

Clinical Excellence Division



Suicide Prevention in Health Services Initiative

Year 1 Progress Report
2016-2017



Suicide Prevention in Health Services Initiative

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1. Suicide Prevention in Health Services Initiative

1.1 Significant background

- Data provided by the Australian Institute for Suicide Research and Prevention (AISRAP) indicated a potential increase in suspected suicides in the Queensland population in January to June 2015.
- 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 (Luoma, Martin, & Pearson, 2002; Pirkis, & Burgess, 1998).
- On 9 February 2016, the System Leadership Forum considered these findings and supported the establishment of a Suicide Prevention Health Taskforce (the Taskforce) as a partnership between Hospital and Health Services (HHS) and the Primary Health Networks (PHN).
- In April 2016, the allocation of \$9.6 million (2016/17 to 2018/19) was approved for the Suicide Prevention in Health Services Initiative (the Initiative).
- The Initiative forms an integral part of the plan for Queensland's state-funded mental health, alcohol and other drug services – [Connecting care to recovery 2016–2021](#), and comprises of three major components:
 1. The establishment and operation over three years of a Queensland Suicide Prevention Health Taskforce (the Taskforce) as a partnership between the Department of Health, HHSs, PHNs and lived experience.
 2. Analysis of events relating to deaths by suspected suicide of people that had a recent contact with a health service to identify when, where and how the provision of existing health services could be improved to reduce suicide amongst at-risk demographic and clinical cohorts, as well as individuals at risk of suicide.
 3. Continued implementation of training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.
- An infographic of the major milestones achieved since the established of the Initiative and discussed herein are shown in Figure 1.



Suicide Prevention in Health Services Initiative

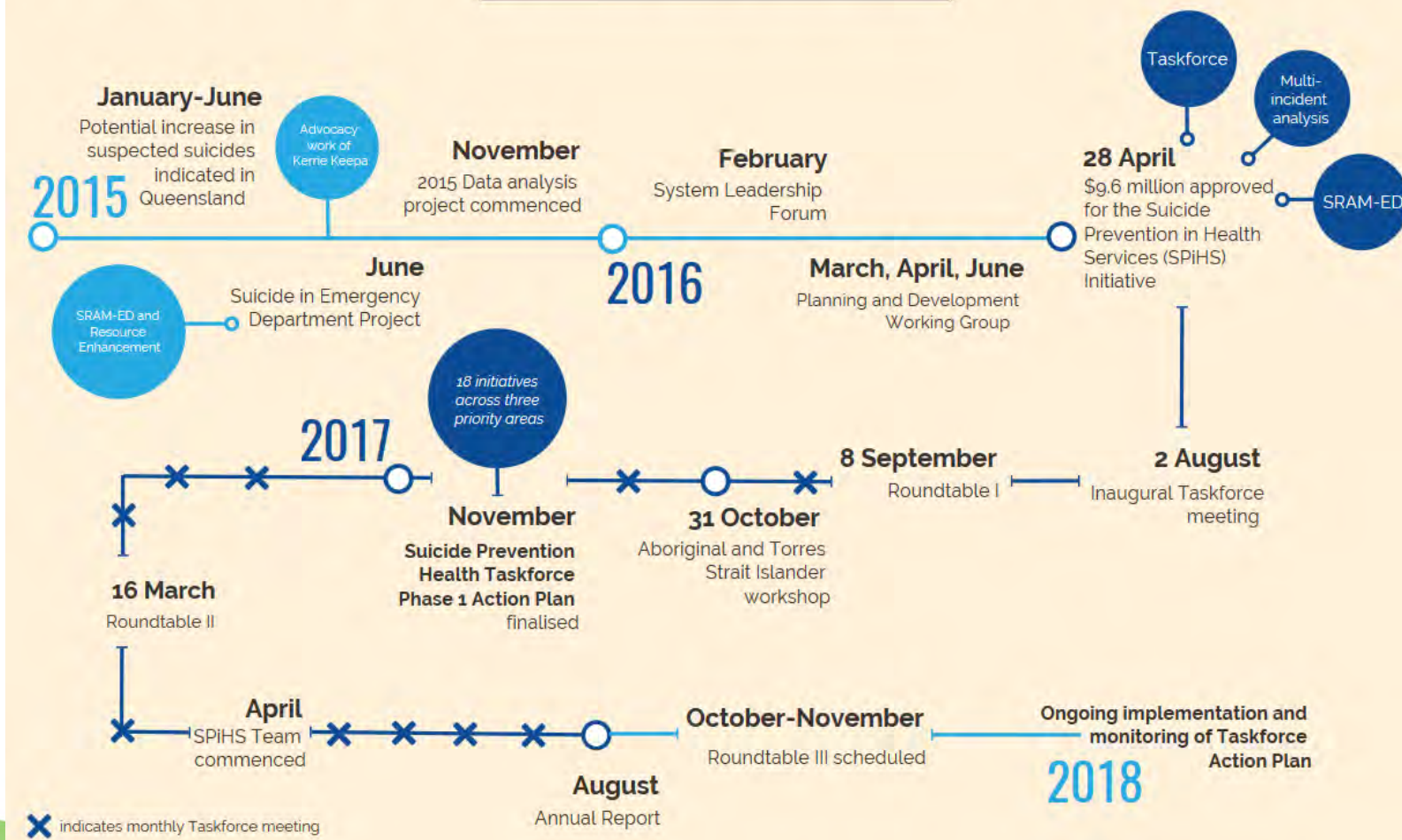


Figure 1. Timeline of the Suicide Prevention in Health Services Initiative



2. Suicide prevention in the broader social service system

- Suicide prevention initiatives require collective action with contributions from different sectors, programs, and services. The integrated systems approach recognises the need for multi-level and multifaceted methodologies for successful suicide prevention.
- The [Fifth National Mental Health and Suicide Prevention Plan](#) (endorsed 4 August 2017 by the COAG Health Council) seeks to establish a national approach for collaborative government effort over the next five years (2017–2022). Suicide prevention has been identified as one of the seven priorities for action.
- The Taskforce recognises that effective suicide prevention is a shared responsibility requiring a comprehensive, cross-sectoral and whole-of-government approach.
- The work of the Taskforce complements the actions identified within the [Queensland Suicide Prevention Action Plan 2015-2017](#) developed by the Queensland Mental Health Commission (QMHC) which aims to reduce suicide and its impact on Queenslanders under four priority areas:
 1. Stronger community awareness and capacity
 2. Improved service system responses and capacity
 3. Focused support for vulnerable groups
 4. A stronger more accessible evidence base.
- The Taskforce continues to engage with the QMHC to ensure intersection with the whole of government, whole-of-community approach to suicide prevention.
 - Taskforce members are represented on the Queensland Suicide Prevention Action Plan Reference Group to identify opportunities to improve and inform the whole of government approach to suicide prevention.

2.1 Why a Health Taskforce?

- Many individuals at risk of suicide are, in principle, identifiable and their deaths preventable on an individual basis (Ahmedani, et al., 2012).
- People with suicidality in the context of emergent, complex and co-morbid mental health and general health needs face significant barriers to accessing appropriate healthcare.
- The Taskforce recognises that HHSs and PHNs play an important leadership role in cooperating with other local service providers to plan and deliver health services.
- The Taskforce represents an opportunity to bring together collective strategic knowledge and experience to develop and implement health sector specific suicide prevention policy, strategies, services and programs.
- The Suicide Prevention in Health Services Initiative team (SPiHS team) contributes a specialist niche within the wider suicide prevention community. A visual representation of the SPiHS team within the suicide prevention community is provided in Figure 2.

