Churchill Fellowship - Bringing Zero Suicide to Northern Ireland

WINSTON CHURCHILL MEMORIAL TRUST

Oscar Donnelly

Services Visited

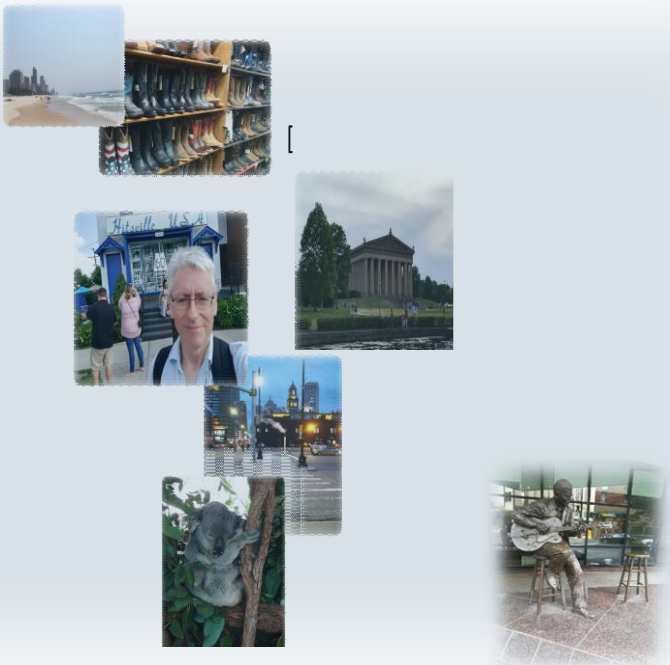
Henry Ford Foundation, Detroit - June 2019

Centerstone Organisation, Tennessee – June 2019

Tennessee Suicide Prevention Network – June 2019

Gold Coast Health – October 2019

Queensland Ministry of Health – October 2019



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Executive Summary

Zero Suicide

Zero Suicide within mental healthcare systems emerged in the 2000s in the USA. Significant reductions in deaths of service users have been reported by early innovators and implementers creating a momentum that has facilitated its spread in the USA and beyond.

I am grateful to the Churchill Trust for giving me the opportunity to visit and learn from a number of these mental health services which have gained an international reputation for reducing patient suicide through adopting a Zero Suicide Approach. I would also wish to thank and acknowledge the support of the John Armitage Charitable Trust, who generously part funded my Fellowship.

Visits

I visited a range of services and service providers in the USA and Australia as detailed in my full report with the principle focus being on three providers; Henry Ford Healthcare, Detroit, USA: Centerstone Healthcare, Tennessee, USA and Gold Coast Healthcare, Australia. I would wish to acknowledge the generosity with time, resources and hospitality I received at all three centres which are committed to excellence and keen to help others to do so as well.

Zero Suicide is embedded in all three organisations each having commenced implementation at different time. Henry Ford from 2001, Centerstone 2012 and Gold Coast 2016.

All Providers are able to demonstrate reductions in suicide levels amongst the users of their services since adopting Zero Suicide. Whilst there are differences, there are broadly similar themes which I found across all three Providers which I summarise below.

Leadership and Culture

Fundamental to Zero Suicide is passionate, focussed and sustained commitment by organisational leadership to suicide prevention and to the aspirational target of zero suicides for the users of their services

This leadership message is embedded through training aimed at developing skills and empathy and changing culture through challenging beliefs that suicide is a choice or that it is inevitable.

Just Culture

All Providers had made an explicit organisational commitment to a supportive Just Culture seeing this as critical to the introduction of Zero Suicide. A Just Culture sits alongside the aspirational zero target and provides balance to it.

Dig. 1 A Restorative Just Culture Framework

A commitment to a Just Culture is an essential engager which allows staff to feel safe in their practice, facilitates learning and avoids harmful risk adverse practice. At the heart of a Just culture is how organisations react and how they support their staff when things do go wrong.

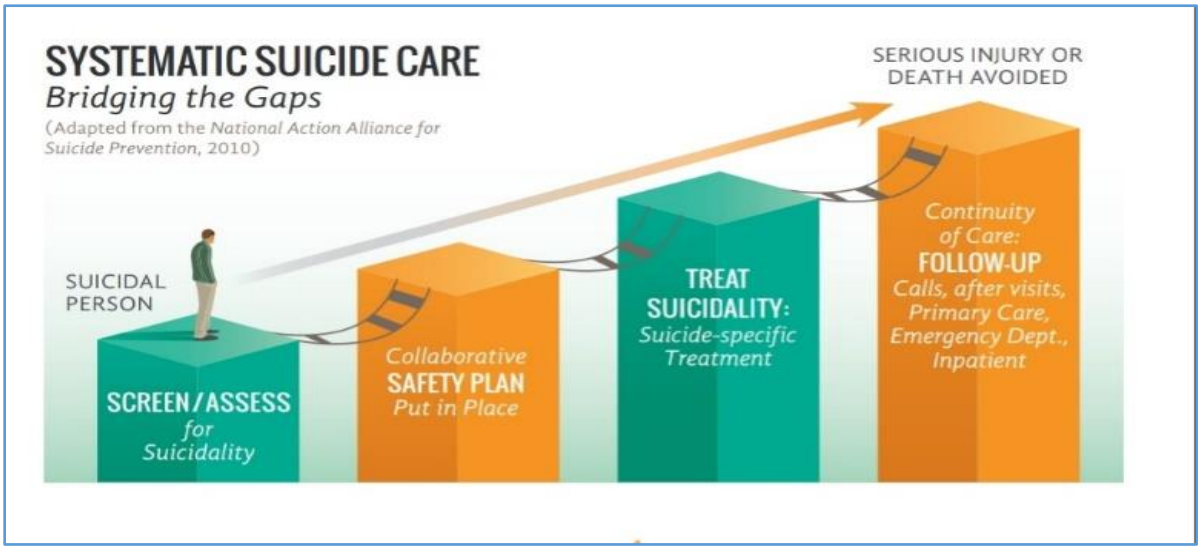
Gold Coast has adopted a framework of a Restorative Just Culture explicitly aimed at ensuring support for all stakeholders impacted upon by an adverse incident (Dig 1).

Suicide Prevention Pathway.

The development and implementation of a Suicide Prevention Pathway (SPP) lies at the heart of Zero Suicide. This approach sees suicide and suicidal ideation as behaviours in their own right which must explicitly be attended to alongside the treatment of any underlying mental health or emotional problems. The presence of suicidality can be elicited by skilled practitioners and ameliorated through a range of clinical approaches and interventions which collectively form the SPP. This differs from traditional approaches which view suicidality as primarily symptomatic with the focus of interventions on the treatment of underlying problems. This doesn't mean that within a SPP underlying causes aren't attended to, rather that the immediate focus of interventions are measures to reduce suicidal behaviours and risk.

All three Providers had implemented a SPP. These varied in practice reflecting the different healthcare structures and systems and the role and focus of the individual organisations within it. However all three evidenced the core elements of a SPP as set out in diagram 2.

Dig 2. Zero Suicide – Clinical Pathway for Suicide Prevention



Elements of a Suicide Prevention Pathway

1) Screen

Systematically identifying and assessing suicide risk among people receiving care is the starting point of the SPP. Evidence based tools used were the Physical Health Questionnaire 9 (PHQ9) and the Colombia Suicide Severity Rating Scale (C-SSRS). Screening is most universal in Henry Ford where their Primary Care Services' screen everyone accessing their system, at least annually, using the PHQ 9 (Q9). In all three Providers there is an emphasis on continually re-checking on patients in mental health care using these screens with the view expressed *'If you don't ask how do you know?*'

2) Assess

In implementing a SPP all three Providers viewed that they needed to shift away from traditional working typically involving ''endless assessments'' and unproductive risk assessments.

In adopting the SPP and Zero Suicide each of the Providers abandoned their previous risk assessment tools and now view tools which attempt to predict risk or to use risk to determine eligibility to services as being of no value.

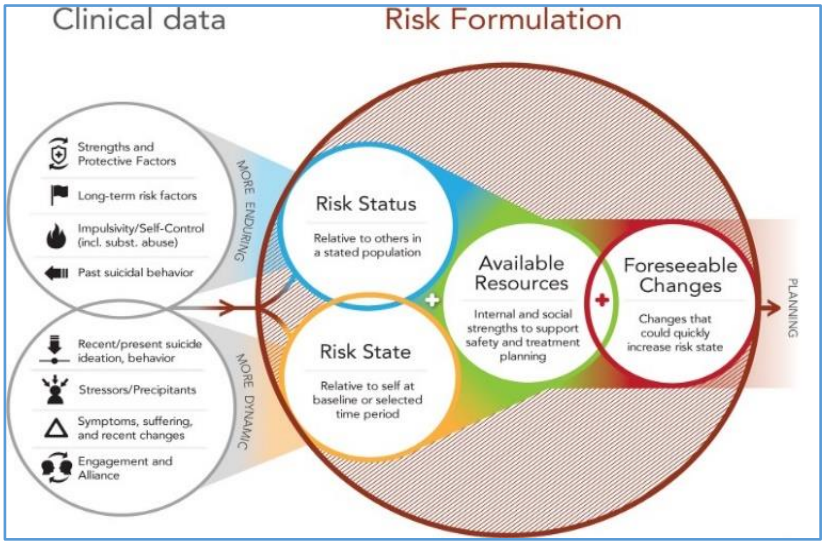
The purpose of risk assessment in the SPP is to identify risks which can then be modified to reduce or to eliminate the risk of suicide. To be of value risk assessments must therefore be capable of yielding actionable results which can then inform subsequent treatment.

Assessments and Reviews which don't do so are dispensed with.

Gold Coast's adopted the Pisani Risk Prevention Orientated Formulation model within their SPP (Diagram 3).

Importantly risk assessment tools and processes must allow risk to be viewed as dynamic as experience shows that a patient's current 'static risk' is no predictor of future suicidality.

Dig 3 Pisani Risk Prevention Formulation



3) Treat Suicidality

3a) Collaborative Safety Plan

Following a crisis event patients may sincerely report that they no longer feel suicidal and that they now have no thoughts of life not worth living. Sadly however the experience often is that they can and do quickly become suicidal again.

Suicide risk fluctuates over time and collaborative safety planning helps pre-empt this fluctuation. The evidence shows that Collaborative Safety Planning can result in an up to 40% reduction in suicidal behaviours compared to comparison groups. All three Provider utilised the Stanley Brown Safety Plan or an adapted version of it.

An essential element of effective safety planning is that it is Collaborative, meaning that it is completed in partnership with the patient and their family or friends. All Providers attached particular importance to ensuring that this occurred.

3b) Counselling on Access to Lethal Means.

An important component of risk formulation and safety planning is Counselling on Access to Lethal Means. Evidence is that when people impulsively decide to take their lives that they often seek to do so in a way that they have previously ideated. Removing or limiting access to that means is an important factor in disrupting a suicidal impulse. This involves exploring with the patient how they have ideated killing themselves and then working with them and their family on how to reduce access to that means e.g. remove the gun, take the rope from the garage, remove the pills, remove the car keys etc.

3c) Follow Up

All Providers were clear about the need for prompt and effective, follow up from initial appointment(s) and placement on the SPP. This follow up is arranged before the patient leaves their 1st appointment. In Gold Coast patients get a follow up appointment which takes place between 24-48 hrs after they leave ED. In the case of Centerstone its Lifeline Service was incorporated into Safety Plans and active follow up arrangements. All of the Providers had developed protocols and approaches to help minimise patient disengagement and to promote reengagement when this occurs including 'Caring Letters'.

Providers emphasised speedy access to evidence based treatments for people placed on the SPP. An example of this was robustly evidenced in the Henry Ford Outpatient Treatment Protocol as follows.

- Acute Risk
  - Same day psychiatry
  - Psychotherapy within 72hrs.
- High Risk
  - Within 48hrs psychiatry
  - Psychotherapy within 5 days
- Moderate Risk
  - Within 7 days psychiatry
  - Psychotherapy within 7 days

Psychiatry could either be medical or nurse practitioners. Psychotherapy for those on the SPP was either modified CBT or DBT largely delivered by mental health practitioners and particularly clinical social workers.

There was a clear view that fidelity to this model of evidenced based care is essential and that medication only approaches are ineffective in addressing suicidal behaviours.

Service User and Carer Involvement

The involvement of Experts by Experience was essential to the implementation and training on the SPP through co design of delivery. In Queensland as part of the state-wide roll out of the SPP explicit measures were identified through Lived Experience Focus Groups to provide Check Points they identified as important against implementation KPIs. This input was largely around how services were delivered and how evidence based practice was put into place.

Collaborative working across clinicians, patients and family is central to the SPP. If this doesn't happen then the SPP cannot effectively address suicidal risks. Training in

processes of assessment and safety planning aim to develop staff skills to promote high levels of collaborative working.

Providers have developed written information to give to patients and families as part of patient education to provide insights into suicidality and help them to better manage and to better support.

Training

All Providers placed considerable emphasis on comprehensive staff training frameworks as essential to the implementation of the SPP. Training on attitudes, myths and beliefs was delivered through skilfully delivered, case-based, open discussions where there were no right or wrong answers. This includes online and class room training. The focus though case studies and role plays is in skills and confidence in having open conversations with people to explore suicidal thoughts, intentions and actions.

Gold Coast have adopted the CASE assessment approach (Chronological Assessment of Suicide Events) which provides core skills for clinicians in engaging with patients with an easily learned interview strategy for eliciting suicidal ideation, planning, and intent. Henry Ford and Centerstone have invested heavily in providing staff in their Outpatient (community) services skills in DBT and CBT which are evidence based therapies in treating suicidality.

Developing and delivering training programmes for staff was the single biggest investment made by all the Providers in their implementation of Zero Suicide. In both Centerstone and Gold Coast there is ongoing work to develop this training further so that more of it can be delivered on-line.

Data and Quality Improvement

All three Providers are committed to excellence and consequently invest in research and quality improvement initiatives. Henry Ford and Centerstone through their impressive Clinical Information Systems ensure fidelity to their SPPs with tools and algorithms built into these systems which are then audited for variation in practice and quality. All three Provider collect information on a range of patient safety and outcomes measures developed to support their SPPs.

Henry Ford are participating in a five year study, due to report in 2022, involving a comprehensive process and outcome evaluation of the Zero Suicide Model implementation in real-world clinical settings across 6 large, diverse Mental Healthcare Systems.

Conclusions

In Australia I attended a workshop in Sydney organised by the New South Wales Department of Health. The focus of that workshop was engagement with all that state's statutory mental health providers on the implementation of Zero suicide and a SPP across the New South Wales health care system. Zero Suicide thus continues to progress and gain traction across mental health systems internationally.

All three Providers I visited were committed to excellence and continuous improvement in the delivery of mental health care. They were all able to evidence reductions in suicide levels linked to adopting models of Zero Suicide. I believe that the natural next step for Northern Ireland's Towards Zero Suicide Collaborative is the development of a local Suicide Prevention Pathway. This would require systemic change to cultures and work practice with major challenges to achieving this within busy and stretched services.

