

The 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**

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Acknowledging our partnerships and supporting frameworks



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Abbreviations used in this document

CBT	Cognitive Behavioural Therapy
CNC	Clinical Nurse Consultant
CRESP	Centre of Research Excellence in Suicide Prevention
DBT	Dialectical Behavioural Therapy
ED	Emergency Department
FDA	Food and Drug Administration United States of America
GC	Gold Coast
GCMHSS	Gold Coast Mental Health and Specialist Services
HEAPS	Human Error & Patient Safety
HHS	Hospital and Health Service
Life	Living Is For Everyone: National Suicide Prevention Framework
MHSS	Mental Health and Specialist Services
NHMRC	National Health and Medical Research Council
NHS	National Health Service (Great Britain)
OECD	Organisation for Economic Cooperation and Development
RCA	Root Cause Analysis
SAC1	Severity Assessment Code
SPP	Suicide Prevention Project
SPS	Suicide Prevention Strategy
SPFW	Suicide Prevention Framework
SRAM	Suicide Risk Assessment & Management
TOR	Terms of Reference
UK	United Kingdom
US	United States of America

Forward

Clinical Director Gold Coast Mental Health and Specialist Services

Suicide has a devastating effect on the lives on many, including consumers, carer's, family, friends and staff.

During 2015, many staff across our service, have been involved in a review of Suicide Prevention Strategies, to discover what we have been doing well, and what other frameworks we can learn from.

Within our field there have been, at times, mixed messages as to the determinants of suicide and what impact we can actually have in the prevention of suicide.

During this process, we have found inspiration in frameworks that are being introduced across the world, that have shown great success in reducing suicide attempts and suicides in people under the care of a health service.

One of these frameworks is "Zero Suicide", which was inspired by work done at the Henry Ford Health System in Detroit, Michigan. It is a comprehensive approach developed by the US Suicide Prevention Resource Centre and the National Action Alliance for Suicide Prevention.

We believe this approach will improve the care and safety of our patients, thereby making our organisation a safer, and hopefully more fulfilling place to work.

There is good cause for optimism, that through a continuous improvement process, we can ensure high quality assessments, engagement, evidence based interventions, and transitions of care that can help prevent deaths from suicide, while supporting the clinicians who do this demanding work.

This document outlines the Suicide Prevention Strategy for our service 2016-2018, "*Reducing Suicide through Leadership, Systems, Training, Treatment and Care*".

We would like to thank each of you for the good work that you already do and for your openness to new ideas in the coming months and years.



Dr Kathryn Turner

Clinical Director Gold Coast
Mental Health & Specialist Services



Executive Summary

Suicide affects people of all ages and all walks of life. Each year around 64 people end their life by suicide in the Gold Coast Community. A number of these consumers tragically end their life whilst under the care of the Gold Coast Mental Health Service the impact of these tragic events are felt across the service by families, consumers and by our staff.

The Gold Coast Mental Health and Specialist Service is committed to reducing Suicide of consumers in our care. This commitment has seen the development and endorsement of a new approach to suicide prevention across the service.

Built on previous achievements the *Gold Coast Suicide Prevention Strategy 2016 -2018* takes a step further and commits to reducing suicide of our consumers by 25% over the next two years.

Zero Suicide is a new approach that is premised on the firm belief that suicide deaths for people under care can be preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems.

A Zero Suicide framework represents a commitment to patient safety—the most fundamental responsibility of health care—as well as the safety and support of clinical staff, who perform the demanding work of treating and supporting people who are suicidal.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers.

Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The Zero Suicide Framework adopted by the Gold Coast Mental Health and Specialist Services focuses on 5 essential elements:

- 1 Leadership** Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles
- 2 Train** Develop a competent, confident, and caring workforce
- 3 Identify / Engage / Treat** Systematically identify and assess suicide risk among people receiving care. Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means. Use effective, evidence-based treatments that directly target suicidality.
- 4 Transition** Provide continuous contact and support, especially after acute care
- 5 Improve** Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

“It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you’re only designing for 90 percent may not materialize. It’s about purposefully aiming for a higher level of performance.” President and CEO of Cedars-Sinai Medical Centre:

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems.

While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

The Gold Coast Mental Health and Specialist Service Suicide Prevention Strategy document outlines the implementation approach and evaluation plan for 2016-2018.



Imagine a World Where... We set aside fear of failure, taboo and stigma.

- Not one patient in healthcare dies by suicide
- Leaders, administrators, professionals, patients, families, and communities line up around the central goal of suicide prevention in high quality mental health and addiction care
- Augmentation of hope, safety, recovery and perspective is core to all interventions within healthcare systems

And, as a consequence, population suicide rates drop dramatically

Background

In 2015 the Gold Coast Mental Health and Specialist Services (GCMHSS) Suicide Prevention Project (SPP) undertook a review of suicide prevention frameworks and strategies from across the OECD. The goal of this research was to review existing suicide prevention paradigms and identify a suicide prevention evidence based framework for the GCMHSS.

