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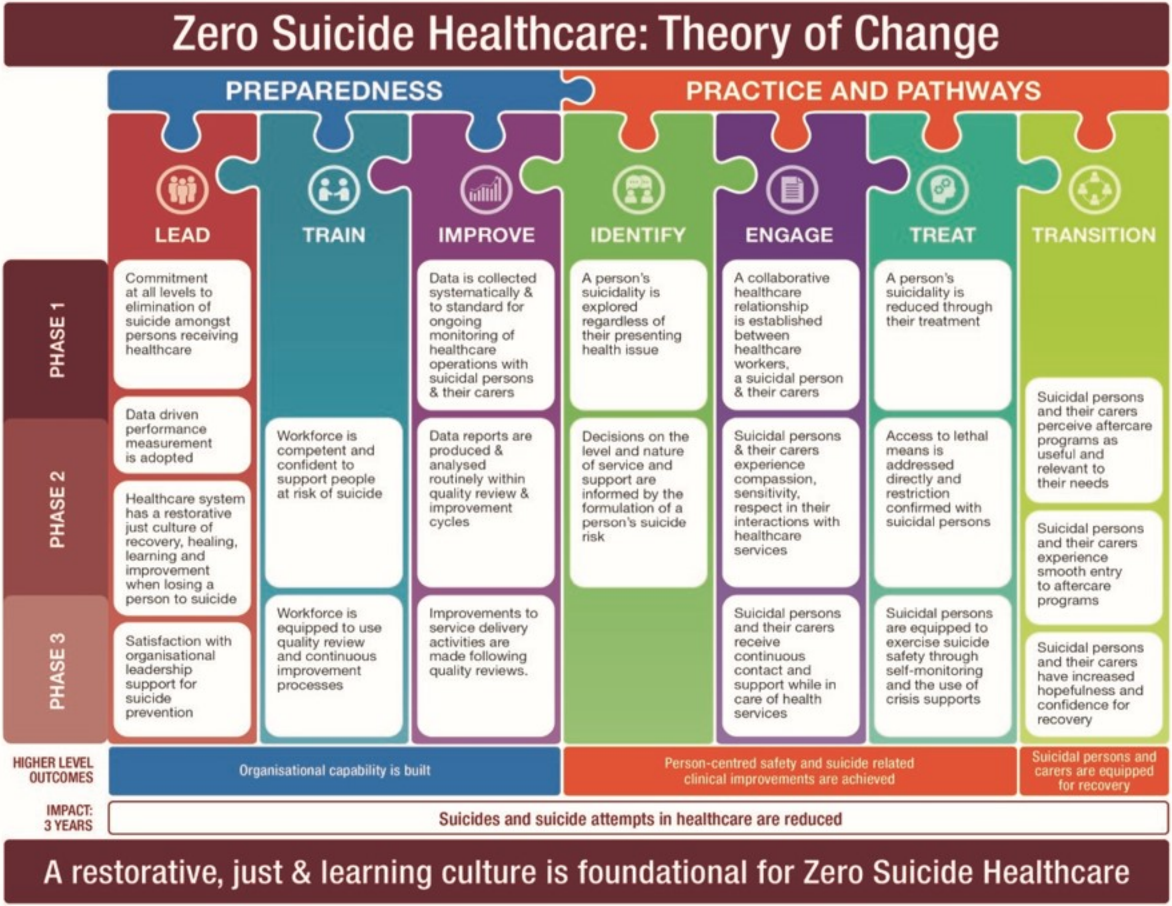
Zero Suicide Healthcare
Part 1

A compendium of publications supporting
the planning & implementation of the
Zero Suicide Healthcare Framework

Zero Suicide Healthcare: Theory of Change



	PREPAREDNESS			PRACTICE AND PATHWAYS			
	LEAD	**TRAIN**	**IMPROVE**	**IDENTIFY**	**ENGAGE**	**TREAT**	**TRANSITION**
PHASE 1	Commitment at all levels to elimination of suicide amongst persons receiving healthcare		Data is collected systematically & to standard for ongoing monitoring of healthcare operations with suicidal persons & their carers	A person's suicidality is explored regardless of their presenting health issue	A collaborative healthcare relationship is established between healthcare workers, a suicidal person & their carers	A person's suicidality is reduced through their treatment	
PHASE 2	Data driven performance measurement is adopted Healthcare system has a restorative just culture of recovery, healing, learning and improvement when losing a person to suicide	Workforce is competent and confident to support people at risk of suicide	Data reports are produced & analysed routinely within quality review & improvement cycles	Decisions on the level and nature of service and support are informed by the formulation of a person's suicide risk	Suicidal persons & their carers experience compassion, sensitivity, respect in their interactions with healthcare services	Access to lethal means is addressed directly and restriction confirmed with suicidal persons	Suicidal persons and their carers perceive aftercare programs as useful and relevant to their needs Suicidal persons and their carers experience smooth entry to aftercare programs
PHASE 3	Satisfaction with organisational leadership support for suicide prevention	Workforce is equipped to use quality review and continuous improvement processes	Improvements to service delivery activities are made following quality reviews.		Suicidal persons and their carers receive continuous contact and support while in care of health services	Suicidal persons are equipped to exercise suicide safety through self-monitoring and the use of crisis supports	Suicidal persons and their carers have increased hopefulness and confidence for recovery
HIGHER LEVEL OUTCOMES	Organisational capability is built			Person-centred safety and suicide related clinical improvements are achieved			Suicidal persons and carers are equipped for recovery
IMPACT: 3 YEARS	Suicides and suicide attempts in healthcare are reduced						

A restorative, just & learning culture is foundational for Zero Suicide Healthcare

Foreword

Across the globe health services are adopting and adapting the seven elements of the *Zero Suicide Healthcare Framework* in an effort to reduce suicide among people who present to the health service in suicidal distress. While there are both advocates and detractors for the label of *Zero Suicide Healthcare*, there is universal agreement that quality improvement is an ongoing requirement for health services to receive, treat, support and discharge people who present with suicidal distress.

The Zero Suicide Institute of Australasia advocates for health services to adopt the model as a key component of efforts to reduce the impact of suicide on communities. Like its US counterpart the Australian organisation seeks to identify gaps in resources that will assist health services implement the framework. This may involve identifying existing resources, on the US website or in other countries, or developing additional resources that are relevant to the local context.

Building the evidence base is also a key driver for health service leadership to adopt the *Zero Suicide Healthcare* approach. This compendium of published papers is designed to provide that evidence. It does not include all the papers published on the model - but it is a start. Also, not every paper is directly related to the framework. We think some offer interesting perspectives that will provide food for thought. However, we hope it will contribute towards health services building the case for change and make it easier to engage leadership in adopting the framework.

Part 1 is directed towards the outcome of Building Organisational Capability. Part 2 contains articles that are most relevant to suicide safety and related clinical improvements outcome. Whenever possible ZSIA will add papers to this compendium as they are made available in the public domain.

Thank you for your interest in this important aspect of suicide prevention.

Susan Murray OAM
Managing Director

Contents

Part 1: Building Capability: Lead, Train & Improve elements

This is the peer reviewed author accepted manuscript (post print) version of a published work that appeared in final form in:

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A model of lived experience leadership for transformative systems change: Activating Lived Experience Leadership (ALEL) project

Mark Loughhead, Ellie Hodges, Heather McIntyre, Nicholas Gerard Procter, Anne Barbara, Brooke Bickley, Geoff Harris, Lisa Huber and Lee Martinez

Abstract: (280 words)

Purpose

This discursive paper presents a lived experience leadership model as developed as part of the Activating Lived Experience Leadership (ALEL) project to increase the recognition and understanding of lived experience leadership in mental health and social sectors. The *Model of Lived Experience Leadership* was formulated through a collaboration between the South Australian Lived Experience Leadership & Advocacy Network and the Mental Health and Suicide Prevention Research and Education Group.

Design/methodology/approach

As one of the outcomes of the ALEL research project this Model incorporates findings from a two-year research project in South Australia using participatory action research methodology and cocreation methodology. Focus groups with lived experience leaders, interviews with sector leaders and a national survey of lived experience leaders provided the basis of qualitative data, which was interpreted via an iterative and shared analysis. This work identified intersecting lived experience values, actions, qualities and skills as characteristics of effective lived experience leadership and was visioned and led by lived experience leaders.

Findings

The resulting Model frames lived experience leadership as a social movement for recognition, inclusion and justice and is comprised of six leadership actions: 1) centres lived experience, 2) stands up and speaks out, 3) champions justice, 4) nurtures connected and collective spaces, 5) mobilises strategically, and 6) leads change. Leadership is also guided by the values of integrity, authenticity, mutuality, and intersectionality, and the key positionings of staying peer and sharing power.

Originality

This Model is based on innovative primary research, has been developed to encourage understanding across mental health and social sectors on the work of lived experience leaders in seeking change and the value that they offer for systems transformation. It also offers unique insights to guide reflective learning for the lived experience and consumer movement, workers, clinicians, policy makers and communities.

Keywords: leadership; lived experience; transformational leadership; lived experience leadership; health service; rural; participatory action research; cocreation; leadership model; systems change.

Introduction and context:

In Australia, reform in mental health care is a constant with history indicating a long line of inquiries, reviews, strategies and national plans (Australian Health Ministers 1992; Australian Health Ministers' Advisory Committee 2003; Commonwealth of Australia 2009; Commonwealth of Australia 2011; Department of Health 2017; Productivity Commission, 2020; State of Victoria 2021). A key expression of most of these processes has been the continuing failure of services to meet community needs and expectations. These include standards of safety and care, service availability or accessibility, consumer experience, carer/family inclusion, recovery orientation, integration with larger health systems and service models, and service outcomes. Accompanying all reform efforts has been the consistent voice of consumers and carers calling for change, through detailed testimony on experience, iatrogenic traumas, gaps, benefits and preferred outcomes. (Fisher & Spiro 2010; Sweeney et al. 2018). There has also been an increasing recognition of peer led models and alternatives (State of Victoria 2021).

A significant feature of local, state and national planning of services has been the involvement of consumers and carers in service planning and evaluation. Consumer and carer participation is the dominant way of organising and inviting people to have a voice in expressing experience, seeking change and shaping systems. Many would say that achieving consistent and sustained levels of lived experience involvement is variable and arbitrary in public mental health services with a range of well documented barriers and limitations (Byrne et al. 2019; Gee, McCarty & Banfield 2016). Many lived experience contributions are constrained in impact or co-opted via complex interests and processes shaping health service environments, including stigma and clinical paradigms. The challenges in reorientating towards a consumer focused and defined recovery approach are a key example (Le Boutillier et al. 2015).

In more recent times, the creation of state and national Mental Health Commissions operating at higher levels of policy making, have arguably worked to increase opportunities and voice for lived experience

(Department of Health 2017). The growth of the lived experience workforce has also raised the profile and need for inclusion and recognition of the value of lived experience expertise (Byrne et al. 2021). Similarly, the growth of the suicide prevention sector has occurred with increasing levels of lived experience influence and community action. In Australia, all governments are now encouraged to …'commit to integrate lived experience knowledge into national priority setting, planning, design, delivery and evaluation of suicide prevention services and programs…' (National Suicide Prevention Adviser 2020). And '…integrate lived experience expertise into leadership and governance structures' (National Suicide Prevention Adviser 2020).

Lived experience leadership

> 1. We want Lived experienced leadership that rises out of our lived experience and reflects our unique learnings and experiences; 2. We want leadership that is built on difference, creativity and deep participatory democracy; 3. We want horizontal power (not hierarchical power), shared networks, full consultation and networks of shared leadership roles (Lived experienced leader participant).

During the 2000s another paradigm of lived experience started to gain prominence. From a New Zealand context and consumer perspective, Gordon's (2005) paper encouraged a shift towards leadership in a way that transcended the common power relations of consumer participation, which often limited consumer and carer leaders to participating as advisors and consultants, rather than decision makers. Consumer leadership was about having leadership within:

> …the managerial and governance structures that plan, fund and deliver mental health services, the provision of service user managed and delivered services and the central involvement of service users in mental health advocacy, training, education and promotion (Gordon 2005 p. 365).

Lived experience leadership as a concept, and as recognition of who leaders are and what leaders do, raises consciousness towards the widespread activities of psychiatric survivor, empowerment and consumer movements in mental health (Daya, Hamilton & Roper 2020). Although not always named directly as leadership, consumers have established the international peer work movement, and collectively promoted the recovery paradigm (Byrne, Stratford & Davidson 2018). Consumers also engage in program consultancy and governance (Cleary et al. 2011), create, operate and manage consumer run organisations (Grey & O'Hagan 2015), lead community advocacy and awareness raising, and prompt systems change (Campbell 2020). Understanding the breadth of this work as leadership demonstrates the power of the concept, as it points to the role of leading change as well as actions across different levels of society. This includes a focus of formal activity within government and organisations and in public places, as well as informal work, such as local advocacy and support. If we think only from the perspective of public mental health services, we lose sense of the broad scope of leadership action and contribution (Scholz, Gordon & Happell 2017).

In terms of leadership models, there is little in the way of established research. A key discursive paper is Mary O'Hagan's (2009) proposal for a model of leadership. O'Hagan (2009) argued that an understanding of leadership needed defining from the context of the lived experience movement, which already had established purpose, shared values and a shared history of injustice and disempowerment. These aspects provided the basis of understanding what leadership was for and how it could be evaluated. Generalist models such as transactional and transformational leadership had limited applicability and relevance given the assumptions of corporate or organisational positioning, or workforce leadership. O'Hagan's model proposed a leadership model featuring a moral purpose, and approach of 'power with' rather than 'power over', as well as appreciating diversity of lived experience. It also sought to define the key competencies qualities, skills and learning needs.

There has been some primary research on aspects of consumer leadership within public mental health services, most of it with an Australian focus. Qualitative work from Stewart et al. (2019) suggested that the leadership concept was undefined yet clearly evident in the roles that people with lived experience, both consumers and carers, play in public services. Participants in their study saw leadership evident across many of the common designated roles and activities. These included advocacy, representative work, support work, leading education and awareness raising, service evaluation and planning, and in management funding and governance. The authors analysis found that leadership is about the key processes facilitating change. This change is based on a shared purpose, communicating, applying lived experience, influence of others, establishing relationship for change and contributing peer culture within mental health settings.

The Activating Lived Experience Leadership Project

The ALELproject was a South Australian participatory action research (PAR) project (2019-2021) which aimed to raise the recognition, valuing and use of lived experience leadership for systems transformation. As a research collaboration between, the South Australian Lived Experience Leadership & Advocacy Network (LELAN) and the Mental Health and Suicide Prevention Research and Education Group (UniSA), the work of ALEL project was to generate an improved understanding of lived experience leadership. This was achieved by gathering insights from local leaders, including service and industry leaders, in creating a shared agenda for collaborative, systems change.

The need for the project was based on sustained observations about inconsistent recognition and support of lived experience leadership across metropolitan, regional and rural areas of South Australia. There are high quality examples of partnership and shared leadership, ally support, and peer workforce development across South Australia. Yet, the project observed that this was often dependent on sector levels and managers who understood, valued and embraced lived experience and also the hard-fought ground gained by individual lived experience leaders that could easily be lost. It was also felt that public health services invited leaders into positions to meet accreditation standards by having people or just one person with a lived experience on various committees without the adequate training, support and mentorship. These experiences were more widely felt in regional and rural South Australia, were there were less health resources to support leadership across large geographical spaces of country health services. However, rural South Australia also demonstrated significant grass roots lived experience leadership activity, in terms of advocacy, support group formation, and contributions to suicide prevention activity and policy development. The numerous challenges of recognising, valuing, resourcing and embedding lived experience leadership, as well as its tremendous potential and justice demands for change, required much stronger efforts for its systematic development and implementation. Resourcing and implementing a universal approach with education training and opportunities for building community and/or networking across the sector would be of extreme value in building the lived experience leadership in metropolitan, rural and remote areas.

A participatory action research approach (Baum, MacDougall & Smith 2006) was chosen to enable a focus on discovery, shared planning, action and reflection. With a systems focus, the project aimed to shift power dynamics and progress strategic and cultural change across the mental health ecosystem toward supporting lived experience leadership and enabling it to flourish. Generously funded through the Fay Fuller Foundation, we believe this was the most significant funding allocation towards researching and building capacity for lived experience leadership we have seen in Australia. The funding supported a full time Project Director, 0.5 FTE Research Fellow and 0.3 FTE Research Assistant, for two years. Approval was gained from the Human Research Ethics Committee of the University of South Australia in January 2020.

Strategies of the project: an action research process.

The project utilised specific qualitative methods within an overall participatory action approach (PAR). The project included specific data generation methods including online focus groups (due to COVID-19) with lived experience leaders, and an online discussion forum with these participants; one-to-one interviews with sector managers from South Australia were also conducted. This was followed by a national online survey for lived experience leaders.

These research processes were augmented with project management including engaging with a project advisory group of lived experience and sector representatives, information literacy workshops, a community of practice group run six-weekly plus two Systems and Sector Leaders' Summits and a project outcome launch where all project outcomes were released to the sector. During the second Systems and Sector Leaders' Summit a consensus statement was developed by those present (Hodges et al., 2021b). This project also supported LELAN, a previously unfunded representative group, to establish its role as the peak body for lived experience in South Australia enabling leadership from LELAN to impact the mental health ecosystem on a broader scale by providing network leadership, consultancy with NGOs, systems advocacy and leading the coproduction process with organisations. The levels of recognition for the ALEL project reflected further significance with the South Australian Minister of Health launching its final products.

Participatory action research was used to guide the planning of all of these project strategies and specific methodologies relating to three points of data collection. As a methodology PAR is highly suitable to working from a lived experience perspective and involving community. PAR is an inclusive approach with a social justice and emancipatory perspective (Benjamin-Thomas et al. 2018). This approach flattens power structures, overcome barriers to involvement and recognition by democratising knowledge production and enabling transformative action (Benjamin-Thomas et al. 2018).

The research team included two researchers with lived experience, a lived experience carer and a mental health nurse academic. Therefore, the project was lived experience led and focused with strategies for working collaboratively with the local lived experience community and leaders, service managers, executives and policy leaders. The interpretive work of the project was led by the team yet also collaborative with the project advisory group and research participants.

The project advisory group, comprised of seven lived experience leaders and five sector representatives, and met 12 times within the two-year timeframe of the project. The group worked through major planning decisions regarding project design, focus of the literature reviews, recruitment of formal research participants, focus group methods and schedules and interview schedules. The group also advised on project strategies for higher level engagement and influence with sector leaders. Once data collection for interviews and focus group were complete the project advisory group met to discuss themes of the data and outcomes.

The research focused outcomes of this project have already been published by LELAN and UniSA as industry level reports. These include a Roadmap for strengthening lived experience leadership for transformative systems change (Loughhead et al. 2021a), a Model of lived experience leadership (Hodges et al., 2021a), a consensus statement process for strengthening lived experience leadership for transformative systems change (Hodges et al., 2021b) and a scoping literature review (Loughhead et al. 2020).

Formal research methods

Focus groups

Seven online focus groups were conducted with diverse lived experience leadership participants across the community including people from rural and urban settings, LGBTIQA+ communities, culturally and linguistically diverse groups and people with disability. Participants were emerging and experienced leaders and had worked in suicide prevention, mental health, peer work from the non-government and government sectors.

Focus groups were conducted online through a video platform and followed up with an asynchronous online discussion forum on a secure platform where all focus group members could contribute to further conversations on topics raised. 31 Lived experience leaders participated in the focus groups and discussion forum. Recruitment was purposive and snowballing, seeking an intersectional approach for inviting lived experience leaders to the project. All participants had experience in various roles such as community advocacy, community speakers, peer support workers, awareness raisers, project workers and consultants.

Round 1 focus groups (participant group 1) were followed by a double blinded online discussion forum which enabled anonymous commentary and reflection to occur on emerging findings with all focus group members in one forum. Round 2 focus groups were held, again through a video platform this time focussing on the required resources, education and practices to enable lived experience involvement in systems change. Mind Maps were created and were used as a visual representation of emerging themes and key findings. These are reported elsewhere (Loughhead et al. 2021b).

Interviews

The second data strategy featured interviews with mental health system and sector leaders (n=14) (participant group 2). Leaders were recruited purposively, and interview schedules were co-created with the project advisory group. These schedules focussed on the challenges around holding lived experience leadership positions, such as barriers, enablers, impacts on personal recovery and suggested changes to drive systems change and enable lived experience leadership to thrive and have impact. Further Mind Maps were generated and discussed and compared with the focus group and forum participants. A summary report about the interviews is published elsewhere (Loughhead et al. 2021c).

Surveys

A third data generation strategy was implemented with lived experience leaders (participant group 3) via a national online survey. It was decided to offer the survey nationally to broaden the knowledge available and to explore data around the different investment and mobilisation efforts that have occurred across different jurisdictions around Australia. Specific lived experience and carer organisations were identified and invited to advertise the survey within their networks. n=48 responses were provided and analysed separately to identify themes. The results of the survey have been reported elsewhere (Loughhead et al. 2021d).

Analysis, reflection and action

All qualitative data from the three groups of participants was coded and thematically analysed by the research team. A separate analysis was completed for each group. As an iterative process, emerging themes were then shared with participants and project advisory group members via text summaries and Mind maps. This encouraged reflection and refinement of the themes over time, across the different participant groups involved. During communications, our work sought significant transparency in sharing our analytical processes and acknowledgement of our interests in seeking improved recognition of the lived experience movement and its value to organisations and systems when embraced.

The research team were also informed by a collaborative impact approach and utilised systems change experience and practice. The ‘six conditions of systems change’ were used as a framework to guide collaborative analysis and decision making across our advisory group meetings, leaders’ summit events, and interpretation of data. (Kania, Kramer & Senge 2018 p.4). Two System and Sector Leaders’ Summits were also held in October 2019 and February 2021 [(see Hodges et al. 2019; Hodges et al. 2021c) as a means of participatory action to test ideas and encourage a shared understanding, vision and commitment to change. Over 40 executive leaders across government and non-government agencies and sectors, including peak bodies, attended at least one of the summit meetings.

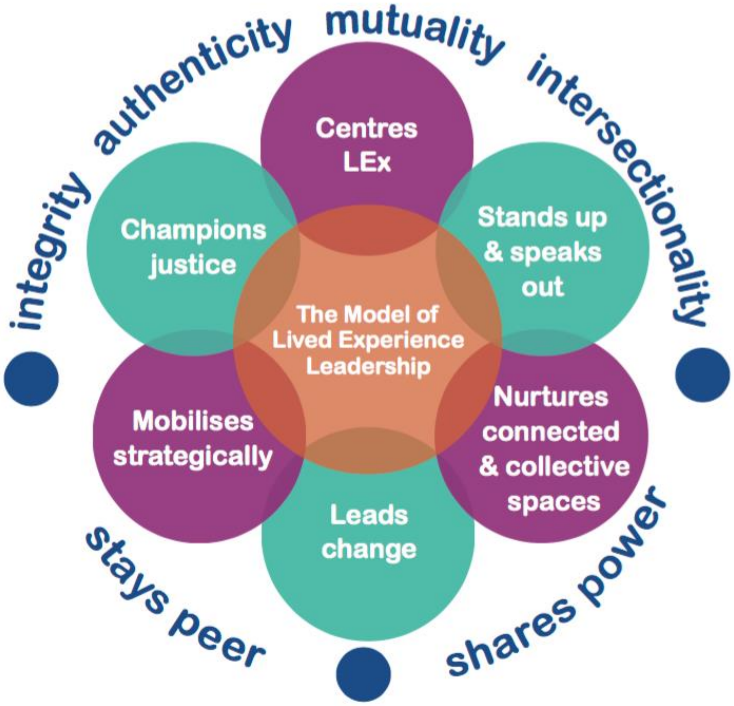
Results: The Model of lived experience leadership

The formulation of the Model occurred as a narrative synthesis of the themes and sub themes generated from the three participant groups outlined above. Initially, the themes and findings from each group were reported separately in project level reports. A higher order analysis combining findings then brought together a rich array of characteristics, values, qualities and skills that participants identified as critical to effective leadership and the change that is generated by people with lived experience.

The overall Model is represented by Figure 1. It is comprised of six leadership themes as well as key values which guide the actions and decisions that leaders do and make, and their relationships with peers and others. Each of the six leadership themes refers to characteristics, qualities and skills identified through the research process. As the Model states:

> The model embeds the values base of the mental health consumer movement and reflects an intersectional social justice approach…Lived experience leaders connect their personal, professional and socio-political worlds in unique ways to lead change, linking local experience with organisational and systems change endeavours. It operates both within and outside of roles, organisations and settings (Hodge et al., 2021, p.1).

Figure 1: Values and leadership themes



Centres lived experience

- Works from lived experience lens and positioning
- Stays true to recovery values and the peer movement
- Recognizes strength in vulnerability
- Supports diverse lived experience: gender, sexuality, ability, culture, and locality
- Articulates distinction between consumer and carer perspectives

Champions justice

- Seeks to rebalance power in policy and service contexts
- Interrupts and innovates for social justice
- Challenges stereotypes, discrimination, and injustice
- Advocates for authentic coproduction and opportunities for lived experience-led action

Mobilises strategically

- Builds relationships and networks with peers and allies
- Responds to dilemmas and complexity using peer values
- Works for big picture and long-term change

Stands up and speaks out

- Speaks with courage and conviction
- Stands tall in ‘being out’
- Shapes communication and expectations effectively
- Uses personal story and collective perspective appropriately

Nurtures connected and collective spaces

- Creates safe spaces and empowers voices and action of others
- Connected to consumer or carer lived experience movements
- Supports own and others self care
- Promotes peer culture and values

Leads change

- Doesn’t settle for the status quo
- Communicates with influence

- Builds collective responses and articulates solutions
- Proactive in working with discomfort
- Thinks deeply and reflects on leadership experience

Discussion:

There are many significant features of the Model that could be discussed, particularly how it describes the range of characteristics and qualities that lived experience leaders often bring to their work. A key focus is how the Model can stimulate awareness for policy makers and other leaders in mental health about lived experience, and how the Model also offers a training/reflection opportunity for lived experience leaders themselves. The other two important features of the Model are its grounding within the social movements of lived experience recovery, rights, and empowerment, and its connection to systems level change.

Our analysis of the work and activity of lived experience leaders recognises that leadership occurs from a unique positioning that spans personal mental health experience, shared knowledge of peer conversations, and connection to broader, consolidated values and knowledge of lived experience movements (Byrne & Wykes 2020). Leading from a lived experience lens, people are simultaneously active across informal, personal, community and formal organisational spaces. Many of the leaders in the project operated in volunteer spaces, were peer organisers and supporters, were active with informal social media posts, sat on formal committees as advisors, or led discussions at community suicide prevention events. Some were employed in formal peer, project or policy roles. This recognition has many facets that we believe need better acknowledgement and understanding in the sector. The outside/inside positioning means lived experience leaders speak up from a position that is separate to institutional interests and the power that binds the perspectives and decision making of professional groups, health bureaucracies and governments. This allows leaders to continually develop their leadership knowledge over time, by reflecting on the quality and outcomes of mental health planning and decision making, and how different influences shape the response to lived experience voices (Campbell 2020).

A theme from our research was that many leaders have been around in mental health for some time, they are aware of the ‘long game’ of change, and the need for a powerful voice and strategy. They see the ‘burn and churn’ of committee work and policy making, the slow development of progress, the gaps between person centred care commitments and what they experience, or what peers report their experience of service to be. As in the literature, leaders see the isolation of lived experience advisors (McDaid 2009) and peers (Moran et al. 2013), lack of authentic organisational commitments and invested partnerships (Scholz, Bocking & Happell 2017). Leaders also experience contests with medical approaches (Byrne, Happell, & Reid-Searl 2016) and co-option of ideas and concepts relating to recovery and peer work (Byrne, Stratford & Davidson 2018; Dent 2011). Many leaders act from a critical analysis, often expressing the rich and inspiring themes of recovery and shared empowerment as well as insights, while also highlighting the impacts of met and unmet needs, of iatrogenic traumas and harms, and preferred support and care from mental health practitioners (Daya, Hamilton & Roper 2020). To overcome the historical legacies of disempowerment, stigma and 'othering' mental health reform requires lived experience leadership as central to organisational and systems level governance.

The unique lived experience lens, as either consumer, carer, or kin, is more than a person being a 'critical friend' to health service decision making, as emphasised in the safety and quality movement (The Kings Fund 2013). In social movement terms, the Model's emphasis is on justice, change and rebalancing power. This points toward the importance of lived experience organisations and coalitions for influencing policy making, and being key advocates and monitors for the resourcing, safety, and quality of mental health services. These groups can also guide how systems should be improved given the experiences of consumers, families, and kin of multiple sector services (Gee, McGarty & Banfield 2015).

Lived experience groups, while reflecting a diversity of views and political positions regarding psychiatry and treatment, comprise local support groups, information networks, peer worker networks, state peak bodies and associations (Campbell 2020). Evaluation of the performance and quality of health services and systems, identification of suitable (recovery based) outcomes for services, and the upholding of standards of care, needs to occur from the systematic involvement and leadership of lived experience, rather than being deferred only to established medical and professional interest groups.

The importance of organised lived experience leadership via peak bodies and third sector organisations has been acknowledged at the United Nations level as critical grounding for advancing the recognition and actioning of the Convention on the Rights for Persons with Disabilities (United Nations General Assembly 2017). We suggest that the model, focussed on leading change, championing for justice and human rights, and grounded in the social movement lived experience lens, can be used to strengthen lived experience leadership as a central actor in mental health policy. This Model has the potential for transformation of services and systems, including shifting mental models of stigma and 'othering' that reside in service culture (Knaak, Mantler & Szeto 2017), and in practices which are disempowering and erode personhood (Glover 2012).

As lived experience leadership is strengthened and becomes more organised, it will include 1) decision making about the design of services and systems, 2) be embedded in governance structures, and 3) lead funding and commissioning of new and innovative services (including peer models of service). Such a vision points towards establishing senior leadership positions in national policy bodies and state health and human service departments (Government of Victoria 2022), that carry decision making power and control of budget resources (Scholz et al. 2017). This vision also enables local development, including alternatives and truly peer-led initiatives where lived experience leadership can be strengthened across metropolitan, rural and remote communities. In this, lived experience leadership will be recognised for setting up local support groups, creating and holding safe conversations, advocacy for increased resources, proposing innovative community or peer sector solutions to distress, crisis and access issues. We suggest the Model can be used to assist sector and service leaders to recognise this vision and the tremendous scope for service, organisational and community development that lived experience leadership offers.

The social movement focus of the Model and its valuing of intersectionality, highlights connections with leaders whose activities occur in/across other areas of lived experience and public policy. While the Model has been developed in the mental health lived experience context, it is relevant and applicable to other areas of lived experience leadership and emancipation given that the underlying positioning, values and characteristics of lived experience leadership are commonly shared by rights-based leaders across diverse public policy spaces. The Model points to fundamental aspects of leadership and the value that lived experience leaders can bring to change not only within specific policy areas, but across them. An example might be the intersectionality of experiences relating to homelessness, domestic and family violence, and drug and alcohol sectors. Intersectionality in this sense is complex, relating to layers of lived experience, identity and activity. Practically, however, this can encourage lived experience leaders and sector leaders in forming broader alliances and creating better ways for involving peers that meet identity and cultural safety preferences (Roche et al. 2020; Uink et al. 2020). As both allies and lived experience, leaders can enable opportunities for community learning, better recognition of needs and preferences, and helping peers to navigate complex health and social service environments (Jeremiah et al. 2020). This work can involve creating innovative pathways and resources that connect local programs/groups to a range of larger health/community services (Meridian 2021).

A key discussion point of the Model concerns its possibilities as a learning framework/tool to guide the training and development of lived experience leaders and articulate the knowledge and skill requirements of training programs (see O'Hagan 2009). All people come to the movement from unique experiences and life situations, and memberships. There is great diversity, even across mental health in terms the types and nature of mental health issues. There is also diversity in the advocacy goals that leaders seek as advisors, representatives and activists or as part of the peer workforce. And there are separate perspectives from consumers, carers, kin and allies (Daya et al. 2020). The breadth of the model, in terms of a focus on social justice, rebalancing power and intersectionality allows different leaders to see how their thinking, activities and goals setting align to these broader aspirations and values. Additionally, the Model expresses many central qualities and characteristics that help leaders identify and reflect on their own capabilities in these areas. How they might view strength in vulnerability, the processing of discomfort and conflict, or responding to dilemmas. How they may reflect on their communication skills and influence, their building of local networks, and the links between their own self-care, recovery, and what experiences support this. It also helps people to see that the spaces they step into as leaders have been forged by others, who have been pioneers for change, and the allies and supporters of lived experience working with them. LELAN has already adapted the Model into a reflective tool that people with lived experience are using within the organisation's evaluation of a leadership skills project.

Conclusion

This paper has described a Model of lived experience leadership that was a key research product from South Australia's Activating Lived Experience Leadership Project. The Model was derived from a participatory action research process using focus groups and interview data, and iterative layers of reflection and refinement via project team and advisor analysis. The synthesis brings together many characteristics, qualities, actions and skills that are expressed by people with mental health related lived experience, who become active in leading change. Learning from the experiences, perspectives, and reflection of ALEL participants, which included mental health service and sector leaders, the Model sees lived experience leadership as grounded in social movement activity and offering unique insights, information and thinking that must be included at systems change level. The Model helps to define how lived experience values, lens and positioning are grounded in recovery and peer mental health movements. The Model also links with other justice-based movements which focus on the inclusion, support and agency of different community groups. In this way it is a framework which can offer learning opportunities and guide training and development, alongside raising recognition of policy makers, health profession leaders, and health service executives that lived experience leaders will bring important qualities, informed insights, critical arguments and proactive solutions to the table. Lived experience leadership also aspires to organise, manage and deliver peer-based services. To overcome the historical legacies of disempowerment, stigma and 'othering' mental health reform requires lived experience leadership as central to all areas within an organisation from governance to delivery of programs and services.

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An implementation evaluation of "Zero Suicide" using normalization process theory to support high-quality care for patients at risk of suicide

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Abstract

Background: Suicide rates continue to rise across the United States, galvanizing the need for increased suicide prevention and intervention efforts. The Zero Suicide (ZS) model was developed in response to this need and highlights four key clinical functions of high-quality health care for patients at risk of suicide. The goal of this quality improvement study was to understand how six large health care systems operationalized practices to support these functions—identification, engagement, treatment and care transitions.

Methods: Using a key informant interview guide and data collection template, researchers who were embedded in each health care system cataloged and summarized current and future practices supporting ZS, including, (1) the function addressed; (2) a description of practice intent and mechanism of intervention; (3) the target patient population and service setting; (4) when/how the practice was (or will be) implemented; and (5) whether/how the practice was documented and/or measured. Normalization process theory (NPT), an implementation evaluation framework, was applied to help understand how ZS had been operationalized in routine clinical practices and, specifically, what ZS practices were described by key informants (*coherence*), the current state of norms/conventions supporting these practices (*cognitive participation*), how health care teams performed these practices (*collective action*), and whether/how practices were measured when they occurred (*reflexive monitoring*).

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Results: The most well-defined and consistently measured ZS practices (current and future) focused on the identification of patients at high risk of suicide. Stakeholders also described numerous engagement and treatment practices, and some practices intended to support care transitions. However, few engagement and transition practices were systematically measured, and few treatment practices were designed specifically for patients at risk of suicide.
Conclusions: The findings from this study will support large-scale evaluation of the effectiveness of ZS implementation and inform recommendations for implementation of high-quality suicide-related care in health care systems nationwide.

Plain Language Summary

Many individuals see a health care provider prior to death by suicide, therefore health care organizations have an important role to play in suicide prevention. The Zero Suicide model is designed to address four key functions of high-quality care for patients at risk of suicide: (1) identification of suicide risk via routine screening/assessment practices, (2) engagement of patients at risk in care, (3) effective treatment, and (4) care transition support, particularly after hospitalizations for suicide attempts. Researchers embedded in six large health care systems, together caring for nearly 11.5 million patients, are evaluating the effectiveness of the Zero Suicide model for suicide prevention. This evaluation focused on understanding how these systems had implemented clinical practices supporting Zero Suicide. Researchers collected qualitative data from providers, administrators, and support staff in each system who were responsible for implementation of practices supporting Zero Suicide. Normalization process theory, an implementation evaluation framework, was applied following data collection to: (A) help researchers catalog all Zero Suicide practices described, (B) describe the norms/conventions supporting these practices, (C) describe how health care teams were performing these practices, and (D) describe how practices were being measured. The findings from this evaluation will be vital for measuring the effectiveness of different Zero Suicide practices. This work will also provide a blueprint to help health care leaders, providers, and other stakeholders "normalize" new and existing suicide prevention practices in their own organizations.

Keywords
Suicide prevention, implementation science, normalization process theory, health services research, Zero Suicide

Introduction

Suicide rates have continued to rise across the United States for the past two decades, thus galvanizing a need for increased prevention and intervention efforts across settings (Caine, 2013; Hogan & Grumet, 2016). Health care systems have a key role to play in suicide prevention, because many individuals see a health care provider prior to death by suicide—nearly a third in the week prior to suicide (Ahmedani et al., 2019), half in the month prior, and the vast majority in the year prior (Ahmedani et al., 2014; Luoma et al., 2002). The Zero Suicide (ZS) model is a quality improvement initiative for safer and more effective suicide care in health care settings that came out of a "call to action" developed by the Office of the US Surgeon General and the National Action Alliance for Suicide Prevention (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). The ZS model is not a formal validated treatment protocol with prescribed interventions, but rather a framework of evidence-based practices and implementation strategies designed to transform organizational culture (Hogan & Grumet, 2016). The ZS model strategy defines four essential clinical functions of high-quality care for patients at risk of suicide: identification of high-risk patients, engagement and care management, effective treatment, and supportive care transitions (see Table 1 for Terms and Definitions) (Brodsky et al., 2018; Education Development Center, 2020). Each of these functions is supported by the application of a procedure or practice intended to support a specific function (Jolles et al., 2019). Identifying high-risk patients involves screening and risk assessment, for example, using the nine-item Patient Health Questionnaire (PHQ-9)] (Kroenke et al., 2001), and the Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011). Engagement practices may include collaborative crisis response and safety planning interventions to help patients identify coping strategies and other resources during suicidal crises (Bryan et al., 2018; Stanley & Brown, 2012). Effective treatments may include evidence-based therapies targeting intensity and/or frequency of suicidal thoughts and behaviors (Brown & Jager-Hyman, 2014). Supportive care transitions ensure that patients receive uninterrupted care as they move between care settings, particularly from inpatient to outpatient settings following suicide attempt (Chung et al., 2017).

Although the ZS model has great potential to improve the way health care systems care for patients at risk of suicide, and has been widely adopted, there is limited evidence of the effectiveness of a collection of linked, mutually supporting clinical practices for prevention of suicide attempts (fatal and non-fatal). For example, the identification function is supported by research demonstrating that disclosure of suicidal thoughts on the PHQ-9 depression assessment is a strong predictor of subsequent suicide attempts (Louzon et al., 2016; Simon et al., 2013, 2016), but the link between identification of patients experiencing suicidal thoughts and the ability of health care systems to intervene effectively and help prevent suicide attempts is unclear. Similarly, though randomized clinical trials have demonstrated efficacy of some psychotherapeutic interventions for reducing suicide attempts, little is known about the effectiveness of these practices for suicide prevention in real-world settings or among people who have not volunteered to participate in research (Brown & Jager-Hyman, 2014). Moreover, though prior research has demonstrated that systemic, bundled suicide prevention practices are more effective than any single practice (M. J. Coffey et al., 2015; Knox et al., 2003; Martin et al., 2016; While et al., 2012), it is unclear which specific practices, or combination of practices, supporting different ZS functions are most effective (Ahmedani & Vannoy, 2014).

Early examples of implementation of clinical practices related to the ZS model have been encouraging, such as the substantial reductions seen in annual suicide rates following implementation of the Perfect Depression Care program at the Henry Ford Health System (C. E. Coffey et al., 2013; Hampton, 2010). Nevertheless, more rigorous study is needed to demonstrate how specific ZS clinical practices are associated with important patient outcomes, specifically suicide attempt and mortality. Therefore, researchers in six large health care systems are investigating the effectiveness of different clinical practices (and combinations of practices) for preventing suicide attempts and deaths (Yarborough et al., 2019). At the time of this evaluation, these six health care systems had all implemented varying combinations of suicide prevention practices and were routinely collaborating via a formal suicide prevention learning collaborative (Bruschke & Flores, 2020). Therefore, in support of the learning collaborative and the planned investigation of ZS effectiveness (Figure 1), this research team sought to build a blueprint of the practices supporting the four key clinical functions (identify, engage, treat, transition) of the ZS model across health care systems.

Thus, this evaluation focused on understanding how these six health care systems had implemented (or planned to implement) clinical practices supporting the four key clinical functions highlighted in the ZS Model, in support of a broader ZS evaluation. Building a thorough working knowledge of practice variation across systems would be essential for measuring and comparing the effectiveness of different ZS practices (Figure 1). Therefore, we used normalization process theory (NPT), an implementation evaluation framework (McEvoy et al., 2014; Nilsen, 2015), to help explain which individual and interrelated practices had been implemented and how those practices had been operationalized across different health care systems to support ZS. NPT was selected because the framework focuses on the organic process of how complex interventions become *normalized* in practice, shaped by four determinants—*coherence* (how the intervention is understood), *cognitive participation* (how users engage in the intervention), *collective action* (how the intervention is performed), and *reflexive monitoring* (how the intervention is monitored over time) (May et al., 2009; May & Finch, 2009). Specifically, these four NPT determinants were applied following key informant data collection to help explain how different clinical practices supporting ZS had become normalized across organizations and care settings.

Methods

Participating health care systems

Six large health care systems, together caring for nearly 11.5 million members in California, Colorado, Michigan, Oregon, and Washington, are implementing clinical practices supporting the ZS model and agreed to participate in the implementation evaluation. All participating health care systems provide both comprehensive health care and insurance coverage to a defined patient population. Each system is described here and additional details are presented in Table 2, using data compiled from 10/2018-9/2019 (Henry Ford Health System, 2019; Kaiser Permanente, 2019). The participating Kaiser Permanente (KP) health care systems in California together served approximately 9 million patient members, followed by Henry Ford Health System in Michigan serving 1.2 million, and KP health care systems in Oregon, Washington and Colorado similarly serving between 600,000–700,00 members each. The Institutional Review Board at each system approved its participation in the ZS evaluation.

The characteristics of the different health care system patient populations vary by sociodemographic characteristics associated with suicide, including age, race/ethnicity, income, and education (Nock et al., 2008; Rehkopf & Buka, 2006). For example, at the time of this evaluation, Henry Ford provided care to the oldest patient population and had the largest proportion insured by Medicare (23.5%), while KP Southern California served the youngest population and had the largest proportion insured by Medicaid (10.4%). Henry Ford served the largest proportion of Black/African American patients (28.2%), KP Southern California the largest proportion of Hispanic/Latinx patients (40.9%), and KP Northern California the largest proportion of Asian patients (20.1%).

Suicide prevention learning collaborative

In 2016, Kaiser Permanente Care Management Institute (CMI), convened a Suicide Prevention Learning Collaborative workgroup, which included clinical, operational, and patient safety stakeholders, as well as peer advisors (KP health plan members and advocates with lived experience from national mental health advocacy organizations), and researchers, including those from all six health care systems participating in the ZS evaluation. The charter of this workgroup included cross-regional collaboration on implementation of best-practices for suicide prevention (Bruschke & Flores, 2020). With oversight from operational mental health leadership, CMI works with members from the suicide prevention learning collaborative to facilitate development new electronic health record (EHR)-based tools, trainings and metrics to support key ZS practices which build from the work described in this evaluation.

Key informant data collection

A key informant meeting guide (see Supplement A) was developed to assist researchers embedded in each health care system (JER, GES, JMB, AB, BHY, KJC, SAS, JW, BKA) to collaborate with key informants and document clinical practices the systems had implemented (or planned to implement) across the different clinical functions of ZS. Prior to data collection, embedded researchers all had some knowledge about suicide prevention initiatives and clinical practices in their health care systems, so data collection was designed to enhance that knowledge. Key informants included local leaders and staff with knowledge of implementation of suicide prevention related processes and protocols in the various clinical settings. A structured data collection template (Miles et al., 2014) was designed to help the researchers catalog details about current and planned suicide prevention practices across care settings (Supplement B). The data collection template did not explicitly assess the domains of the ZS Model focused on implementation strategies (training, leadership, and continuous quality improvement) (Education Development Center, 2020), but these domains were implicitly addressed in questions about how the practices had/or would be implemented. The template was originally developed and tested at KP Colorado and subsequently tested at two other health care systems, with the finalized version made available for widespread use in March 2018. Templates were populated and reviewed iteratively by the embedded researcher and team members at each participating health care system. In parallel, templates were also uploaded to a private web-based file storage platform available to Health care System Research Network members (Health Care Systems Research Network, 2019) and each reviewed in detail by members of the full study team online during routine all-site team meetings (December 2018 through April 2019). Following these presentations, some researchers made additional edits and updates to their templates to reflect changing ZS practices across their systems and uploaded current versions to the shared private website. In August 2019, a health services research (JER) used the most recent version of the template from each health care system to summarize ZS practices across health care systems, including (1) the function addressed; (2) a brief description of the practice intent and mechanism of intervention (e.g., EHR-based clinical decision support tools), standard workflows/processes and health care system policies; (3) the target patient population and service setting; (4) when/how the practice was (or will be) implemented; and (5) whether/how the practice was documented/measured.

Application of NPT

NPT was applied following key informant data collection to help understand how health care systems had implemented different clinical practices, and combinations of practices supporting the ZS model (May et al., 2009; May & Finch, 2009). NPT assumes the way that practices become routinely embedded and integrated into their social contexts—how they become *normalized*—is not a structured sequence of events, but instead is an organic process shaped by four determinants: *coherence*, *cognitive participation*, *collective action*, and *reflexive monitoring* (May & Finch, 2009; Nilsen, 2015). To support this evaluation, we first developed a working interpretation of the NPT determinants for application to ZS implementation, guided by two prior studies evaluating implementation of depression care in primary care (Franx et al., 2012; Gunn et al., 2010). Specifically, like Gunn et al. (2010), we developed working definitions for how each of the NPT determinants would apply to health care system implementation of practices (and combinations of practices) supporting the ZS model (Table 3). Specifically, we used NPT to catalog and connect the descriptions of current and future clinical practices to ZS implementation (i.e., creating *coherence*) across the health care systems, and to facilitate the specification of the workflows/processes (*cognitive participation; collective action*) and approaches to measuring these workflows/processes (*reflexive monitoring*). This approach involved using NPT pragmatically to define specific products resulting from our application of NPT to the key informant data (Table 3) to support the goals of the broader ZS evaluation (Figure 1). Specifically, to describe *coherence*, a health services research (JER), first used the templated key informant data to create a thematic network (Attride-Stirling, 2001) (i.e., affinity diagram) of the existing practices supporting the four key clinical functions of ZS across all six participating health care systems. Embedded researchers from all participating health care systems, responsible for data collection, participated in several rounds of iterative review and refinement to ensure ZS practices were comprehensively and accurately represented in the final version of the thematic network. Second, we summarized the current state of practices supporting ZS across health care systems and created a list of tools (e.g., screeners, assessments, templates) supporting those practices to describe *cognitive participation* and *collective action*. Third, to describe *reflexive monitoring* we built a working knowledge of whether and how ZS practices were being measured and how different practices and combinations of practices could be measured over time. This work also involved conceptually mapping a suicide care continuum, similar to treatment cascades used to evaluate care gaps for patients living with HIV (Kay et al., 2016).

Results

Key informant data collection and application of NPT

Embedded health care system researchers had all begun populating the implementation templates in collaboration with local key informants by June 2018. An average of 14 key informants per health care system provided data to help populate each template (range 7–26). Key informants included providers, administrators, EHR programmers, and project managers (often known to embedded researchers) who were responsible for supporting implementation of practices supporting ZS in different ways. All health care systems had participated in virtual team review and updated their templates at least once before the designated health services researcher (JER) begin reviewing template data in August 2019. Prior to application of NPT, the health services researcher organized the practices summarized in the templates by function. In some cases, the function was changed (e.g., "treat" to "engage") to be consistent with the ZS framework definitions, in collaboration with a ZS expert (JGG).

Each product associated with application of NPT to the templated data (Table 3) was created consecutively and is described in detail below, including (1) the catalog of practices understood to support ZS (*coherence*); (2) the summary of the current state of norms/conventions supporting these practices and how health care teams performed these practices (*cognitive participation and collective action*); and (3) a list of tools available to measure practices across systems and a model describing combinations of practices available to measure the continuum of suicide care across settings (*reflexive monitoring*).

Coherence

In Figure 2, we present the thematic network of clinical practices key informants understood to support ZS (*coherence*), derived from the implementation templates completed by an embedded researcher at each site. The number of current/planned clinical practices described by key informants varied across health care systems (average per health system = 32, range 19–55), as did the level of detail in the description of each practice (Supplement B). All templates included fairly detailed descriptions of practices supporting the identify function (i.e., standard workflows and tools), but practices supporting the engage, treat and transition functions were often less clearly defined. Moreover, often the clinical, operational, and patient safety stakeholders did not explicitly reference the ZS model when they described the current state of health care system practices supporting suicide prevention. Some templates also included descriptions of practices that were not specifically designed to support suicide prevention, but rather mental health and addiction care more generally. For example, substance use disorder screening/assessment, social support, care coordination/outreach, and types of psychotherapy. Relatedly, some of these practices had been in place at most health care systems more than 5 years prior to this evaluation (like depression severity assessment with the PHQ-9 and different types of psychotherapy), while others had been implemented more recently (suicide severity assessment with the C-SSRS).

Table 1. Terms and definitions.

Term	Definition
Determinant	A factor that enables or hinders the clinical practice from achieving the desired effect.
Function	The purpose of a practice. The core 4 clinical functions of high-quality suicide care defined in the ZS Model include identification, engagement, treatment and transition.
Mechanism	Process or event through which a clinical practice operates to affect outcomes.
Practice	The application of a procedure intended to support a specific function (aka "form following function"). This evaluation focuses on clinical practices intended to support the ZS Model.
ZS Model	A framework designed to support system-wide, organizational commitment to high-quality suicide care in healthcare.