I further reflect that perhaps the most striking attribute of all three Providers I visited was the passionate and courageous leadership that galvanised staff and systems to drive transformative change. I believe that with such leadership and focus we can achieve similar change, with similar outcomes, in N Ireland. Excellent foundation and preparatory work, including staff and lived experience engagement, level 1 suicide prevention training, organisational self-assessment and evidence based safety planning has already being undertaken through the Regional Collaborative which we should now build upon in defining and implementing a Suicide Prevention Pathway for Northern Ireland.

Recommendations

I have focussed upon Zero Suicide in this Executive Summary. There are other aspects of mental health care referenced in the main report which I feel are also worthy of consideration. In particular my visits cause me to reflect upon how mental health care is delivered in N Ireland particularly around the complexity of our structures, therapeutic models and suicide prevention work in inpatient services, alternative approaches to crises care, mental health collaborative care models and the use of data and technology to improve quality, efficiency and accessibility to care. This learning is reflected in the recommendations summarised below and described more fully in the main report.

1. The Northern Ireland's Towards Zero Suicide Collaborative (the Collaborative) should development a Suicide Prevention Pathway (SPP) for Northern Ireland.

2. Inpatient admissions should be reviewed as an element of the SPP so that where an admission is assessed as being required this should be aimed at a brief intervention informed by therapeutic models of suicide prevention work.

3. Staff training in skills and in developing a positive suicide prevention culture are essential to the SPP. The Towards Zero Suicide Collaborative should consider and

develop a training model similar to that used in Gold Coast to support the implementation of a SPP in Northern Ireland.

4. It is recommended that a skills and competencies framework linked to evidence based suicide prevention practise be developed and a subsequent training needs analysis of mental health practitioners be completed to ensure that mental health service users are receiving high quality evidence based interventions.

5. In developing a SPP for N Ireland the TZS Lived Experience group should be involved through, in particular, the development of lived experience led key performance indicators and outcomes for the delivery of Zero Suicide

6. The SPP requires evidence based interventions delivered in a timely and integrated way across providers. The local SSP should include the identification and incorporation of relevant local independent sector provider partners on a common evidence based pathway.

7. The implementation of a SPP needs to be in the context of a supportive Just Culture. Health & Social Care in N Ireland incorporates the NHS Just Culture model. It is recommended that the Collaborative should undertake a review of staff beliefs and experience of SAI investigations and how staff feel they are supported and how this could be improved. This should inform the development of a staff support framework

8. It is recommended that the Collaborative along with PHA/HSCB should look to identify a range of common patient safety metrics for the mental health system in N Ireland which would help inform practice and guide service improvement.

9. A contrast between the services visited and N Ireland mental health services is the complexity of our local mental health system. Handovers between clinicians and teams heightens risks, leads to delays, provides a poorer patient experience and can lead to poorer outcomes. It is recommended that mental health services in N Ireland should review their structures with the aim of reducing complexity and patient handovers and improving continuity of patient care.

10. It is recommended that a collaborative care approach to meeting mental health needs on a population basis co-designed across primary and secondary care and incorporating the independent sector and local community services be implemented and evaluated within a GP federation area in N Ireland.

Churchill Fellowship - Bringing Zero Suicide to Northern Ireland

Context for Visits

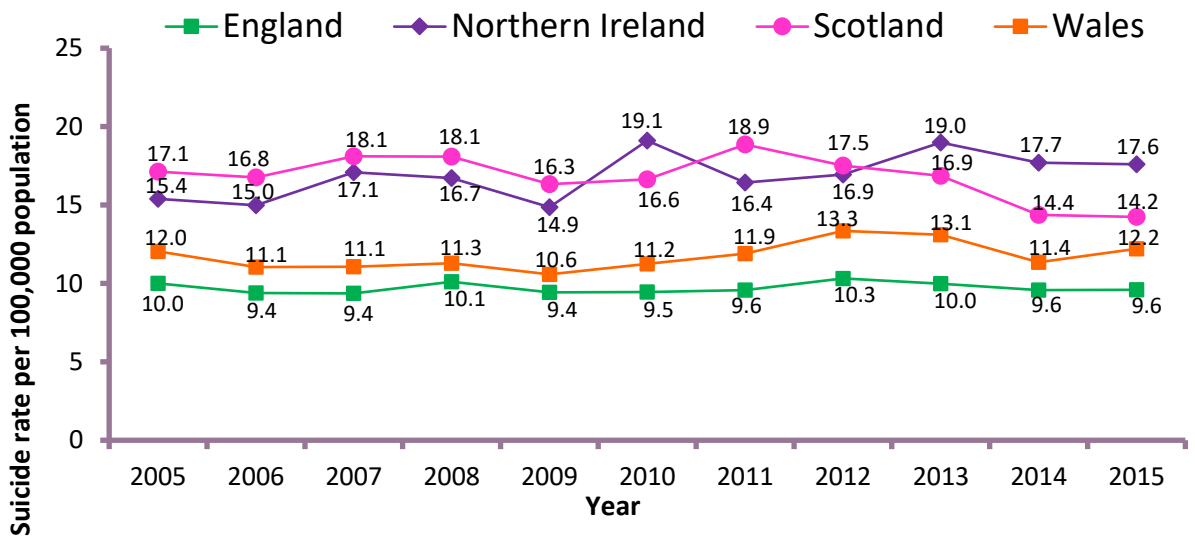
The context for my visits to services which have gained an international reputation for reducing suicide amongst people using their services is the ongoing high levels of deaths through suicide experienced in N Ireland. The overall aim of visiting these services was to find out how they had achieved reductions and to bring this learning back to mental health services in N Ireland.

Suicide in N Ireland

Being bereaved through suicide is possibly the most traumatic and devastating loss that anyone will suffer with a profound and lasting impact upon relatives and friends. Sadly it is all too common an experience in Northern Ireland. Between 1998 and 2004 the suicide rates in N Ireland doubled with the current rate now of approximately 18 deaths per 100k. In global terms this places N Ireland in the top 25% of the international suicide rates.

Northern Ireland has the highest suicide rates compared to other jurisdictions in the UK and Ireland (ref Dig 1). Of those who lose their lives through suicide, on average 27% will have accessed statutory mental health services in the year before their death. Deaths in Northern Ireland as a result of suicide in 2017 were 305. The figure for 2016 was 297 and 2015 was 318. Suicide is currently the biggest cause of death in the under 40yrs.

Dig 1 Suicide Rates in the UK General Population 2005 – 2015 (source NCISH 2018)



Protect Life Strategy

In response to this challenge the Department of Health in Northern Ireland in 2006 published its Protect Life Suicide Prevention Strategy. Protect Life included a number of evidence based suicide prevention measures on a population basis. These included community led suicide prevention and bereavement support services, enhanced crises intervention services, local research into suicide and the establishment of the Lifeline 24/7 crisis helpline. The value of these and other initiatives undertaken thorough Protect Life is recognised however the high suicide rates which inspired these actions has not been impacted upon and remains an intractable societal challenge. The Protect Life Two strategy launched in [i]September 2019 has Zero Suicide as an action to reduce the incidence of suicide amongst people under the care of mental health services.

Zero Suicide

The Concept of Zero Suicide was first developed in Detroit, USA by the Henry Ford Health Care Organisation who sought to provide perfect depression care through a rigorous approach to improving the care and journey of patients in every aspect of their system. This approach saw a sustained 75% reduction in the suicide rate in their patient population. The significance of this reduction has inspired other healthcare organisations, particularly in N America who have also successfully tested the approach over recent years. These include Cornerstone Healthcare in Tennessee which saw a 65% decrease in suicide rate in a 20 month period. More locally Mersey Care NHS Trust in Liverpool, drawing upon experiences and approaches globally implemented a Zero Suicide approach in 2014 and has in 2018 reported a 22% reduction in suicides in people accessing its services.

The early successes of Zero Suicide created a momentum that has facilitated its spread in the USA and beyond with the U.S. Surgeon General endorsing the goal of zero suicide and its inclusion within the 2012 US National Strategy for Suicide Prevention.

What is Zero Suicide?

Zero Suicide can be understood as an approach, a concept, a set of tools and a practice.

- As an approach it involves a system wide commitment to suicide prevention through improving outcomes at all levels and eliminating gaps within the delivery of care.
- As a concept it is a transformative goal involving a radical shift in thinking where suicide is no longer understood as an unfortunate but inevitable outcome in some patients with mental illness.

- As a set of tools, it requires mental health services to seek out and implement best practice, quality improvement and evidenced based care – the Zero Suicide Alliance identifies 4 key cornerstones of Zero Suicide (ref dig. 2 below).
- As a practice it sees suicide and suicidal ideation as behaviours in their own right which must explicitly be attended to alongside the treatment of any underlying mental health or emotional problems.

Critically these understandings are accompanied by organisations explicitly adopting a Just Culture where staff feel safe in their practice and learning rather than fearing retribution in situations where things do go wrong.

Dig 2 The Four Cornerstones of Zero Suicide (Zero Suicide Alliance)

A literature review of Zero Suicide indicates that there is no one model of Zero Suicide though all will have elements of the above. The complexity of suicidal behaviours, the range of cultural differences and the variations in how mental health care is commissioned and delivered means that different health care systems will adopt different approaches though all with the common goal of improving patient safety and reducing or eliminating lives lost to suicide.

Bringing Zero Suicide to N Ireland

Given the challenges faced in N Ireland of high levels of suicide and the fact that approximately 1/3 of those losing their lives through suicide will be known to statutory mental health services (approx. 2/3 if we include primary care) it is incumbent upon Mental Health services in N Ireland to look at the evidence from Zero Suicide approaches elsewhere and seek to implement these as a means to improving patient safety and reducing death by suicide in N Ireland.

In September 2018 following two earlier workshops involving senior clinicians and leaders in mental health care provision from across statutory Health and Social Care Trusts in N Ireland a Towards Zero Suicide Mental Health Collaborative Board met for the 1st time. The aim of this Collaborative Board is to improve safety and outcomes for people accessing statutory mental health services in N Ireland through the adoption of a Zero Suicide Approach.

This approach has the backing of the Boards of the five Health and Social Care Trusts in N Ireland and its aims have been endorsed and supported by the Department of Health's Transformation Implementation Group comprised of the most senior civil servants, professional leads and chief executives within health and social care in N Ireland. The Towards Zero Suicide approach has also gained the support of the NI Divisions of the Royal College of Psychiatrists and the British Psychological Society.

The Collaborative Board is chaired by the author and it was the work of establishing this Board that motivated my application to the Churchill Fellowship to visit exemplars of excellence in the USA and Australia and to bring back learning from these to inform a N Ireland approach to suicide reduction in Mental Health services.

Churchill Fellowship

I am extremely fortunate and privileged to be the recipient of a Churchill Fellowship which facilitated me with the opportunity to visit and learn from some remarkable and inspiring people working in the fields of mental health and suicide prevention. I would also wish to thank and acknowledge the support of the John Armitage Charitable Trust, who generously provided 50% of the cost of my Fellowship.

The aims and objectives of my Fellowship are given in appendix 2. To achieve these aims and objectives I visited three services, two in USA in June 2019 and the third in Australia in October 2019. My selection of these three services was informed by a literature review and the contrasting service models. All three providers are cited as 'Full Scalers' on the Zero Suicide International website meaning that they have implemented Zero Suicide concept and approach on a system wide basis as I am seeking to do in N Ireland. A brief overview of each and my specific objectives in choosing to visit them is as follows:

The Henry Ford Institute, Detroit, pioneered the Zero Suicide concept with their model of perfect depression care. I want to understand their approach and learn how they as a large mixed healthcare organisation integrated this across all their primary & secondary care services. How did they achieve buy in from both mental health clinicians and non-mental health providers and how have they sustained improvements.

Cornerstone Healthcare Tennessee, were an early adopted of Zero Suicide and I want to learn how they as a specialist secondary mental health provider have achieved & sustained suicide reduction through their Zero Suicide approach. Have they used different approaches across different specialities e.g. Severe Mental Illness,

Personality Disorder, Addictions. How/if they have they worked and shared resources with the Tennessee Suicide Prevention Network as a community sector suicide prevention organisation.

Gold Coast Health Services, Queensland, Australia. To learn about the development and implementation of their 'Journey to Zero, Suicide Prevention Strategy' within the context of a statutory sector mental health system similar to N Ireland model. To visit centres incorporating their Prevention-Oriented Risk Formulation model. Meet with the Queensland Department of Health to discuss how they have scaled up a Zero Suicide approach across multiple organisations which is similar to the challenge in our N Ireland collaborative. To discuss practical challenges in creating a Just Culture.

Visit to Henry Ford Foundation Detroit - Behavioural Health Services Division

Background

In 2001, the Behavioural Health Services division of Henry Ford Foundation Health System (BHS) set out to radically transform its mental health care delivery system through its "Perfect Depression Care" (PDC), with the audacious goal of eliminating suicide, as a means of achieving dramatic and sustained reductions in patient suicide, as well as improved performance of its entire delivery system. This was the genesis of the Zero Suicide approach which has since become an international movement.

Four key messages from BHS's approach are;

- Pursuing perfection is a viable model for health care system transformation.
- Pursuing perfection is most successful within a Just Culture.
- Zero suicides is a social transformation, not a bundle of specific interventions.
- Suicide is preventable.

The background to BHS's approach was suicide rates remaining unchanged over several decades. Despite advances in mental health care clinicians could not easily predict whether or when a patient would take their life. The BHS selected depression care as the target for transformation responding to the challenge of the Institute for Healthcare Improvement of 'Pursuing Perfection' which challenged health care systems to dramatically improve patient outcomes by redesigning all major care processes with the aim of delivering perfect care.

The goal of zero suicide as an outcome of perfect depression care became the galvanizing force behind the BHS's effort which achieved a dramatic and sustained reduction in suicide amongst its patients.

Zero suicide was part of the BHS's larger goal to develop a system of perfect care for depression. Quickly however zero suicides became the overarching goal for its entire transformation.

Three key strategies were used to achieve this goal;

- Improving access to care. To improve access to care, BHS developed, implemented, and tested new models of care, such as drop-in group visits, same-day evaluations by a psychiatrist, and department-wide certification in cognitive behaviour therapy.

- Reducing access to lethal means of suicide. BHS partnered with patients and families to develop new protocols for weapons removal. Importantly it redesigned the structure and content of patient contacts to reflect the assumption that every patient with a mental illness, even if that illness is in remission, is at increased risk of suicide. They eliminated suicide screens and risk stratification tools that yielded non-actionable results, freeing up valuable time.

- A Just Culture for staff. The BHS believes this the most important strategy in achieving zero suicides. Since the goal was to achieve radical transformation, not just to tweak the margins clinicians couldn't justly be punished if they came up short on these lofty goals. The BHS adopted a root cause analysis process that treated suicide events equally as tragedies and learning opportunities. Participating in this process left staff feeling not only supported but also empowered to be agents of improvement. The key to establishing a just culture was to hold people accountable for learning and improving.

The overall result of this transformative approach was a dramatic 80% reduction in suicide amongst BHS patients which importantly has been sustained for over a decade, including one year (2009) when the service actually achieved zero suicides.