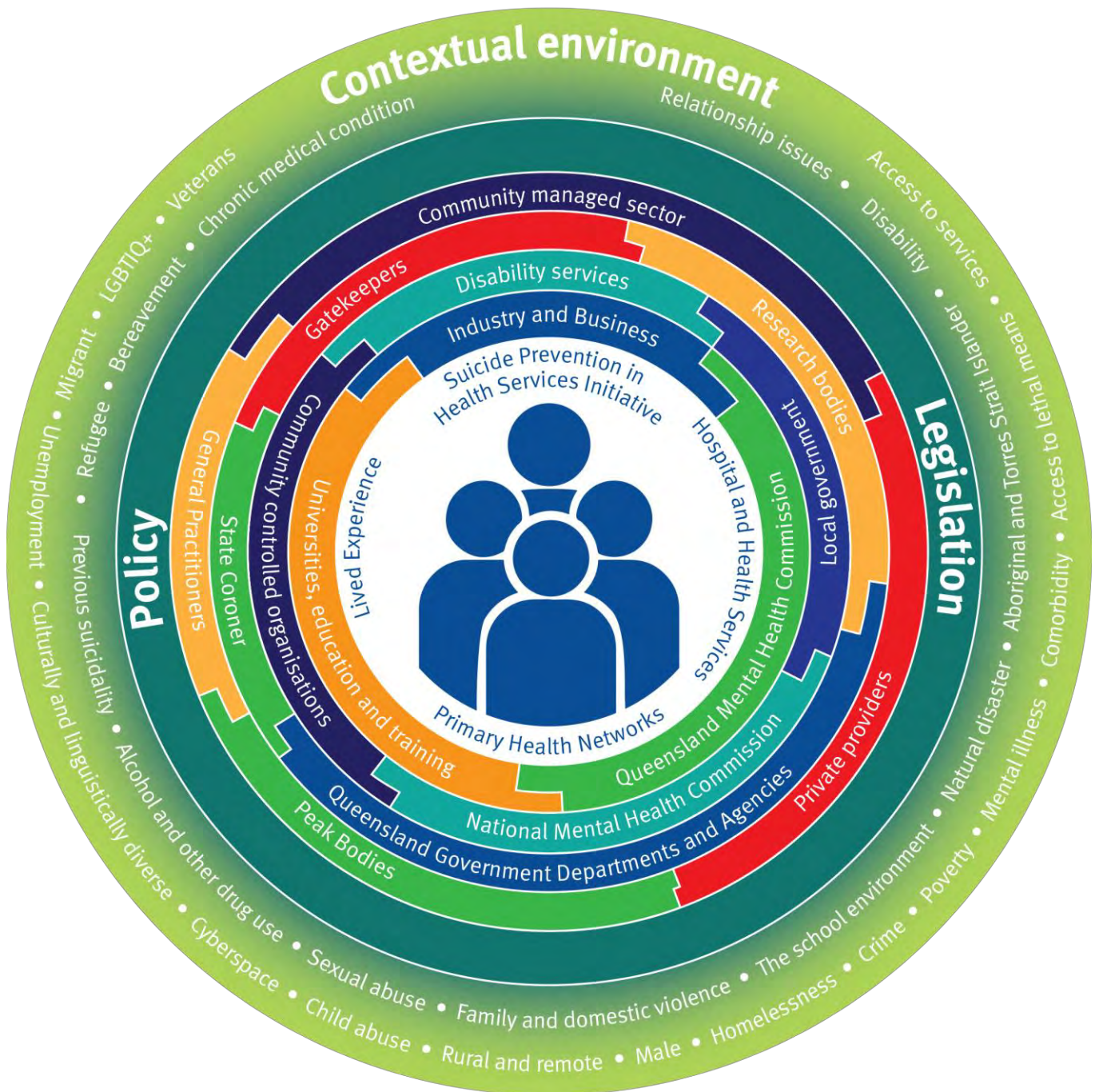


Figure 2. Suicide prevention in health services initiative within the broader social service system.



3. Establishment of the Suicide Prevention Health Taskforce

3.1 Planning and Development Working Group

- Following the February 2016 System Leadership Forum meeting, a Taskforce Planning and Development Working Group was established and met in March, April, and June 2016. Working Group membership is included in Appendix A.
- The Working Group developed draft Taskforce Terms of Reference, deliberated Taskforce membership based on constituencies' strategic knowledge and experience and coordinated calls for nominations and invitations of representatives of those constituencies and special cohorts.

3.2 Current membership

- Taskforce membership is selective to ensure that it remains focused on its core goal of development and implementation of suicide prevention policy, strategies, services, and programs in a health service context.
- Current membership includes representation from the following constituencies:
 - Hospital and Health Service Chief Executives Forum
 - Primary Health Network Chief Executive Officers Collective
 - Queensland Emergency Department Strategic Advisory Panel
 - Mental Health Alcohol and Other Drugs Clinical Network
 - Rural and Remote Clinical Network
 - Aboriginal and Torres Strait Islander Community Controlled Health Sector
 - Queensland Mental Health Commission
 - Lived experience (including carer of a person with suicide risk, personal experience of own suicidality, and Aboriginal and Torres Strait Islander)
 - Roses in the Ocean
 - Deputy Director General, Clinical Excellence Division.
- The following Co-chairs have been appointed:
 - Fionnagh Dougan – Chief Executive, Children's Health Queensland Hospital and Health Service
 - Pattie Hudson – Chief Executive Officer (CEO), Primary Health Network Central Queensland, Wide Bay, Sunshine Coast
 - Bronwen Edwards – CEO and Founder of Roses in the Ocean
- Taskforce Coordinator support is provided by the Mental Health Alcohol and Other Drugs Branch (MHAODB), Clinical Excellence Division, Department of Health.
- Full membership details are provided in Appendix B.



3.2.1 Terms of Reference

- Terms of Reference (ToR) were endorsed by members during the inaugural Suicide Prevention Health Taskforce meeting held 2 August 2016.
- ToR were reviewed in July 2017 and endorsed by Taskforce members in August 2017.

3.3 Suicide Prevention in Health Services Initiative Team

- From August 2015 to April 2017, 1.8 FTE Principal Project Officers have been progressing suicide prevention in health activities within the Clinical Governance Unit, Office of the Chief Psychiatrist, MHAODB.
- In April 2017 the SPIHS team, consisting of 3.8 FTE (Manager and 2.8 FTE Principal Project Officers) was established within the Clinical Governance Unit (see Figure 3).
- The team has leadership and expertise in suicidology and evidence based best practice suicide prevention. Other collective skills include research, data analysis, systems review, project management, cross-sectoral collaboration and partnerships, mental health clinical practice, policy and leadership advice.



Figure 3. SPIHS Team (L to R: Dr Rebecca Soole, Ms Janet Martin, Ms Nikki Bushell, Ms Linda Leatherbarrow and Dr Kelly Dingli)

4. Consultation

- Stakeholder buy-in is vital to the success of identified initiatives, both in terms of development and sustainable implementation of service delivery improvements.
 - Where relevant, each Taskforce body of work has detailed governance, communication and engagement strategies identified within it.
 - The stakeholders engaged with by the Taskforce are provided in Table 1 (page 14–16).

4.1 Roundtables

- The Taskforce has committed to holding a series of Roundtables to bring together the collective expertise of a broad range of stakeholders across government, industry, and the community, and those people with a lived experience, in order to inform the key priority areas identified within the [Suicide Prevention Health Taskforce Action Plan](#) (Taskforce Action Plan).