ZS: Zero Suicide.

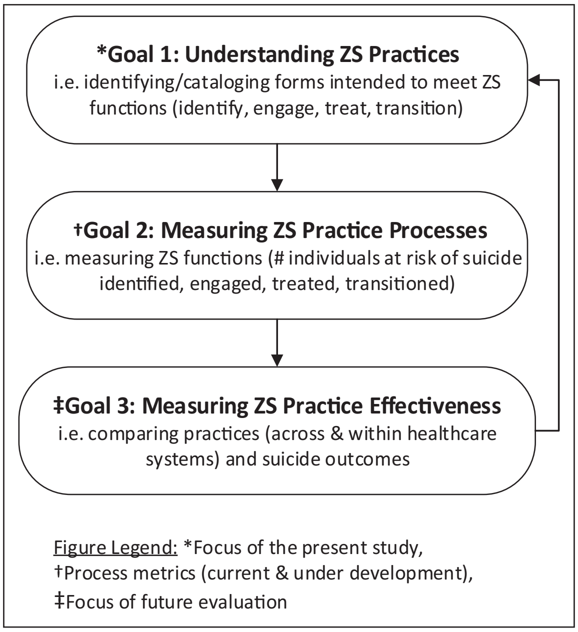

Figure 1. Goals of the planned Zero Suicide evaluation.

Cognitive participation and collective action

Identification of high-risk patients. Practices described by key informants used to support the identification function of ZS

Table 2. Characteristics of participating health care systems and patient-populations (10/1/2018-9/30/2019).

System characteristics	KPSC	KPNC	KPNW	KPCO	HFHS	KPWA
Members	4.6 million	4.4 million	620,000	640,000	1.2 million	700,000
Outpatient Medical Centers/Clinics	231	252	59	34	50	34
Hospitals	15	21	2	0	6	0
Patient characteristics						
Female	51.7%	51.6%	52.1%	52.9%	57.4%	53.9%
Age						
0–19	23.4%	22.2%	20.9%	19.9%	18.1%	15.9%
20–39	27.4%	27.1%	25.8%	23.6%	21.5%	25.7%
40–64	33.4%	34.3%	34.7%	35.9%	36.6%	39.9%
65+	15.9%	16.4%	18.6%	20.6%	23.8%	18.4%
Insurance						
Medicaid	10.4%	7.3%	9.2%	6.8%	0.4%	0.6%
Medicare	13.6%	19.6%	19.6%	21.7%	23.5%	19.6%
Socioeconomic status						
Neighborhood income < 25 K	0.8%	1.2%	0.4%	0.6%	6.7%	1.2%
Neighborhood education < 25% college	53.8%	37.6%	39.3%	25.4%	52.9%	38.9%
Race/Ethnicity						
Asian	10.9%	20.1%	6.4%	3.5%	4.6%	7.4%
Black/African American	8.2%	6.9%	3.4%	4.2%	28.2%	3.4%
Hispanic/Lantinx	40.9%	21.1%	8.5%	15.9%	2.3%	4.0%
Hawaiian/Pacific Islander	0.8%	1.0%	0.9%	0.3%	0.1%	0.9%
American Indian/Alaska Native	0.3%	0.5%	0.8%	0.6%	0.4%	1.0%
Multiple/Other	0.0%	0.0%	0.4%	3.1%	1.8%	1.0%
Unknown	7.0%	7.1%	8.1%	12.4%	8.7%	34.1%
White	31.9%	43.4%	71.6%	59.9%	54.0%	48.2%
Any Mental Health Diagnosis in 2018	16.2%	14.4%	22.3%	20.3%	16.8%	20.4%

KP: Kaiser Permanente; KPSC: KP Southern California; KPNC: KP Northern California; KPNW: KP Northwest (Oregon/Southern Washington); KPCO: KP Colorado; HFHS: Henry Ford Health System; KPWA: KP Washington.

Table 3. Normalization process theory (NPT) determinants and application to Zero Suicide (ZS) evaluation.

NPT determinant	Definition (May & Finch, 2009)	Application to ZS Evaluation	Product
Coherence	Do people know what the work is?	What clinical practices support the four clinical functions of ZS?	Thematic network
Cognitive Participation	Do people join in to the work?	What norms/conventions support ZS practices?	Summary of current workflows supporting ZS practices
Collective Action *Skillset Workability* *Contextual Integration* *Interactional Workability* *Relational Integration*	How do people do the work?	What tools are used to support ZS practices? How?	Summary of clinical decision support tools used across healthcare systems
Reflexive Monitoring	How do we know the work is happening?	How should we measure ZS practices?	Care continuum model

NPT: normalization process theory; ZS: Zero Suicide. z

included standard clinical decision support tools, implemented in the EHR, to support suicide risk screening followed by more comprehensive risk assessment. At the time of this evaluation, all health care systems monitor depression symptom severity, including suicidal ideation, among adult patients receiving care in the outpatient mental health specialty setting. All systems also had screening/assessment practices in place for substance use disorders, although the norms/conventions supporting these screening practices varied. Workflow variation across care settings was common and the health care systems had different screening and assessment approaches (e.g., varying criteria for deciding which patients received the PHQ-9). In the primary care setting, population-based screening and suicide risk assessment were less common; screening and assessment were more often done at the discretion of primary care providers and many systems were engaged in planning future implementation of different approaches for more universal screening/assessment. Some systems were also in the process of planning implementation of suicide risk prediction algorithms (Simon et al., 2018) for purposes of enhancing suicide risk assessment and engagement in suicide-related care.

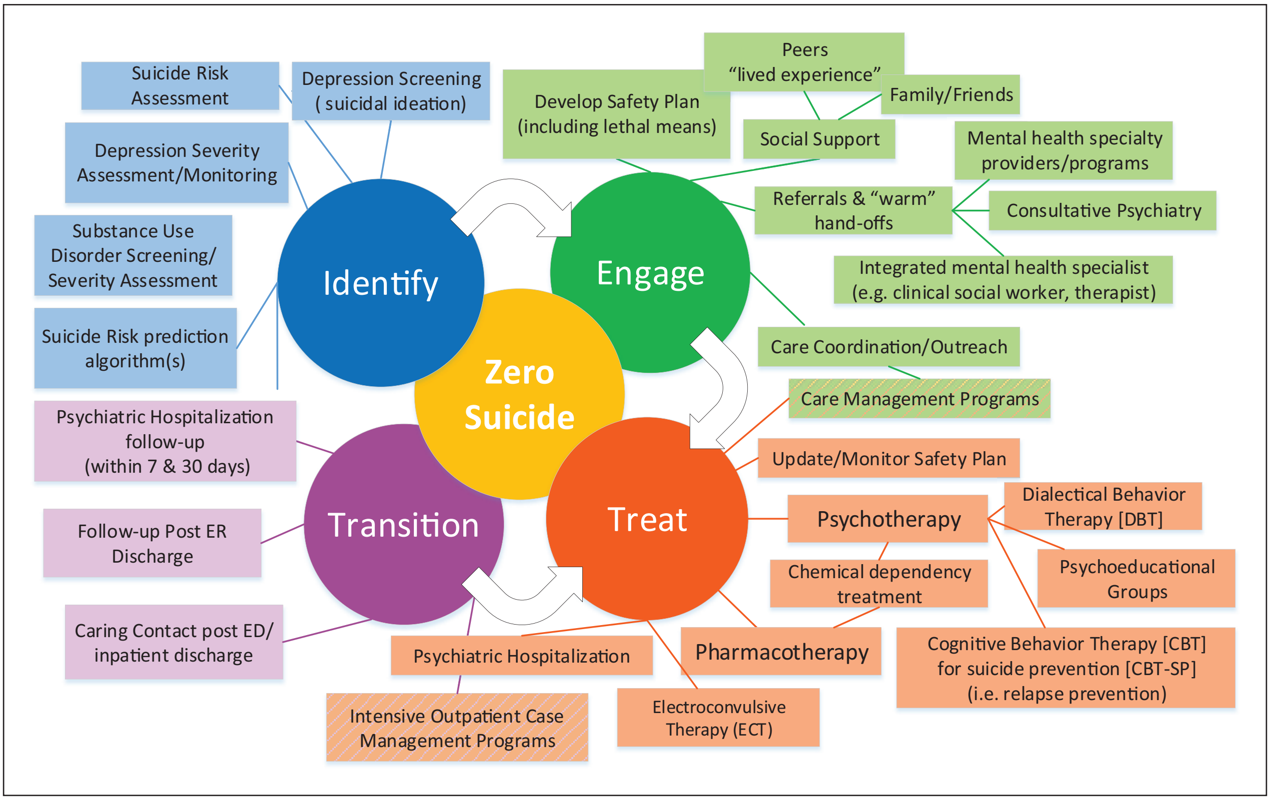

Figure 2. Zero Suicide (ZS)-related practices across all participating health care systems cataloged by the clinical function of ZS.

Engagement and care management. Practices designed to support the engagement function of the ZS model consistently included references to development of a safety plan or crisis response plan (Bryan et al., 2018; Stanley & Brown, 2012), which usually included lethal means assessment (i.e., discussions about prescription medications, firearms, and planning how to limit access). Researchers cataloged varying safety planning workflows and documentation practices across sites and providers (Yarborough et al., 2019); however, a shift toward practice standardization was underway. CMI was facilitating the standardization of safety planning by promoting use of a common EHR-based template across health care systems (i.e., KP regions). Key informants also described integrating social support, referral practices, and care coordination programs to engage patients in care for suicidality. The norms/conventions supporting these practices, however, were often not well-defined.

Effective treatment. Embedded health system researchers documented a variety of practices across health care systems that addressed the treatment function of ZS. These included pharmacotherapy; different types of evidence-based psychotherapy available for depression and other mental health disorders, including psychoeducational group-based therapy and cognitive behavioral therapy (CBT) (Hofmann et al., 2012), electroconvulsive therapy (Pagnin et al., 2004; UK ECT Review Group, 2003); and psychiatric hospitalization, which is the current standard of care for patients at high risk of suicide (Brown & Jager-Hyman, 2014). Researchers also cataloged evidence-based psychotherapies being used in some health care systems that were designed specifically for patients at high risk of suicide, including CBT for suicide prevention (CBT-SP) (Stanley et al., 2009) and dialectical behavior therapy (DBT) (Linehan et al., 2006). Generally, mental health specialty providers in all systems were responsible for treatment of patients at risk of suicide, but the specific treatments providers were using were unknown in some health care systems and difficult to discern in others (e.g., differentiating CBT from CBT-SP, and DBT groups from other group-based therapies). Moreover, it was not possible to know exactly what parts of specific therapies patients were receiving (e.g., specific DBT/CBT skills/strategies) (Bryan, 2019; Koerner, 2013).

Supportive care transitions. The practice consistently documented across health care systems designed to support the transition function of ZS was follow-up care after discharge from inpatient psychiatric settings. However, follow-up practices after discharge from the emergency department (ED) setting (without inpatient admission) were varied. Other practices designed to support care transitions included intensive case management programs typically designed to

Table 4. ZS practices measured with common tools across health care systems.

ZS function	Practice	Healthcare system						Measured with common tools across systems[a]		
		1	2	3	4	5	6	No	Yes	How?
Identification	Depression/Suicide Risk Screening	X	X	X	X	X	X		X	PHQ-2, PHQ-9Q9
	Depression Severity Assessment	X	X	X	X	X	X		X	PHQ-9
	Suicide Risk Assessment	X	X	X	X	X	X		X	C-SSRS
	Suicide Risk Prediction Algorithm						X	X		
	Substance Use Screening/Assessment	X	X	X	X	X	X		X	AUDIT-C
Engagement	Collaborative Safety Planning	X	X	X	X	X	X		X	[b]Safety Plan
	Social Support Programs		X					X		
	Referrals/“Warm” hand-offs	X	X	X	X	X	X	X		
	Care Coordination/Outreach Programs	X	X	X	X	X	X	X		
	Care Management Programs	X	X	X	X	X	X	X		
Treatment	Safety Plan updates/monitoring	X	X	X	X	X	X		X	[b]Safety Plan
	Psychotherapy	X	X	X	X	X	X		X	ICD-10
	Pharmacotherapy	X	X	X	X	X	X		X	NDC Code
	Electroconvulsive Therapy	X	X	X	X	X	X		X	CPT Code
	Psychiatric Hospitalization	X	X	X	X	X	X		X	ICD-10
Transition	Follow-up Post Hospitalization	X	X	X	X	X	X		X	FUH HEDIS Measure
	Follow-up Post ED Discharge	X	X	X	X	X	X		X	[c]Encounter
	Caring Message		X		X			X		
	Intensive Case Management (Out-patient)	X		X		X		X		

ZS: Zero Suicide; PHQ: Patient Health Questionnaire; C-SSRS: Columbia Suicide Severity Rating Scale; AUDIT-C: Alcohol Use Identification Test Consumption; ICD-10: 10th revision of the International Statistical Classification of Diseases; NDC: National Drug Code; CPT: Current Procedural Terminology; FUH: Follow-Up After Hospitalization for Mental Illness; HEDIS: Healthcare Effectiveness Data and Information Set; ED: emergency department.

[a] Defined as more than 1 health care system presently or in the process of being implemented.

[b] Discrete data element(s) implemented to capture EHR documentation.

[c] Healthcare encounter (in-person, phone, etc.) EHR documentation.

support patients with severe and persistent mental illnesses in outpatient settings (Dieterich et al., 2017). Finally, key informants at two health care systems reported sending caring messages (Motto, 1976; Motto & Bostrom, 2001) following inpatient discharge which addressed the ZS transition function, but the norms/conventions supporting this practices were not well-defined.

Reflexive monitoring

The data from key informants were also used to conceptualize how different practices and combinations of practices could be measured over time to support development of standard process measures and evaluation of ZS effectiveness (Figure 1). First, we summarized the common screening tools/assessments and health care utilization codes that could be extracted from EHRs across systems (Table 4). Specifically, at the time of this evaluation all health care systems were using the PHQ-9 to measure depression severity (Kroenke et al., 2001) and most participating health care systems also implemented a standardized tool for suicide risk assessment (most commonly the C-SSRS) (Madan et al., 2016; Posner et al., 2011) in their mental health and addiction medicine settings. No systems were using the same tools for drug use disorder screening/assessment, but several systems were using a common screening tool for alcohol use disorders (AUDIT-C) (Bradley et al., 2007; Bush et al., 1998). All systems were also in various stages of implementing new EHR tools designed to support consistent documentation of the key components of a safety plan (Bottomley, 2019; Stanley & Brown, 2012). Providers in all systems also had routine procedures for documenting treatment in patient EHRs via diagnosis and procedure codes (i.e., ICD and CPT) associated with health care encounters (CMS.gov Centers for Medicare & Medicaid Services, 2019; World Health Organization, 1992). Finally, follow-up within 7-day and 30-day post-discharge from inpatient psychiatric settings was consistently measured across all health care systems in accordance with national quality metrics measuring (National Committee for Quality Assurance [NCQA], 2019).

Next, we defined a conceptual care continuum (i.e., treatment cascade) (Figure 3) to measure combinations of measurable practices supporting the ZS model. In this continuum, primary care patients enter the ZS care pathway at the point of population-based depression screening. Patients receiving mental health specialty care enter the care pathway via routine depression and/or suicide risk severity assessment. Patients seen in emergency or urgent care settings for mental health-related concerns also enter at the point of depression/suicide risk severity assessment. Patients identified as being at risk of suicide via screening/

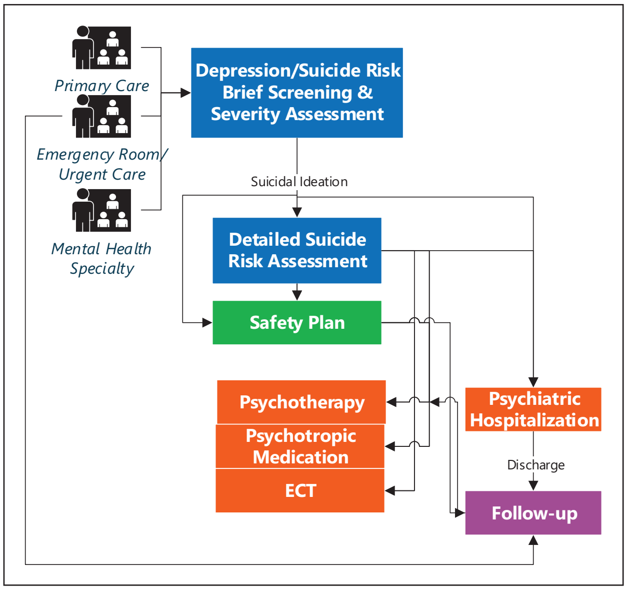

Figure 3. Suicide risk care continuum.
Legend: color coding corresponds to the ZS function defined in Figure 2 (blue = identification, green = engagement, orange = treatment, purple = transition).

assessment may be engaged in collaborative safety planning and receive one or more types of treatment (e.g., pharmacotherapy, psychotherapy). Finally, patients who received care for suicidality in an inpatient or ED setting receive proactive outreach following discharge.

Discussion

This evaluation used NPT (McEvoy et al., 2014; Nilsen, 2015) to build a fundamental understanding of how six health care systems had implemented ZS practices to support four key clinical functions of high-quality care for patients at risk of suicide, and lays the foundation for health systems nationwide to understand the impact of implementing these practices. Our innovative application of NPT to data from key informants enabled us to comprehensively catalog practices understood to support ZS (*coherence*); summarize the current state of norms/conventions supporting these practices (*cognitive participation*) and how health care teams performed these practices (*collective action*); and define how we know ZS practices are happening and how to measure when they occur (*reflexive monitoring*). Embedded researchers who all had some knowledge about suicide prevention initiatives and clinical practices in their health care systems strengthened data collection and interpretation. The most well-defined practices focused on the identification function—specifically, the use of common screening/assessment tools (Kroenke et al., 2001; Posner et al., 2011) to identify patients at high risk of suicide attempt. Many potential treatment practice options were also defined, but few treatment practices identified were designed specifically for patients at risk of suicide and it was difficult to differentiate whether and how providers were using various therapy options. In addition, engagement and transition practices were often inconsistently used and measured within health care settings; but health care systems were consistently measuring health care encounters documentation following psychiatric hospitalization (NCQA, 2019) and a shift toward standardized safety planning was underway (Bruschke & Flores, 2020; Stanley & Brown, 2012).

This working knowledge of ZS practice variation will be used to support efforts to continue to improve suicide care across health care systems nationwide (Bruschke & Flores, 2020) and large-scale evaluation of the effectiveness of ZS practices, both alone and as part of a continuum of care for patients at risk of suicide. Specifically, defining an approach for measuring different practices (and combinations of practices) over time via development of standard process metrics (i.e., *reflexive monitoring*) have enabled participating health care systems, and will enable others nationwide, to undertake their own appraisal processes in support of ZS implementation. CMI worked in collaboration with mental health leaders to develop a standardized set of metrics to track implementation of ZS practices and suicide prevention outcomes (Bruschke & Flores, 2020). These metrics will enable clinical, operational, and patient safety stakeholders to measure whether identification and engagement practices are occurring when expected (i.e., continuous quality improvement) within their own health care systems. The working knowledge of the variation of ZS practice implementation across health care systems will also allow researchers to compare the effectiveness of different approaches (i.e., workflows) used for identification, engagement, and transitioning patients at high risk of suicide. This evaluation will also support treatment metric development; however, as this work demonstrated, the investigation of the real-world effectiveness of specific psychotherapies for suicide prevention may be limited until we are able to more accurately define ways to measure variation in these treatment practices.

Future directions

This project can provide a framework to support ongoing ZS implementation and evaluation in health care systems across the country. Specifically, this evaluation suggests important considerations for integrating or *normalizing* new practices to support the ZS model. For example, as suicide risk prediction algorithms (Kessler et al., 2017; Simon et al., 2018) are implemented to improve identification and engagement of patients at risk (U.S. Department of Veterans Affairs, 2017), it will be important to consider how to support this practice within the context of existing norms/conventions, workflows, and tools. This evaluation also underscored the potential utility of using standardized definitions and tools to measure existing engagement and transition practices, such as care coordination/outreach and caring message programs. Caring contact programs in particular have potential to be a simple and effective ZS practice, scalable across different types of health care systems (Carter et al., 2005, 2007; Comtois et al., 2019; Hassanian-Moghaddam et al., 2011; Luxton et al., 2012; Motto, 1976; Motto & Bostrom, 2001).

The work presented here will also provide a vital foundation for understanding potential adaptation of practices supporting ZS during environmental disruption and evaluating those changes. For example, in response to the coronavirus disease 2019 (COVID-19) pandemic many US health care organizations rapidly converted to providing many services, including mental health and addiction medicine care, virtually (Wosik et al., 2020). The processes used to identify patients at risk of suicide via virtual screening/assessment practices may be different than prior in-person practices. Moreover, reduced reliance on emergency and inpatient psychiatric settings during the COVID-19 response may also impact suicide rates and our understanding of the effectiveness of mental health care provided in these settings (Loch, 2014; Rabinowitz et al., 1994). When the effects of COVID-19 on suicide become clearer (Reger et al., 2020), understanding how ZS implementation adapted and changed during this time across these health care organizations will be vital for understanding which practices may have helped mitigate potential unintended negative effects of social isolation on suicide outcomes (Ahmed et al., 2020; Fatke et al., 2020; Vieira et al., 2020).

Limitations

This evaluation did not explicitly address the implementation strategy domains of the ZS model—training, leadership, and continuous quality improvement (Education Development Center, 2020). These domains are critical to ensuring that practices supporting the four key clinical functions of ZS we evaluated result in high-quality suicide care. For example, providing training in specific evidence-based interventions provides clinicians with valuable skills and enhances fidelity to the intervention. The presence of a completed safety plan in an EHR does not necessarily mean that the safety plan was completed collaboratively in a way that was meaningful to the patient. Training, leadership, and continuous improvement are implementation strategies critical for ensuring consistent delivery of high-quality care and will be important considerations for the future evaluation of the effectiveness of different ZS practices (and combinations of practices).

This evaluation also did not take variations in practice maturity into account or consider all the ways that clinical ZS practices interact with related interventions in health care systems. For example, screening and assessment for substance use disorders was identified as a ZS identification practice, which makes sense given the strong association between suicide and substance use disorders (Espinet et al., 2019; Wilcox et al., 2004), particularly alcohol use disorders (Bagge et al., 2013; Caetano et al., 2013; Cherpitel et al., 2004; Lejoyeux et al., 2008; Powell et al., 2001; Richards et al., 2020b). However, we did not consider whether and how to measure engagement in care for alcohol and drug use disorders (NCQA, 2020), which could also be useful mechanism for improving suicide-related care (Richards et al., 2020a, 2020b) or addressing suicidal ideation and risky patterns of alcohol use *together* for purposes of suicide prevention (Kalk et al., 2019).

Last, health care systems participating in this evaluation provide both integrated, comprehensive health care and insurance coverage to a defined member/patient population. This enabled us to define a conceptual care continuum for patients at risk of suicide across care settings (e.g., primary care/mental health specialty, inpatient/outpatient), but this care continuum may not be generalizable to organizations without the same responsibility to provide comprehensive health care to a defined population of members/patients across care settings. Health care organizations may also not have embedded researchers to assist with monitoring ZS implementation progress. However, many organizations have stakeholders invested in suicide prevention (like the clinical, operational, and patient stakeholders who participate in the suicide prevention collaborative within our health care systems) who can utilize the products of this evaluation (e.g., practice descriptions, measurement tools) to inform their own quality improvement processes.

Conclusion

This novel evaluation used NPT in combination with data from key informants to improve our understanding of clinical practices supporting the ZS model and inform recommendations for implementation of high-quality care for patients at risk of suicide in health care systems nationwide. Specifically, NPT was applied to create a catalog and description of practices supporting the four key clinical functions of ZS and model how to measure specific practices. These schemas will be used to inform a large-scale evaluation of the effectiveness of different ZS practices (and combinations of practices) and provide a blueprint to support suicide prevention practice implementation across health care systems, service settings, and patient populations.

Declaration of conflicting interests

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Supplemental material

Supplemental material for this article is available online.

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CASE STUDY

Challenges of Population-based Measurement of Suicide Prevention Activities Across Multiple Health Systems

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Suicide is a preventable public health problem. Zero Suicide (ZS) is a suicide prevention framework currently being evaluated by Mental Health Research Network investigators embedded in six Health Care Systems Research Network (HCSRN) member health systems implementing ZS. This paper describes ongoing collaboration to develop population-based process improvement metrics for use in, and comparison across, these and other health systems. Robust process improvement metrics are sorely needed by the hundreds of health systems across the country preparing to implement their own best practices in suicide care. Here we articulate three examples of challenges in using health system data to assess suicide prevention activities, each in ascending order of complexity: 1) Mapping and reconciling different versions of suicide risk assessment instruments across health systems; 2) Deciding what should count as adequate suicide prevention follow-up care and how to count it in different health systems with different care processes; and 3) Trying to determine whether a safety planning discussion took place between a clinician and a patient, and if so, what actually happened. To develop broadly applicable metrics, we have advocated for standardization of care processes and their documentation, encouraged standardized screening tools and urged they be recorded as discrete electronic health record (EHR) variables, and engaged with our clinical partners and health system data architects to identify all relevant care processes and the ways they are recorded in the EHR so we are not systematically missing important data. Serving as embedded research partners in our local ZS implementation teams has facilitated this work.

Keywords: suicide prevention; health systems; electronic health record; population-based; zero suicide

Context

The age-adjusted suicide rate in the United States increased 28 percent between 1999 and 2016 when nearly 45,000 Americans died by suicide [1], a figure that is likely an underestimate given the high burden of proof on coroners and medical examiners to determine that suicide deaths are intentional [2]. Though it is a leading cause of death in the United States, suicide is a preventable public health problem [3].

In 2012, the National Action Alliance for Suicide Prevention (Action Alliance) and the U.S. Surgeon General published the National Strategy for Suicide Prevention (NSSP) [4]. A call to action, the NSSP outlines a comprehensive, long-term plan to address the heavy burden of suicide in the U.S. Among its top four priorities are the integration of suicide prevention into health care reform and the transformation of health care delivery systems to significantly reduce suicide morbidity and mortality. More recently, the Action Alliance issued recommended standard care guidelines for people with suicide risk [5]. These guidelines advance goals 8 and 9 of the NSSP: To promote suicide prevention as a core component of health care services (Objective 8) and to promote and implement effective clinical and professional practices for assessing and treating those identified as at-risk for suicidal behaviors (Objective 9) [4]. Health care settings are recognized as one of the most promising environments to implement suicide prevention practices. Indeed, among patients at least minimally engaged in health care, most make an outpatient visit in the year prior to their suicide death, almost half have a visit within a month of their death [6], and nearly all of those who make non-fatal suicide attempts have received at least some prior year outpatient care [7]. Each of these visits are opportunities for suicide prevention.

The NSSP promotes the adoption of "zero suicides" as an aspirational goal for health systems serving defined populations (Objective 8.1) [4]. One systems-level suicide prevention framework, Zero Suicide (ZS) [8], is currently being promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is widely implemented throughout the United States and internationally [9]. ZS is a flexible set of evidence-based interventions, recommendations, and strategies encompassing seven domains (lead, train, identify, engage, treat, transition, improve) that, collectively, are designed to mitigate suicide risks, enhance protective factors, and close gaps in health care that leave at-risk patients vulnerable. ZS implementation begins with strong leadership commitment to systemwide change that promotes suicide prevention as a core responsibility, followed by strategic planning, training, and practice changes. Specifically, resources available for implementation include a free and publicly available toolkit (www.zerosuicide.com), an active e-list with over 2000 members, a workforce survey, and an organizational self-study. Implementation strategies are meant to be tailored to each health system's unique population and local context. Therefore, ZS is not a one-size-fits-all, manualized intervention. Rather, it is a set of recommendations, best practices and customizable tools to improve the quality of suicide prevention efforts.

ZS promotes several evidence-based suicide prevention interventions developed in the past decade and is based on the Henry Ford Health System (HFHS) Perfect Depression Care program that resulted in a near 80 percent reduction in the suicide death rate among patients receiving behavioral health care [10–14], an impressive rate that was sustained for more than a decade [12, 13, 15]. Since then, other health systems implementing ZS have also measured and observed reductions in suicide mortality [16]. However, apart from these few systems, no large-scale evaluation of ZS has been conducted and therefore implementation endorsements are moving in advance of robust evidence to support the model. More rigorous study is needed to understand suicide outcomes within various health systems, service settings (e.g., primary care), and diverse patient populations. Further, it is unclear which specific ZS components, bundle of components, or process of care implementation strategies are most effective.

Case description

Currently, investigators within the Mental Health Research Network (MHRN) [17] are conducting an evaluation of the implementation of ZS across six health care systems serving more than nine million patients annually. The MHRN is able to accurately capture suicide attempt and death outcomes because each system has a defined patient population with comprehensive electronic health records (EHRs) and insurance claims data available to track health care use within and outside of each participating system. Data includes complete capture of injury or poisoning diagnoses from all care settings (ambulatory care, emergency department, and inpatient). The MHRN has also linked official government mortality records to health system records at each site to measure suicide death. This is unique as most health systems do not consistently link their populations to mortality data.

Because of their relationships to the health systems and their roles as embedded researchers, the MHRN investigators are also able to accurately identify and describe suicide care processes and measure quality improvements. The health systems participate together in a Zero Suicide national learning collaborative where they share approaches, decisions, and lessons learned as they design a unique implementation strategy for their individual systems. The systems are also working together with MHRN researchers to compare and evaluate specific components of ZS. Health system and clinical leaders with responsibility for ZS implementation and health system data analysts are partners in the research; the project aims to demonstrate a 'Learning Healthcare System for Suicide Prevention.'

Because each of the health systems are implementing different ZS components in different settings (e.g., behavioral health, primary care) at different times, certain sites will serve as 'intervention' sites for specific ZS components while others serve as 'controls' allowing a pragmatic interrupted time-series analysis of suicide outcomes that overcomes the costs and impracticalities of a randomized controlled trial. This kind of evaluation, using EHR data to measure ZS processes and outcomes across multiple diverse health systems implementing varied suicide prevention approaches within defined, large populations sufficiently powered to test suicide outcomes, could only be conducted within the HCSRN. One practical goal of this project is to develop EHR-based tools for implementation and evaluation that can be replicated in other health systems using EHR data.

This paper describes the work our team is doing to develop population-based suicide prevention metrics for use in, and comparison across, the health systems. While measuring suicide outcomes is important and comes with its own unique set of challenges [18, 19], here we discuss measuring process improvements. Robust process improvement metrics are necessary for the evaluation study but are also sorely needed by the hundreds of health systems across the country preparing to implement their own best practices in suicide care, as well as by other entities and organizations implementing ZS through funded federal awards from SAMHSA, the National Institute of Mental Health, the Indian Health Service and others. Developing generalizable EHR-based suicide prevention metrics is complicated. Here we articulate three examples of challenges in using health system data to assess suicide prevention activities, each in ascending order of difficulty. These challenges are not unique to this evaluation study, nor to suicide prevention research, and represent broader difficulties encountered when using EHR data to assess processes and outcomes across health systems, even among systems with enriched data resources such as those in the HCSRN.

Findings

Challenge 1: Mapping and reconciling different versions of suicide risk assessment instruments across health systems

ZS emphasizes the importance of using an evidence-based, scorable risk assessment tool. For the purposes of population risk management, ideally that tool would be easily be embedded in the EHR with discrete data fields, so the data can be easily identified and harvested for quality improvement monitoring. Most health systems participating in the ZS evaluation study use the Patient Health Questionnaire (PHQ-9) [20] item 9 to identify potential suicide risk and have been doing so, as standard care, within the EHR, for some time. The PHQ-9 is a discrete, standardized tool to screen for depression; it has a single suicide item (item 9) which is used clinically to determine which patients might require additional assessment of suicide risk [21]. While versions of the PHQ-9 have varied slightly across and within the participating health systems and over time, because of its long history of use in these systems for both care delivery and research, it is relatively easy to determine whether a PHQ-9 was collected. PHQ-9 scores (summary and item-level) are easily harvested from EHR data at most of these systems; the MHRN has used PHQ-9 data extensively in our suicide prevention research.

In contrast, the Columbia Suicide Severity Rating Scale (C-SSRS) [22], used to assess suicide ideation severity and intensity and suicide behavior, also a discrete, standardized tool, has only recently been made available in the EHR to all participating health systems. It has not been fully implemented in all systems or in a standardized manner across systems. For example, some systems plan to eventually use the C-SSRS exclusively in all departments throughout the health system while others are only using some of the items and only in certain settings (e.g., behavioral health department). Modes of C-SSRS administration have also varied (e.g., electronic and paper versions). In some systems scores have been recorded as discrete data fields but more frequently scores, or sometimes only a narrative summary, have been documented in progress notes. This variability increases the likelihood of undercounting important risk assessment efforts and creates much greater difficulty in operationalizing use of the C-SSRS for measuring suicide prevention. Ongoing work with the C-SSRS is focused on standardizing metrics and data collection across sites for use in quality improvement efforts and research.

Challenge 2: Deciding what should count as adequate suicide prevention follow-up care and how to count it in different health systems with different care processes

Despite the aforementioned challenges, suicide risk screening involves a relatively standardized care process, unlike follow-up care once risk is identified, which could include many different interventions at varying levels of care with distinct clinicians. Considerable effort has been made to coordinate staff, organize workflows, and bolster services that will address additional risk uncovered by more comprehensive risk screening. Many health systems have developed monitoring and outreach programs but the way those programs are organized and how patient contacts are documented varies widely across health systems, making measurement of risk mitigation exceedingly complicated. There is also the issue of whether health systems are implementing core ZS components with fidelity. Local adaptation is necessary as long as it does not compromise fidelity. Both measuring how ZS is implemented and what is being implemented are important quality improvement goals. One challenge for developing generalizable suicide prevention metrics is determining what efforts should be measured; a secondary challenge is determining how those efforts can be measured using EHR data across different systems.

Returning to the example of our systems' relative advantage of using easily retrievable PHQ-9 data, if a health system process improvement initiative is, for example, to administer the PHQ-9 at all mental health specialty visits for patients 13 and older, the measurement question is straightforward: "How often is a PHQ-9 recorded during these visits?" In systems with robust capture of well-organized PHQ-9 data this is an uncomplicated metric to produce. However, if a follow-up care process improvement initiative is to administer the C-SSRS for all mental health specialty patients scoring 2 or 3 on PHQ-9 item 9, and the measurement question is "How often is the C-SSRS recorded during these visits?" then it becomes necessary to identify all sources of C-SSRS scores (see above) and specify what counts as a qualifying C-SSRS. For example, if the clinician administers the C-SSRS but records the result in the narrative section of the progress note only, rather than in the C-SSRS flowsheet (where the data can be easily retrieved), will that C-SSRS score be captured and counted? Further, if the first C-SSRS item, "Have you wished you were dead or wished you could go to sleep and not wake up?" is not endorsed by the patient and no further questions are administered, does that C-SSRS administration still count?

As another example, if a process improvement initiative is to schedule a follow-up visit within two weeks for every patient scoring ≥3 on the C-SSRS, should any subsequent visit count? Does the visit need to be in-person or would video visits, phone encounters, or secure message exchanges also satisfy the requirement? Does the visit need to be with the same clinician? Should the visit be with a behavioral health clinician or would a visit with an accompanying diagnostic code in any department by any clinician count? Does there need to be some kind of documentation that suicide risk was acknowledged? If the intent of the visit is to follow up on the elevated suicide risk, should there be some standard for visits that do and do not count? And if so, what should that standard be? There is insufficient evidence to guide these decisions, but these are empirical questions that we can address in the ZS evaluation project. Once specifications of what counts are determined then the challenge is to operationalize the metrics across different health systems with varying capture and documentation of follow-up visits.

Challenge 3: Trying to determine whether a safety planning discussion took place between a clinician and a patient, and if so, what actually happened

Finally, many variables of interest represent clinical processes that are not discretely captured and easily retrievable in the EHR or claims data. For example, safety planning is a recommended engagement intervention in ZS. A safety plan recognizes that individuals may have chronic or intermittent suicidal thoughts and, as the name implies, the goal is to prepare for how to respond to those thoughts. Safety planning is intended to be a tangible process that is often recorded on paper by the patient in collaboration with the clinician. As such, it can be difficult to identify when safety planning has occurred because paper plans are not always documented in the EHR. Furthermore, unlike the PHQ-9 or the C-SSRS that have discrete response categories, safety plans are unique to each patient and the majority of safety plan components require an open, unstructured response format. Text is often embedded in clinical progress notes and rarely in a discrete, retrievable field. Therefore, apart from time-intensive manual chart review, it can be difficult to determine whether and how many specific safety plan components (e.g., identification of warning signs, internal coping strategies, distractions, supports) were completed.

To address some of these challenges, all of the participating health systems are working together to build standardized EHR-based safety planning tools. While the health systems have agreed to use a core set of safety planning components (in most cases modeled after the Stanley-Brown template [23]), each requires the ability to implement local adaptations, such as additional questions that their clinicians feel are important to include as well as local crisis resources. Further, it has proven difficult to create a single safety planning template that accounts for differing documentation norms and preferences across health systems. As a result, Kaiser Permanente is building a customizable set of national tools that can be linked to a common set of core safety planning variables. This approach will allow local adaptation of the safety plans such that unique additional site-specific components may be added to the standard components and local resources may be customized. Importantly, this approach allows front-end, clinician-facing safety plan presentations that accommodate documentation preferences within each health system to be yoked to back-end smart data elements (i.e., EHR data entities for capturing discrete values; can be linked to other EHR tools such as smart forms) that are common across the health systems. These common data elements then enable comparisons for research and evaluation. For example, the task of identifying warning signs can be displayed as a "doc flowsheet" in health system A, as a "smart form" in health system B, or as a "smart phrase" in health system C. Each of these different displays is linked to a single smart data element that can easily be identified by quality improvement teams or researchers. To evaluate the impact of safety planning on suicide outcomes in our ZS evaluation project, safety planning exposures (in general and specific components) will be measured using these smart data elements. We will create a binary variable to indicate that a safety plan was invoked during a patient encounter.

The scope of the evaluation project does not include examining the quality of safety plans to better understand what actually happened in the safety planning exchange between the clinician and the patient. However, a subset of a few sites participating in the larger project have received supplemental funding to develop an advanced method using natural language processing (NLP) to determine when lethal means assessment and safety planning have been documented in the narrative, open-text sections of progress notes in the chart or in the electronic safety plan templates linked to smart data elements. Simple programs can give an indication of quality such as whether all sections of the safety plan were completed, whether phone numbers and crisis contacts were provided, or whether a minimum of three coping skills were documented. More advanced methods using NLP could include more sensitive content evaluation such as: whether there was inclusion of proper names of informal contacts, references to feelings or behaviors documented in the warning signs, and whether a plan for lethal means removal was documented when appropriate.

Major Themes

This paper details the challenges of conducting a large-scale, multi-site suicide prevention evaluation and creating generalizable suicide prevention metrics using health system data. Specifically, we highlight the early experiences of our health systems as they have adopted ZS, demonstrated by three progressively more difficult challenges in measuring process improvements. First, mapping and reconciling suicide risk assessments involves a relatively standard care process (PHQ-9 or C-SSRS) that's usually recorded as discrete data elements (responses to specific PHQ-9 or C-SSRS questions). There is some variability in PHQ-9 or C-SSRS versions across systems, but the number of variations is finite and relatively small. Then assessing adequate outreach and follow-up involves much more variable care processes (many routes for and types of outreach contacts) and more variability in how contacts are recorded. The number of variations is finite, but much larger. Finally, assessing adequacy of safety plans involves an infinitely variable care process (a highly variable interaction between two human beings) that can be recorded in an infinite number of ways (mostly in free text). This is the most challenging problem to overcome.

To address each of these problems, our team has followed a similar approach. Whenever possible, when we have been engaged early in the cycle of care improvement, we have recommended that health system leaders standardize care processes and their documentation. We have advocated for using standardized screening tools and encouraged that measures be recorded in the EHR (e.g., through use of templates) or be universally retrievable (e.g., through use of smart data elements). Serving as embedded researchers in our local ZS implementation teams and in the multi-system ZS learning collaborative has facilitated this partnership. When care improvement processes have been in place and we could not influence their design, we have engaged first with our clinical partners to identify all the relevant care processes and then with our health system data architects to identify the ways those processes are recorded in the EHR so we are not systematically missing important data.

Conclusions

The challenges described herein are generalizable beyond suicide prevention work. The challenge of aligning process and outcome measures for comparison across health systems with differing source data is longstanding and universal. The challenge of deciding what should count as adequate and appropriate follow-up care has beset national quality improvement measures when well-intended metrics fail to specify qualifying services or do so in ways that exclude important care processes or include extraneous and irrelevant visits. The challenge of assessing safety planning is similar to the challenge of using EHR records to assess whether shared decision-making about treatment alternatives actually happened—where the presence of an indicator of shared decision-making is probably insufficient to conclude that meaningful patient engagement actually occurred. These are problems that deserve attention. In the context of this pragmatic evaluation, we resolve to address these issues as we seek to create generalizable process improvement metrics for broad use.

Competing Interests

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Connecting Research and Practice: Implementation of Suicide Prevention Strategies in Learning Health Care Systems

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The health care systems affiliated with the Mental Health Research Network strive to be learning health care systems that identify and address evidence gaps of importance to clinicians, patients, and funders. This column describes how research guides clinical care and clinical care guides research in the area of suicide prevention as well as some of the challenges of conducting embedded research.

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The transformation of health care systems into learning health care systems—where science, informatics, incentives, and culture align for continuous improvement—could improve clinical care and decrease delays in implementing best practices. However, it can be challenging to ensure a learning health care system's necessary elements: a well-developed infrastructure to organize and analyze health records data, a culture of shared responsibility, and an organizational philosophy promoting bidirectional learning between health care practice and research. Nonetheless, strengthening research-practice partnerships to accelerate the adoption, implementation, and improvement of evidence-based mental health care is a priority for federal funding agencies and health care organizations. This column discusses the benefits and challenges of establishing and maintaining engaged clinical partnerships in the area of suicide prevention.

Building Partnerships

We previously described an evolving model of a learning health care system in the Mental Health Research Network (MHRN) (mhresearchnetwork.org) (1), a network of 14 research institutes embedded in health care organizations across the United States. National Institute of Mental Health (NIMH) funding supports infrastructure work, including establishment and maintenance of a virtual data warehouse at each site as well as pilot and signature projects.

MHRN-affiliated health care systems care for and insure 25 million patients across 16 states, with embedded mental health researchers who conduct federally funded research and maintain relationships with health care system leaders and clinicians at each site. This engagement varies and includes researchers attending leader and departmental meetings to learn of system priorities and disseminate research findings, engaging with or working as frontline clinicians, and serving on or acting as advisors to health care system committees. Challenges to building and maintaining these partnerships include competing organizational priorities, limited leadership and clinician bandwidth, and the perception of research as being too slow to meet the demands of pressing clinical decisions (with leaders often required to make decisions in weeks, not years). Researchers have addressed these challenges by scheduling quarterly meetings with leaders,

HIGHLIGHTS

- Achieving learning health care systems requires partnerships and shared priorities between health care leaders, clinicians, and researchers.
- This column describes the development of a learning health care system in the area of suicide prevention and research methods and clinical strategies used in this effort.

supporting organizational priorities, identifying and leveraging overlap between the funding agency and organizational priorities, serving as interpreters of external evidence and generators of internal evidence, and designing pragmatic trials that can quickly adapt as needed.

The Patient Health Questionnaire–9 (PHQ-9) and Suicide Risk

MHRN health care systems were early adopters of the PHQ-9 to screen for and monitor depression and suicide risk. Responses to item 9 in the PHQ-9 data revealed that approximately 6% of respondents reported thoughts of suicide more than half the days in the previous 2 weeks, with 0.5% attempting suicide in the next 30 days and 3% within 2 years (2). These findings led to four streams of clinical or research activities in our health care systems: use of the Columbia Suicide Severity Risk Scale (CSSRS), implementation of the Suicide Prevention Trial (SPOT), evaluation of Zero Suicide implementation, and use of machine learning to improve suicide risk prediction.

Use of the CSSRS to Assess Suicide Risk

Despite evidence that elevated scores on item 9 of the PHQ-9 were reasonably good at identifying people at increased risk of suicide, there is no evidence that suicide screening by itself prevents suicide attempts or deaths. Despite this evidence gap, health system leaders felt compelled to act and implemented workflows for patients reporting suicidal ideation. In many systems, these workflows led to systematic use of the CSSRS for patients with elevated scores on PHQ-9 item 9. Implementation varies across health care systems, but most prompt completion of the CSSRS in the electronic health record (EHR), followed by actions such as further clinical assessment of risk or protective factors, lethal means counseling, and/or completion of EHR-based suicide safety plans. The clinical use of the CSSRS in MHRN health care systems provides an opportunity to study whether clinicians use the CSSRS, whether its use prompts subsequent clinical actions, and whether these actions influence suicide attempts.

Researchers and health system leaders also sought to understand the limitations of self-reported measures, such as the PHQ-9 and CSSRS, and how to improve these measures. In one health system, researchers conducted semistructured qualitative interviews with suicide attempt survivors (3) and primary care patients (4), who described the value of being asked about suicidality but also how disclosing suicidal thoughts often involved weighing hope for help against fears of negative consequences associated with stigma and loss of autonomy. This research confirmed and extended research among veterans who reported similar fears and underscored the importance of direct and caring communication about suicidality and relationships with trusted providers (5). Recognizing these limitations, MHRN investigators are collaborating with health system leaders to improve screening and assessment practices and are developing and evaluating alternative methods to identify risk using medical records data, discussed below.

SPOT

To generate evidence to guide large-scale secondary interventions for populations at risk of suicide, we conducted a pragmatic trial enrolling 18,882 patients (67.3% [N=12,701] women, 0.8% [N=158] American Indian or Alaskan Native, 3.1% [N=579] Asian, 0.4% [N=82] Native Hawaiian/Pacific Islander, 4.2% [N=797] Black or African American, 77.1% [N=14,558] White, 8.3% [N=1,563] Hispanic, 3.4% [N=640] more than one race, 11.0% [N=2,068] unknown or not reported) from March 2015 through September 2018 across four health care systems (6). Patients who reported suicidal ideation on the PHQ-9 were randomly assigned to receive ongoing usual care or one of two interventions: an online dialectical behavioral therapy skills training program supported by a health coach or a phone-based care management intervention designed to keep patients connected with their behavioral health clinicians. Of note, SPOT care managers used the CSSRS to assess suicide risk and to inform risk-based care pathways, which will ultimately contribute information about whether the CSSRS may be useful for suicide prediction and prevention. The primary outcome was suicide attempt, assessed via EHR and state mortality data. Importantly, patient and clinician stakeholders were engaged in the design and implementation of this study, and health care leaders helped design the intervention to minimize disruption of clinical workflows, maximizing sustainability should either intervention be found effective. Study results are expected in 2021.

Evaluation of Zero Suicide Implementation

In response to MHRN findings, health care systems began implementing a series of suicide prevention and intervention approaches as part of large-scale Zero Suicide initiatives (http://zerosuicide.edc.org). The Henry Ford Health System began this work in 2001, whereas Kaiser Permanente began evaluating varying models of Zero Suicide implementation across five regional health care systems in 2016 (7). Systems chose from a range of evidence-based interventions, including screening and assessment, safety planning, engagement in care, care management, caring contacts, follow-up after hospital or emergency discharge, means reduction, and intensive suicide risk treatment. A NIMH-funded grant has supported evaluation of the model at each system by using the normalization process theory framework. Researchers partner with leaders and clinicians to document the implemented interventions, develop metrics aligned with each approach, facilitate a learning collaborative across sites, and support ongoing improvement efforts.

Use of Machine Learning to Improve Suicide Risk Prediction

Although PHQ-9 item 9 data were reasonably good at identifying patients at increased suicide risk, we adopted machine-learning methods to develop potentially more accurate suicide risk prediction models. Models use data from nearly 20 million visits from 2.96 million patients (58.3% [N=1,727,335] women, 0.9% [N=26,139] American Indian or Alaskan Native, 7.1% [N=209,094] Asian, 1.6% [N=47,113] Native Hawaiian/Pacific Islander, 8.3% [N=247,083] Black or African American, 59.0% [N=1,748,406] White, 25.5% [N=754,585] Hispanic, 0.8% [N=23,039] more than one race, 22.3% [N=659,993] unknown or not reported) to better consolidate multiple factors for suicide risk than use of the PHQ-9 alone (8). This method could allow health care systems to provide more intensive interventions for those at highest risk while opting for less intensive interventions for patients at lower risk. Importantly, and in contrast with results from PHQ-9 item 9, health care systems have the ability to set these risk thresholds to match available interventions and resources. Our models and others have a global classification accuracy of ≥80%, but given relatively low baseline rates of suicide attempts, positive predictive values (PPVs) are low, often below 0.01 (9). However, models with similar PPVs are widely used in other clinical areas. For example, many guidelines recommend statins for people with at least 10% risk of a cardiovascular event in the next 10 years. Similarly, using suicide risk models, we can accurately identify individuals with a 5% risk of a suicide attempt in the next 90 days. Essentially, the threshold for acceptability of a PPV depends on the balance of risks and harms with the indicated subsequent clinical actions. Most clinicians would agree that the risk of starting a statin is low and a reasonable secondary prevention strategy; the equivalent strategy for elevated suicide risk is not yet known but represents an opportunity for future research within this learning health system.

Next Steps: Using Suicide Risk Models to Address Suicide Risk

Researchers have been working with care delivery leaders to adopt suicide risk models for clinical use. At Kaiser Permanente Northern California, suicide risk models have been embedded in the EHR and run in the background (without display to clinicians), demonstrating similar model performance in this diverse external validation cohort. Researchers are now working with clinical leaders to determine an appropriate risk alert threshold and suitable workflows (10). At HealthPartners in Minnesota, suicide risk models are integrated with the EHR to produce weekly reports of members with serious mental illness or increased risk of hospitalization who are also at elevated risk for suicide. This approach prompts behavioral health case managers to complete CSSRS assessments and evaluate the need for more intensive interventions. Behavioral health clinicians at one outpatient clinic at Kaiser Permanente Washington are piloting use of a column in clinicians' EHR calendars flagging patients with elevated suicide risk; clinicians are encouraged to have flagged patients complete the CSSRS.