During the research journey it was identified that most innovative contemporary suicide prevention programs did not simply rely upon skills, policies and procedures, or pathways; Cultural and system changes were common components of the frameworks that underpinned these programs.

A review of the Frameworks for Suicide Prevention identified three broad categories of frameworks

1. Broad overarching, population level frameworks :

- The “Life” Living is for everyone Framework: The National suicide prevention Framework for Australia.
- The Queensland Mental Health Commission Suicide Prevention Action Plan 2016-2017
- The Black Dog Institute and the NHMRC Centre of Research Excellence in Suicide Prevention, (CRESP) describe an evidence based multi-sector systemic approach to Suicide Prevention, identifying 9 key strategies that range from community level to individual (as outlined in Figure 1):
- US National Strategy for Suicide Prevention (2012). It outlines four strategic directions with 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide in the US.

2. Health Service Frameworks

- Suicide Care in a Systems Framework (2012): the National Action Alliance for Suicide Prevention Clinical Care and Intervention Task Force completed an environmental scan of innovative national suicide prevention programs with demonstrated positive outcomes.
- Zero Suicide Framework is a key concept of the 2012 US National Strategy for Suicide prevention and a project of the Suicide Prevention Resource Centre.
- National Institute for Health and Care Excellence (NICE) clinical guidelines
- Mersey Care NHS Trust Zero Suicide Policy

3. Components of a Health Care System

Focus on Emergency Departments

The Suicide Prevention Project (2015) review identified that many important components of Suicide Prevention frameworks had been identified and worked on over the past few years within the GCMHSS, so there is a foundation on which to build.

A key finding was that there could be significant advantages of embedding this work, building on it, and enhancing it, within a broader framework which captures all of the components identified as being critical success factors in services internationally.

Key Findings Identified that:

- A consistent application approach has seen significant reduction in suicide attempts and suicides of consumers under care.
- A Suicide Prevention Framework provides a shared understanding of the cultural issues, and agreement about expected pathways of care.
- Addressing issues around culture (for example ensuring a “Just Culture”) at a team level or even a Directorate level is not sufficient. It must be at an HHS level.
- Implementing a suicide prevention framework endorsed at an HHS level will provide an opportunity to enhance a safety culture and Just culture.



Figure 1. Black Dog Institute and NHMRC multi-sector approach to suicide prevention

Suicide Prevention Project (2015) Key Findings and Recommendations

The SPP review identified important issues influencing the development of the GCMHSS Suicide Prevention Strategy 2016 – 2018.

- 1 Foundation work has been undertaken in the service to enhance suicide prevention activities. However, there is a need to further enhance this to embed it consistently within a broad Suicide Prevention Framework for the GCMHSS.
- 2 Limited guidance at a state and national level regarding a comprehensive Suicide Prevention framework at a service level
- 3 Hard working and dedicate clinicians working with individual consumers. There is a need for support of this work by the development of a clear Suicide Prevention framework that will guide staff training, interventions and pathways of care
- 4 Lack of a clear framework may lead to variable management of suicide risk across the MHSS.
- 5 Risk averse culture – clinical care dictated by staff managing potential risk rather than actual risk, which may be detrimental to clinical decision making

Analysis of these issues determined that the GCMHSS Service further enhance and build on the existing GCMHSS Suicide Prevention Plan, through the development and implementation of a whole of service/system level, Suicide Prevention Framework.

Implementation of the recommendations will aim to reduce suicide rates and increase in recovery focused person-centred care.

A key component of this will be improving staff morale ensuring that staff feel supported by management and the organisation.

This means that as a service we adopt a “Just safety culture”.

A Just Culture is a learning culture, that encourages accountability and takes human error into consideration.

This approach will require the engagement of the wider HHS and to communicate the GCMHSS strategy across GCHHS.

Communication of the strategy will also play a vital role in informing consumers, carers, families and the wider GC community.



Adopting a Zero Suicide Approach

In 2015 the GCMHSS endorsed the implementation of the Zero Suicide Framework. This section provides an overview of the concepts and key components of a Zero suicide framework to be adopted by the GCMHSS

Conceptualising a Zero Suicide approach...

In the last 60 years, tremendous strides have been made in the fight against cancer, polio, smallpox, and other diseases. The healthcare workers, scientists, and policy makers engaged in those fights transformed their angst and set for themselves an audacious goal to reduce or eliminate deaths caused by those diseases. And they were successful.....

Consider the following achievements:

- Smallpox was eradicated in 1980
- The five-year survival rates in 1975 of certain forms of cancer, such as breast, prostate, and colorectal, were 75%, 69%, and 51%, respectively. In 2007, survival rates increased to 99% and 67%, respectively.
- And the incidence of polio has gone down dramatically since 1988, when over 350,000 cases were reported. In 2014, that number plummeted to only 359 reported cases, a 99% decrease

In the case of polio and smallpox, it meant a global effort to immunize every human being. In the case of cancer, it meant more research, better screening, and aggressive therapies.