Learning from Henry Ford Visit

Dr Catherine Frank, Chair of the Department of Behavioural Health

Dr Frank is passionate about the concept to Zero Suicide and was a key author and driving force behind the development and implementation of this model of care. She is very clear about the factors which have made the difference within their services to achieve and sustain such remarkable outcomes of 80% reductions in suicide levels in people accessing BHS.

Having Zero Suicide as a goal was the single most important thing that they did as it galvanised staff (it was a nurse who suggested Zero). This is Detroit home of industry where organisations routinely set zero defect goals. It did meet resistance and one of the keys to dealing with this was not having a top down approach but involving staff in the design of perfect care. Where the Zero Concept was challenge the question asked in response was, '*'if not zero what*

should the target be - 20%...30%?'' And *''who then are these people to be: what if it was your son, your niece would it be ok for them to be part of this 20% or 30%?''*

Identifying the Risk Factors and then have a strategy for modifying these (ref Dig 3. Suicide Prevention Guidelines). Safety contracts (i.e. patient guaranteeing to keep themselves safe) have no validity. The nature of suicidal behaviour is that it comes and goes. Some risks are static and these you can do little about e.g. age, gender etc. other are dynamic and these you can do something about.

Identifying risk as Acute, High, Moderate, Low. Many people with a high risk will not have a mental disorder. Evidence based review of risk factors which have to be reviewed at every encounter with the patients which in turn should lead to actions aimed at modifying these risks. This doesn't hinge on a diagnosis. ''*At every encounter – identify the risk factors and then what to do about them.''*

Dr Frank also talked about the shortage of MH professionals and particularly medical and how they have responded to the challenge of delivering this model in that context through increasing use of telemedicine and use of nurse practitioners. Most psychotherapy is delivered by psychiatric social workers.

If a patient has an Acute level of risk they must be seen by a psychiatrist within a 24 hr timeframe (within 48hrs if high risk) and a psychotherapist within 72 hrs (within 5 days if high risk). Approach is quick access to medication and evidence based psychotherapy.

Dr Frank views that suicidal behaviour will in due course become a distinct ICD diagnosis.

The majority of referrals to BHS come from within the Henry Fold health care system which provides all medical specialities including primary care. Patients are signposted rather than referred from PC (they are given the name and telephone number of the physician or service by the GP and it's left to them to make contact) so a significant number of these don't attend. Stigma and costs two main factors.

The GPs screen using PHQ9 – the BHS system trained them in the use of the tool as part of guidelines and training for them in how to treat major depression,

Advanced nurse practitioners (APPs) were embedded in sites to work with primary care to identify and treat common mental health disorders. However this wasn't sustainable and they now use a Collaborative Care model utilising telemedicine and technology (see Dig 4).

There is a significant use of telemedicine including in inpatient care. Psychotherapy is also delivered through telemedicine with good outcomes.

Dig. 3 Henry Ford BHS Suicide Prevention Guidelines

SUICIDE RISK ASSESSMENT

One of the cornerstones of Henry Ford's Zero Suicide Model is that clinicians cannot predict suicide, but they can and must assess suicide. Each assessment leads to determining risk factors and the modification of those risk factors leads to a reduction in suicide risk and rates. Key tenets of our model include:

- Every patient must be assessed for suicide risk at every encounter. Clinicians are often adept at assessing suicide risk at intake and then may not thoroughly evaluate risk again unless the patient professes to suicidal thoughts, plan, or intent.
- Suicidal ideation, or lack thereof, is not a valid predictor of suicide. Suicidal ideation, plan, and intent, are risk factors but there are many others that are of equal importance including hopelessness, anhedonia, and chronic pain to name a few.
- Modifications of risk lead to elimination of suicide. The results of the risk assessment drive clinical innovations that are structured to modify the risk factors.
- When Zero Suicide debuted in 2001, BHS divided risk into high, moderate, and low. Our revised guidelines have four levels of risk: acute, high, moderate, and low. Of note, there is no category of "no risk" as every patient who comes to a mental health facility by definition has risk of suicide.
- Access to an array of intensity of care: inpatient, partial hospitalization, IOP, and outpatient are essential interventions to modify suicide risk. In the outpatient arena, the risk level determines how quickly the patient must be evaluated by a psychiatrist: same day for acute risk, within 48 hours if high risk, within a week if moderate risk.
- Modifications or innovations to change risk must be evidence-based; this is the case in both psychotherapy as well as psychopharmacology. The two major psychotherapies that the literature supports to modify suicide risk are CBT and DBT. Staff must be trained and proficient in these modalities.
- Weapon removal is essential – particularly firearms and stashes of medications to overdose. Availability of lethal weapons increase suicide risk.
- Family involvement is essential to modify suicide risk. Families often are the eyes and ears of patient wellness as well as decompensation. Families/significant others must be allies in Zero Suicide.
- Self-management tools to support the patient on his or her path to wellness and the development of increased coping strategies is essential to modify suicide risk. A Safety Plan is one essential element of self-management. A new format for the Safety Plan is enclosed.
- Community involvement is another element to help support the patient and family between appointments and allow the patient to develop support systems outside of the therapy session and their home. Such interventions can be one tool to modify social factors including isolation.
- Comfort or caring cards are one of the best-researched and effective strategies that inpatient as well as outpatient facilities can use to reduce suicide risk during times that patients are statistically at risk: the 7-30 days post inpatient discharge and following missed outpatient appointments.

Therese Samarco Director of Performance, Excellence and Quality.

Therese discussed how BHS review incidents including those which have death through suicide as an outcome.

Henry Ford use a Root Cause Analysis approach and look at where the gaps are at against how the system was designed. This informs process improvement. All RCAs on deaths by suicide are led by Theresa and Catherine Frank. Initial meeting within 24 hrs & conversation with clinical and treating team, additional information if you need to get it. Chart review. Timeline – looking for gaps in care e.g. access problems, delays in getting care etc.

They achieved Zero in 2009. This was as a result of very tight processes and high levels of fidelity to the model. The protocols are most important from the clinician's perspective including Risk Assessment tool embedded in the Electronic Record which reduce subjectivity.

Since the beginning of 2019 BHS have had no suicides in outpatient care. Everyone gets PHQ9 at every visit,

The ability to coordinate care within and across the HF system is an important safety factor.

Use of quality measures on a clinical dashboard: metrics e.g.

- Use of PHQ9.
- Experience of care –how involved people are in decision making,
- Inpatient levels of violence and aggression.

Dr Brian Ahmedani Director for Health Policy and Health Research.

Dr Ahmedani described the geography and demographics of the population served by the HF Foundation and the means of accessing Mental Health Services i.e. Health Insurance, Medicare (for over 65s – ok funded) and Medicaid (for people below a certain income level – poorly funded/doesn't cover costs). There is also a strata of the population not so poorly off as to qualify for Medicaid but not able to afford Health Insurance these are the people that Obamacare sought to bring into the health care system through an extension of Medicaid. This provision is being steadily eroded.

Detroit city is an area of significant deprivation with 80% of the population African American. It has low levels of income and low levels of educational attainment. In contrast however Henry Ford also serves Oakland County which is the 4th most affluent district in the USA,

Health Insurance Plans only covers 10% of their patients in mental health so they are predominantly funded in other ways particularly Medicare and Medicaid. They undertake approximately $350m of ''uncompensated care'' each year in mental health care. .

Dr Ahmedani described overall a '*fractured*' health care system in the state with a range of public (community health centres), not for profit and private sector providers with limited sharing of information between them. A large part of the BHS success lies

in how they have integrated care within Henry Ford and have kept people within one system.

Appointments are immediately available. Where someone is at an acute risk they will have same day access to a psychiatrist. All 'providers' (clinicians) are trained in evidence based suicide reduction therapies i.e. CBT and/or DBT and in mandatory safety planning.

Means Counselling – very important. Explore with the patient how they have considered killing themselves and then work with the family on how to address that – remove the gun, take the rope from the garage, remove the pills etc. There is evidence that when people impulsively decide to take their lives that they will seek to do so in the way that they have previously imagined doing it, so removing the means is an important factor in disrupting a suicidal urge.

The 9th question in PHQ 9 is used as a mental health suicide screening question. There are four response answers indicating an increased level of risk to suicide. Where a risk is identified they automatically get an appointment with an integrated behavioural health practitioner. Everyone who attends an appointment anywhere in the HF service is asked that question on an at least annual basis. If you indicated a level of risk previously then you are always asked this question at every future appointment. Globally 2.9% of people in the general population will screen positive. If you are indicated as acute risk you will receive a same day appointment by a psychiatrist and a psychotherapist within three days

Other discussions:

- The BHS has a strong research tradition with research and innovation being of high importance in the HF system generally. Dr. Ahmedani with Dr. Gregory Simon has initiated a five year study funded by the National Institute of Health (NIH) to perform a large and national evaluation of the Zero Suicide in Healthcare model.

  This study, which is due to report in 2022, is a comprehensive process and outcome evaluation of the National Zero Suicide Model (NZSM) implementation in real-world clinical settings across 6 large, diverse Mental Healthcare Systems which collectively provide healthcare for over 9 million individuals each year. The project aims are to:

  - Collaborate with health system leaders to develop EHR metrics to measure specific quality improvement targets and care processes tailored to local NZSM implementation,
  - Examine the fidelity of the specific NZSM care processes implemented in each system, and
  - Investigate suicide attempts and mortality outcomes within and across NZSM system models.

- Peer support. Developing peer support models+ where paid peers who themselves have gone thought suicide attempts will work as a buddy to those

at acute or high risk. These peer workers will be specifically trained in providing this support (reference Caitlin Heath).

- Maththematrics/Machine learning. Devising algorithms for proactively identifying risks using all the information that they hold across their IT systems. Dr Ahmedani believes that these have the potential to have a high percentile validity. This approach is still being developed.

And finally from Dr Ahmedani; *''Suicide Risk is its own illness and needs to be treated as one.''*

Caitlin Heath, Research Project Coordinator.

I met Caitlin in Kingswood hospital which is one of the HF psychiatric inpatient units. Caitlin talked me through the Prevail Project which is an innovative suicide reduction approach jointly established and being studied by the BHS in collaboration with the University of Michigan.

The project is a clinical trial to determine the effectiveness of a peer mentorship intervention for reducing suicide attempts and suicidal ideation amongst recently hospitalised adult psychiatric patients at risk of suicide.

The trial has been running since the end of July last year and is due to complete in 2022. So far they have recruited an average of 14 patients per month to participate in Prevail.

Kingswood psychiatric hospital has three inpatient units. Two of these are a male and a female ward for people with acute psychotic illnesses. The third ward is a 24 bedded mixed gender unit for patients admitted in crises and this is the unit from which potential patients are identified.

Of note the average length of stay in any of these wards is around 7 days. In the ward for mental health crises the focus is on starting people on anti-depressant medications, having them attend group therapies - Coping Skills/DBT/Social Skills etc. and making plans for them to link with outpatients follow up in the community including addressing social care needs. The patients will generally have been admitted to inpatient care mostly from an ED or other therapists due to concerns about risk of suicide or other significant self-harm. They may either be voluntary or involuntary admissions. Patients appear to be actively managed to attend therapy classes and to not to overly spend time in their rooms/beds see ward programme Annex 2.

For all patients admitted 24hrs to this unit Caitlin screens and then refers these to the supervising consultant who will screen out those with a psychosis, substance abuse patients, severe personality disorders etc.

All who are not screened out are then allocated by an automatic system to either a control group or a Prevail group. The latter are approached by Caitlin. The Prevail Clinical Trial is explained to them and they are invited to participate.

Those who agree to participate are allocated to a peer support specialist mentor. Mentors are recruited from the State of Michigan Peer Support Programme. All of these selected will be people who have made attempts previously to end their lives though have not attempted to do so in the last 24 months. These Peer Support Mentors are given an additional 5 days training programme by the University of Michigan in Suicidality.

Peers are given weekly supervision. The 1st meeting takes place whilst the patient is still in hospital. All further meetings take place in the community after the patient is discharged. Mentoring can be face to face or by phone. All sessions are recorded both for learning purposes during supervision and in the event of a complaint. For the 1st three months the support is twice a week and then once a week. A baseline is taken of the patients and this is then repeated at three months intervals over the programme. The patients will also attend outpatient appointments. Focus of mentoring is to lessen hopelessness and lessen helplessness.

At this time there have been no suicides in either the Prevail group or the control group.

Dr Mellissa Hendriks, Medical Director, Outpatient Paediatric Psychiatry.

''The important thing is that Zero Suicide is woven in to our services as part of what we do.''

The Electronic Medical Record (EMR) system requires that the PHQ scores have to entered in at initial and follow up encounters. This lets BHS track the patients and how they are progressing and as they have integrated electronic records allows BHS to do this even across different practitioner appointments. BHS can also show the patient their progress over time utilising their IT system. Of note the EMR is visible to all clinical staff, including GPs employed within the HF system.

The Risk assessment is also built into the EMR and clinicians update it and do so at each appointment.

Clinicians have been specifically trained in having very open and direct conversations on suicide. For example, ''*what made you try to take your life?*'', ''*How do you feel about that now.* ''

Engaging families is key part of their approach.

Essentially the same approach is used for under 18s as for adults though the process of family engagement happens more readily.

Henry Ford - Some jotted reflections

Evidence based therapies – medication/CBT/DBT

Model applicable to both Adults and Children

Woven into what we do – staff may not even think in terms of ZS

Clear protocols and a focus on fidelity of the model

Integration with primary care

Telemedicine

Risk Stratification

Risk assessment at every encounter.

Integration across physical and mental health, primary and secondary care and across mental health services

Electronic clinical records in which the model of care is embedded

The biggest staff engager is a supportive Just Culture.

Dr Victor Gardner – Snr Staff Psychologist

Key to success is the early identification of people at risk.

Two key innovations when Zero Suicide was first implemented were 1) having mental health care providers embedded in primary care and 2) continuity of care across the system and clinicians facilitated by the Electronic Care Record.

More recently the emphasis is on telemedicine and tele-therapy. As part of the introduction of this BHS completed a survey of Psychotherapists and Psychologists and 85-90% had either a strong interest in it or something of an interest so there wasn't widespread resistance from therapists to this mode of working.

Community teams are called outpatients or for Children's paediatric outpatients. Outpatient teams consist of Psychiatrist, Psychotherapy staff (Psychologists or MH Social Work Therapists), Social Work, Counsellors and Practitioner Nurses.

Also chemical dependence team – alcohol and other drugs. Addiction is a risk factor – there are detox/rehab services

First point of contact is usually a psychotherapist & psychiatrist (or a nurse practitioner if less complex). Weekly treatment team meetings.

Big focus on consistency of service delivery across sites. DBT has a very good evidence base for treatment of suicidal urges.

The key is good diagnosis, assessment of risk factors and interventions based on the stratification of risk.

Those with the highest assessed risk may be hospitalised or alternatively based on safety planning etc. a same day psychiatric consultation. Those at high risk will see the psychiatrist and be seen weekly for psychotherapy sessions such as DBT skills training for patients.

DBT therapy may be face to face or may be over the phone (which suits many patients). The DBT therapists also hold a specific mobile phone (on a rota basis) and patients if in distress can call and speak to a DBT therapist 24x7 (this is not abused – may only happen 2 or 3 times per month).

