Queensland Health

Clinical Excellence Division

Suicide Prevention in Health Services Initiative

Year 2 Progress Report
July 2017–June 2018

Queensland Government

Suicide Prevention in Health Services Initiative: Year 2 Progress Report

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1. Suicide Prevention in Health Services Initiative

1.1 Context

- In April 2016, in response to an increase in suspected suicides in the Queensland population, the Suicide Prevention in Health Services Initiative (the Initiative) was established.
- The Initiative comprises three major components:
  1. The operation of the Suicide Prevention Health Taskforce (the Taskforce) as a partnership between the Department of Health, Hospital and Health Services (HHS), Primary Health Networks (PHN) and people with a lived experience of suicide.
  2. Multi-incident analysis of suspected suicide deaths of individuals who had a recent contact with a health service.
  3. Continued implementation of suicide risk assessment and management in emergency departments training.
- The Suicide Prevention Health Taskforce Phase 1 Action Plan (the Action Plan), finalised in November 2016, focuses on the development of suicide prevention policy, strategies, services, and programs to be used in a health service delivery context in order to contribute to a measurable reduction in suicide and its impact on Queenslanders.
- The Suicide Prevention in Health Services Initiative: Year 1 Progress Report 2016-17 articulates key achievements of the Initiative in its first year of operation, including the forging of strategic relationships with stakeholders essential to the delivery of an integrated systems approach to suicide prevention policy, strategies, services and programs.

1.2 Funding

- The Suicide Prevention in Health Services Initiative has a budget of $9.6 million over four years (2016-17 to 2019-20). Approximately $2.48 million was expended in the 2017-18 financial year.

1.3 Extension

- On 9 February 2018, the Minister for Health and Minister for Ambulance Services approved the extension of the initiative to 30 June 2020 within the existing funding envelope.
- Extension of the Initiative supports embedding a systems approach to identifying and responding to suicide risk across HHSs.
- A sustained effort also creates a stronger and more accessible evidence base to drive continuous improvement in suicide prevention research, policy, practice and service delivery and to inform future investments in Queensland's suicide prevention in health services efforts.
- The extension enables the Initiative to transition to a sustained funding source available from 2019-20 under Connecting care to recovery 2016–2021: A plan for Queensland's state-funded mental health, alcohol and other drug services. The recurrent funding will support a comprehensive and sustained systems approach through strengthened clinical governance for suicide risk screening, assessment and management across Queensland HHSs.

2. Policy context

2.1 Suicide prevention as an identified priority

Suicide is recognised as a serious health and social policy issue at all levels of government in Australia.

2.1.1 National context

- In 2014, the National Mental Health Commission (NMHC) undertook a review of mental health programs and services. The resultant report, Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, set the strategic direction to reduce suicides and suicide attempts by 50 per cent in 10 years.
- Suicide prevention is one of eight targeted priority areas identified within the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) released 14 October 2017. This priority commits Federal, State and Territory Governments to a systems-based approach incorporating the 11 suicide prevention elements identified within the World Health Organization (WHO) Preventing suicide: A global imperative.
  - Key actions articulated in the Fifth Plan include:
    - The establishment of a new Suicide Prevention Subcommittee, with jurisdictional representation from the Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch;
    - The development of a National Suicide Prevention Implementation Strategy, which will align and operationalise the 11 WHO elements; and
    - Support to PHNs and Local Hospital Networks to develop regional plans focused on integrated, whole of community approaches to suicide prevention.

2.1.2 Queensland context

- The role of the Queensland Mental Health Commission (QMHC) is to drive reform toward a more integrated and recovery oriented mental health and drug and alcohol system; this includes work towards reform in suicide prevention.
  - The Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 (Strategic Plan) is a whole of government initiative, developed by the QMHC, which aims to improve the mental health and wellbeing of Queenslanders, and identifies suicide prevention as a priority.
- Under the Strategic Plan, reform in suicide prevention commenced with the development of the Suicide Prevention Action Plan 2015 – 2017 (Action Plan).
  - The Action Plan set a shared goal 'to reduce suicide and its impact on Queenslanders [as] a step towards achieving a 50 per cent reduction in suicides in Queensland within a decade' and included 42 actions across four priority areas to be delivered by more than ten government departments and agencies.
- My health, Queensland's future: Advancing health 2026 also commits to the target of reducing suicide by 50 per cent as a headline success measure of its 10-year vision for 'promoting wellbeing' of Queenslanders.

- Connecting care to recovery 2016–2021: A plan for Queensland's state-funded mental health, alcohol and other drug services was released in October 2016 to guide Queensland's investment priorities and facilitate improved access to a range of comprehensive, recovery-oriented mental health and alcohol and other drug services. Suicide prevention is one of the plan's five priorities.
- Our Future State: Advancing Queensland's Priorities identifies thirteen major challenges facing Queensland and commits to the target of reducing suicide by 50 per cent by 2026 as a government action under the 'Keep Queenslanders Healthy' priority.

2.1.2.1 Paradigm shifts in suicide prevention within Queensland Health

National and State strategic policies highlight that effective suicide prevention is a shared responsibility requiring a comprehensive, cross-sectoral and whole-of-government approach. Within this context, HHSs and PHNs play an important leadership role in partnering with other local service providers and people with a lived experience to improve the health system's capacity to respond to people at risk of suicide. To maximise the effectiveness of health services in preventing suicide, the Suicide Prevention in Health Services Initiative is supporting a number of paradigm shifts in the way that Queensland Health considers and responds to suicide risk.

Towards prevention orientated risk formulation

- A fundamental objective of the Initiative is to promote and facilitate a renewed focus on the responsibility of health services in recognising, responding to, and providing care to people at risk of suicide.
  - The delivery of quality, timely, and appropriate suicide risk assessment, management and ongoing care are acknowledged as vital components of a comprehensive approach to suicide prevention.
  - Traditionally, risk assessment, formulation and management has been erroneously conceptualised as synonymous with risk prediction.
- The Initiative is working towards challenging entrenched practices and closing the gap between what has historically been done and contemporary advancements within the suicide prevention field. Notably, several suicide prevention activities are underpinned by a discernible shift from a prediction to the central tenet of prevention, including:
  - A transition from risk stratification/categorisation towards a multifaceted process driven by the individual's narrative in order to determine the person's needs and stressors, and working collaboratively to mobilise the most appropriate strengths and supports.
  - A transition from attempting to predict which individual might take his or her own life towards a commitment to increasing safety, reducing risk, and promoting wellness and recovery.

Targeting the suicidality

- Suicide prevention has historically focussed on the treatment of mental illness and lethal means restriction. In recent years, a paradigm shift has emerged globally towards recognition of the need to consider psychosocial and environmental risk factors in the assessment and treatment of suicidality.
- Whilst mental illness is strongly associated with suicide, it is important to acknowledge the potential influence of other risk factors (e.g. prior suicide attempt; family conflict) and respond with evidence-based treatments that directly target suicidal thoughts and behaviours.

Towards a system's approach to suicide prevention and the pursuit for zero suicides in healthcare

- The pathways to suicide are often complex and multifaceted. Such complexity necessitates parallel complexity in prevention approaches.
- Research indicates that the most effective strategies are multi-level, multi-component, systems-based approaches. It is when a range of elements operate in conjunction with one another in a systematic way that suicide risk in the population is lowered and suicide prevention outcomes are maximised.
- The Zero Suicide in Healthcare framework is both a concept – which embraces the foundational belief that suicide deaths for people receiving care from health systems are preventable – and a practice including an array of tools and strategies.
- The Zero Suicide in Healthcare framework provides an opportunity for service providers to use better, evidence-based approaches to suicide care that are available and effective and that will reduce the likelihood that people at risk of suicide fall through the cracks in the care system. The implementation of Zero Suicide is not the sole responsibility of clinicians, but requires a system-wide approach to improve outcomes and close gaps.
- An underlying principal of the Zero Suicide in Healthcare framework is a culture of trust, learning and accountability. Restorative just culture enables continuous quality improvement free of blame for practitioners when a patient attempts or dies by suicide, resulting in emotional healing for practitioners and organisational learning.
- The restorative just culture approach asserts that for changes in health service delivery to be ethical and effective, clinicians should play a genuine role in organisational learning processes. Healthcare clinicians contribute to the development suicide prevention measures that are cognisant of time pressures, in situ practices and other constraining factors.
- To read more about the implementation of the Zero Suicide in Healthcare framework within Queensland Health refer to Section 3.1.5.

Active inclusion of people with a lived experience of suicide

- Historically, people with a lived experience of suicide have typically been left without a voice. The active inclusion of those with a lived experience is progressively becoming an acknowledged cornerstone in the development and implementation of policy, strategies, services and programs.
- The Suicide Prevention Health Taskforce principles of action include a commitment that all initiatives endeavour to be informed by the lived experience voice.
    - This commitment is tangibly reflected through both the Taskforce membership structure which includes several lived experience representatives and within governance structures of specific projects funded by the Taskforce.
- The Taskforce endeavours to contribute to building the capacity of the lived experience community to participate in consultation and advisory roles to ensure participation occurs in a safe and strategic manner that is mutually beneficial (refer to Section 3.1.6.1).
- Authentic collaboration with people with a lived experience allows for service providers to better understand the needs of the individuals we aim to support by offering an opportunity for making meaning for those with a lived experience of suicide.