In the case of suicide, it means setting a goal of ZERO DEATHS.

Targeting zero is neither innovative nor controversial, but simply a technique other industries utilise daily. "All Harm is Preventable... Target Zero," Fostering a mindset that presses beyond instrumentalism.

Zero defect and perfect process approaches are common in aviation, automobile, manufacturing, and other industries.

Who would consider flying on an airline that can only guarantee a safe landing for 98 out of 100 flights?

Who would want to give birth in a hospital that is proud of the fact that last year, only two infants were sent home with the wrong mother?

Yet zero defect initiatives are commonplace in healthcare. Zero medication errors. Zero inpatient falls. Zero surgical mistakes. Zero infections.

So why not zero suicides?

Too many clinicians believe that suicide is a personal choice, a choice they cannot often influence, and if they intend to act to influence this choice, they will be blamed if the person dies by suicide. Suicide scares and mystifies many of us.

*"The reality of healthcare is fear, logistics, low research funding and more risk than reward all conspire to make suicide the neglected disease."
(Forbes Magazine, 2010)*

In fact, many US pharmaceutical companies refuse to perform clinical trials of antidepressants on individuals with elevated risks of suicide, even though the US Food and Drug Administration (FDA) has approved such trials.

The impact of this pervasive fear and misunderstanding of the patient's experience of his/her suicidality is that these patients typically receive less compassionate, supportive attention than those in the current care system's "bullseye."

Many patients don't feel heard, understood, or taken seriously. They experience mental healthcare as superficial, ambiguous, condescending and sometimes disrespectful.



Is it possible to aim for Zero?

Some reservations have been expressed regarding terminology used by some service level frameworks that express an aim for “Zero Suicide”. Organizations that are following the “Zero Suicide” framework are using various names such as “Zero Suicide”, “Perfect Depression Care”; and “Suicide Safer Care”.

The rationale for this aim of “Zero Suicides” is that it borrows from “the language and principles of robust performance improvement, and all aspire to innovative solutions that will change paradigms and dramatically improve results.”

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. For example Mersey Care NHS Trust have publically committed to “the ambitious aspiration to eliminate suicide from within its care over the next five years.”

The Queensland Mental Health Commission, whilst not a service level framework, has also made the ambitious goal of “reducing suicide (within the broad population) by 50% within a decade.”

The setting of ambitious targets is an important component of effective suicide prevention frameworks. “Suicide Care in a Systems Framework”, notes that one of the critical success factors included “setting achievable goals to reduce and hopefully eliminate suicide attempts and deaths.”

Originating in the US, with the Henry Ford Health System “Perfect Depression Care” being cited as the inspiration, this concept has now provided the framework for Suicide Prevention systems in services across the UK, and at least one example now being developed in New Zealand.

What Does “Zero Suicide” Mean?

Stated quite simply, Zero Suicide reflects a commitment by healthcare leaders to strive to make suicide a “never event” so that not one person dies alone and in despair.

To achieve this ambitious goal, there is a just culture where caring, competent, and confident staff are supported to continuously improve and learn together.

Patients are actively engaged and supported to talk about suicide and despair. They are also supported to rediscover hope and find ways to survive, with a continuous eye to re-engagement with and contribution to the communities in which they may live, work, and play for a lifetime.

What It Does Not Mean...

Zero Suicide is not a zero tolerance approach, as there is already a significant burden felt by many clinical professionals related to suicide. Furthermore, it doesn’t mean that people that die by suicide are “bad” or that healthcare providers should be ashamed when one of their patients dies by suicide.

It means that together we will need to be brave and innovative and do everything we can to bring the number of deaths by suicide to zero.



“Aiming for Zero” across the World

In January 2015 in the UK, then Deputy Prime Minister, Nick Clegg, called on all NHS trusts to commit to a new ambition for ‘zero suicides’ in order to dramatically reduce suicides in the NHS.

This ambition has already been adopted in some areas with Mersey Care in Liverpool, South West England and East of England all making the commitment. There was an expectation that local solutions would be developed.

The East of England has taken a broad approach, noting that up to 75% of people who take their lives have not been seen by mental health services in recent times. They focus on partnerships with community organizations and training of workers external to the health system.

South West of England has developed “Project Zero – South West Regional Suicide Reduction Collaborative”, with a focus on “improving services for people experiencing mental health difficulties.

This commits a variety of providers across public services to work together to improve the system of care and support so that people in crisis, because of a mental health condition, are kept safe and helped to find the support they need whatever the circumstances in which they first need help and from whichever services they turn to first.”

Mersey and Cheshire in the UK have a two pronged approach with a Mersey NHS Zero Suicide strategy, which “sets out the standards of care that will be offered to all service users who express suicidal ideas to ensure they have the highest quality assessment, support and treatment until they have recovered and are safe.” In addition to this there is a Public Health Collaborative that aims for Zero Suicide “No More”.

Canterbury in New Zealand is also implementing a Suicide Prevention Framework based on the Zero Suicide Principles; Canterbury Suicide Prevention Initiative. It is aimed at the prevention of suicide for consumers under the care of Adult General services.

