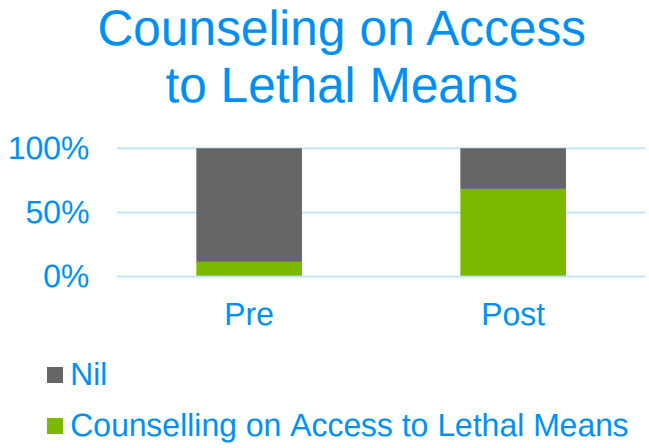
- 3 SRAM-ED Modules (QCMHL)
- 1 GCMHSS Module
- 1 day face to face training.
- Support post training (first 2 weeks, then ongoing)
- Initial target community
- Now all inpatient
- Over 690 staff so far.
- Sustainable: Booked in as part of Orientation.

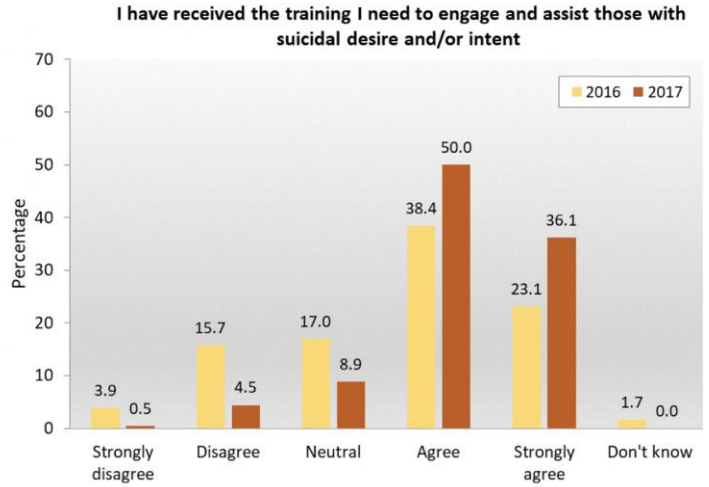
Outputs:

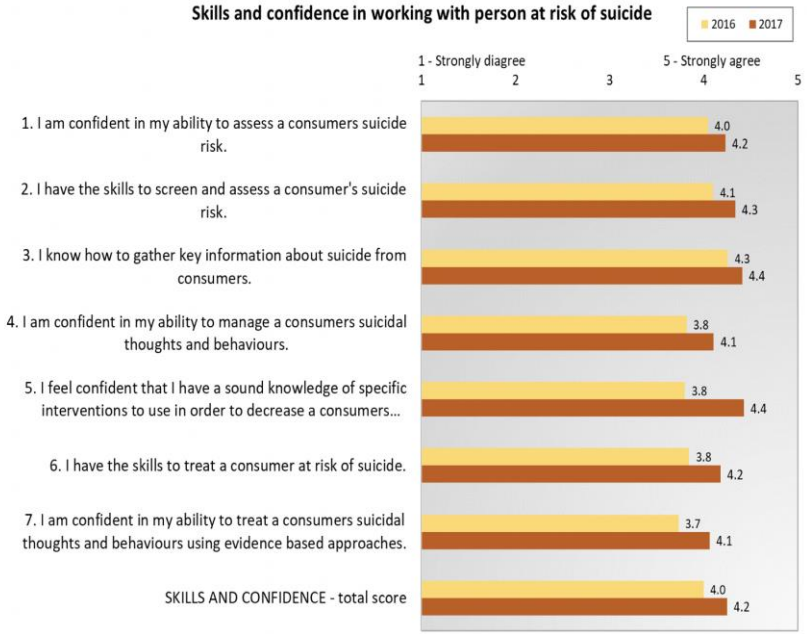
- Trained > 690 Staff;
- Trained 100 Private Practitioners
- Over 2800 patients through the SPP
- PHN “Lotus” Program – non-clinical support
- Staff Survey
- Restorative Just Culture principles embedded into practice.







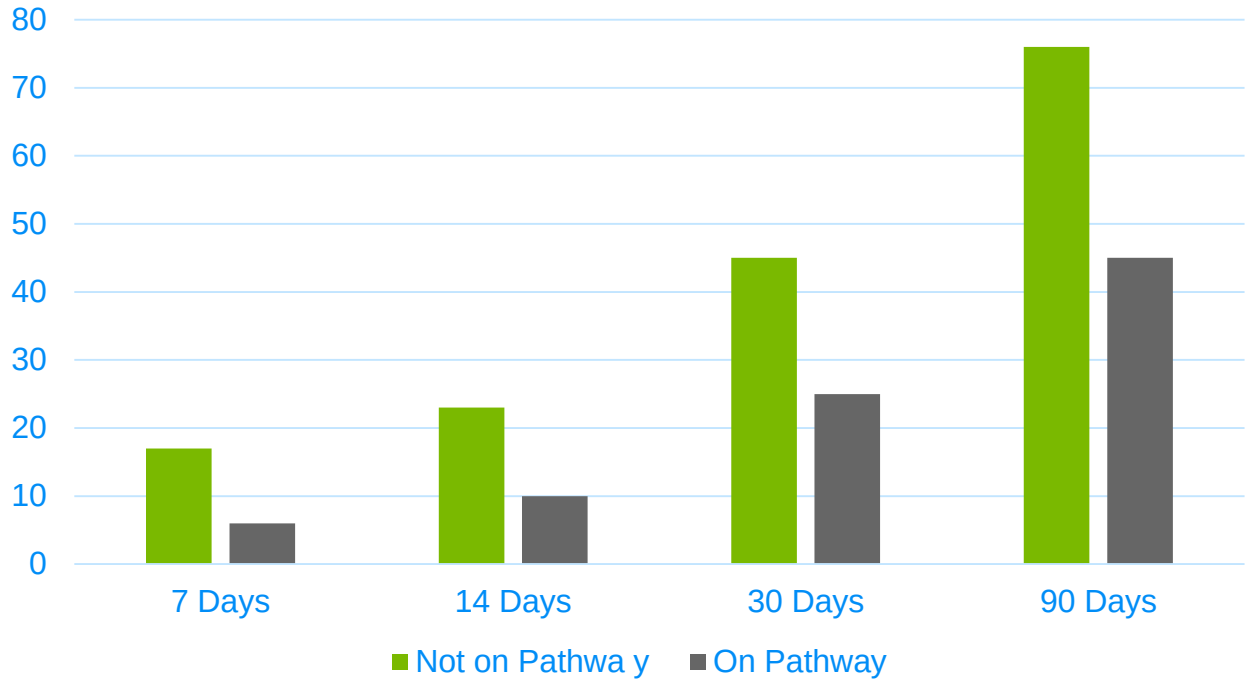




Organization Wide Staff Survey: Significant improvement noted in:

- 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?