2.1.3 Reflections on target setting in suicide prevention

- LifeSpan is an evidence-based approach to integrated suicide prevention developed by the Black Dog Institute and the National Health and Medical Research Centre of Research Excellence in Suicide Prevention comprising nine strategies (see Figure 1).
- Based on scientific modelling, LifeSpan predicts it may be possible to prevent 21 per cent of suicides and 30 per cent of suicide attempts if each strategy is implemented *simultaneously within a local area* (Ridani et al., 2016):
  - These nine strategies incorporate health, education, other frontline services, business and the community.
  - Reduction in suicide deaths requires leadership and action from all parts of the community at all levels, including government and non-government service providers.

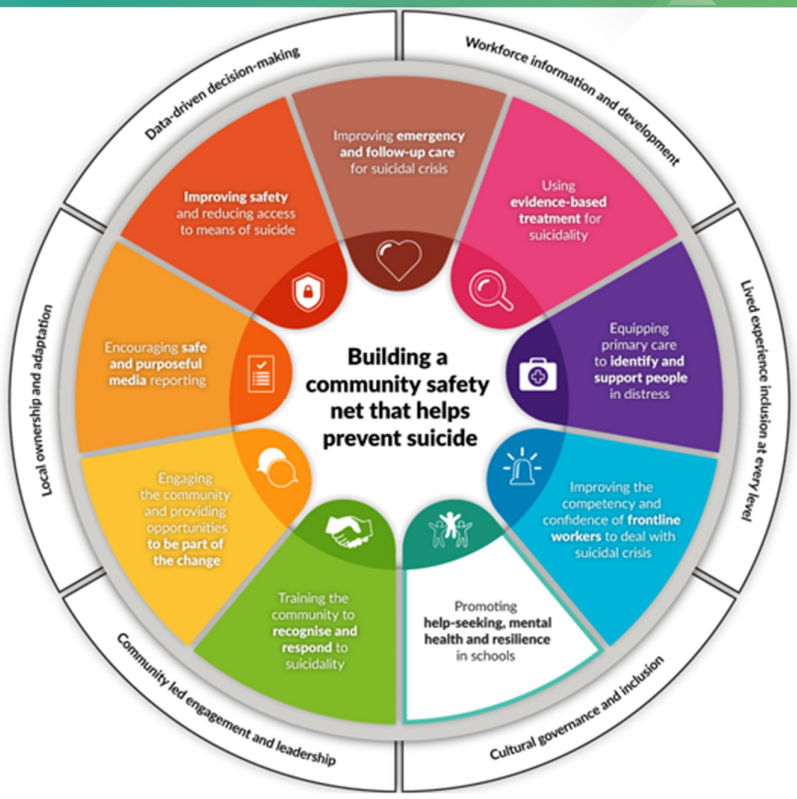


Figure 1. LifeSpan Framework, Black Dog

- Target setting is a common approach to measuring achievement and progress and the Suicide Prevention Health Taskforce acknowledges the target to reduce suicide by 50 per cent in 10 years included at both a national and state policy level (refer to Section 2.1.1 and 2.1.2).
- Several caveats pertaining to suicide mortality data and the potential impact on annual reporting require acknowledgement:
  - Recorded deaths attributed to suicide, and observed changes over time, can be affected by a range of factors including delays in finalising coronial processes.
  - Due to a low base rate, suicide rates fluctuate year to year. Changes based on single-year comparisons can be over-interpreted.
- Ethical quandaries also warrant consideration:
  - It could be argued that a 50 per cent reduction implies passive acceptance that over 300 Queenslanders, or approximately 1,300 Australians[1], will die by suicide each year or that there is an unavoidability of suicides occurring regardless of comprehensive suicide prevention strategies

[1] Based on average number deaths by suicide 2007–2012; Australian Bureau of Statistics, 2017.

and coordinated appropriate service responses.

- Patient safety is the most fundamental responsibility within a health care system. The Suicide Prevention Health Taskforce maintains a preference to move away from a suicide prevention target within healthcare of anything other than zero, with the rationale being that no target other than zero is considered acceptable.
- To read more about Zero Suicide refer to Section 3.1.5.

"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".

Thomas Priselac, President and CEO of Cedars-Sinai Medical Center

2.2 The role of Primary Health Networks in suicide prevention

- PHNs play an important role in suicide prevention on account of their links to hospitals, general practice, non-government organisations, and the communities which they serve.
- PHNs have two overarching objectives: (i) to focus on increasing the efficiency and effectiveness of services; and (ii) to focus on improving coordination of care to ensure those in need receive the right care, in the right place, at the right time.
- For further information http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home.

PHNs have the capacity to commission a range of mental health, suicide prevention and alcohol and other drug treatment services with the aim of improving the health system and delivering better consumer outcomes.

2.3 National Suicide Prevention Trials

- The Commonwealth Government has funded 12 National Suicide Prevention Trials, being led by PHNs across Australia. The trials will develop and deliver a range of targeted activities based on local needs using the Black Dog Institute's LifeSpan framework (see Figure 1).
  - Black Dog Institute is also funded by the Commonwealth to support the 12 National Suicide Prevention Trials through the provision of access to information on evidence-based suicide prevention strategies and support to implement.
  - Evaluation will be undertaken by the University of Melbourne.
- Three of the 12 regional trials are based in Queensland. In addition to 'whole of population' activity, each participating Queensland trial site has identified several priority populations for activity through stakeholder consultations and available data:
  - Brisbane North PHN: Lesbian, gay, bisexual, trans and or intersex (LGBTI); Aboriginal and Torres Strait Islander people; and young and middle-aged men.
  - Central Queensland, Sunshine Coast and Wide Bay PHN (Gympie, Maryborough and North Burnett): Aboriginal and Torres Strait Islander people; and men.
  - North Queensland PHN (Townsville): Ex-Australian Defence Force (ADF), their families and communities; Aboriginal and Torres Strait Islander people; and young people in collaboration with

the Townsville Suicide Prevention Network.

2.4Community-based suicide prevention networks

- Community networks provide opportunity for people and organisations to come together to raise community awareness and empower local people to deliver suicide prevention strategies at a grass roots level.
- The Commonwealth Government funds Wesley Lifeforce to provide Networks across Australia. There are currently 19 Wesley Lifeforce Networks across a variety of Queensland communities which utilise the Living is for Everyone (LIFE) framework, helping members of the community who are dedicated to suicide prevention to take ownership of the issue and work towards real solutions to address the problem of suicide in their community.

3. Suicide Prevention in Health Services Initiative: Progress and spotlight achievements

3.1 Suicide Prevention Health Taskforce Action Plan

- The planning and implementation of Phase One Taskforce initiatives commenced from January 2017 and are in varying stages of progress (outlined in Sections 3.1.1–3.1.8).
- The planning and delivery of initiatives delineated in Phase Two are currently being determined for development in 2018–19.
  - Several areas for potential investment identified in Phase 2 have an emphasis on Aboriginal and Torres Strait Islander suicide prevention and have been further considered by a series of Roundtable discussions held with Aboriginal and Torres Strait Islander communities (refer to Section 4.1.1).
- Stakeholder buy-in is vital to the success of identified initiatives, both in terms of development and sustainable implementation of service delivery improvements. Where relevant, each Taskforce body of work has detailed governance, communication and engagement strategies identified within it. Key stakeholders engaged in each Taskforce activity are highlighted in Appendix A.

3.1.1 Action Area 1: General Practitioners

Description and objectives

- Many people experiencing suicidal thoughts and behaviours visit a General Practitioner (GP) in the weeks or days before their death by suicide.
- The vital role GPs play in suicide prevention is acknowledged by the Taskforce. It follows that the enhancement of GP attitudes, knowledge, skills and resources in relation to appropriately recognising, responding and referring people experiencing a suicidal crisis was identified in the Taskforce Action Plan. Specifically, within Action Area 1, the Taskforce aims to:
  - Ascertain the inclusion and representation of lived experience within existing suicide prevention education programs which target GPs; and
  - Identify opportunities in collaboration with relevant peak bodies regarding identification of

development and support needs of GPs in relation to suicide prevention.

Outputs achieved July 2017 to June 2018

- To ensure efforts were not unnecessarily duplicated, the Taskforce undertook strategic communication with peak bodies to scope what suicide prevention training is available to GPs, what level of inclusion of lived experience representation is available in training, and to ascertain the most suitable avenues for consultation and communication with GPs.
- The Taskforce has been advised that GPs may receive the Black Dog Institute's Advanced Training in Suicide Prevention (ATAP). Of note, this training is accredited by the Royal Australian College of General Practitioners. Learning objectives include:
  - Undertake a suicide risk assessment effectively
  - Develop a collaborative safety plan
  - Implement a team approach to treatment planning
  - Provide effective management following a suicide attempt
  - Respond to the needs of people bereaved by suicide
- Integral to the delivery of this training is the lived experience voice. Individuals with personal experience of suicide are featured in the video content, case studies and role plays. Lived experience representatives can also be part of the training delivery to share their experience of suicidal ideation and their experience with health professionals.
- Several PHNs are rolling out ATAP training to GPs (along with Psychologists and Social Workers) in their regions.
- Information regarding the Taskforce and the broader Initiative were disseminated via two PHN kiosks displayed at the Rural Doctors Association of Queensland 29th Annual Conference held in Brisbane, 7–9 June 2018.
- Using a multi-pronged communication approach, the Taskforce endeavours to promote and encourage GPs to utilise the statewide suicide prevention HealthPathway once finalised (refer to Section 3.1.8).