A Just Culture.....

A significant enabler toward zero suicide is establishing a Just culture in our workplace.

The term “Just Culture” is common in the aviation world and is described by the Euro control organisation as:

“a culture in which front line operators or others are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated”.

Continuous quality improvement can only be effectively implemented in a safety- oriented, “just” culture free of blame for individual clinicians when a consumer attempts or dies by suicide”

A “Just” culture as an organisation can be best described as an environment in which front line staff feel comfortable disclosing errors, especially their own, while still maintaining professional accountability.

Within a just culture, it becomes possible to implement specific strategies and tactics to pursue perfection. Along the way, each step towards “zero defects” is celebrated because each defect that does occur is identified as an opportunity for learning.”



Implementing The GCMHSS Suicide Prevention Strategy 2016 - 2018

This section identifies:

1. The critical components and Key Actions of GCMHSS SPS
2. Governance Structure
3. High level Implementation Approach & Schedule
4. Key Actions: Smart Solutions

“If a study of history on these conditions has shown anything, it is that action by organizations can, eventually, make a large and life-saving difference, even for issues that at first seem intractable”.

Thomas Insel, National Institute of Mental Health, April 2, 2015

1. The Critical Components of the GCMHSS Suicide Prevention Strategy

The GCMHSS Divisional Governance Committee endorsed five priority areas to implement a new approach to suicide prevention across the GCMHSS. The Implementation plan outlines key actions under each Zero Suicide priority area

1. Leadership drives Cultural transformation that instills the belief that suicide of consumers under care can be significantly reduced by improving service access and quality through continuous improvement.

2. Staff Training will be provided in evidence based assessment and treatment interventions to ensure consistency in approach across the service.

3. Identify / Engage / Treat ensuring systems and procedures are in place to identify and respond in a timely way to people at risk of suicide, providing a patient centered assessment, support and treatment. This includes Aboriginal and Torres Strait Islanders, minority at risk groups and all groups across the life cycle.

4. Transition ensuring procedures and resources enable intensive support, at times of crisis and transitional points of care.

5. Improve and develop data driven quality improvement approach to inform system changes that will lead to improved consumer outcomes and better care for those at risk.

These priority areas will often interrelate and key actions will be grouped into smart solutions to ensure that all actions are measurable.



Leadership: Key Actions

1. That the GCMHSS Leadership drives a cultural transformation that instills the belief that suicide of consumers under care can be significantly reduced by improving service access and quality through continuous improvement.
2. That there is a clear commitment to a reduction in suicide rates and rate of repeat suicide attempts of consumers under care.
3. There should be alignment to learning's from organizations that have developed the "Zero Suicide" framework. There will need to be further discussion and agreement on naming the framework within the GCMHSS and targets. Targets should be ambitious but realistic.
4. Consideration should be given to step wise targets. It should be noted that feedback has been received that ultimately aiming for anything other than zero may be unacceptable.
5. The development of a culture of safety, a just culture, which will require the development of a clear plan around how this will be achieved, based on evidence and learning's from other successful organizations. This will require engagement, leadership, support and endorsement at a Board and HHS level.
6. Leadership for this project should include suicide attempt and loss survivors in leadership and planning roles; and should engage in partnerships with primary care, emergency services and departments, and other non-government organizations.

In addition to the service level framework, there should be an understanding of how our service works in with the multi-sector systemic approach to Suicide Prevention, such as FINAL REPORT – MHSS Suicide Prevention Project 25 the 9 key strategies outlined by the Black Dog Institute and the NHMRC Centre of Research Excellence in Suicide Prevention (CRESP).

7. There should be representation from all parts of the MHSS in the leadership of this project to ensure it represents a service wide framework including community, inpatient, Child and Youth, AODS and Specialist Programs.

Leadership drives Cultural transformation that instills the belief that suicide of consumers under care can be significantly reduced by improving service access and quality through continuous improvement.

Staff Training: Key Actions

8. Staff Training will be recognized as an important component of the implementation of a Suicide Prevention strategy.
9. Following determination of the framework and specific interventions to be endorsed in the assessment and management of suicidal patients, there will be an assessment of current levels of confidence, skills and knowledge of staff in providing this care.
10. Provide training for staff in evidence based assessment and treatment interventions to ensure consistency in approach across the service. Training will include collaborative safety planning, counselling on restriction to access to lethal means, and medication safety, and will include training in engaging family and other support people in these processes.

Staff Training will be provided in evidence based assessment and treatment interventions to ensure consistency in approach across the service.

Identify / Engage / Treat : Key Actions

11. Ensure systems and procedures are in place to identify and respond in a timely way to people at risk of suicide, providing a patient centred assessment, support and treatment.
12. Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning, restriction of access to lethal means and medication safety. Family and carers should be engaged with this process wherever possible.
13. Adopt a Safety Planning Template that will be used consistently across the whole organization.
14. Review evidence based assessment and management interventions that directly target suicidality. Decide upon which will be implemented across the service. Determine if there is a need for alternative interventions in specific groups (e.g.. Child and Youth Group). Implement with the support of staff training.