4.1.1 Roundtable I

- On 8 September 2016 the Taskforce held the inaugural Roundtable to examine suicide prevention issues across the whole of life continuum and pertaining to a health service delivery context.
- Key themes that emerged from the Roundtable included:
 - Enduring cultural and systemic issues which may impact and/or hinder suicide prevention efforts.
 - The importance of identifying and translating the evidence base, supporting innovation, and



ensuring a commitment to robust and embedded evaluation.

- The importance of coherent, connected and consistent treatment and care for individuals at risk of suicide.
- Identifying gaps and improving linkages between hospitals and community sectors and appropriately engaging families and other support persons in the treatment and care of individuals at risk of suicide.
- During the opening address the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services announced that the Taskforce would develop a detailed plan of action by November 2016.

4.1.2 Roundtable II

- In recognition of the breadth and value of lived experience, a Lived Experience Roundtable was held on 16 March 2017 to inform the development of key areas identified within the Taskforce Action Plan.
- Learnings indicate how lived experience adds value by contextualising the challenges, realities and opportunities for suicide prevention. Graphic recorder, Dr Sue Pillans skilfully captured Roundtable II's discussion visually (see Figure 4).
- Following the Roundtable, attendees were invited to nominate themselves for continued involvement in activities associated with the Taskforce.

4.1.3 Roundtable III

- The Taskforce has committed to hosting an Aboriginal and Torres Strait Islander Roundtable in October/November 2017 to bring together the collective cultural expertise across government and community including those people with a lived experience to inform key priority areas of the Taskforce Action Plan, particularly those for consideration in Phase 2 (see page 17).

4.2 Submissions and Connections

- The Taskforce invites or receives submissions or information from external sources where relevant to Taskforce ToRs, including but not limited to
 - Academics that have expertise in suicidology and suicide prevention, particularly with reference to Queensland.
 - Any persons holding expertise in matters relevant to these Terms of Reference: including any persons with a lived experience relating to suicide, emergency services and Government and non-Government department or agency (including Suicide Prevention Australia).
- Presentations to the Taskforce by external agencies include but are not limited to Beyondblue, Black Dog Institute and Queensland Maternal and Perinatal Quality Council (*pending*)
- Agencies, organisations and/or programs engaged by the SPIHS team as a conduit to the Taskforce include but are not limited to:
 - AISRAP, Department of Education and Training, Australian Medical Association Queensland, Community Action for the Prevention of Suicide (CAPS), the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Tackling Regional Adversity through Integrated Care (TRAIC), Ed-LinQ and School Based Youth Health Nurses (SBYHN).



Figure 4. Graphic recording of Roundtable II (by Dr Sue Pillans).



5. Taskforce Phase 1 Action Plan

- The Suicide Prevention Health Taskforce Phase 1 Action Plan (Action Plan) was developed by Taskforce members during a series of workshops held October–November 2016.
- The Action Plan and agreed principles for action (see Figure 5) were informed by a discussion paper synthesising evidence from the literature and identified Roundtable themes.
- The Action Plan was also informed by an Aboriginal and Torres Strait Islander suicide prevention workshop held 31 October 2016.
- The Action Plan focuses on the development of suicide prevention policy, strategies, services, and programs to be used in a health service delivery context in order to contribute to a measurable reduction in suicide and its impact on Queenslanders.

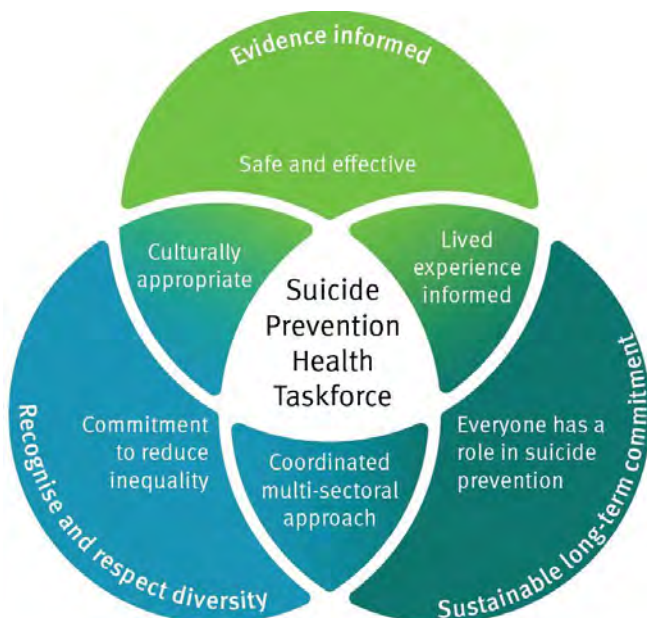
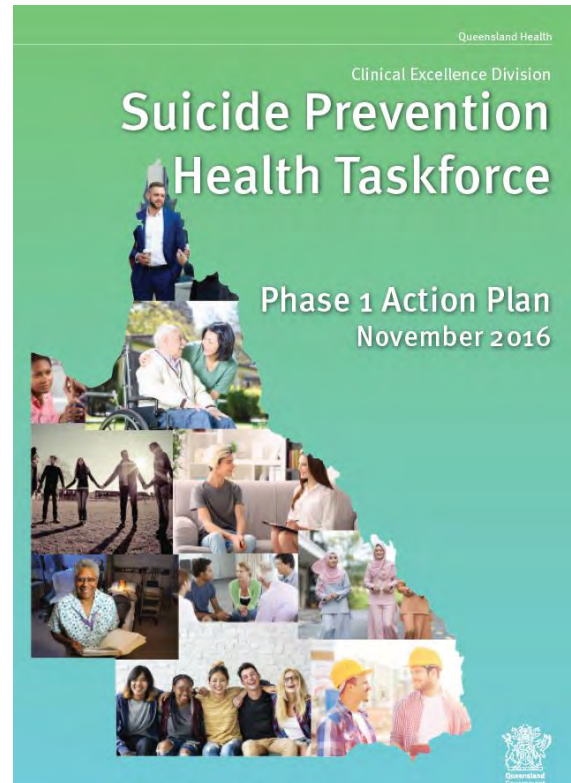


Figure 5. Suicide Prevention Health Taskforce agreed principles of action.

- The Action Plan encompasses three priority areas:
 1. Skills development and support;
 2. Evidence based treatment and care; and
 3. Pathways to care within and external to specialist mental health services.
- Taskforce initiatives will be delivered in two phases.
 - The planning and delivery of Phase 1 initiatives is currently underway. Progress of Phase 1 initiatives is outlined in Table 1 (page 14–16).
 - Phase 2 initiatives (listed on page 17) require further consideration towards prioritisation for development in 2018–19.