3.1.2 Action Area 2: Partners in Prevention

Description and objectives

- Partners in Prevention is a research informed suicide prevention project funded for the period January 2017–June 2019. It builds on an existing collaboration between the Queensland Forensic Mental Health Service (QFMHS), Queensland Ambulance Service (QAS) and Queensland Police Service (QPS).
  - The project seeks to better understand the characteristics of individuals who make suicide related calls to emergency services, the types of responses that could best serve their needs, the capacity of the services to deliver the responses, and how to improve continuity of care following a suicidal crisis that results in a call to emergency services.
  - The project has five major project components: Literature reviews; service mapping; a data linkage study; knowledge, skills, confidence and attitudes of first responders; and process mapping.

Outputs achieved July 2017 to June 2018

- Completion of research protocols, ethical clearances and research governance, and commencement of major work elements, including the Partners in Prevention Data Linkage Study and Knowledge, Skills, Confidence and Attitudes of First Responders Study.
- Identification of the Partners in Prevention cohort. This unique dataset identifies a cohort of individuals who were the subject of a suicide related call to police or ambulance services and forms the basis of the data linkage study.
- Drafting and circulation of service mapping of statewide police-ambulance-mental health 'touchpoints' for consultation among the Partners in Prevention service mapping sub-committee.
- Briefs on service mapping, and preliminary data linkage findings, circulated to Partners in Prevention Steering Committee and Working Groups.
- Receipt of a commissioned report – *Developing an evaluation framework for collaborative suicide crisis response models* (Central Queensland University) – which provides a review of frameworks for evaluating collaborative suicide crisis response models and developing a bespoke evaluation framework for Queensland services that leverages the Partners in Prevention project dataset.
- The Partners in Prevention project team have extensively disseminated work to a variety of stakeholders. This includes early communication with child and youth mental health service representatives following identification of the over representation of young people experiencing suicide crises (young women in particular) in data from police and ambulance responders. Engagement with child and youth mental health service representatives has focussed on improving referral pathways for children and young people in crisis.

3.1.3 Action Area 3: Queensland Health school based clinicians

Description and objectives

- The Taskforce acknowledges that the school environment falls within the remit of the Department of Education and Training (DET) and the myriad of initiatives related to student mental health and emotional wellbeing currently being undertaken in the public-school environment by DET.
- Notwithstanding this, the Taskforce recognises that School Based Youth Health Nurses (SBYHN) are in a unique position to perform a gatekeeping function in the school environment, identifying students at risk and providing support and referrals to appropriate services.
- In collaboration with SBYHN and Ed-LinQ Co-ordinators, Action Area 3 aims to build the capacity of Queensland Health clinicians who work within the school environment to support students experiencing mental health issues.

Outputs achieved July 2017 to June 2018

- In collaboration with the Black Dog Institute, the Suicide Prevention in Health Services Initiative team held a Suicide Prevention in Schools forum in Brisbane on 22 November 2017.
    - 28 representatives attended from DET head office, DET regional mental health coaches relevant to PHN trial sites, PHN staff from trial sites, Ed-LinQ, SBYHN, and the Queensland Mental Health Commission.

- The purpose of the forum was to provide attendees with an overview of the evidence base for suicide prevention in school-aged children, and how to implement evidence-based training in secondary schools.
- The forum provided attendees with valuable information regarding cross-sectoral child and youth suicide prevention work, networking and collaboration opportunities. Feedback was also provided about gaps in services, best practice and information on resources, services and training.

- Establishment of a working group comprising representatives from SBYHN, Ed-LinQ, Child and Youth Mental Health Services (CYMHS) and School Health Management (Children's Health Queensland HHS) to support the delivery and implementation of skill development activities targeting SBYHN.
- Statewide consultation was undertaken seeking information about what is currently available to assist SBYHN with identifying and preventing suicidal behaviour and their personal insights into what is necessary to improve suicide prevention efforts.
- SBYHN reflected on the current context, existing gaps and barriers (real and perceived) of their roles and offered potential solutions to these issues. Three main themes were identified within feedback:
  - SBYHN skills development and support
  - Recognition of and response to at risk students
  - Support for students.
- In response to the feedback received, a three-tier suicide prevention training recommendation guideline for SBYHN is currently under development. The guideline will identify evidenced based training encompassing mental health education and awareness, suicide risk assessment and management skills and brief interventions.

3.1.4 Action Area 4: Cultural appropriateness of Suicide Risk Assessment and Management in Emergency Department settings training package

Description and objectives

- The Queensland Centre for Mental Health Learning (Learning Centre) was commissioned to enhance the existing Suicide Risk Assessment and Management in Emergency Department settings (SRAM-ED) training package to reflect cultural considerations for Aboriginal and Torres Strait Islander people experiencing a suicidal crisis.
- An overarching aim of this project was to improve cultural safety and promote the delivery of culturally sensitive care within ED settings.

Outputs achieved July 2017 to June 2018

- SRAM-ED eLearning content was reviewed and enhanced to include cultural considerations for assessment and safety planning with an Aboriginal and Torres Strait Islander person.
- An e-Learning video scenario script was developed in consultation with Indigenous expertise and rural and remote SRAM-ED trainers for contextual feedback.
- The eLearning storyboard amendments were included in the SRAM-ED e-Learning modules (QC50 and QC51) following quality assurance and testing (see Figure 2 for a screen grab example of e-

Learning content).

- Filming for the video resource was undertaken at the Clinical Skills Development Service hospital simulation studio. The clinical roles were played by Learning Centre clinicians and Indigenous actors from the Aboriginal Centre for Performing Arts were engaged to play the role of patient and patient's mother in the scenario.
- e-Learning content and the video resource were released 1 March 2018 and statewide communication of enhancements to existing SRAM-ED trainers has been completed.

Figure 2. Screen grab of updated e-Learning content to enhance cultural appropriateness of SRAM-ED.

3.1.5 Action Area 5: Zero Suicide in Healthcare Multi-site Collaborative

Description and objectives

- The Zero Suicide in Healthcare Multi-site Collaborative utilises a systems approach to change incorporating best practice in quality improvement and evidence based care models that have demonstrated a reduction in the suicide rate amongst people receiving care from a health service.
- Health services are well placed to recognise and intervene with suicidal persons and contact with a health service is typically considered protective against the risk of suicide.
- Ten HHSs are participating in an 18-month project (January 2018 – June 2019) to implement the Zero Suicide in Healthcare framework using collaborative methodology – Central Queensland, Children's Health Queensland, Darling Downs, Gold Coast, Mackay, Metro North (Redcliffe/Caboolture area), Metro South (Bayside area), Torres and Cape, Townsville and West Moreton.

What is Zero Suicide in Healthcare?

- The core principle of Zero Suicide in Healthcare is that suicide deaths for people under care are preventable, and the bold goal of zero suicide among persons receiving care is an aspirational challenge that health systems should accept.
- The Zero Suicide in Healthcare approach aims to improve care and outcomes for individuals at risk of suicide in the health care system. It represents a commitment to patient safety – the most fundamental responsibility of health care – and to the safety and support of clinical staff, who do the demanding work of treating and supporting individuals experiencing a suicidal crisis.
- The approach builds on work undertaken in several health care organisations including the Henry Ford Health System in Michigan USA, and is currently being implemented in health services across the United States, United Kingdom, New Zealand and Australia.
- The Zero Suicide in Healthcare framework guides implementation of the multi-site collaborative and has seven essential elements:

LEAD	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.
TRAIN	Develop a competent, confident and caring workforce.
IDENTIFY	Systematically identify and assess suicide risk among people receiving care.
ENGAGE	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.
TREAT	Use effective, evidence-based treatments that directly target suicidality.
TRANSITON	Provide continuous contact and support, especially after acute care.
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.

Further information about the Zero Suicide in Healthcare framework can be found at www.zerosuicide.com.

Just Culture

Suicide is a serious clinical event in healthcare services which drives significant distress in healthcare workers, potentially producing second victims with profound effects for those staff members. The Zero Suicide in Healthcare Multi-site Collaborative advocates for a culture of trust, learning and accountability as a central tenet of implementation.

- Continuous quality improvement can only be effectively implemented in a safety-oriented, 'just culture' free of blame for individual clinicians. A quality improvement attitude promotes the opportunity to learn from errors and within a 'just culture' it becomes possible to pursue excellence.

'It has to do with being open, with a willingness to share information about safety problems without fear of being nailed for them'

Professor Sidney Dekker, Safety Science Innovation Lab, Griffith University

What is Collaborative methodology?

- Pioneered in the United States by the Institute of Healthcare Improvement, the collaborative methodological approach has proven to be an effective method of implementing change across an organisation, or between different teams within an organisation, across diverse sectors, including health.
- The approach involves participating groups sharing information and ideas, building existing knowledge, developing expertise and solving problems with the aim of making real, system level changes towards dramatic improvements in care. As changes are guided by best available evidence, the collaborative methodology has demonstrated utility for its application in closing the gap between what is known and what is practiced.
- By utilising a continuous improvement cycle, small rapid changes occur resulting in larger changes within the system. A key element of the methodology is the provision of the necessary knowledge and skills to ensure sustainability once the formal collaborative period has ended.
- The Zero Suicide in Healthcare Multi-site Collaborative is a leading exemplar of this relatively new global movement.