Discussions between researchers and clinicians about these implementation strategies have led to shared recognition of the importance of research to understand how patients and clinicians interpret these risk models, how they experience conversations about suicide risk and prevention, and what clinical capacity is needed to respond to at-risk patients to inform future implementation strategies. A qualitative study at three health care systems uses the Consolidated Framework for Implementation Research to interview administrators, clinicians, case managers, patients, and insurance members to assess these needs. Interviews are conducted at different stages of preimplementation and implementation as an important step in improving patient-centered care and soliciting stakeholder perspectives about the appropriate uses and limitations of predictive modeling. Understanding the implementation context at various levels across organizations will inform future implementation strategies in other clinical settings.

Conclusions: Value of Ongoing Partnerships

A learning health care system where care informs research and research informs care hinges on ongoing relationships and shared priorities between health care system leaders, frontline clinicians, and researchers. These partnerships are built on trust that has evolved over many years of collaboration, shared common interests and goals, and frank conversations. To forge successful partnerships, in some cases researchers hear clinical concerns that are translatable to fundable research ideas. In other cases, researchers learn of research priorities that are translatable to care system priorities. Over time, researchers have become more embedded in clinical operations, and clinical leaders have become embedded members of the research teams. Bidirectional communication and collaboration between research and clinical staff require efforts on both sides to keep these partnerships viable and valuable to both groups.

As described in this column, successful learning health care systems do not undertake just one kind of research. A variety of research methods have been utilized, including observational studies, pragmatic clinical trials, implementation, machine learning, and qualitative research. This broad array of approaches allows researchers flexibility to tailor approaches to specific research or clinical questions, making use of existing data sources when possible and fitting into clinical workflows as necessary. Researchers need all of these tools to function effectively in learning health care systems and to better understand implementation issues across cultures, diverse patient populations, and varied clinical contexts.

The goals of health care systems and researchers are the same: to improve the care, outcomes, and experiences of patients. Conducting embedded research in a learning health care system not only provides opportunities to improve patient care more quickly than with traditional research models but also requires researchers to be flexible and adept at designing pragmatic research that minimizes clinical disruptions. Aligning health-care-system, funder, and research priorities is key to success.

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Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses

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Background

The Zero Suicide framework is a system-wide approach to prevent suicides in health services. It has been implemented worldwide but has a poor evidence-base of effectiveness.

Aims

To evaluate the effectiveness of the Zero Suicide framework, implemented in a clinical suicide prevention pathway (SPP) by a large public mental health service in Australia, in reducing repeated suicide attempts after an index attempt.

Method

A total of 604 persons with 737 suicide attempt presentations were identified between 1 July and 31 December 2017. Relative risk for a subsequent suicide attempt within various time periods was calculated using cross-sectional analysis. Subsequently, a 10-year suicide attempt history (2009–2018) for the cohort was used in time-to-recurrent-event analyses.

Results

Placement on the SPP reduced risk for a repeated suicide attempt within 7 days (RR = 0.29; 95% CI 0.11–0.75), 14 days (RR = 0.38; 95% CI 0.18–0.78), 30 days (RR = 0.55; 95% CI 0.33–0.94) and 90 days (RR = 0.62; 95% CI 0.41–0.95). Time-to-recurrent event analysis showed that SPP placement extended time to re-presentation (HR = 0.65; 95% CI 0.57–0.67). A diagnosis of personality disorder (HR = 2.70; 95% CI 2.03–3.58), previous suicide attempt (HR = 1.78; 95% CI 1.46–2.17) and Indigenous status (HR = 1.46; 95% CI 0.98–2.25) increased the hazard for re-presentation, whereas older age decreased it (HR = 0.92; 95% CI 0.86–0.98). The effect of the SPP was similar across all groups, reducing the risk of re-presentation to about 65% of that seen in those not placed on the SPP.

Conclusions

This paper demonstrates a reduction in repeated suicide attempts after an index attempt and a longer time to a subsequent attempt for those receiving multilevel care based on the Zero Suicide framework.

Keywords

Suicide prevention; Zero Suicide framework; suicide attempt; time to event analysis; brief interventions.

The Zero Suicide framework in healthcare is a system-wide approach to care after a suicide attempt with the goal that no suicides should occur when a person is in contact with the health service.[1] It is predicated on seven elements: lead, train, identify, engage, treat, transition and improve. These elements of clinical care rely on systematic protocols that should involve ongoing risk screening and assessment, collaborative safety planning, access to evidence-based suicide-specific care, focus on lethal means reduction, consistent engagement efforts and support during high-risk periods.[2] The Zero Suicide framework has seen a rapid adoption, having been implemented in over 200 healthcare and behavioural health organisations worldwide by 2016.[3] The Zero Suicide framework was substantially influenced by the Perfect Depression Care initiative,[4] of the Henry Ford Health System in Michigan, USA, which was shown to reduce the rate of deaths by suicide by 75% in the first 4 years of implementation.[5–7] More recently, Centerstone in Tennessee reported a 65% reduction in the rate of deaths by suicide among patients treated for a variety of psychiatric conditions after implementing the Zero Suicide framework.[3] However, initial evaluations have drawn criticism, owing to their observational nature, concerns about overstated outcomes and caution being expressed in comparing the Zero Suicide framework with the Perfect Depression Care model.[6,8] Despite the widespread rollout of Zero Suicide framework, there remains a lack of robust evidence for its effectiveness published internationally[1,6] and we are not aware of any such research from Australia.

Implementation of the Zero Suicide framework at Gold Coast Mental Health and Specialist Services, Queensland, Australia

Although the Zero Suicide framework provides an overarching framework, it does not prescribe in detail the clinical components to be implemented. At Gold Coast Mental Health and Specialist Services (GCMHSS), a clinical suicide prevention pathway (SPP) based on Zero Suicide framework was rolled out in December 2016. Table 1 illustrates the tools and interventions comprising the SPP; they are listed in the order of their use following an individual's presentation to the hospital.

A concerted focus on training all GCMHSS clinical staff in the delivery of individual components of the SPP and developing attitudes, beliefs, confidence and skills in accord with the Zero Suicide framework, alongside a strong focus on cultural change and incorporation of Restorative Just Culture principles,[9] contributed to the rapid adoption of the new practices across GCMHSS.[10]

Reports on the Zero Suicide framework's efficacy have frequently focused on deaths by suicide. However, this metric has limitations as suicide deaths are relatively rare, making it challenging to ascribe statistical significance to clinically important associations or to build models that adequately consider possible confounders. Considering that a suicide attempt is one of the greatest risk factors for suicide completion[11] and that people with a suicide attempt share substantial clinical similarities with those who die by suicide,[12] re-presentation with a suicide attempt

Table 1 Suicide prevention pathway (SPP) elements based on the Zero Suicide framework implemented at the Gold Coast Mental Health and Specialist Services

Suicide prevention pathway element	Assessment tool/Treatment	Additional details
Screening and engagement	Mental health assessment after presentation with suicidal ideation or after suicide attempt	A screening triage tool (UK Mental Health Triage Scale)[13] was implemented and embedded in the electronic medical record
Assessment	Chronological assessment of suicide events (CASE) approach	CASE is an interviewing strategy for eliciting suicidal ideation, planning, behaviour, desire and intent. It uses a range of validity techniques (e.g. normalisation, shame attenuation, gentle assumption) that help clinicians explore content that is sensitive or taboo for the patient[14]
Risk formulation	Prevention-oriented risk formulation	The formulation provides a synthesis of information gathered in a comprehensive assessment based on contextually anchored risk relative to specified subgroups (risk status) and relative to the individual's own baseline (risk state). The formulation also assesses available internal and external resources, and foreseeable changes that might lead to a change in risk[15]
Brief interventions	Safety planning intervention (SPI)[16]	The SPI, based on work by Stanley & Brown,[17] was developed for inclusion in the SPP. It includes individualised warning signs, internal coping strategies, social contacts to distract from suicidal thoughts, social and professional supports to assist with resolving suicidal crises, and strategies to restrict access to lethal means of suicide
	Counselling on access to lethal means	This counselling is contained within the SPI
	patient and carer education	A patient brochure and a family/carer brochure developed in conjunction with people with lived experience in the service are given to individuals on the SPP
Follow-up	Rapid referral	Face-to-face appointment is scheduled for patients on the SPP within 48 h of discharge from emergency department or in-patient care. This is typically performed by the clinical staff in the GCMHSS acute care team or child and youth mental health service
	Structured follow-up	Includes regular assessment of suicidality; review and revision of the safety plan; creation or updating of a care plan; and ongoing communication with family/carers and other health professionals. The number of follow-up appointments depends on the circumstances and needs of the individual and follow-ups are typically performed by the clinical staff in the GCMHSS acute care team or child and youth mental health service
Transition of care	Warm handover	A 'warm handover' means that the patient should have had their first appointment with the next provider prior to closure from GCMHSS
	Support and transition services	Transition to follow-up care in the community is supported through the collaborative development of a treatment plan and identification of any barriers to treatment

provides an alternative outcome measure for suicide intervention studies.[18,19]

The aim of this paper is to report on the efficacy of the SPP with respect to reducing re-presentations with a suicide attempt following an initial attempt. As certain subgroups have an elevated risk of repeated suicide attempts, for example those with previous attempts[20] or those diagnosed with borderline personality disorder,[21,22] the efficacy of the SPP with respect to these high-risk subgroups will be specifically explored.

A novel aspect to this work is that we embrace the fact that an individual may present with a suicide attempt multiple times. Traditional approaches limit analysis to the first subsequent event and either its occurrence within a certain time frame (relative risks or logistic regression models) or the time to that first subsequent event (e.g. Cox proportional hazards analysis). Limiting analysis to the first recurrent suicide attempt ignores both a considerable amount of information and the clinical nature of the attempt. However, recurrent events are by definition correlated, which violates the independence assumption required by traditional methods. A number of different statistical models have been developed for analysis of multiple event data. As this is a relatively new area of statistical analysis, there is no consensus on which may be the most appropriate for a given situation. In this paper, we present the results of six different models that we considered, *a priori*, to be suitable for analysis of suicide attempt events and use the consistency of their results to infer an appropriate model to predict suicide attempt recurrence. Although there is literature reporting time-to-event analyses with regard to first subsequent suicidal presentation or suicide,[23,24] such studies are relatively uncommon, and we are unaware of other studies using time-to-recurrent-event analysis with respect to suicide attempts. However, the approach is highly relevant to suicide attempts in the evaluation of interventions that aim to delay time to re-presentation. Although novel with respect to analysis of repeated suicide attempts, time-to-recurrent-event analysis has been used in other areas of mental health research, such as self-harm.[25]

Method

Context of the project

The Gold Coast Hospital and Health Service (GCHHS) is government-funded and serves approximately 560 000 people on the Gold Coast, Queensland, Australia. The GCHHS has two emergency departments and these are the most common access points for persons presenting with suicidal thoughts or behaviours. Gold Coast Mental Health and Specialist Services (GCMHSS) within GCHHS adopted the Zero Suicide framework in 2015.

Design

This project employs two designs, an initial observational cross-sectional design and a subsequent historical cohort design. In both cases re-presentation with a suicide attempt after a previous suicide attempt is the primary outcome.

Identification of suicide attempts

Presentations following a suicide attempt between 1 July and 31 December 2017 to GCHHS emergency departments were identified from the Emergency Department Information System (EDIS). A machine learning tool 'Searching EDIS for Records of Suicidal Presentations' (SERoSP)[26] identified a total of 3417 suicidal and self-harm presentations. A team of trained research officers then reviewed the associated medical records contained in the Consumer Integrated Mental Health Application (CIMHA) and electronic medical record (eMR) to confirm suicide attempts. Cases were coded as a suicide attempt if they contained evidence of self-harming behaviour with intent to die, following literature-based definitions[27] and the World Health Organization manual on surveillance and monitoring of suicide attempts and self-harm.[28] This yielded 737 presentations with a suicide attempt, relating to 604 persons. An initial cross-sectional analysis investigated the relationship between being placed on the SPP and subsequent re-presentation with a suicide attempt within certain time frames.

For each of the 604 persons who presented with a suicide attempt between 1 July and 31 December 2017, all previous suicide attempt presentations since 1 January 2009 and subsequent suicide attempt presentations until 31 December 2018 were identified, providing a 10-year longitudinal history of suicide attempts for this cohort and including a total of 1534 suicide attempt presentations. This historical cohort data was used in a time-to-recurrent-event analysis. Analyses were based on presentations, rather than on individuals, as placement on the SPP related to a presentation rather than an individual and individuals may have presented with more than one suicide attempt within the observed time period.

Variables

For every suicide attempt event, it was recorded whether the person was placed on the SPP or not. Not all persons presenting to GCMHSS after a suicide attempt engaged with the SPP; reasons for not engaging typically included the individual declining follow-up care, residing outside the geographical catchment area or receiving follow-up from a different health service or private healthcare providers. In some cases, clinicians decide not to commence the SPP, for example owing to lack of familiarity with the protocol and confidence in the early phase of implementation, time pressures in the emergency department and clinical judgement about the likely benefits of placing someone on the SPP. Patients not commenced on the SPP after presentation with a suicide attempt may still receive certain components of the SPP and follow-up care (e.g. risk formulation, safety planning and telephone follow-up on discharge) but not the structured face-to-face follow-up that is mandated in the SPP.

Patients are typically placed on the SPP following the initial assessment by a mental health clinician in the emergency department or, when receiving in-patient care, during their admission. The date of discharge – either from emergency department or in-patient care – was considered as the starting point in the analysis of subsequent re-presentations with a suicide attempt within 7, 14, 30 or 90 days. The date of discharge was also considered when measuring the length of placement on the SPP for in-patients. On average, individuals were placed on the SPP for 15.6 days, with no significant difference in this duration between those admitted to in-patient care and those discharged following their emergency department presentation (Gold Coast Mental Health and Specialist Services, unpublished data. Note that due to strict confidentiality of this material we can not release any further details, apart from data vetted by our Ethics Committee and disseminated in peer-review publications.)

For each individual on the SPP, patient identification number, date and time of presentation, age, gender (male/female), Indigenous status (yes/no), triage notes, method of suicide attempt, destination after presentation to the emergency department (admitted to hospital for at least 24 h/discharged), and primary and secondary diagnoses according to the ICD-10-AM,[29] were extracted from EDIS. Additionally, ICD diagnostic codes (F60–F69 'Disorders of adult personality and behaviour', recorded as a primary or secondary diagnosis) at any engagement with GCMHSS were used to identify persons with personality disorders.

Statistical analysis

Descriptive statistics were used for demographic and clinical data of the person associated with each presentation. Comparisons were made between the characteristics of presentations that led to the person being placed, or not placed, on the SPP. The chi-squared (χ^2) test, Fisher's exact test or *t*-test were used as appropriate. Re-presentation proportions within 7, 14, 30 and 90 days were compared between initial presentations associated with being placed on the SPP or not. Relative risks and their 95% confidence intervals were calculated. All analyses were performed using Microsoft Excel and Stata 15 for Windows.

Time-to-recurrent-event analyses

Time-to-recurrent-event analyses were conducted in which suicide attempt was modelled as a recurrent event for all suicide attempt presentations from 1 January 2009 to 31 December 2018, associated with the 604 persons who presented with a suicide attempt between 1 July 2017 and 31 December 2017.

As there is no consensus on the most appropriate method for modelling recurrent events,[30–32] six models were used: (a) the Anderson–Gill counting process (AG–CP); (b) Prentice–Williams–Petersen total time (PWP–TT); (c) Prentice–Williams–Petersen gap time (PWP–GT); (d) Weibull gamma shared frailty (shared frailty); (e) multilevel mixed effects parametric (mixed effects); and (6) Cox proportional hazards shared frailty (Cox shared frailty). Details of these models and the rationale for using a variety of models are provided in the supplementary material, available at https://doi.org/10.1192/bjp.2020.190.

The predictor variable of primary interest was the person being placed on the SPP (SPP, no = 0, yes = 1). Other variables considered were gender (female = 0, male = 1), age (decades), a diagnosis of personality disorder (personality disorder, no = 0, yes = 1), Indigenous status, defined as identifying as Aboriginal and/or Torres Strait Islander (Indigenous, no = 0, yes = 1), the number of previous suicide attempts (*n*), method of suicide attempt (overdose = 1, other = 0), admitted to hospital (no = 0, yes = 1) and year the suicide attempt occurred (year). As a small number of persons was known to re-present many times, it was considered that this might unduly skew effect estimates of predictors in favour of the attributes of the overrepresented individuals. To test this possibility, models were run using the full data-set and then truncated at various suicide attempt presentation frequencies based on the relative contribution of events by individuals. A truncation point of 5 offered the most robust modelling of the effects of frequently re-presenting individuals while still demonstrating all factors significantly predicting time to re-presentation observed at other truncation points. This truncation point is consistent with others reported in similar time-to-recurrent-event analyses.[32]

Graphs of predicted hazards against time to re-presentation were plotted for specific values of variables associated with significant hazard ratios. The hazard is the instantaneous probability that a suicide attempt event occurs at a particular time, given that a suicide attempt has not already occurred to that time.[33] The hazard ratio (HR) is the ratio of the hazard under one condition as compared with an alternative, e.g. being on the SPP versus not being on the SPP.

For each model type, each possible covariate was added to a model containing SPP status. Those with $P \leq 0.10$ were included in all possible combinations and retained in the final model if consistently $P < 0.05$. Plausible interactions were tested (SPP × personality disorder, SPP × Indigenous status, SPP × order (whether it was a person's first or subsequent suicide attempt) and SPP × age) and retained in the model if $P < 0.05$. Where a covariate was shown to be significant in one of the model types, it was included in all for comparison purposes. Regression diagnostics including calculation of variance inflation factors to test for collinearity were undertaken. Where appropriate, the proportional hazards assumption was checked for all covariates using Schoenfeld residuals.

Ethics and consent

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The project was recognised as a quality activity by the Gold Coast Hospital and Health Service Human Research Ethics Committee (HREC) on 10 October 2018 (reference LNR/2018/QGC/47473) and did not require consent from patients.

Results

Population description

There were 737 suicide attempt presentations between July and December 2017. Demographic and clinical characteristics of patients associated with each presentation were similar between those who were placed on the SPP and those who were not (Table 2). The exceptions were persons presenting having a diagnosis of a personality disorder and having had a previous suicide attempt. People with personality disorder were far less likely ($P = 1.5 \times 10^{-8}$) to be associated with subsequent placement on the SPP than those who did not have such a diagnosis, and people with a first suicide attempt were more likely to be placed on the SPP ($P = 0.01$).

Re-presentations with a suicide attempt: cross-sectional analysis

Persons who had a suicide attempt presentation between 1 July and 31 December 2017 were followed for 90 days; re-presentation rates within 7, 14, 30 and 90 days for persons placed on the SPP and those who were not are shown in Fig. 1. Of 444 presentations in which the person had not been placed on the SPP, 37, 50, 67 and 102 re-presented within 7, 14, 30 and 90 days respectively. Of 293 presentations in which the person had been placed on the SPP, 5, 10, 25 and 42 re-presented within 7, 14, 30 and 90 days, respectively. The relative risks of re-presentation when placed on the SPP compared with not being on the SPP were the following: within 7 days, RR = 0.29 (95% CI 0.11–0.75), $P = 0.007$; 14 days, RR = 0.38 (95% CI 0.18–0.78), $P = 0.006$; 30 days, RR = 0.55 (95% CI 0.33–0.94), $P = 0.028$; and 90 days, RR = 0.62 (95% CI 0.41–0.95), $P = 0.027$.

Time-to-recurrent-event analysis

Time-to-event analysis was conducted on 1534 suicide attempt presentations, from 1 January 2009 to the censor date of 31 December 2018. These presentations constituted a history of up to 10 years for each of the originally identified 604 persons. Results of this analysis are shown in Table 3 and Fig. 2.

The number of suicide attempt presentations for an individual was found to be a significant time-to-event predictor across each model. Specifically, the first suicide attempt was associated with a lower hazard for re-presentation, whereas all subsequent presentations were each associated with higher hazards of similar values. Consequently, the 'order' variable was dichotomised to represent either the first (1) or a subsequent (2) suicide attempt event and renamed '>1st attempt'.

In addition to the SPP, four covariates (personality disorder; >1st attempt; age; and Indigenous status) were shown to significantly influence time to re-presentation with a suicide attempt. Placement on the SPP was associated with an HR < 1.0, meaning that it reduced the probability of a repeated suicide attempt after the initial attempt to approximately 65% of that of a person not on the SPP (the range was HR = 0.568–0.675, depending on the model). Conversely, being diagnosed with a personality disorder was associated with an increased hazard for a repeated suicide attempt presentation (by up to 2.7 times) compared with a person not diagnosed with personality disorder. Having had a preceding suicide attempt in the observation period

Table 2 Description of presentations with suicide attempts July–December 2017, by placement on the suicide prevention pathway

	On suicide prevention pathway (*n* = 293)	Not on suicide prevention pathway (*n* = 444)	P^a
Demographic variables			
Gender, *n* (%)			
Female	189 (64.5)	283 (63.7)	
Male	104 (35.5)	161 (36.3)	0.83
Age, years: mean (s.d.)	32.0 (15.8)	34.2 (16.1)	0.08
Indigenous status, *n* (%)			
Aboriginal and/or Torres Strait Islander	15 (5.1)	36 (8.1)	
Not Indigenous	278 (94.9)	408 (91.9)	0.12
Clinical variables, *n* (%)			
Personality disorder			
Yes	14 (4.8)	86 (19.4)	
No	279 (95.2)	358 (80.6)	1.5×10^{-8}
>1st suicide attempt, *n* (%)			
Yes	109 (37.2)	205 (46.2)	0.01
No	184 (62.8)	239 (53.8)	
Method, *n* (%)			
Overdose	180 (73.8)	276 (73.0)	
Other	64 (26.2)	102 (27.0)	0.84
Admitted to hospital, *n* (%)			
Yes	88 (30.0)	149 (33.6)	
No	205 (70.0)	295 (66.4)	0.32

a. *P*-values were derived from χ^2-tests or *t*-tests, as appropriate.

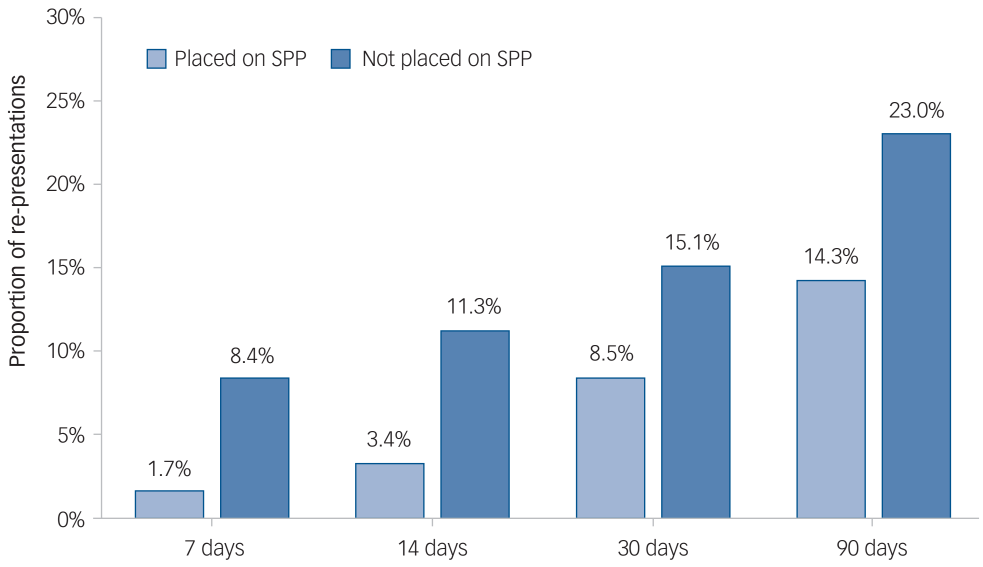

Fig. 1 Re-presentations with a suicide attempt at 7, 14, 30 and 90 days, by placement on the suicide prevention pathway (SPP).

Table 3 Hazard ratio estimates for each time-to-event model[a] considered

Model	Predictor	HR	Lower 95% CI	Upper 95% CI	*P*
AG-CP					
	SPP	0.643	0.511	0.809	1.63×10^{-04}
	>1st attempt	2.021	1.688	2.420	1.87×10^{-14}
	Age, decades	0.940	0.879	1.005	7.19×10^{-02}
	Personality disorder	2.056	1.595	2.649	2.55×10^{-08}
	Indigenous	1.565	1.150	2.131	4.37×10^{-03}
PWP-TT					
	SPP	0.675	0.534	0.852	9.67×10^{-04}
	>1st attempt	1.000			
	Age, decades	0.951	0.892	1.013	1.21×10^{-01}
	Personality disorder	2.104	1.688	2.622	3.59×10^{-11}
	Indigenous	1.630	1.256	2.117	2.43×10^{-04}
PWP-GT					
	SPP	0.654	0.523	0.819	2.16×10^{-04}
	>1st attempt	1.000			
	Age, decades	0.937	0.878	1.000	5.12×10^{-02}
	Personality disorder	2.065	1.639	2.601	7.27×10^{-10}
	Indigenous	1.440	1.053	1.971	2.26×10^{-02}
Shared frailty					
	SPP	0.568	0.451	0.714	1.37×10^{-06}
	>1st attempt	1.782	1.464	2.167	7.93×10^{-09}
	Age, decades	0.919	0.859	0.984	1.51×10^{-02}
	Personality disorder	2.698	2.034	3.579	5.99×10^{-12}
	Indigenous	1.456	0.983	2.157	6.15×10^{-02}
Mixed effects					
	SPP	0.570	0.451	0.721	2.73×10^{-06}
	>1st attempt	1.720	1.407	2.103	1.22×10^{-07}
	Age, decades	0.919	0.856	0.987	1.98×10^{-02}
	Personality disorder	2.826	2.098	3.806	8.49×10^{-12}
	Indigenous	1.477	0.971	2.245	6.88×10^{-02}
Cox shared frailty					
	SPP	0.652	0.514	0.827	4.16×10^{-04}
	>1st attempt	1.790	1.479	2.167	2.23×10^{-09}
	Age, decades	0.917	0.854	0.986	1.88×10^{-02}
	Personality disorder	2.718	2.043	3.616	6.42×10^{-12}
	Indigenous	1.506	0.992	2.285	5.49×10^{-02}

HR, hazard ratio; SPP, suicide prevention pathway; >1st attempt, subsequent suicide attempt presentation compared with the first; AG–CP, Anderson–Gill counting process; PWP–TT, Prentice–Williams–Petersen total time; PWP–GT, Prentice–Williams–Petersen gap time; shared frailty, Weibull gamma shared frailty; mixed effects, multilevel mixed effects parametric; Cox shared frailty, Cox proportional hazards shared frailty.

a. Models shown are based on a truncation point of five suicide attempts.

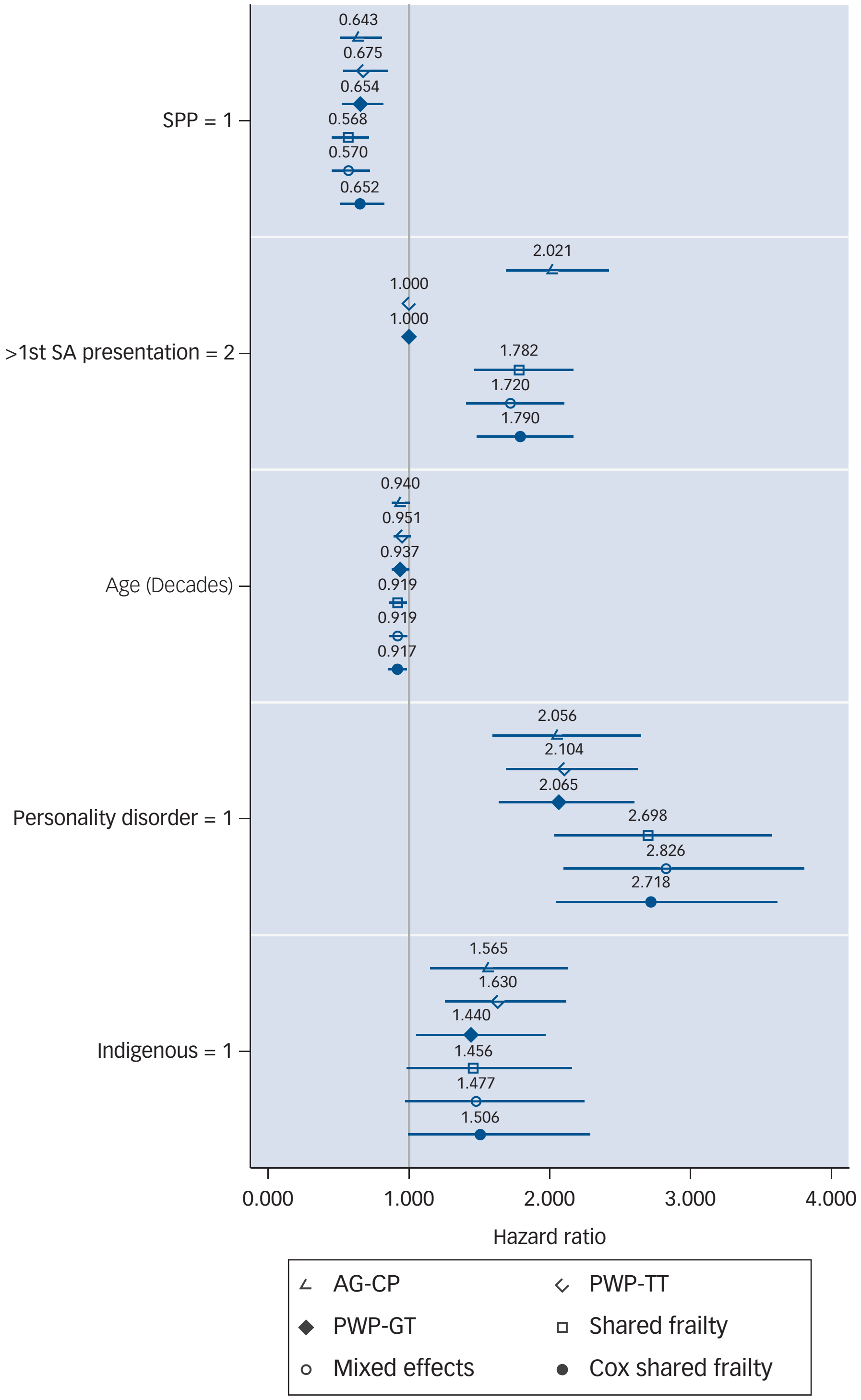

Fig. 2 Hazard ratio estimates for each predictor variable in each model.

SPP, suicide prevention pathway; SA, suicide attempt; AG–CP, Anderson–Gill counting process; PWP–TT, Prentice–Williams–Petersen total time; PWP–GT, Prentice–Williams–Petersen gap time; shared frailty, Weibull gamma shared frailty; mixed effects, multilevel mixed effects parametric; Cox shared frailty, Cox proportional hazards shared frailty.

(>1st attempt) was also associated with an increased hazard, compared with first-time presenters (detected in four out of six models). Being Indigenous increased the hazard of a repeated suicide attempt presentation by approximately 1.5 times, compared with not being Indigenous. Increasing age by 10 years decreased the hazard of a repeated suicide attempt by approximately 5–8%.

Using the complete data-set, an interaction between SPP and >1st attempt was associated with an increased time to suicide attempt (HR = 1.6, $P = 0.036$). That is, there was a differentially greater effect of the SPP to increase time to suicide attempt re-presentation if the person was put on the SPP after their first suicide attempt presentation rather than after a subsequent presentation. The effect was similar in truncated data-sets (e.g. truncated at five presentations for the shared frailty model; HR = 1.5, $P = 0.095$) but was not included in the presented models (Table 3 and Fig. 2) because $P > 0.05$. For interest, however, its effect, if included, is demonstrated in Fig. 3(b). No other interactions tested were found to be potentially important. The apparent lack of an SPP × personality disorder interaction (e.g. HR = 1.1, $P = 0.77$ for the shared frailty model) was of interest owing to the observation that people with a personality disorder were less likely to be placed on the SPP (Spearman rank correlation −0.40, $P < 0.001$), which may have been the result of clinical decision-making (see Discussion).

The relative relationships of factors influencing time to repeated suicide attempt are shown in Fig. 3. Different levels of each predictor

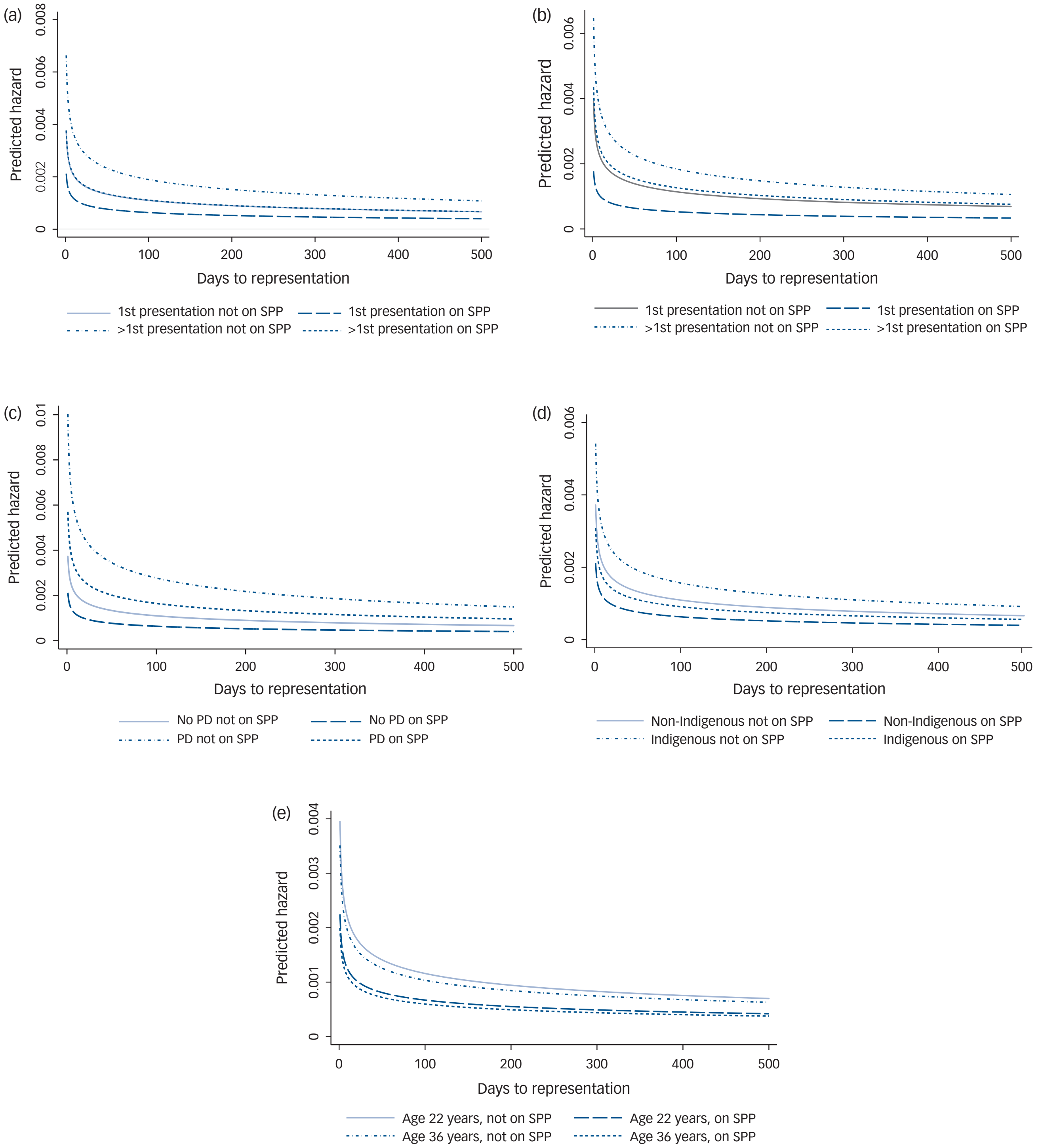

Fig. 3 Population predicted hazards based on the Weibull gamma shared frailty model.

(a) Effect of the suicide prevention pathway (SPP) and first or subsequent suicide attempt (SA) presentations for a non-personality disorder, non-Indigenous, 29-year-old (50th centile) individual. The curves for 1st presentation not on the SPP and >1st presentation on the SPP are superimposed. (b) Effect of the SPP and first or subsequent suicide attempt presentations when an SPP × 1st presentation interaction ($P = 0.095$) was included in the model. Hazards are shown for a non-personality disorder, non-Indigenous, 29-year-old individual. (c) Effect of the SPP and diagnosis of personality disorder (PD) for a 1st presentation, non-Indigenous, 29-year-old individual. (d) Effect of the SPP and Indigenous status for a 1st presentation, non-personality disorder, 29-year-old individual. (e) Effect of the SPP and age (22 years, 25th centile; or 36 years, 75th centile) for a 1st presentation, non-personality disorder, non-Indigenous individual.

variable are shown along with being placed on the SPP or not. These graphs also demonstrate how the hazard for a repeated suicide attempt decreases rapidly as the time from the previous attempt increases. Figure 3(a) shows that being placed on the SPP is essentially equivalent to the suicide attempt event being the first for an individual rather than a subsequent attempt (as is indicated by the curves being virtually superimposed). As noted earlier, the effect of an interaction between SPP and >1st attempt is shown in Fig. 3(b). Compared with Fig. 3(a), the curve for 1st presentation resulting in placement on the SPP is lower and the curve for >1st presentation resulting in placement on the SPP is higher, indicating that the SPP has a greater beneficial effect if applied at the first suicide attempt.

Being Indigenous and presenting with >1st attempt were positively correlated with a diagnosis of personality disorder (Spearman rank correlation 0.33, $P < 0.001$, and 0.24, $P < 0.001$ respectively). However, the variance inflation factors of 1.3 (SPP), 1.4 (personality disorder), 1.2 (Indigenous status) and 1.1 (>1st attempt) do not suggest that these correlations would unduly affect the HR estimates.

It should be noted that the effect of each predictor variable on time to a repeated suicide attempt is proportionally additive with the effects of other predictors in the model. This means that being on the SPP will reduce the hazard for a repeated suicide attempt equally in proportion for any individual. For example, being placed on the SPP will reduce the hazard to about 65% of the original hazard whether the presenting individual is an Indigenous person, a young person, a person with personality disorder or none of these.

Discussion

The Zero Suicide framework has gained international momentum in recent years while at the same time drawing criticism due to the lack of robust evidence-base supporting its effectiveness.[1,6] In this paper we demonstrate a significant reduction in risk of repeated suicide attempts to approximately 65% of a natural risk in patients receiving a suite of interventions following the Zero Suicide framework.

Significant reductions in suicide attempt re-presentation rates were seen within 7, 14, 30 and 90 days after the initial attempt for people on the SPP compared with those not on the SPP. Being on the SPP was shown to be particularly efficacious in the first 14 days, which is probably due to the average duration of placement on the SPP being around 16 days, during which time the patient remains in active contact with the health service through face-to-face appointments. However, the continued effectiveness of the SPP after this period suggests a sustained effect of the suite of interventions delivered during those first 2 weeks. We note that the rates of repeated suicide attempts at 90 days were relatively high in both groups, compared with an average of 16% reported in earlier systematic reviews.[11,34] The discrepancy could be partly explained by the limitations of the utilised project design; Owens et al[11] showed that low-quality studies showed more dispersed values around a higher median than high-quality studies (21 *v.* 15% repetition rates). Additional factors may be the use of presentation-based rather than person-based analysis, and the high levels of sensitivity in detecting suicide attempts in hospital administrative data through the use of a machine learning algorithm in our work.[26,35]

Time-to-recurrent-event analysis was used to model the effect of the SPP and other covariates on time to re-presentation with a suicide attempt. Irrespective of the model used, results showed that being placed on the SPP led to a longer time to re-presentation compared with those not placed on the SPP. In addition, we were also able to show that people diagnosed with a personality disorder, Indigenous people, those presenting with their second or subsequent suicide attempt as opposed to their first, and younger people were associated with higher HRs, indicating an increased risk of re-presentation. This aligns with literature identifying Indigenous persons,[36] people diagnosed with personality disorder (especially borderline personality disorder)[21,22] and those with multiple past suicide attempts[20,37] as having a heightened risk for suicide attempts.

The effects of the SPP act proportionately in reducing hazards for suicide attempt re-presentation for all patient groups in the study. For example, a person diagnosed with a personality disorder benefits proportionately from being placed on the SPP, as their hazard is reduced to 65% of their original hazard, and the hazard for a person not diagnosed with personality disorder is also reduced to 65%, even though the former begins with a higher natural hazard. This finding has an important practical implication as it was observed that people diagnosed with personality disorder were less likely to be placed on the SPP, possibly because clinicians assumed that the SPP would be less effective. Suicide attempts in people with personality disorder are frequently perceived to be communicative gestures or ambivalent in intent.[22,38] As there was no SPP × personality disorder interaction, the SPP was seen to be equally effective in those with a diagnosis of personality disorder. We strongly recommend that all patients with personality disorder presenting with a suicide attempt be placed on the SPP.

Our demonstration of the efficacy of the SPP in first-time presenters makes it imperative for services to identify vulnerable individuals who have not previously presented and provide assertive outreach and clinical interventions for them. Such action may involve strengthening partnerships with referral sources such as the primary care sector and non-government services and improving screening. Furthermore, we can help prevent first presenters from becoming multiple presenters (who have a higher natural hazard) by placing all first-time presenters on the SPP. This would ensure gaining the benefits of the SPP and of being a first-time presenter simultaneously and take advantage of the possibility that the SPP has a greater beneficial effect if applied at the first suicide attempt.

Finally, we note that our work shows a significant reduction in risk of repeated suicide attempt that is larger than for other studies that have previously evaluated the outcomes of individual aftercare interventions.[16,39] In this work, we measured the cumulative effect of a suite of interventions, which may act synergistically in terms of positive benefit, making comparison with studies of individual interventions challenging.

Limitations

This work focused on re-presentations with a suicide attempt as an indicator of the efficacy of the SPP. While there is a substantial relationship between the clinical profiles of suicide attempts, particularly those of high lethality, and deaths by suicide,[12] it is recognised that the definitive measure of the SPP effectiveness will be a reduction in deaths by suicide.

We could not identify whether a person who did not re-present during the follow-up period had died. Owing to the rarity of such instances, however, it is unlikely that these cases would contribute significantly to the observed difference in re-presentations. A data linkage project is planned to track the long-term outcomes of GCMHSS patients and hence measure the effect of placement on the SPP on deaths by suicide. Another limitation was that we were only able to detect people who presented or re-presented to the GCHHS catchment area. This has likely accounted for an under-enumeration of repeated suicide attempts, particularly given some estimates that less than 30% of people seek help at a hospital after engaging in suicidal behaviour.[40]

As this work employed an observational design involving implementation of the SPP in a functioning health service there was obvious potential for ‘cross-contamination’ of elements of the SPP to treatment as usual. This might have occurred because clinicians used certain elements of the SPP in the treatment of patients not denoted as being placed on the SPP or because patients were placed on the SPP following a previous suicide attempt but not the current one. Further, some patients in the SPP group may not have completed all the elements of the SPP, particularly as the time frame from which the cohort of suicide attempt presentations was sourced (July to December 2017) was a relatively early period after the implementation of the SPP at GCMHSS in December 2016, and the desired fidelity to the full clinical protocol may have not yet been achieved. However, it should be noted that the above limitations related to potential cross-contaminations of the groups would tend to decrease the discriminating ability with respect to the effect of the SPP placement on repeat suicide attempts. As we still noted a beneficial effect of the SPP placement, we believe that this in fact enhances the reliability of our findings. At the same time, we acknowledge that the fact that this project tested for the effectiveness of the SPP as a suite of interventions, each exposed to a range of variables difficult to measure and subsequently control for, limits the potential for replicability of our findings in other contexts.

Although some of the measured differences in participants’ characteristics are shown in Table 2, a further limitation is that not all differences in clinical and personal characteristics can be measured and accounted for. Furthermore, we are aware of the potential lack of accuracy of the diagnostic codes used by emergency department staff, particularly in identifying individuals with personality disorders.[41]

Finally, we acknowledge that the project design prevents making firm conclusions about the efficacy of the SPP, in that the observed relationships cannot be interpreted as causal. There is thus a requirement for future studies to use more robust designs to demonstrate causality, such as a randomised controlled trial (RCT). We note, however, that such designs might pose significant ethical challenges regarding randomisation and masking and would be challenging to implement pragmatically for evaluation of the SPP outcomes.

Future directions

It is hoped that the results of this work will inform the design and analysis of future evaluation studies in this field.

Future work might examine long-term trends in the balance between repeated suicide attempts, self-harm and death by suicide and how these are affected by the SPP. For example, among persons with a past suicide attempt, increased future presentations with suicidal ideation could, in fact, be indicative of improved help-seeking behaviour. It is therefore possible that placement on the SPP may result in a shift in the nature of subsequent presentations from more to less severe.

There are some indications that certain interventions that constitute key elements of the SPP may have particular ‘protective’ value in the long term (e.g. when safety planning is done well, in particular if it includes the family).[42] Assessing individual contributions of the elements of the SPP, including the effect of increased clinician time with patients or exposure to elements of other evidence-based interventions received during their engagement with the mental health service, remains a goal for future work. This is especially important because different services might implement different clinical assessment tools or interventions as part of a Zero Suicide framework. Method and lethality of suicide attempt is another area of interest, as some literature indicates that these have a differential impact on the frequency of subsequent suicidal behaviours.[43]

With many hospital and health services across Australia, and globally, adopting the Zero Suicide framework, a key recommendation is that a robust evaluation, including quantitative analysis methods used here, be incorporated as an integral component of a clinical pathway implementation. Future work should pivot to examining changes in rates of death by suicide as well as suicidal presentations and, if possible, adopt a design that can establish causal relationships between clinical service changes and these rates. Such work would require an all-of-services approach in a given region, including working with primary care providers and non-governmental service providers.

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Supplementary material

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Data availability

This study used data collected at Gold Coast Mental Health Specialist Service as part of clinical practice and used in the evaluation of its suicide prevention strategy.

Author contributions

Authors’ contributions to this study were as follows: formulating the research questions – NJCS, KT, MW, JS; designing the study – NJCS, KT, JS; carrying out the study – NJCS, JS, KT, TG-A, AA-C, MW, SW-M, JS, IH, LL, CP, RK, NG, SW, MW; analysing the data – IH, JS, NJCS, TG-A; writing the article – NJCS, JS, IH, AA-C, TG-A, NG, DG, RK, LL, CP, HVE, SW, MW, SW-M, KT.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bjp.2020.190.

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Health services, suicide, and self-harm: patient distress and system anxiety

Michael J Smith, Joe Bouch, Simon Bradstreet, Trevor Lakey, Anne Nightingale, Rory C O'Connor

Patients often become distressed in health settings, and provision of emotional support is a routine part of clinical care. However, in some situations, patient distress can become disturbing to both clinicians and patients, and can affect ordinary therapeutic engagement. We argue that health systems that support people presenting with suicidal acts and self-harm are particularly at risk of providing maladaptive responses, which we have termed dysregulation. If health systems become dysregulated, staff and patients might find it difficult to think clearly and respond adaptively. We describe some common characteristics of dysregulation, including negative feelings about patients, an inappropriately narrow focus on diagnosis and risk assessment, and ad-hoc, abrupt, and inconsistent decision making. These dysregulated responses might impair more adaptive responses such as containment of distress, safety planning, and negotiated responsibility with patients and carers. We discuss the main drivers of dysregulation and the implications for clinical practice in the management of self-harm and suicide risk.

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Organisations and anxiety

The rationale for writing this Personal View began with a hunch: that the response to suicide and self-harm in clinics and hospitals is flawed in some way, and that the key to understanding these flaws lay not only in the relationship between staff and patient, but also between staff and the wider health system. Despite the extensive published work about suicide and self-harm, relatively little has been published about the experience of responding to a suicidal person.[1] Yet that experience can be emotionally disturbing for staff, and its effects can have widespread repercussions.

Prevention of suicide is difficult. Suicide rates vary over time[2] and are strongly affected by clinical, psychological, social, cultural, and economic factors.[3–6] Many risk factors for suicide have been identified, but the causes of suicide remain poorly understood, and evidence of what works to reduce suicide is scarce.[4,7]

Public health interventions, multilevel interventions, improved organisational responses, and drug treatments have been shown to be effective in the prevention of suicide.[7–9] However, interventions have only a slight effect,[10,11] or are sometimes counterproductive—such as admission to an inpatient mental health unit.[12]

Clinical settings are dramatic and emotionally challenging places, an observation not missed by television producers, but one that the system of care itself sometimes overlooks. In a classic study of student nurses working in general hospitals, Menzies Lyth[13] described the ways in which hospitals sought to contain the anxiety of their nurses, often unsuccessfully. She argued that this effort to manage the emotional dynamics of the institution was not a marginal activity, but instead a fundamental responsibility: "the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety".[13]

Furthermore, a recent report[14] from the UK Department of Health noted that "fear is toxic to both safety and improvement", yet is endemic in some systems: "Time and again, we see the harvest of fear...a vicious cycle of over-riding goals, misallocation of resources, distracted attention, consequent failures and hazards, reproach for goals not met...if the system is unable to be better, because its people lack the capacity or capability to improve, the aim becomes above all to look better, even when truth is the casualty."