This key action will target the identification, treatment and management of depression, with a focus on evidence based practice and the “perfect depression care” model.
11. Benchmark current staffing levels, to ensure adequate staffing to meet expectations of assessment, and follow up at critical risk times such as transitions of care.
16. Review recommendations from the NHMRC Centre for Research Excellence i Suicide Prevention and Black Dog Institute to consider level of adherence in our current practice and steps required to meet these evidence based interventions, with particular reference:
 - Appropriate and continuing care once people leave Emergency Departments (ED), and for those at risk in the community at any one time
 - 24/7 call out emergency teams experienced in adult/child/adolescent suicide prevention;
 - Crisis-call lines and chat services for emergency callers;
 - Assertive outreach for those in the ED and discharged including those hard to engage with; E-health services of web programs through the Internet.
 - High quality treatment, such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) for those with mental health problems (including online treatments).

Identify / Engage / Treat
ensuring systems and procedures are in place to identify and respond in a timely way to people at risk of suicide,
: providing a patient centered assessment, support and treatment

Transition: Key Actions

17. Ensure procedures, staff training and resources that:
 - Enable intensive support, especially at times of crisis and discharge from inpatient units.
 - Ensures the collaboratively developed management plan describes how support will be provided during transitions of care
18. Explore and consider implementation of evidence based bridging strategies and follow up tools (e.g. caring letters, telehealth, text messages).

Transition ensuring procedures and resources enable intensive support, at times of crisis and transitional points of care.

Improve: Key Actions

19. Develop a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.
20. Decide upon measures that will assist in evaluation of interventions. These may include SAC1 events, suicides in the 12 months following care, suicide attempts, staff satisfaction and confidence, patient satisfaction.
21. Taking the opportunity to showcase Quality Improvement initiatives and outcomes.
22. Contribute to the development of a stronger evidence base in suicide prevention, through the development of a Suicide Prevention Research Strategy, in collaboration with academic partners.
23. A Research Strategy to include a framework to analyse and evaluate outcomes of implemented interventions.
24. The development of this Framework/further project is sponsored and supported by the GCMHSS Executive and in collaboration with the GCHHS Strategic Project Management Office.
25. The Suicide Prevention Framework is incorporated into the GCMHSS Research Strategy to strengthen the process of research and evaluation of suicide prevention interventions and management. This will ensure that all aspects of the SPFW can be accurately assessed, build on strengths and inform future planning and policies within GCMHSS.
26. The Communication Strategy developed, to include strategies, that will ensure a 'whole of service' consultation process is facilitated in regard to the development of the Suicide Prevention Framework, as well as branding and development of a contemporary philosophy of care being; "suicide prevention is everyone's business"
27. Quality improvement embedded, such as, but not limited to, i.e. all staff in GCMHSS to be given the opportunity to participate in quality improvement processes such as completing HEAPS training and for future HEAPS/RCA processes to foster a culture of continuous quality improvement within a Just Culture.

Improve “develop” data driven quality improvement approach to inform system changes that will lead to improved consumer outcomes and better care for those at risk.