Commitment from patients is for one year for DBT with weekly psychotherapy sessions. There is also a children's model CDBT developed by Rathus and Miller which is used in their paediatric services. There are 16 DBT trained therapists across the 5 outpatient sites. 1-2% of patients are the high risk people who require DBT. This therapy will involve relatives, involve homework assignments and is a commitment of at least twice a week for a year.

Dr Doree Ann Hendrix, Consultant Psychiatrist

Dr Hendrix was present from the inception of ZS in the Henry Ford System and is committed to it.

Aiming for Zero is very anxiety provoking for staff. The single most important thing in gaining staff acceptance was ensuring that ZS wasn't accompanied by a Blame Culture. ‘*'The biggest staff engager is a supportive Just Culture; Will I feel safe as a clinician?"*

A review is completed 24 hrs after a death by suicide – 24hr write up. The leader of the review, when contacting practitioner needs to say ‘*'I'm so sorry for you, can I help*?'' Rather than asking, *"what did you do?"* Root Cause Analysis need to focus upon the system of care not what a person did or did not do. Incident reviews include everyone who was involved in any way in the patients care e.g. the receptionists at the hospital ward would also be included.

The idea of ZS started as a commitment to perfect depression care. ‘*'When we were looking for a metric to measure this a nurse suggested Zero Suicide."* After much discussion that audacious goal was taken on by Dr Coffey and Dr Frank. There was understandably concern at the time including from the leadership of the Henry Ford Foundation.

They use a Collaborative Care Model – Developed at the University of Washington (see Dig 4). At the outset everybody got a paper based GHQ9 and GAD7. Within HF Primary Care had already identified depression as a 'core measure' initially they had three nurse practitioners and a psychiatrist embedded in PC practices. Where there

was an acute or high risk the patient would be seen the same day. However this was not a sustainable model.

The shift in 2014 to the EPIC electronic patient record system was a significant enabler,'' *EPIC was a game changer''*. They now work an integrated or collaborative care service through telemedicine supported by the EPIC system which drives the template of care. This system has significantly improved productivity over the previous arrangement of having clinicians embedded in or working into primary care.

They had gone through a period where lots of patients were screened in primary care but there wasn't the capacity to follow up as required in their model. They were forced to temporarily close the service to primary care and during this time devised and implemented their telemedicine model.

The Collaborative Care team consists of Behavioural Care Manager and Psychiatric Consultant. Care stays with the GP with antidepressants being dispensed from the GPs surgery. All the people with mild to moderate MH problems are treated in and remain with primary care. This is being rolled out across all HF GP practices. These vary in size with 17 GPs in the biggest practice. All the therapists receive weekly supervision from Dr Hendrix.

When asked about working in such a remote way from patients Dr Hendrix indicated that she has found the changes to how they work very energising for a physician. *''its fun!''*

All the evidence based assessments are held on the ECR e.g. ASMI, PHQ9, GAD7, Alcohol etc.

What would you do differently if implementing Zero Suicide again? *''More refreshing and training for staff''* And *''need to constantly innovate to keep it sustainable.''*

Performance dipped peaking in 2014 when deaths by suicide had increased to circa 80% of the pre Zero Suicide baseline. A renewed focus upon fidelity to the model driven by Dr Frank has seen performance rapidly improve again and when I visited in June BHS had not had a patient death through suicide in 2019.

Dig. 4 Collaborative Care Model (https://aims.uw.edu/collaborative-care)

Behavioral health problems such as depression, anxiety, alcohol or substance abuse are among the most common and disabling health conditions worldwide, collectively robbing millions of their chance to lead healthy and productive lives. The good news is that there are effective treatments for most mental health conditions. The bad news is that most people in need don't receive effective care due to stigma, a shortage of mental health specialists, and lack of follow through.

Integrated care programs try to address this problem by providing both medical and mental health care in primary care and other clinical settings. Offering mental health treatments in primary care is convenient for patients, can reduce the stigma associated with treatment for mental disorders, builds on existing provider-patient relationships, and can help improve care for the millions of patients who have both medical and mental disorders. There is a wide range of integrated programs, some of which are based on evidence and some of which are not.

Collaborative care is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based on principles of effective chronic illness care, collaborative care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

Collaborative care originated in a research culture and has now been tested in more than 80 randomized controlled trials in the US and abroad. Several recent meta-analyses make it clear that collaborative care consistently improves on care as usual. It leads to better patient outcomes, better patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform. Collaborative care necessitates a practice change on multiple levels and is nothing short of a new way to practice medicine, but it works. The bottom line is that patients get better.

Use our Resource Library to find materials about collaborative care, have our Implementation Guide take you through the process of implementation, or browse this section to better understand the model of collaborative care.

Visits to Centerstone HealthCare and Tennessee Suicide Prevention Network (TZPN)

Visit to Tennessee Suicide Prevention Network

The Tennessee Suicide Prevention Network (TSPN) is the statewide organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the 2001 National Strategy for Suicide Prevention.

TSPN is a grass-roots association which includes counselors, mental health professionals, physicians, clergy, journalists, social workers, and law enforcement personnel, as well as survivors of suicide and suicide attempts. TSPN works across the state to eliminate the stigma of suicide and educate communities about the warning signs of suicide, with the ultimate intention of reducing suicide rates in the state of Tennessee.

TSPN has provided training to thousands of people across the state including training for staff of juvenile justice facilities with the development of Shield of Care, an evidence-based suicide prevention and intervention training curriculum for juvenile justice staff.

Meeting with Joanne Perley TSPN

TSPN is a non-profit agency whose role is to go out into the world and energise public and private sectors in suicide prevention measures. It attracts visitors from all over the world.

It is a public and private network including the Tennessee State and Centerstone. It participates on, and is accountable to, the Governor of Tennessee's Advisory Council on Suicide Prevention. Many of the people who also sit on this council have lived experience.

Tennessee has a state plan for suicide prevention and the Advisory Council holds everyone to account in the delivery of that plan. The members of the Advisory Council effectively hold each other to account for the overall delivery of the plan.

The TSPN has 6 or 7 paid staff with a significant number of volunteers many of whom work in mental health services such as Centerstone. The TSPN coordinates and delivers along with volunteers from other partners a significant annual training programme aimed at suicide prevention (3-400 trainers across the state). Last year 30K people received training in ASSIST or QPR (Question, Persuade and Refer- developed by Dr Paul Quinett 1-2 hr training programme)

The TSPN does a lot of work with doctors to train and educate them in suicide prevention.

Centerstone has also done a lot of work within the Veterans system – biggest provider of MH care to veterans in the USA.

Strongly expressed view that Zero Suicide is a distinct model and is a legitimate goal. There is a ZS Accredited model provided by the National Action Alliance (https://theactionalliance.org/).

Initiative in prison healthcare? They have undertaken some work entitled Shield of Care aimed at suicide prevention in the Juvenile Justice system however this stalled due to funding issues.

Suicide prevention training has been provided for people working in Addictions services – QPR (these are generally IS addictions services providers).

Despite all the efforts made by all the partners the suicide levels keep going up. A factor in this is the means and an increase, particularly amongst teenage girls of the most lethal means of self-harm whereby 70% now use guns. Suicide is the leading cause of death in those between the ages of 10 and 24 in Tennessee, the biggest number is in the 45 – 64 age range and the highest rate is in the 75+.

The reflection on the effectiveness of the Tennessee state suicide prevention legislation was that it has worked well on the educational front as training in schools, and police is now mandated. It has also improved awareness of mental health issues however it has been less effective at reducing stigma.

Visit to Centerstone HealthCare, Tennessee

Centerstone is a specialist not-for-profit health care organization providing mental health care, addictions treatment and community education in Florida, Illinois, Indiana, Kentucky and Tennessee.

Nationally it has specialist programs for members of defence services, veterans and their loved ones. Its research institute improves behavioural healthcare through research and technology and the Centerstone foundation secures philanthropic resources to support its work.

Centerstone joined the Zero Suicide in Health and Behavioural Care initiative in 2012 and is actively helping to lead pioneering efforts related to this cause on local, national and global fronts. Becky Stoll, Centerstone's vice president of crisis and disaster management, is the executive lead in Centerstone's drive to Zero Suicide

Centerstone's patients are treated for conditions such as depression, anxiety, bipolar disorder and schizophrenia placing them at a higher risk for suicide compared to the general population. The difference starts with the screening process, where the patient is evaluated using the Columbia Suicide Severity Rating Scale which is embedded into the patient's electronic health record. If he or she is determined to be at high risk the patient goes onto the suicide pathway. An education sheet, vetted by suicide survivors, lets patients know they've been identified as high-risk and should receive stepped-up care.

At Centerstone suicide prevention measures are "baked into" the roles of staff at all levels and across the continuum of care. These measures include:

- Implementing best practices around screening/assessing for suicide risk;
- Counselling on access to lethal means;
- Development of crisis management plans;
- Increasing the frequency of treatment;
- Monitoring those identified as high risk for suicide.

Efforts have also involved engaging the broader community, especially suicide attempt survivors, family members, policymakers and researchers.

Twenty months after starting Zero Suicide Centerstone recorded a reduction from 3.1 to 1.1 [suicides] per 10,000 people.

Centerstone Cohen Veterans Clinic, Clarkesville

Jennifer Smith, Lead Clinician


Lisa Eggebeen and Jennifer Smith

This clinic was specifically founded through philanthropic funding to meet the needs of military veterans and their families. It is situated in the city of Clarkesville the location of Fort Campbell a major military base. The Cohen foundation funds these clinics across the USA with the services being delivered in partnership with local provider organisations such as Centerstone. This provision is in addition to state funded and insurance based provision.

Veterans face significant challenges both coping with trauma experienced in conflict situations and to the huge adjustment associated with moving from military to civilian life. Each day on average 22 veterans take their lives in the USA. The clinic aims to provide veterans with speedy and easy access to mental health care.

Veterans can be referred from other providers, primary care, family or self-referral. The target is that they are contacted within 24 hrs of referral. Initial triage is generally done by telephone and takes an hour overall. A screening takes place to provide a baseline. PHQ9 (depression), GAD7 (anxiety), C-SSRS (suicide risk), PCL5 (PTSD) DVBIC (TBI)

If the client is seen as at acute risk of suicide they will be asked to come to the centre for immediate fuller assessment. This may mean hospitalisation (either voluntary or involuntary) for treatment or may mean referral to a Stabilisation Unit (which also can act as a hospital stepdown). The Stabilisation Unit is a non-hospital residential therapy unit which is accessed on a voluntary capacity. It provides therapeutic interventions and medications management (psychiatry& psychotherapy), family work and case management (work to prepare for non-residential follow up). LOS is between 48 and 72 hrs. Neither of these services are provided by Centerstone. Where admission occurs of a client referred by Centerstone then an Encrypted copy of their patient record is sent to the provider.

Inpatient Care – Detroit & Tennessee

General length of stay 5-7days for inpatient episode. The LOS is set by what funders are prepared to pay as evidence based – there can be high levels of readmissions of psychotic patients.

Inpatients are grouped by diagnostic types facilitating dedicated programmes on the wards. On a unit I visited where people with high risk of suicide were admitted the inpatient care involved very active programs of psychoeducational courses, group work, individual therapy as well as medication.

If there are very immediate concerns police may be asked to do a welfare visit to the home. Family will also be spoken to.

Where a high risk is identified they move immediately to safety planning especially where the client is actively considering suicide. The client would be asked to come in to the clinic immediately

The view of Jennifer is that under such circumstance even without the clients permission you can talk to family - you should always try to get permission however where a client is having active suicidal thoughts then even if you don't get consent you should speak to family anyway, *''If they die they cannot come back for treatment – ''I would prefer to have to work very hard to mend a therapeutic relationship than not involve family and increase the risk of suicide. ''*

Where clients don't need these levels of intervention they attend the clinic (outpatient) where they receive appropriate therapeutic interventions. The shortened C-SSRs is completed at each contact with the client, *''what we know is that if we don't ask the question we don't give the opportunity to disclose''.*

So they are effectively screened for suicide at every contact using the C-SSR Screener as part of their BioPSychopSocial model of care. This is completed electronically and in each consulting room there is a large VDU where the client can see what the clinician is filling in against each of the fields. Centerstone adopted the C-SSRs 6 or 7 years ago. For outpatients each patient will have a therapist, and a case manager (this is a social work role and involves ensuring the supports the person needs can be accessed in the community). There is also input from a psychiatrist and/or senior nurse practitioner. Main therapeutic modalities are CBT, DBT and EMDR – the latter is very

effective in the treatment of trauma. These are targeted and structured programmes of therapies delivered on the back of the assessments – usually a 12 week programme.

In terms of how this is done the therapist needs to have the questions built in as part of the conversation and not doing it as a tick box exercise.

The initial assessment, after triage, will take about 1 & 1/2 hours. This will include C-SSRs Adult lifetime.

Immediately it becomes apparent that the client is suicidal then their safety becomes the primary concern and the therapist may devote the rest of the session to the safety plan.

Anyone above moderate risk will have a safety plan completed.

There is a telephone crises line which is used proactively as part of safety plan i.e. they may call the client every day – importantly this is a call informed by a referral from Centerstone. The client can also contact the crises line when in crises.

RE Zero Suicide *''from where we were 10 years ago nobody asked about suicide. The best way to mitigate suicide is to talk about it and explore it with the client and make it part of the treatment''.*

Tammy Pawlak – Therapist Cohen Centre – Pilot of the CAMS Process.

The Collaborative Assessment and Management of Suicide (CAMS) developed by Dr David Jobes is a therapeutic framework for suicide specific assessment and treatment of a patient's suicidal risk. This model has been around since 2007/08. This is not in widespread use in the Centerstone system and is being piloted as part of the joint working with the Cohen system. It would replace the full CSSRS if it were implemented.

Where following initial triage it is evident that the client is at high risk of suicide then the therapist completes the CAMS assessment with the client. This is necessarily a paper based exercise as the client fills in elements of the form with the therapist.

CAMS is about being collaborative. The client and the therapist sit beside each other and go through the process. The format supports a conversation. This is encouraged to be open and direct, "*helping people to say, 'I have suicidal thought''; 'You [the client] need to write down your reasons for wanting to die; 'Currently what is driving that?''.* This conversation allows the clinician to drill down into the issues and discover what is or are actually the issues which may be different than initially presented by client.

At the end of page two of the assessment the client starts to get hope. '*We can fix it', but I'm here to be through that mess with you*'. CAMS is undertaken for 3 consecutive sessions. The treatment plan is reviewed at every session of CAMS.

These clients would also have support through case management and psychiatry (in this case commissioned from another provider).

Zero Suicide more generally: *''Leadership has been about focusing on all the population we serve. All our patients are trained in mental health 1st aid. Have to continually train and audit to ensure fidelity to the model. Engaging champions who will take on a high profile. Ensuring consistency in the model from clinic to clinic."*

''So much research, care, concern and time was spent on planning for this [ZS] *that even if it was rolled out and wasn't perfect it wasn't down to a lack of trying''*

Becky Stoll Vice President for Crisis and Disaster Management and Megan Williams, Director of Suicide Prevention Centerstone

Becky Stoll is the driving force behind the development and implementation of ZS in Centerstone. She took me through a presentation on ZS and the approaches, challenges and future development within Centerstone.