When failures in the health system occur, investigations are commissioned to establish the causes of the failure, to identify wrongdoing, and to learn lessons. These investigations are undertaken typically by clinical peers and are often perceived as threatening by staff, which could affect clinical practice. Mattinson and Sinclair[15] observed the ways in which investigations into the deaths of children who died as a result of their parents' behaviour did not address the paradoxes associated with failures in care: "We do not dissent from most of the conclusions of these reports, yet there remains an uneasy feeling that something has been missed. It is clear that the workers missed cues, failed to communicate or failed to communicate what was important. Quite rightly, the reports say this should not have happened. To draw such obvious conclusions, however, does not advance our understanding of why such mistakes continue to be made by intelligent, concerned and frequently well-trained and experienced people."[15]

To understand the causes of such apparent paradoxes needs an understanding of the system in which staff work, and the ways in which that system might respond to the stress and anxiety it encounters. Here, we argue that suicide and self-harm are potent causes of distress and anxiety among staff, and that careful attention should be paid to organisational responses. Unless health systems can respond adaptively to manage this anxiety, substantial problems will emerge.

Responding to a unique health problem

When someone presents to health services with suicidal or other self-harming behaviour, they are often thought of as a needy person seeking help, and are subsequently assessed for their suitability for various forms of care and treatment. But what if those needs are not health needs at all? What if the assessment itself is ill founded? And what can be done if no effective forms of care and treatment are available? We argue here that the current model of care presents everyday clinical problems in each of these areas.

Self-harm is defined by the National Institute for Health and Care Excellence (NICE) as "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting."[16] Although the NICE definition of self-harm includes acts with high and low levels of suicidal intent, in this Personal View we use the terms self-harm and suicidal acts separately to reflect their widespread use in clinical practice. All suicidal acts include self-harm of some kind, but self-harm need not be suicidal in intent. For example, one of our patients disclosed that having a razor to self-harm with is the only thing that had stopped the patient from killing themselves.

We recognise that self-harm and suicidal acts are often distinct problems[17] but consider them together in this Personal View for three reasons. First, suicidal acts and self-harm can be hard to distinguish when attempting to clarify suicidal intent; we thought that to acknowledge that uncertainty would be best, rather than to artificially exclude it. Second, both self-harm and suicidal acts share a crucial feature: the person involved is both the cause and the casualty of the harm. This duality conflicts with the conventional, so-called sick role and the behaviour usually associated with it.[18] Third, when self-harm and suicidal acts threaten life, they need an urgent health service response. However, the ambiguities that we have described mean that staff might not know how best to act, beyond dealing with the immediate injury, and the person could try to resist treatment.

When a clinician begins to engage with the problems of a self-harming or suicidal patient, they often feel some sense of responsibility for the outcome of that person's actions, even though they cannot influence those actions directly. This experience of feeling both responsible and powerless is unwanted by clinicians, emotionally difficult to bear, and is likely to affect their relationship with the patient.

Ambiguity around the origins of the problem further exacerbate anxiety. If suicide is regarded as a patient presenting as both cause and victim in a potentially lethal act, then the rights, obligations, and expectations associated with the sick role become complicated. Not only has that person been the proximate cause of their presenting problem (however complex the underlying social and emotional factors might be), but they might or might not have sought help for their disorder, and might or might not follow clinical advice about it.

Situations that combine severe distress, role confusion, uncertainty about responses, and a potentially fatal outcome will be emotionally charged for staff and patients. Although health services typically make huge efforts to save life, some acts of self-harm could result in the patient being discharged from care (eg, when a patient is intoxicated), even when the risk of death is acknowledged. If so, this action could contribute to the recognised risk of repeat self-harm or suicide in the months after discharge from hospital.[19,20]

The emotionally charged situations we have described are unique and unsettling: a person in need who does not behave like a patient, and a health system that feels obliged to intervene, yet isn't always clear how to do so. Such situations could be experienced by a range of clinical staff in various care settings, such as the family doctor's practice, emergency department, and psychiatric ward. These difficult situations often present unexpectedly, and often (although not always) recede quickly.

Here, we refer to these unique situations, in which the usual assumptions and social rules that govern patient–clinician interactions are suspended or unclear, as a dysregulated zone. We use dysregulated here to describe an absence of order, and it suggests a loss of emotional control for the parties involved. Importantly, not all patient–clinician interactions concerning suicide and self-harm will take place in a dysregulated zone.

In some situations, the patient conforms to a sick role, and staff feel confident that their care and treatment is helpful. For example, a mother who becomes depressed with psychotic features after the death of her only child will elicit empathy and care; she is unlikely to experience dysregulated responses. By contrast, an angry and intoxicated young man presenting with his tenth episode of cutting is likely to elicit a dysregulated system response. Furthermore, if staff are over-worked, or distressed by contact with previous suicidal acts, the zone is more likely to become dysregulated. Components of the dysregulated zone are represented in figure 1.

Characteristics of the dysregulated zone

Dysregulated feelings: conflicting emotions about the patient

Patients tend to respond positively to therapeutic engagement:[21] clinical compassion and empathy in response to self-harm are essential therapeutic factors. Yet first-response staff (eg, in emergency departments) sometimes have a negative attitude towards people who self-harm.[22,23] People presenting with self-harm are likely to evoke strong feelings in staff, who might empathise with a vulnerable person, but simultaneously feel angered and repelled by their act of violence against their self.

Staff might respond with several coping strategies. For example, these unsettling, untherapeutic feelings might be disallowed or deemed inappropriate (eg, "I feel angry towards this person, but I can't feel like that about a patient"). Alternatively, staff might complain that suicidal patients waste resources, clog up the system, or are attention seekers whose maladaptive behaviour would only be encouraged by professional help. Difficult and contradictory feelings risk impairing clinicians' confidence and clinical judgment. Fortunately, negative staff attitudes are amenable to change.[24] To facilitate such change, the health-care system would need to be able to take account of the complex origins of the emotions elicited in staff.

Dysregulated responsibility: avoidance and over-control

Health-care systems seek to impose order on unstructured and distressing situations.[13] When responding to suicide risk and self-harm, the order imposed is often implemented on the basis of diagnosis: people with an illness should be treated within the health service, but those who are not ill should seek alternative forms of help elsewhere. This perspective does not apply to all services, and is more often implicitly recognised than formally expressed in policy.

A key issue for staff working in the health-care system is to establish whether a person's underlying problems have been caused by mental illness, social factors, or other difficulties. The results of that distinction are important: small differences in presentation or interpretation could result in either discharge or compulsory inpatient treatment. Yet the boundaries between illness and so-called problems in living are hard to define. Because psychiatric diagnoses are symptom based, clinicians can have difficulty in distinguishing between symptoms that suggest the presence of a disorder from expected reactions to situational difficulties.[25] Loss, grievance, frustration, humiliation, defeat, entrapment, and childhood adversity are all strongly correlated with suicidality,[26] but none would correspond to a diagnosis of mental illness in its own right. For example, a man presenting with suicidal distress after the break-up of his marriage would be considered more appropriate for National Health Service treatment if his distress was thought to have been so severe as to precipitate a depressive illness. The importance of a mental illness diagnosis in the distinction between illness and distress is summarised in figure 2.

No reliable method to manage these decisions exists and staff often find their way to clinical responses through ad-hoc methods,[27] which can be confused and inconsistent. Those who have dysregulated responses might do some or all of the following: make abrupt decisions, consider binary alternatives, think in stereotypes, create simplistic narratives, and implement solutions before the problem has been identified. If a person has self-harmed and has not been diagnosed as having a mental illness, staff might perceive a moral hazard if they respond empathetically to their distress. To respond in such a way might be thought to encourage similar self-harm in the future, or to unhelpfully capitulate to manipulation by the patient. This sense of compulsion felt by staff has similarities with the sense of entrapment often felt by patients.[26]

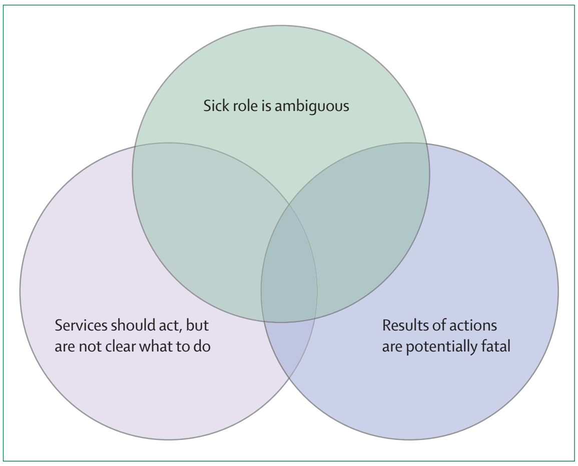

Figure 1: **Factors contributing to dysregulated responses to people presenting with suicidal acts and self-harm**
Three main factors contribute to a dysregulated zone: ambiguity about the sick role; a need to respond, matched by uncertainty about what to do; and potentially fatal outcomes. The greater the overlap between these three factors, the greater the risk of dysregulation. Many other influences affect the dysregulated zone, because the patient, clinician, and system will influence the dynamic of that interaction.

Dysregulated interventions: a therapeutic relationship displaced by risk assessment

Service users appreciate engagement, information, and empathy from staff, but often report that service responses are uncaring,[22] and psychosocial assessments are superficial and rushed.[28]

Conventional risk assessment shows weak evidence of predictive utility,[29] and provides very little information about the potential motivation for suicide or self-harm. Clinical guidelines state that risk assessment should not be used to predict future suicidal acts, or to make decisions about treatment or admission to hospital.[16] Nonetheless, risk assessment has come to dominate other therapeutic tasks and perspectives such as engagement or containment of distress.[23] Reasons for this dependency on risk assessment is understandable. For example, the ability to accurately predict risk would be an immensely useful clinical tool; therefore, risk continues to be assessed in the hope that outcomes can confidently be predicted, even though experience and evidence shows that this prediction is not possible. Additionally, risk assessment provides staff with a clear goal when the appearance of doing nothing would be unacceptable, confers some protection against criticism or medico-legal action, provides structure (albeit inadequate) for communication with patients, and offers a sense of control for service providers in an often chaotic and distressing situation.

Management of emotional engagement with the patient's distress is difficult, and risk assessment can be used to categorise patients to process them through the system (eg, transfer of care, and admission). By contrast, a therapeutic assessment might improve engagement[30] and reduce repetition of self-harm.[31]

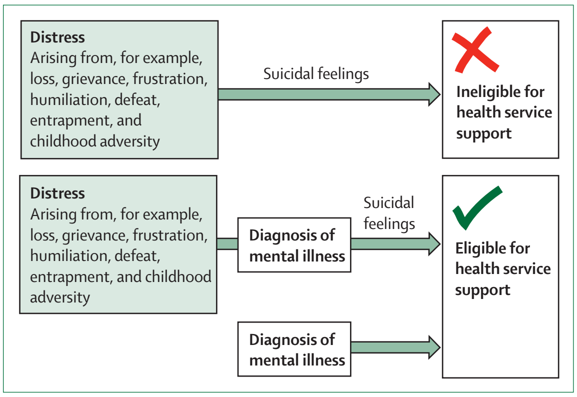

Figure 2: Distinguishing illness from distress when considering health system support—the importance of a mental illness diagnosis

Responses: working better in the dysregulated zone

Systems should acknowledge the risk of dysregulation, and seek to recognise it when it occurs

Dysregulation is contagious and can quickly affect everyone in that zone. For that reason, for clinicians to recognise dysregulation as it happens is often difficult, because they are often already involved in it. This irony—that clear thinking is impaired by dysregulation, just at the point when it is most needed—presents a tricky challenge in clinical practice.

The language that is used in the health-care system could be an indicator of dysregulated behaviour, as described by Ruch[32] in a social-work context. Clinicians often feel that they are expected to behave in ways that are rational, straightforward, risk free, and outcome driven. We suggest that such behaviours are not always adaptive. Instead, clinicians should be allowed to acknowledge the subjectivity, complexity, and risk-laden nature of the tasks they are expected to undertake. This kind of approach is difficult or impossible to achieve if the system regards any death by suicide to be a service failure. Some have argued that health services should accept the bold goal of zero suicides among persons receiving care;[33] however, our view is that such an aspiration could adversely affect clinician behaviour by increasing the risk of dysregulation, and that a more realistic goal would be to aim for effective mitigation of suicide risk.[34] In our view, staff appropriately engaged with a goal of mitigating suicide risk are more likely to be successful than staff confronted with the impossible task of eliminating risk altogether. A comparison of staff attitudes and behaviours between settings that have a so-called zero suicide policy and those that do not would test this view.

Staff and the systems in which they work do not find it easy to accept that some suicides will continue to happen. To express such a view could be argued as being complacent in the face of potentially fatal risks, yet to deny it might impose an unfair and disabling burden on clinicians.

Clinicians are perhaps especially prone to imposing unattainable standards on themselves. During an earlier draft of this Personal View, this section opened with the sentence: “At a senior (consultant) level, practitioners need to be able to articulate, understand, and resolve the emotional and interpersonal complexities of care for the suicidal patient.” After several revisions, one of us remarked that “this sentence makes me feel scared”. The sentence provoked anxiety because it assumed a level of omniscience and authority that no clinician could consistently achieve in practice. In other words, it was showing signs of dysregulation. We removed the sentence, but point it out here as a reminder of the ease with which clinicians might unconsciously seek to regulate themselves against unattainable standards.

Use of diagnosis and risk assessment for guidance rather than as the gateway to help

Repetition of self-harm could be fatal, whether the person is mentally ill or not. A vital task for assessing clinicians should be to explore the context and motivations for suicidal feelings and acts. Whether the person meets criteria for diagnosis, admission, or detention under mental health legislation should not negate the fundamental importance of understanding the patient’s situation and building the patient–clinician relationship. Risk assessment is only one part of a comprehensive psychosocial assessment, and should be regarded as the beginning of a mitigation plan rather than an endpoint in itself.

When a patient has suicidal thoughts or self-harms, their risk of further acts is far higher than that of the general population.[3,6] Seeking to refine estimates of that increased risk is unlikely to be productive, particularly because population risks are poorly associated with individual patient needs, and many risk factors—such as age, gender, and past self-harm history—are not amenable to change.

Risk assessment and the identification of care needs should as far as possible involve the full participation of the person in receipt of services and the people close to them so that the risk is understood, responses are negotiated, and responsibilities shared. Several useful interventions that mitigate the risk of suicidal behaviour include the following: immediate (rather than conditional) empathy and engagement, including routine enquiry about suicidal thoughts;[35] containment of distress;[35] implementation of a safety plan;[36] an assessment of the person’s response to these interventions, with a step up to more intensive care if needed;[34] and engagement, communication, and support for carers, including professional carers.[37] Promotion of this kind of therapeutic response might foster clinician–patient engagement, by helping them both to feel safer, reassuring patients that their concerns are being addressed, and reassuring staff that by taking action they will have some protection against future criticism or legal action.

Using a relational approach to engagement with the patient

Effective interventions depend on clinician engagement and empathy with the patient. At the first contact with a patient, establishment of a working therapeutic relationship should therefore be prioritised over diagnosis or risk assessment. Specifically, the engagement by a clinician with a suicidal or self-harming patient should begin by asking "what happened to you?", rather than "what's wrong with you?". The former question is non-judgmental, prioritises an understanding of the patient's perspective, and takes special care not to presume that clinicians know the reasons for patient behaviours. In this way, it seeks to foster the core conditions of effective therapeutic relationships, including authenticity, security, understanding, and empathy.[38]

A thoughtful enquiry about patient distress is analogous to the so-called not-knowing standpoint taken towards the patient in mentalisation-based therapy,[39] the curiosity emphasised in attachment-focused parenting,[40] and the acknowledgment of shame and self-criticism emphasised in compassion-focused therapy.[41] Relational thinking keeps the patient's distress at the forefront of attention, rather than thinking of it as an impediment to other actions. A clinician who is sensitively seeking to understand the causes of self-harm and suicidal thoughts is likely to foster empathy, and so help to contain distress.

Relational thinking is easier to describe than to implement in practice, particularly because dysregulated situations tend to generate negative inferences about patients, so-called black and white thinking, and immediate or abrupt responses. Good quality training and supervision is needed to help staff recognise and manage their own emotional response to suicidal or self-harming patients.

Conclusion

Distress is contagious. If clinicians are to engage sympathetically and effectively with a suicidal or self-harming patient, they too will experience some of the turmoil and anguish that led the patient to seek help. The anxiety this engagement generates affects not only patients and staff, but also the health systems themselves. Health services sometimes respond adaptively or unhelpfully to these emotional demands, and their responses will have a profound effect on both staff and patients within the organisation.

We argue that the person presenting with self-harm or suicidal acts makes particular and predictable emotional demands on health services, and we describe three factors that are particularly potent: ambiguity about the sick role, a need to respond matched by uncertainty about what to do, and potentially fatal outcomes, whatever actions are taken.

These three factors could generate dysregulated zones in clinical settings, in which it is temporarily difficult for staff and patients to think clearly and respond adaptively. We have described some common characteristics of dysregulation, including negative feelings about patients, an inappropriately narrow focus on diagnosis and risk assessment, and ad-hoc, abrupt, and inconsistent decision making. These responses might militate against the therapeutic responses that are favoured by patients and shown to be effective: containment of distress, safety planning, and negotiated responsibility with the patient and carers.

These therapeutic responses are sophisticated tasks in a normal environment but much harder to achieve in a dysregulated environment. This achievement is particularly difficult if the system and staff working in it find it hard to accept that not all so-called problems in living can be fixed, or every suicide prevented. More work should be done to develop and test ways to manage clinician anxieties in these situations.

The best of care might need, paradoxically, to aim to be good enough, because this goal might be sufficient to minimise the risk of dysregulation, and improve the chances of a genuinely therapeutic encounter. This aim is not to dismiss the importance of diagnosing illness when it exists, and to manage risk whenever possible, but diagnosis should not be a prerequisite for help, and risk assessment itself does little to improve outcomes. Not all suicides can be prevented, but we shouldn't stop trying.

Contributors

This is a Personal View based on clinical experience, knowledge of published work, and group discussion. All authors contributed equally to the design, analysis, revision, and approval of this report.

Declaration of interests

We declare that we have no competing interests.

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VIEWPOINT ARTICLE

WILEY

Humanizing harm: Using a restorative approach to heal and learn from adverse events

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Abstract

Background: Healthcare is not without risk. Despite two decades of policy focus and improvement efforts, the global incidence of harm remains stubbornly persistent, with estimates suggesting that 10% of hospital patients are affected by adverse events.

Methods: We explore how current investigative responses can compound the harm for all those affected—patients, families, health professionals and organizations—by neglecting to appreciate and respond to the human impacts. We suggest that the risk of compounded harm may be reduced when investigations respond to the need for healing alongside system learning, with the former having been consistently neglected.

Discussion: We argue that incident responses must be conceived within a relational as well as a regulatory framework, and that this—a restorative approach—has the potential to radically shift the focus, conduct and outcomes of investigative processes.

Conclusion: The identification of the preconditions and mechanisms that enable the success of restorative approaches in global health systems and legal contexts is required if their demonstrated potential is to be realized on a larger scale. The policy must be co-created by all those who will be affected by reforms and be guided by restorative principles.

Patient or Public Contribution: This viewpoint represents an international collaboration between a clinician academic, safety scientist and harmed patient and family members. The paper incorporates key findings and definitions from New Zealand's restorative response to surgical mesh harm, which was co-designed with patient advocates, academics and clinicians.

KEYWORDS

adverse events, incidents, investigations, patient safety, restorative

1 | BACKGROUND

Healthcare is not without risk. Despite two decades of policy and improvement efforts, the global incidence of harm remains stubbornly persistent.[1] Investigating adverse events, particularly those leading to disability or death, provides the foundation of patient safety management systems globally.[1] International policy approaches usually direct providers to undertake a transparent internal investigation of single events within a specified protocol. In some countries, such as the United Kingdom (UK) and Norway, the review of clusters of incidents is also supported. Regardless of the model applied, investigations usually seek to understand what happened and why, aiming to learn from events, improve systems and reduce the risk of reoccurrence.

The efficacy of the numerous investigation approaches used, and their impact on system learning is debated.[1,2] 'Watershed' public inquiries repetitively report 'preventable' deaths while illustrating devastating human impacts. Although these investigations provide a window into the scale of the problem, they are not without limitations. Often relying on retrospective analysis of written documents,[2] the extent of the response of incident investigations and large-scale inquiries, and their impact on system improvement, remains both challenging and under-researched.[3] Broader policy and reputational concerns, investigator preferences and embedded legal structures can impede the desired changes and the commitment to a 'just and learning' approach.[4,5]

The role of those directly affected by the harm is usually limited to being a passive source of evidence, with the 'testimony' focused on the events themselves. Clearly, all those involved—patients, families and health professionals—provide credible information that is crucial to capture and learn from,[6,7] but this focus arguably prejudices the act of learning, over the experience of harm.[8] Further, well-intentioned investigative processes that pursue system improvement can create additional negative impacts.[7,9] In the aftermath of death or disability, and through the processes that follow—disclosure, investigation, resolution and change—not only are the human impacts of the initial event inadequately addressed but the experience of harm can be *compounded*.

In this paper, we propose that current investigative responses to adverse events can compound the harm for all the people involved—patients, families, health professionals and organizations—by neglecting to appreciate and respond to human impacts. We propose that the risk of compounded harm may be reduced when investigations provide the opportunity for healing alongside models that seek system learning, with the former having been consistently neglected. We argue that incident responses must be conceived within a relational as well as a regulatory framework, and that this—a restorative response—has the potential to radically shift the focus, conduct and outcomes of investigative processes.

2 | WHAT IS COMPOUNDED HARM?

The assumption that system 'learning' and harm prevention are the only outcomes patients, families and health professionals desire from investigations is not in keeping with emergent evidence. In fact, there are increasing calls to acknowledge the wide-ranging human impacts.[8–11] When an incident occurs, the people receiving and providing healthcare are hurt, and their relationships are affected. If this harm is to be adequately addressed—and safety enhanced—we contend that well-being must be restored, and trust and relationships rebuilt. Compounded harm arises when these human considerations are not attended to, resulting in shame, contempt, betrayal, disempowerment, abandonment or unjustified blame, which can intensify over time.[11,12] Public inquiries often illustrate the negative impacts of embedded investigative responses, including the erosion of public trust in institutions and relationships, and the diminishment of individual or community wellbeing.[3,9]

Compounded harm can also be derived from the failure of a responsible party, to give account to a harmed party, for harm that occurs whilst providing or receiving care.[12] We define a responsible party as 'any individual, group or entity that has had a significant role to play in the occurrence of the harm and/or the resulting reparative and preventative actions'.[12] We submit that taking responsibility is not the same as accepting culpability; rather it is *a validating act* that can dignify all parties and may also be received as a demonstration of professional duty. The endurance of retributive approaches to investigations is a barrier to responsibility taking and is concerning given the evidence that health systems are complex and dynamic, and that events involve multiple people and systems.[13]

3 | HOW DOES COMPOUNDED HARM ARISE?

Safety investigations are increasingly characterized by civil litigation and the criminalization of human error, despite assurances from safety scientists that individuals are rarely solely culpable.[7] The actors involved in an incident are usually assigned roles more familiar in legal systems than safety critical industries. Typically, these roles are an initial 'victim', usually the patient or family member, and a 'perpetrator', a person, organization or regulator perceived to have caused the harm.

The adversarial conditions and entrenched positions of lengthy investigations usually prevent opportunities to bring patients, families and health providers together.[4,14] Ultimately, those closest to the incident lose their voice as assigned 'advocates' adopt the role of storyteller, and the narrative is shaped within frameworks concerned with system learning, litigation or reputation. Compounded harm can feel worse than the original injury, especially when people feel unheard or invalidated, and for some results in mental illness or suicidal ideation.[9,11,15] These conditions prevent healing, defined as the restoration of wellbeing, relationships and trust.

Keeping people apart compounds harm because dialogue is necessary for healing. The wellbeing of injured patients and families suffers as the quality of therapeutic relationships is diminished and their experiences minimized.[9,15] Health professionals may experience distress as they lose their identity as healers, face 'moral injury' or are unable to express feelings of shame or remorse.[11,16] Public institutions can also lose the trust of the people they serve.[12] Further, the often formal, distancing language associated with written reports and legal documents lacks the compassion of empathetic discourse.

Perhaps most importantly, relationships cannot be restored when trust in the fundamental, explicitly stated values and policy commitments are contradicted by lived experiences. A restorative response is required to repair substantive losses, employ a fair and transparent process of resolution and address the psychological needs of acknowledgement, respect and dignity of all the people involved.

4 | WHAT IS A RESTORATIVE RESPONSE TO HARM?

Restorative responses belong to the collaborative, nonadversarial 'Alternative Dispute Resolution' (ADR) pathways that seek to function as an alternative to the formal system. Established pathways in international health settings incorporate approaches used in civil litigation, such as negotiation and mediation. While they share some common features with a restorative approach, each ADR pathway is distinguished by the practices, underpinning principles and values, and the outcomes sought.[12,17] The key differences are outlined in Table 1.

Established ADR pathways are common in Australia, Canada, the United Kingdom and the United States. Approaches, such as 'Communication and Resolution Programmes' (CRPs) and 'open disclosure' focus on early transparent communication with harmed patients and families, complaint resolution and compensation when appropriate. While information exchange is understood to be crucial for learning, improvement and resolution, a paradigm based purely on information exchange provides no incentive or mechanism for building relationships or understanding one another.[18,19] Further, CRP programmes usually seek to reduce liability costs and the emphasis on financial risk may also limit their potential to respond to the human impacts.[20] Research examining the patient and family experience of CRPs concluded that development should focus on nonadversarial communication, involvement of the treating clinician and 'restorative competency'—defined as 'listening to patients stories without interrupting… to foster understanding and restore trust'.[21]

In contrast to approaches that promote disclosure, communication and resolution, restorative responses are fundamentally relational in nature. They appreciate that human relationships are at the core of the human experience of the world, are fundamental to human wellbeing and are implicated in our healing. We define a restorative response to an adverse event as:

TABLE 1 The differences between current ADR approaches and a restorative response

Response	Underpinning values and principles	Procedure	Practices	Outcomes sought
Communication and resolution programme/open disclosure/ Duty of candour (US, UK, Australia, Canada)	Transparency Learning Accountability Resolution	Procedure is predetermined. Hospitals and liability insurers disclose adverse events to patients; investigate; explain what happened; apologize; and in cases where substandard care caused harm, proactively offer compensation.	The people affected by the event are often represented by a proxy (lawyer, hospital manager). Mediation Arbitration Formal legal process (e.g., civil claims) Incident investigation	Reduce the number of malpractice claims and associated costs Legal agreement Formal apology System learning Compensation
Restorative response (NZ)	Active participation, respectful dialogue, truthfulness, responsibility-taking, empowerment, equal concern	Procedure is codesigned by all the parties (patients, families, clinician and organization) and is underpinned by a restorative inquiry framework. Disclosure is expected from multiple actors.	Ideally, all the people affected by the event come together with the help of a skilled facilitator. Restorative conversations Facilitated meetings Circles Storytelling Actions captured in a shared document	To address harms, meet justice needs, restore trust and promote repair for all the people involved. An apology that meets people's needs (can include compensation) Healing and learning

Abbreviation: ADR, alternative dispute resolution.

> *A voluntary, relational process where all those affected by an adverse event come together in a safe and supportive environment, with the help of skilled facilitators, to speak openly about what happened, to understand the human impacts, and to clarify responsibility for the actions required for healing and learning.*

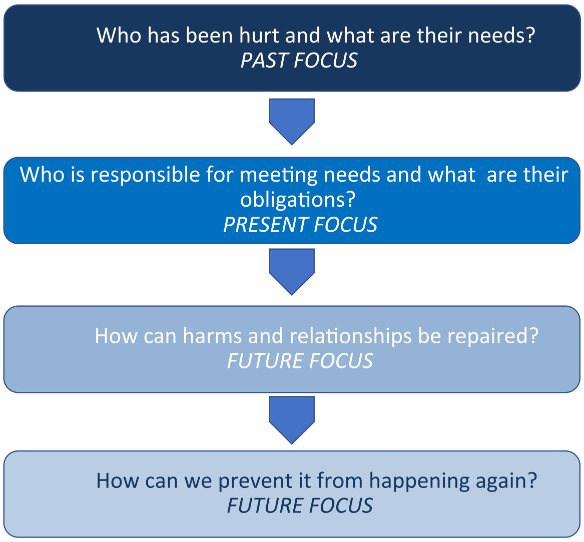

FIGURE 1 Restorative inquiry framework

The relational principles, values and goals strive to create open, trusting and respectful relationships that can help to prevent, mitigate or respond to harm. They include active participation, respectful dialogue, truthfulness, accountability, empowerment and equal concern for all the people involved.[9,17] The goal of a restorative response is to restore well-being and relationships alongside understanding what happened. Accordingly, the dialogue is guided by a concern to address *harms*, meet *needs*, restore *trust* and promote *repair* for all involved.[9,17] Empathetic, respectful dialogue is achieved by bringing people together in a safe environment in face-to-face dialogue to answer the four questions of a restorative inquiry (Figure 1).

The questions asked in restorative inquiry support listening to understand and uncover the justice needs of the people involved. Justice needs are not synonymous with punishment. Rather, they encompass a holistic and caring approach that results in meaningful action for all the people affected. It is important to note that meeting justice needs is often a shared responsibility that requires access to diverse expertize and community support alongside the assistance offered by an investigator or team. Table 2 depicts some of the justice needs identified for harmed patients and families, health professionals and teams and the health provider and regulator during the restorative response to surgical mesh harm commissioned by New Zealand's Ministry of Health.[9]

TABLE 2 Examples of Justice needs identified during New Zealand's restorative response to surgical mesh harm[12]

Justice need	Patient/family	Health professional/team	Health provider/regulator
Substantive The actual harms that need to be remedied	Compensation Trauma counselling Peer support Childcare Meaningful apology Transport	Annual leave Trauma counselling Peer support	Reduce the likelihood of recurrence Make recommendations that will improve system safety Maintain public trust
Procedural The process of interacting, communicating, and making decisions about the harms	A just response where one can speak openly and honestly without fear of retribution Dialogue with parties identified as responsible e.g., clinicians, chief executive An advocate able to provide specialist advice and support Emotional support	A just response where one can speak openly and honestly without fear of retribution Dialogue with parties identified as responsible e.g., other clinicians, chief executive, professional bodies Open disclosure An advocate to provide specialist advice and support Emotional support	'System learning' within a 'restorative just culture' Meet regulatory requirements Open disclosure Dialogue with parties identified as responsible e.g., professional bodies, government agencies and policy makers
Psychological The way one is acknowledged, respected and treated throughout the process, ensuring those affected can honestly communicate their differences, concerns and potential similarities with each other in a safe way	To be heard and have their experience validated Restoration of trust and confidence in therapeutic relationships To trust the confidential nature of open conversations	To be heard and have their experience validated Restoration of trust and confidence in therapeutic relationships To trust the confidential nature of open conversations	To trust in the confidential nature of open conversations (e.g., not to be vilified in the press)

5 | HOW MIGHT A RESTORATIVE APPROACH REDUCE COMPOUNDED HARM?

A restorative approach includes all the affected parties because they are best placed to explore what happened and make suggestions about how to promote restoration and mitigate future risks. This is a far more comprehensive and complex response than one which seeks to identify a victim, a perpetrator and a punishment; or indeed, one which simply assumes that system learning is the overwhelming priority. It has the potential to result in a meaningful apology because of the focus on essential apology characteristics; respectful dialogue, acknowledgement of responsibility and actions that address justice needs.[15]

A restorative approach uses specific practices that aim to create the conditions for psychological safety so that multiple perspectives of an incident can be understood through storytelling. Telling one's personal story of trauma has certainly been shown to have a range of cathartic effects,[22] and there is tentative evidence that being able to choose how, to whom and how often to share a story of healthcare harm in a restorative process is a validating and dignifying experience for most people.[12] A strength of the approach is a procedural adaptation, meaning emergent justice needs can be responded to as the story unfolds.[12]

The empathy elicited in dialogic exchanges between harmed patients, families and responsible parties is a powerful intrinsic motivator for learning, action and behaviour change.[12] Restorative practices include affective statements, facilitated meetings between two parties or ‘Circle’ processes that may be used to establish group norms and respond to harm when there are larger groups involved. A Circle process involves a structured and intentional conversation in which people sit in a circle, and sequentially respond to questions posed by a facilitator.[9] Both facilitated meetings and Circle practices typically follow the restorative inquiry framework.

To date, few studies have investigated restorative approaches within healthcare settings despite evidence for their utility across several domains.[23] However, recent studies evaluating the approach provide tentative evidence for therapeutic, social and economic benefits. For example, the implementation of a ‘restorative just culture’ at one NHS Trust in England aimed to ‘fundamentally change the response to incidents, patient harm and complaints’.[24] The approach responded to poor staff engagement and focused on improving the worker experience of disciplinary processes, incidents and complaints; an evaluation concluded that a range of positive economic, workforce outcomes was associated with this approach.[24] However, given the study design, findings should be interpreted cautiously. Further, we view the lack of inclusion of the patient and family voice as problematic, if the goal is to fundamentally change the response to healthcare harm for all involved.

New Zealand's restorative response to harm from surgical mesh was facilitated by restorative justice experts and co-designed with all the affected parties, including harmed patients, clinicians and policy makers. Examples of how restorative principles and values underpinned the New Zealand approach are provided in Table 3. The approach was evaluated within a health impact assessment framework, using mixed methods, to examine people's experiences of the process and the immediate impacts. The researchers determined that a restorative response can meet the justice needs of most patients, families and responsible parties, concluding it should be provided alongside existing regulatory structures, policies and procedures.[12]

6 | HOW MIGHT THE RESTORATIVE APPROACH SHAPE AND IMPROVE THE RESPONSE TO ADVERSE EVENTS?

A restorative approach will be novel to many people working in healthcare policy and practice settings. This section briefly describes some areas where a restorative approach might shape and improve the response to a range of formal investigative processes, for example, adverse events, safety reviews of multiple incidents and national inquiries.

First, taking a restorative approach alters the process of disclosure in which apology plays a central role. Studies conclude that an informal explanation and assurances that an investigation will follow do not reduce formal complaints, can be associated with an increased risk of litigation and do not respond to individual needs.[15,25] A restorative approach may offer a way forward because of the explicit focus on understanding both what happened, and the unique justice needs, before responding within a meaningful apology characterized by reparative and preventative action.

Second, in eliciting, understanding and acting on the range of needs arising from an adverse event, a restorative response is likely to reduce the level of compounded harm experienced by all the people affected. The evaluation of New Zealand's inquiry reveals that the potential of a restorative approach is dependent on several critical success factors that should be considered (Table 3), all of these being usual in the successful application in other sectors.[12]

Third, in hearing from all the affected parties, when combined with traditional investigation approaches, the storytelling involved in a restorative response has the potential to improve individual, organizational and system learning.[12,26] Uncovering multiple perspectives of an event and developing recommendations within a psychologically safe, restorative consensus-building approach, may improve the quality of recommendations and support their implementation, which is often challenging.[27–29]

Swiftly responding to the justice needs created by physical and/or psychosocial injuries can support the restoration of wellbeing, to the extent that repair is possible. Arguably, a no-fault approach to financial compensation could assist in meeting justice needs. It could also reduce the risk of compounded harm resulting from lengthy legal processes associated with the retributive approach.[30,31] In New Zealand, where no-fault legislation is embedded, efficacy and experience are influenced by several factors. Access to psychological support, and how the legislation is interpreted and interacts with other complaints and disciplinary processes, is particularly relevant.[9,12]

TABLE 3 Examples of how restorative principles and values underpinned the New Zealand approach[9,12]

Principle	Practice examples
Process is voluntary	Participants are prepared for a facilitated meeting Consent to proceed agreed by all parties (including the facilitator) Confidentiality parameters agreed
Process is relational and designed to meet the needs of those impacted	Substantive, procedural and psychological needs of all parties clarified during preparation, e.g., who needs to be involved? How would people like to tell their story and to whom? Access to emotional support before, during and immediately after a meeting
Respectful communication	Ground rules established during preparation and start of the meeting Facilitators minimized interruption and ensured conversational turn-taking Facilitators upheld the ground rules and interjected to reframe, redirect or remind participants of their commitments when required If required, facilitators supported private conversations to clarify and repair any perceived hurtful comments
Safe environment	Confidentiality rules agreed at the outset, e.g., what will be shared and with whom Emotional support and breakout rooms provided Practical/comfort needs attended to
Skilled facilitation	Experienced practitioners guided the co-design, preparation, restorative process and debriefing
Responsible parties are involved	Responsible parties heard directly about the harm experience to identify individual and shared responsibilities
Participants have an equal voice	Circle processes and facilitated meetings supported a democratic structure that is psychologically safe and supports shared decision-making Responsible parties asked to listen and reflect key themes
Collaborative decision-making	Potential actions collectively agreed to by consensus
Outcomes documented and shared	Actions committed to documented in a shared public document Collaborative governance approach for implementation agreed by all parties

To successfully achieve the restoration of wellbeing, relationships and trust, requires the embedding of restorative values and principles within interdependent policies, collaborative governance structures and organizational cultures.[12,24,32] The development of theory about what works for whom and how, and research that investigates the impact of contextual conditions is essential to develop policy that enables successful implementation.[9]

Evidence regarding how minority groups and other vulnerable people experience patient safety interventions is limited.[29] Authentic partnership and cultural diversity are essential considerations during policy development, implementation and evaluation of restorative responses. Arguably, some countries have a cultural disposition towards the restorative approach (e.g., New Zealand, Canada, North America and Australia), because an important root of restorative philosophy is Indigenous wisdom.[33] However, systemic racism and inequities have recently been highlighted within these health systems,[34–36] and such countries have an obligation to protect tribal authority over Indigenous knowledge and unique practices. Further, the success of restorative initiatives in European criminal justice settings indicates there is a broader appeal.[37] This is perhaps because a key goal of all restorative approaches is to preserve the dignity of all the people involved. It has been suggested that, regardless of the cultural context, humans experiencing conflict or trauma share a fundamental need for dignity, where one is seen and heard as though one matters.[38]

Finally, including the perspectives of all the parties affected by adverse events in the design and evaluation of processes is essential to understand the numerous impacts and may serve as a protective factor when harm inevitably occurs.[12] Further, embedding restorative theory and practice in health professional education may build capability and assist practitioners to heal those affected by an adverse event, including themselves, their colleagues and their communities, alongside safety science that emphasizes system learning.

7 | CONCLUSION

We argue for a new approach to responding to adverse events, to reduce compounded harm and potentially provide a healing experience for all those involved, as well as enhance the scope and scale of learning. However, despite emergent evidence for restorative approaches in healthcare, many questions and evidence gaps remain. Identification of the preconditions and mechanisms that enable success in global health systems and legal contexts is required if their demonstrated potential is to be realized on a larger scale.

At their heart, restorative approaches are owned, developed and led by the people who are most affected by an incident. We must therefore transcend the dominant focus of enforcing a just and learning culture. The policy must be co-created by all those who will be affected by reforms and be guided by restorative principles. Ultimately, embedding healing alongside learning is a worthy goal that will likely unite and be embraced by patients, families, health professionals and policy makers.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

No data are shared for the purposes of this viewpoint article.

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Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework - ANZJP

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Abstract

Objective:

The Zero Suicide Framework, a systems approach to suicide prevention within a health service, is being implemented across a number of states in Australia, and internationally, although there is limited published evidence for its effectiveness. This paper aims to provide a description of the implementation process within a large health service in Australia and describes some of the outcomes to date and learnings from this process.

Method:

Gold Coast Mental Health and Specialist Services has undertaken an implementation of the Zero Suicide Framework commencing in late 2015, aiming for high fidelity to the seven key elements. This paper describes the practical steps undertaken by the service, the new practices embedded, emphasis on supporting staff following the principles of restorative just culture and the development of an evaluation framework to support a continuous quality improvement approach.

Results:

Improvements have been demonstrated in terms of processes implementation, enhanced staff skills and confidence, positive cultural change and innovations in areas such as the use of machine learning for identification of suicide presentations. A change to ‘business as usual’ has benefited thousands of consumers since the implementation of a Suicide Prevention Pathway in late 2016 and achieved reductions in rates of repeated suicide attempts and deaths by suicide in Gold Coast Mental Health and Specialist Services consumers.

Conclusion:

An all-of-service, systems approach to suicide prevention with a strong focus on cultural shifts and aspirational goals can be successfully implemented within a mental health service with only modest additional resources when supported by engaged leadership across the organisation. A continuous quality improvement approach is vital in the relentless pursuit of zero suicides in healthcare.

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VIEWPOINT

Implications of Zero Suicide for Suicide Prevention Research

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Over the past 2 decades, deaths by suicide have increased by 30%. In 2016, more than 45 000 people died by suicide in the United States, making suicide the second-leading cause of death among individuals aged 10 to 34 years.[1] The causes of this increase are manifold: a fragmented mental health care system, the opioid addiction epidemic, unregulated handgun ownership, and posttraumatic stress and other mental illnesses experienced by veterans, who die by suicide at higher rates than the general population.[2]

Given the frequency and burden of suicide, studies of interventions to reduce suicide are needed. Clinical trials of potentially suicide-reducing interventions have many logistical challenges. For example, suicide is a rare event, so studies powered to detect reductions in rates of completed suicides must be very large. Also, because prognostic factors for suicide are poorly defined, it is difficult to identify high-risk individuals for inclusion in studies. In addition, given the nature of serious mental illness, individuals who withdraw from suicide-prevention studies may be more likely to die by suicide than those who remain in the study, complicating the ability of these investigations to detect the effects of interventions and potentially biasing results in unpredictable directions.[3]

> There are compelling methodological, inferential, and ethical reasons to include actively suicidal individuals in suicide prevention trials.

However, researchers aiming to test suicide-reducing interventions may also encounter barriers to optimally designed trials that are rooted in ethical misconceptions. First, institutional review boards (IRBs) may insist on excluding individuals with histories of suicide attempts or who are actively suicidal. Second, investigators may be expected to report deaths by suicide and suicide attempts as adverse events. Third, IRBs may object to the use of completed suicide as the primary study end point.[4] Such objections make it difficult to conduct rigorous, ethical, and high-quality research.

These ethics-based objections to optimal suicide-reduction research align with the philosophy underlying the zero suicide model. Developed by the National Action Alliance for Suicide Prevention in partnership with federal agencies and adopted by health systems worldwide, the zero suicide model considers suicide deaths—particularly among individuals in treatment—as being entirely preventable.[5]

The zero suicide model serves as a laudable aspiration for society. A corollary of the zero suicide model, however, is that every suicide represents a culpable failure on the part of health professionals. Applied in research contexts, the model paradoxically constrains the ability of investigators to conduct studies that will reduce the incidence of suicide and help to approach the zero suicide goal.

Inclusion and Exclusion Criteria

Suicide is rarely considered a specific target for intervention but rather a symptom of a serious mental illness. Historically, individuals who are actively suicidal have been largely excluded from participation across a range of intervention trials. In studies of selective serotonin reuptake inhibitors from 1984 to 2001, only 10% of clinical trials included suicidal individuals, who ostensibly represent the population that could benefit the most from an effective antidepressant medication. Furthermore, as of 2013, there were no trials to evaluate the efficacy of selective serotonin reuptake inhibitors in actively suicidal individuals.[6] Recent US Food and Drug Administration draft guidance suggests that suicidal participants may be included in research involving major depressive disorder, but does not address other serious mental illnesses such as bipolar disorder or schizophrenia.[7] Some research teams now include participants with suicidal ideation or history, but continue to exclude those with more recent or active suicidal plans and attempts.

The reasons that investigators and IRBs may wish to exclude actively suicidal individuals from suicide prevention research are understandable. For example, IRBs may view such individuals as especially vulnerable, may seek to protect them from risk associated with research participation, or may question their capacity to give valid informed consent. Researchers may also be concerned—contrary to recent evidence—that asking participants about suicidality might increase the likelihood of suicide.[8] However, as calls for insurance coverage for investigators and institutions conducting suicide-related clinical trials suggest, concerns about being held responsible for participants' suicides also contribute to the exclusion of suicidal individuals from such trials.[4]

There are compelling methodological, inferential, and ethical reasons to include actively suicidal individuals in suicide prevention trials. When individuals who are considered to be at highest risk are excluded from studies, suicide events become even more rare,

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making it necessary to increase the number of participants to achieve adequate statistical power. In addition, if individuals at highest risk are excluded, the results of trials will not generalize to the populations for which they are most needed. Moreover, as long as usual treatments are not withheld and joining the trial does not predictably increase suicide risk, participants are not disadvantaged. There should be no ethical objection to the inclusion of these individuals in these investigations.

Adverse Events

Equally problematic is the misconception that, unique to trials seeking to reduce the incidence of suicide, the outcome of interest should simultaneously be considered a serious adverse event. In oncology research, for example, death caused by the patient's cancer is, barring unusual circumstances, not considered an adverse event. If deaths by suicide or suicide attempts are considered adverse events, then participants must be warned through informed consent conversations and documents that joining the study might entail a risk of suicide, investigators must report completed and attempted suicides to IRBs and regulatory bodies, and the occurrence of suicides or attempts might lead IRBs or others to require changes to the study protocol or even study closure. In research designed to reduce the incidence of suicide, this is incoherent.

Rather than treating suicides and suicide attempts as adverse events, investigators and data and safety monitoring boards must be alert to the possibility that interventions hypothesized to decrease suicides will paradoxically increase them. High-quality interim monitoring by an independent expert body is essential. But when the goal of a trial is to reduce suicide and suicidality, suicides and attempts should not be considered adverse events.

Choice of End Points

If a trial tests an intervention hypothesized to reduce suicide, then the methodologically ideal end point is death by suicide. All other end points, such as attempted suicide and suicidal ideation, are surrogates that may correlate to varying degrees with the clinically important end point of death by suicide.

In cancer trials, the ideal end point is overall survival. Other end points, such as response rate and progression-free survival, are often used, but are recognized as surrogates (usually imperfect ones) for the clinically important outcome. Because investigators, patients, and IRBs do not view every death from cancer as preventable, cancer researchers are not held responsible for deaths due to the underlying disease. Logistical reasons related to sample size or study duration may make using death by suicide as the primary end point in a clinical trial impracticable. But just as oncologists commonly and ethically use overall survival as the primary end point in cancer trials, psychiatrists should not hesitate on ethical grounds to use death by suicide as the primary end point in suicide prevention trials.

Conclusions

Trials of interventions to reduce deaths by suicide are a public health priority. Conducting methodologically rigorous and socially valuable trials requires including participants who are at highest risk of suicide, avoiding the error of treating deaths by suicide and attempted suicides as adverse events, and using death by suicide as the primary end point whenever feasible. To demonstrate which interventions are effective for reducing the suicide epidemic, it is necessary to let go of the belief that every suicide is preventable.

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Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework

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Abstract

Objective: The prevailing paradigm in suicide prevention continues to contribute to the nihilism regarding the ability to prevent suicides in healthcare settings and a sense of blame following adverse incidents. In this paper, these issues are discussed through the lens of clinicians' experiences as second victims following a loss of a consumer to suicide, and the lens of health care organisations.

Method: We discuss challenges related to the fallacy of risk prediction (erroneous belief that risk screening can be used to predict risk or allocate resources), and incident reviews that maintain a retrospective linear focus on errors and are highly influenced by hindsight and outcome biases.

Results: An argument that a Restorative Just Culture should be implemented alongside a Zero Suicide Framework is developed.

Conclusions: The current use of algorithms to determine culpability following adverse incidents, and a linear approach to learning ignores the complexity of the healthcare settings and can have devastating effects on staff and the broader healthcare community. These issues represent 'inconvenient truths' that must be identified, reconciled and integrated into our future pathways towards reducing suicides in health care. The introduction of Zero Suicide Framework can support the much-needed transition from relying on a retrospective focus on errors (Safety I) to a more prospective focus which acknowledges the complexities of healthcare (Safety II), when based on the Restorative Just Culture principles. Restorative Just Culture replaces backward-looking accountability with a focus on the hurts, needs and obligations of all who are affected by the event. In this paper, we argue that the implementation of Zero Suicide Framework may be compromised if not supported by a substantial workplace cultural change. The process of responding to critical incidents implemented at the Gold Coast Mental Health and Specialist Services is provided as an example of a successful implementation of Restorative Just Culture–based principles that has achieved a culture change required to support learning, improving and healing for our consumers, their families, our staff and broader communities.

Keywords

Suicide prevention, Restorative Just Culture, Zero Suicide Framework, second victim, hindsight bias, outcome bias, Safety I, Safety II

Introduction

In the Margaret Tobin Oration at the 2018 Royal Australian and New Zealand College of Psychiatrists (RANZCP) Congress, Turner (2018) outlined the need for a paradigm shift in suicide prevention in mental health services. This includes a shift away from the pervasive pessimism regarding the ability to prevent suicides, the focus on assessment and categorical risk prediction, the lack of focus on meaningful interventions, disjointed training and

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Table 1. The seven essential elements of the Zero Suicide Framework.

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

support provided to staff and the use of diagnosis as a gateway to services. The oration argued that an alternative approach is provided by the Zero Suicide Framework (ZSF), which emerged from the National Action Alliance's Suicide Care in Systems Framework (Covington et al., 2011). ZSF entails

> *suicide specific evidence-based practices, reliably delivered by well-managed whole systems of care that are continuously improving service access, quality and safety; and that are firmly rooted in core values reflecting a service culture that no longer accepts suicide as an outcome*. (Mokkenstorm et al., 2017: 2)

The shift in values and culture is facilitated by the relentless pursuit of the aspiration of zero suicides within a healthcare setting, through the delivery of highly reliable healthcare (May, 2013). This framework consists of seven essential elements (see Table 1) and can complement an all-of-community systems approach such as Lifespan (Baker et al., 2018).

While aiming to create the cultural transformation and shift in mindset through an aspirational goal, there are potential risks associated with the use of the zero terminology. Legitimate concern has been expressed about use of the word 'zero' as it may be interpreted as a target or key performance indicator rather than an aspiration and may create or worsen a culture of blame or risk aversion (Coyne, 2016; Smith et al., 2015). Turner (2018) acknowledged these issues but noted that concerns about blame are not new to the ZSF and are already present and impacting clinicians.