Outputs achieved July 2017 to June 2018

- In October 2017, the Deputy Director-General invited all HHS Chief Executives to express an interest in participating in the Zero Suicide in Healthcare Multisite Collaborative.
- Twelve HHSs expressed interest and participated in readiness interviews conducted by the Suicide Prevention in Health Services Initiative team.
- Ten HHSs demonstrated sufficient readiness to participate by displaying leadership commitment for a safety orientated culture, strong lived experience engagement, proactive support for building a competent, confident and caring workforce and supportive governance processes in place for suicide prevention.
- The Suicide Prevention in Health Services Initiative team is developing a strategy to work with the

remaining six HHSs in Queensland to assist with their readiness to participate or explore alternative models appropriate to local needs. Work has commenced with the Sunshine Coast HHS who will be joining the collaborative in 2018-19, as well as the Cairns and Hinterland HHS who have started examining the Zero Suicide in Healthcare framework for local applicability.

- $2.5 million has been committed to support the 10 HHSs to implement the Zero Suicide in Healthcare framework.
- Project leads and local governance structures have been established in each service, including the verification of executive sponsors. Each service has submitted a project plan including project logic and a work plan, and is required to report against the work plan monthly.
- The first Learning Session for the Zero Suicide in Healthcare Multi-site Collaborative was held in Brisbane on 13 and 14 February 2018 for the 10 HHS project teams and executive sponsors. Keynote speakers presented a range of topics relevant to Zero Suicide, including:
  - Mrs Kerrie Keepa, a lived experience advocate, spoke about her personal journey and involvement in supporting suicide prevention in health services and conveyed a sense of hope providing encouragement to learning session attendees.
  - Dr John Wakefield, Deputy-Director General, Clinical Excellence Division provided the context for the Multi-site Collaborative, reiterating commitment towards ongoing service improvement.
  - Professor Sidney Dekker, Director, Safety Science Innovation Lab, Griffith University advocated for a Just Culture in the context of health which seeks to build a culture of trust, learning and accountability.
  - Dr Kathryn Turner and team described application of the Zero Suicide in Healthcare framework in the Gold Coast Mental Health and Specialised Services.
  - Dr Tom Meehan and Dr Rebecca Soole asked attendees to consider opportunities for change grounded in contemporary research.
- Project leads attend monthly virtual learning sessions. Topics have included '*Laying the foundation for success'* and *'The power of influence, gaining momentum and support from clinicians'.*
- A whole of service workforce online survey was launched on 16 May 2018 and closed 11 July 2018. Almost 1,200 surveys were completed.
  - Results will inform participating HHSs about the organisation's ability to address issues related to suicide, provide a baseline against which to monitor improvement and inform planning for future education and training to fully implement the Zero Suicide framework.
  - Data will also contribute to the statewide evaluation of the Initiative (refer to Section 6).
- The second Learning Session is scheduled to be held on 16 and 17 July 2018 and includes keynote speaker David Covington, CEO and President of RI International (provider of mental health services including crisis, health, recovery and consulting across the USA and internationally). He will be presenting on 'Suicide prevention: Why zero is the only number we can live with'.

3.1.6 Action Area 6: Lived Experience Peer Support

Description and objectives

- Peer support approaches provide a unique and complementary role to health service provision and can be an important source of authentic empathy and validation on an individual's journey to

recovery.

- The development, trial and evaluation of a Lived Experience Peer Support Service will explore the enhancement of continuing care options for people following an acute crisis through lived experience peer support as a therapeutic option.
- This investment builds on identified gaps and will provide an opportunity to build the evidence base for future investment.

Outputs achieved July 2017 to June 2018

- A market sounding via a Request for Information was released on 9 September 2017 via QTenders.
- The Request for Offer was released to market via QTenders on 5 January and closed on 29 January 2018.
- The Evaluation Panel convened to assess the submissions identified two successful offerors:
  - Brook RED: A consortium of lived experience experts will design a service delivery model utilising design thinking methodology. The model will be tested and evaluated in the ED at Redland's Hospital, Metro South HHS.
  - Flourish: The model will operate as an adjunct to the Peer Operated Service in Hervey Bay and be tested and evaluated in selected EDs in Wide Bay HHS, commencing at Hervey Bay Hospital.
- Both providers have been funded $250,000 (excl. GST) for a period of 15 months. Independent evaluation will identify sustainability and scalability of the service delivery models post funding.

3.1.6.1 Building the capacity of people with a lived experience

- In September 2017, Authentica Consulting were commissioned by the Mental Health Alcohol and Other Drugs Branch to report on the training and support available to prepare people with a lived experience for involvement in service development initiatives.
- A resultant Suicide Lived Experience Report explored training and support gaps as well as priorities for training support enhancement.
  - The 'surprising scarcity of specific training and support for people with a lived experience to participate in sector initiatives' was acknowledged.
  - The need to support Aboriginal and Torres Strait Islander people and people identifying as LGBTIQ+ with a lived experience to improve the delivery of training and programs across a range of suicide prevention activities as relevant to their respective communities, and with recognition that identification with either community is not mutually exclusive, was highlighted.
- The Taskforce recognises that people with a lived experience have a valuable, unique and legitimate role in improving the health system's capacity to respond to individuals at risk of suicide.
- Moreover, the Taskforce supports the genuine inclusion of Aboriginal and Torres Strait Islander people and LGBTI people with a lived experience of suicide in the development of appropriate suicide prevention initiatives, policy, strategies, services, programs and the delivery of programs in a manner that supports individual, carer and family needs.
- In July 2017, Taskforce members supported investment in a capacity building initiative to enhance the meaningful engagement and involvement of people with a lived experience of suicide. The Taskforce recognises:

- Whilst all Taskforce actions are lived experience informed, representation of lived experience is specifically identified in three of the eight Phase 1 actions.
- Representation from people with a lived experience from culturally diverse groups will also be required to progress Phase 2 actions.
  - Of the identified areas for Phase 2 Taskforce investment, 50 per cent are focused on Aboriginal and Torres Strait Islander peoples. Building the capacity of Aboriginal and Torres Strait Islander lived experience representation is therefore an identified priority.

3.1.7 Action Area 7: Carer Support

Description and objectives

- The support service for people caring for someone experiencing a suicidal crisis aims to reduce 'caregiver' burden and result in enhanced carer's ability to respond to a suicidal crisis, whilst looking after their own health and wellbeing.

Outputs achieved July 2017 to June 2018

- An expert panel consisting of Taskforce members and people with lived experience has been convened to identify the specifications and principles of the service delivery model, which will inform the Request for Offer.

3.1.8 Action Area 8: HealthPathways

Description and objectives

- HealthPathways (originating in Canterbury, New Zealand) is a web-based information portal used primarily by GPs at the point of care and tailored to reflect local resources.
- The Suicide Prevention in Health Services Initiative team are developing a statewide suicide prevention HealthPathway to facilitate localisation at each site.

Outputs achieved July 2017 to June 2018

- In September 2017, the development of a standardised statewide pathway to facilitate localisation was proposed by the Taskforce and supported at the HealthPathways Coordinators meeting.
- In collaboration with GP Clinical Editors from Brisbane North PHN, Metro South HHS, and Townsville HHS, the assessment and management section of the suicide prevention HealthPathway was revised to include contemporary best practice.
- Following necessary formatting to align with the Style Guide of the website authors (Streamliners New Zealand), the statewide pathway was uploaded to the Brisbane South PHN draft website.
- Final review and editing was completed in collaboration between Brisbane South PHN, Townsville HHS and Brisbane North PHN Clinical Editors.
  - The statewide pathway was also subject to a final Subject Matter Expert review by relevant stakeholders including psychiatrists in each HHS.
- In alignment with the HealthPathways GoLive checklist the final statewide Suicide Prevention HealthPathway will be released by the end of August 2018.

3.2 Suicide Prevention Health Taskforce: Phase 2

- The 10 action areas identified for potential investment under Phase 2 of the Taskforce Action Plan require further consideration and prioritisation.
- Several of the action areas have a significant focus on Aboriginal and Torres Strait Islander suicide prevention in a health services context.
  - In light of this, the need for further targeted consultation with First Nation peoples was acknowledged to ensure that Phase 2 initiatives are applicable, culturally sensitive and take a holistic view of an Aboriginal and Torres Strait Islander person and consider family and community contexts (including the influence of trauma, grief, and loss).
- As a result, a series of Roundtable discussions with a focus on the lived-experience of Aboriginal and Torres Strait Islander people were held from March to June 2018 (refer to Section 4.1.1).

3.2.1 Solution Focused Brief Intervention

Description and objectives

- Funding was provided to West Moreton HHS in December 2017 to support a Solution Focused Brief Therapy (SFBT) training and evaluation intervention for nurses undertaking mental health placements within an inpatient setting.
- The project aims to identify the feasibility and effectiveness of brief interventions for people with suicide and self-harm risk as identified in Phase 2 of the Suicide Prevention Health Taskforce Action Plan.

Outputs achieved July 2017 to June 2018

- Two Solution Focused Brief Therapy (SFBT) workshops with Michael Durrant (Australia's leading international trainer of Solution Focused Brief Therapy) have been completed with 32 participants.
  - Workshops were very highly regarded/evaluated with interest expressed for further sessions/workshops.
- In February 2018, 10 nurses undertaking the second year of their Masters degree participated in a workshop on SFBT. These nurses are currently undertaking placements (for up to six months) in a range of West Moreton HHS facilities and services including the acute mental health inpatient unit at Ipswich Hospital, acute care team, community adult and child and youth mental health teams, and secure inpatient services at The Park.
  - Provision of supervision sessions to support participants with this intervention is progressing
  - Data collection is currently in progress regarding:
    - Nurse experience and perspectives on delivering SFBT within different settings of a mental health service.
    - Factors that facilitate or hinder nurse capacity to deliver therapies such as SFBT in clinical practice across inpatient and community-based settings.
    - Patient experience and engagement in SFBT and how the therapy assisted them to better manage their stressors.
- A second cohort of 10 students will be invited to participate in the program in February 2019.