Megan Williams, Becky Stoll and David Guth CEO

The ZS approach started implementation in Centerstone in 2012. They have clinical pathways for different conditions. Clients coming into services or on clinical pathways are screened for suicidal risk. Where screened and they meet the threshold they are escalated onto a clinical pathway for suicide prevention which runs alongside their presenting treatment pathway.

As part of the preparation an organisational self-study was undertaken. They also undertook a workforce readiness study (this indicated that the workforce was not that ready!). They undertook significant research on suicide prevention and tools and training. A zero suicide approach was first piloted in 2013 in four locations. As this went well it ended early and Centerstone moved to rolling the approach out across all its services.

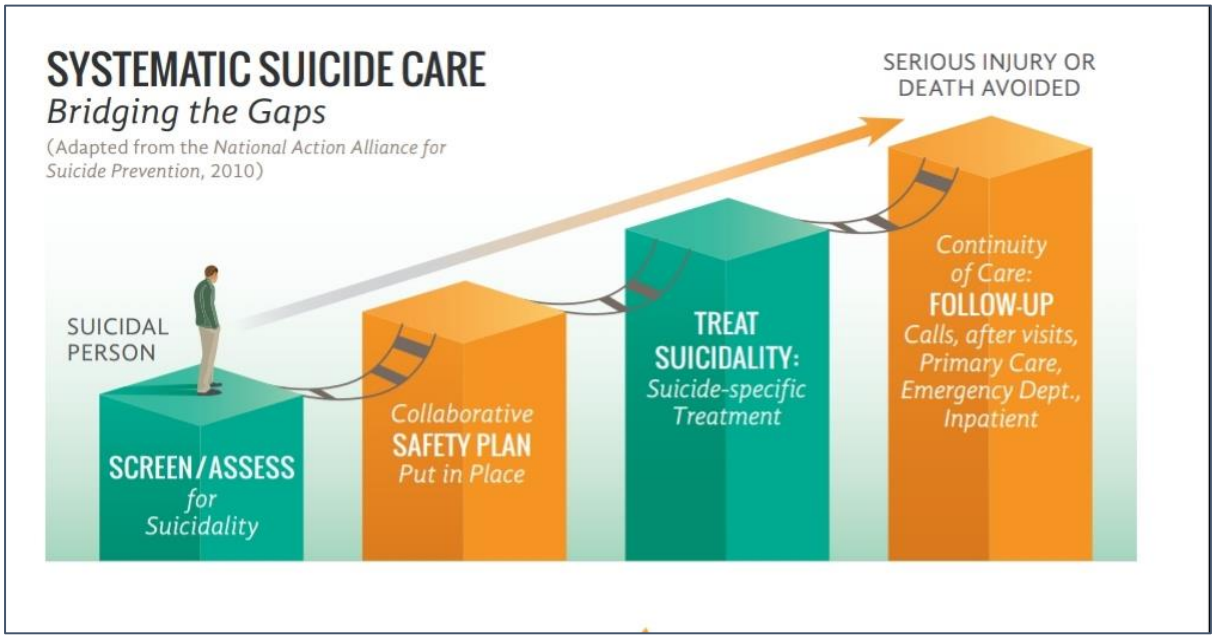
Structurally a Suicide Prevention Centre was established. Centerstone also established a suicide champions group with each service line nominating one champion however this has proven difficult to sustain. They had an internal communications plan including people with lived experience.

Training for staff was key and they sought to make this easy, affordable, quick and sustainable. It was particularly on the CSSRS & on counselling on access to lethal means. They developed their own internal PowerPoint for training. This training has now been incorporated into induction. As part of this training they have their clinical pathway for suicide prevention. This include training on the new tools and lists of FAQs for clinicians.

Suicide Prevention Pathway SPP; (see Dig 5 Suicide Prevention Pathway). The 1st stage of the SPP is to identify those at risk through Screening. Whilst this is not an exact science it is one of the easiest to implement. Each patient is screened at every appointment. This screening is mandatory and is made so by the Electronic Health Record (EHR). Screening is done against the full PHQ 9. Where someone scores 10 or more on questions 1-8 and above 0 on question 9 this triggers the need to complete

the CSSRS. This is built into an algorithm on the EHR which would have to be explicitly overridden by the clinician and reason given. Exceptions are audited by more senior managers for quality of reasons given and to identify where a practitioner is operating as an outlier.

Dig 5. Zero Suicide – A Suicide Prevention Pathway



The 2nd Stage is to engage through Assessment. Any level of clinician can place a client on the pathway but only a therapist trained to master's degree can take someone off. Within the EHR there are programme codes for suicide prevention which are automatically assigned by the EHR. These mean that these clients are highlighted in red on the system. Additionally the system will automatically send email alerts to any clinician that the patient is currently open to – anyone who has seen the client in the last 90 days or has a future appointment scheduled. When the patient is placed on the suicide pathway there is a follow-up within 24 hours. This will include for the therapist tools maintained on the EHR such as the CSSRS, Patient/Family Education Sheet and the Stanley Brown Safety Plan (this is evidence based and well regarded by therapists).

The 3rd Stage is Treatment. The approach with ZS is to treat the suicidality directly. This is challenging and often these can be an incredibly difficult group of people to keep engaged in treatment. Many only wish to have medication and Centerstone discourages medication only approaches as not being effective. However a lot may not consistently attend therapy. Where this happens they try to get the medical people (i.e. the Drs and nurses) to work with the therapists e.g. 9am appointment to see the therapist scheduled prior to 10am appointment to see the doctor however this can be difficult to achieve. Targeted suicide prevention treatment is CBT or DBT though these

are expensive both in terms of training for staff and in terms of staff time delivering the interventions. So they are currently looking at adapting their own training (see Dr. Banks below)

The 4th Stage is enhanced monitoring and follow-up. Centerstone do not have acute mental health beds in Tennessee however where their patients are placed in another provider's inpatient services, and Centerstone will be providing the outpatient care post discharge, then Centerstone staff will work into the outpatient setting. All hospital discharges are placed on the suicide pathway automatically. Where a patient on the suicide pathway calls to cancel an appointment they must be spoken to by a therapist and the reasons explored and another appointment arranged. Again this is monitored through the EHR. Where there is DNA of someone who is high risk then the High Risk Follow Up Team is activated. They will make three attempts to contact the client and send a 'caring letter' from the crises team.

The final Stage is exiting the suicide pathway. A client can only exit the pathway by being discharged from it by a master's level therapist or is a bachelor's level therapist with the oversight of the master's level therapist. The decision will be a clinical judgment made by the therapist heavily influenced by the scores on the C-SSRS.

Centerstone have encountered challenges particularly to routinely ensuring best practice in a resource constrained environment. It is very apparent that they are convinced of committed to Zero Suicide and to actively problem solving the challenges in operationalising and sustaining the ZS approach. These reflections are reassuring and feel authentic to the world facing services in N Ireland.

Quality Improvement; Centerstone place a significant emphasis on quality assurance and improvement informed by data from the EHR which generates a number of reports e.g. suicide deaths, numbers of clients not engaging etc. Most people who die open to services are not on the suicide pathway. Monthly death figures are given as rolling 12 month averages.

There is a fidelity chart audit review which presents the levels of fidelity to the model being followed and gives management the opportunity to follow up with individual therapists. They also seek to track and present data on suicide attempts but this is challenging to do robustly – relying on self-reports and information from Emergency Departments.

There is ongoing development, training and engagement including seeking to develop the interface with primary care.

Like Henry Ford they are also seeking to develop predictive modelling through the use of algorithms. This has been done successfully by the veterans administration however is more challenging for civilians due to the limits on the information held.

Impact of ZS; Over the last 12 months there have been 8 deaths. This is a low figure from highs previously of over 20 in a 12 month period. Where there is a death there is

a meeting to audit the care, the pathway and fidelity to the model. Over the first 22 months of the ZS initiative there was a 67% reduction in suicide deaths but about 2 years ago it rose back up again – analysis of this indicated that lack of fidelity to the model and in particular clients on medication only treatments (47%) and not engaging in therapy. The numbers did go down again however this was followed by a second spike which has been followed by a decline over the last year to current low level of 8 over the past 12 months.

Lifeline Crises Service; Centerstone have a crises call centre providing 24x7 call line. Most of the staff work from home and the technical system allows them to do this. This service is used a lot to provide support to clients in crisis over weekends. Teams would formally refer clients – *'can you check up on these patients over the weekend'*

Staff social work therapists/ licenced counsellors and a peer support worker. Bachelors and Master's Degree levels of qualification.

50% of work over telephone and other half face to face.

Referrals received from ED/ICU overdoses/suicide attempts – approx. 500 per month. Also take calls from prison inmates. Lifeline also will provide MH inpatient post discharge follow up. All referrals/self-referrals will receive a PHQ9 risk assessment and crises management safety plan (they would involve family support in completing these). They would also set up referrals through to outpatient services.

Dr Bre Banks, Manager Centerstone Research Institute

Dr Banks is nationally recognised for her research within the field of DBT therapy. She has been undertaking research in partnership with the University of Tennessee around treatment and training models in an effort to improve robustness, deliverability and sustainability. It's difficult to implement the existing suicide prevention pathway so the aim is to develop a new training programme which will allow more people to access evidence based approaches. This will be an effective and cost effective tool tailored for suicide prevention work.

Looking specifically to develop new models to support the suicide enhanced care pathway based on evidence and statically predictive models. CBT for suicide and depression and also to have an adapted form of DBT (adapted for community behavioural health)

They have just trialled the programme (RELATE) and are now collecting outcome data on its effectiveness (i.e. suicide rates in clients). This approach focusses on 3 core constituents;

- Burdensomeness
- Belonginess
- Capability

They are drilling down into DBT to extract its core components. Currently it's a 10 day training programme, the adapted programme would be at most a 3 day programme. This will be available online through video e-learning and staff can complete this at their own time.

Similar for DBT, CBT is service response which is difficult to sustain. A programme is delivered over 8 sessions lasting 30 to 45 minutes. It can be difficult to get clients to commit to completing this.

They are currently developing the training content and seeking to get it accredited by the National Council (not by the BECK inst). Building a full research and evaluation base for both the adapted DBT and CBT programs. The outcome will be effective interventions which can practically be delivered by staff to a high level of fidelity with higher levels of client engagement. As things currently stand this is challenging to achieve.

''Currently we [Centerstone] are good at screening and identification, the *big challenge is delivering treatment to a high level of fidelity. ''*

Training, working with a couple of platform providers. Identifying the core components of the training. Clinicians will access most of the training program content online using videos on line and in context – '*core interactive'*. They will also be offering a clinical supervision training program.

Planning to have the initial pilot completed in October 2019. Being piloted over 75 clinicians work.

Susan Seabourn – Clinical Manager, White Avenue Clinic.

White Avenue is a Centerstone outpatient facility in Nashville. Based at the centre are 7 medical staff (Drs and Nurses) and twenty therapists. They are in two teams; one children's and one adults.

They provide this service to the local community insured population. This includes the full range of socio- economic spectrum. People who are not covered by health insurance will access White Avenue through Medicaid, Medicare or the Tennessee State Grant program.

They also have a separately funded Case Management Team. This is through a grant from the Tennessee Health Centre. This service is integrative and helps to ensure better care of people's physical health. It provides level 2 case management – involvement in care related activities such as psychosocial counselling, complex discharge planning and arrangements with voluntary sector providers including funding. This team is comprised six clinic based case managed providers.

Everyone seen at the outpatient clinic is screened through the PHQ9 and where indicated the Colombia C-SSRS '*we do it as best practice'*.

The use of the C-SSRS came with Zero Suicide, this and counselling around access to lethal means has been a game changer; *'It's about getting as much time and space between the person and their preferred means'.*

They have completed training with Ursula Whiteside NowMattersNow.org. This is an online video program that includes skills for managing suicidal thoughts based on DBT. They run group therapy for people with suicidal ideation based upon this program.

People who come to outpatients are placed on an initial care plan for six months. The pathway is less of an intervention and more of a framework. First contact is with a therapist, social worker or licenced professional counsellor, who gets the initial demographic information, history, presenting complaint and also does PHQ9.

The patient may also see a medical provider which would be a psychiatric nurse or a psychiatrist. Caseloads for practitioners in the clinics is between 120 and 150 per clinician.

Evidence Based Safety is an element of the ZS pathway with Centerstone using the Stanley Brown safety plan which they regard highly. There is also an App to support this*, ''safety contracts don't work''*

Staff trained and supported in direct, open conversations regarding suicidal ideation and behaviour and giving them the language to discuss suicide e.g. '*what do you mean by you wish you were not here? ''*

Trauma informed care is important. Actively ensuring that professionals don't re traumatise clients. DNAs are actively followed up both by telephone and caring letters,

Where people don't have insurance funding then their care can generally be funded through grants which Centerstone receives from state providers as behavioural health safety nets.

At the White Avenue clinic they have a group for people who experience suicidal ideation. This group exclude those with addictions, psychosis or intellectual disability.

They use a range of approaches based upon DBT developed by Ursula Whiteside and available on NowMattersNow.org. The curriculum for the approach has been based upon this and includes practical techniques in dealing with suicidal urges when they occur e.g. Ice Water Technique. The group also uses mindfulness techniques. This group is a dynamic group of people with people coming and going – it consists of 8 discreet sessions so there no beginning or end. The clinic is planning its own review of the efficacy of this group as a contribution to Zero Suicide.

Visit to Gold Coast Health, Queensland

Gold Coast Healthcare is one of 16 state funded health care providers in the state of Queensland. As in N Ireland each of these providers serves a defined population within a specific geographical area though unlike N Ireland there is a well-developed private sector which people may access for healthcare either through individuals' resources or through state funded care.

I visited the Mental Health and Specialist Services (MHSS) of Gold Coast Healthcare which in 2016 published its Suicide Prevention Strategy 2016-18 entitled Journey to Zero through Leadership, Support and Continuous Improvement (https://clinicalexcellence.qld.gov.au/sites/default/files/2018-02/Gold%20Coast%20Health%20Journey%20to%20Zero%20Suicide%20Prevention%20Strategy.pdf)

This Strategy was inspired by the pioneering work in organisations such as Henry Ford in Detroit and their success in reducing suicide levels by services users through a Zero Suicide approach.

The strategy was introduced by Gold Coast Health's Mental Health and Specialist Services in December 2016 to reduce the incidence of suicide. At the time of my visit it is still relatively early days for outcomes however the initiative was awarded a highly commended for 'Delivering Healthcare' at the 2017 Queensland Health Awards for Excellence ceremony

Gold Coast Journey to Zero – Introduction

During my three days with MHSS and a further day accompanying Dr Kathryn Turner in Sydney to a New South Wales, Towards Zero Suicide Workshop, I met many committed leaders who discussed various elements of their Journey to Zero. In this section I am going to reflect on these discussions thematically rather than individually as in my report on Henry ford and Centerstone visits.