The central thesis of this paper is that the implementation of ZSF may be compromised if not supported by a substantial cultural change, and our central recommendation is that ZSF be implemented in parallel to concerted efforts towards achieving just culture. In order to support this argument, we describe several 'inconvenient truths', which represent significant cultural and procedural barriers to preventing suicides in healthcare settings. We first examine the impact of deaths by suicide on frontline clinicians in health services through the concept of the second victim. We then focus specifically on the processes surrounding organisational reviews of suicide-related critical incidents, which, when done in the context of the current paradigms, have a potential to perpetuate a blame culture. We then introduce the principles of Restorative Just Culture (RJC) and discuss how workplace cultural challenges could be addressed by embedding RJC principles as a foundation to support a ZSF. Finally, we describe the learnings gained in the context of implementation of a ZSF alongside RJC in a large Hospital and Health Service in Queensland, Australia.

'Inconvenient truths' in suicide prevention

Through the lens of the clinician: second victims and clinician welfare

Clinicians working in the complex world of mental health and suicide prevention face many challenges. One of these is the devastating impact of the loss of a consumer to suicide. Another is the impact of working within a complex system, where those complexities are not overtly acknowledged or reconciled within our responses to critical incidents such as suicides.

Mental health workers have significant exposure to consumers who die by suicide. Nijman et al. (2005) estimated that on average, a mental health nurse working full time experiences a consumer suicide every 2.5 years. Wu (2000) introduced the term 'second victim' to describe healthcare providers who are involved in an adverse event and subsequently emotionally traumatised (with the consumer considered the first victim).

Death of a consumer due to suicide frequently results in mental health staff experiencing a range of adverse outcomes. Physical symptoms can include fatigue, insomnia and nausea, and psychological symptoms can include disappointment, self-blame, anger, guilt, shame, troubling memories and anxiety (Joesten et al., 2015; Newman, 1996; O'Beirne et al., 2012; Paparella, 2011). Second victims may have ideations of having failed the consumer, and second-guess their clinical skills, knowledge and even career choice (Newman, 1996; Scott et al., 2009). Involvement in an adverse event may also lead to fear of legal retribution, prejudice and loss of reputation, licensure or income or even criminal charges (Joesten et al., 2015; Paparella, 2011).

In mental health care, a 'culture of blame' continues to exist around events such as suicide, which is exacerbated by political forces, and criticism from public agencies and the media (Wand, 2017). Medical errors are often not discussed, which further reinforces feelings of isolation, mistrust, guilt and abandonment in second victims (Paparella, 2011). This 'culture of silence' (Paparella, 2011) can result in changes to clinical treatment driven by high levels of risk aversity that is potentially harmful to consumers as well as mental health services (Bowers et al., 2006; Morgan, 2007).

There have been increasing calls for organisations to provide specific support to mitigate against the second victim experience in their staff (Scott et al., 2010). Denham (2007) proposed five rights of second victims that should drive healthcare responses under the acronym TRUST: Treatment that is just, Respect, Understanding and compassion, Supportive Care, and Transparency and the opportunity to contribute.

The need to respond to second victims has been likened to a psychological emergency, and the need for a formalised response by leaders at all levels from local to national leadership has been described as 'mission critical' (Denham, 2007).

Through the lens of healthcare organisations

The failures to adequately recognise and support second victims are often intertwined with the limitation of the existing structures for critical incident reviews. In particular, these processes are impacted by inadequate recognition of the complexity of healthcare settings, and the resilience and flexibility required in suicide prevention endeavours. They also fail to reconcile with the limitations of risk assessment, and outcome and hindsight bias. We refer to these as 'inconvenient truths', as they are unsettling concepts which challenge current concepts of linear, cause-and-effect understanding, and are difficult to address.

Fallacy of risk prediction. There has long been a preoccupation with risk assessment in consumers presenting with suicidality to healthcare settings, as if this activity was an end in itself. Despite mounting evidence that the use of risk stratification (high, medium or low) cannot adequately predict suicidal outcomes and should not be used to allocate resources (e.g. make decisions about admission or interventions provided) (Large and Nielssen, 2012; Large and Ryan, 2014), documentation used in clinical practice has long supported a categorical risk prediction model. Retrospective reviews of incidents are also frequently undertaken through this lens of risk prediction, implying that an improved risk assessment could have led to a different outcome. In doing so, factors that may have equal or greater impact on preventing suicide, such as therapeutic relationships and instilling a sense of hope, are often overlooked (Steeg et al., 2018). It has been suggested that

> *we need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk. We need to acknowledge this to ourselves, and communicate this to health departments, to the courts, and most importantly to our patients and their families*. (Large et al., 2017: 162)

In many ways, this 'inconvenient truth' of the fallacy of risk prediction lies at the heart of the need for both a systems approach to suicide prevention and RJC. For too long, clinicians have been judged in incident reviews after a loss of a consumer to suicide, based on this fallacy of risk prediction. Of key importance is that the ZSF is grounded on the belief that our inability to predict suicidal outcomes does not preclude us from preventing suicides through a robust systems approach. However, there are several other challenges pertaining to incident reviews, when there is a death by suicide; these are discussed next.

Fallacies of hindsight and outcome bias in incident reviews. Incident reviews frequently focus predominantly on the issues that occurred close to the time of the incident. This may have a number of repercussions, including the under-appreciation of the quality of engagement, and the therapeutic and rehabilitative care provided to the consumer. There is also the risk that proximal issues will be seen as 'contributing factors' leading to the implementation of restrictive practices, such as locking of units to prevent people from absconding and increase in involuntary admission to hospital (Vine and Mulder, 2013). Vine and Mulder (2013) further highlight the importance of members of the review team being trained in a recovery focus that balances personal dignity and choice with more restrictive practices. As will be described, an RJC approach provides this opportunity.

Hindsight bias is another complex issue that routinely impacts incident analyses. Reviewers who are aware of the outcome tend to overestimate the likelihood of that outcome and the ability of the involved clinicians to have predicted it. This bias tends to colour the evaluation of actions taken prior to an outcome, such that actions taken before a good outcome are deemed good, and actions taken prior to an adverse outcome are deemed negative (Dekker, 2012; Henriksen and Kaplan, 2003).

Furthermore, the processes that review rule violations as decision points in assessing culpability are highly vulnerable to hindsight bias. For example, algorithms may ask whether the clinician who departed from agreed protocols or safe procedures took an unacceptable risk (Queensland Health, 2014). The challenge with this approach is that the decision about 'unacceptable risk' is highly influenced by hindsight bias and fails to consider or learn why the system essentially enabled the clinician to take that decision at the time.

Hindsight bias is impossible to remove, however, may be mitigated by 'reconstructing and understanding the mind-set of people as they experienced the events unfolding and why their assessments made sense at the time, rather than using hindsight to work out why they did not make sense' (Henriksen and Kaplan, 2003: 49). As will be described, engagement of all stakeholders should 'hardwire' this input, with the individuals or teams involved in critical incidents acting as a central component of the review process.

Outcome bias, where we allow the outcome of an event to influence our response to it, also represents a barrier to safety and a sense of justice. As noted by Marx (2019), there is a need to understand the actions of staff, rather than the outcomes they produce, as reacting to the severity of the outcome may simply punish the unlucky. Our current review systems revolve around outcome bias, focusing predominantly on events with the worst outcomes. In addition to the sense of injustice this may create, it allows unsafe actions, which do not lead to adverse outcomes, to go unexamined and therefore contributing to the persistence of an unsafe system.

Limitations of a Safety I approach given the complexity of suicide. A linear, cause-and-effect approach to patient safety has been a predominant paradigm across much of healthcare in performing incident analysis following deaths by suicide. This has been enhanced by consideration of human factors that can contribute to failures and also seeing humans as interacting with a challenging system impacted by latent factors (e.g. workload pressures, technology, resources, procedures) (Ball and Frerk, 2015; Mannion and Braithwaite, 2017). This traditional approach to patient safety, labelled 'Safety I' (Hollnagel et al., 2015), can lead to important learnings in the system; however, they are thought to be most effective where activities are well understood, relatively stable and have limited external influences, such as using theatre checklists, or protocols to reduce central line infections (Braithwaite et al., 2015).

Braithwaite et al. (2015), however, argue that the traditional understanding and approach to patient safety (Safety I) cannot satisfactorily address increasingly complex healthcare settings. Specifically, a retrospective view does not help foster understanding as to how clinical incidents, particularly the most complex and multifaceted ones, such as suicides, come about and what perpetuates them (Diptee and Baker, 2013). Therefore, a change in approach is required, one that 'switches the focus from preventing things going wrong to purposefully enabling them to go right' (Braithwaite et al., 2015: 2). This new paradigm of patient safety has been termed Safety II and can be complementary to Safety I. It 'focuses on creating success rather than eliminating failure and pays greater attention to how clinicians create safe, high quality care through adaptation, improvisation and dedication' (Smaggus, 2019: 667).

Human variability and trade-offs. A central consideration of Safety II is the role of human variability in health care. While Safety I and traditional frameworks for just culture view variability as violations of practice, non-compliance or deviations (Hollnagel et al., 2015), Safety II understands that in order to have a resilient system, clinicians need to adapt when the unexpected occurs and according to the conditions in which they find themselves, which includes a flexible response to procedures. In these situations, performance variability is essential to maintaining a safe system (rather than being viewed as a violation in traditional patient safety). Reason (2000) noted that human variability may be essential in emergency situations where the control must shift to 'the experts on the spot' (p. 770) who must adapt and compensate, and then when the emergency is over, return to consistency, albeit with an alertness to the possibility of failure.

Human variability also allows for trade-offs depending on the circumstances at the time (Sujan et al., 2016). A prime example is the so-called Efficiency-Thoroughness trade-offs; efficiency is favoured where throughputs are a focus; however, thoroughness must take precedence where safety is of paramount importance. This tension is critical in an emergency department setting, a common setting for assessments of suicidality, and although it is impossible to maximise both at the same time, there must be a minimum of each (Hollnagel, 2016). When the system does not acknowledge the trade-off being made in order to achieve efficiency, efficiency will be rewarded until there is an adverse outcome which will then be reviewed through the lens of a need for more thoroughness (McNab et al., 2016). This represents a failure of the Patient Safety focus on errors and waiting for that error, rather than understanding how work is currently being undertaken and what work-arounds are actioned to achieve functioning.

It therefore follows that both successes and failures in healthcare can arise from individual or systemic performance variability, and a more useful focus of understanding our system is on the 'continued functioning of systems under challenging circumstances, rather than the search for and rooting out of errors and mistakes' (Hollnagel et al., 2019: 1). Braithwaite et al. (2019) refer to 'resilient health care', highlighting the importance of taking an everyday clinical work perspective when reviewing incidents to achieve learnings that have more relevance to, and greater ownership from, clinical staff (Sujan et al., 2016). Everyday clinical work of mental health clinicians also includes balancing principles of recovery and least restrictive alternatives alongside responsibilities for the protection of consumers and the community.

Work as imagined versus work as done. Hollnagel et al. (2019) argue that 'there will always be a gap in understanding between those who plan, prescribe, fund or mandate initiatives to keep things safe and those who treat, care for or intervene directly to alleviate patients' conditions' (p. 2). This gap is demonstrated by the contrasting concepts of Work as Imagined (WAI) and Work as Done (WAD) (Funabashi et al., 2018).

Frequently, reviews of adverse events are approached from the belief that WAD should be identical to WAI, and that safety can be maintained through widespread use of procedures and compliance that attempt to reinforce WAI. Linked to it is an assumption that good outcomes occur as a result of WAI, and bad outcomes occur because of deviations from it (Ball and Frerk, 2015; Hollnagel et al., 2015). Such bimodal thinking then reinforces the aim to keep everyone functioning in WAI. However, Hollnagel et al. (2019) recognise that it is impossible for healthcare providers to adhere completely to all the instructions, policies procedures and rules, just as it is impossible that policy makers and managers striving for WAI could alter these same procedures and rules such that they corresponded with WAD: 'People are not the problem to be solved or standardized: they are the adaptive solution ... and we should try to understand the characteristics of everyday performance variability' (Hollnagel et al., 2015: 16–17). In learning about our system, there is therefore a need to understand the gap between WAI and WAD, without judgement of whether one is right or wrong (Sujan et al., 2016). The authors argue that safety will rely on our better understanding of WAD, and why things go right, and ensuring that the capacities to make things go right are identified and enhanced.

Clinician welfare. Clinicians work in complex systems which are unpredictable and do not conform to the linear expectations and mechanistic thinking that often drives service improvement efforts, thus requiring highly flexible adaptive responses. These complex systems may be exhausting for clinicians to navigate, together with dealing with a system based on Safety I thinking that judges negatively variations in practice and trade-offs required (Smaggus, 2019).

This risk of a predominant focus on Safety I is that clinicians' expertise and knowledge will be de-emphasised in favour of focusing on the importance of those who design and regulate our healthcare systems. This can have an impact on clinician well-being through loss of sense of self-esteem, self-efficacy and personal accomplishment (Smaggus, 2019). On the contrary, Safety II may provide an opportunity to better understand and support the demands and successes of their everyday work. This perspective 'affords clinicians the esteem they deserve, as it casts them not as hazards, we must restrain, but as essential ingredients whose strength we must enable to attain safe, high-quality care' (Smaggus, 2019: 669). This insight gives us a new incentive to engage clinicians within the learning process following adverse events, as we will not learn the right lessons without their input.

Supporting and empowering staff in health care services, as well as protecting them against blame and inappropriate guilt, represents a key determinant for success of the ZSF (Mokkenstorm et al., 2017). Furthermore, it has been recognised that continuous and sustained quality improvement – another essential element of the ZSF – is reliant primarily on changing workplace culture (Cohen et al., 2003).

From just culture to RJC

Despite the long-standing acknowledgement that culture is central to patient safety and that blame cultures are contributing to unacceptably high rates of adverse events (Catchpole et al., 2006; Cook et al., 2004), organizations have struggled to move away from cultures of blame (Khatri et al., 2009). This can have impacts on risk aversion, increasing restrictive practices and failure to support capacity building and autonomy (Wand, 2017). A just culture, on the contrary, seeks to achieve a balance between ensuring learning from adverse events and accountability of staff. The predominant paradigm, documented in most existing guidelines on post-incident processes, focuses on algorithms which aim to differentiate between acceptable and unacceptable behaviour (Marx, 2001; Reason, 1997; Wachter and Pronovost, 2009). It assumes that answering a variety of questions – What rule is broken? How bad is it? What should the consequences be? – leads to the development of a proportional and fair response (Boysen, 2013; Dekker et al., 2013).

However, several authors have raised concerns around just culture, citing limited evidence that it has led to improvements in reporting or reductions of the blame culture (Edwards, 2018). Von Thaden et al. (2006) and Dekker and Hugh (2010) express caution about the ability to draw a line between blameworthy and blameless acts, and about who should draw that line. An algorithmic approach 'may imply that actions committed by staff are binary (either acceptable or unacceptable) without appropriate appreciation of the messiness of the system in which the action occurred' (Peerally et al., 2016: 419).

In addition, the prevailing paradigm of just culture offers limited engagement for either the clinician or the consumer, and their family or carers. Instead, it implies that those in the organisation will know where to draw the line between blameworthy and blameless actions (Reason et al., 1997) and that '... clinicians know they will be treated fairly and will be held accountable for their actions and behaviours' (Queensland Health, 2014: 27).

The insights provided by Safety II suggest alternative perspectives to reviewing critical incidents. These include the need to understand and reconcile WAI versus WAD without assuming one is right; to understand why things are done the way that they are at the 'sharp end' of business; to understand what trade-offs are being undertaken by staff; and to understand that the same variability in practices found in retrospective reviews may be the reasons for successes as well as failures. These considerations are far less convenient than a retrospective lens that sees all human variability as 'violations' which must be assessed against an arbitrary line separating errors from reckless acts. Yet, adopting these considerations has been shown to reduce the fear of blame which impedes improvement in complex human systems (Berwick, 2013).

RJC poses very different questions from the traditional retributive questions posed by just culture approaches. RJC asks: Who is hurt? What they need? and Whose obligation it is to meet those needs? It promotes the healing of trust, relationships and people (Weitekamp, 1999; Zehr, 2002) and empowers first and second victims (Barton, 2003). RJC moves away from asking *who* did something wrong and what should be done about them, to *what* was responsible for things going wrong and how this can be addressed. This framework accepts that involved staff can have both accountabilities and needs, and is predicated on the principle of inclusive engagement of all stakeholders. This aligns well with the second victim rights as outlined by Denham (2007).

Accountability is a strong theme of RJC, which recognises that staff are accountable for being part of the healing, learning and improving process after a clinical incident; however, at the same time, they too may have needs for support, and these needs are recognised within this framework. RJC is action orientated, assigning roles and responsibilities for all who have a stake in the event and advocates for forward-looking rather than backward-looking accountability, and the avoidance of blame (Dekker, 2016; Khatri et al., 2009; Sharpe, 2004; von Thaden et al., 2006). A peer led, non-punitive, restorative response has proven more successful in changing behaviour towards a safer system (Dekker, 2016). Implementing RJC has also been found to be cost effective (Kaur et al., 2019).

Engagement of all stakeholders in the post-incident review acknowledges that the greatest learning can be achieved through a social and participative process (Macrae, 2016). Leistikow et al. (2016) argue that staff participating in the learning at a local level, and coming up with local solutions, can improve safety in that setting by changing the way they think about, and maintain an awareness of, risk. Safety II principles imply an imperative to understand everyday clinical practice, WAI, WAD, and trade-offs occurring in our healthcare settings. This may challenge some in positions of power; however, it is only with true engagement of all stakeholders that the WAI versus WAD gap can be reflected upon, ensuring that 'double loop learning' occurs (Sujan et al., 2016: 116). An RJC approach, which requires the engagement of all stakeholders, is well placed to bring together everyone's perspective to gain that understanding – from clinicians involved in the event, to families, consumers and healthcare leaders.

RJC also places obligations and accountability on health care organisations and leaders to provide support for all of those in need and to provide clinicians with an adequate response to their distress. This can be crucial for suicide prevention among healthcare staff who become second victims (Dekker et al., 2013; Jones and Treiber, 2012; Wu, 2000).

We propose that an RJC helps an organisation learn and improve, and equips staff and management with processes to offset or remedy the guilt and other negative emotions commonly experienced by second victims (Bowers et al., 2006; Joesten et al., 2015; Paparella, 2011).

Where is individual performance accountability?

Healthcare systems have various processes in place to deal with individual performance of concern, impaired clinicians or (very rarely) malicious criminal acts. This occurs by way of supervision frameworks, performance reviews and appropriate state legislation. These frameworks and processes are critical for effective maintenance of high professional standards and should be adhered to regardless of the occurrence of critical incidents. Outcome bias should not be the driver of professional development and accountability frameworks, and therefore, the algorithms suggested by the traditional just culture frameworks should not be required – in fact, they can easily become misleading.

Implications for incident review processes and root cause analyses

There have been reservations expressed about the widespread adoption of root cause analysis (RCA) in healthcare (Peerally et al., 2016). As the name implies, this process searches for a 'root cause' behind a critical incident by using tools such as the 'five whys' and timelines which may favour a 'temporal narrative' rather than consider the complex interplay of factors in a system. They are often performed independently from the treating team.

Due to these concerns, the Canadian Incident Analysis framework (Incident Analysis Collaborating Parties, 2012), for example, decided to discontinue use of the term RCA. Instead, it proposes the use of concepts related to complexity theory to avoid the trap of linear representation. The use of a constellation diagram presents clusters of possible factors rather than suggesting cause-and-effect relationships. These clusters of factors provide an opportunity to consider systems, and their connections, including tasks, equipment, work environment, consumer, care team, and organisational factors.

Peerally et al. (2016) suggest that some RCA reports are overtaken by other competing factors and may end up containing information in them that does not always reflect the actual events or the discussions with the review team. Causes for this may include pressure of timelines and a focus on the report as the end point rather than the learning process, as well as lack of independence, attempts to preserve relationships, and partisan interests. Recommendations that arise from RCAs are frequently weak in strength and are often not shared across the service or even fed back to the involved team. Many of these concerns resonate well with the drivers towards RJC.

Implementation of RJC at the Gold Coast Hospital and Health Services: lessons learned

The Gold Coast Mental Health and Specialist Services (GCMHSS), based in Queensland, Australia, adopted ZSF in 2015 as part of the GCMHSS Suicide Prevention Strategy (Gold Coast Mental Health and Specialist Services, 2016). A central component of the implementation of ZSF at GCMHSS was the replacement of a categorical risk prediction approach (high, medium, low) with the Prevention Oriented Risk Formulation (Pisani et al., 2016). The purpose of the risk assessment within ZSF therefore is not to predict suicide but rather to inform effective suicide care. This change was based on the identified need to move away from the expectation that clinicians should be able to predict risk of a consumer's suicide and respond to that prediction. The new framework supports universal approaches to people presenting with suicide risk, and support for clinicians to develop improved skills for engaging collaboratively with consumers to understand their stories, develop individualised risk formulations that inform a care plan, engage in collaborative safety planning (Stanley and Brown, 2012) and support smooth transitions of care.

The principles of RJC have been embedded into the implementation of the Suicide Prevention Strategy from the very beginning, particularly through an increased focus on training of all staff and enforcing of the message that suicides in healthcare are preventable, while at the same time safeguarding clinicians' own well-being. Based on staff feedback, a review of the literature and focus groups, the following main issues were identified with respect to responding to and learning from incidents, which also represent the underlying principles that became drivers of change in the service:

Building the culture

- Clinicians require a high level of trust in the organisation to engage in a Zero Suicide aspiration and to openly learn from incidents. Trust is fostered through the use of an RJC framework.
- Everyone is accountable: RJC demands actions by all, by allocating roles and responsibilities for those who have a stake in the event. Some may have multiple roles, including the need to support the healing of others, learn and improve, but they may also be in need of support for healing.

Healing

- The negative impacts of being a second victim are significant, foreseeable and require an urgent response by leaders at all levels of our healthcare system.
- Healing for all is an important consideration, including availability of skilled staff and pathways for supporting consumers, their families and the community following critical incidents.

Learning

- A strong foundation of incident review expertise is important, including expertise in Human Factors within the review teams.
- Reviewing the continuum of care for the consumer rather than focus on issues proximal to and leading back from the incident in a linear way, to allow for mitigation of hindsight bias, and a greater understanding of important issues such as development of a therapeutic relationship over time.
- Use of tools that can assist with understanding complexity such as constellation diagrams, and avoidance of linear approaches to learning.
- Use of tools that can support enhanced quality and strength of recommendations.
- Some independent representation on the review teams can further enhance accountability.
- Involving the clinical teams in the review process is essential to:
    - Allow the 'right' lessons being learned through a true understanding of WAD, everyday clinical work, trade-offs, and appropriateness of human variability in practice.
    - Ensure involvement of staff with a good understanding of recovery principles to allow for a balance between personal dignity and more restrictive practices.
    - Ultimately will support the translation of learnings into improvements in the workplace.
- Ensuring a place for the service leadership to be involved in the review, allows opportunities for 'double-loop' learning where the WAI is overtly critiqued.

Table 2. Responding to incidents using an RJC framework.

Who is hurt?	What do they need?	Obligations and Actions
Consumer/ Family/Carers	Support, Healing, Information Engagement in review and learning	**Clinician Disclosure following Incident** Train staff in clinician disclosure and engagement with family/carers following adverse incidents. **Referral to Postvention Support agency** Clinicians to have information and material available about the Postvention Support Services. **Engagement of the family in the in the Review process** Family interviewed to gain their perspective of the events; identify lessons they feel need to be learned from the incident; and gather any questions that would like answered within the review process. **Open Disclosure** Meet with family to communicate findings of the review; Structured interaction in the Open Disclosure format; feedback answers to any questions they have; feedback regarding the recommendations being made. **Evaluation** Obtain feedback from the family with respect to their experiences of the post incident process.
Clinicians	Support, healing and learning	**Develop Resilience and Reflective Practice prior to an event** **'Always There' Staff Support Programme** Three-Tier Staff Support Programme using trained peer supporters to provide psychological first aid following critical incidents **Active Engagement of involved staff in the Review process wherever possible** Avoidance of RCAs where possible to enable active involvement of the involved team in the review. Facilitators trained in all relevant components of the post-incident review process. Familiarisation for all staff in the process, including concepts of RJC. **Engagement in dissemination of findings, including Morbidity and Mortality Meetings for all service lines** **Introduction of a weekly MHSS Triage meeting to look at a broader range of incidents, including near misses, suicide attempts, suicides outside of the SAC1 timeframe, and developing themes across all incidents** Determination of most appropriate review process (e.g. comprehensive, concise, multi-incident)
Organisation	Support and learning	**Six-Step Post-Incident Process aligned with RJC principles that supports all measures:** Incorporates multiple perspectives (family, clinician and leadership). A forward-looking review of 'the clinical care pathway' rather than looking back from an incident. Considers review against best practice, considered exploration of Human Factors, and view of systems through the Constellation Diagram. Involvement of team ensures WAD is understood; Involvement of Leadership ensures WAI is understood. Consider what was done well. Use SMARTER to assist with the development of high-quality recommendations. Use a hierarchy of hazard controls tool to guide strength of recommendations. All learnings of relevance are incorporated into Recommendations, not just those deemed 'Contributory Factors'. **Continue development of Just Culture across the health service** **Overt support of staff following adverse incidents**

MHSS: Mental Health and Specialist Services; RJC: Restorative Just Culture; WAD: Work as Done; WAI: Work as Imagined.

- Hardwiring opportunities for the consumer, family or carers to input into the review process, to ensure a full understanding of the many perspectives of the event.
- Reviewing a range of clinical incidents instead of focusing on a small group of severe adverse events. These may include near misses, or more frequent yet

less severe events (e.g. suicide attempts), as well as analyses of groups of incidents.

Improving

- Greater involvement in and ownership by the clinical teams will facilitate translation of recommendations into actions in their workplaces to make the system safer.
- Feedback of learnings and recommendations to the teams and other teams across the service will maximise the opportunity for learning and improvements.

As part of this process, and based on the above findings, GCMHSS decided to move away from the 'commissioned' RCAs which give legislative protection to the teams reviewing incidents (Queensland Health, 2014), as the process was seen as secretive, and would frequently produce recommendations that were difficult to reconcile with available information from both a clinician and management perspective. They also appeared to be out of step with the philosophy of RJC that emphasises engagement of all stakeholders, including clinicians and consumers' families. However, it is recognised that there will be some instances where a process involving a fully independent team with legislative protections will be more desirable. These are now rare instances and would include events surrounded by particular political or media sensitivities.

Activities outlined in Table 2 describe the approach towards responding to critical incidents that has been implemented at GCMHSS, aligned with the principles of RJC.

Conclusion

Despite the recognition that just culture needs to be a key consideration in ensuring patient safety, organisations have struggled to move from cultures of blame (Khatri et al., 2009). In mental health care, in addition to the risk to clinician welfare, a culture of blame can lead to risk aversion, increasing restrictive practices, and failure to work within a recovery paradigm.

RJC, as a foundation to a ZSF, can counteract the risk of blame culture and system anxiety following a critical incident. It provides an ideal framework that can build trust among staff to adopt a bold goal and aspirational challenge of zero suicide by creating an environment in which all stakeholders involved in an incident can feel safe to be open to learning and improving care systems. RJC also provides a framework that mandates the involvement of all parties, so that the complexities of the work can begin to be understood and appropriate learnings made. It provides tools to assist in mitigating against the old paradigms that relied on the fallacies of risk prediction, and outcome and hindsight bias. Equally important, it helps to overcome pessimism and nihilism with respect to our ability to learn from, and prevent, suicides. Involvement of all stakeholders also fosters greater engagement in the improvement process, resulting in a safer system for all, and facilitating healing, learning and improvement for all.

The authors argue that there is an urgent need for greater recognition and understanding of the concepts of RJC, given the adoption of the ZSF across 11 health services in Queensland, Australia, following its successful implementation at Gold Coast Health, and the recent announcement by the New South Wales government of their adoption of a Zero Suicides in Care framework (Mental Health Commission of NSW, 2018).

On the balance of evidence, a change towards RJC and active support of healthcare staff is imperative for a systems approach to suicide prevention to succeed within a hospital and health service. Leaders at a national, state and local level have accountability for addressing these cultural changes as a matter of priority, not only because healthcare workers are already overrepresented in suicide statistics (Milner et al., 2013; Tramutola, 2015), but also because, as has been outlined, this is a vital patient safety issue. A Zero Suicide aspiration not only supports the accommodation of RJC but demands it as a necessary accompaniment to ensure healing, learning and improvement for all.

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ORIGINAL ARTICLE

Just culture: "Evidence", power and algorithms

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Abstract

Background: The notion of "just culture" has become a way for hospital administrations to determine employee accountability for medical errors and adverse events.

Method: In this paper, we question whether organizational justice can be achieved through algorithmic determination of the intention, volition and repetition of employee actions.

Results and conclusion: The analysis in our paper suggests that the construction of evidence and use of power play important roles in the creation of "justice" after iatrogenic harm.

Key words

Just culture, Accountability, Algorithm, Human error, Compliance, Violation, Evidence-based medicine, Justice

1 Introduction

Nurse Kimberley Hiatt committed suicide in 2011. Seven months earlier, a pediatric patient of hers at Seattle Children's Hospital had died from a calcium chloride overdose. Kimberley Hiatt was first suspended, and then fired, and her license to practice was re-instated only after a settlement that put onerous and humiliating conditions on it. She never found work as a nurse again. Aged fifty, Hiatt, a healer at heart according to friends and family, had lost a patient, a job and an identity [1]. The tragedy highlighted how hard it is for society in general and hospital administrations in particular, to act justly in the wake of an adverse event. Hiatt's case, of course, is not unique, despite its doubly tragic outcome. This is a problem that all hospitals face at some point [2-9]. Independent of outside intervention after an adverse event (e.g. by the criminal justice system), hospitals need to be just not only to first victims (the patient and family) but to second victims too: the healthcare worker involved in the incident for which he or she feels personally responsible [10-12]. The notion of a "just culture" has attempted to fill that need.

In this journal previously, researchers sought to clarify the conceptual meaning of just culture, with a focus on the attributes of incident reporting processes that make such systems "just" in the eyes of healthcare workers [13]. They questioned whether a just culture looks the same for all health professionals—which it indeed does not. This is confirmed by survey research [14], organizational change studies [15, 16], studies into the perception of error by particular healthworker groups [17, 18], as well as growing case material on second victimhood [19-25].

Just-culture-by-algorithm, however, reifies the idea that hospital administrations can be led to the univerally "right" or ethical answer by following a set of rules—as for a problem-solving operation—independent of the background and hierarchical location of the healthworker. Such algorithms for "just culture" are currently gaining popularity to determine employee accountability for adverse events [26]. They try to answer whether a medical error deserves forgiveness and restoration, or demands retribution and sanction. In this paper we examine the relationship between moral processes in healthcare and modern evidence-based medicine (EBM) to understand both what sustains the belief in a universal approach of a just-culture-by-algorithm, and why it might not work in practice. We affirm how "justice" is linked to one's location in the organization and medical competence hierarchy. We explore whether justice-by-algorithm might be primarily a vehicle for particular parties to guard their interests, and conclude with alternative suggestions for creating a just hospital culture.

2 Moral process and evidence-based medicine

A current just culture "algorithm" recognizes that even competent professionals make mistakes and acknowledges that they too can develop shortcuts, workarounds, routine rule violations, yet declares zero tolerance for reckless behavior. It distinguishes between human error, at-risk behavior, and reckless action—three categories which involve increasing degrees of willfulness and disregard [26]. It proposes that occasional, inadvertent errors should lead to reflections on clinical processes and procedures, training or design. At-risk behaviors, seen as conscious choices that trade thoroughness for efficiency, require coaching or different incentive structures, and should not be repeated. Reckless behavior is a conscious disregard of unreasonable risk and should be sanctioned, including possible dismissal.

What underlies this algorithm is a belief that justice arises from a correspondence between these kinds of human action and the organizational responses to it. This is consistent with the ideas of EBM, suggesting that social and moral facts exist likes visible disease symptoms, that these are reasonably unambiguous and easy to discover, and that the objective application of an algorithm to these facts will yield fair and equitable interpretations. Ideologically, EBM elides the social and cultural shaping of "evidence" [27, 28], and so does just-culture-by-algorithm. It takes the reality of someone's behavior, as well as the intentions behind it, as unambiguously and objectively available to others—for them to appraise and judge. Evidence can be repeated, independently verified and measured according to standards on which reasonable, informed people can agree.

This belief extends to the human capacity for unbiased and objective observation and analysis [29]. The assessment of a worker's intentions, repetition and volition is a largely self-evident process, as if it were the diagnosis of an illness. The evidence, or "symptoms," from an adverse event, or multiple adverse events, are "diagnosed" —whether the worker suffered from an occasional error or from worse conditions of carelessness or recklessness. The diagnosis emerges from an objective science and results in empirical, quantifiable steps that can be turned into fair and equitable interventions. Incidentally, this program is consistent with still dominant theories of rational choice [30] and regulative management [31]. The environment is seen as a target of rational managerial control, which can be exercised through objective practices of evidence gathering and decision making. Fairness, or justice—like a correct diagnosis—is the logical end-point of applying the appropriate evidence and rationality.

Morally classifying behavior in healthcare predates the idea of a just culture algorithm [32] and has relied on positivism and essentialism for a longer time, even if not directly evident from the data. In his 1970's study of surgical trainees, for example, Bosk found that surgeons considered most "technical" errors remediable, and not morally questionable. As with just culture's occasional "human errors," more skills training and practice could solve these mistakes. "Normative" errors were more problematic: they were not role or performance errors but errors of role, errors of self, failures to live up to the moral duty to act responsibly and autonomously. Surgical trainees who continued to make normative errors (which overlaps with the at-risk or reckless behavior categories in terms of the more recent algorithm) were almost always terminated [33].

Like just-culture-by-algorithm, Bosk finessed the question of how these errors acquire the meanings he ascribed to them [Granted, in a later foreword to his 1979 study, Bosk argued that errors have no essential quality but are constructed through physician interaction and interpretation. When pressed, Bosk had no (analytic) choice but to argue that the meanings he attributed to (and derived from) micro-clinical events emerged from other such events and that they inform subsequent ones]. The current just culture algorithm also sidesteps how its categories of culpability are constructed. Neither Bosk nor the just culture algorithm invoke higher-order structure(s) such as culture, medical competence hierarchy, history or society to account for the emergence of moral judgments within healthcare practice. This leaves the impression that achieving justice is an objective process, easily isolated from clinical or social interpretation. No analysis or critical reflection is necessary because these acts and categories are "what they are". The problem, as flagged by Weiner et al. [13], is that they are not. It depends on where one is located in the organization and medical competence hierarchy, and who gets to say.

3 Justice depends

A recent survey of almost 2,000 healthcare staff across 12 facilities in the US offered empirical validation of Weiner et al.'s critique. Researchers asked about the organization's reporting system and whether people felt safe using it; they inquired about what happens with the reports once they are filed—whether information and feedback is shared around; and they explored whether the organization recognized honest mistakes or engaged in blame and favoritism [14]. Generally, respondents had moderate views of their hospitals' just cultures, with efforts at reporting and feedback receiving the most positive assessment, yet accountability the worst. The survey confirmed a widespread perception of negative repercussions for reporting and fears of blame for errors that are committed [20, 21, 34].

More specifically, the survey revealed how different employee groups rate their hospital's just culture differently. Non-clinical staff rated the justice of their culture less favorably than physicians, but still better than nurses rated it [14]. Physicians overall had the most positive views of their hospitals' reporting, feedback and accountability mechanisms. Non-clinical and nursing staff had considerably less positive views, driven by concerns about how their organizations apportion blame and denies them a voice. There is a sustained belief that disciplinary action gets adjusted on the basis of who makes the error. There are differences in department and specialty too: in acute care (intensive care, surgery and emergency departments) everybody except physicians held a negative view of their organization's just culture. Von Thaden's research, like Weiner's, showed that "justice" is adjusted according to where the person receiving justice is located in the organization and in the medical competence hierarchy. What is seen as a just response to an adverse event by one group was likely to be seen as unjust by all other groups in a hospital. The most powerful group (doctors) was most likely to see responses as just.

The study confirms that evidence on intention, volition and repetition cannot readily speak for itself. The meaning attributed to evidence emerges from other orders of significance altogether [29]. To ascertain both truth and culpability is not just a matter of looking at an adverse event and then knowing (applying) what moral consequence these acts have. Of course, making sense of an adverse event (and, deciding which acts represent morally objectionable behavior) involves issues of power because different views of reality and their vested interests both reflect and generate struggles for dominance [31]. A conclusion of wrongdoing could owe more to a hospital's risk manager's fears (of liability, loss of reputation or political influence) or it could say a lot about how and why a particular manager is held accountable.

It is unlikely that the application of a just culture algorithm would be capable of erasing this. It is in fact more plausible that just-culture-by-algorithm amplifies and legitimates it. Consultancy on just culture in hospitals has been seen as as a way to restore management control over staff performance after the rise of emancipatory practices (and policies) that tended to blame the system, not the worker, for failures and adverse performance outcomes [35-37]. The just culture algorithm invokes the idea of justice, emancipation, fairness. Yet it risks becoming one more rhetoric or metric by which dominant groups can judge others. In an early Platonic dialogue, Sophists challenged Socrates by arguing that there is no point in members of society being just. Sophists rejected the idea that there is something absolutely good in being just. People get what they want by being unjust, not by being just. They just have to sell it as "justice" to the rest—if they have the resources to do so. With respect to the just culture algorithm, few questions have been asked about the considerable resources elites have to co-opt or derail rational, fair initiatives that attempt to empower and provide justice to all.

Yet its "covert" essentialism may precisely be what makes its categories and arguments seem reasonable. They reflect and emerge more from common sense than social-scientific or ethical analysis. Its moral categorizations (and the implicit assumptions about how classification is achieved) strongly reflects folk sociology or a kind of nineteenth-century social science, now mainly repudiated, which holds that the social order is made up of "facts" that exist in the world and that this is self-evident. The just culture algorithm represents, more than anything else, lay ontology and epistemology. It is not clear what ontological status is attributed to the various categories of error and their factual basis. The algorithm reflects common sense and the confidence that both social and moral facts exist and are reasonably easy to discover. This can easily lead to a misplaced concreteness or universalism. The algorithm's blend of positivism and strong pragmatism is easily recognizable in evidence-based healthcare, reflecting the stance much of biomedicine takes on both epistemology and ontology. The result is that the algorithm's argument and categories have become "science" as well as rhetoric and instrument by which to judge the work (and the intentions) of others. And all this is (like Bosk's book Forgive and Remember) done to bring some "fairness" into an arena where previously there has been so little.

4 Conclusion

The generation of justice-by-algorithm offers the illusion that healthcare practices reflect (and are driven by) objectivity, evidence and utility. The result is that justice becomes just one more "thing" in a busy clinic or health care institution to be ranked and categorized. This seems to underlie much of the just culture movement's agenda. What is not widely acknowledged is that the algorithms that have emerged, the ones that control the process by which evidence appears and is weighted, are biased and slanted by a larger social matrix that encompasses hospital risk management, lawyers, quality control, the pharmaceutical industry, departmental managers and physicians. This web of influence and ideology benefits from portraying the achievement of justice-by-algorithm in healthcare as rationality and science. But what is represented as natural, objective, rational and common sense, is often anything but. As in Socrates' nightmare scenario, power and the knowledge of "the right thing to do" (ostensibly change, counsel, coach and not punish) often become aligned in ways that can mask the routine production of injustice. That power wins out in almost any social project, no matter how well-intentioned, is hardly a Socratic victory. Unless these issues are put firmly on the table, the just culture movement runs the risk of collusion and cooptation. The result could be that its algorithms and agendas will in the end do nothing more than legitimize and perpetuate Foucault's "natural order of things" where injustice is often legitimatized and justice forgotten.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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The National Mental Health Commission

Sit beside me, not above me

Supporting safe and effective engagement and participation of people with lived experience

Australian Government
National Mental Health Commission

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Preface

The National Mental Health Commission (NMHC) is strongly committed to improving engagement and participation with people with lived experience, their families and other support people.

Engagement and participation with people with lived experience in mental health and suicide prevention that actively supports co-design, co-production, and co-delivery of systems and services leads to better health and wellbeing outcomes, aids recovery, and achieves better experiences for service users and service providers. This requires strong policy commitment to partnering with people with lived experience in monitoring and reviewing system and service performance, and decision-making about what is deemed to be a desired outcome.

Further to the NMHC's 2017 Consumer and Carer Engagement and Participation Project, this report was commissioned to examine ways to support people with lived experience to effectively and safely participate with services, organisations and systems. In 2018, we worked with David Butt & Associates to consult with key leaders to understand how to support people with lived experience to fulfil appointed or assigned roles, regardless of whether they are a CEO, a peer worker, a committee member or a board member.

This report describes essential ingredients and considerations for effective and safe engagement and participation, and demonstrates positive changes. But it also confirms that more still needs to be done. It highlights that supporting better, safer and more effective engagement and participation with people with lived experience, their families and other support people requires shared or mutual development for all people engaged in mental health and suicide prevention, and not just those with lived experience.

The NMHC's forward work program focuses on strengthening partnerships with consumers, carers, families and support people, as well as service providers, peak bodies, primary health networks and governments, to enhance opportunities for genuine and meaningful engagement and participation. Building on our previous work, we are developing a national guide to assist policy makers, service providers, professionals and people with lived experience achieve best practice in engagement and participation. We are also committed to undertaking an annual consultation with people with lived experience so we can hear and better understand their experience and impact of mental health reforms. And we are working with the Safety and Quality Partnership Standing Committee and the National Mental Health Consumer and Carer Forum to develop a consumer and carer guide that addresses how consumers and carers can participate in all aspects of what is undertaken within a mental health service so their role in ongoing safety and quality initiatives is strengthened.

"I need someone to sit with me, not save me."
Jackie Crowe

Acknowledgements

We thank all those who shared their experiences to inform this report. This included leaders from within the system who have lived experience, and their families and other support people. It included clinical and non-clinical leaders working on service, organisation and system change that involves the engagement and participation with people with lived experience. And it included people expressing opinions on behalf of their service, organisation or system.

Our deepest thanks go to Jackie Crowe's family, Gary Jaensch and children, Zak and Cassie, who supported Jackie in her numerous roles across the mental health and suicide prevention systems. Jackie was an inaugural National Mental Health Commissioner who fiercely championed better outcomes for people with lived experience over the course of her life and was an inspirational and driving force behind the Commission's work in this space.

As a Commissioner, Jackie's impact was profound in ensuring the NMHC always took a person-centred approach – that people with lived experience, their families and other support people were at the centre of all the NMHC did. She was a fearless champion against stigma and discrimination and for the rights of the millions of people impacted by mental ill health and suicide. She was a powerful advocate for ending seclusion and restraint and wanted to see all mental health units have multidisciplinary teams with the skills to deliver a therapeutic program and environment on an extended-hours basis. She was fearless and in awe of no one. She was always willing to ask the hard questions, to push for changes that would benefit people. Jackie was always asking "Why?" or, perhaps more importantly, "Why not?" She had an exceptional capacity to combine her own lived experience as a consumer and carer, to walk with people and families affected by mental health conditions and suicide, and then to add that knowledge to her continuously growing expertise in being able to communicate and passionately advocate strategically and nationally.

Jackie always had time for everyone – and that must have been incredibly demanding because everyone wanted to talk with Jackie. She was warm and compassionate, full of ideas, and she was always willing to contribute. And she was fun – and funny. She was absolutely passionate about the value of families, their relationships and support, epitomised by her love for her own family. Jackie is sadly missed by us all. She passed away on 21 October 2017 from natural causes due to physical health complications.

"The values of Kindness, Respect and Understanding cost so little yet have such powerful impacts that last for a very long time."
Jackie Crowe blog, 10 October 2017

About the project

The NMHC initiated the project to provide advice on ways to support people with lived experience to safely and effectively participate in consumer and carer engagement.

The intent of the project was to identify what good practices exist and what can be improved.

The project involved reviewing current practices in policies, frameworks and practice guidelines, and face-to-face or phone interviews with 55 key stakeholders including many people with lived experience and others who operate as leaders and managers within mental health and suicide prevention services, organisations and systems. Some information was also provided by email. The NMHC and the consultant determined the stakeholders. The findings in this report come from the information, experiences, priorities and opinions expressed by these various people, reviews from current literature, and draws on the consultant's experience working in mental health and suicide prevention.

A note on language

Words and language were identified in this project as being extremely important.

Consistent with the language of recovery, the terms ‘person’ and ‘people’, ‘person in recovery’, ‘person with lived experience’ and ‘people with lived experience’, ‘lived expertise’ and ‘expert by experience/training’ are used wherever possible rather than the terms ‘clients’, ‘service users’ or ‘patients’, which focus on deficits or relationships to services.

For similar reasons, this report uses the term ‘families and other support people,’ which includes family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one.

It is acknowledged that many people prefer the words ‘consumers’ and ‘carers’ or ‘people with lived experience’. In this report, ‘lived experience’ refers to people who have experience of mental ill-health either as a consumer or a carer/family member/support person. Where quotes are used from people with lived experience, even though they largely are de-identified, the title they have used for themselves has been used – for example, Senior Consumer or Carer Leader.

References to ‘safe’ relate to everyone who works in mental health and suicide prevention – not just to those people who declare a lived experience and includes practices and environments that support the safety of all involved.

Participation is described as:

> *participation by consumers and carers in formal or informal planning, delivery, implementation, and evaluation of all activities associated with mental health services (voluntary or paid), as well as in all processes which effect[sic] the lives of consumers and carers, through sharing of information, opinions, and decision making power.*[1]

The terms engagement and participation are used together in this report to include the methods of engagement and the practice of participation. This can occur along a continuum, through no or low engagement, tokenism and minimum consultation, representation, co-design, and to lived experience-led models. In co-design and lived experience-led models, other stakeholders are also engaged in the process, but the process, and the achievement of results, cannot proceed unless a majority led group of people with lived experience support it.

1. The role of lived experience

People with lived experience, families and other support people need to be recognised as active partners with the same rights and responsibilities as people without lived experience.

People with lived experience can and do operate at all levels of the system – individual, service, organisational or strategic systems levels. They may be advocates, advisors and supporters, and may have roles in governance, policy development, planning, service design, delivery, or monitoring and evaluation:

- for individuals (potentially themselves, a family member or friend)
- for services and programs
- within and across entire organisations (small, medium and large)
- at a strategic systems level, with potential impact on regional, state/territory or national policy, planning and implementation.

A number of people spoke of the different cultures between the mental health and suicide prevention sectors; there are areas of commonality and differences that need to be recognised and respected. Mental health focuses on functional capacity (or functional impairment) with a diagnostic basis. Suicide on the other hand may not have any obvious clinical diagnosis. It is important that boards, CEOs, managers, policy makers, and clinical leaders develop processes and approaches that support the different perspectives and cultures of people with lived experience, their families and other support people in relation to mental health and suicide prevention.

> ***"With mental illness, there is often a lot of anger associated with the way a person – or their family or carer – has been treated. With suicide, it tends to be more about grief and an inability to understand."***
>
> ***Person with lived experience of suicide within the family***

Discussions about engagement and participation must include all people who are impacted, whether they are primary users of the system, or families and other support people. There is extensive recognition that everyone needs to be in this together – that a 'them and us' approach is not the pathway to success. Despite the overwhelming evidence of the value that people with lived experience can bring to improving the safety, quality, efficiency and effectiveness of services and systems, too often there is a lack of respect and recognition of the value of these perspectives. People with lived experience should be treated, remunerated and reimbursed appropriately and in a manner that recognises them as genuine partners with other stakeholders at the decision making table.

Lived experience is only one skill or attribute which a person may need to perform a particular role or function, and the full range of skills required will change according to the role. There is a difference between experience and expertise and it is recognised that as the roles of people with lived experience move 'higher' or expand in scope, so does the need for different levels of expertise. For example, a person may have skills as a peer worker engaged in supporting individuals in their recovery journey but this in itself does not equip them to participate on national, state or territory mental health commissions, boards or broader policy advisory committees. Similarly, people working at systemic levels may not have worked on the frontline and may not necessarily have the skills to provide effective and meaningful peer support at an individual or group level. Each role has different objectives and requires a different range of skills.

2. Safe engagement and participation

The system in which people live and work needs to be safe for all, regardless of whether or not people have a declared lived experience.

Ensuring safe practices and environments is a requirement of all workplaces, all roles, and all communities – not just within mental health or suicide prevention.

Work Health and Safety practices and legislation apply to all Australian workplaces and focus on the environment a person works within, rather than on the individual person. However, when a person shows signs of psychological or physical distress, there is a requirement for leaders and organisations to focus on the supports that an individual person needs. Some stakeholders identified an increased adoption of voluntary self-care and/or wellbeing plans available to all staff, such as Flourish Australia's Personal Situation Plan,[2] that address individual safety.

A safe environment is subjective and can vary from individual to individual. Sharing personal stories and exposing vulnerability requires courage in oneself and trust in others. Safe engagement and participation means that people with lived experience feel comfortable being involved and speaking about their experience because the behaviours and actions of others demonstrate respect and a willingness to listen and learn. This can also be supported by training on safely sharing personal stories.

Support also needs to come from peers. A number of those consulted noted that lateral, or horizontal, violence (i.e. displaced violence or aggression directed against one's peers, often in the context of feeling powerless with authorities or systems) impacts safety and security of all involved. When this occurs, it was felt this behaviour should be identified and responded to with processes and systems that emphasise the importance of respect and kindness.

People with a lived experience may have unique needs and require specific supports but they are not necessarily the most vulnerable. Some people may have a lived experience, but may not have declared this experience and others may discover they are vulnerable when exposed to complex and emotionally challenging circumstances. For example, a person with a lived experience may have developed resilience and coping mechanisms to deal with vicarious trauma when they are exposed to it. Others who have not had that experience may find such circumstances highly traumatising.

Stakeholders support embedding safe and effective engagement and participation in mental health and suicide prevention as key requirements within the National Safety and Quality Health Service Standards and the National Standards for Mental Health Services.

3. Effective engagement and participation

If people with lived experience are to engage effectively at all levels of the system, they need to be supported.

People with lived experience engage and participate at individual, service, organisational and systems levels within mental health and suicide prevention. However, implementation of engagement and participation is not uniform and too often there is a lack of respect and recognition of the value of the perspective people with lived experience bring. It is important that discussions and arrangements about engagement and participation include all those impacted, whether they are primary users of the system, or families and other support people.