3.3 Multi-Incident Analysis of Suspected Suicides

3.3.1 Description and objectives

- The Multi-incident Analysis of Suspected Suicides (MIA) is an in-depth analysis of health service system factors related to the suspected suicide deaths of individuals who had contact with a Queensland health service within one month of death (during 2015 and 2016 calendar years).
- The MIA aims to identify when, where and how the provision of existing health services could be improved to reduce suicide amongst at-risk demographic and clinical cohorts, as well as individuals at risk of suicide.
- The review will examine aggregate and cohort-specific data to identify how system factors apply to discrete and vulnerable populations in the context of contact with a HHS.
- The project data source is linked coronial and Queensland Health information (six Queensland Health Databases). Project data will be scrutinised to reveal characteristics of suspected suicide deaths at individual and population levels, as relevant to the delivery of health services.
- Through consultation with stakeholders (e.g. HHSs, people with a lived experience), findings will be developed into recommendations to inform future actions and improvements in service responses at localised and statewide levels.
- MIA findings will contribute to suicide prevention by highlighting how health service system factors can be reformed to more effectively respond to individuals who have contact with a HHS when at-risk of suicide.

3.3.2 Milestones achieved July 2017 to June 2018

- Project governance documentation developed and approved.
- Research ethics and governance responsibilities achieved, including:
    - Ethical approval from the Forensic and Scientific Services Human Ethics Committee, September 2017
    - Status as a genuine researcher granted by the State Coroner, October 2017
    - Public Health Act application approval, December 2017
    - Site Authorisation, December 2017
    - Approval from multiple data custodians (September – December 2017)
- Project scope, research questions, variables and data parameters developed.
- Four specific cohorts were selected for the first phase of the project (2017-18):
    - Children and young people
    - Older people
    - People receiving care from the acute mental health care pathway
    - Aboriginal and Torres Strait Islander people
- Data was sourced from six Queensland Health databases and linked with coronial information. A unique identifier was assigned to each case via a complex data linkage process that linked records of health services contact of individual consumers across the multiple databases.

- Four cohort-specific panels involving 40 experts from across Queensland were convened from an Expression of Interest (EOI) process to conduct in-depth analysis and contribute to recommendations for health service delivery improvements. Panels were assembled to ensure each group represented the perspectives of clinicians, consumers and carers, and cohort specialists. Panel members were named on the Public Health Act application and were all Queensland Health employees with the exception of two Indigenous panel members (from the Queensland Family and Child Commission and the Queensland Aboriginal and Islander Health Council).
- A full-day induction workshop for all panel members was held in February 2017. In addition to a project orientation, the day included a presentation by Associate Professor Peter Burnett, Director of Clinical Governance, North Western Mental Health, Royal Melbourne Hospital who facilitated an engaging session on the challenges and opportunities of aggregate incident review.
- A minimum of five panel meetings (3-4 hours each) per cohort were held between March and June 2018.
- The analysis model adopted a clinical analysis approach and commenced with sequencing of events followed by in-depth individual case reviews. Deidentified data was then developed into themes identified across cohort cases in preparation for the recommendations stage of the project.
- Lived experience representatives joined expert panels to help formulate recommendations based on themes identified from the clinical review of individual data.

Figure 3. The Children and young people panel and the Aboriginal and Torres Strait Islander people panel, Recommendations meetings

- Draft recommendations are currently being prepared for consideration and dissemination from July 2018.
- Annual research ethics and governance reporting responsibilities have been fulfilled.
- Key MIA priorities from July 2018 include: (i) Conducting quantitative analysis of the aggregate data to identify additional cohorts for potential review in the next phase of analysis; (ii) Distributing draft recommendations to relevant stakeholders; and (iii) Continued drafting of findings from analysis of the initial four cohorts.

3.4 Suicide Risk Assessment and Management in Emergency Department settings

3.4.1 Description and objectives

- The Suicide Risk Assessment and Management in Emergency Department (SRAM-ED) training is targeted for all clinicians delivering care in an emergency department (ED) environment who may not have specific training in mental health or suicide prevention, or would benefit from re-exposure to contemporary resources. This includes medical, nursing and allied health staff.
- More specifically, the SRAM-ED training package comprises:
  - **QC25 SRAM-ED (Train-the-trainer):** Clinicians and educators working in an ED setting to be trained to deliver the SRAM-ED training package on an ongoing basis within their local HHS (refer to Appendix B).
  - **QC50 SRAM-ED: Foundational:** For non-mental health clinical staff working in the ED; clinicians who engage with patients at risk of suicide but for whom decisions regarding discharge are not in their scope of practice (refer to Appendix C).
  - **QC51 SRAM-ED: Advanced:** For key clinical staff in the ED who are tasked with conducting suicide risk assessment and safety planning (i.e. those who make decisions regarding discharge) as well as mental health clinicians (refer to Appendix D).
    - The Advanced Course can also be accessed by those working in ED who demonstrate an interest in mental health and suicide prevention, and are supported by their respective line manager.

3.4.2 Trained facilitators

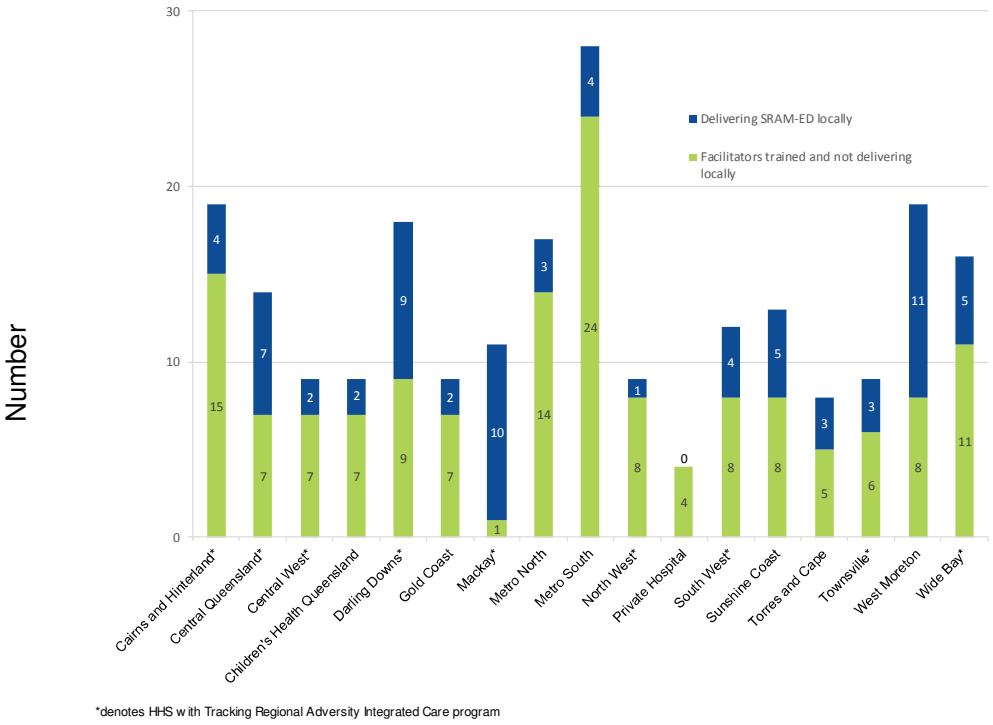
3.4.2.1 Recruitment and enrolment process

- Recruitment to become a trained SRAM-ED facilitator occurs via a mix of self-selection and line manager selection. Regardless of selection method, line manager or Executive endorsement is required. Those selected to attend must submit an expression of interest (EOI). The EOI covers a range of areas to assess their suitability as a trainer.
- Trained facilitators are provided with ongoing resources from the Learning Centre, including but not limited to:
  - Tailored training promotional materials and training planning support
  - Access to clinical experts, mentoring, and support with training deliveries
  - Opportunities to share and work through training challenges
  - Opportunities for debriefing following deliveries
  - Technical support for the online learning component (i.e. support person available to guide those with low information technology literacy through the online course)
  - Ongoing train-the-trainer opportunities for content refreshers

3.4.2.2 Status

- In 2017-18, five train-the-trainer sessions were offered across the state in Mackay, West Moreton and South West HHSs.
- As of 30 June 2018, a total of 224 clinicians state-wide have been trained as facilitators to deliver the SRAM-ED training package locally within their HHS.
  - 75 of these trained facilitators are currently delivering SRAM-ED locally within their HHS; depicted in blue in Figure 4.
    - Clinicians who are trained as facilitators but are not delivering training at the local level (depicted in green in Figure 4) are arguably still delivering higher quality care within their HHS to individuals presenting with suicidality.

Figure 4. Number of trained SRAM-ED facilitators per HHS and the number delivering SRAM-ED locally within their HHS



3.4.3 Local uptake

- As of 30 June 2018, a total of 1,362 clinicians state-wide have participated in SRAM-ED training in some capacity. The number of clinicians who participated in SRAM-ED training at a local level during 2017-18 is depicted in Table 1.
  - Both foundational and advanced courses have an eLearning and face-to-face training component

(refer to Appendix D).

- Where participants have completed both eLearning and face-to-face training from either the foundational or advanced course, they are deemed to have completed the respective course in its entirety (shaded in grey, Table 1).
  - The eLearning components are a stipulated pre-requisite for the face-to-face components. However, the enforcement of prior completion of eLearning is managed at a HHS local level.