Table 1. Implementation progress update of Phase 1 Initiatives

Action area	Anticipated outputs	Outputs achieved July 2016 to June 2017	Outputs planned July 2017 to June 2018	Short-term aspirational goals	Stakeholders engaged
Action area 1 General Practitioner (GP) attitudes, knowledge and skill development needs	Strategic communication with relevant peak bodies regarding greater inclusion and representation of lived experience within education programs targeted at GPs	Identification of scope and stakeholders Discussion with peak bodies to identify opportunities to strengthen lived experience voice in GP education programs	Strategic communication with the key peak bodies to strengthen lived experience voice in GP education programs	Increased involvement of individuals with a lived experience of suicide in GP education programs	<ul style="list-style-type: none"> Royal Australian College of General Practitioners (RACGP) Queensland and Australian College of Rural and Remote Medicine (ACRRM) Black Dog Queensland PHN CEO Collective
	Strategic communication with peak bodies and practicing GPs regarding identification of GP development and support needs	Identification of avenues and determination for GP consultation	Strategic communication with the key peak bodies to scope GPs development and support needs GP ambassador engaged	Identification of GP's development and support needs	<ul style="list-style-type: none"> RACGP ACRRM Black Dog Queensland PHN CEO Collective GP Liaison Officer (GPLO) group
Action Area 2 First responders attitudes, knowledge and skill development needs	Education and development needs analysis of Queensland Ambulance Services (QAS) with respect to responding in suicide crisis situations	Funding agreement with Metro North HHS to deliver Partners in Prevention Appointment of project team Establishment of governance structure	Development of Project Plan Data collection and analysis	Training resources for QAS Identification of appropriate care pathways QAS access to mental health clinical advice	<ul style="list-style-type: none"> Forensic Services Metro North HHS
Action area 3 School based 'gatekeepers' attitudes, knowledge and skill development needs	Scope of practice review and needs analysis of support required for school based 'gatekeepers'	Consultation with DETE and QMHC regarding scope of development of support needs within the school environment Consultation with School Based Youth Health Nurses (SBYHN)	Development and support needs of SBYHN identified Suicide specific training relevant to scope of practice for SBYHNs Consultation with interim steering Ed-LinQ committee to identify value add to Ed-LinQ renewal plan	Early recognition of risk in children and adolescents Enhanced capacity of SBYHNs and Ed-LinQ Coordinators and stakeholders to appropriately respond and refer	<ul style="list-style-type: none"> Department of Education and Training (DETE) QMHC SBYHN statewide managers SBYHNs Ed-LinQ interim steering committee QH representatives CHQ HHS



Action area	Anticipated outputs	Outputs achieved July 2016 to June 2017	Outputs planned July 2017 to June 2018	Short-term aspirational goals	Stakeholders engaged
Action area 4 Strengthen the cultural appropriateness of the Suicide Risk Assessment and Management training program for emergency department staff (SRAM-ED)	Video resources depicting a culturally appropriate assessment of an Indigenous person for use in the simulation training component of SRAM-ED	Funding agreement with West Moreton HHS to strengthen cultural appropriateness of SRAM-ED and deliver video resource with consortium lead by the Queensland Centre for Mental Health Learning (Learning Centre) Aboriginal and Torres Strait Islander consultant engaged Storyboard and video script developed	Clinical and cultural review of storyboard and script by relevant Taskforce members Design and implementation within existing SRAM-ED modules Series of train-the-trainer master class sessions co-facilitated with a cultural consultant to up skill existing SRAM-ED facilitators	Strengthening of cultural appropriateness of SRAM-ED	<ul style="list-style-type: none"> Learning Centre
Action area 5 Establishment of a multi-site collaborative program	Development and implementation of a coherent, connected and consistent evidence based suicide prevention pathway within specialist public mental health services: <ul style="list-style-type: none"> - Establishment of local collaborative groups - Provision of training in a range of evidence based interventions - Development of local implementation plans - Development and implementation of evaluation framework 	Provision of learning in collaborative methodology to Taskforce members Draft project logic model Recruitment of Multi-site Collaborative Program Coordinator	Delineation of enrolment criteria and change bundle using Zero Suicide Framework Enrolment of participating HHS sites Development of local project plans Development of evaluation framework Delivery of first Collaborative Learning Session	Best practice management of presentations for suicidal behaviour	<ul style="list-style-type: none"> Healthcare Improvement Unit



Action area	Anticipated outputs	Outputs achieved July 2016 to June 2017	Outputs planned July 2017 to June 2018	Short-term aspirational goals	Stakeholders engaged
Action area 6 Lived experience peer support care model	Development and evaluation of lived experience peer support approaches (including Aboriginal and Torres Strait Islander peer support)	Consultation with Community Services Funding Branch (CSFB) Establishment of procurement processes Identification of scope and stakeholders	Engaged Probity Advisory Service Project team established Engaged procurement specialist Procurement process completed Contract successful offerer(s) Development of project plan(s) Governance structure(s) established	A clearly articulated continuing care lived experience peer support model following an acute suicidal crisis	<ul style="list-style-type: none"> • Management Options • CSFB • Health Services Queensland • Recovery and Consumer and Carer Participation, Metro North Mental Health Service
Action area 7 Carer support model of care	Development and evaluation of a model of care for people who care for someone who has attempted a suicide	Consultation with Community Services Funding Branch (CSFB) Establishment of procurement processes Identification of scope and stakeholders	Engaged Probity Advisory Service Project team established Engaged procurement specialist Procurement process completed Contract successful offerer(s) Development of project plan(s) Governance structure(s) established	A clearly articulated model of care for people who care for people with issues related to suicide	<ul style="list-style-type: none"> • Management Options • BeyondBlue • Health Services Queensland • CSFB
Action 8 HealthPathways	Review and strengthen HealthPathways to incorporate professional and patient resources relating to suicide risk	HealthPathways presentation Strategic conversation with HealthPathways Coordinator Establishment of resource enhancement process	Consideration of supporting statewide suicide prevention pathway to facilitate localisation	Increased access to relevant patient and professional resources relating to suicide risk recognition and pathways to care	<ul style="list-style-type: none"> • Health Improvement Unit • GPLO



6. Identified areas for Phase 2 Taskforce investment

- Phase 2 initiatives require further consideration and prioritisation for development in 2018–19.
- It is pertinent to note that identified areas for investment may become superseded by suicide prevention activities and strategic directions both statewide and nationally.

Skills development and support

Health related students	Cross sectoral strategic conversation regarding the education and training needs of new staff in health related fields. Development of core competencies in suicide prevention in clinical placements undertaken within Queensland Health.
Supporting Aboriginal and Torres Strait Islander led/facilitated training	Work with the Queensland Mental Health Commission and other key agencies to develop a model of statewide support and coordination for Aboriginal and Torres Strait Islander led/facilitated training.
Culturally diverse groups	Ensure skills development and support resources respond appropriately to the needs of culturally diverse groups including: <ul style="list-style-type: none">• Culturally and Linguistically Diverse communities (based on research currently being completed by the Queensland Mental Health Commission).• Lesbian, gay, bisexual, transgender, intersex and/or queer (LGBTIQ+) communities.

Evidence based treatment and care

Sensory-based approaches	Conduct a feasibility study of sensory-based approaches in hospital emergency department settings.
Trauma informed model of care for Aboriginal and Torres Strait Islander persons	Develop protocols relating to the presentation of an Aboriginal and Torres Strait Islander person experiencing a suicidal crisis.

Pathways to care within and outside specialist mental health services

Alternative models of care	Conduct a feasibility study regarding community based models of care such as place of sanctuary.
Culturally appropriate resources for Aboriginal and Torres Strait Islander individuals, families and workers	Conduct a feasibility study for the development, maintenance and marketing of an online portal of resources for Aboriginal and Torres Strait Islander individuals, families and workers.
Aboriginal and Torres Strait Islander community-based suicide surveillance system for the provision of wrap-around postvention support	Development of pilot project replicating the White Mountain Apache Tribe (WMAT) project occurring in the US adapted to be applicable to an Indigenous Australian population context – requires liaison with the Queensland Mental Health Commission and other key agencies.
Brief interventions	Pilot project in a clinical context to evaluate the effectiveness of brief contact interventions for people with suicide and self-harm risk.
Pathways to care mapping	Map pathways to care for people identified at varying levels of suicide risk.



7. Contribution to suicide prevention evidence base

- A stronger more accessible evidence base that drives continuous improvement in research, policy and practice is an identified priority area of the QMHC Suicide Prevention Action Plan 2015-2017.
- The Taskforce endeavours to fund initiatives based on the best available evidence and where empirical evidence is absent, or lacking, based on 'good practice' derived from clinical and lived experience.
- The Taskforce endeavours to contribute to the evidence base by ensuring a commitment to robust and embedded evaluation.