Much has been said and written about 'enabling' people with lived experience, their families and other support people, to engage and participate in co-design of policies, services and actions that impact on their ability to live contributing lives within thriving communities. Yet 'enabling engagement' is likened to doing 'to' people, rather than doing 'with' or doing 'for' people. Ideally, the relationship should be seen as two-way, with co-design principles helping to overcome power imbalances and to deliver activities and results that are acceptable to all.

To break down power inequities that often exist in decision making between consumers and carers and health professionals, effective engagement and participation needs to be seen through a different lens, or in fact through two lenses:

- people with lived experience, their families and other support people need to support ('enable') services, organisations and systems to learn and benefit from their experiences (including from using their services, organisations and systems) and their knowledge and skills
- services, organisations and systems need to engage with people with lived experience in mental health and suicide prevention in the design, production, delivery and performance monitoring of systems and services so they can learn from their experiences, improve their services, and achieve better health and wellbeing outcomes.

Very importantly, there was strong feedback that any steps taken to improve, strengthen or introduce engagement and participation should avoid creating new behavioural or risk management approaches that single out people who declare they have a lived experience. That would be discriminatory and would take the engagement and participation process backwards. Risk management should apply equally to everyone, not only those who identify as having a lived experience. Identification of the potential risks for all stakeholders involved in projects, actions and committees should be considered.

There needs to be more collaborative practice, where people with lived experience, their families and other support people work alongside clinicians, other staff, managers, CEOs, board directors, funders, researchers, and policy makers in a range of areas, including identifying problems, co-design and implementation of proposed solutions, and learning which promotes continuous improvement.

4. Essential ingredients for safe and effective engagement and participation

Maximising potential for safe and effective engagement should involve reciprocal responsibilities that sit with people with lived experience, their families and other support people, services, organisations and system leaders.

There is a range of supports and tools that should be used so all people across individual, service, organisational and systems levels can engage and participate effectively and safely. These apply to all people working within or with services, organisations and systems, as well as to people with lived experience, their families and other support people – they are all in this together. This means a powerful culture of effective and safe engagement and participation with people with lived experience, their families and other support people can be embedded as the norm for how policies, programs, services, strategies and systems are designed, delivered and experienced throughout Australia.

Safe and effective engagement and participation is enhanced by the following key ingredients:

- strong leadership
- a culture that recognises engagement and participation is everyone's responsibility
- values of kindness, respect and understanding
- freedom from stigma and discrimination
- enhanced health literacy
- continuous quality improvement
- training and skills development for all involved
- ongoing research and evaluation.

These ingredients have been identified as being not only important to safe and effective engagement, but essential in demonstrating respect and recognition of people with lived experience as equals in processes and activities. Stakeholders identified operational (e.g. secretariat support) and strategic (e.g. training and development in corporate and clinical governance) support is required to fulfil lived experience roles.

A major deterrent to safe and effective engagement and participation is the stigma and discrimination which occurs from within the health workforce. Building awareness and knowledge about the impact of stigma and discrimination in mental health and suicide prevention fosters mutual respect and understanding across the workforce and with people with lived experience, their families and other support people.

Notably, the promotion of the importance of safe and effective engagement and participation of people with lived experience should not be borne solely by peer workers or positions such as senior consumer and carer advisors, but recognised and promoted by leaders and managers. Safe and effective engagement and participation is the responsibility of everyone within the system. Responsibility for effective engagement and participation does not rest with, nor should be substituted by, the peer workforce. Boards, CEOs, managers, policy makers and clinical leaders must take responsibility for leadership in effective and safe engagement and participation with people with lived experience, their families and other support people.

> ***"You need to come with a positive outlook and that means you need to have processed your stuff – you can't do it once you get appointed. You need to listen and treat people with respect… As they say, you catch more flies with honey than with vinegar."***
>
> Senior consumer leader and advocate

People with lived experience wanting to maximise the benefits of their engagement and participation should be supported and encouraged to:

- be clear with themselves and with others as to why they want to engage, what the decision making process is and what they are aiming to achieve
- determine where they want to focus: individual engagement, advocacy and support, service and organisational change, and/or strategic systems and policy levels
- ensure they have (or develop) the skills and capacities to engage and contribute at that level (which often will extend beyond their own lived experience)
- be prepared to demonstrate those skills through formal selection, appointment and performance review processes
- practice self-care and awareness
- ensure they are linked into networks and other supports, including the ability to be informed by the experiences and knowledge of others
- treat others with respect and understanding – just as they would expect to be treated
- engage and participate in respectful, civil debate, recognising the potential different views and experiences of other people.

Services, organisations and systems leaders wanting to maximise the benefits of safe and effective engagement with people with lived experience have a duty to:

- take responsibility for initiating and leading service engagement activities
- be clear up front – with themselves and with people they engage with – as to why they are engaging, what they are aiming to achieve and what the decision making process is
- document what they are seeking and how they are going to go about it
- begin early: plan and engage people at the start of the process
- take the time to build relationships
- be transparent with individuals, and organisations representing or identifying those individuals, about what their engagement will involve in terms of skills requirements, time commitments, remuneration and expense arrangements, what supports are available (e.g. printing, travel, technical advice), and in particular about decision making processes
- be transparent about the types of issues people with lived experience are likely to confront in the role or process e.g. experiences of other people's lived experience including potentially trauma
- communicate frequently and regularly, 'close the loop' and provide feedback on decisions and actions
- engage and participate with people representing diverse community groups e.g. Aboriginal and Torres Strait Islander peoples; people from Culturally and Linguistically Diverse (CALD) communities; people with intellectual and physical disabilities, people with lived experience of dual diagnosis; people who identify as Lesbian, Gay, Bisexual, Transgender, or Intersex (LGBTI); and children, adolescents and young people
- make processes and supports transparent and equitable
- ensure adequate and formal processes, matching the requirements of the task at hand, rather than informal and ad hoc (this could include documented task specifications, position descriptions, selection processes, feedback and review)
- recognise where their duty of care lies from the perspective of work health and safety policy to individuals they engage
- ensure people are treated with respect, and are not subjected to stigma and discrimination - provide people with details of complaints handling processes, and have available methods of escalating or supporting individuals where evidence emerges that this is required
- ensure cultural competence, particularly for Aboriginal and Torres Strait Islander peoples
- ensure people can access time out when they need it e.g. safe spaces, breakout rooms
- identify risks and use agreed mitigation strategies
- offer individual self-care and/or wellbeing plans for anyone who requests one
- use review processes to promote learning and opportunities for continuous improvement
- continuously build a culture which recognises the value of lived experience and actively seeks safe and effective engagement and participation with people with lived experience in all activities they undertake
- continuously build the leadership capacities of the workforce to ensure people at all levels work respectfully and effectively with each other and with external stakeholders, including people with lived experience, and that they recognise the specific value that lived experience can add

5. Supporting safe and effective engagement and participation

This section summarises key factors that support better, safe and more effective engagement and participation. Many of these factors are universal, applicable beyond mental health and suicide prevention. They apply to anyone wanting to engage and participate with individuals, families or communities in co-design, production, and delivery of systems and services, across a range of sectors including health, education, disability, and employment.

Connections

Relationships, communication, connectedness, shared experience, understanding, growth, empowerment, respect and kindness should be employed as pathways to recovery, supporting engagement and participation.

A clear and frequent message from consultations in the development of this report was the importance of people with lived experience, their families and other support people being provided with strong support networks tailored to their individual needs and not operating in isolation.

Peer support was identified as an extremely important tool to provide this support. The principle of peer support is based on 'being there', for and with others. The purpose is to support engagement and participation through providing advice, debriefing and escalation mechanisms when necessary. Peer support can be provided formally or informally to people with lived experience, their families and other support people to be linked into networks.

Peer support can be provided in a range of ways:[3]

- one-on-one or in a group
- by volunteers or paid employees
- peer-led or facilitated
- in person, on the phone or via the internet
- through workshops or social activities
- in ad hoc or ongoing formats.

Communities of Practice are another mechanism that can support connections. It involves collective learning and identifying problems, co-design and implementing proposed solutions to those problems, to collectively benefit from the learnings of those processes, and to look for continuous improvement opportunities. Communities of Practice involve people with lived experience, their families and other support people, clinicians, other staff, managers, CEOs, board directors, funders, researchers, and policy makers.

> ***"…my peers across the world mostly just ask for one thing when it comes to how they would like to be treated in the workplace – the one thing they ask for is kindness. And I understand how they feel and why they value kindness so highly."***
>
> Jackie Crowe

Digital innovation

The digital age is driving systems, services, and greater opportunities for engagement and participation which should be explored.

New digital solutions have generated entirely new ways to engage and participate with people with lived experience. Social media provides more opportunities to link with others in peer support chat rooms or through blogs, Facebook, Snapchat, and Instagram. Views, advice and feedback on issues and improvements needed in mental health and suicide prevention can be sought 'en masse' and quickly. Real-time feedback on people's experience of service is achievable, as demonstrated in retail services and suppliers. To support safe and effective engagement and participation, policy makers, funders and service providers need to be ready to respond to real-time feedback and manage online discussion in their respective mental health and suicide prevention space.

We live in a digital age, where people communicate and receive information online rather than face-to-face and receive, process, and generate information and data at an incredible speed. This is particularly the case for young people who are likely to have a different experience and expectations of mental health and suicide prevention services to that of their parents or grandparents. It is likely that their engagement and participation preferences may also be quite different. Services, organisations and system managers should utilise a broad range of digital strategies to enhance engagement and participation opportunities. This will involve many of the same duties as are listed on page 11. Very importantly, digital engagement and participation needs to be safe and should consider safeguards against cyber bullying, body image pressures, suicide and suicide attempts.

Generational differences

There are vast variations in people's lived experiences across generations – all of which are valid and need to be represented.

There are vast differences in people's experiences of the system. Contributing to this is generational change, relative improvements in mental health and suicide prevention treatments and supports, increased diversity of populations, and the range of functional impairment.

Many of those who originally took up the voice of lived experience in the 1980s and 1990s lived through what could be called the 'institutionalisation era'. They may have been subjected to what now is recognised as dehumanising and highly traumatic treatment (to the individual, their families, carers and other support people), including high rates of seclusion and restraint. It has taken incredible courage, commitment and tenacity for them to be able to challenge and advocate for change – for themselves but also for those who come after them – over what for many has been a sustained (and often frustrating) period of many, many years.

The next generation experienced the 'deinstitutionalisation era', where large institutions were progressively downsized or closed, and increasingly services were mainstreamed into general hospitals or into community settings (albeit in stops and starts and with serious concern about the lack of adequate support within the community, including psychosocial supports).

Now another generation is emerging, with young people having different experiences to previous generations. Many young people would not identify themselves as a 'consumer' or user of mental health services. They live in a different era – a digital age where they do much of their transacting and receipt of knowledge online rather than face to face and they are likely to have a different experience of stigma and discrimination

These different experiences are all relevant and all matter. Current senior consultants with lived experience need to be involved in supporting succession planning for current and future consumer and carer leaders. Experiences and learnings from different generations need to be understood, valued and built upon.

> ***"I'm a firm believer in a post-modernist view of truth – truth is relative to one's own experience so you cannot discount the views of those who have come before, of those now, and of those who are coming through. They have all had their challenges, some things are common – for example, the disrespect – and some things are different. One thing we can all see as a common platform is the need for mutual respect: Respect for the cause, for the people you share the cause with, and respect for those who work in services and systems and who are being asked to go through the change. We are all here to work together to change and make that difference. Understanding is an important means of acknowledging where they've all come from."***
>
> Young leader with lived experience

Skills based approach

Lived experience is only one skill or attribute that a person may need to perform a particular role or function; the full range of skills required will change according to the role.

Of itself, having a lived experience does not make an individual an expert in systems, strategy, governance, policy or service delivery. In the same way that training as a clinician – such as a psychiatrist, psychologist or mental health nurse – does not of itself equip a person with the expertise to sit on boards and national advisory structures.

Feedback from consultations for this project confirmed the importance of supporting people to contribute at the levels they would like to contribute, and the need to support people from diverse backgrounds so they can effectively and safely engage and participate at all levels of the system. Recognising and valuing people with lived experience as partners in health and health service provision is necessary for safe and high-quality care. This means everyone involved needs to be able to give and receive, listen and understand, and interpret and act on data, information and knowledge. It requires the use of appropriate communication methods and content so that information is understood, discussed and debated and sound decisions can be made. Training and development in health literacy is one way to support people to be involved as equals when they are engaging and participating with other experts who have health professional backgrounds.[4]

The development of clearly defined specifications for positions and roles where lived experience is a requirement and a skills-based approach to training and development will further support co-design and production in mental health and suicide prevention systems. Building capacity in a broad range of areas – such as leadership, clinical and corporate governance, financial management, strategy, policy development, advocacy, conflict management, co-design, co-production, monitoring and reporting – is required to fill the increasing number of roles needed for a contemporary and future-focused system. Processes of co-design, co-production and co-commissioning take time, and may require new skills. It is recognised that capability development applies to all people working in the mental health and suicide prevention sector, including people with lived experience.

There is an increasing range of organisations providing opportunities for skills development – peak bodies, mental health commissions, non-government organisations (NGOs), service providers, government agencies, and educational institutes. There are also many organisations that have set up lived experience registers and networks. Some sit within the existing mental health and suicide prevention systems but those found in other sectors like disability and employment may still be applicable and highly relevant.

Example:

Roses in the Ocean was formed by people with lived experience of suicide and aims to build the capacity of people with lived experience to be involved in all different aspects of suicide prevention. People are trained to fulfil the skills required for various roles – on reference groups for Primary Health Networks, research and other committees, public speaking and events management – whatever it is that suits their skills set and appetite for involvement. It includes a national mentoring program, which wraps supports around them, working to gauge the impact on them as individuals and the impact on the organisations which engage them.

At present there is no systematic approach within the mental health and suicide prevention systems to create a pipeline of trained and skilled people who have lived experience and want to contribute. Participants suggested a systematic approach was needed and considered that this function could be led by a newly developed peak organisation, or facilitated through an existing organisation such as the National Mental Health Consumers and Carers Forum if resourced appropriately, or the NMHC. It was considered NMHC could achieve this by partnerships with the State Commissions, peak bodies such as Mental Health Australia and Suicide Prevention Australia, and other peak bodies for people with lived experience, their families and other support people.

Another suggestion was to engage senior people with lived experience operating at senior levels within society – in health, business, executive and other leadership roles, who for various reasons have not declared their lived experience – to contribute to governance and other roles in mental health and suicide prevention. This requires an ongoing focus on reducing stigma and discrimination in the workplace and broader community so that that they are willing to declare their lived experience and become engaged and involved in reform. Training and support for these people also is needed to build capacity to share their lived experience and apply it in a meaningful and purposeful way.

It was suggested a National Framework on Skills and Competencies could be developed to describe the skills and requirements of safe and effective engagement and participation of people with lived experience, at different levels within the system. This may range from core competencies such as the ability of people to speak about their own lived experience to higher level skills required for good corporate and clinical governance.

Workforce Culture

There is a well-known saying "culture beats strategy", so it is essential to build and maintain a culture that supports engagement and participation.

Safe and effective engagement and participation needs to be supported by strong community and workplace culture underpinned by shared values. There also needs to be a willingness to engage and connect in a meaningful way with people with lived experience, their families and other support people. There was agreement that behavioural and culture change in the workforce occurs when there is understanding and recognition that mental health and suicide impacts everyone, and that safe and effective engagement and participation is relevant to all people. Embracing this increases the use of the skills and knowledge of people with lived experience. A major factor in building, measuring and demonstrating strong, high performing culture is the alignment of experience and satisfaction between staff and people, their families and other support people who use systems and services.

Workforce factors impacting safe and effective engagement and participation evident from this project include:

- workforce shortages, poor distribution and composition
- poor culture, at individual, service, organisation and systems levels
- varying degrees of recognition, commitment and action demonstrated by executives and senior management of the value of lived experience
- limited awareness of responsibilities and duty of care in engaging people with lived experience, their families and other support people
- limited capacity and capability in understanding and knowing how to effectively engage and participate at different levels of decision making
- limited collaborative leadership
- pressure to perform, often across a range of competing or even conflicting priorities, among policy makers, funders and service providers
- time and funding pressures
- stigma and discrimination which occurs from within the health workforce
- limited prioritisation or recognition of the importance of engagement and participation in service commissioning, contracting, funding and performance reporting arrangements
- limited engagement with diverse populations
- absence of compelling incentives to make effective engagement and participation a program, organisational or systems priority.

Example:

The challenge of engaging leadership is outlined and highlighted well in *The Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities,*[i] chaired by NSW Chief Psychiatrist Dr Murray Wright and with Jackie Crowe as a review team member.

Recommendation 1 of that Review reads:

"There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture. Collaborative leadership was not evident to the review team. NSW Health must establish and adopt an integrated leadership development framework applicable to all staff at all stages of their career."

All recommendations of the Review have now been accepted by the NSW Government.

[i] NSW Ministry of Health. Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities. Sydney: NSW Ministry of Health; 2017. Available from: http://www.health.nsw.gov.au/patients/mentalhealth/Documents/report-seclusion-restraint-observation.pdf

There is a need for training and continuous development for those who engage with people with lived experience, their families and other support people both in the mental health sector and in other areas such as education, disability, employment, police and justice. This is not easy: processes of co-design, co-production and co-commissioning take time, and often new skills. Investment in integrated leadership development applicable to all staff at all stages of their career is important. It was felt the mechanisms, structures and strategies needed to implement safe and effective engagement and participation need to be complemented by comprehensive, sustainable and widespread cultural change.

What gets measured, gets done. People working in services, organisations and systems tend to do what they are rewarded for, and what their performance is assessed against – particularly where there is benchmarking and public reporting. The incentive to ensure effective and safe engagement and participation with people with lived experience would be significantly strengthened if commissioning and funding of services and organisations included performance reporting requirements and evidence of that engagement in co-design, monitoring and service improvement.

There also is support for the implementation of mechanisms which can assess and demonstrate safe and effective engagement and participation; for example, as key requirements within the National Safety and Quality Health Service Standards and the National Standards for Mental Health Services.

> ***"Accreditation could be strengthened to require organisations to demonstrate they are engaging effectively in co-design with people with lived experience – if organisations want to operate in this space there are certain expectations or requirements they have to meet."***
>
> Mental health service CEO

Research

Lived experience-led research in areas identified as important by those with lived experience, their families and other support people is fundamental to future change and better outcomes.

For safe and effective engagement and participation in research, monitoring and evaluation, people need to know and experience that their views are listened to and respected, and that a focus on the users of services will be at the centre of the approach. Fundamental to this is the development and application of research into practice. Research and evaluation should demonstrate a strong focus on lived experience including:

- co-design of research proposals
- measures of person and family experience of service
- lived experience self-rated measures
- measures of staff attitudes, beliefs, behaviours, and overall wellbeing

The need for a more strategic approach is confirmed in the Fifth Plan:

A strategic approach to research is necessary to ensure better treatment options are available in the future and the best outcomes are achieved from care. Involving consumers and carers in the prioritisation of research objectives, targeting research funding to high priority areas and improving data collection tools are potential improvements that could translate to better services.[5]

Self-determination

It is an individual's choice – their right to determine – what roles and responsibilities they wish to take on and to put themselves forward to participate and engage.

A fundamental right of all Australian people – regardless of whether or not they have a lived experience – is the right to self-determination – in line with Australia's obligations contained in:

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Rights of Persons with Disabilities
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Rights of the Child
- Convention on the Elimination of All Forms of Discrimination Against Women
- International Convention on the Elimination of All Forms of Racial Discrimination
- United Nations Declaration on the Rights of Indigenous Peoples

There is support for rigorous and transparent screening and selection processes for lived experience roles, supported by clear information on capabilities and commitments. These are normal processes for job positions, boards, councils and advisory committees and means people with lived experience are not treated differently from those who do not have a lived experience. Organisations need to be very clear upfront about the role or roles they are seeking to fill, their expectations of the work and workload involved, levels of reward or remuneration, and what supports will be provided to individuals. This assists people with lived experience to choose which roles or responsibilities they wish to pursue. Consultations to develop this report confirmed that some organisations already do this well.

Example:

The headspace Youth National Reference Group (hY NRG) is made up of a diverse group of young people of varying ages, genders and cultural backgrounds. People on hY NRG represent each state and territory and work with headspace to ensure young people's voices and opinions remain front and centre. They have support networks through their local headspace, each of which has a Youth Reference Group.

In 2017, 150 young people from these local networks applied for membership of hY NRG. After a rigorous shortlisting process, 50 of them were interviewed and 20 of them were selected (including four Indigenous young people). They then underwent an induction process as well as developing their own Wellbeing Plans where they advised of anything they currently were dealing with that they wanted headspace National (hN) to know about. They also rated how difficult they were finding life at the moment, nominated someone as a support person and advised how they would like to be supported if they experienced difficulties. Before each meeting, they filled in a new Wellbeing Plan.

hY NRG participants are not required to appear in the media but where that is requested and they choose to do so hN takes them through media readiness training, including a Media Plan and a Media Readiness Checklist.

Where there are requests for representation from young people, these requests come through hN and they must be documented so there is clarity about what is required. These opportunities are shared around the group and the intent is to always have two people in attendance, never just one – they work as a team. This is so that young people are able to support each other, share the workload, and ensure that a diversity of voices and experiences are included in each project. They consult on a variety of hN programs and initiatives, have the opportunity to design and lead their own projects, sit on interview panels for staff, and hN works with them to identify skills and experiences from their time on hY NRG which can add value to their CVs – for example, as public speakers, conference organisers, project managers and media representation.

“It’s not easy to be a leader in this space. There’s a lot of aloneness no matter how many people are around you. You’ve got everyone’s hopes hanging on your back and your own crap to deal with at the same time. No-one external to you can help you manage that if you can’t manage yourself. You have to find your own philosophy. It’s how much of your own life you can keep stable while you maintain the message. If your key role is clear then it’s easier to manage. We’ve chosen this role. We all could have done different roles but we didn’t and we therefore have an obligation to people to do this well.”

Senior consumer leader and advocate

Supporting diversity

Support needs to be provided so that people from diverse backgrounds can effectively and safely engage and participate at all levels of the system.

Services, organisations and systems need to recognise and support the particular requirements to ensure people from diverse backgrounds are able to effectively engage and participate at all levels.

This includes:

- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse groups, as well as refugees and survivors of torture and trauma
- Lesbian, Gay, Bi-sexual, Transgender, Intersex, Queer people
- people experiencing economic disadvantage
- people in rural and remote communities
- socially isolated people
- older people
- people in justice and forensic systems
- people with disability
- people who are homeless or at risk of homelessness.

At times, various governments, Commissions and NGOs have developed and implemented leadership training programs for people with lived experience that are responsive to gender, age, culture, spirituality and other diversity. These programs have been delivered at no or low cost for the people involved helping to support people with lived experience regardless of income or financial position.

Example:

An excellent place to start in identifying the approach which should be taken in engaging and participating with Aboriginal and Torres Strait Islander communities is through recognition and application of the *Gayaa Dhuwi (Proud Spirit) Declaration*.

The *Gayaa Dhuwi Declaration* was developed in recognition that the mental health of Aboriginal and Torres Strait Islander peoples is significantly worse than that of other Australians across many indicators, and that in particular, suicide rates are twice as high. The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) notes:[i]

The reasons for the gap are many but include the lack of culturally competent and safe services within the mental health system, that balance clinical responses with culturally-informed responses including access to cultural healing. To rectify this, Aboriginal and Torres Strait Islander leadership is needed in those parts of the mental health system that work with Aboriginal and Torres Strait Islander populations.

The NMHC and State Mental Health Commissions have pledged their support for the Gayaa Dhuwi (Proud Spirit) Declaration; its five elements are central to the development and implementation of actions in the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan).

[i] National Aboriginal and Torres Strait Islander Leadership in Mental Health. Gayaa Dhuwi (Proud Spirit) Declaration: a companion declaration to the Wharerātā Declaration for use by Aboriginal and Torres Strait Islander peoples. National Aboriginal and Torres Strait Islander Leadership in Mental Health; 2010. Available from: http://natsilmh.org.au/sites/default/files/gayaa_dhuwi__declaration_A4.pdf.

6. Conclusion

The engagement and participation of people with lived experience in mental health and suicide prevention has achieved much over the years and continues to bring about positive change. People are working together with good intent; they want to develop policies and plan and provide services that result in better health and wellbeing outcomes. There are supports, frameworks and tools for people to safely and effectively engage and participate so that people with lived experience sit at the table as equals. These range from operational to high level strategic support and include environmental factors. But more is needed. A paradigm shift is required to align a whole new set of beliefs, behaviours, systems, and data.

Supporting safe and effective engagement and participation requires shared or mutual development between all people engaged in mental health and suicide prevention, and not just those with lived experience. Responsibility sits with people with lived experience, their families and other support people, as well as with leaders, service providers, organisations and systems which engage with people.

Based on the views, experiences and evidence collected for this project, the NMHC considers the following actions particularly relevant to drive cultural change and achieve safer and more effective engagement and participation:

1. Develop a National Framework on Skills and Competencies to support people with lived experience to operate at different levels within the mental health and suicide prevention systems - this may range from core competencies such as the ability of people to speak about their own lived experience (or desire to contribute to mental health and suicide prevention) to higher level skills required for good corporate and clinical governance
2. Establish agreed objective and comparable performance reporting requirements and indicators for services and organisations on safe and effective engagement and participation
3. Further investigate whether the lived experience workforce supply will meet increasing requirements across different levels in the system for people with lived experience to engage and participate
4. Include safe and effective engagement and participation in mental health and suicide prevention as key requirements within the National Safety and Quality Health Service Standards and the National Standards for Mental Health Services
5. Increase awareness of and access to evidence-based education, training and development to support and develop skills required for lived experience roles to operate at different levels of the mental health and suicide prevention systems – these programs could be in areas such as health literacy, leadership, clinical and corporate governance, financial management, strategy, policy development, advocacy, conflict management, co-design, co-production, monitoring and reporting
6. Promote and develop the capabilities, principles and practices of recovery-oriented practice for providers, practitioners, managers and support staff and others working in mental health and suicide prevention who work with people with lived experience, their families and other support people.

Many elements of these actions will be supported by work the NMHC is currently undertaking. For example, under the Fifth National Mental Health and Suicide Prevention Plan, the NMHC has been tasked with the development of a guide for consumers and carers to engage in all aspects of mental health services to strengthen their role in safety and quality initiatives, as well as the development of Peer Workforce Development Guidelines. The NMHC is also supporting emerging leaders both within and outside the mental health sector through its Australian Mental Health Leaders Fellowship. The NMHC will also seek to progress the above actions through other processes, such as the Workforce Development Program to be developed under the Fifth Plan, and through engagement with other agencies, such as the Australian Commission on Safety and Quality in Health Care and jurisdictional mental health commissions.

This project, together with other work where the NMHC examined policies and frameworks for consumer and carer engagement and participation, demonstrates there are countless policies, procedures, strategies, plans, reports, standards and indeed laws about what needs to and should happen. There are excellent examples of good practice. Things have improved and continue to improve. But like many issues in mental health and suicide prevention, systems are patchy, siloed, highly dependent on individual endeavour and commitment, and lack uniform application. Work must continue to support better, more safe and effective engagement and participation with people with lived experience, their families and other support people. The NMHC will continue to promote safe and effective consumer and carer engagement and participation as it has done since its establishment, as a focus area and an important and ongoing part of the NMHC's core business.

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The Way Forward:

Pathways to hope, recovery, and wellness with insights from lived experience

Prepared by the
Suicide Attempt Survivors Task Force
of the National Action Alliance for Suicide Prevention
July 2014

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NATIONAL Action Alliance FOR SUICIDE PREVENTION

The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

This report advances Objective 10.3 of the
National Strategy for Suicide Prevention:
Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

To download a copy of the NSSP, please visit
www.actionallianceforsuicideprevention.org/NSSP.

Message from the Suicide Attempt Survivors Task Force Co-Leads

The newly revised *National Strategy for Suicide Prevention*, advanced through the National Action Alliance for Suicide Prevention, calls for a new conversation to reduce suicidal actions and death. That conversation is being given a new voice and a new tone by inviting suicide attempt survivors to share their insights on both staying alive and finding hope.

The mission of the Suicide Attempt Survivors Task Force of the Action Alliance is to create a resource that would convey the voice of suicide attempt survivors. The untold stories of hope and recovery that belong to attempt survivors are the stories of suicide prevention; what they learned is what we all must learn. With these new voices come new ideas, new questions, and new insights. *The Way Forward* emerges from those new voices.

For far too many years suicide prevention has not engaged the perspectives of those who have lived through suicidal experiences. Because of social stigma and fear, as well as personal shame, a culture of silence prevailed. *The Way Forward* represents a seminal moment in this field's history; it is an opportunity to benefit from the lived experience of suicide attempt survivors. Many of its recommendations are derived from evidence-based practices, and several are aspirational. All are grounded in the evidence of recovery and resiliency that is clear in the lives of our Task Force members. Viewing suicide prevention through the lens of the eight core values presented in *The Way Forward* can help us enhance safety while also bringing hope and meaning to those in suicidal despair.

It is our hope that *The Way Forward* will also help serve as a bridge to developing a conversation about suicide prevention between mental health policy makers and consumer advocates. Often, many mental health professionals have narrowly focused on ‘identifying persons at risk and getting them into treatment.’ Conversely, many mental health consumer advocates either avoid or react negatively to suicide prevention discussions, at times due to traumas associated with historically coercive practices and policies. This resource may enable these two powerful forces for change to come together and develop new, more effective approaches to reducing suicide attempts and deaths.

Like the Task Force itself, we, its co-leads, bring a range of personal and professional perspectives to these efforts. Through our work together over years, one a survivor of suicide attempts and mental health advocate, the other a psychologist with years of experience working with people in suicidal crisis, we have come to believe that collaboration and understanding are critical. Like all of the partners, colleagues, and supporters that helped to develop this resource, we feel deeply that suicide is preventable. It will be the spirit of collaboration – from policy-makers and advocates to clinicians and clients – that will make suicide prevention possible.

We greatly hope that *The Way Forward* will serve as a model for your new collaborations with others, aligned around a new vision for a world free of the tragedy of suicide.

Eduardo Vega, M.A.
Executive Director
Mental Health Association of San Francisco

John Draper, Ph.D.
Project Director
National Suicide Prevention Lifeline

Acknowledgements

The Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention (Action Alliance) would like to acknowledge the significant contributions of many individuals in the development of this unprecedented document, which recommends suicide prevention practices, programs, and policies for saving lives from the perspective of those who have lived through experiences of suicidal feeling, thinking, and acting.

First, we would like to thank the primary writer for *The Way Forward*, Dr. DeQuincy Lezine of Prevention Communities, for his outstanding skills, energy, and thoughtfulness in consolidating vast research along with a wide array of inputs from many stakeholders into this cohesive, highly-readable work. Dr. Lezine has been a leader in advocating for the inclusion of suicide attempt survivors in our field since 1996, and his stewardship in developing this resource has emerged through a combination of his own experience as a suicide attempt survivor and his years of experience as a well-respected professional in suicide prevention.

We would also like to acknowledge the important feedback we received from the many insightful experts who were interviewed to provide input about this resource and others who reviewed it (See Appendix E). They helped us prepare *The Way Forward* for a broad audience including researchers, clinicians, policy makers, advocates, and persons who have lived—or are living—with experiences of suicidal thoughts, feelings and behaviors.

In addition, we would like to recognize the extraordinary efforts of the National Action Alliance of Suicide Prevention's Secretariat, specifically, David Litts, former Executive Secretary, for his support and insightful feedback throughout the process, and Jason H. Padgett, Manager of Operations and Technical Assistance, for his dedicated support, patience and organizational skills in helping our Task Force accomplish responsibilities/activities in more efficient ways. Angela Mark, a Public Health Advisor in SAMHSA's Suicide Prevention Branch, also lent her valuable time and expertise to this effort in organizing, documenting, and resourcing Task Force meetings. We are also extremely grateful to staff from the Mental Health Association of San Francisco, Center for Dignity, Recovery, and Empowerment, particularly Melodee Jarvis, Suicide Prevention Specialist, and Anita Hegedus, (former) Executive Associate, for support with coordination and communication that aided Task Force efforts in many ways.

Finally, we would like to thank our Task Force members (See Appendix B for more detail), whose collective intelligence and passion made this possible. Their individual discoveries of hope and meaning following their suicidal experiences provided the heart and soul of this effort, and now provide a pathway for disseminating hope and meaning for all who read *The Way Forward*.

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Executive Summary

Purpose and Goals: Who Should Read *The Way Forward*

The Way Forward is, first and foremost, about preventing suicide and bringing new wisdom to that challenge. Until now, suicide prevention efforts have predominately relied on information from suicide research and clinical observation. The field of suicide prevention has rarely tapped the first-person knowledge of suicidal behavior and real-world wisdom that suicide attempt survivors bring to the table. **This long-neglected "lived experience" can help save lives and provide hope to millions of people who survive a suicidal crisis each year.**

The people with the most intimate information about suicidal thoughts, feelings, and actions are those who have lived through such experiences. For decades, people have combined experiential knowledge with professional training to guide research, treatment, prevention efforts, teaching, and advocacy across a range of public health and social issues. However, *The Way Forward* is the first to specifically bring ideas and insights from lived experience into focus for suicide prevention research and practice.

In 2012, 11.5 million people in the U.S. seriously considered suicide

4.8 million made a suicide plan

2.5 million made a suicide attempt

National Survey on Drug Use and Health (2012) and Youth Risk Behavior Surveillance System (2011)

The overarching goal of *The Way Forward* is to inspire better resources, and far more support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts. An overview of its recommendations is included in this Executive Summary.

The Way Forward is designed to be of value to:

- policy- and decision-makers
- public and private agencies that fund suicide prevention research and programs
- program developers working in suicide prevention
- clinicians and other professionals working with people who are, or have been, suicidal
- family members, friends, and support persons

Finally, it is hoped that anyone using this resource who has ever had thoughts or feelings of suicide may gain hope and a sense of empowerment through connection to the strength and experience of those who have "been there."

> "I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide."
> – Jamison in *An Unquiet Mind,* 1997.

In an effort to limit the length of *The Way Forward,* it focuses on approaches that should be promoted. Negative and inappropriate practices and policies are often noted, but not discussed in extensive detail. The brevity of those discussions should not be taken to indicate that such occurrences are unimportant. Ideally, such issues would be covered in greater detail, and more extensive work in the future to elaborate on this dialogue is highly anticipated.

Attempt Survivors and Lived Experience of Suicide

While *The Way Forward* reflects widely shared perspectives from individuals who have lived through a suicidal crisis, it cannot represent the full diversity of viewpoints that exist. In addition to differences associated with racial, ethnic, cultural, gender, spiritual, geographic, and other influences, it is important to recognize that suicidal experiences exist on a continuum. Some people have seriously considered suicide, some have made plans that were not carried out, and some have attempted suicide. Of the millions of people who have lived through a suicidal crisis, the vast majority recover. However, the degree of recovery varies, particularly for people who have lived through an experience of self-injury with some intent to die (i.e., suicide attempt survivors – also referred to as attempt survivors).

Attempt survivors' perspectives encompass the entire range of suicide prevention and intervention activities, so this resource focuses on their point of view. Nonetheless, it is hoped that many of the recommendations that are offered will benefit people throughout the continuum of suicidal experiences.

How *The Way Forward* Was Developed

The clinical and research communities have long recognized that important knowledge could be gained from people who have lived through a suicidal crisis. However, most endeavors to acquire that knowledge came in the form of using those people as research subjects or clinical case examples. Such efforts, while generally beneficial, filtered information through assessment instruments designed by clinicians and research scientists.

For decades, the real "voices" from lived experience were missing from the table where suicide prevention stakeholders met to discuss and create solutions.

In 2010, former U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention (Action Alliance), which envisions "a nation free from the tragic event of suicide with a goal of saving 20,000 lives in five years." The Action Alliance is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority NSSP objectives, and cultivating the resources needed to sustain progress.

Over time, a few attempt survivors publicly disclosed that they had lived through a suicidal crisis, and some became advocates and spokespersons in suicide prevention. As a result of advocacy by both attempt survivors and suicide loss survivors, attempt survivors are emerging as important partners in suicide prevention efforts. In 2012, the Action Alliance[a] identified support for attempt survivors as a priority for focus in the revised *National Strategy for Suicide Prevention* (NSSP).[b]

In 2011, the Action Alliance co-chairs established a Suicide Attempt Survivors Task Force (the Task Force) led by

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[a] http://www.actionallianceforsuicideprevention.org

[b] http://actionallianceforsuicideprevention.org/NSSP

attempt survivor advocates. The major goal of the Task Force was to help forge a path for stopping suicide attempts and deaths by engaging and supporting people with lived experience of a suicidal crisis. **The initial objective of the Task Force was to support implementation of the NSSP by creating a framework for national, state, and local stakeholders to use when developing resources and initiatives to prevent suicide. These resources and initiatives necessarily seek to engage and empower attempt survivors.**

The Task Force includes people with lived experience of suicide from nearly every region of the U.S., several professional perspectives, and a broad range of racial, ethnic, and cultural backgrounds. The group was convened many times over a three-year period in the development of *The Way Forward*. Task Force members contributed significantly through their time to the form and content herein.

By thoroughly delineating recommendations, *The Way Forward* fulfills the Task Force's principal objective. Guided by the wisdom of people who have "been there," the ideas presented here have the potential to significantly shift the status quo, save lives, and foster hope.

"Core Values" from the Perspective of Lived Experience

The Way Forward seeks to filter the evidence base used for suicide prevention through the core values shared by many attempt survivors (the Core Values). These Core Values were generated through extensive dialogue of the Task Force membership. Many are based in the tenets of mental health recovery developed through decades of work by peer advocates, behavioral health professionals, and community feedback. They reflect the consensus perspectives that emerged and were clarified through Task Force discussions, and correspond with many protective factors that counter risk for suicidal thinking and behavior.

> "Our best route to understanding suicide is … directly through the study of human emotions described in plain English, in the words of the suicidal person."
> – Shneidman in *The Suicidal Mind, 1996.*

All activities designed to help attempt survivors, or anyone who has been suicidal, should be consistent with one or more of the following Core Values:

- Foster hope and help people find meaning and purpose in life
- Preserve dignity and counter stigma, shame, and discrimination
- Connect people to peer supports
- Promote community connectedness
- Engage and support family and friends
- Respect and support cultural, ethnic, and/or spiritual beliefs and traditions
- Promote choice and collaboration in care
- Provide timely access to care and support

Summary of Task Force Recommendations

The Recommendations in *The Way Forward* follow a path consistent with an ecological framework. Approaches start at the individual level and move progressively through relationships, community-based supports and services, and broad community and social change.

Attempt survivors as helpers: self-help, peer support, and inclusion

Every form of help and support for someone who has been suicidal depends on that person's willingness and capability to seek and accept help. Further, given that the suicidal crisis is predominately internal, all changes, regardless of where they are initiated, must ultimately occur within individuals. Beginning with the individual attempt survivor is consistent with mental health recovery practices, person-centered care practices, and the Core Values.

The journey to recovery often begins with self-help practices (e.g., self-advocacy, community involvement, religious/spiritual activity, exercise) which can be supported by family, friends, and professionals. An additional approach to extend support is the peer-operated warm line, which can provide non-crisis assistance at times when traditional services are unavailable. After surviving a suicidal crisis and successfully navigating available systems and supports, peers can model self-care practices, and provide unique and powerful contributions to another's recovery.

The Task Force recommends that suicide prevention and behavioral healthcare organizations engage, hire, and/or collaborate with peer support professionals. Beyond work as peer support professionals, attempt survivors should be included as key partners in a wide range of suicide prevention efforts.

Family, friends, and support network

Community connectedness is one of the Core Values and an established protective factor against suicide. An essential part of that is the assistance provided by family and friends. Each attempt survivor should define a support network, and the people in that network should be offered educational and other resources. It is important to establish who those supportive persons are and how they can assist before, during, and after a crisis.

Family and friends also need support for themselves. Unfortunately, there are very few support resources that have been developed to fulfill this need.

The Task Force recommends developing, evaluating, and promoting programs specifically intended to help the family and friends of attempt survivors.

Clinical services and supports

Behavioral healthcare organizations can enhance care and support for individuals experiencing, or recovering from, a suicidal crisis in multiple ways. At the leadership level, organizations should make suicide prevention a core component of care. Individual professionals should begin care with clear discussions about how they approach crisis situations. Beyond a focus on the suicidal crisis, however, professionals should conduct a comprehensive assessment that recognizes the strengths and challenges in multiple dimensions of life whenever possible. Similarly, all treatment, including use of medication, should take place within a collaborative approach that discusses multiple options, respects informed choices, and engages a wide range of supports.

While most of the professional care for suicidal persons takes place within behavioral healthcare settings, many key services are provided in general healthcare offices, clinics, and hospitals. In every setting and situation, care for someone who is in, or recovering from, a suicidal crisis would be greatly improved by addressing negative stereotypes, prejudice, and discrimination around suicide and mental health issues among medical professionals. Treating people with dignity and respect can help ease tensions and facilitate the type of collaborative care relationships that are most effective in addressing suicide risk.

The Task Force recommends that medical and behavioral health providers integrate principles of collaborative assessment and treatment planning into their practices.

Crisis and emergency services

Many crises can be addressed before emergency services are needed through the use of key crisis supports such as hotlines and crisis respite centers. In support of the Core Value emphasizing timely access to care, developing and/or sustaining supports and services that can be available 24/7/365 is critical. Yet, many people are wary of hotline services because they fear police involvement or inpatient commitment, based on prior experience or stories from others. Crisis hotlines can do much to alleviate such concerns by following protocols like those established by the National Suicide Prevention Lifeline for active engagement of callers and the use of least invasive approaches, with active rescue being a “last resort.” As an additional resource, more crisis respite centers (particularly ones that employ peer providers) should be developed and promoted.

In cases where active rescue, or non-medical on-site intervention, is required, it would be ideal to call a mobile crisis team that includes a peer support professional. When such a team is unavailable, first responders with training about behavioral health emergencies should be engaged.

The recommendations for professionals in emergency departments mirror those for general medical and behavioral healthcare professionals in many ways. Improvements in care should begin with shifting attitudes toward collaborative, respectful, and dignified treatment of persons undergoing a suicidal crisis. The person in crisis can also benefit greatly from the expanded support available from family, friends, and peers, who should be offered relevant information and resources. Peer professionals could provide additional support during on-site crisis intervention, follow-up after a crisis, or emergency department visit and/or discharge.

The Task Force recommends that providers of crisis or emergency services develop formal partnerships with organizations which offer peer support services and especially organizations that are operated or driven by people with lived experience.

Systems linkages and continuity of care

Long-term connections between educational, social, healthcare, and behavioral healthcare settings are solidified through formal agreements and partnerships. As one example, both educational systems and hospitals can establish formal ties with peer support programs or organizations to enhance services. Connecting attempt survivors to peer specialists provides an additional source of support, connection to the community, and a means to facilitate access to other services.

Continuity of care can be furthered through follow-up and/or innovative approaches with technology. Follow-up practices or programs can demonstrate compassion and caring while encouraging help-seeking. Innovative approaches such as online self-help tools and mobile applications can be used to facilitate timely access to care.

The Task Force recommends that hospitals and providers of crisis services establish formal strategies for ensuring continuity of care by helping people transition to community supports.

Community outreach and education

At the broadest level of support, community organizations often use communications and/or social marketing campaigns. The Action Alliance *Framework for Successful Messagin*g[c] encourages campaign developers and champions to have a clear strategy, convey a hopeful message, and follow relevant guidelines including maintaining safety. Those messages could be effectively promoted by individuals who have lived through a suicidal crisis.

Many recommended programs and practices in *The Way Forward* can be seen as promising, often having evidence for supporting Core Values but lacking formally measured evidence of effects on suicidal thinking or behavior. Research and evaluation efforts are needed to strengthen the evidence base for such approaches, adding science-based knowledge to the insights from lived experience. Developing a network of professionals with lived experience related to suicide to initiate and implement such research and evaluation projects would be a major catalyst for this work.

As a key message in this section, and overall, the Task Force recommends that suicide prevention and behavioral health groups engage attempt survivors as partners in developing, implementing, and evaluating efforts.

A Call to Action

Each year, millions of people in the U.S. seriously consider suicide. Some who survive suicide attempts have recurring or ongoing suicidal thoughts and feelings, and a substantial number of people attempt suicide again. It is imperative to develop and disseminate effective supports that are critically needed. Confronting and abolishing the fear, discrimination, and misunderstanding that have blocked these efforts is long overdue.

With *The Way Forward*, the Task Force aims to begin a new and more inclusive chapter in suicide prevention, sparking the development of innovative programs and projects, altering public policy, and promoting much-needed social change. The recommendations in this resource combine research and practice with lived experience from attempt survivors to help put the NSSP into action. They provide a blueprint for a newly-invigorated community effort to reduce suicide attempts and deaths.

Achieving these goals requires social and political support from attempt survivors, families, friends, and allies. To translate the collective vision of *The Way Forward* into reality, the Task Force recommends developing a national center focused on helping attempt survivors and including attempt survivor peer specialists in current mental health technical assistance centers.

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[c] http://www.suicidepreventionmessaging.org

Introduction

In 2012, approximately 11.5 million people in the U.S. seriously considered suicide, 4.8 million made a plan for suicide, and 2.5 million made a suicide attempt[d].[1,2] Of the millions of people who have lived through the experience of a suicidal crisis, the vast majority recover. However, the degree of recovery varies, particularly as one moves closer to potentially deadly behavior (i.e., suicide attempts). A suicide attempt survivor – hereafter referred to as an attempt survivor – is a person who has lived through an experience of self-injury with some intent to die. Although a suicide attempt is the strongest predictor of future death by suicide, 90% of attempt survivors avoid death by suicide.[3] Nevertheless, many of them have recurring or ongoing suicidal thoughts and feelings, and some attempt suicide again.[4,5] Thus it is imperative to develop and disseminate effective supports.

The overarching goal of *The Way Forward* is to inspire better resources, and far more support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts.

The Way Forward is designed to be of value to:

- policy- and decision-makers
- public and private agencies that fund suicide prevention research and programs
- program developers working in suicide prevention
- clinicians and other professionals working with people who are, or have been, suicidal
- family members, friends, and support persons

Ideally, anyone using this resource who has ever had thoughts or feelings of suicide may gain hope and a sense of empowerment through connection to the strength and experience of those who have “been there.” Indeed, many of the ideas being promoted hold the potential to create more caring systems and more supportive communities in general. However, specific focus is given to attempt survivors as the ones at highest risk for future injury or death by suicidal acts.

> The people with the most intimate information about suicidal acts are those who have lived through such experiences.

Because suicide is an individual act, the people with the most intimate information about suicidal thoughts, feelings, and actions are those who have lived through such experiences – attempt survivors. Yet, the experiential knowledge of suicidal behavior and real-world wisdom that attempt survivors can contribute about what might help stop suicide has rarely been tapped, and has never been broadly documented. Nonetheless, attempt survivors, whether publicly known or undisclosed, have made many contributions to suicide prevention.

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[d] Data combines results from the National Survey on Drug Use and Health (2012) for adults with Youth Risk Behavior Surveillance System (2011) for high school students

By combining professional training and skills with insights from lived experience (i.e., lived expertise) many have contributed to research, behavioral health[e] and prevention programs, clinical services, and advocacy.

A recent review of national suicide prevention efforts acknowledged that addressing attempt survivor needs has been a challenge for the field thus far.[6] The Action Alliance released the revised *National Strategy for Suicide Prevention* (NSSP)[f] in 2012, which reaffirmed that supportive communities and appropriate services for attempt survivors can have a major impact in reducing future attempts and suicides. The NSSP also clearly identifies the need to engage attempt survivors in the development of new approaches to suicide prevention[g]. *The Way Forward* aims to support and build on the NSSP, and highlights connections to it throughout the text. Advancing the social dialogue about suicide and behavioral health can help counter shame and discrimination, encouraging people to seek help and support.

With *The Way Forward*, the Task Force combines information from research and practice with lived experience from attempt survivors. The resulting recommendations are intended to spark the development of innovative programs and projects, alter public policy, and promote social change. The end goal is to generate better support for the person experiencing suicidal thoughts and feelings, with the hope of saving lives and preventing future suicide attempts. The recommendations and information in *The Way Forward*, written with the perspective and insights of attempt survivors, offer guidance for efforts to put the NSSP into action. They provide a blueprint for a newly invigorated community effort to reduce suicide attempts and deaths. Guided by the wisdom of people who have "been there," the ideas have the potential to significantly shift the status quo, save lives, and foster hope. Achieving these goals requires social and political support from attempt survivors, families, friends, professionals, and allies.

> **"Our mandate for future action is clear… dramatically improve how we incorporate the perspectives and needs of attempt survivors into our suicide prevention and aftercare efforts."**
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> *-First National Conference for Survivors of Suicide Attempts, Health Care Professionals, and Clergy and Laity. Summary of workgroup reports, 2008*

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[e] Note: As in the NSSP, the term behavioral health is used here for "mental and emotional well-being and/or choices and actions that affect wellness. Behavioral health problems include mental and substance use disorders and suicide."

[f] National Strategy for Suicide Prevention: http://actionallianceforsuicideprevention.org/NSSP

[g] Please see Objective 10.3 and Appendix D: Groups with Increased Suicide Risk. Suicide Attempt Survivors.

Section I: Core Values for Supporting Attempt Survivors

Part 1: The Core Values

The Task Force initiated the development of its core values (Core Values) by examining the tenets used in the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Recovery Framework.[7] Those tenets reflect the combined contributions of peer advocates, mental health professionals, and community feedback over three decades. Many also echo the values and principles outlined in "*Practice Guidelines: Core Elements for Responding to Mental Health Crises*[8]." Through group discussions that took place over email, telephone conference calls, and in-person meetings, the Task Force identified principles that could be further specified, enhanced, or added to fit the context of suicide prevention. The Core Values represent the group consensus on the values that attempt survivors want suicide prevention professionals and organizations to consider when developing or implementing suicide prevention supports. Research has indicated that promoting protective factors and addressing risk factors for suicide can prevent suicidal behavior.[9] Therefore, it is reasonable to believe that activities that support the Core Values have the potential to prevent future suicide attempts, and improve the quality of life for people who have survived a suicide attempt.