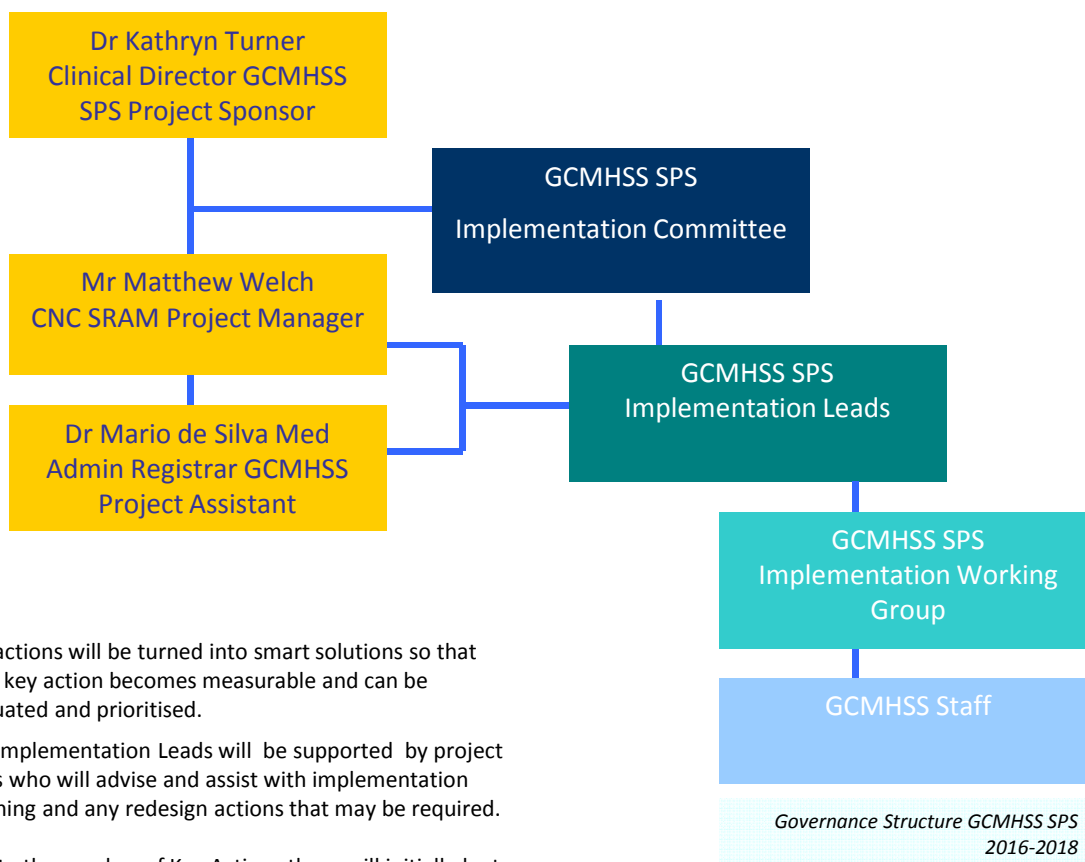
2. Governance and Monitoring

As part of the implementation approach to GCMHSS suicide prevention Strategy 2016-2018 and to drive continuous improvement, strong governance, Leadership and coordination of key actions is needed.

The establishment of the SPS Implementation Committee is essential in the overall implementation and governance of the implementation strategy. The members of this group have been selected to provide leadership, oversight and coordination of suicide prevention and risk reduction activities being undertaken across the service.

At 3 months the Implementation committee will receive a progress report and outcome of Phase 1. from the Project Team. This report once endorsed should be presented to the Divisional Governance Committee.

The Strategy sponsor will receive a progress update in relation to each implemented action plan on a fortnightly basis from the implementation leads..



Key actions will be turned into smart solutions so that each key action becomes measurable and can be evaluated and prioritised.

The Implementation Leads will be supported by project leads who will advise and assist with implementation planning and any redesign actions that may be required.

Due to the number of Key Actions there will initially be two phases. Phase 1. will prioritise key actions that require immediate implementation and will undergo a redesign implementation approach. Phase two priorities will be determined at 3 months from the launch of the strategy.

3. Implementation: Approach & Schedule

Phase 1.

The GCMHSS Suicide Prevention Strategy 2016 – 2018 Implementation strategy will utilise an adaptation of a clinical re design approach initially staged over 2 phases for the first 12 months and evaluated Jan 2017.

Stage 1.

- Establish Project Team & Develop the GCMHSS Suicide Prevention Strategy (SPS)
- Develop Approach and Implementation plan.
- Develop a voice of the staff survey focus on current beliefs, practice, knowledge, training and an organisational viewpoint related to suicide.
- Establish Implementation Committee / TOR / agenda and approach

February 2016 Commence Phase 1.

Stage 2.

- Group Key Actions into Smart Solutions – measurable key actions
- Present findings of the Surveys to the Implementation Committee
- Prioritisation of Key Actions by the Implementation Committee
- Allocation of Key Actions prioritised to Implementation Committee Leads.
- Develop Implementation approach for Service Leads to follow

February / March 2016

Stage 3.

- Supported by the Project Team Service leads establish working groups.
- Develop an implementation plan over two workshops
- Workshop 1. Generate Ideas to address the issue and identify critical steps to achieve this
- Workshop 2. Refine the Critical Steps of the Key Action and consider measures / benefits and high level plan for implementation: Identifying the critical moves: Resources, Risks Benefits and Measures, High Level implantation plan

Toll Gate: Implementation Plan endorsed by Implementation committee



March / April 2016 Phase 1 Implementation plans due

Stage 4.

- Implementation Key Actions utilising the implementation plan.
- Teams assigned and mobilised
- Transition to business as usual
- Continue Implementation, Measure progress, Implement corrective responses, Identify learning's, Share knowledge and outcomes

May / June 2016 End Phase 1. SPS Implementation progress report due



Implementation: Approach & Schedule

Phase 2.

Stage 5.

- Present evaluation update of implemented key actions
- Re Prioritisation of Key Actions by the Implementation Committee
- Allocation of Key Actions prioritised to Implementation Committee Leads.
- Develop Implementation approach for Service Leads to follow

June 2016 Commence Phase 2.

Stage 6.

- Supported by the Project Team Service leads Re establish working groups.
- Develop an implementation plan over two workshops
- Workshop 1. Generate Ideas to address the issue and identify critical steps to achieve this
- Workshop 2. Refine the Critical Steps of the Key Action and consider measures / benefits and high level plan for implementation: Identifying the critical moves: Resources, Risks Benefits and Measures, High Level implantation plan

Toll Gate: Implementation Plan endorsed by Implementation committee



July / August 2016 implementation Plans Due

Stage 7.