Whilst I met a great number of people each of whom I would thank, I would wish to particularly acknowledge the following who gave generously of their time and resources to facilitate my visit. Kathryn Turner, Clinical Director, Malcom McCann, Executive Director, Matt Welch Nurse Consultant ZS Project Lead, Brian Mayahle Director of Clinical Governance and Innovation, Dr Sarah Walker Senior Clinical Psychologist, Professor Chris Stapelberg, Chair in Mental Health for Bond University and Gold Coast Health, Carla Patist, Clincal Lead Acute Care Team, Luke Lindsay Project Lead Crises Now, Catherine King Governance and finally a particular thanks to April Croydon, Executive Support Officer.

The Gold Coast Journey to Zero (JTZS) strategy drew significantly on the Zero Suicide framework and tools as available on the Zero Suicide International Website http://zerosuicide.sprc.org . In describing my learning from this visit I will use the Essential Elements of the Zero Suicide framework of Leadership, Identify, Engage, Treat, and Transition within a framework of staff training and innovation and a Just Culture.

1. Leadership


Kathryn Turner and Catherine King

'' Compassion needs to come from the top down".

There is clear strong, clinical and managerial leadership for the JTZ approach in the MHSS with Kathryn Turner as the Clinical Director providing overall leadership along with senior medical, nursing and psychology colleagues who also had leadership roles.

This leadership position was established in their Suicide Prevention Strategy 2016-2018 which provided the vision for their JTZ and a framework for its implementation. This strategy was also the vehicle for achieving top leadership buy in from the Executive Board of Gold Coast and was further endorsed by the Queensland Government. This provided a very public statement of leadership intent from the outset.

The strategy identified two key leadership commitments of improving patient safety and providing a Just Culture where clinicians feel safe to practice and safe to disclose without fear of blame.

JTZ includes both Children's and Adult's mental health services. It set a target of a 20% reduction in suicide levels however Dr Turner questions now if targets are helpful in the context of Zero which is seen as "*an aspiration not a target"*

The process of developing a strategy was important to its subsequent implementation. In developing the strategy the question asked of clinicians/teams was "*can you say that your service consistently uses the best evidence based approaches to suicide prevention?"* There was an agreed need to shift away from endless assessments and unproductive risk assessments.

The initial focus with staff was to achieve buy in from senior clinicians which was mostly successful. There were a few outliers and the approach taken was to engage with those who want to be engaged with.

Whilst there was no significant injection of funding for new services MHSS did on the back of the strategy get funding for a project officer. They were also able to free up people within the service to take on leadership and training roles.

They regarded JTZ as a bottom-up provider driven initiative *"We did this as a service; it's our work - business as usual."*

2. Train

Sarah Walker

Staff training and development was central to the strategy implementation. Training was led by Matt Welch, Nurse Consultant and Zero Suicide Project lead and Sarah Walker, Senior Clinical Psychologist.

Every clinician of the MHSS is trained in the Suicide Prevention Pathway this comprises 4 online modules and 1 day face to face training programme.

In delivering this training Mr Welsh and Dr Walker reported that they particularly focused on attitudes and beliefs, prior to moving onto skills training. They believe that the only way to change culture is to improve the level of compassion towards people who are suicidal. Training on attitudes, myths and beliefs was delivered through skilfully delivered, case-based open discussions where there were no right or wrong answers. Tackling the belief that "*Suicide is a Choice*" through discussion. The aim is to develop empathy and the debunking of myths. Focus on compassion, attitudes and beliefs.

The approach now as they move from implementation to 'business as usual' is 3 hrs online training on suicidality followed by 1 day's classroom training. As part of the embedding of training, as work as usual, Dr Walker and Mr Welsh have trained trainers within the organisation who train everyone as part of induction as well as refresher training.

The 1st group of people trained were the Consultants reflecting their leadership role in teams.

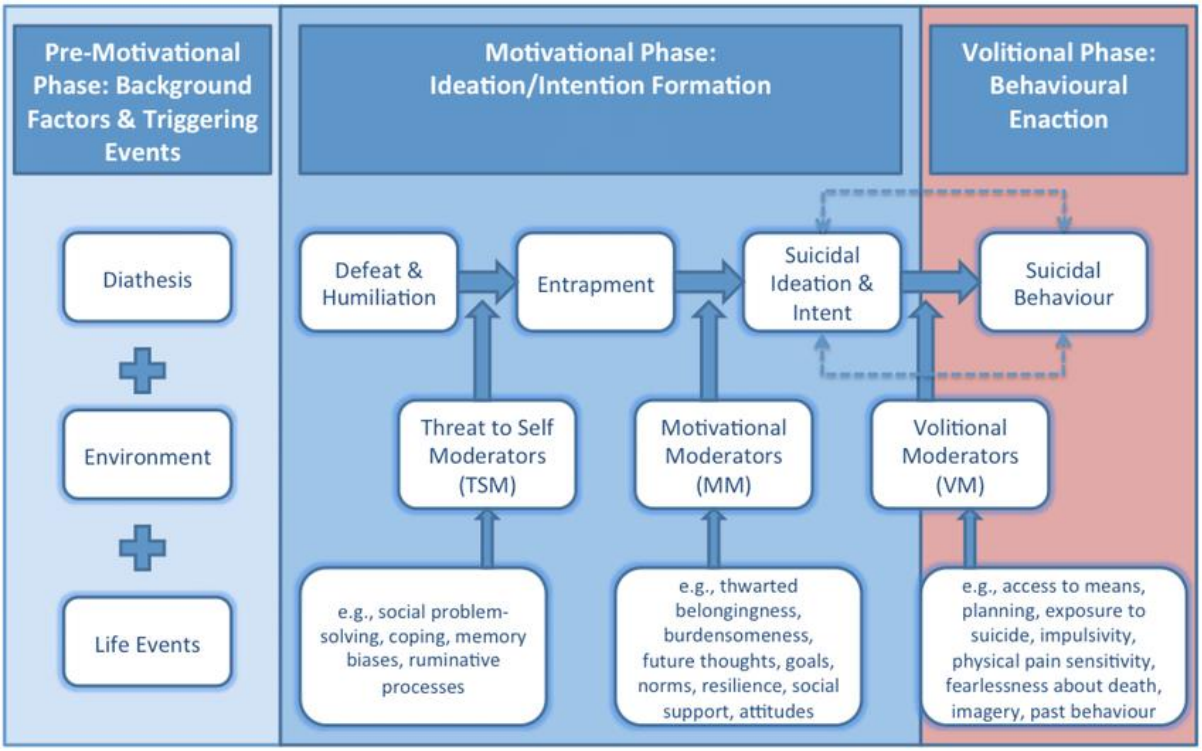
They also undertook specific training for staff in the ED on supporting people with a personality disorder. Again this focused particularly on building compassion through empathy. This was completed by in service and consumer training.

The key components of the training is structured around the MHSS Suicide Prevention Pathway. In addition to addressing beliefs and cultural elements training is informed by;

- Integrated Motivational Volitional Model of Suicide (Prof. Rory O'Conner)
- Chronological Assessment of Suicide Events (CASE approach – Prof Shawn Shea)
- Prevention-Oriented Suicide Risk Formulation approach (Prof Anthony Pisani)
- Safety Planning (Stanley & Brown – adapted)
- Reducing Access to lethal means
- Patient and Carer information and education
- SBAR and Follow up – Care plan
- Self-Care and resources for staff.

Professor Rory O'Conner's Integrated Motivational Volitional Model of Suicide (Dig 6) is used in training to help clinicians to better understand suicidal behaviour, the factors which influence ideation and those which when present can trigger suicidal behaviours

Dig 6 Integrated Motivational Volitional Model of Suicide



This training along with a 'Suicide Prevention Pathway of Care Manual' and resources for patients and families are the basis of how the JTZ was implemented in MHSS. Every member of staff receives a copy of the 133 page Suicide Prevention Pathway of Care Manual, detailing each element of the pathway and supporting best evidence / clinical practice elements.

Training was delivered utilising a trauma informed approach e.g. asking "*what has happened you"* rather than *"what is wrong with you"*

They believe that their training alongside the SPP has had a positive impact on culture.

They report that the number of patients who have family member support has increased from the past with fewer problems now in obtaining permission from the patient to involve family members.

Training also followed through at initial rollout of the SPP where Dr Walker and Mr Welsh were available to support and advise staff on the screen and on the formulation. Also initially there were daily team huddles to help to ensure that issues were dealt with.

3. Identify/Engage;

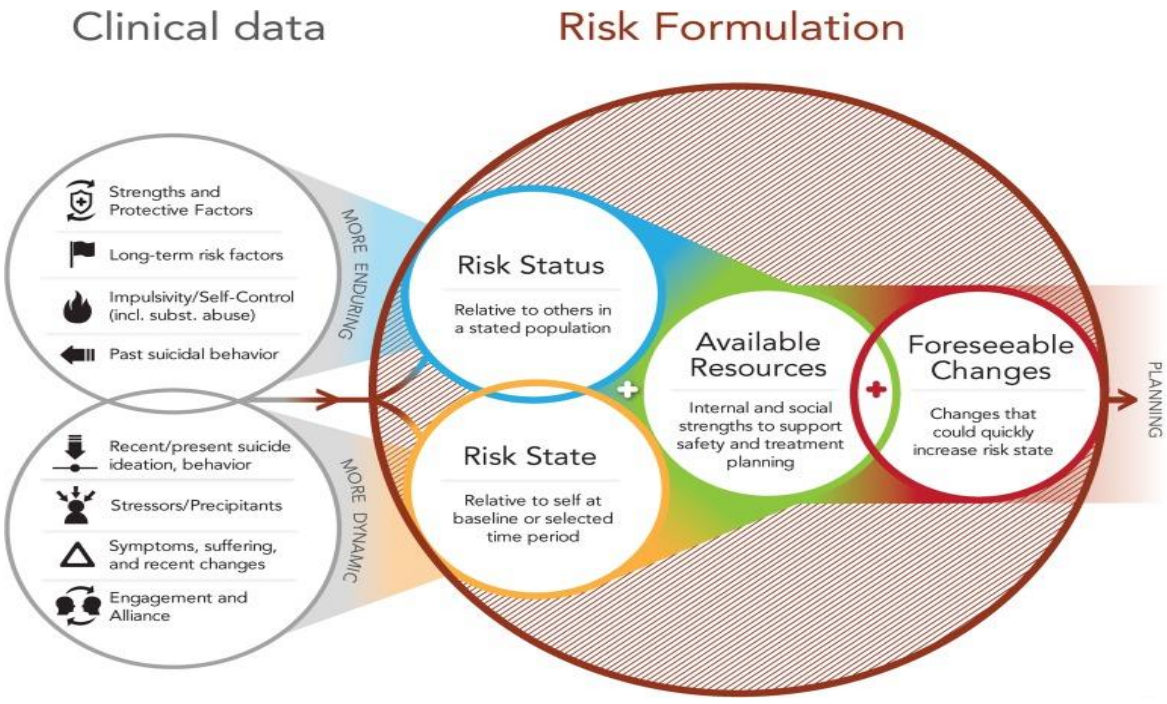
"*Yes we're busy: but what are we busy doing?* "

All patients open to or who make contact with the MHSS are screened for suicidal risk on every contact (UKMH Triage Scale). People are placed on the SPP where they are presenting with a suicidal attempt or someone with a past history of a suicidal attempt is presenting with suicidal ideation.

Assessment; Staff are trained in the CASE assessment approach (Chronological Assessment of Suicide Events) which provides core skills for clinicians in engaging with patients. CASE supports solution focussed interviews and is considered to be a practical, and easily learned interview strategy for eliciting suicidal ideation, planning, and intent. It is designed to increase validity, decrease errors of omission, and increase the patient's sense of safety with the interviewer. I met Dr Shawn Shea, who developed CASE, at a training event in Queensland and he advised me that on-line training programmes in CASE will be available from early next year.

Risk Formulation; MHSS were clear that Risk Assessments should not be used for resource allocation or for determining access to services as they have low predictive validity and a bias to accept low risk, '*''If you didn't say someone was low risk how you could discharge them?''*

Dig 7 Risk formulation; Pisani Prevention Orientated Risk Formulation



The JTZ approach dispenses with risk assessment in favour of the Pisani Prevention Orientated Risk Formulation which synthesises assessment data into four distinct judgments to inform intervention plans: (1) risk status (the patient's risk relative to a specified subpopulation), (2) risk state (the patient's risk compared to baseline or other specified time points), (3) available resources from which the patient can draw in crisis,

and (4) foreseeable changes that may exacerbate risk. http://www.sprc.org/sites/default/files/migrate/library/PisaniRfmltngSuicdRskFrmltnFrmPrdctn2Prvntn2015.pdf

Clinicians I met were supportive of the use of the Pisani Risk Formulation. They believe that it was easily integrated into clinical practice and its universal use is *''great for handover everyone is speaking the same language''.*

4. Treat

Initial Interventions

Collaborative Safety Planning: A ''trap'' which services frequently fall into is that of believing that the crisis is over if the patient reports that they are no longer actively suicidal – that they now have "no intent or plan". But what then has changed? Despite the patient reporting that they are no longer suicidal, the evidence is that often they quickly become suicidal again after leaving the consultation. We know therefore that suicide risk fluctuates over time. Collaborative Safety planning pre-empts this fluctuation. The evidence shows that Collaborative Safety Planning can result in up to 40% reduction in suicidal behaviours compared to comparison groups. MHSS adapted the Stanley Brown Safety Plan to include a more acute crisis component. This is completed in partnership with the patient and their family. If the patient has presented on his or her own they will bring family in from home even if it means that the patient breeches in ED

Counselling on Access to Lethal Means. This is a key component of the safety plan intervention and involves eliminating or limiting access to any potential lethal means in the environment. This may include safely storing and dispensing of medication, alcohol, implementing firearm safety procedures, removing a rope or formulating an agreement restricting access to transport and places identified by the person that they may end their life.

It's important to involve family and carers in all aspects of this work.

- Identify Method/s
- Identify location of means
- Identify Actions to mitigate access
- Identify roles and responsibilities
- Check this has been actioned and contingency planning

This is considered to be one of a small number of suicide prevention interventions which is proven to be effective – if lethal means are not immediately available the individual may go onto make a less lethal attempt, *''Going out to buy medication or a rope would be way beyond capability while depressed, but having them near is another matter….* "

Brief Patient & Carer Education; MHSS has developed a range of advice geared towards family carers as well as for the individual designed at instilling hope, creating

understanding, making sense of the situation and reducing shame and stigma. Patients and families are provided with this information to take home with them from the appointment.