The purpose of adhering to the values is to identify actions that would be both helpful and preferable for attempt survivors. Each Core Value is linked to protective and/or risk factors, or best practices in behavioral health care. Please note that to reinforce the intent of the Core Values and to communicate the voice and perspective of the Task Force each value in this section is written in first person.

All activities designed to help suicide attempt survivors should be consistent with one or more of the following values:

- Foster hope and help people find meaning and purpose in life
- Preserve dignity and counter stigma, shame, and discrimination
- Connect people to peer supports
- Promote community connectedness
- Engage and support family and friends
- Respect and support cultural, ethnic, and/or spiritual beliefs and traditions
- Promote choice and collaboration in care
- Provide timely access to care and support

Foster hope and help people find meaning and purpose in life

It has long been recognized that the absence of hope (i.e., hopelessness) is a major risk factor for suicidal thinking and behavior.[10] More recently, studies have found that hope and optimism can help guard against suicide.[11-14] Hope is also linked to self-esteem and self-efficacy, as well as improved problem-solving.[15,16] The pursuit of meaning can help a person cope with pain and suffering.[17] Similarly, research on reasons for living has demonstrated that meaning and purpose are keys to recovery in many different groups of people who have lived through a suicidal crisis.[18,19]

When we find hope, we are less suicidal. Hope is a key protective factor against suicidal behavior, and it is a catalyst for the recovery process. Hope is nurtured by finding meaning and purpose in life. If we can see our lives as having meaning and purpose, then we can picture a hopeful future.

Preserve dignity and counter negative stereotypes, shame, and discrimination

The negative perceptions of behavioral health issues and subsequent discrimination pose major barriers to help-seeking.[20] Use of negative stereotypes and discriminatory actions robs people of their dignity, stifles compassion, and crushes hope.[20] Social rejection and discrimination have negative effects on life satisfaction and well-being.[21]

Stigma, negative stereotypes, and discrimination (overt or subtle) are particularly damaging when we are already suffering from depression, hopelessness, damaged self-image, trauma, self-doubt, and shame - thoughts and feelings common during a suicidal crisis. In contrast, when we are treated with dignity and compassion it reaffirms our sense of worth and value. On a larger scale, direct and implied messages about hope, recovery, and genuine concern can encourage us to seek out help and support when needed.

Connect people to peer supports

The meaning of “peer” depends on context, applying to fellow students or military veterans, for example. For the purposes of *The Way Forward,* a peer is someone who has lived experience with a similar mental health condition or issue (i.e., suicidal feelings or past suicide attempt).

Research indicates that people engaged in peer support tend to have positive mental and behavioral health outcomes along with general psychological and social benefits.[22,23] Recent practice guidelines recommend that peer supports be available in response to mental health crises because peers are in a unique position to “convey a sense of hopefulness.”[8(p8)] Thus, providing and receiving help from peers counteracts risk factors for suicidal behavior such as hopelessness, impulsiveness, isolation, shame, and symptoms of mental health disorders.[24-26]

As peers, we can provide social support and a sense of community while also sharing experiential knowledge and practical advice about coping skills, serving as positive role models for others. Furthermore, when we enter the role of helper we also experience benefits.

Promote community connectedness

The report *Promoting Individual, Family, and Community Connectedness to Prevention of Suicidal Behavior* notes that “Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention.”[27(p3)] The report indicates that connectedness includes relationships between individuals and between organizations. Through social connections, risk factors of loneliness and isolation are countered, while protective factors of belongingness and social integration are enhanced. Benefits also come from access to resources through social capital and networking. Some studies have found that social connections help people cope with stress (i.e., psychological, physiological, and neurological responses to stress) and enhance general health.[28,29]

Connections between community organizations facilitate access to care and continuity of care, enabling services like follow-up programs to help many people after a crisis.[27,30] Furthermore, as noted in the report *Suicide Care in Systems Framework* from the Action Alliance Clinical Care and Intervention Task Force (CCI Report), connections between professionals eases fears about providing services, and equips them with additional resources.[31] Additionally, both personal connections and organizational ties can be used to encourage community groups and organizations to contribute tangible supports (e.g., funds, meeting space, use of equipment or supplies, availability of volunteers) to suicide prevention efforts.

In the first type of connectedness, we benefit from maintaining or (re)building social connections and support networks in the community. As a second form of connectedness, it is easier to get quality care when healthcare organizations (i.e., medical, mental health, behavioral health, and insurance groups) and social services have formal relationships that allow them to work together.

Engage and support family and friends

Research indicates that people often turn to family and friends for help[19], even when they do not seek help from mental health or medical professionals, emphasizing the critical role of support networks. A strong support network can serve as a safety net in times of crisis and a trusted resource during recovery. This core value is also consistent with NSSP Objective 9.4 to engage a person's support network throughout the course of care. The CCI Report recommended that "families and significant others should be engaged and empowered" in care plans whenever "appropriate and practical."[31(p8)] It is also clear from research that it is extremely stressful to care for someone else, especially in life-or-death situations.[32] Family and friends need additional support. Moreover, a robust literature exists describing the risk for suicide in family members and friends of an attempt survivor or person who has died by suicide.[33] Similar research points to the higher-than-average chance of risk behaviors in friends of a suicidal person.[34] Thus, support for family and friends may have direct benefits to all involved, even if the focus is primarily on helping the attempt survivor.

We have to decide which family, friends, and/or significant persons to engage in our care or support. This agreed-upon support network should be included in informed care decisions, treatment, follow-up, and other forms of help. However, the family members, friends, and peers in our support network also need education, assistance, and resources for themselves.

Respect and support cultural, ethnic, and/or spiritual beliefs and traditions

Differences in suicide rates by gender, race, ethnicity, sexual orientation, geography, and community point to the potential role of social and cultural factors in risk and resilience.[35,36] Such differences form the basis for ongoing research that seeks to understand how human diversity affects suicidal behavior and the practical implications that it has on prevention or intervention efforts.[36] Additionally, many people turn to cultural or spiritual leaders as trusted sources of support, and religion or spirituality often serves as a protective factor.[37] Incorporating such potential strengths into plans for recovery can open the door to many non-clinical options for support.[38] Both contemporary and traditional healing practices can contribute to recovery and wellness. Further, the CCI Report specifically noted that a productive clinical relationship "should respect the cultural preferences and values of the individual as much as possible."[31(p11)]

We want programs and services to: (a) acknowledge and respect our beliefs and traditions (cultural, ethnic, spiritual); (b) incorporate them into our recovery plans; and (c) assess how they might interact with care and identify ways for the traditions, healing practices, beliefs, and/or communities to help keep us well.

Promote choice and collaboration in care

Many calls for mental health system transformation recommend consumer-driven or person-centered care.[39-41] The CCI report recommended that "care for persons at risk for suicide should be person centered, where their personal needs, wishes, values, and resources should be the foundation for continuing care and safety plan."[31(p8)] This value is consistent with the practice of shared decision-making (SDM). In SDM, "providers and consumers of health care come together as collaborators in determining the course of care."[42(p2)] Research indicates that SDM grants the person seeking care lower stress, a greater sense of control, and better functional outcomes.[42] Becoming a partner in care directly counters ideas of helplessness, powerlessness, and hopelessness. Treatment outcomes are generally better when the person has the opportunity to be a partner in the process.[43]

Programs, policies, and initiatives should preserve our autonomy, promote hope, build from our strengths, and empower us to pursue the goals we identify. Professionals should consider all dimensions of wellness when developing plans for care. We need to be informed about care and support choices in language and terms that we can easily understand. Respect our decisions. Provide us with diverse opportunities for involvement in our own care and in broader suicide prevention and mental health promotion activities.

Provide timely access to care and support

Objective 8.3 of the NSSP is to "promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide" as something that is "critically important."[(p54)] With more timely access to care, someone might be able to get help before attempting suicide. Similarly, the CCI Report recommended "immediate access to care for all persons in suicidal crisis," with "effective treatment and support services … how and when they need them."[31(p4,5)] Early intervention is likely to have a meaningful and long-lasting impact. Recent practice guidelines note that expedient support can reduce the intensity and duration of a crisis and allow the person to choose from a wider variety of options.[8] In defining timely access, the guidelines encourage "24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site."[8(p7)]

> "Many a suicide might be averted if the person contemplating it could find the proper assistance when such a crisis impends." – Clifford Beers, 1908,
> *A Mind That Found Itself*

We should have the opportunity to access care and supports that fit our needs, are acceptable and are appropriate 24/7/365. A full range of supports should be available, including crisis alternatives to hospitalization such as peer respite, call or text lines, and mobile crisis teams. When the ideal form of support is not immediately accessible, we should have timely and expedient access to an alternative and/or get a referral. Professional services should continually assess the quality and accessibility of care and support to identify and remedy any gaps. These reviews should be carried out by a group that includes both professionals and peers.

Part 2: Core Values in Relation to Recovery and the National Strategy

In creating the Core Values, the Task Force identified values and tenets that have been used in mental health recovery, the mental health consumer movement, and personal experiences. The Task Force modified the concepts to make them more applicable to the suicide prevention context. The NSSP was a key resource. As a result, the Core Values are consistent with recognized principles of recovery and concepts used throughout the NSSP (see Table 1).

Table 1. Core Values compared to recovery principles and NSSP concepts

Core Value	Recovery Principles[7]	NSSP Concepts
Foster hope and help people find meaning and purpose in life	"Recovery emerges from hope." "Hope is the catalyst of the recovery process."	"Positive messages of recovery and hope" "Recovery-oriented services"
Preserve dignity and counter stigma, shame, and discrimination	"Recovery is based on respect."	"Foster positive dialogue, counter shame, prejudice, and silence."
Connect people to peer supports	"Recovery is supported by peers and allies."	"Appropriate peer support … holds a similar potential for helping those at risk for suicide." "Providers should develop linkages with … peer support services."
Promote community connectedness	"Recovery is supported through relationship and social networks"	"Connectedness to others is another key protective factor" "Increasing collaboration among providers"
Engage and support family and friends	"Recovery involves individuals, family, and community strengths and responsibility."	"Effectively engage families and concerned others" "Provide appropriate clinical care to individuals affected by a suicide attempt…"
Respect and support cultural, ethnic, and/or spiritual beliefs and traditions	"Recovery is culturally-based and influenced." "Recovery is holistic."	"Be tailored to the cultural and situational contexts" "Grounded in a full understanding of and respect for the cultural context"
Promote choice and collaboration in care	"Recovery occurs via many pathways" "Recovery is person-driven"	"Person- and relationship-centered care …" "Patient is actively engaged in making choices"
Provide timely access to care and support	<not addressed>	"Increase access to and delivery of effective programs and services" "Promote timely access …"

Section II: Task Force Recommendations –
Practices, Programs, and Policies for Effective Suicide Prevention

Through reviews of published literature and web-based resources, as well as expert opinion, the Task Force identified approaches to supporting recovery from a suicidal crisis that are consistent with the Core Values. The approaches could be described by three types of activities: practices, programs, and policies. To more clearly delineate Task Force recommendations, each one will be labeled as a practice, program, or policy.

An example may help to introduce the differences between these activities, which are further clarified below. If a crisis support volunteer at a call center generally calls someone back for follow-up, then that would be considered a practice. When the crisis center establishes a separate phone line, designated times, procedures, outcomes and/or funding for follow-up calls, then that would be a follow-up program. If the crisis call center clarified in writing that follow-up practices should always happen and made it part of their training and oversight, then the practice would become a formal policy.

Practices

A practice is a process, method, technique, approach, procedure, or other behavior that occurs on a regular basis. Practices describe *how* people and organizations interact with a person seeking support or services. Generally, practices are consistent, sometimes default, responses to situations.

Programs

A program is a specific intervention, therapy, treatment, campaign, course, workshop, seminar, or other activity designed to support or help someone. In many ways, programs are systematic and well-defined uses of practices and resources.

Policies

A policy is a written statement intended to guide governments, organizations, or individuals. Most large organizations, for instance, have manuals that cover a range of topics such as policies, standard procedures, protocols, grant requirements, or general practice guidelines. Public policy generally entails legislation, statute, regulation or ordinance that clarifies, limits, or prescribes individual, governmental or organizational behaviors.

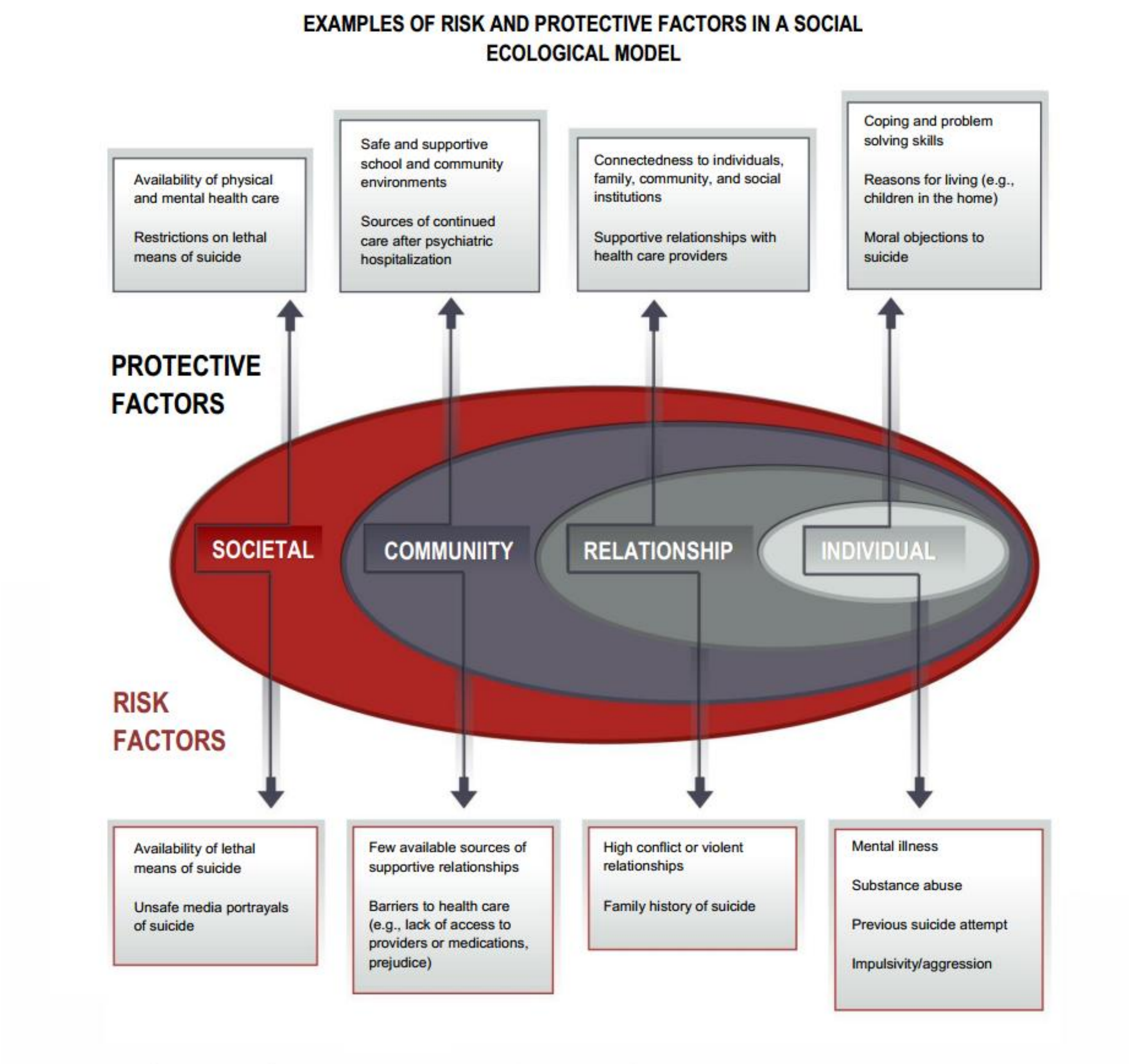
Categories of supports and services

Approaches were sorted into six categories:

1. Attempt Survivors As Helpers: Self-Help, Peer Support, and Inclusion
2. Family, Friends, and Support Network
3. Clinical Services and Supports
4. Crisis and Emergency Services
5. Systems Linkages and Continuity of Care
6. Community Outreach and Education

The presentation order of the categories maintains the framework in the Ecological Model used in the NSSP (see Figure 1). Approaches start at the individual level (i.e., self-help) and move progressively through relationships, community-based supports and services, and broad community and social change.

Figure 1. Protective Factors and Risk Factors for Suicide, as presented in NSSP



Adapted from: Dahlberg LL, Krug EG. Violence—a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002:1–56.

This section describes the approach categories, highlights the Core Values supported, discusses needs and challenges from an attempt survivor perspective, and provides specific recommendations for action.

Each section begins with a brief vignette that illustrates a possible path to recovery and hope after surviving a suicide attempt. The stories follow the main character, Jamie, in a world that matches the ideals and recommendations described in The Way Forward.

Part 1: Attempt Survivors as Helpers: Self-Help, Peer Support, and Inclusion

In the aftermath of the suicide attempt, Jamie reflected on past activities that were helpful. It seemed reasonable to think that what worked before could work again. However, Jamie had some trouble coming up with positive activities. Fortunately, family and friends recommended some books and guides that could help nurture hope, support recovery, and enhance self-advocacy skills. They also suggested checking out the new attempt survivor support group being hosted by a local crisis center. Jamie not only joined the group, but became a peer co-facilitator for the group. Having enjoyed the experience of helping others, Jamie trained to become a peer specialist. The idea was to get certified and look for a job at one of the organizations looking to hire people "with lived experience from a suicidal crisis." Ideally there would be a central and specific resource that promoted attempt survivor supports and engagement, like a National Technical Assistance Center on Lived Experience in Suicide Prevention. In the meantime, the search could include organizations or centers looking for the combination of professional and lived experience that Jamie brought to the table.

Self-Help

Recommendation 1.1 – Practice: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Self-help is a way for a person to improve his or her health and welfare by changing thinking and/or behavior without the assistance of others (especially without professional intervention). This may include both ways to help oneself directly, or through improved interactions with others (including health or mental health professionals). Such resources may be particularly important supports in rural or tribal communities that have few traditional services. Empowering a person with self-help options supports his or her **dignity** and enhances **hope** by countering perceptions of helplessness. At the same time, providing people with self-help resources gives them the **opportunity to choose** supports that are almost always **accessible**. Self-help practices can also be used for self-care by any person or professional. Some specific resources are included in Appendix C.

Approaches to self-help

Self-help guides or bibliotherapy

Bibliotherapy uses self-help materials, or recommended readings, to assist people in coping with mental or emotional distress. Study results[44,45] indicate that as an adjunct to therapy, bibliotherapy is associated with increased resilience, decreased psychological distress, and decreased hopelessness when added to therapy. In a study that used an unguided online self-help curriculum, results indicated that participants experienced less suicidal ideation and hopelessness.[46]

Guidance or advice

There are different forms of advice from peers, professionals, or both, that are written for the benefit of people looking to help themselves. These readings often provide stories of recovery that offer **hope** and guidance for combating **shame** or seeking **collaborative care**. Two resources that gather self-help material of this kind are the National Mental Health Consumer Self-Help Clearinghouse[h] and the National Empowerment Center[i]. An additional upcoming resource is the booklet "*A Journey Toward Help and Hope*."[j] Several helpful practices can also be found in the self-help guides from SAMHSA[k]. One should also note that some autobiographical books or materials include advice or guidance.

Autobiographical accounts from peers

Stories, encouragement, and advice **from peers** can be found in multiple formats that include books, booklets, brochures, blogs, and videos (see Appendix C). Most of the accounts offer **hope** by demonstrating how peers have overcome personal crises and challenges. For example, many books and blogs by suicide attempt survivors are primarily written to help other individuals who may be suicidal.

General self-care

Additionally, individuals often use one or more self-help practices as part of their overall plan for recovery and wellness. Some of the most common or useful techniques used to cope with suicidal thoughts or feelings include[47,48]:

- Spirituality: religious attendance, prayer and meditation
- Family and social support: receiving and providing help, time with family or support persons
- Talking to someone: phone call, hotlines, peer warm lines that offer supportive listening or advice
- Positive thinking: positive self-talk, believing in oneself, positive affirmations
- Effective treatment / having a trusted therapist
- Self-care or distraction: listening to music, having a hobby, movies, humor, exercise, resting

A few self-help practices merit additional consideration because they relate to multiple Core Values and/or encompass both benefits and challenges. These are: (a) advocacy, (b) community involvement, (c) religion and spirituality, and (d) exercise.

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[h] http://www.mhselfhelp.org/techasst/index.php

[i] http://www.power2u.org/articles.html

[j] SAMHSA, in press.

[k] See for example, *Action Planning for Prevention and Recovery: A Self-Help Guide* (http://store.samhsa.gov/product/Action-Planning-for-Prevention-and-Recovery-A-Self-Help-Guide/SMA-3720); and *Recovering Your Mental Health: A Self-Help Guide* (http://store.samhsa.gov/product/Recovering-Your-Mental-Health-A-Self-Help-Guide/SMA-3504)

Recommendation 1.2 – Practice: Provide information about self-advocacy to every attempt survivor.

Advocating for oneself is the direct opposite of considering or attempting self-destruction. To do so, a person must see himself or herself as worth fighting for and hold the **hope** that a better life is possible. One of the most important parts of self-advocacy is actively **collaborating** with professionals and people in a **support network** to plan for safety, recovery, and making life meaningful and enjoyable. Self-advocacy is consistent with practices such as Self-Directed Care, Psychiatric Advance Directives, Wellness Recovery Action Plans (WRAP), and Motivational Interviewing that have demonstrated benefits for enhancing treatment and recovery.[49-52]

Self-advocacy also lays the foundation for someone to offer others peer support or become a partner in suicide prevention efforts. Several mental health advocacy organizations, while not specifically focused on suicide prevention, may be powerful allies for this task.

Recommendation 1.3 – Practice: Encourage attempt survivors to participate in community activities.

When someone is involved in activities outside of medical or mental health systems, he or she establishes or reconnects with community supports that are vital for recovery. As noted in a report on connectedness, "although the influence of such positive attachments on suicidal behavior needs to be better studied, many theoretical reasons support the idea that stronger connections to [community] groups may decrease suicidal behavior."[27(p4)] Through involvement with community groups and projects, someone can establish or solidify an identity outside of the roles of patient or attempt survivor. In support of this idea, the first principle in the *Federal Action Agenda for Transforming Mental Health Care* was to "focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation."[l] Consistent, positive experiences and interactions restore **dignity**, shape quality of life, and give a person **meaning and purpose**.

Recommendation 1.4 – Practice: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Religion and/or spirituality deserve particular attention because the practices are widespread and may be the most often-cited individual practices. Many people turn to religion and spirituality as a source of help. Research indicates that several protective factors may be present in religion and spiritual practices.[37,53] In addition to the direct relationship with the Core Value of **respect**, other Core Values that may be supported include finding **hope, meaning, and purpose**; **community connectedness**; and **support from family and friends**.

However, it is also important to note an unresolved conflict. Some research suggests that negative attitudes about suicide, which are supported by some religious beliefs, might protect against suicide. However, the Core Values advocate for working against **shame and discrimination**. Based on reviews of the association between religiosity and suicide, it appears that the outcomes depend on a person's individual perception of the religious or spiritual experience.[37] If the primary experience offers **hope** and provides **meaning and purpose** for life,

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[l] Transforming Mental Health Care in America: The Federal Action Agenda. SAMHSA. http://www.samhsa.gov/federalactionagenda/NFC_FMHAA.aspx

connection to others, or a belief that suicidal behavior should be avoided, then someone may be protected from risk. On the other hand, if the primary experiences involve condemnation, judgment, guilt or isolation, then it is unlikely to offer protection and may aggravate risk.

Recommendation 1.5 – Practice: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

While it has long been recommended that individuals with depression should consider adding an exercise routine as a way to help, this has rarely been studied for individuals with suicidal thinking or behavior. However, one study in Austria examined mountain hiking as an addition to therapy.[54] In that study, participants experienced less hopelessness, depression, and suicidal thoughts. Additionally, a recent study with veterans found that exercise had direct and indirect effects (i.e., by helping depression or improving sleep) on suicidal thinking and attempts.[55]

Supported Self-Help

Self-help with assistance or advice from others can be called supported self-help or supported self-management. It most commonly refers to self-care recommended as part of therapy or other services. The most structured supports are self-management guides or workbooks that may be completed with coaching from others. A recent and positive review discussed types of support self-management, their effectiveness, safety, and acceptability.[56]

Peer Supports

Approaches in this category are directly related to the Core Value of connecting people to supportive peers. Many of the approaches are also consistent with increasing **hope**, **timely access** to supports, **connectedness,** and **choices** for recovery planning, while empowering persons with lived experience as helpers, which **challenges negative stereotypes**.

Notably, peers work in many types of programs (e.g., professional therapists, crisis workers, emergency department doctors). However, the approach described here specifically relates to areas where having lived experience is an essential part of the job and is included in the qualifications or description of the job. Peer support includes mutual help groups, warm lines for support over the telephone, internet support groups for online support, and mental health services delivered by peers.[22]

Recommendation 1.6 – Program: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Many successful peer support groups in mental health have been conducted in a structured manner, with closed groups (i.e., a set number of sessions), a manual, and trained peer providers. The content of group sessions usually focuses around concepts of recovery or specific skill-building. These types of groups have been studied extensively, and results have shown increased **hope**, self-esteem, self-efficacy, **connectedness,** knowledge, and social support, as well as decreased symptoms.[26,57-60]

Positive reports from groups for suicidal individuals were published as early as 1968.[61] One study[62] found that groups were beneficial, with only 5% of the 105 attempt survivors having a re-attempt in the one-year follow-up (compared to approximately 15% in a year in general)[3,63,64]. Currently, there are few groups specifically for suicide attempt survivors (see Appendix C), but the ones that have been evaluated show positive results. An ongoing group for attempt survivors in Toronto, Canada, with a peer co-facilitator has reported improvements in mood, thinking, impulsivity, **connectedness**/belonging, and **hope**.[65] Another attempt survivor group with a peer co-facilitator in Los Angeles, California, has reported increased **connectedness**, decreased suicidal desire, and improved safety planning.[66]

Recommendation 1.7 – Policy: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Attempt survivor peer support is building on a long history of support by people with lived experience in mental and behavioral health[26,67]. However, existing behavioral health peer programs can be improved by adding suicide prevention resources. Some practice recommendations that are particularly relevant to peers in suicide prevention are noted here:

- Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them. Such training can lead to establishing certified attempt survivor peer specialists. Additionally, evaluation and research results will help improve programs and secure funding.
- Establish plans and protocols for support when a peer experiences a mental health crisis.
- Evaluate peer supports and disseminate results to develop an evidence base for program funding and improvement.
- Establish relationships between peer support groups or organizations and local crisis center(s) or hotline(s):
  - For peer specialists, when necessary, they will easily be able to get crisis support for people they are helping.
  - For crisis centers, they can use the partnership to provide follow-up care for callers or people being discharged from the emergency department or hospital.
- Establish mutually beneficial relationships with mental health peer supports (e.g., Depression and Bipolar Support Alliance (DBSA), National Alliance for Mental Illness (NAMI), Mental Health America (MHA), local health (e.g., emergency department) services, and behavioral health care services. Having ongoing relationships will improve continuity of care between services and is an important aspect of community connectedness.

Warm Lines

The warm line is a pre-crisis support service that is usually staffed by peers or paraprofessionals, and provides supportive listening, social support, and, sometimes, advice on coping. The intention is not to replace traditional crisis hotlines, but instead to provide after-hours care that is a source of social support. Research findings indicate that warm lines are associated with decreased loneliness, increased **connectedness**, decreased use of crisis services (e.g., emergency departments, police, and hotlines), and increased recovery.[68]

Recommendation 1.8 – Policy: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Warm lines may receive calls from suicidal individuals, and staff would benefit from knowing how to assist someone with getting to crisis services, or doing a basic assessment of the dangerousness of a situation (e.g., involvement of weapons or lethal substances). The National Empowerment Center (NEC)[m] and the National Mental Health Consumers' Self-Help Clearinghouse (Clearinghouse)[n] offer *A Guide to Developing and Maintaining a Sustainable Warm Line*[o] that provides guidance on developing and running a warm line, including a section on suicide prevention. In addition to a list of warm lines[p], the Clearinghouse also houses warm line training and administrative materials.[q]

Peer Specialists

Recommendation 1.9 – Program: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

One promising model for developing attempt survivor supports is the use of a peer specialist. A certified peer specialist is a person with lived experience who has undergone specialty training and certification in order to provide services to others, often with the benefit of reimbursement from insurers.[69] Research indicates that the peer specialists experience benefits themselves (e.g., increased self-image and self-esteem), while also helping others.[70,71] There appear to be positive, indirect effects on co-workers (e.g., decreased stigma and increased organizational change).[70] Additionally, studies show that the recipients of peer specialist services may have increased quality of life, decreased life problems, and increased engagement with traditional care systems.[70,71]

In most cases, a peer specialist works as part of a group or organization.[69] However, in some circumstances a specialist works with someone in a one-to-one capacity as a mentor or coach.[72] The pairing usually occurs at admission or discharge from a hospital or emergency department and provides support during the early recovery phase. Research indicates that this approach can result in fewer re-admissions to the hospital, fewer hospital days, and increased use of traditional programs.[72]

NSSP Goal 7 addresses the need for all professionals who interact with people at risk for suicide to have knowledge and skills in suicide prevention. Given the heightened risk for suicide with mental health issues, or following a suicide attempt, specific outreach efforts should be made to include peer specialists in the list of groups offered training and support for the prevention of suicide and related behaviors.

Programs and settings seeking to hire peer specialists or to fund peer support programs can look to the Center for Medicaid Services (CMS) and the Veterans Affairs (VA) for some guidance.[73] The CMS allows states to include peer support services in Medicaid programs and has provided specific guidance on requirements for states to follow. Example core competency areas for peer specialists[73] are included here for reference:

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[m] http://power2u.org/index.html

[n] http://www.mhselfhelp.org/

[o] http://www.power2u.org/downloads/Warmline-Guide.pdf

[p] http://www.mhselfhelp.org/warmlines-index/

[q] http://www.mhselfhelp.org/warmline-training-and-administ/

- An understanding of their job and the skills to do that job
- An understanding of the recovery process and how to use one’s recovery story to help others
- An understanding of and the ability to establish healing relationships
- An understanding of the importance of and the ability to take care of oneself

Additional peer-run services

Several types of programs, services, or initiatives are operated by people with lived experience of mental or behavioral health challenges. Though not the same as connecting with somebody who has lived through a suicidal crisis, these individuals may also be peers in many instances. Example approaches that may be beneficial for suicide attempt survivors include mutual support groups that focus on mental or emotional distress and peer-operated clubhouses[r] or peer recovery centers[s]. Further discussion about peer- or consumer-operated services, including evidence for their benefits and effectiveness, can be found in the SAMHSA Consumer-Operated Services Evidence-Based Practices (EBP) Kit.[t]

Recommendation 1.10 – Program: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

A Technical Assistance Center would cultivate a support network for peer specialists in suicide prevention to provide training, ongoing development, and leadership support. The center could unify a peer network and partner with other consumer peer support services. Additionally, the center would provide assistance to community organizations or professionals trying to implement peer support programs, or increase supports for suicide attempt survivors more generally. In building up to a specialized center, peer specialists focused on supporting individuals who have lived through a suicidal crisis could be recruited for existing suicide prevention and mental health technical assistance centers.

Hiring and Supporting Peer Providers in The Workplace

Recommendation 1.11 – Policy: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Human Resources (HR) staff may require additional guidance for the hiring and support of people who have attempted suicide or experienced a mental health crisis. In the hiring process, or arranging for reasonable accommodations in accord with the Americans with Disabilities Act (ADA)[u], this type of history should remain completely confidential. In the case of peer specialists, or other positions where lived experience is an integral part of the job, HR should keep specific details about someone’s experiences confidential. By protecting an

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[r] See ICCD Clubhouses and Clubhouse Research Outcomes (http://www.iccd.org/images/recent_ch_research_joel_tweet_website_092611.pdf)

[s] From the Ground Up, The Recover Project (http://ftgu.recoverproject.org/)

[t] http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD

[u] Equal Employment Opportunities Commission (http://www.eeoc.gov) and Job Accommodation Network (http://www.askjan.org)

employee's right to privacy, HR can support his or her sense of **dignity**. During the course of employment, someone may experience a mental health crisis. In that case, when properly trained, HR can facilitate arrangements for Family and Medical Leave Act (FMLA)[v] time in a sensitive way, and then help connect people to Employee Assistance Programs (EAP)[w] or other resources when they return. This type of care plays a large role in fostering a "mental health-friendly workplace" as described in *Workplaces That Thrive*.[x]

Recommendation 1.12 – Practice: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Organizational leaders and managers should help protect confidentiality and privacy while also facilitating supports for their employees. As an example, managers could enable people to have flexible schedules to allow for health or mental health appointments, or gradual reentry to full-time employment after a leave that perhaps begins with part-time shifts. For additional practice recommendations, also see general recommendations on hiring and supporting people living with mental health issues at *Workplaces That Thrive*[x].

Including Attempt Survivors as Partners in Suicide Prevention

Recommendation 1.13 – Practice: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

One of the most important practices that should be widely adopted is the inclusion of suicide attempt survivors and people with lived experience in suicide prevention efforts. Inclusion supports the Core Values of **hope**, **dignity**, and **connectedness**. This is one of the critical aspects of achieving Objective 10.3 of the NSSP: "Promote positive engagement of suicide attempt survivors in support services, treatment, and community suicide prevention education, including the development of guidelines and protocols for suicide attempt survivor support groups." At a 2005 conference for attempt survivors, a key recommendation was to "actively involve suicide attempt survivors and mental health consumers in planning, implementing, and evaluating all suicide prevention efforts."[74(p3)] Outreach efforts may be facilitated by having a suicide attempt survivor as a primary contact or partner in these efforts.

The following examples illustrate ways to increase inclusion, by recruiting attempt survivors:

- to join crisis centers as members of boards of directors, leaders, and staff / volunteers
- to participate in oversight or advising behavioral health systems change
- to review communications campaigns or social marketing endeavors aimed at consumers /suicidal individuals
- to act as spokespersons, advocates, or resources for legislative hearings / testimony

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[v] Department of Labor (http://www.dol.gov/esa)
[w] Employee Assistance Professionals Association (http://www.eapassn.org)
[x] *Workplaces That Thrive* (http://www.promoteacceptance.samhsa.gov/publications/business_resource.aspx)

- to be partners in the development of research / evaluation for suicide prevention initiatives – with Core Values as essential indicators of "effectiveness"

Recommendation 1.14 – Program: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

It should be noted that while inclusion is generally beneficial for the community, the benefits for the suicide attempt survivor depend on his or her readiness to be open up about the past crisis and use the lived experience as a strength. Some guidance exists for attempt survivors talking to individual family and friends[y], and for being a public speaker talking about lived experiences related to suicide[z]. However, there is a need for specific guidance about public disclosure when becoming a partner in a suicide prevention or mental health effort as an “out” suicide attempt survivor. A specific workgroup could develop such guidance. Ideally, attempt survivors should have easy access to a combined resource that can provide considerations and guidance for a range of activities that require self-disclosure, for example:

1. addressing self-stigma and shame
2. disclosing to family, friends, and support people
3. discussing suicidal thoughts and feelings with a behavioral health professional
4. disclosing to medical providers (e.g., primary care or emergency department)
5. disclosing for peer support
6. disclosing in public speaking
7. becoming a partner or leader in suicide prevention

There are some considerations for disclosure that are shared across multiple types of activities. For example, people should be aware of the potential for others’ negative reactions or discrimination. On the other hand, a recent study found that disclosure had beneficial effects, reducing loneliness and countering suicidal feelings.[75] However, there are some topics that are specific to the audience for the disclosure. The workgroup would also have to address the need for wide distribution, availability, and accessibility of the guidance so that attempt survivors are likely to find and use the resource.

The workgroup might address additional considerations for hiring suicide prevention peer specialists:

1. example functions and goals for peer programs
2. clearly written job descriptions and qualifications that value lived experience
3. leadership support at high levels and among immediate supervisors or managers
4. training for staff to prepare them for working alongside peer professionals
5. specific guidance for addressing role conflicts (i.e., the role of patient versus the role of peer specialist) and disclosure practices in the course of providing support

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[y] See Journey Toward Help and Hope, in press from SAMHSA.
[z] See http://www.suicidology.org/c/document_library/get_file?folderId=258&name=DLFE-542.pdf

6. suggested ways to help support peer providers' recovery or post-traumatic growth; specific challenges to be addressed may include stigma, shame, discrimination, and the potential for relapse[76]
7. sources and availability of consultation or technical assistance during the startup process (or ongoing support)

Recommendation 1.15 – Policy: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Beginning with the suicide prevention community, agencies and organizations should move beyond limited representation of attempt survivors into real partnerships. Ideally, inclusion can become significant or meaningful involvement. In the highest forms of inclusion (full integration), attempt survivors are invited as partners in key positions that have decision-making authority (e.g., management, staff, oversight boards) and receive compensation for their time and expertise.[aa] With expert guidance, more agencies and organizations may become prepared to reach out to attempt survivors as partners. In some cases, persons already in leadership or professional positions may have survived a suicidal crisis. When agencies and organizations develop supportive environments, such persons may feel safer with openly using their lived expertise.

Recommendation 1.16 – Policy: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

A policy example that primarily involves a formal shift in practices is the requirement for suicide attempt survivors to be included in suicide prevention efforts. An excellent example of this is legislation in Oklahoma that authorizes a Suicide Prevention Council and requires "survivors of attempted suicide" to be on the Council.[77] In many areas, there are already policies that require people with lived experience, related to mental health and substance abuse issues, to be included in programs or oversight.

[aa] As an example, see Prescott & Harris, *Moving Forward, Together* (http://pathprogram.samhsa.gov/channel/moving-forward-together-integrating-consumers-as-colleagues-603.aspx) - a guide for integrating people with lived experiences related to homelessness into policy, planning, evaluation, and delivery of services.

Part 2: Family, Friends, and Support Network

As part of starting therapy, Vickie asked Jamie about the family or friends who should be included in the support network part of the wellness plan. Who was there throughout Jamie's crisis? Who was around in good times and bad times? When the list was finalized, it had father, sister, close friends Chris and Pat, Prof. Jones, Chaplain Nelson, and Dr. Jamison. Among other resources, Vickie provided a list of times that the local hospital was offering educational programs for community members. Jamie also selected some booklets for them and a flyer for a new group just for family and friends of attempt survivors. There's nothing like having a support group of your own.

Recommendation 2.1 – Practice: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Each attempt survivor defines for himself or herself the people who should be consulted and included in care, and in what stage of recovery they are engaged. Helpers can make suggestions or provide ideas in the process of exploring potential supports, but each person should have the opportunity to define his or her own care network. In particular, for youth, the support network usually includes parents or guardians, but someone may feel closer to siblings or another trusted adult in the extended family (e.g., aunt or uncle, grandparent) or the community (e.g., teacher, pastor). As a specific example, a recent study with Latina adolescents found that support from fathers and teachers may be particularly important in protecting against suicidal thinking and attempts.[78] However, individual choice for some (e.g., minors, dependent adults) will need to be balanced with clinical and/or legal needs to involve caretakers.

Getting help from a support network

On multiple occasions, attempt survivors have indicated that simple acts of caring make a major difference in their lives, particularly when they are most vulnerable. The importance of cumulative acts is indicated by research on family-based protective factors and the buffering role of having a network of supportive friends. As an example, a recent study from Taiwan showed that for preventing repeat suicide attempts, social support was just as important as willingness to get professional help.[79] Additionally, a study with U.S. Air Force personnel demonstrated that support that enhanced self-esteem or provided tangible help (e.g., money, transportation) decreased suicidal thinking.[80] Several supportive actions are listed in **Table 2**, and two resources for such actions (Reach Out campaign, and Lifeline E-cards) are highlighted on this page.

Reach Out.
Check In.
Save A Life.

[The campaign] encourages everyone to take some time out of their day to reach out and connect with someone who might be struggling... People need to feel connected to others, and to feel that someone notices them and cares. You never know who might be feeling alone, and something as simple as a smile or a conversation can go a long way.

reachoutcheckin.org

Lifeline E-cards are a quick way for people to send a brief note with support, sympathy, or well wishes.
suicidepreventionlifeline.org/getinvolved/ecards.aspx

Table 2. Example social supports

General support	- initiate regular, positive contacts (e.g., calls, emails, text messages, etc.) – see Reach Out campaign in box. - send a letter, postcard, or e-card – see Lifeline e-Cards in box. - explicitly offer messages of care, affection, pride, love, or concern - provide encouragement and tangible supports (e.g., transportation, reminders) for seeking additional help - offer support and encouragement for engaging in self-help practices - maintain an emotionally supportive home with consistent communication for children
Crisis support	- visit a family or friend in the hospital - accompany him or her to the emergency department or crisis center - help arrange for child care and support during a crisis and/or recovery - offer to take care of his or her pets, plants, or property - be particularly vigilant just after he or she gets out of the hospital or emergency department, and in the weeks that follow

Information on helping an attempt survivor

Recommendation 2.2 – Practice: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Many programs are designed to assist people in a care network with identifying suicide risk or warning signs, and providing support to a person recovering from a suicide attempt (or at risk for suicidal behavior). Some educational interventions for community members have been included in research studies and found to be effective[81-84], including a specific educational program within the emergency department[85,86]. Participants have demonstrated improved knowledge, attitudes, and skills which help by increasing **reasons for living** and promoting use of both professional and informal supports (i.e., **connectedness**). Some community organizations, including churches and faith-based groups, can better serve their members as local resources by offering such trainings to their leaders and staff.

Other resources (e.g., fact sheets, brochures, booklets, and self-help materials) are also designed to provide information, but no published evaluations were found. Family and friends might also benefit from guidance about talking to an attempt survivor or suicidal person about reducing access to lethal means. Some specific guidance for mental health professionals, seeking to include family or support persons in discharge planning, can be found through the American Association of Suicidology (AAS).[87] In particular, the AAS guidelines recommend scheduling a family session and providing support persons with specific information and resources.

Support for The Family and Friends of Attempt Survivors

The person recovering from a suicide attempt benefits from the support and **connectedness** that comes with having a network of people who care about them. However, the people in the network themselves often require some support and assistance.

Recommendation 2.3 – Program: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Supporting a person through a suicidal crisis can entail terrifying experiences and even development of secondary trauma symptoms. Yet, there are few programs that have been designed to support the family of attempt survivors, and no programs were identified for friends and other support persons. In related successful programs, trained family members (i.e., peers for family) offer groups that focus on providing education, skills, training, and support. Outcomes have included decreased stress among family members and increased coping abilities.[32,88] There are also some brochures, booklets, and self-help materials designed to help family with behavioral health recovery.

The following practices might be helpful in developing efforts to assist the family and friends of attempt survivors[32,89]:

- Coping strategies to avoid burnout, especially in consideration of their vigilance and help-giving efforts
- Information about the short-term and long-term factors that contribute to suicidal thinking and behavior, including those from the attempt survivor, from the family, from the environment, and from the larger culture
- Consideration of cultural and/or spiritual differences that influence support practices

Recommendation 2.4 – Practice: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

There are few programs that offer support for family or friends of individuals who have been suicidal. Many people gain support from **connecting** with others while attending programs that were originally intended for educational purposes.[88] As a specific point for intervention, it may be helpful to have a structured meeting with family and friends when a person needs to go to a psychiatric hospital during a suicidal crisis. Resources such as groups or online forums that might foster support through connectedness for people who care about attempt survivors are desperately needed. One way to quickly foster wider availability of support is to enhance related behavioral health programs for support persons by including resources and discussion specifically about suicidal crises.

Part 3: Clinical Services and Supports

Vickie's question, "Who referred you here?" brought back memories for Jamie. Most directly, the referral for a therapist came from Dr. Jamison, a psychiatrist. Dr. Jamison worked with all of her patients to develop a care plan that included a wide variety of support, including therapy, so that they could use minimal medication management. Before that, though, the journey really started with a nurse named Dan who told Jamie that he had gone through a suicidal crisis himself. He said that Dr. Carson, the primary care physician Dan worked with, was understanding and supportive. As it turned out, Dr. Carson and Dr. Jamison were at the forefront of an effort to make suicide prevention a core part of the clinic's mission.

Jamie was not sure how Vickie would react to learning about the suicidal crises of the past. She offered a warm and reassuring smile and explained how she would be working side-by-side with Jamie through crises and challenges, always in light of strengths, hopes, and goals. Together they would develop a care plan that had specific steps they would try if a crisis occurred, and which supports and services they might engage for help. Vickie's insistence on working together to see the whole picture and make plans they would both be comfortable with was the start of a wonderful therapeutic relationship.

General Medical Services

Recommendation 3.1 – Practice: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Many individuals who have lived through a suicidal crisis use medical, mental health, or behavioral health services. Professionals offer specialized knowledge and resources that have the potential to enable and support recovery. Working to restore **hope** should be a major goal of treatment for someone who is seriously considering suicide for the first time, someone who has attempted suicide multiple times, and persons with experiences throughout that continuum. However, services tend to work in isolation from each other and focus only on a specific part of the recovery process (e.g., medical stabilization, detoxification from substance use, individual therapy). As noted in several reports,[31,39,40] this approach has led to a fragmented system with many gaps in care. Additionally, "there is substantial evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide."[9(p52)] Thus, in line with prior recommendations, the Task Force supports a collaborative, person-centered approach that maintains continuity of care and is aligned with the Core Values.

When elements of healthcare align with the Core Values, they can benefit all patients and contribute to the prevention of suicidal behavior. For example, providing collaborative care and **engaging a person's support network** would be universally beneficial. Focusing on enhancing care in ways that align with the Core Values provides an opportunity to partner with many other groups (e.g., domestic violence prevention, substance abuse treatment and prevention, disability rights, etc.) to make and implement policy changes.

Recommendation 3.2 – Policy: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

As an initial step, a relatively simple policy change is a position statement or formal announcement of support for helping suicide attempt survivors. This approach is exemplified by Suicide Prevention Australia (SPA; a national community organization in Australia focused on suicide prevention) that issued a position paper in support of attempt survivors. Through the position paper, the organization officially endorsed concepts such as expanding care beyond clinical systems, collaborative decision-making, alternatives to hospital-based intervention, and attention to the needs of family and friends of attempt survivors. Similar statements can be made by organizations in the U.S. to formally support recommendations from *The Way Forward*.

Health systems change through policy: The role of political will

In a series of papers co-authored by the U.S. Surgeon General in charge of developing the first "Healthy People" initiative, three essential components were identified for successful health policy as (1) knowledge base about the issue; (2) a comprehensive strategy for taking action; and (3) political will.[90,91] Social and political support, i.e., "political will," are needed to change policies in ways that advance public health.[92,93]

Political will is "society's desire and commitment to support or modify old programs or to develop new programs. It may be viewed as the process of generating resources to carry out policies and programs."[90(p388)] Political will is based on "public understanding and support."[91(p451)] Here, "public" refers to both government leadership and the broader community.[92] Public support can influence public health outcomes when economic, social, and intellectual resources are committed to address an issue.[93]

As noted in a report on the state of suicide prevention in the U.S., "the movement's capacity for activism will be central to its future success."[6(p40)] Securing funding is an essential part of health reform efforts. Community support and pressure help ensure that crucial resources are available (i.e., political will). The Mental Health Services Act in California[bb], which has funded many suicide prevention activities, including attempt survivor supports, is probably the best known example of policy change through public support. [see box]

[bb] http://mhsoac.ca.gov/MHSOAC_Publications/docs/Publications/TransformationPolicyPaper_May2011.pdf

Political will in action: The California Mental Health Services Act

Specific funding for mental health in California began with ballot initiative, Proposition 63 (Prop 63; Mental Health Services Act, or MHSA) in the 2004 election cycle. Prop 63 added a 1% extra tax to income over $1 million a year, with the purpose of funding initiatives to reform and enhance the mental health system in California, and it passed with 53.8% of the vote. In part, the MHSA established programs for prevention and early intervention that specifically address suicide. In 2009, in a special election ballot, Proposition 1E sought to shift funds earmarked for the MHSA to help balance the state budget. Prop 1E did not pass, garnering 33.5% of the vote. See official site: http://www.dmh.ca.gov/prop_63/mhsa/

Elements of transformation addressed in MHSA statutes include:

- requirements for significant stakeholder involvement from clients, family members, parents, and caregivers in local planning and services
- services and supports that are comprehensive, integrated and focused on wellness/recovery/resiliency
- promotion of the employment of mental health clients and family members in the mental health system
- promotion of consumer-operated services as a way to support recovery

Health Professionals

Recommendation 3.3 – Practice: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Health systems can further support the Core Values by developing a workforce with the knowledge, skills, and resources needed to respond appropriately in a suicidal crisis. The Task Force agrees with recent guidance recommending that quality improvement efforts examine system readiness for assessing suicide risk and responding appropriately.[31,40] Research indicates that some people prefer to get help for mental health challenges through primary care, and many individuals who die by suicide had contact with health care settings before their deaths.[31,94] Some communities may only have access to primary care. Increasing the number of settings and professionals with basic competence in understanding and supporting a suicidal person opens up additional **choices** for seeking care and facilitates **faster access to care**.

As recommended in the CCI Report, evidence-based clinical care for a person at risk of suicide should be person-centered, engage his or her support network, and respect cultural values and preferences. The report identified the four key parts of care: (1) screening and assessing risk for suicidal behavior; (2) collaborating with the person at risk to plan for safety; (3) addressing suicide risk directly, through collaboration with other professionals, and/or appropriate referral to a mental health care provider; (4) follow-up contact.[31] Additional information about developing a competent health care workforce can be found in the Zero Suicide Tool Kit[cc] and guidance

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[cc] http://www.zerosuicide.com/developing-competent-workforce

for specific workforce guidelines for professionals in the forthcoming *Suicide Prevention and the Clinical Workforce: Guidelines for Training*[dd].