7.1 Sponsorship and bursary support

7.1.1 The National Suicide Prevention Conference 2017

- Queensland Health was the principal sponsor of the 2017 National Suicide Prevention Conference, hosted by Suicide Prevention Australia in Brisbane, 27–29 July 2017.
 - Sponsorship benefits enabled attendance for five MHAODB officers responsible for the Initiative, along with six individuals associated with the Taskforce including people with a lived experience of suicide and Aboriginal and Torres Strait Islander people.
- Key messages and learnings of the conference included:
 - Findings shared by national and international speakers provided further validation of work being undertaken as part of the Initiative
 - Reiteration of the complexity and importance of suicide prevention for Aboriginal and Torres Strait Islander peoples
 - The need for a sustained approach to suicide prevention and the importance of evaluation in order to build the evidence base of effective suicide prevention activities.
- In recognition of her advocacy work creating positive change Ms Kerrie Keepa was awarded the recipient of the Local Hero Award during the conference's annual LiFE Awards (see Figure 6).



Figure 6. LiFE Awards recipient Ms Kerrie Keepa (centre with [L to R] Mr Dan Mobbs, representing the Learning Centre, Ms Janet Martin, Dr Rebecca Soole and Mr Rhett Foreman)

7.1.2 5th Australian Postvention Conference

- Queensland Health provided bursary support to the National Association for the Bereaved by Suicide, 5th Australian Postvention Conference, Sydney, 23–24 March 2017.
 - Bursary support facilitated conference attendance for a number of lived experience community members.



7.2 Publications

- Nydam, K. & Soole, R. (2017). [Do you see what I see: A mother's plea](#). *Emergency Medicine Australasia, New to early view*. doi: 10.1111/1742-6723.12843.

7.3 Conferences

7.3.1 Presentations

- Presenting at conferences provides opportunities to contribute to suicide prevention research by disseminating key learnings associated with the Initiative and explore potential collaborations in relevant networks.
- In addition to several internal forums, members of the SPiHS team have presented at a number of conferences from June 2016. In reverse chronological order these are:
 - Biennial State-wide School Based Youth Health Conference, Brisbane, 14 September 2017 (*invited speaker*)
 - *Suicide prevention in children and young people*
 - AISRAP World Suicide Prevention Day Community Forum, Brisbane, 8 September 2017 (*invited speaker*)
 - *Suicide prevention in a health service context*
 - Australian Police Psychological and Wellbeing Services, Brisbane, 9 June 2017 (*invited speaker*)
 - *Suicide risk assessment and management*
 - Rural and Remote Mental Health Symposium, Kingscliff, 2–4 November 2016 (*panel session*)
 - *Tackling Regional Adversity Through Integrated Care - How We Established a Suicide Prevention and Resilience Building Program*
 - 2016 ACHSM / ACHS Asia-Pacific Annual Congress, Brisbane, 26–28 October 2016 (*presenter*)
 - *Unlocking big data to drive innovation in suicide prevention*
 - Australian Rotary Health Early Psychosis and Youth Mental Health Symposium, Gold Coast, 7 September 2016 (*invited speaker*)
 - *Suicide in childhood: An idiographic examination.*

7.3.2 Attendance

- Conference attendance enables networking and facilitates learning from national and international clinicians and researchers, and ensures that the work of the Initiative is contemporary and considers suicide prevention perspectives as relevant to clinicians.
- The following conferences have been attended by members of the SPiHS team from June 2016:
 - 18th International Mental Health Conference, Gold Coast, 22 August 2017
 - National Suicide Prevention Conference 2017, Brisbane, 27–29 July 2017 (*sponsorship benefit*)
 - Root Cause Analysis Workshop, Clinical Skills Development Service, Herston 6 July 2017
 - 2017 International Initiative for Mental Health Leadership (IIMHL) Leadership Exchange, Sydney, 27 February–3 March 2017 (*invited Taskforce representative*)
 - 5th Postvention Conference, Sydney, 23–24 March 2017 (*invited Taskforce representative*).



8. Observations and challenges

- Significant work in the area of suicide prevention is currently being undertaken nationally and internationally.
- Whilst the breadth of suicide prevention stakeholders is an asset for achieving a reduction in deaths by suicide, the volume of involved parties can make it difficult to identify areas of specialisation and responsibility.
 - The SPiHS team regularly receives requests outside the scope of their remit, and this issue is anecdotally acknowledged to occur throughout much of the suicide prevention community. Essentially, *suicide prevention is everybody's business, but not everybody has the same business.*
- There are promising approaches emerging nationally and globally that are demonstrating success in reducing suicide attempts and suicides in people under the care of a health service. The Taskforce has found inspiration from these renewed approaches and from empirical research.
- The importance of the Taskforce and its commitment to identifying and translating the evidence base for suicide prevention initiatives, supporting the implementation of early intervention initiatives and strengthening partnerships across HHS and PHNs is becoming increasingly acknowledged.
 - Whilst this acknowledgment is encouraging, the Taskforce remains aware of the expectations being created around scope and timeframes of the Taskforce Action Plan deliverables.
- The relationship between those with lived experience, practitioners and researchers is crucial to the development and implementation of suicide prevention programs capable of demonstrating sustained outcomes.
- The Taskforce acknowledges that there are a number of existing exemplar programs and activities occurring within the health system and the broader social service system. A number of these programs and activities occur in the context of considerable in-kind support.
 - Whilst requiring further consideration, establishment of a Taskforce 'Innovation Fund' would allow greater flexibility in the delivery of Taskforce priority action areas and provide opportunity to test innovative proof of concepts that align with the strategic direction of the Taskforce.
- A sustained approach to suicide prevention is required and the importance of robust and embedded evaluation in order to build the evidence base of effective suicide prevention activities cannot be overemphasised.
- A sustained focus on suicide prevention in a health service delivery context beyond the three years of the Initiative requires consideration.



9. Multi-incident analysis

9.1 Aim

Identification of system factors related to health services contact of individuals who died by suspected suicide within one month prior to their death.

The review of clinical and coronial information related to the health services contact made by individuals who are experiencing a suicidal crisis is expected to reveal systemic and modifiable system factors that can be used to improve health service responses for vulnerable people. The identification of these latent system failures is discrete from errors or violations, and is needed to drive universal and Hospital and Health Service level improvements.

Evidence-based recommendations to inform improvements in service delivery for individuals at risk of suicide at a state-wide and localised level.

Strong, relevant and targeted recommendations are needed to inform the design and implementation of service delivery improvements relevant to individuals who make contact with a health service when at-risk of suicide. This group represents approximately one quarter of individuals who die by suicide, and the potential to implement service delivery improvements is a significant intervention opportunity at a critical juncture of an individual's suicidal crisis.

Identification of non-system factors related to individuals who died by suspected suicide and had contact with a health service within one month prior to their death.

The identification of system factors is the fundamental aim of the research, and is integral to informing evidence-based recommendations. Findings of the Multi-incident analysis are likely to reveal errors and violations in the delivery of health services not related to system factors. It is also foreseeable that factors outside the scope of health services contact will be identified in the review. Whilst not the subject of the research, these supplementary factors will help contextualise the benefit of ascertaining the risk and protective factors present in the lives of individuals who made contact with a health service within one month prior to their death.

These proximal factors have the potential to provide insights about how system factors may apply to a person at risk of suicide, thereby informing recommendations for service response improvements relevant to their needs. For example, inadequate processes related to the discharge planning for an individual at risk of suicide (system factor) may exacerbate the immediate risk of suicide if there is no capacity for adequate follow-up post-discharge due to homelessness (risk factor). Increased recognition and consideration of the interplay between system factors and individual characteristics has the potential to reinforce the effectiveness of any proposed system improvements.