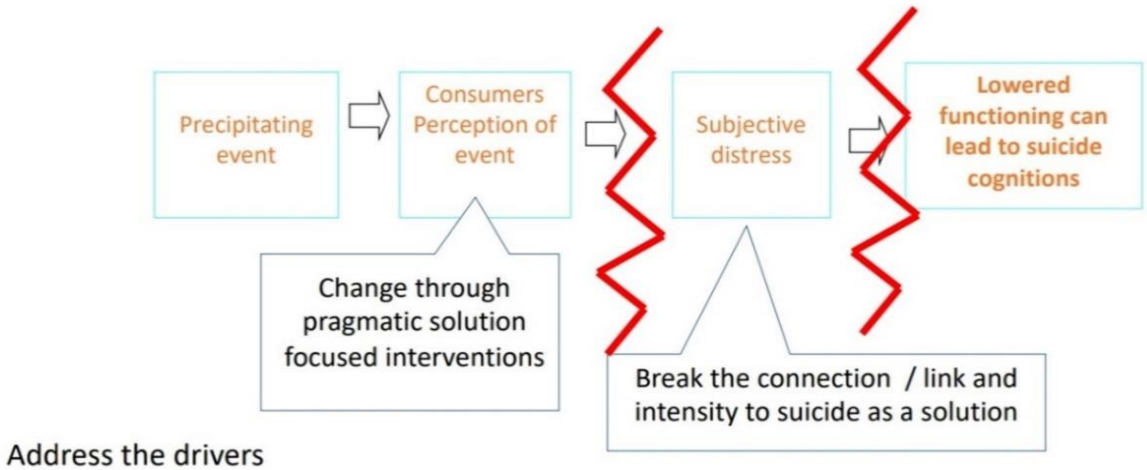
The approach in the initial interventions is identifying what the patient needs and how can we help. They will also spend time engaging and getting information to ensure that follow up occurs and the patient is not lost to contact *"if we can't get in touch with you, who else can we call?"* This would include home visits.

When I asked about the additional time burden of these approaches the view was that it's the safety plan that takes the extra time. The CASE and Pisani approaches after the initial learning period don't take any longer than previous approaches. The thing which can particularly take the time around the safety planning is where they have to wait for family to come in to allow collaborative completion.

Structured Follow-up;

Patients get a follow up appointment before they leave ED. This should ideally take place within 24-48hrs and should be face to face. There are a range of task identified for the follow up appointments including developing and reviewing a Care Plan which expands on steps 1& 2 of the safety plan. The Care Plan identifies the suicide drivers and strategies to address those drivers. The approach of the Care Plan (see Dig 8) is that by identifying potential solutions or coping strategies which address the person's feelings about events which are causing them to feel suicidal, that this decreases the impact of those events and in consequence leads to a decrease in the intensity of suicidal thoughts.

Dig 8 Rationale for Developing a Care Plan with the Patient and Family Carers



Further activities associated with the follow up appointments include

- Ensuring communication with carers, family, and other health professionals (GP, Private Psychiatrist, Private Psychologist etc.)

- Identify other agencies required and initiate referral process
- Agree on care plan, and the next appointment.
- Document a progress note in SBAR format
- Any changes to safety plan upload new safety plan to CIMHA (MHSS's electronic record system)

5. Transition

Patients placed on the SPP will generally be seen 2-3 times by the acute care team before being transitioned. There is a clear set of criteria identified to taking an individual off the SPP.

Gold Coast MHSS commission a voluntary sector organisation FSG to provide non-clinical support and transition service for patients on the pathway. FSG Community workers provide coordination, linkage, and referrals to services who can provide longer term support, in line with the individual's needs. Community Workers work in partnership with the Acute Care Team. Community workers follow up with the consumer post discharge from MHSS for up to 4 weeks ensuring ongoing transition support

It seems that much of the follow up after the discharge from acute care is provided by IS providers e.g. Private Psychologist, Private Psychiatrist, voluntary sector organisations such as FSG or Way Back Support services whom I met in Brisbane (see below). There are also Adult Community Mental Health Continuing Care teams which provide assessment, case management and treatment for 18-65 year old's who live with an enduring mental health condition.

The emphasis is on a "warm handover" which connects the patient with the new provider before the first appointment. (e.g. facilitated phone call before appointment)

Could be via an IS organisation worker or peer support worker. Written handover (e.g. discharge summary) is sent to the new provider a few days prior to the first appointment.

The patient should have their first appointment with the new provider prior to their discharge from the SPP. There is a final face to face appointment, together with further collateral from carer/family prior to discharge.

6. Improve - Data /Research and Evaluation

Data is collected by MHSS on a number of metrics including number of patients on the SPP, number of patients discharged from the SPP re-presenting in MH crises, number of deaths through suicide of people known to services. The number of patients has averaged 120 per month with a steady increase over the implementation period. In terms of the latter two metrics the data to date, which was shared with me, is very encouraging however Dr Turner is of the view that data on suicides needs to be based on 3 year rolling averages as individual yearly data is not sufficiently robust to show trends.

The data collected shows reductions in the numbers of people re-presenting with a further suicide attempt compared to control groups (control groups are those who re-present with a suicide attempt but who for a number of reasons had not been placed on the SPP e.g. people who refused). This reduction is consistent across all types of presentations e.g. children and young people, people with a personality disorder, people with SMI, etc.

They intend publishing their data next year.

Fidelity to the model is emphasized and Gold Coast use electronic audit tool SPRE (Software Process Risk Evaluation) which measures fidelity through two dimensions of fidelity. Firstly Dose – are we doing each step for each person? and secondly Reach – is everyone who is eligible placed on the pathway? It is however difficult to measure fidelity to the CASE approach.

7. Restorative Just Culture

This was strongly emphasized as an essential element of the JTZ approach. It was felt at the outset that post incident reviews had traditionally reflected a culture of blame. Whilst that was not the intention of the incident reviews it was how they were experienced by staff, as was evidenced through staff focus groups undertaken as part of the organisational readiness work.

Two interlinking elements of the Just Culture are how incidents are reviewed and how staff are supported when things go wrong.

Incident Review; Initially Gold Coast drew upon David Marks' work on Just Culture who questions many organisations self-view is that they have a just culture however "*the only people that think it's a just culture are the leaders of the organisation*" – "*who draws the lines; who gets to make that decision?*"

Within healthcare systems there is a trade-off between efficiency and thoroughness. Commonly efficiency is valued and rewarded until there is an adverse outcome, then the system and the clinicians are no longer evaluated through a framework of efficiency but through a framework of thoroughness.

The original Just Culture concept has now been further iterated as ''Restorative Just Culture" (Dig 9). Conceptually this differentiates between Backward Looking Accountability (Just Culture or Safety 1) and Forward Looking Accountability (Restorative Just Culture or Safety 2).

Backward Looking is accountability for the incident and for what happened. Forward Looking is the accountability of the clinician and the organisation to inquire and learn from what happened in order to reduce the chance of it happening again.

Backward looking accountability is prone to Hindsight Bias which influences the mind set and judgements of those undertaking incident reviews.

Forward looking accountability allows for consideration of human variation and trades offs as resilient systems require humans to adapt when the unexpected occurs. Safety

2 maintains that ‘things go wrong’ and ‘things go right’ for the same basic reasons and corresponds to a definition of safety as the ability to succeed under varying conditions.

The MHSS approach now is influenced by Professor Sidney Dekker’s work on human factors & safety

Incident reviews seek to reflect a Forward Looking Accountability approach though it was stressed that there is a place for both approaches. When an incident occurs there is “Immediate Clinician Disclosure”. This means that the family of the patient is contacted usually by the psychiatrist and team leader. They offer to meet with the family and seek to offer support and answer any questions.

A team is identified for the review process by the Clinical Director and the Patient Safety Coordinator (PSC). The review process is coordinated by the Patient Safety Coordinator who is skilled in human factors. The review takes a human factors approach as opposed to a RCA. The PSC will pull together a timeline and set up the review meeting which will include the treating team and a clinical peer from outside the team who is appropriate to that patient’s needs.

Dig. 9 Gold Coast Restorative Just Culture Framework

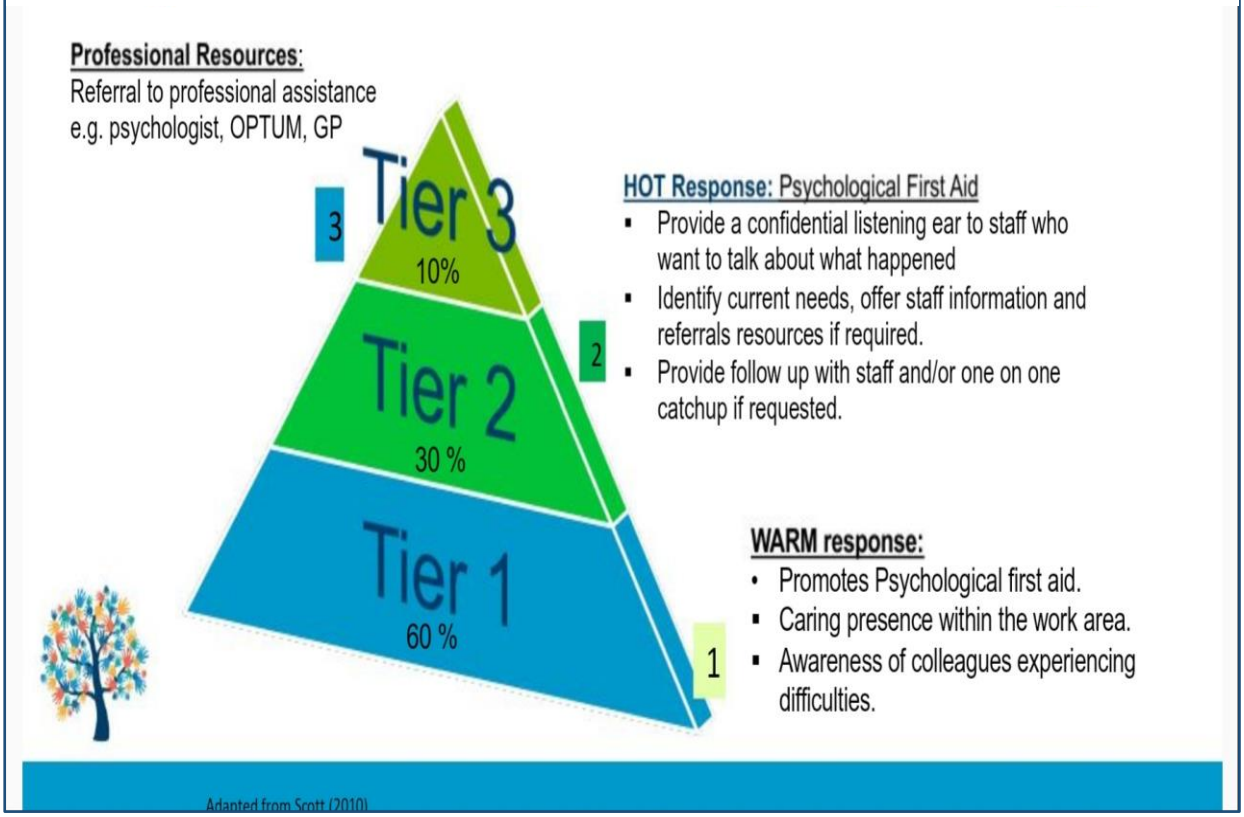
Who Has been hurt?	Needs (Address harms and Causes)	Whose Obligation to meet these needs?	How will this be achieved?
Patient / Family / Carers	Support, Healing, Information. Engagement in review and learning.	Clinicians, Leaders, Organization. Post Vention NGO	Train staff in engagement with family / carers following adverse incidents; Clinician Disclosure; Referral to Pathways (Post-Vention); Engagement in Review process; Open Disclosure.
Clinicians	Support, Healing and learning	Peers, Trained Peer Supporters, Employee Assistance, Leaders, Organization.	Resilience and Reflective Practice; “Always There” Staff Support Program; Engagement in Review Process (Avoid RCAs where possible); Engagement in dissemination of findings.
Organization	Support, Learning	Board and Executive, Leadership, Clinicians, QH / MHAOD.	6 Step Process that supports all measures; Continue development of Just Culture across HHS, QH; Overt support of staff following adverse incidents.
Community	Support, Post-Vention, Prevention, Early Intervention.	Suicide Prevention Network, Primary Health Network, Communications.	Continue development of Network; Encourage systems approach across whole of community.

Staff Support; Despite best intentions, adverse outcomes will occur which will impact upon the patient their family and carer as primary victims or casualties. In addition to this commonly a second person(s) who is impacted by the event can be the clinician involved in the care who is emotionally traumatized by what happened (Wu, 2000). Looking after this second person(s) is an essential part of a “Just Culture” in an organization. Employee support – particularly peer support – is *“one of the strongest predictors*” of good psychological outcome.

MHSS have developed their Always There (Dig. 10) staff support framework which is an essential element of their Just Culture.

- Scott's Model of Peer Support Intervention for the Second Victim: developed for healthcare and prepares individuals to provide non-judgemental, confidential, emotional support to their peers.
- GRACE model of compassion, Social Resilience Framework, Denham's five rights of the second victim. ("TRUST: Treatment that is Just, Respect, Understanding and Compassion, Supportive Care, Transparency and the Opportunity to Contribute.")
- Psychological First Aid (PFA): gold standard for crisis intervention, can be adapted to meet the needs of high risk organizations, and utilised by any healthcare staff when trained.

Dig.10 Always There; Tiered Model of Second Victim Support



Visit to Queensland Government - Mental Health Alcohol and Other Drugs Branch

Janet Martin Director, Clinical Governance and Melissa Heather, Project Lead Queensland Government.

The current rate of suicide in the Queensland State is 16.6 per 100k of population. This has been an increasing trend. Further analysis of this data indicated that almost 25% of people who died by suspected suicide had contact with a Queensland Health service within the seven days prior to their death. Whilst it is unknown what proportion of these people had recent contact with a General Practitioner (GP) or other primary health care provider, research has identified that up to 45% of individuals who died by suicide saw their GP within one month prior to death, and up to 20% within one week before death. https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/service-improvement/suicide-prevention-health-services-initiative/suicide-prevention-poster-2018.PDF)

In February 2016, the Queensland System Leadership Forum considered these findings and supported the establishment of a Suicide Prevention Health Taskforce as a partnership between Hospital and Health Services (HHS – State funded) and the Primary Health Networks (PHN –Federally funded). In April 2016, the allocation of $9.6 million (2016/17 to 2018/19) was approved for the Suicide Prevention in Health Services Initiative (https://clinicalexcellence.qld.gov.au/sites/default/files/2018-01/suic-prog-report.pdf) This identified 4 priority groups for suicide prevention approaches – Older People, People presenting with Mental Illness, Aboriginal and Torres Strait Islander people and Children and Young People.

There are 16 health care provider organisations delivering services on geographical basis across the Queensland State Area. One of these is Gold Coast. The Queensland Government under its suicide prevention initiative is rolling out a Suicide Prevention Pathway approach across the Queensland State area which is taken forward by providers as a model of Zero Suicide.

Janet and Melissa wanted it to be a bottom up rather than a top down approach. This was commenced through sending out an Expression of Interest to all 16 providers. Message was *"you all have to have a pathway"* but it had to be their approach. Responses to the EOI involved an Organisational Self Audit Tool used to gauge if the organisation had the leadership commitment and the infrastructure in place to develop a Suicide Prevention Pathway. Eleven of the 16 are now involved in the ZS approach as part of a state-wide ZS Collaborative i.e. 10 plus Gold Coast. Some areas were not successful and two pulled out. This commenced in February 2018. Gold Coast provided support to other organisations in their approach.

There is state-wide monitoring of KPIs. The work is ongoing and there are clear expectations on the past of Melissa, who oversees the initiative, in terms of returns from each of the participants. The project has full time dedicated data officer and project management support.