Table 1. Completion numbers for Foundational and Advanced Course trained at a local level by SRAM-ED facilitators

	1 July 2017 - 30 June 2018						
	Foundational Course			Advanced Course			
Hospital and Health Services (HHS)	eLearning only	Face-to-face only	**Both** eLearning and Face-to-face*	eLearning only	Face-to-face only	**Both** eLearning and Face-to-face^	Total training events
Cairns and Hinterland	46	1	9	22	3	23	104
Central Queensland	47	6	7	32	31	61	184
Central West	14	8	0	3	1	25	51
Children's Health	0	0	0	0	0	0	0
Darling Downs	56	20	33	11	11	31	162
Gold Coast (Zero Suicide)	N/A	N/A	N/A	77	17	145	239
Gold Coast (SRAM-ED)	40	0	1	13	2	0	56
Mackay	19	25	33	11	13	10	111
Metro North	43	4	3	5	1	0	56
Metro South	41	2	16	11	1	1	72
North West	2	0	0	0	5	6	13
South West	18	0	0	3	0	1	22
Sunshine Coast	9	3	8	19	0	0	39
Torres and Cape	2	2	18	1	0	0	23
Townsville	4	6	7	4	0	0	21
West Moreton	6	8	19	6	0	20	59
Wide Bay	34	13	24	8	15	43	137
Not specified	3	1	7	2	0	0	13
Total	384	99	**185**	228	100	**366**	1362

* Participants who have completed both eLearning and face-to-face have completed the Foundational Course in its entirety.

^ Participants who have completed both eLearning and face-to-face have completed the Advanced Course in its entirety

3.4.3.1 Caveats

- Online training completion is tracked directly by the Learning Centre (i.e. for those completed within the Learning Centre's online learning system) and indirectly (i.e. regular requests to those who manage HHS online learning systems).
- Face-to-face training completions are provided by each local HHS trainer back to the Learning Centre for tracking in a state-wide database.
  - Data presented in Table 2 is an under-representation of training completed for the 2017-18 period. Additional data is anticipated to be received by the Learning Centre from HHS sites for this period. Furthermore, eLearning data is dynamic and dependant on completion of training.
- The eLearning modules are openly available to all Queensland Health staff. The data reported in Table 1 for eLearning represents completions by clinicians in a relevant setting for the course.

3.4.4 Evaluation

- The overarching aim of the evaluation plan for SRAM-ED is to assess the impact of SRAM-ED in terms of: Clinician attitudes towards suicide, confidence to implement learned content on the job, and to explore HHS implementation of the course.
- SRAM-ED is evaluated at three time-points: pre-eLearning, post-eLearning, and post-face-to-face evaluations
- A brief overview of participant profiles, self-reported perceptions of confidence, training efficacy, satisfaction, and attitudes towards suicide are outlined below.
  - It is important to note the following information is generated solely from **evaluations completed** by participants. It may bear little relationship to attendance numbers. Differences in frequencies of responses between items may be explained by incomplete evaluations or participants not wishing to complete an item.

3.4.4.1 Training outcomes

- The general trend across all items, and SRAM-ED versions, shows a marked increase in confidence for training transfer from pre- to post-eLearning. This is followed by a noticeable, but less pronounced, increase in confidence from post-eLearning to post-face-to-face training.

Selected verbatim participant feedback regarding *training transfer*:

"[I will] consider and look towards the big picture [and] not to be afraid to talk to the client on presentation to the Emergency Department"

"I will endeavour to use the different interview techniques to develop a better space for open communication with consumers. The hope being to minimise the withheld intent as much as possible to ensure support plans for consumers can be made with the most information."

- Participants expressed generally high levels of confidence and commitment to apply the learned content after the eLearning. These high levels were maintained, and indeed increased somewhat, after the face-to-face training.
- Participants generally believed that the training was very effective in improving their core skills relating to suicide risk assessment and management. This high level of perceived efficacy of the training was maintained at the post-face-to-face time point.
- Within the context of the SRAM-ED course, it was deemed important to determine how, if at all, participants' attitudes toward suicide changed as a result of training.
  - Attitudes Towards Suicide Scale (Renberg & Jacobsson, 2003) was used as an index of this attitudinal shift and appeared at all three time-points of the evaluation. Notable shifts in attitudes included:

Selected verbatim participant feedback regarding *confidence and/or commitment*:

"I feel more confident talking to people about their thoughts on suicide, and getting a relationship started to gain insight on their risk and safety."

"This workshop has given me more confidence to start a conversation. It is something that makes me feel uncomfortable and I used to feel like I didn't have the appropriate skills to deal with it. This course has shown me how important it is to start the conversation."

    - **Agreement** that 'it is always possible to help a person with suicidal thoughts' increased from 52% at pre-eLearning to 68% at post-eLearning, and was maintained at 70% at the post-face-to-face interval.
    - **Disagreement** that 'there is a risk of evoking suicidal thoughts in a person's mind if you ask about it' increased from 67% at pre-eLearning to 75% at post-eLearning, and increased further to 81% at the post-face-to-face interval.
- The next phase of evaluation of the SRAM-ED course will focus on the enablers and barriers that have influenced the ability of participants to deliver, access and/or implement the training within their own clinical setting or service. It will investigate the value of the train-the-trainer course, the sustainability of the train-the-trainer model, and the overall application of the course to general clinical practice within Queensland Health

3.4.5 Other Queensland Health suicide prevention training

3.4.5.1 QC2 – Engage, Assess, Respond to, and Support Suicidal People (EARS)

- This course explores the issues of suicide risk across the full lifespan and is designed to foster clinical competence in working with suicidal people. It contains content related to basic epidemiology of suicide, barriers to engagement, privacy and confidentiality, risk and protective factors for suicide, the Chronological Assessment of Suicide Events approach (Shea, 1998), including skills demonstration videos, the Integrated Motivational Volitional model of suicidal behaviour (O'Connor, 2011), Prevention Orientated Risk formulation (Pisani, 2016) and care planning.

3.4.5.2 QC28 Youth: Engage, Assess, Respond to, and Support Suicidal People (YEARS)

- YEARS is an adaptation of the EARS course and uses the same theoretical and practical approaches that are contextualised and adapted for use with children and adolescents. It explores the developmental and systemic differences that have an influence on youth suicide.

3.4.5.3 QC31 Supporting a Suicidal Young Person – pilot and new course development

- This course provides participants with the skills to identify young people at risk of suicide and gain practical skills to ask directly about suicide. It targets non-clinical workers and bridges the gap between clinical training and more general crisis support training.

4. Consultation

4.1 Roundtables

- The Taskforce committed to holding a series of Roundtables to bring together the collective expertise of a broad range of stakeholders across government, industry, and the community, including those people with a lived experience, to inform the key priority areas identified within the Taskforce Action Plan.
- The inaugural Suicide Prevention Health Taskforce Roundtable consultation was held in September 2016, with the second Roundtable, exclusively involving people with a lived experience of suicide, held in March 2017.

4.1.1 Aboriginal and Torres Strait Islander Suicide Prevention

- To inform priority areas for investment in Phase 2 and to ensure genuine and authentic engagement with Queensland's First Nation's people, a series of Roundtables were held in three locations. The multi-location approach was adopted to help gain a greater understanding of the contexts and priorities of Indigenous communities in geographically diverse regions across the state. Specifically:
  - **Remote** (Bamaga; held 22 March 2018);
  - **Metropolitan** (Redcliffe; held 19 April 2018); and
  - **Regional** (Townsville; held 24 May 2018) (See Figure 5).

Figure 5. Cultural activities held during Aboriginal and Torres Strait Islander suicide prevention Roundtables in Bamaga, Redcliffe and Townsville (top to bottom)

- The purpose of the Roundtables was to bring together Indigenous community representatives to examine suicide prevention policy, strategies, services and programs used in a health service delivery context related to Aboriginal and Torres Strait Islander people.
- Indigenous local working groups were established in each location for co-design of key components such as structure of events, culturally appropriate activities, support persons and potential attendees.
- Local working groups comprised representatives from:
  - The respective HHS and PHN;
  - Local Aboriginal and Torres Strait Islander Community Controlled Health Organisations;
  - Local Aboriginal and Torres Strait Islander Community Controlled Family and Community Organisations; and
  - A variety of local organisations leading or contributing to suicide prevention initiatives.
- The Roundtables were attended by approximately 90 participants including Aboriginal and Torres Strait Islander community members with a lived experience of suicide, individuals representing local Aboriginal and Torres Strait Islander community interests and other relevant local agencies.
- Roundtable participants were invited to pre-scheduled feedback sessions held in June 2018. The purpose of these feedback sessions was to 'close the loop' and communicate to those who shared their stories 'what was heard' and 'recommendations the Taskforce could influence, explore, and action.'
- The need for Indigenous facilitation at each location and for the same consultant/s to be involved in the write-up to ensure the narrative is authentic, consistent and culturally appropriate was considered integral to the success of these events. Further benefits of involving an external Indigenous facilitator included creating a layer of independence from Queensland Health which was thought to promote greater participation from attendees.
- Waratah Partners, an Indigenous owned and led consultancy firm, were engaged to develop a culturally appropriate methodology, to facilitate each event and develop a final report of integrated findings.
- The Waratah Partners report will highlight commonalities amongst communities, as well as issues relevant to discrete areas, and address the Taskforce Action Plan's identified priority areas in the context of Aboriginal and Torres Strait Islander Suicide Prevention in health services.
- The Waratah Partners report will be an important source for informing Phase 2 areas for action by the Taskforce.