9.2 Methodology

- Cases are a sub-population of the total number of suspected suicide deaths that occurred in Queensland during the calendar years of 2015 and 2016 (N≈1500).¹ The research population (n≈400)¹ represents the group of individuals who had contact with a public health service within one month prior to their death.
- In addition to aggregate analysis, a selection of vulnerable cohorts of clinical and sociodemographic groups within the research population will be identified through preliminary analysis for further in-depth examination.

¹ Figures presented are estimates based on data from the first six months of 2015



- Expert panels will be established for assistance in the review of incidents. Experts will be appointed based on their specialist skills as relevant to the broader project, and specific cohorts.

9.3 Analysis

Suspected suicide data as recorded in the interim Queensland Suicide Register (iQSR; AISRAP) and the Child Death Register (CDR; the Queensland Family and Child Commission [QFCC]) will be linked with health services data recorded in PRIME-CI, CIMHA, ATODS-IS, QHAPDC, and EDIS. The suspected suicide deaths occurring during 2015 and 2016 will be filtered for analyses as follows:

- **Quantitative analysis:** Descriptive and multivariate analysis of suspected suicides of individuals who had contact with a health service within 30 days of death.
- **Qualitative analysis:** Thematic analysis of specific cohorts (including but not limited to, children and young people, Aboriginal and Torres Strait Islanders, older people) who had contact with a health service within 30 days of death.

9.4 Project summary and timeline

Procedures for the Multi-incident analysis are highlighted in Figure 7. Whilst mainly sequential, some processes may be conducted simultaneously, such as concurrent quantitative and qualitative analyse.



Multi-Incident Analysis

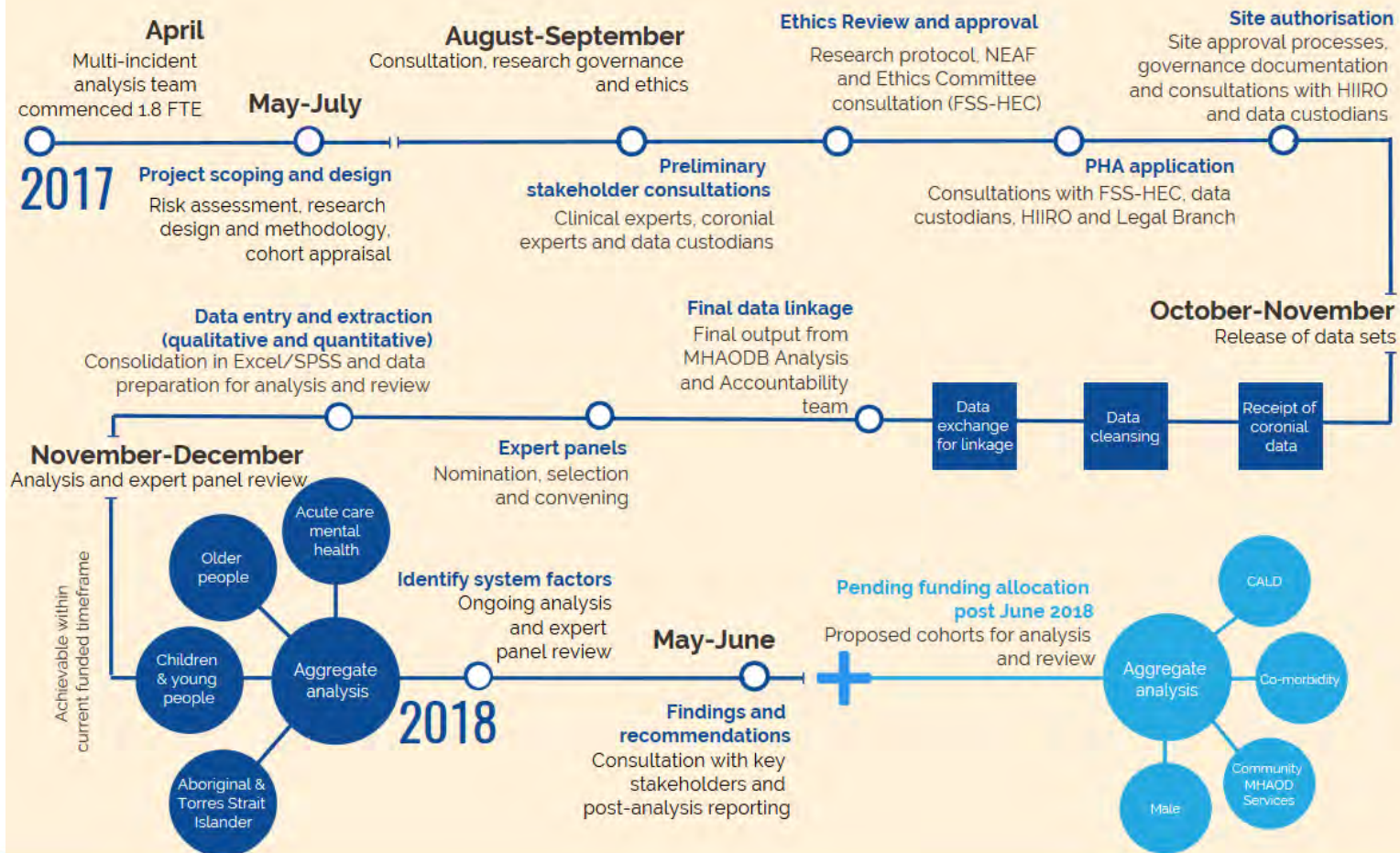


Figure 7. Multi-incident analysis project timeline



10. Suicide Risk Assessment and Management in Emergency Department (SRAM-ED)

10.1 Significant Background

- The Minister made a well-publicised commitment to Ms Kerrie Keepa to provide training to emergency department (ED) staff following the tabling on 5 May 2015 of a petition with over 65,000 signatures. The petition requested the urgent implementation of specialised training for ED staff on how to recognise and respond to suicidal individuals.
- In response, the Queensland Centre for Mental Health Learning (Learning Centre), in collaboration with the Clinical Skills Development Service (CSDS), was commissioned to develop the Suicide Risk Assessment and Management in Emergency Department settings (SRAM-ED) training package.
- Adopting a train-the-trainer model, the training package utilises a blended learning model and is comprised of four eLearning modules (foundational and advanced), a one-day face-to-face training workshop, and a half-day train-the-trainer workshop. A diagrammatic representation of the SRAM-ED training package is provided in Appendix C.