- Implementation Key Actions utilising the implementation plan.
- Teams assigned and mobilised
- Transition to business as usual
- Continue Implementation, Measure progress, Implement corrective responses, Identify learning's, Share knowledge and outcomes

December 2016 End Phase 2. Project Progress Report Due

Stage 8.

- Re issue voice of the staff and organisational surveys
- Present findings to Implementation Committee
- Implementation committee to workshop and Set priorities for 2017
- SPS evaluation report due end December 2016
- Update key components and key actions of the strategy and plan for the next 12 months



Jan 2017 Evaluation report update: Continue the Journey towards Zero Suicide

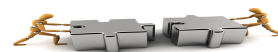


4. Key Actions: Smart Solutions

The GCMHSS SPS 2016-2018 identifies 27 Key Actions to Implement over the next two years. Some of these actions provide statements of intent and aspirations.

In order to measure the efficacy of these actions it is imperative that they are grouped into smart Solutions.

This means that key actions become solutions that are able to be measured and evaluated and clearly identify the action objective.



“ We have very intentionally incorporated high reliability into everything we do. It’s not just a ‘strategy’—it is the prevailing, defining attitude in our organization.” Lisa K. Jones, DSc, FACHE Owensboro Medical Health System

Leadership: Key Actions into Smart Solutions

Objective:

The GCMHSS Leadership drives a cultural transformation that instils the belief that suicide of consumers under care can be significantly reduced by improving service access and quality through continuous improvement.

Smart Solution: Key Actions	Smart Solution Quality Indicator
<p>1. Establish an Implementation Committee Of Service Leaders representing all service lines of the GCMHSS commencing February 2016 and reviewed February 2018. Include lived experience survivors of suicide , primary care partnerships, emergency department representatives.</p>	<p>A SPS Implementation Committee is established by end February 2016.</p>
<p>2. GCMHSS leadership develops & Implements a strategy aimed at a cultural change across the service in respect to the way suicide is viewed.</p>	<p>Development of a Strategy Survey results: pre and post</p>
<p>3. The Implementation Committee commits to a 25% reduction in suicide rates and rate of repeat suicide attempts of consumers under the care of the GCMHSS over the period 2016-2018.</p>	<p>There is a 25% reduction in the number of completed suicides and suicide attempts of consumers of the GCMHSS over 2016 - 2018 All members of the Implementation committee commit to a 25% reduction in suicides / attempts and this is recorded in the committee minutes.</p>
<p>4. The development of a culture of safety, a just culture and engagement from the HHS leadership, support and endorsement at a Board and HHS level by 2017.</p>	<p>The GCHHS Board & Executive endorse a Zero Suicide approach within a just culture framework by December 2016</p>
<p>5. GCMHSS works with HHS community partners, including Primary Health Network to support an HHS wide and multi sector systems approach to suicide prevention such as that articulated by The Black Dog Institute & NHRC (CRESP).</p>	<p>The Development of a business case to support the implementation of this strategy by December 2016. Implementation of a multi sector suicide prevention strategy by June 2017</p>



Staff Training: Key Actions into Smart Solutions

Objective:

Staff Training will be recognised as an important component of the implementation of a Suicide Prevention Strategy and will include targeted actions based on survey outcomes by February 2016.

Smart Solution: Key Actions

Smart Solution Quality Indicator

<p>6 Develop and Implement a staff survey that will identify current levels of confidence, skills and knowledge in respect to the assessment and management of suicide risk by end February 2016.</p>	<p>A voice of the Staff survey is disseminated throughout the whole GCMHSS An organisational Survey is disseminated throughout the Senior Leadership</p>
<p>7 Present findings to the implementation committee to support prioritisation of key actions 29 February 2016.</p>	<p>Outcomes are presented to the Implementation Committee by End February 2016</p>
<p>8 Provide training for staff in evidence based assessment and treatment interventions to ensure consistency in approach across the service. Training will include collaborative safety planning, counselling on restriction to access to lethal means, and medication safety, and will include training in engaging family and other support people in these processes by end July 2016.</p>	<p>By the end of July 2016 all mental health staff will have received training on safety planning, restriction of access to means, medication safety.</p>



Identify / Engage / Treat : Key Actions into Smart Solutions

Objective:

By July 2016 the GCMHSS will ensure systems, procedures and treatment interventions are in place to identify and respond in a timely way to people at risk of suicide, providing consumer centred assessment, support and treatment.