4.2 Submissions and Connections

- The Taskforces invites or receives submissions or information from external sources where relevant to Taskforce Terms of Reference (ToR), including but not limited to:
  - Academics with expertise in suicidology and suicide prevention, particularly with reference to Queensland.
  - Any persons holding expertise in matters relevant to these ToR: including persons with a lived experience of suicide, emergency services and Government and non-Government department or agency (including Suicide Prevention Australia).

- Presentations to the Taskforce by external agencies include: Townsville Suicide Prevention Network (January 2018); Australian Institute for Suicide Research and Prevention (February 2018); Brisbane North PHN (April 2018); *beyondblue* (May 2018) and Central Queensland, Sunshine Coast and Wide Bay PHN (May 2018).
- Agencies, organisations and/or programs engaged by the Suicide Prevention in Health Services Initiative team as a conduit to the Taskforce include but are not limited to:
    - The Australian Institute for Suicide and Prevention (AISRAP), Australian Medical Association Queensland, Black Dog Institute, Department of Education and Training, Tackling Regional Adversity through Integrated Care (TRAIC), Queensland Rail, RI International (New Zealand), Suicide Prevention Resource Centre (USA) and Wesley Mission Australia.

4.2.1 Australian Research Council Linkage research collaboration

- In January 2018, the Taskforce received a proposal from AISRAP to participate in an Australian Research Council (ARC) Linkage research collaboration investigating the reactions and coping mechanisms of health professionals following the suicide of a patient or co-worker.
    - Partner organisations include the Australian Medical Association, Australian Psychological Society, Australian Nursing and Midwifery Federation, National Mental Health Commission, and the Queensland Doctors' Health Program.
- The proposed project aims to analyse the impact of patient and co-worker suicide on health and allied health professionals (medical doctors, nurses, and psychologists), and understand their reactions and coping mechanisms to develop a framework and practice guidelines for future interventions to provide support.
- The Taskforce acknowledges the recent evidence of elevated rates of suicide among health professionals and the need to understand the individual, organisational and environmental issues which impact negatively on health professionals' emotional health and well-being.
- As per the Taskforce's ToR, a quorum of support for AISRAP to participate in the research collaboration (as consortium lead) was provided in March 2018.
- Following the ARC review process, a final decision regarding the research collaboration is anticipated in November 2018.

4.2.2 Chronological Assessment of Suicide Events Approach (CASE) Approach Certification training

- In collaboration with GROW, New Zealand and the Gold Coast Mental Health and Specialist Services the Taskforce is facilitating the delivery of Experimental Training in the Chronological Assessment of Suicide Events (CASE Approach) on 22 August 2018.
    - Developed by Dr Shawn Shea, the CASE Approach provides clinicians with a flexible and useful framework for enquiring about suicidal ideation and behaviours. The CASE approach is complemented by six questioning techniques devised to increase the likelihood of eliciting a valid response to traditionally taboo or sensitive topics such as experiences of suicidality.
- Dr Shea will provide a full-day Level 1 certification role-playing training in the internationally acclaimed interviewing strategy for uncovering suicidal ideation, planning, actions, and intent. Training will be provided for groups of clinicians using Scripted Group Role-Playing (SGRP) and are designed to greatly enhance actual clinical skill at using the CASE Approach.

- Participation and attendance at the workshop will be prioritised for the participating sites in the Zero Suicide in Healthcare Multi-Site Collaborative project (refer to Section 3.1.5), and extended to include all HHSs.

5. Contribution to suicide prevention evidence base

5.1 Sponsorship and bursary support

5.1.1 2018 Life Awards: National Suicide Prevention Conference 2018

- Queensland Health is the sponsor for the 2018 Life Awards presented at the Annual National Suicide Prevention Conference scheduled to be held in Adelaide, 23–26 July 2018.
  - The LiFE Awards are a prestigious national event that attract nominations from all areas including business, industry, media, community, government.
- The focus of the 2018 conference is centred around quality – in research, practice and speaking about lived experience.
  - The meaningful engagement and partnerships with people with a lived experience to deliver high quality evidence based programs, services and treatments for people identified with suicide risk is aligned with the ethos of the Suicide Prevention in Health Services Initiative.
- Support for this event builds upon sponsorship benefits received as principal sponsor in 2017, including ensuring Queensland Health stands out as an active contributor to suicide prevention in Australia and highlight to our partners, stakeholders and employees our continued commitment to suicide prevention. Sponsorship benefits also included one full conference registration.

5.1.2 Lived Experience Summit 2018

- Queensland Health is a principal sponsor for the inaugural Roses in the Ocean Lived Experience Summit scheduled to be held in Brisbane, 21–22 August 2018.
- Sponsorship represents an opportunity to contribute to improving and strengthening reciprocal understanding, attitudes and confidence between people with a lived experience and participating organisations and key stakeholders.
- The Summit will create an innovative workshop style forum connecting people with a lived experience of suicide with key organisations, practitioners and government across workplaces, research, clinical, hospital, health and community services, and digital areas for suicide prevention.

5.2 Publications

- Kinchin I, Doran CM, Hall WD, Meurk C. Understanding the true economic impact of self-harming behaviour. *The Lancet Psychiatry.4*(12):900-1.

5.3 Conferences

5.3.2 Presentations

- Presenting at conferences provides opportunities to contribute to suicide prevention research by disseminating key learnings associated with the Initiative and explore potential collaborations in relevant networks.

- In addition to several internal forums, facets of the Initiative have been presented at the following conferences:
  - Heather, M. *'Zero Suicide in Healthcare Multi-site Collaborative'* (presentation, Responding to Crisis, National Zero Suicide Forum 2018, Auckland, New Zealand, 19 June 2018.
  - Ferris, L. '*Understanding and enhancing first responses to suicide crises*' (presentation, Society of Australasian Social Psychologists conference, Wellington, New Zealand, 5–7 April 2018,
  - Soole, R. '*Enhancing suicide risk assessment and management practices within Queensland Health'* (presentation, Nursing and Midwifery Conference, Brisbane, 2 February 2018).
  - Meurk, C. *'Partners in Prevention: Understanding and enhancing first responses to suicide crisis situations'* (presentation, Central Queensland University Safe Talk Symposium, Brisbane, November 2017).
  - Meurk, C. *'Partners in Prevention: Understanding and enhancing first responses to suicide crisis situations'* (presentation, University of Melbourne Centre for Mental Health, Seminar Series, Melbourne, 27 October 2017).
  - Martin, J. '*Suicide prevention in a health services context*' (presentation, AISRAP World Suicide Prevention Day Community Forum, Brisbane, 8 September 2017).

5.3.2 Attendance

- Conference attendance enables networking and facilitates learning from national and international clinical and academic experts. This ensures that the work of the Initiative is contemporary and considers suicide prevention perspectives as relevant to clinicians.
- The following conferences were attended by members of the Suicide Prevention in Health Services Initiative team in 2017-18:
  - National Zero Suicide Forum 2018, Auckland, New Zealand, 19 June 2018.
  - Shifting the dial: New settings, new players in suicide prevention, Noosa, 8 May 2018.
  - 1st Asia Pacific Conference on Integrated Care, Brisbane, 6–8 November 2017.
  - Zero Suicide in Healthcare Practice Forum, Christchurch, New Zealand, 26 October 2017.
  - 9th Australian Rural and Remote Mental Health Symposium 2017, Albury, NSW, 11-13 October 2017.
  - 18th International Mental Health Conference, Gold Coast, 22 August 2017.
  - National Suicide Prevention Conference, Brisbane, 27-29 July 2017.

6. Evaluation

- Evaluation is increasingly identified as critical for creating a stronger and more accessible evidence base to drive continuous improvement in suicide prevention policy, services and programs.
- The Suicide Prevention Health Taskforce Action Plan specifies that activities funded under the Initiative will be evaluated where appropriate. The findings and recommendations will contribute to the emerging evidence for reform of suicide prevention efforts and the mental health alcohol and

other drug service system in Queensland.

- The Sax Institute has been engaged to develop two evaluation frameworks for:
  - the overarching Suicide Prevention in Health Services Initiative, and
  - the Zero Suicide in Healthcare Multisite Collaborative.
- These evaluation frameworks will enable a planned and structured approach to critically analyse and assess the ongoing success of the Initiative and identify priority areas for future investment.