10.2 Current status

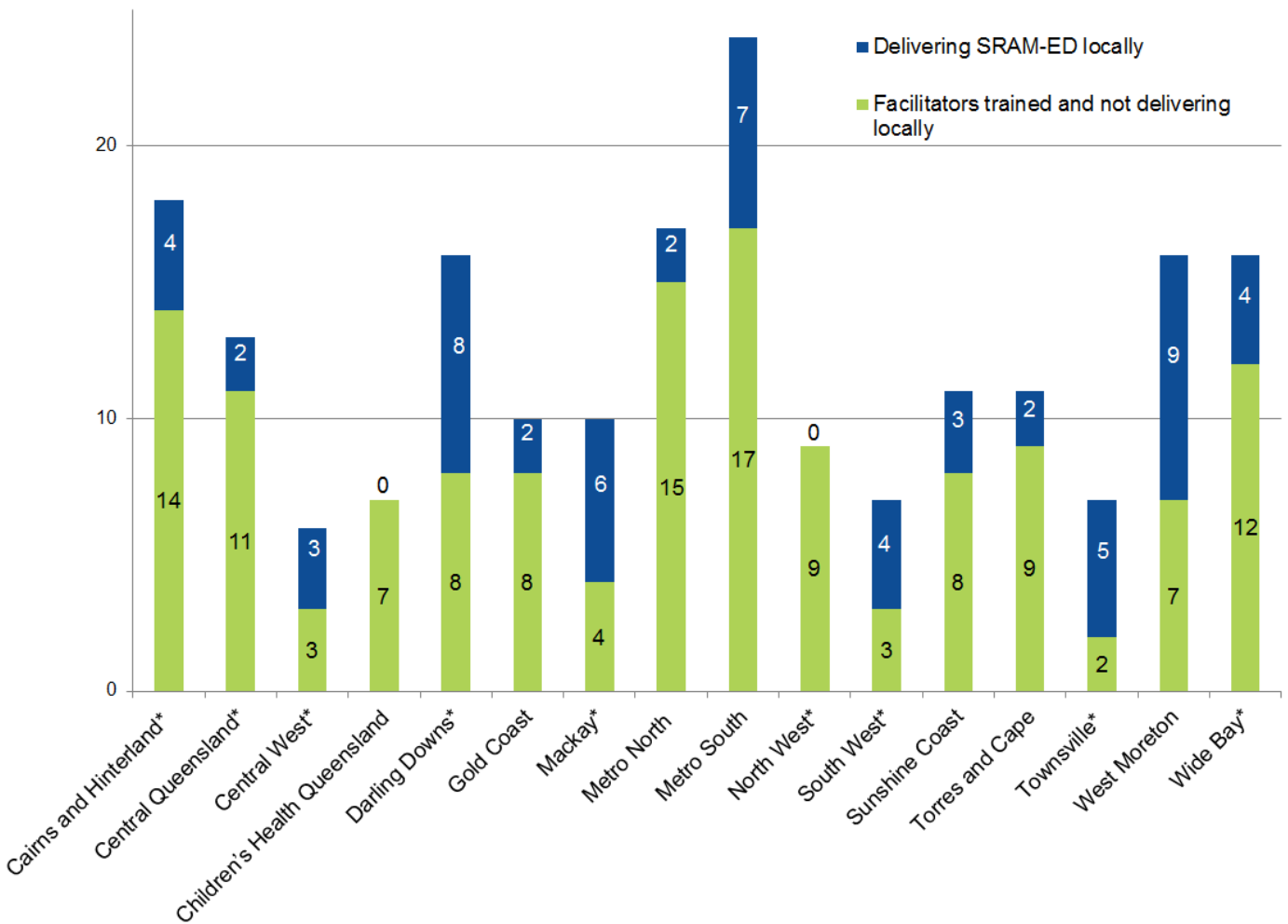
- The mandated minimum number of ‘trained facilitator’ staff (medical, nursing, allied health, and ED staff) provided to the Learning Centre and the current status against these goals is depicted in Table 2.

Table 2. Goal and achieved numbers of clinicians trained as facilitators

	Goal	Achieved
2015/16	150	148
2016/17	Additional 40–60	52
2017/18	Additional 40–60	Planning underway for additional train-the-trainer sessions

10.2.1 Trained facilitators

- As of 30 June 2017 a total of 200 clinicians state-wide have been trained as facilitators to deliver the SRAM-ED training package locally within their HHS (includes two clinicians within Mater Private).
- 61 (of 200) trained facilitators are delivering SRAM-ED locally within their HHS; depicted in blue in Figure 8.
 - Clinicians who are trained as facilitators but are *not* delivering training at a local level (depicted in green in Figure 8) are arguably still delivering higher quality care within their HHS to individuals presenting with suicidality.



*denotes HHS with Tracking Regional Adversity Integrated Care program

Figure 8. Number of trained SRAM-ED facilitators per HHS and the number delivering SRAM-ED locally within their HHS

10.2.2 Local uptake

- A memorandum (from Deputy Director-General, Clinical Excellence Division) to each individual HHS Chief Executive outlining the number of staff trained within the relevant HHS, requesting continued senior managerial support and reiterating HHS responsibility for the ongoing implementation was distributed 1 January 2017.
- Table 3 shows the number of clinicians who have participated in SRAM-ED training *in some way* at a local level.
 - Both foundational and advanced courses have an eLearning and face-to-face training component (refer to Appendix B).
 - Where participants have completed both eLearning and face-to-face training from either the foundational or advanced course, they are deemed to have completed the respective course in its entirety (shaded in grey).
 - The eLearning components are a stipulated pre-requisite to face-to-face components. However, the enforcement of prior completion of eLearning is managed at a HHS local level.



Table 3. Completion numbers for Foundational and Advance Course trained at a local level by SRAM-ED facilitators.

Hospital and Health Services (HHS)	1 July 2016–30 June 2017						Total training events
	Foundational Course			Advanced Course			
	eLearning only	Face-to-face only	Both eLearning and Face-to-face*	eLearning only	Face-to-face only	Both eLearning and Face-to-face^	
Cairns and Hinterland	43	3	20	127	1	57	251
Central Queensland	71	0	1	162	4	14	252
Central West	3	1	19	13	12	12	60
Children's Health	0	0	0	2	0	0	2
Darling Downs	15	31	124	51	0	0	221
Gold Coast (Zero Suicide)	N/A	N/A	N/A	83	61	398	542
Gold Coast (SRAM-ED)	43	N/A	N/A	2	N/A	N/A	45
Mackay	102	15	62	39	0	0	218
Metro North	194	0	11	34	0	0	239
Metro South	61	3	63	27	0	0	154
North West	3	0	0	2	0	0	5
South West	78	19	99	8	0	0	204
Sunshine Coast	4	21	1	4	1	0	31
Torres and Cape	36	3	25	20	0	0	84
Townsville	23	10	21	4	1	13	72
West Moreton	72	3	63	40	15	4	197
Wide Bay	94	16	75	27	2	5	219
Not specified	26	N/A	N/A	1	N/A	N/A	27
Total	868	125	584	646	97	503	2823

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

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



10.3 Evaluation

- The Learning Centre has developed an evaluation plan for SRAM-ED. The overarching aims of the evaluation is to measure the process of delivering a train-the-trainer model, the impact of SRAM-ED in terms of participant knowledge, attitudes, confidence, and implementation of SRAM-ED within a health service context.
- Local HHS deliveries are evaluated at three time points' (pre-, post-, and 3 months post training). The first report of this evaluation data has commenced.
- Training fidelity checks of local trainers are scheduled for 2017–18.
- Adopting a mixed-methods approach, the evaluation will incorporate both quantitative and qualitative methodologies. Data generated throughout the evaluation will be used to inform the ongoing training resource review cycle and to provide recommendations to support the sustainability of the SRAM-ED program.
- MHAODB will undertake a transparent procurement process by going to the market to seek offers for a more comprehensive evaluation of SRAM-ED, to be undertaken in 2018–19.

10.4 Sustainability

- Commitment from senior management is pivotal in ensuring SRAM-ED is embedded within existing structures and a sustainable delivery model is established across Queensland.
- Each HHS is responsible for the ongoing implementation of the program through the designation of responsibility to an appropriate senior staff member to ensure that the ongoing delivery is accessible to all ED staff on an ongoing basis.
- The Learning Centre has developed a three year sustainability plan to support the continued state-wide roll-out of the SRAM-ED program including the delivery of a minimum of four train-the-trainer programs per year.
- In collaboration with the Learning Centre the MHAODB will be conducting further targeted engagement with key stakeholders to facilitate the development of local training plans including reconnecting with those who have been trained.