Each provider in the initiative was required to develop its own clinical pathway for suicide prevention. As these were supported through the Gold Coast arrangements and other shared resources there is a fair degree of uniformity across them. Additionally funding was provided to support training in the CASE approach to all the providers. The next step is to seek to agree across these a single state-wide clinical pathway for suicide prevention. They are confident that this will be achieved given their approach to providing training, support and other resources.

Restorative Just Culture not fully sure what this might mean in practice as politicians or the media can demand 'why did this happen"? There doesn't appear to be a state-wide system of oversight of SAIs and these stay within the healthcare organisation.

Way Back Service – Emma Leyden

The Way Back Support Service, developed by Beyond Blue (an IS organisation working to address issues associated with depression, suicide, anxiety disorders and other related mental disorders) delivers personalised support to people for up to three months after they're discharged from hospital following a suicide attempt.

This is a high-risk period for reattempts and we know that if someone has attempted suicide, there's an enhanced risk they will try again within three months. The Way Back supports people to stay safe, to keep connected with others and to access health and community services as part of their recovery. Evidence shows co-ordinated aftercare has the capacity to decrease suicide attempts by almost 20 per cent. The Way Back bridges that gap and provides non-clinical, one-on-one care to guide people safely through this critical risk period.

This new service integrates, complements and works collaboratively with the Redcliffe Hospital to improve the immediacy of follow-up response for people who have recently attempted suicide or who are experiencing a suicidal crisis. They aim to turnaround referrals within 24 hrs.

Initial contact is by phone or text *''What can we do for you''?* Key thing to do is to complete a safety plan with them. The safety plan is reinforced every time there is contact with the person. Support can be provided for up to three months period of postvention. Seeking to build resilience. Trying to prepare patients for discharge from when they first engage. Domestic Violence and Childhood trauma is very high amongst patients.

Beyond Blue developed the service four years ago because too often people were leaving hospital with no follow up support and returning to the circumstances that contributed to their distress, The Way Back team works with the individual and their support people, to identify their needs, develop a personalised safety plan and connect them to services or clinical care as needed.

There are also Safe Haven Cafes as an alternative to busy Emergency Departments for people in high distress (this concept is also commissioned in NHS England https://www.england.nhs.uk/mental-health/case-studies/aldershot/).

This service supports people who are 15 years of age or older and who are referred by the Redcliffe Hospital. It operates seven days a week including after hours and on weekends. Staffing comprises Clinical Advisor, Counsellors and Support Coordinators.

Dan Mobbs, Clinical Educator and Suicidologist - Queensland Centre for Mental Health Learning

The Queensland Centre for Mental Health Learning provides state-wide training in support of the implementation of Zero Suicide. They have agreed a competency framework around suicide risk assessment encompassing the CASE approach and Pisani Risk Formulation. This includes e-learning that everyone goes through as well as face to face training. Focus on uncovering suicidal intent. The training is for both Adult and Children's services. This has seen a movement away from stratified risk assessment.

The CASE approach is used in risk screening where the emphasis is on the encounter rather than on a list of questions. Training overall is influenced by the O'Conner Motivational/Violation model. Dan very kindly gave me a copy of their QC2 Engage, Assess, Respond to, and Support Suicidal People (EARS) training participant workbook.

Melissa Horton West Morton Health Zero Suicide Project Lead

Melissa has been the lead for the implementation of the Suicide Prevention Pathway in West Morton Healthcare for almost two years. The SPP has been implemented across West Morton including staff training. Data elements of fidelity are in place and they are now moving to suicide prevention as business as usual. Recent workforce surveys indicated that 90% of the respondents were aware of the Zero Suicide initiatives.

In terms of involving people with Lived Experience this was important to the implementation. The approach seems to be co-design of implementation rather than co-design of the elements of the SPP which relied on evidence based tools and therapies. The engagement of lived experience was achieved through focus groups which identified Lived Experience Checkpoints against KPI measures of the SPP implementation (see Dig 11 below for an extract of this).

Dig. 11 – SPP Key Performance Indicators and Lived Experience CheckPoints

Zero Suicide element & KPI	KPI measure	Lived Experience Checkpoint	Suggested strategy
1. Train 2.1 Implementation of training to provide a Competent, confident and caring workforce	• completion rates of designated training • Feedback from staff completing training • Feedback from consumers receiving care	**Confirmation that communication and connection skills are included in the training, not just emphasis on a clinical tool implementation.**	• Involvement with clinical design sub-group • Inclusion in key components of training content • Ensure the design of the training includes Case Studies and outcomes measured to Lived Experience ideals • Clinical training includes communication techniques: listening without judgement, empathy, values and beliefs
COMPLETED ACTIVITIES: • Peer worker was involved in document design with the Clinical Design subgroup – December 2018 • May 2019 – Peer Worker to assist with the review of the ACT Trial POTENTIAL ACTIVITIES: • Peer worker to be a member of the Training subgroup			

Conclusions & Recommendations

Completing these visits was a privilege. In every case I was met with considerable warmth and generosity of time and resources. I was impressed by the innovation and outcomes and I was moved and inspired by the passionate and courageous leadership I witnessed.

Each Provider I visited was committed to excellence and continuous improvement in the delivery of mental health care. They all drew upon the fundamental framework of Zero Suicide adapted to the needs of their systems. They all particularly emphasized the need to win staff hearts and minds at the outset through challenging ingrained defensive beliefs within teams and clinicians and in creating a Just Culture within which staff could learn and implement best practice without fear of retribution. They were each able to evidence reductions in suicide levels linked to adopting models of Zero Suicide.

Contrasts between the providers reflected different commissioning and delivery contexts and where they each are at upon their Zero Suicide journeys. Henry Ford's integration of its perfect depression care across primary and secondary care supported by an excellent IT infrastructure was outstanding. At Centerstone I was impressed by the commitment to sustainable evidence based treatment interventions to a secondary mental health population through innovation and developing of group approaches and DBT therapies. In Gold Coast the delivery of system wide team based training aimed at developing knowledge and skills and changing culture was striking in being both effective and achievable in a busy statutory mental health system. In West Morton healthcare their involvement of people with Lived Experience and establishing user lead key performance indicators is an excellent model for co- design in the implementation of mental health service reform. Finally the Queensland Government's model for system wide implementation across a range of providers recognised the need for local development to ensure provider buy-in whilst achieving consistency of approach through the development of common training and systems resources.

A final reflection is that the most singular attribute of all Providers I visited was an organisational mission that galvanised staff and systems to change cultures and drive transformative change. I believe that with strong leadership and focus we can achieve similar change, with similar outcomes in reducing suicide levels in N Ireland.

Recommendations

- The Northern Ireland's Towards Zero Suicide Collaborative (the Collaborative) should development a Suicide Prevention Pathway (SPP) for Northern Ireland. This would build on the work completed to date by the Collaborative which incorporates elements of the suicide prevention pathway.

- The use of inpatient admissions should be reviewed as an element of the SPP so that where an admission is assessed as being required this should be a brief intervention informed by therapeutic models of suicide prevention work.

- Staff training in skills and in developing a positive suicide prevention culture are essential to the SPP. The Towards Zero Suicide Collaborative should consider and develop the training model used in Gold Coast to support the implementation of a SPP in Northern Ireland.

- The implementation of the SPP requires the skilling up of teams in evidence based interventions. It is recognised that this cannot easily be separated from core skills requirements of mental health practitioners. It is recommended that a skills and competencies framework linked to evidence based suicide prevention practise be developed and a subsequent training needs analysis of mental health practitioners be completed to ensure that mental health service users are receiving high quality evidence based interventions.

- An effective model of suicide prevention involves the active engagement of service users. In developing a SPP for N Ireland the TZS Lived Experience group should be involved through, in particular, the development of lived experience led key performance indicators for the delivery of Zero Suicide

- The SPP requires evidence based interventions delivered in a timely and integrated way across providers. The local SSP should include the identification and incorporation of relevant local IS providers partners on a common evidence based pathway.

11. The implementation of a SPP needs to be in the context of a supportive Just Culture. Health & Social Care in N Ireland incorporates the NHS Just Culture model. We need to understand what this means in local MH services. In particular it is recommended that the Collaborative should undertake a review of staff beliefs and experience of SAI investigations and how staff feel they are supported and how this could be improved. This should inform the development of a staff support framework

- The use of data to improve patient safety, ensure fidelity to the model and to drive continuous improvement was a consistent feature with all providers. The implementation of the Encompass IT system in N Ireland has the capacity to be the 'game changer' it was in Henry Ford. However in the interim it is recommended that the Collaborative along with PHA/HSCB should look to identify a range of common patient safety metrics for the MH system in N Ireland which would help inform practice and guide service improvement.

- A contrast between the services visited and N Ireland mental health services is the complexity of our local mental health system with its layers and range of teams and services. Handovers between clinicians and teams heightens risks, leads to delays, provides a poorer patient experience and can lead to poorer outcomes. Much of the complexity has been created to delineate roles, develop specialist competencies and to ensure protected time. The experience from services visited is that these features can, with careful coherent design, be incorporated within teams. It is recommended that mental health services in N Ireland should review their structures with the aim of reducing the levels of complexity and patient handovers and improving continuity of patient care.

- The Henry Ford system has invested heavily in its model of collaborative care across primary and secondary care supported by the use of technology. This ensures excellent support and early intervention within primary care whilst ensuring the best use of scare specialist secondary mental health care resources. It is recommended that a collaborative care approach to meeting mental health needs on a population basis co-designed across primary and secondary care and incorporating the independent sector and local community services be implemented and evaluated within a GP federation area in N Ireland.

Annex 1 PHQ 9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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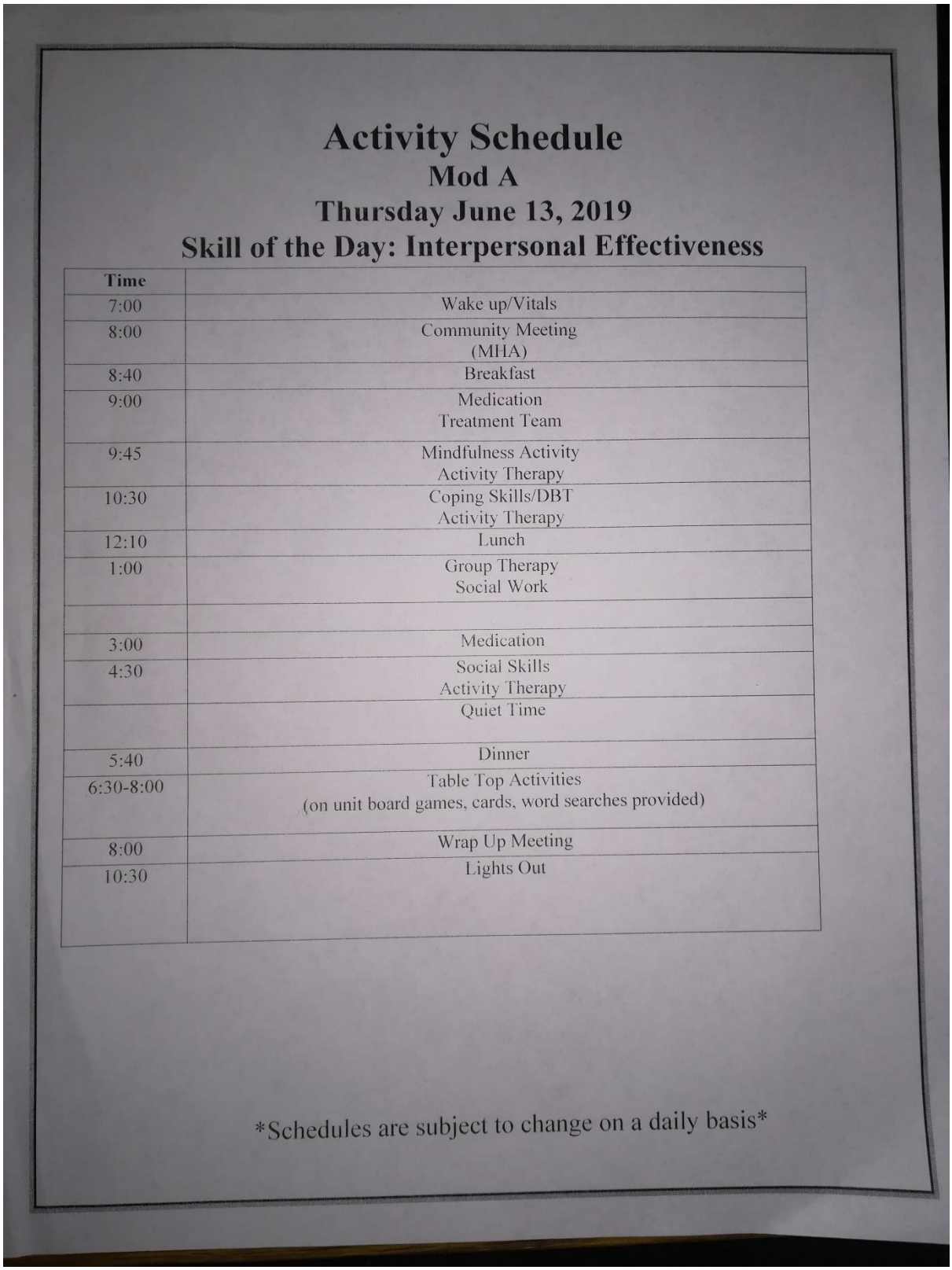
Annex 2 Ward Programme, Kingswood Hospital, Detroit



Activity Schedule
Mod A
Thursday June 13, 2019
Skill of the Day: Interpersonal Effectiveness

Time	
7:00	Wake up/Vitals
8:00	Community Meeting (MHA)
8:40	Breakfast
9:00	Medication Treatment Team
9:45	Mindfulness Activity Activity Therapy
10:30	Coping Skills/DBT Activity Therapy
12:10	Lunch
1:00	Group Therapy Social Work
3:00	Medication
4:30	Social Skills Activity Therapy
	Quiet Time
5:40	Dinner
6:30-8:00	Table Top Activities (on unit board games, cards, word searches provided)
8:00	Wrap Up Meeting
10:30	Lights Out

Schedules are subject to change on a daily basis

Appendix 1

Churchill Project objectives: Please list the objectives over time that you wish to achieve as a result of your Fellowship, and on which the success of your Fellowship will be evaluated. ***(limit:1,000 characters)***

1 A measurable reduction in suicide levels in mental health service users in N Ireland

2 The introduction of evidence based practices in suicide prevention utilising a Zero Suicide (ZS) approach.

3 A N Ireland Mental Health ZS Collaborative informed by knowledge & understanding of best practice design & implementation elsewhere.

4 To identify and implement tools & processes proven effective elsewhere and how they were embedded in practice.

5 To identify and focus on changes demonstrated elsewhere as having the most impact.

6 To develop effective staff and service user & carer engagement, training structures and programmes.

7 To achieve buy-in across sectors, services and professions.

8 To develop and implement an effective ZS communications strategy.

9 To Implement best practice in learning from incidents & a just culture.

10 To have a N Ireland ZS approach informed by lessons learned elsewhere & what they might now do differently.

11 To develop a peer support network of exemplars of excellence

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