Appendices

Appendix A. Stakeholders engaged in Taskforce activities

Action Area	Stakeholders engaged
General Practitioners	Black Dog Institute Queensland PHN CEO Collective Brisbane North PHN GP Liaison Officer (GPLO) group Queensland PHN CEO Collective Royal Australian College of General Practitioners (RACGP) Rural Doctors Association of Queensland Australian College of Rural and Remote Medicine (ACRRM)
Partners in Prevention	Indigenous Mental Health Intervention project staff (QFMHS) People with a lived experience of suicide Primary Health Networks Queensland Ambulance Service Queensland Health Queensland non-government mental health sector Queensland Police Service
Queensland Health school based clinicians	School Based Youth Health Nurses Ed-LinQ Black Dog Institute Children's Health Queensland Child and Youth Mental Health Services Department of Education and Training
Cultural appropriateness of the Suicide Risk Assessment and Management in Emergency Department settings training program	Queensland Centre for Mental Health Learning Clinical Skills Development Service Indigenous consultant Aboriginal Centre for Performing Arts SRAM-ED trainers
Zero Suicide in Healthcare Multi-site Collaborative	Ten Hospital and Health Services involved in the collaborative Suicide Prevention Resource Centre, USA Mersey Care, NHS, UK Griffith University La Trobe Hospital, Melbourne, Victoria Ri International New Zealand SAX Institute Roses in the Ocean Healthcare Improvement Unit, Clinical Excellence Division

Action Area	Stakeholders engaged
Lived Experience Peer Support	Management Options Community Services Funding Branch Health Support Queensland Recovery and Consumer and Carer Participation, Metro North Mental Health Service Brook RED Flourish
Carer Support	Management Options Community Services Funding Branch Roses in the Ocean Lived experience advocates Social Inclusion and Recovery team, Addiction and Mental Health Services, Metro South HHS
HealthPathways	Healthcare Improvement Unit, Clinical Excellence Division Brisbane North PHN Metro South HHS Townsville HHS
Solution Focused Brief Intervention	Service Evaluation and Research Unit, West Moreton HHS Clinical and Operational Directors for Acute and Community Services, West Moreton HHS Co-ordinators of the Masters of Mental Health Nursing program

Appendix B. SRAM-ED Train-the-trainer

2 hours eLearning + 1.5 days

Risk Training

Q25 Suicide Risk Assessment and Management in Emergency Department settings
(Train-the-trainer)

Suicide Risk Assessment and Management in Emergency Department settings (SRAM-ED) is a blended train-the-trainer program (eLearning and face-to-face). The course is designed to enhance existing knowledge and skills of clinicians delivering care in an emergency department context, working with patients who are at risk of suicide.

The training package comprises completion of four eLearning modules (more information about the eLearning component is available on page 39 in the eLearning section - refer to QC51) prior to attending the one and a half day face-to-face workshop.

This program provides training for clinicians and educators working in an emergency department setting to deliver SRAM-ED training on an ongoing basis within their local HHS.

As the intention of the program is for participants to become facilitators of SRAM-ED in their own HHS, it is preferred that they can demonstrate some experience in the following areas:

- experience in education delivery or workshop facilitation
- willingness to facilitate simulation training
- mental health and suicide prevention knowledge and experience.

Learning outcomes

On completion of the course participants will be able to:

- posess increased participant awareness of personal reactions to suicidal people and their impact on practice
- posess increased participant capacity to develop a therapeutic alliance with a suicidal person
- posess increased knowledge and skills in suicidal risk assessment and management with the context of an emergency department
- access information related to a patients suicidal ideation, planning, behaviours, desire and intent using the Chronological Assessment of Suicide Events framework
- assess information related to risk and protective factors
- apply clinical decision making based on information gathered to generate a formulation of risk plan.

ALIGNED TO:

Queensland Health Suicide Risk Assessment and Management guidelines (Engaging and Responding to the needs of a suicidal person)

CONTINUING PROFESSIONAL DEVELOPMENT:

14 Hours
Active Learning

14 CPD Points

Appendix C. SRAM-ED Foundational and Advanced

QC50 Suicide Risk Assessment and Management in Emergency Department Settings: Foundational

This blended learning course comprises of two eLearning modules and a half day face-to-face workshop.

The course is designed to enhance the knowledge and skills of clinicians' working in emergency department settings with patients who are at risk of suicide.

Module one - Introduction to working with patients who are at risk of suicide

This module will provide learners with:

- a broad overview of the entire SRAM-ED training program
- an introduction to the issue of suicide and increased knowledge of warning signs
- an awareness of the impact of stigma and personal values in working with patients who are at risk of suicide.

Module 2 - Patient-centred care and the therapeutic alliance

This module will assist learners to:

- enhance their understanding of how to provide patient-centred care
- develop a positive therapeutic alliance with a patient who is at risk of suicide.

Note: Taking approximately 30 minutes each to complete, the modules and are prerequisites to attending the face-to-face foundational workshop delivered by your local SRAM-ED trainer.

CONTINUING PROFESSIONAL DEVELOPMENT:

1 CPD Point

QC51 Suicide Risk Assessment and Management in Emergency Department Settings: Advanced

(also pre-learning for the QC25 SRAM-ED face-to-face course)

This is a blended course comprising of four eLearning modules and a face-to-face workshop (one day or two half days). The course is designed to enhance the knowledge and skills of clinicians' working in emergency department settings with patients who are at risk of suicide.

Module one - Introduction to working with patients who are at risk of suicide

As above.

Module two - Patient-centred care and the therapeutic alliance

As above.

Module three - Risk assessment

This module will assist learners to:

- conduct a suicide risk assessment using the chronological assessment of suicide events (CASE) framework
- use specific evidence-based techniques for eliciting suicidal intent.

Module four - Formulation, safety planning and support

This module will assist learners to:

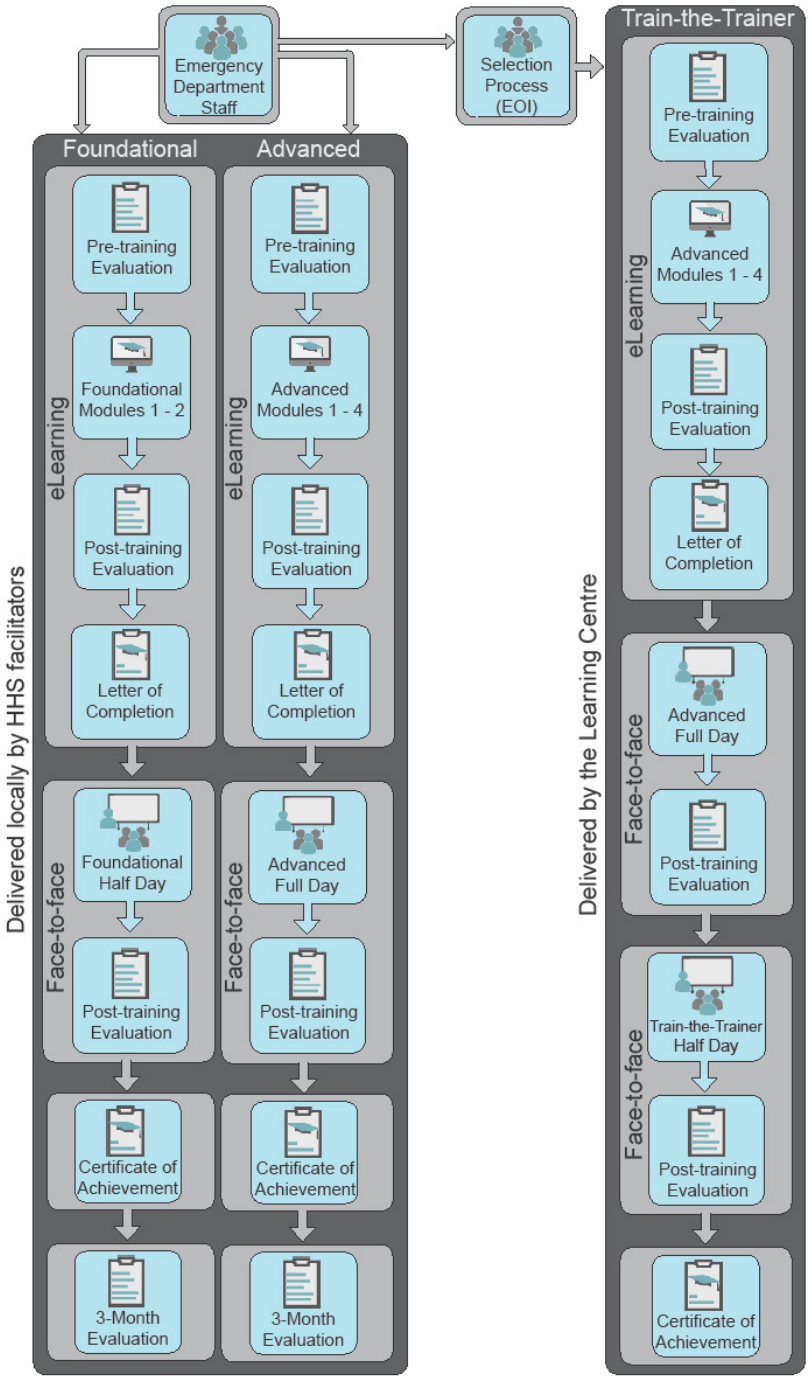
- write a suicide risk formulation
- use structured professional judgement concepts to assess suicide risk
- create a safety and support plan.

Note: Taking approximately 30 minutes each to complete, the modules and are prerequisites to attending the face-to-face advanced workshop delivered by your local SRAM-ED trainer.

CONTINUING PROFESSIONAL DEVELOPMENT:

2 CPD Points

Appendix D. Diagrammatic representation of the SRAM-ED training package



Abbreviations

Action Plan	Suicide Prevention Health Taskforce Phase 1 Action Plan
AISRAP	Australian Institute for Suicide Research and Prevention
CDR	Child Death Register
CEO	Chief Executive Officer
ED	Emergency Departments
GP	General Practitioners
HHS	Hospital and Health Services
the Initiative	Suicide Prevention in Health Services Initiative
iQSR	interim Queensland Suicide Register
Learning Centre	Queensland Centre for Mental Health Learning
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and/or queer
MHAODB	Mental Health Alcohol and Other Drugs Branch
PHN	Primary Health Networks
QAS	Queensland Ambulance Service
QFMHS	Queensland Forensic Mental Health Service
QMHC	Queensland Mental Health Commission
QFCC	Queensland Family and Child Commission
SBYHN	School Based Youth Health Nurses
SPiHSI	Suicide Prevention in Health Services Initiative
SRAM-ED	Suicide Risk Assessment and Management in Emergency Department settings training program
Taskforce	Suicide Prevention Health Taskforce
ToR	Terms of Reference

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