Appendices

Appendix A

Planning and Development Working Group Membership

- Ms Fionnagh Dougan, Children's Health Queensland HHS
- Mr Frank Tracey, Executive Director, Community, Mental Health and Statewide Services, Children's Health Queensland HHS
- Ms Sue McKee, Chief Executive, West Moreton HHS
- Ms Julie Hartley-Jones, Chief Executive, Cairns and Hinterland HHS
- Dr John Wakefield, Deputy Director-General, Clinical Excellence Division
- Dr Bill Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch
- Ms Janet Martin, A/Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch
- Dr Rebecca Soole, Principal Project Officer, Mental Health Alcohol and Other Drugs Branch.



Appendix B

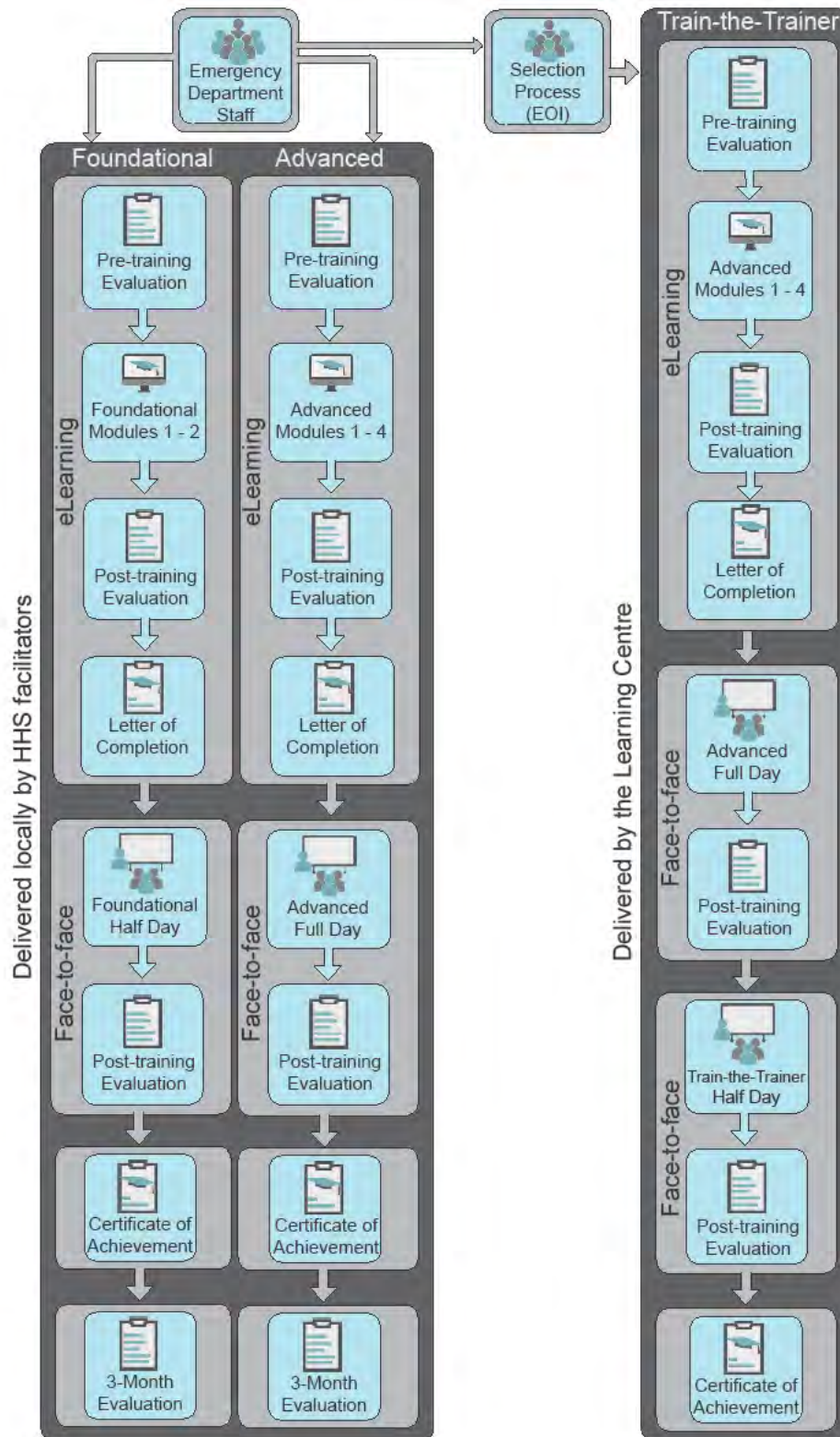
Taskforce membership details

Constituency	Name, Position
Hospital and Health Service Chief Executives Forum	Fionnagh Dougan, CE Children's Health Queensland HHS
Primary Health Network Chief Executive Officers Collective	Pattie Hudson, CEO, Central Queensland, Wide Bay, Sunshine Coast Primary Health Network
Roses in the Ocean	Bronwen Edwards, CEO and Founder
Deputy Director General, Clinical Excellence Division.	Dr John Wakefield, Deputy Director-General, Clinical Excellence Division
Queensland Emergency Department Strategic Advisory Panel	Dr Niall Small, QEDSAP Chair and Medical Director, Medical Services Group, Townsville HHS Dr Ruth Barker, Senior Medical Officer (Emergency), Lady Cilento Children's Hospital
Mental Health Alcohol and Other Drugs Clinical Network	Dr Darren Neillie, Chair and Psychiatrist, Queensland Forensic Mental Health Services
Rural and Remote Clinical Network	Sandra Corfield, Chief Executive Officer, Central Queensland Rural Division of General Practice Diana Friday, Team Leader, Aboriginal and Torres Strait Islander Health Workers
Aboriginal and Torres Strait Islander Community Controlled Health Sector	<i>Invitation extended to Gallang Place</i>
Queensland Mental Health Commission	Ivan Frkovic, Queensland Mental Health Commissioner
Aboriginal and Torres Strait Islander Lived Experience	Leilani Darwin
Lived Experience	Rhett Foreman
Mental Health Alcohol and Other Drugs Branch	Associate Professor John Allan, Executive Director MHAODB Janet Martin, Director, Clinical Governance Nikki Bushell, Manager, Suicide Prevention Dr Rebecca Soole, Taskforce Coordinator



Appendix C

Diagrammatic representation of the SRAM-ED training package





Abbreviations

Action Plan	Suicide Prevention Health Taskforce Phase 1 Action Plan
AISRAP	Australian Institute for Suicide Research and Prevention
CAPS	Community Action for the Prevention of Suicide
CDR	Child Death Register
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CSDS	Clinical Skills Development Service
ED	Emergency Departments
GP	General Practitioners
HHS	Hospital and Health Services
the Initiative	Suicide Prevention in Health Services Initiative
iQSR	interim Queensland Suicide Register
Learning Centre	Queensland Centre for Mental Health Learning
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and/or queer
MHAODB	Mental Health Alcohol and Other Drugs Branch
PHN	Primary Health Networks
QAS	Queensland Ambulance Service
QMHC	Queensland Mental Health Commission
QFCC	Queensland Family and Child Commission
QPASTT	The Queensland Program of Assistance to Survivors of Torture and Trauma
SBYHN	School Based Youth Health Nurses
SLF	Systems Leadership Forum
SPiHS team	Suicide Prevention in Health Services Initiative team
SRAM-ED	Suicide Risk Assessment and Management in Emergency Departments
Taskforce	Suicide Prevention Health Taskforce
ToR	Terms of Reference



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