Smart Solution: Key Actions	Smart Solution Quality Indicator
<p>9 The GCMHSS will identify a range of evidence based Interventions for suicide (e.g. CBT) that our consumers should have access to.</p>	<p>Develop an implementation plan that will include the development of training for all staff in evidence based interventions for suicide (e.g. CBT). By end Dec 2016</p>
<p>10 By end June 2016 Develop a consumer suicide pathway and Procedure that ensures systems and procedures are in place to identify and respond in a timely way to people at risk of suicide, providing a patient centred pathway for clinicians to follow in the assessment, formulation and management of suicide risk. Include recommendations from the NHMRC Black Dog institute.</p>	<p>By end June 2016 a Consumer Suicide Pathway Procedure will be in place to ensure a consistent approach to the assessment and management of suicide risk across the service. Staff training will be developed to support implementation of this pathway</p>
<p>11 By end July 2016 Implement a risk management planning template (safety plan) to be utilised consistently by all clinicians and consumers across the GCMHSS, includes safety planning, restriction of access to lethal means and medication safety.</p>	<p>By end July 2016 A safety plan is embedded in practice as usual across the GCMHSS. An implementation plan and education to support implementation is developed by end March 2016</p>
<p>12 By the end of April 2016 Review evidence based assessment and management interventions that directly target suicidality and implement best practice interventions that includes interventions across the life cycle.</p>	<p>Develop and implement training that targets key areas of deficit identified from the staff survey in phase 2 of the implementation strategy.</p>



Transition: Key Actions into Smart Solutions

Objective:

By end of July 2016 ensure that procedures and resources enable intensive support, at times of crisis and transitional points of care.

Smart Solution: Key Actions	Smart Solution Quality Indicator
<p>13 By end July 2016 develop and implement a Suicide consumer pathway to care that will include post discharge follow up.</p>	<p>By end June 2016 a Consumer Suicide Pathway Procedure will be in place to ensure a consistent approach to the assessment and management of suicide risk across the service.</p>
<p>14 Ensures the collaboratively developed management plan describes how support will be provided during transitions of care</p>	<p>By end July 2016 A safety plan is embedded in practice as usual across the GCMHSS. An implementation plan and education to support implementation is developed by end March 2016</p>
<p>15 Explore and consider implementation of evidence based bridging strategies and follow up tools (e.g. caring letters, telehealth, text messages).</p>	<p>By end of July 2016 that a bridging strategy process has been developed an implemented across the GCMHSS.</p>



Improve: Key Actions into Smart Solutions

Objective:

Develop a data driven Quality approach to inform system changes that will lead to improved consumer outcomes and better care for those at risk of suicide.

Smart Solution: Key Actions

Smart Solution Quality Indicator

16 By end July 2016 the GCMHSS will have developed a research strategy that includes analysis from SAC 1 and 2 events, include suicide attempts within 7 and 30 days and also 6 and 12 months. This will include the identification of retrospective data in order to benchmark initiatives.

By End April 2016 there will be an implementation plan for a Suicide Research Strategy developed.

17 Each key action that is implemented will identify quality indicators to measure the effectiveness of the implemented actions.

The project team will ensure that a redesign approach is utilised to develop implementation strategies which include the identification of quality indicators for each key action.

18 By the end of July 2016 there will be an expedited data process in place that will capture quality aspects of clinical Practice in relation to suicide risk assessment and management and produce monthly reports on adherence to the suicide framework / pathway.

BY end April 2016 there will be an implementation plan developed that will identify key indices to be used to develop a an expedited monthly report to measure adherence to procedures and pathways in relation to suicide risk assessment and management.

19 Review the current process following a death by suspected suicide. Explore and identify best practices form other organisations. Implement changes to ensure a standardised approach to post incident reviews that support a culture of learning that is supportive of staff, carers, family.

By December 2016 there is a new process in place for the review of suspected suicides within the GCMHSS that ensures learning's are shared across the organisation in amore timely way.

The process should include a system that expedites learning's across the organisation.



Further reading

We have selected the following reports, books and articles as a starting point for further reading.

NO MORE-A Zero Suicide Strategy for Cheshire and Merseyside 2015-2020 (ed.) C.P.H. Collaborative. UK.

Zero Suicide. S. P. R. Centre. (2015). Washington, DC, Education Development Centre, Inc.

BJ, Sadock. (2012). Inevitable suicide: a new paradigm in psychiatry. *Journal of Psychiatric Practise* 18.221-24.

Committee, National Action Alliance for Suicide Prevention Executive. (2011). *Suicide Care in Systems Framework*. Clinical Care and Intervention Task Force.

Department of Health and Human Services, U. S. (2012) *National Strategy for Suicide Prevention: Goals and Objectives for Action: A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*. Washington DC.

Government, A. (2007). *A Framework for Prevention of Suicide in Australia: Living Is For Everyone (LIFE) Framework* (2007). D. o. H. a. Ageing. ACT, Commonwealth of Australia.

Government, Q. (2015). *Queensland Suicide Prevention Action Plan 2015-17*. Q. M. H. Commission. Brisbane, Queensland Mental Health Commission 2015.

Martinez, Dr Rebeca. (2015). *Zero Suicide Policy* (ed.) M.C. NHS. Liverpool UK: Mercey Care NHS Trust.

May, E. L. (MAR/APR, 2013) *The Power of Zero: Steps Towards High Reliability Healthcare*. Healthcare Executive.



Document details

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The Gold Coast Mental Health and Specialist Service

Journey to Zero through Leadership, Support and Continuous Improvement