Health professionals may also benefit from practical discussion guidance like maintaining dignity and supporting autonomy, teaching or encouraging self-advocacy, and addressing access to materials used for suicide (e.g., guns, large quantities of medicine). The NSSP recommends leveraging the power of credentialing and accrediting agencies / organizations to change professional practices.[9]

Beyond competent care, the Task Force urges professionals to practice compassionate care. NSSP Objective 9.3 focuses on promoting safe disclosure; a process that depends on addressing **negative stereotypes, fear, and discrimination** among health care professionals.[89,95,96] A report from the U.K. provided many specific examples for improving "bedside manner." Most reinforce the idea that individuals currently in, or recovering from, a suicidal crisis "have the right to be treated with dignity and respect … and valued as human beings, as do all service users."[97] Research indicates that presentations with or by people with relevant lived experience can have a bigger impact on reducing negative stereotypes and stigmatizing attitudes than presentations that depend solely on sharing information.[98,99] Engaging attempt survivors in planning and delivering training is emerging as a recommended practice.[97,98]

Recommendation 3.4 – Practice: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

A person living with a mental and/or substance abuse disorder has a greater risk for suicidal behavior. Yet, even when behaviors that appear to be symptoms of a mental disorder are present, they may not be the root cause of suicidal thinking or behavior. Recent practice guidelines for mental health crises reinforce the notion that "established psychiatric disability may be relevant but may – or may not – be immediately paramount"[40(p6)] and recommend that "appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated …"[40(p5)] While acknowledging the increased suicide risk associated with behavioral health issues, Motto observed that "many suicides are not caused by illness, but by psychic pain or anticipation of pain that exceeds an individual's threshold of pain tolerance" and may be due to "stressful life circumstances that do not constitute a disorder."[100(p226)]

Both theoretical[101-103] and empirical studies[10,104,105] have found that the suicidal crisis may have more to do with subjective experiences of emotional pain and hopelessness, and less to do with diagnosis or symptoms. As noted in the CCI Report, "targeting and treating suicidal ideation and behaviors independent of diagnosis holds the greatest promise for care of suicidal risk."[31(piii)]

[dd] National Action Alliance for Suicide Prevention: Clinical Workforce Preparedness Task Force (in press). *The Clinical Workforce: Guidelines for training.* http://actionallianceforsuicideprevention.org/task-force/clinicalworkforce

Behavioral Health Systems and Supports

Behavioral Health Systems

Recommendation 3.5 – Policy: Behavioral health systems should make suicide prevention a core component of care.

There is a need for system transformation that makes suicide prevention a core component of care. A system that believes that suicide is an unacceptable outcome is likely to try new approaches and be open to change existing programs or policies to ensure that people receive quality, **collaborative care**. When addressing suicidal behavior as a core part of care, the negative perception (**stigma**) of a suicidal person as a “waste of time” is replaced by considering him or her a priority. With a value on life, **access to care** and what happens after hospital or emergency department discharge become critically important. The change might also provide an impetus for creating formal connections to aftercare and follow-up services, thus strengthening the type of interagency **connectedness** that is a Core Value.

At the 2007 National Summit on Recovery, participants identified 17 elements of recovery-oriented care[106]:

- Person-centered
- Family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Inclusion of the voices and experiences of recovering individuals and their families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes-driven
- Research based; and
- Adequately and flexibly financed

As noted in the NSSP, changes require “leadership support, changing the organizational culture around suicide prevention, and engaging each component of a system to assume its legitimate role in suicide prevention."[9(p52)] Similarly, a review of large-scale transformations to align health systems with the values of recovery-oriented care concluded that “leadership, innovative thinking, flexible planning, and analysis of existing strengths and weaknesses emerged as key elements in each change process.”[106(p23)] Such changes have been applied with success in large systems like the VA, the Henry Ford Health System, and the Central Arizona Programmatic Suicide Deterrent Project.[31] Further information, resources, and support can be found at the Action Alliance’s Zero Suicide Initiative website.[ee]

[ee] http://www.zerosuicide.com

Behavioral Health Professionals

Recommendation 3.6 – Practice: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

While some providers clearly specify that they are able and willing to work with suicidal clients (see HelpPRO in box), for most it is unclear how they would approach a suicidal crisis. As part of informed consent, clinical providers should be "up front" about their stance on suicide (e.g., always support life), and their approach to working through a crisis. The delicate balance required for such decisions and discussions was well described by Linehan: "Two factors are important in treatment planning and deciding on how active to be in responding to a suicidal crisis. The first factor is the short-term risk of suicide if the therapist does not actively intervene. The second factor is the long-term risk of suicide, or a life not worth living, if the therapist does actively intervene."[107(p174)] Regardless of a provider's choices about how to approach crisis situations, the person receiving services should be fully informed about the potential benefits and risks of disclosing suicidal thoughts. Involuntary confinement, even if it provides some therapeutic value, could create "extremely serious, negative repercussions both for the patient's therapy and for his or her life."[107(p178)]

Early discussion of issues like potential crisis situations might reduce instances of professional abandonment (actual or perceived). Some attempt survivors have reported being dropped from treatment after a suicidal crisis, at times without a referral to another provider. For the client, when care is abruptly terminated it may feel like professional rejection, deepening the trauma of the crisis experienced and intensifying feelings of shame. The clinician may also experience anxiety and guilt, in addition to ethical and legal ramifications of abandonment, which is considered medical malpractice. If necessary, the appropriate way to end treatment may include providing information, sharing resources, arranging referrals, follow-up contact, and sufficient time for the termination process.[108]

HelpPRO Suicide Prevention Therapist Finder

This resource was launched on World Suicide Prevention Day in 2013 (September 10th) as an online referral source of behavioral health providers trained in suicide assessment and support. It is a joint venture of HelpPRO (developers of a comprehensive therapist finder) and partners including the National Suicide Prevention Lifeline, the American Association of Suicidology (AAS), the QPR Institute, The Carson J Spencer Foundation (CJSF), and the Suicide Prevention Resource Center (SPRC) of the Education Development Center, Inc.

The project has two major goals: (1) connect people to qualified professionals who specialize in working with persons in, or recovering from, a suicidal crisis; (2) encourage behavioral health professionals to enhance their suicide prevention skills.

Professionals who specialize in helping suicidal individuals, and are accepting new clients, are encouraged to list their practice information at the site.

http://www.helppro.com/SPTF

Some guidance about treatment planning, including the development of a crisis plan (also called a safety plan or emergency plan) can be found in the Zero Suicide Toolkit[ff]. While this type of plan can be devised or revisited

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[ff] http://www.zerosuicide.com

during the course of treatment, the process should start at the beginning of treatment. This type of plan flows naturally from the process of assessment, and presents an excellent opportunity to start collaborating on care and support.

Behavioral Health Treatment

Recommendation 3.7 – Practice: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

An accurate assessment sets up the possibility for appropriate and effective treatment. Additionally, a person's sole interaction with the behavioral health system may be the assessment. There are at least two models that illustrate ways for assessment to adhere to the Core Value supporting **dignity** and **collaborative care**: the internationally recognized Aeschi approach and the empirically supported Collaborative Assessment and Management of Suicidality (CAMS) model.

- The Aeschi Working Group and Conference is "a group of clinicians and researchers dedicated to improving clinical suicide prevention practice by developing and promoting patient-oriented and **collaborative** models of understanding suicidal behavior."[gg] The approach values the therapeutic relationship and focuses on understanding someone's personal narrative of his or her suicidal thoughts or feelings. Attention to the inner experience is a compassionate approach that is inherently supportive of someone's **dignity**. They offer the following guidelines for clinicians:

    1. *The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality.*
    2. *The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.*
    3. *The interviewer's attitude should be non-judgmental and supportive.*
    4. *The interview should start with the patient's self-narrative.*
    5. *The ultimate goal must be to engage the patient in a therapeutic relationship.*

Dr. Jobes, a member of the Aeschi group, developed the CAMS model[102] as a framework for collaborative assessment and treatment planning specifically designed for working with suicidal individuals. One of the core aspects of the approach is a **collaborative** assessment of a person's goals or perceived benefits for suicidal thinking. The therapist can then help the person consider alternative coping strategies or supports that can help the person achieve those goals or realize those benefits. The effectiveness of the model has been demonstrated in several studies and ongoing research. The results showed that people engaged in CAMS experience increased **hope and reasons for living**, improved satisfaction with care, and decreased suicidal thoughts and distress.[104]

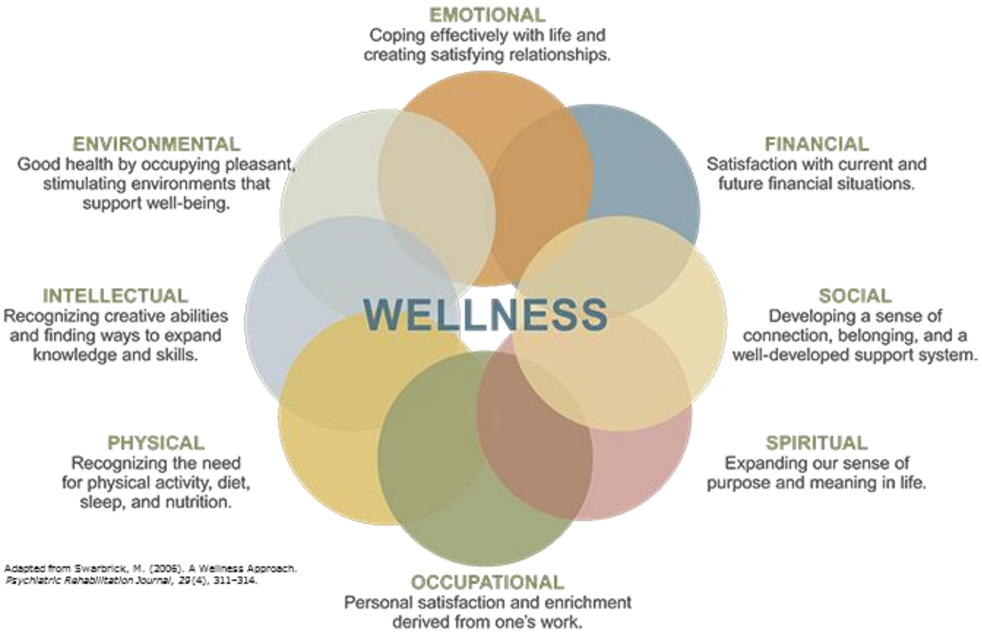
[gg] http://www.aeschiconference.unibe.ch/

Recommendation 3.8 – Practice: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Everyone should have the chance to receive a comprehensive assessment. Care for someone, beginning with assessment, should address the current crisis, as well as his or her multiple needs. One research report noted (emphasis added) "After a suicide attempt, needs in several different aspects were present. The number of needs and unmet needs was reduced after 1 year, **but a number of needs were still common, especially in health aspects but also in basic needs and social needs**."[109(p362)] Additionally, a study of young attempt survivors found that they often had more health and social problems over time than youth without a history of suicide attempts.[4]

A comprehensive assessment would also examine several life domains, facilitating a discussion of individual strengths and possible community **connections**. Reminding someone that he or she has multiple dimensions (see, for example, Figure 2) that include strengths could help restore a sense of self-respect or **dignity**. One resource on assessment recommended using questions about supports and challenges within both the person and his or her environment.[110] As a specific example, one review recommended that clinicians "be aware of the religious and spiritual activities of their patients, [and] appreciate their value as a resource for healthy mental and social functioning."[37(p289)] For additional information and resources for promoting wellness, please see the SAMHSA Wellness Initiative.[hh]

Figure 2. SAMHSA Wellness Initiative - Eight Dimensions of Wellness



Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

[hh] http://promoteacceptance.samhsa.gov/10by10/

Recommendation 3.9 – Policy: Protocols for addressing safety and crisis planning should be based on principles of informed and collaborative care.

Many people have been sent to involuntary, or coerced, inpatient care when they could have benefited from alternatives. During hospitalization, patients might endure physical and/or psychiatric restraints or solitary confinement. Such practices intensify the crisis, deprive a person of dignity, and substitute potential trauma for treatment while having practically no effect on long-term risk for suicide.[40,107,111,112] As stated by the Bazelon Center for Mental Health Law, "Forced treatment – including forced hospitalization, forced medication, restraint and seclusion, and stripping – is only appropriate in the rare circumstance when there is a serious and immediate safety threat."[ii] The ethical, legal, and scientific consideration of forced treatment available through the Bazelon Center is consistent with the Core Values. Additionally, the practice guidelines for responding to mental health crises remind providers that such interventions carry the risk of physical and psychological harm.[40]

The NSSP recommends that "specialty centers that provide care for mental and substance use disorders should have in place policies, procedures, and programs designed to identify the level of suicide risk and intervene to prevent suicide among their patients."9(p61) It was also recommended that "protocols should emphasize patient-centered and stepped approaches that allow relative suicide risk to be assessed and matched with a continuum of services."9(p62) It is particularly important to help people find appropriate care for their level of risk. The CCI Report includes further recommendations for assessing and responding to suicide risk in multiple healthcare settings.[31]

Whenever possible, even crisis care should be provided in an environment that maintains **connectedness** to a person's **family and/or peers**, and has as few restrictions as possible. Any restrictions on personal wellness should cease once basic health and safety are attained. For example, at inpatient and partial hospitalization settings, individuals would benefit from having therapeutic contact daily (including weekends) along with a chance to exercise and/or spend time outdoors. Providing care in alternative settings will be greatly facilitated when behavioral health providers follow guidance from the NSSP to "coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide."9(p65)

Regardless of where care takes place, to make informed decisions, as early as possible, each person should receive a guide to rights and treatment options written in a language and manner that is easily understood. Individuals receiving care would also benefit from ready access to a peer advocate whenever possible.

Recommendation 3.10 – Practice: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

In many cases someone who is in, or recovering from, a suicidal crisis can benefit from therapy. While there are many types of therapy, generally, for people to cope with suicidal thoughts or recover from a suicide attempt, cognitive and/or behavioral treatment is recommended. As noted in the NSSP, "there is now substantial

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[ii] http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment.aspx

evidence that interventions such as dialectical behavior therapy (DBT) and cognitive behavior therapy for suicide prevention (CBT-SP) can help reduce suicidal behaviors." Moreover, as noted in the CCI Report and the NSSP, care is most effective when it is specifically designed to counter suicide. [9,31]

A detailed discussion of therapeutic practices is beyond the scope of *The Way Forward*. However, the ideal therapies will value **dignity**, **collaborative care**, and the **engagement and support of family and friends**. Care practices are discussed at length in the CCI Report[31] and Zero Suicide in Healthcare initiative from the Action Alliance.[jj] In addition to the Aeschi and CAMS models (see Recommendation 3.7) a few additional approaches are exemplary in adhering to the Core Values:

Trauma-informed care

Many individuals have histories that include trauma (e.g., physical, sexual, emotional abuse).[113] Thus, past trauma can be a primary factor or a complicating factor to consider in assessment and treatment.[114] Additionally, for some attempt survivors the suicidal event itself (e.g., injury, loss, shame, discrimination, or negative encounters with services) can serve as a traumatic event. Therefore, it may be beneficial for professionals working with attempt survivors to learn from the approaches in trauma-informed care. SAMHSA has developed a National Center for Trauma-Informed Care that provides additional education and assistance regarding these practices.[kk] In brief, this type of approach begins from a basic understanding about how trauma impacts the life and experience of care for the person who survived a trauma. Common principles include the need for **respect**, informed care, **hope**, and **collaboration** that may also **engage family and friends**. Given the increased risk for multiple negative outcomes associated with childhood trauma, early intervention is invaluable.[113]

Connecting with hope

One approach to working with suicidal people was developed based on a review and synthesis of in-depth interviews with attempt survivors.[115] In part, care plans based on the theory might seek to:[116]

- Counter isolation by engaging in treatment and promoting supportive relationships (**connectedness**)
- Validate a person's emotional pain, help them express their feelings (e.g., journaling, art, music) as opposed to attempting to suppress the pain
- Help someone find ways to cope through specific blocks of time and stay connected to **reasons for living** or form a safety alliance during the most suicidal times
- Help someone work through emotional pain in the short term, and in the long term learn to value and use his or her strengths and continue moving toward a **meaningful and hopeful life**

[jj] http://www.zerosuicide.com/using-effective-evidence-based-care
[kk] http://www.samhsa.gov/nctic/

Personalized community-based treatment

The Need Adapted Treatment Model[ll] emphasizes providing **timely access to care** that is flexible in terms of allowing people to choose times and locations for treatment based on individual needs (i.e., **choice**). The person receiving care and the people in their **social support network** are engaged to collaborate with professional support networks in planning and carrying out treatment plans. A particularly important part of this type of care is the spirit of **collaboration** that builds from having the person and her or his support network act as equal partners in seeking solutions and providing care.

The internationally recognized Open Dialogue[mm] model is similar in providing **access to care** within 24 hours of initial contact, organizing treatment meetings at times and locations that accommodate individual needs, and engaging the **family and support network** in care. Research on the model has demonstrated that people can decrease symptoms and return to work while avoiding hospitalization and additional psychiatric medication.[117]

Prescribing practices / medication

Recommendation 3.11 – Practice: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Many individuals who have survived a suicidal crisis live with behavioral health challenges and often benefit from ongoing treatment or support, which may include therapy and/or medication. Use of medication may entail both benefits (e.g., decreased symptoms, improved functioning) and costs (e.g., financial expenses, negative side effects that may even increase risk for suicidal behavior[118]). Ongoing research has led to advances in medications[nn] and supplements[oo] with the potential to help a person cope with mental, emotional, or physical health concerns. Thus, someone seeking care depends on the professional to bring knowledge about those options into the treatment planning process. Additionally, the person seeking care, his or her support persons, and/or the professional may have concerns about accidental or intentional overdose, interactions with other medications or supplements, habit-forming or addiction potential, or practical issues such as keeping track of multiple medications. As underscored in the Core Value on choice and collaboration, the Task Force encourages use of a well-informed, shared decision-making approach to address concerns and optimize care.

Treatment that includes medication may be especially beneficial during acute or short-term care, but it is not always required for the long term. Some studies report long-term benefits for medications,[119,120] while others argue that recovery is at least as likely without continuous medication[121,122]. Unfortunately, there is not (yet) enough information about the factors involved in recovery to predict which patients do better with continuous medication, which ones only benefit from acute care with medications, and which ones would be well without medication.[123-125]

[ll] http://recovery.rfmh.org/index.php?id=346

[mm] http://willhall.net/opendialogue/

[nn] See http://druginfo.nlm.nih.gov

[oo] See http://nccam.nih.gov

Research indicates that a treatment approach which focuses on **hope** and uses recovery principles is most likely to be successful.[123] Based on research and consensus among recovery-oriented psychiatrists, guidance for prescription practices[123] would be consistent with the Core Values and include:

- Care must be founded on a strong and **collaborative** therapeutic relationship with mutual **respect** and trust.
- Multiple types of care and supports should be considered, including medication(s). For example, everyone benefits from having a circle of **social supports** and meaningful relationships.
- If treatment is going to be changed, then transitions should be done gradually, with honest communication guiding each step of the process.
- It would often be beneficial to have a “wellness coach” or a **peer supporter** who can advocate for the person receiving care, facilitate communication, and assist the person with making informed decisions that support their long-term goals.

Part 4: Crisis and Emergency Services

Jamie and Vickie had carefully laid out a crisis plan, something they both agreed on. Jamie could call people in the support network list, which now included Vicki as well. Additionally, the National Suicide Prevention Lifeline was a key resource because it was available 24/7/365. The crisis center worked with a mobile outreach team, with a psychiatrist and a peer specialist, who could go out to meet with someone in crisis. Most of the local police officers had completed Crisis Intervention Team training, but it still felt better knowing that a mental health team could respond in an emergency. In spite of a decent experience with a hospital before, Jamie really liked the idea of trying the peer respite house as an alternative in case of a significant crisis. If a trip to the emergency department was required, a peer specialist could be called to the hospital for additional help. As an advocate, the specialist would make sure the treatment was respectful and attentive, while also assisting with the engagement of an ongoing support network.

Recommendation 4.1 – Policy: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

In some areas, only basic emergency services are available. Other regions devote considerable resources to expensive, and often unnecessary, hospital or public safety interventions. Quality clinical services in the community; peer supports such as warm lines, crisis centers and hotlines; and crisis respite care provide help that is often preferable and less costly.[47,48,68,126] A person may be encouraged to specify his or her preferred type(s) of services through a psychiatric advance directive (see box). Communities should invest in those services. Several effective training programs are available to enhance the competence of professionals, paraprofessionals, and volunteers who provide crisis or emergency care.[82-84,127]

Psychiatric Advance Directives

The directive is a legal document that describes someone's specific instructions and/or preferences regarding treatment if he or she is in an acute mental health crisis. Usually, a specific person(s) is designated as a surrogate decision-maker to address needs that are not specifically noted in the document.

Information and resources can be found at the National Resource Center on Psychiatric Advance Directives. http://www.nrc-pad.org/

Help During a Crisis: Crisis Centers, Hotlines, and Crisis Respite Care

Crisis Hotlines

As noted by the NSSP: "Timely access to care is critically important to individuals in crisis. Crisis hotlines … play an important role in providing **timely care** to patients with high suicide risk."[9(p54)] In most places, crisis centers and/or hotlines are always available and offer brief mental health support and triage to further care. Originally, crisis hotlines operated through local or toll-free telephone numbers; however, an increasing number of centers are also adopting new technologies to provide support (e.g., online chat or SMS text messaging). More details about the use of technology can be found in Part 5: Systems Linkages and Continuity of Care (see page 59).Additionally, some centers work alongside, or even operate, on-site crisis counselors or teams. Finally, many centers are offering follow-up calls to people who have called a hotline or people being discharged from an emergency department. More details about follow-up can also be found in Part 5 (see page 58).

Recommendation 4.2 – Practice: Crisis center and hotline staff should review "Lifeline Service and Outreach Strategies Suggested by Suicide Attempt Survivors."

The National Suicide Prevention Lifeline gathered a group of attempt survivors to discuss crisis center service and outreach strategies. The resulting report, *Lifeline Service and Outreach Strategies Suggested by Suicide Attempt Survivors Final Report of the Attempt Survivor Advisory Summit Meeting and Individual Interviews*,[pp] presented themes for helping attempt survivors within the crisis center and hotline context, including:

- **Peer support** is an invaluable resource. Trust and **connection** is easier when talking to others with lived experience. Centers can engage "open" or "self-disclosed" attempt survivors as crisis line or outreach workers.
- Crisis center staff need to understand that talking about suicide does not necessarily indicate imminent risk. Compassionate listening should always come first.
- Crisis line workers may be able to help by gently engaging a caller in conversation about the **important people in his or her life**, gently pointing out how the caller is cared about or loved.
- **Spirituality and faith are important.** Crisis centers can provide information and outreach to faith-based organizations.
- Follow-up calls from crisis line workers can help callers feel supported and **connected. Follow-up peer to peer outreach is** particularly powerful.

In line with the above points, a recent study with training crisis center staff indicated that helpers should explore reasons for living (i.e., **hope, meaning and purpose**) and informal sources of support (i.e., **engaging family and friends**, **connectedness**). Doing so can help people feel more hopeful, less depressed, less overwhelmed, and less suicidal.[127] Centers are also encouraged to review the National Suicide Prevention Lifeline Imminent Risk Policy (see box on following page) for practices that support the ideals and principles outlined here.

Warm lines are described in Part 1: Attempt Survivors as Helpers (see page 27), and make excellent partners for crisis services, offering one source of peer support and connectedness as suggested by the attempt survivor meeting. Some warm lines have formal relationships with crisis hotlines, and with some training and technology, staff can refer or transfer callers in crisis over to a hotline when necessary. Similarly, crisis hotlines can provide warm line information to callers who might benefit from supportive services. In some communities a single organization or site operates both types of services, providing a seamless connection between the two.

[pp] http://www.sprc.org/library_resources/items/lifeline-service-and-outreach-strategies-suggested-suicide-attempt-survivors

National Suicide Prevention Lifeline (NSPL) Imminent Risk Policy[a]

The policy guidance for working with callers at imminent risk for suicide developed by the NSPL is an excellent resource that is consistent with the Core Values. A few relevant points are included below as examples:

> The NSPL "seeks to instill **hope**, sustain living, and promote the health, safety and well-being" of people. Active engagement is consistent with that mission by "holding **hope** for recovery and empowering the callers."

Centers were directed to "develop formal and informal relationships with community services that can assist in the use of less invasive interventions and/or better ensure optimal continuity of care for callers at imminent risk of suicide." While the policy guidance does not specifically name crisis respite or **peer services**, they could be key partners in shared responsibility, and promoting **interagency connectedness**.

Crisis Respite Care

Recommendation 4.3 – Program: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Respite care offers an alternative to emergency department or hospital services for a person in a mental health or suicidal crisis, when that person is not in immediate danger. Usually, respite centers are located in residential facilities that are designed to feel more like homes than hospitals. Given a relaxed setting that often includes peer staff, this type of care is generally preferred by someone in crisis[126,128-130] and has shown better functional outcomes than acute psychiatric hospitalization.[126,129]

One report specifically examined multiple respite centers as part of an in-depth review.[131] A few suggested practices noted in the report are:

- Assisting with continuity of care and establishing longer-term support resources
- Providing phone/text/online "virtual" supports for a person before and/or after a stay
- Evaluating the development, operation, and outcomes of services provided

Approaches to Crisis Respite Care

Inclusion of peers on staff

While many crisis respite services are operated by mental health professionals, there are also some alternatives that are staffed by peers.[131] This is a very promising model, and initial reports indicate that these respite centers can be cost-effective alternatives to traditional hospitalization.[126,130,132-134] The National Empowerment Center[qq] maintains a directory of peer-run crisis alternatives, as well as evaluation studies for them and resources for operating them. Ideally, all crisis respite centers would include some peer providers as staff.

Limits of stay and exclusion criteria

[qq] http://www.power2u.org/crisis-alternatives.html

Centers vary in the length of care that is provided, as well as limitations on the number of times a person can use its services. In a recent review, one center allowed a one-time only, four-night (five-day) stay, while others allowed stays of 21 days or more.[131]

Some centers have criteria that exclude individuals with active suicidal thoughts or behaviors, and thus not all "crisis respite" centers should be considered alternatives to other emergency services for a suicidal person. Additionally, many exclude individuals who need urgent or complex medical care, with some accepting a person only after he or she is medically stabilized in a hospital or clinic.[131]

Amount of therapeutic care

Some crisis respite centers focus on providing a safe, calm, and peaceful environment (i.e., a sanctuary).[128,131] A person in crisis is allowed to form new relationships with people in a relaxed environment, where others understand his or her experience and offer support and hope. There is some evidence that this approach can be effective in reducing clinical distress, and helping people solve problems or address risks even after leaving the center.[128,131] Other centers provide a supportive environment but also facilitate connections to community resources or agencies, helping to provide continuity of care between crisis services and ongoing care. In addition, some centers have individual therapy, group therapy, and/or psycho-education on-site.[131]

Emergency Department (ED)

Recommendation 4.4 – Practice: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

As noted in Part 3: Clinical Services and Supports, all health care providers should develop competency in responding to a suicidal crisis. Recent sources[31,135] offer specific guidance for ED professionals including:

- Screening all patients for suicide risk at intake, when feasible
- Collaborating with behavioral health professionals for further assessment if indicated
- Collaborating with a patient to develop a safety plan[136]
- Providing a patient with informed and appropriate referrals for additional care
- Following up with a patient after discharge in support of continuity of care[137,138]

Sometimes interactions with someone who recently tried to end his or her life will be difficult or unpleasant. There are often strong emotions involved. Anger can turn into hostility. Despondency can become desperation. Anxiety can initiate panic. However, every person still desires to be treated with **dignity**, **respect**, and kindness. Yet, research reports indicate that attempt survivors often encounter negative interactions in the ED.[139-141] The most common complaints include derogatory comments, judgmental attitudes, dismissiveness, extended waiting times, and lack of information for the attempt survivor and support persons.

Due to the intensive nature of treatment and emergency and inpatient settings, it may be easy to neglect interpersonal aspects of care. Yet, people are at their most fragile and sensitive state in crisis settings, and they can benefit greatly from compassionate care. Some attempt survivors have felt comforted and relieved when professionals reveal, even briefly, that they have had similar experiences. Each provider, considering professional guidelines and personal comfort, has to decide whether to disclose personal experience. However, it may be useful to know how much their disclosure may be appreciated. Some additional guidance on professional self-disclosure and its impact on individuals who received mental health services can be found in the SAMHSA monograph on self-disclosure[rr].

Attempt survivors have also expressed appreciation for times when professionals listened, showed respect, and demonstrated care and compassion. In addition to general attitude and demeanor, some tangible supports in the ED are also recommended that would improve the experience of all persons seeking ED services, including attempt survivors:

- Provide written information about what a person can expect (e.g., length of wait), what happens during wait times and interactions with providers, and what his or her rights are.
- Express care for his or her comfort and dignity, such as allowing a person to wear "street clothes" unless it is necessary to disrobe.
- Check in with him or her on a regular basis to see how the ED visit is going.
- Provide information to the person and his or her support persons in the form of take-home materials (booklet, video, brochure, pamphlet – see Self-Help on page 23, Information on Helping the Attempt Survivor on page 34).

Provision of collaborative and compassionate treatment in a suicidal crisis should be incorporated into training and continuing education for health care providers. One study included both staff training and brief therapeutic intervention for adolescent female suicide attempt survivors and their mothers, with positive results.[86] Such training would be consistent with Joint Commission standards on patient-centered communication and suicide prevention (National Patient Safety Goal 15A). Additionally, brief reference materials such as posters, brochures, guides, or reference sheets are also available from the SPRC[ss]. Reference materials usually include things such as warning signs that indicate acute or ongoing risk, potential interview questions or approaches, tips for evaluation and triage, and/or suggestions for discharge instructions.

Recommendation 4.5 – Policy: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.6 – Program: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

ED interventions are brief programs that are completed during the time between initial triage at the ED and discharge. The NSSP states that "many types of motivational counseling and case management can also be used to promote adherence to the recommended treatment."[9(p55)] This type of intervention often involves a single

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[rr] http://store.samhsa.gov/product/Self-Disclosure-and-Its-Impact-on-Individuals-Who-Receive-Mental-Health-Services/SMA08-4337

[ss] http://www.sprc.org/for-providers/emergency-departments

therapy session conducted by a mental health professional while a person is in the ED. Self-help materials (see Self-Help on page 23, Information on Helping the Attempt Survivor on page 34) may be used to supplement ED-based programs.

Beyond having a brochure or booklet to take home, there are some programs and materials that are designed to help the patient and/or family while they are in the ED. These enhancements to care may involve an additional staff or volunteer person who can provide assistance ranging from companionship to mental health assessment. One program with positive results, including improved patient satisfaction, used a paid Certified Peer Specialist to provide additional care to patients waiting for treatment in the ED.[70] Some places are starting to offer similar services in the ED, often in concert with either peer support organizations or crisis centers.

On-Site Interventions

When a person is actively suicidal, or initiating a suicide attempt, a person or small group may be sent to intervene. Ideally, the response would be by a Mobile Crisis Team (described below). For policy guidance, agencies and organizations should consider principles like the following from the NSPL guidance on active rescue[142]:

- "The Lifeline promotes the most collaborative, least invasive courses of action to secure the health, safety and well-being of individuals." Centers are required to adhere to this policy to retain network mentorship.
- Emergency intervention should be reserved unless a suicide attempt is in progress, or a person remains at imminent risk and "in spite of the center staff best efforts to engage" a person, he or she is unwilling or unable (e.g., intoxicated or experiencing psychotic symptoms) to get help for himself or herself.
- The NSPL policy notes that the focus on always using the least invasive approach is consistent with federal and state laws in the U.S., and international perspectives as well.

Mobile Crisis Teams

Recommendation 4.7 – Policy: Promote use of mobile crisis teams, including a peer specialist who can use his or her lived experience as an asset during interventions.

These groups specialize in mental or behavioral health care and provide care in the community at the location of the person that is suicidal. Ideally, such teams include peer specialists and multiple professional disciplines (e.g., psychiatry, psychology/counseling, social work/case management). At times, such teams have been dispatched along with law enforcement. Research has shown that mobile outreach can help people address psychiatric symptoms and reduce the number and cost of psychiatric hospitalizations, the need for law enforcement intervention, and the number of ED visits.[143-146] However, mobile outreach services vary in availability and in the extent of connections with law enforcement.[147] Some public safety officials have promoted mobile crisis teams as a beneficial alternative to other crisis responses.[147]

Integrating mobile crisis teams into community services would be consistent with NSSP Objective 8.3 to develop protocols and improve **collaboration** among crisis centers, law enforcement, mobile crisis teams, and social services to ensure **timely access to care** for individuals with suicide risk."[9(p54)]

Public Safety and Crisis Intervention Teams (CIT)

Recommendation 4.8 – Policy: Law enforcement agencies should provide training about behavioral health emergencies to all officers, with a minimum requirement to have a specialized response team that is easily identified by community members.

For someone in crisis, it is best when the group that actually interacts with the person specializes in crisis intervention. However, due to resource and/or time limitations, on-site intervention often includes law enforcement.[147] Dispatchers and organizations that initiate crisis responses should recognize that police presence might increase anxiety, agitation, and/or trauma (or reminders of prior negative experiences) as well as elevate risk for everyone involved.[40,147] As reported by the Center for Public Representation, some communities have a history of public safety officers using extreme, aggressive, and even lethal force in interactions with people experiencing mental or emotional distress.[148] To improve crisis response and community relations, a recent report suggested that "law enforcement agencies should take the lead" on creating local advisory groups involving the justice system, behavioral health, adult and youth peers, families, and advocacy organizations.[147(p14)]

When it is necessary to activate a public safety response, agencies should consider dispatching one or more law enforcement officers with specialized training. It is particularly helpful when those officers can work in concert with a mobile crisis team. Generally, the training encompasses some degree of recognition of a mental health crisis, assessment, and pre-booking diversion to care whenever possible. Employing co-facilitators with lived experience may further the impact of training.[98,147] The topics covered in educational programs should include information about respecting the privacy of the person in crisis, guarding the confidentiality of reports, and treating the cases as protected health information unless a booking offense has been committed. It would be extremely beneficial for entire law enforcement agencies to receive training about behavioral health emergencies.[40,147] It has been recommended that enough officers are trained to enable an appropriate response for all shifts and service areas.[147] Additional information and resources can be found at the University of Memphis CIT Center[tt], or the National Alliance on Mental Illness (NAMI) CIT Center[uu].

[tt] http://cit.memphis.edu/

[uu] https://www.nami.org/template.cfm?section=CIT2

Part 5: Systems Linkages and Continuity of Care

Once, after a brief hospitalization during college, Jamie met with a peer specialist. The school, hospital, crisis center, and peer support organization had formal partnerships to make care more seamless. Within a day of leaving the hospital and returning to campus, Jamie got a follow-up call to set up a meeting with the peer specialist to talk about options for ongoing services and support. There were other signs that people cared as well. Within the first week of being back at school, a short note from the hospital came in the mail – it was a nice touch. One of the college's resident assistants sent a supportive e-card, and included a link for a safety plan mobile app. The peer specialist helped Jamie add contacts and some recommended online resources into the new app once it was installed.

Systems Linkages

Connecting the education system with suicide prevention

Recommendation 5.1 – Policy: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

One non-clinical system that is often connected to health care services is the education system, providing services or referrals for both students and staff. Colleges and universities must balance the needs of a student in crisis with the needs of his or her fellow students and of the institution itself.[149,150] Some campus administrators, though usually well-intentioned, created policies that appear to be more concerned with institutional image or potential liability than for student welfare – policies that use a disciplinary process and/or force students to leave the school.[149,151,152]

As noted by one text on college suicide prevention, requiring a student to leave campus "creates a significant sense of isolation and alienation from the community that may be all that remains of a student's support system … a traumatic experience … this action has momentous impact on their psychological state."[149(p211)] Similarly, the Jed Foundation, an organization that develops mental health tools and guides for campus policymakers, described the policy of forced withdrawal for suicidal students as "clinically questionable and ethically dubious."[150(p16)] Punitive actions may "serve to exacerbate the suicidal state and propel the student more rapidly toward serious suicidal actions."[149(p212)] Such responses can "have the unintended consequence of discouraging students from seeking treatment."[150(p16)] Indeed, they could have a negative effect on the entire student body and expose the college or university to legal risks as well.[150,152,153]

As noted in the NSSP in the discussion about promoting safe disclosure: "Settings that provide care to [persons] with suicide risk must be nonjudgmental and psychologically safe places in which to receive services. [Persons] who have thoughts of suicide may feel embarrassed, guilty, and fearful of disclosing their thoughts and feelings to others … may also fear losing autonomy or the ability to make their own treatment decisions. To address these barriers to treatment, collaborative and non-coercive approaches should be used whenever possible."[9(p59-60)] Schools have been encouraged to develop helpful and caring policies[9,149,151,154,155] that encourage students to use mental health and counseling services and make them more accessible; and train relevant school staff to recognize students at risk, treat them with compassion and sensitivity, and refer them to appropriate services.

Recommendation 5.2 – Program: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Ideally, a student who is struggling with suicidal thinking could meet with a peer specialist. The specialist could assist the student with identifying short-term safety resources, understanding the available support options, and getting connected to care. Such an approach can remove school policies regarding suicide from the disciplinary sphere and place it in the realm of community supports instead. In a recent survey of students living with mental health challenges, peer supports and advocates were cited as programs that would exemplify a supportive campus.[156] Outreach to students in need can engage them in ways that support connectedness[157], and may be effectively implemented by a peer specialist. For example, a study using student leaders to provide peer support in high schools demonstrated increased help-seeking and enhanced protective factors throughout the schools.[81] In addition to clinical services, campus supports might include Student Life or Residential Life and Spiritual Advisors / Chaplains. It would also be useful to provide students with information about their rights[158] and options to get involved with mental health promotion (e.g., Active Minds on Campus[vv]).

Recommendation 5.3 – Practice: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

When suicide prevention and mental health advocacy groups highlight exemplary school policies, it may put "peer pressure" on others within the district or state to adopt similar policies. Such community support can build the political will needed to change policy or law. Given that most primary and secondary schools are publicly funded, many of the rules, regulations, and policies are consolidated at the state level. Thus, legislation about suicide prevention education for school personnel is usually at the state level. For example, in Texas, a recent bill directs the Department of State Health Services to coordinate with the Texas Educational Agency to identify and implement "early mental health intervention and suicide prevention programs" for schools.[159] Private schools, charter schools, and other independent learning centers can adopt similar positions. Beyond training clinical providers in recognizing and referring youth at risk, some sources also encourage schools to engage a wide range of potential participants (e.g., counselors, nurses, teachers, coaches, school resource officers, administrators).[9,154]

Connecting hospital and community-based supports

Recommendation 5.4 – Policy: Hospitals and clinics should establish formal relationships with community support organizations or groups to facilitate continuity of care.

A recent report by the SPRC and AAS, specifically about continuity of care[ww], provides a succinct description of the concept. The goal is to link "one care provider to another in a timely manner and, in the process, provides all the necessary clinical information required to make the transition smooth and uninterrupted."[94(p8)] This concept is particularly important because "as many as 70 percent of suicide attempters of all ages will never make it to their first outpatient appointment,"[94(p9)] although many suicide attempts and suicide deaths occur soon after

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[vv] http://activeminds.org/

[ww] http://www.sprc.org/library_resources/items/continuity-care-suicide-prevention-and-research

discharge from the emergency department or psychiatry inpatient unit. Linking crisis treatment to outpatient care and support is essential.

As noted in the NSSP, “collaborations among EDs and community providers, such as health and mental health centers, crisis centers, hotlines, and outreach teams, can improve the quality and continuity of care … [and] help expand alternatives to EDs, such as the same day scheduling for mental health services and in-home crisis care, and secure rapid and continuous follow-up after discharge.”[9(p57)] Collaborating with **faith-based and other community organizations** can enhance **connectedness** and expand the circle of potential supports.

It is possible for continuity of care between the ED and community services to become an established practice. A review study in Norway found that the keys to long-lasting continuity of care were formal collaborative relationships between a coordinator or team at the hospital and community providers; regular training and supervision of staff providing aftercare or follow-up services; and local guidelines for continuous quality improvement.[160] As noted in the NSSP, continuity of care “strategies may include telephone reminders of appointments, providing a ‘crisis card’ with emergency phone numbers and safety measures, and/or sending a letter of support.”[9(p55)] Ideally, such “outreach interventions and bridging strategies that motivate adherence to the recommended treatment plan” could enable individuals to make it to a follow-up appointment within a week of discharge.[94(p16)]

Coordinated Care

Recommendation 5.5 – Program: Develop coordinated care systems that can ensure continuity of care, particularly during high-risk periods for suicide.

Care coordination (also called case management, care management, or systems navigation) is when a professional assesses needs, develops/monitors/adjusts a care plan through regular meetings with a client, and may provide assistance with a wide variety of needs in addition to behavioral health care such as housing, employment, and community connectedness. The NSSP reported that coordinated and collaborative care systems can reduce suicide risk by improving assessment, engagement in treatment, and use of follow-up practices.[9] Enabling multiple services and supports to be available in a central location would significantly reduce the burden of travel and other barriers to **timely access**. A similar option is the use of models like the Network of Care[xx], which provide a virtual central location for care options. Healthcare systems might also consider virtual models such as Health Information Exchanges[yy] that help providers exchange records and coordinate services.

In some cases, like Assertive Community Treatment (ACT), primarily for people with a severe or persistent mental health issues, intensive care may include interventions that range from outreach to involuntary hospitalization. ACT has research support for reducing symptoms, improving quality of life, and decreasing the need for hospital-based care.[161,162] In response to concerns about the potential for ACT to employ control or coercion, some communities are emphasizing choice, collaboration, and including peer supports as ways to be

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[xx] http://www.networkofcare.org/

[yy] http://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

more consistent with recovery practices.[163] Using a certified peer specialist on a care coordination team can have benefits for a person receiving care, including role modeling and improved problem solving, as well as indirect benefits through an improved relationship with the primary coordinator.[164]

Follow-up to Ensure Continuity of Care

Recommendation 5.6 – Policy: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

The primary purpose of follow-up is to maintain therapeutic contact with a person after he or she has received some form of primary, emergency, or behavioral health services. As noted in the NSSP, "although referral is necessary, it may not be sufficient. There is increasing evidence that specific outreach programs can be highly effective in increasing the proportion of patients who engage in mental health care after hospitalization."[9(p55)] The time immediately after hospitalization is the period with the highest risk for a (potentially lethal) suicide attempt.[94] Some organizations or groups conduct follow-up as a practice, such as re-contacting someone who called a crisis hotline. At other times, follow-up can involve a "stand-alone" program that is designed to (re-) engage an attempt survivor after he or she received initial services. Specific forms of follow-up[165] may include:

- Brief written contact such as letters or postcards, which increase connectedness and have some evidence for decreasing suicidal behavior.[165-167]
- Enhanced assessment in the hospital, with referral to community supports and additional contact to encourage use of those supports.
- Initial hospital assessment with assistance, preferably from a peer, with understanding and navigating the system of potential supports (sometimes called community or peer bridging).[131]
- Hospital-based assessment and brief therapy with community-based counseling by the same person or organization after discharge.

In the process of increasing continuity of care, one consideration is the costs associated with follow-up care. At least one report indicates that improved continuity of care may decrease hospital costs while increasing community costs.[168] On the other hand, a recent study[169] demonstrated an economic or business case for conducting follow-up calls after someone is discharged from a hospital or emergency department. According to the analysis, for every $1 spent on follow-up services, a single payer/insurer could get $1.70 - $2.43 in savings compared to traditional treatment approaches. While many factors could affect the actual Return On Investment (ROI), it was estimated that if post-discharge follow-up reduced readmissions by 13% or more, it would result in overall cost savings. The study results suggest that continuity of care can reduce overall costs in a system. However, communities should consider which payers or organizations will actually bear the costs, and shift resources accordingly.

Another concern some have about follow-up involves individual privacy and/or confidentiality. Such concerns may be particularly elevated in small communities or other circumstances when a person receiving care may be well-known. Potential loss of social status, employment, housing, or other needs makes strict confidentiality essential. This also highlights the importance of challenging negative stereotypes and discrimination. Another issue involving privacy and confidentiality is the Health Insurance Portability and Accountability Act (HIPAA)[zz] which is sometimes cited as a barrier to collaboration. When care is planned in collaboration with someone and his or her support network, obtaining necessary consents or authorizations should not be a barrier. However, there may be times when specific authorization is not obtained before someone leaves the hospital. For example, a peer specialist or crisis center might be engaged to offer follow-up assistance after someone has already been discharged. Even in such cases, according to the U.S. Department of Health and Human Services, "the privacy rule allows covered health-care providers to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so."[aaa] The NSPL policy on helping people at imminent risk for suicide also stressed that HIPAA should not impede people from exchanging information with other professionals when doing so can increase a person's safety.[142]

Technology to Extend Services and Supports

Recommendation 5.7 – Practice: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

While technology may be used as a way to present or provide information about existing programs (e.g., telemedicine, telepsychiatry)[170], it is also being used in ways that have created new services or reached new audiences. Technology has the potential to increase **access to support** for new (and, at times, very isolated) individuals. Anecdotal reports show an appreciation for the availability (and privacy) of self-help information provided over the internet, along with opportunities for enhancing **connectedness**. There is a tension between the desire for anonymity on the part of persons seeking support and the desire for tracking information to enhance safety on the part of helpers. As the field moves forward, such challenges are being identified and considered[171-173], with an evolving list of Best Practices for Online Technologies.[bbb]

Older technologies, such as telephone, television, and radio, continue to have the potential to reach many groups, including audiences in rural or isolated communities that have limited internet access. Some research supporting the use of telephone-based outreach and follow-up has come from studies with the NSPL. Results from a large evaluation study of crisis calls showed that while two out of five people had suicidal thoughts since the time of their call, most individuals who received a referral for behavioral health services did not follow through with it.[174,175] A more in-depth study[176] revealed that callers are very likely to follow through with referrals if they are already receiving behavioral health care, but very few without prior care follow through with referrals. While financial concerns played a role for many who did not seek services, perceptions about their behavioral health problems or services also had a major impact on the decision to not seek care. At times expecting a person to seek out care does not produce connect him or her to effective care. In general, and especially in these cases, follow-up or outreach efforts may help. In further research with crisis center callers who received follow-up calls[177], comments from callers who received follow-up overwhelmingly indicated that

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[zz] http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
[aaa] http://www.hhs.gov/hipaafaq/providers/smaller/482.html
[bbb] http://www.preventtheattempt.com/

the calls were helpful, that the caller felt that someone cared, and that the calls help individuals stay safe and feel less suicidal.

Several studies indicate that some individuals prefer to seek help through technology-based or non-traditional channels. A large international study using World Health Organization (WHO) World Mental Health Surveys from 21 countries reported that most participants did not seek clinical treatment often because they did not perceive a need for professional care or they preferred to handle the problem themselves[178] As noted above, many callers to the NSPL do not believe that they need professional help and/or would like to handle concerns on their own.[176] However, as noted by both the NSPL study and a study using follow-up telephone calls after emergency department discharge in France[137], a person may be open to telephone-based assistance even if he or she rejects traditional clinic-based care. Considered together, the research suggests that technology may be able to reach people in crisis even when traditional services cannot, however further study is warranted.

Recommendation 5.8 – Practice: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Online (internet-based) groups and forums present a potential alternative to telephone-based services. Anonymous or confidential peer discussions are taking place already. However, the safety and efficacy of such support is unknown. Developing forums moderated by **trained peers** might prove beneficial to many otherwise isolated people. One study combined technology with the use of peer providers, and found that peer coaching improved engagement with an online course and completion rates.[179] Similar practices might be established by training peer providers (e.g., peer specialists and warm line staff) on promising self-help tools. When feasible, sites that offer such tools could then link visitors to the peer services for additional assistance.

One international study[46,180] examined the results of an online self-help curriculum that included elements from several successful therapy models. The curriculum was compared to a waitlist where individuals were offered a website with information links to care. Study safety protocols included screening at the beginning and telephone intervention as necessary. Results indicated that both study groups had fewer suicidal thoughts after the trial, though the decrease was largest for the individuals who had access to the course. Participants who were using the self-help curriculum also experienced less hopelessness and worry. A cost analysis validated the idea that online self-help courses could present a significant cost savings for healthcare systems.[181]

Given the increasing use of smartphones and other mobile devices, some groups are developing mobile applications (apps) that can facilitate **timely access** to care and support. Several groups have developed apps for keeping track of moods and stressors, others allow users to create a virtual “hope box” for pictures, contacts, and messages that could help in a mental health crisis (see Appendix C). Recently, SAMHSA asked groups to submit a “continuity of care suicide prevention app.” The app was specifically aimed at promoting continuity of care and follow-up for a person after discharge from an inpatient unit or emergency department. Many of the apps that were developed have since been offered to the public through marketplaces (e.g., Google Play, iTunes). SAMHSA intends to create or modify a single app that would use promising elements from the various submissions.

Part 6: Community Outreach and Education

Jamie was contacted to help with a new communications campaign that was planning to use the Action Alliance's *Framework for Successful Messaging. Even after years of being a self-disclosed attempt survivor, it was still nerve-racking to get involved in a media effort. It helped Jamie to learn that the producer also had suicidal thoughts earlier in life. Also, it was going to be a campaign strategically focused on a positive narrative and supported by the local community. A local church was providing space for the production. One of the news channels loaned out the filming equipment and donated airtime. Students at the college volunteered to help with editing. The campaign developers planned to keep attempt survivors involved from beginning to end. In addition to being featured in the campaign, Jamie was able to use prior education and training to help with the research and evaluation that followed.*

Communications Campaigns

Recommendation 6.1 – Policy: In accord with the Action Alliance Framework for Successful Messaging[ccc], communications campaigns should focus on successful recovery and hope.

Communication campaigns use tools and channels designed to reach a specific group with the intention of raising awareness, providing information, and especially, encouraging some action. Usually, these campaigns include efforts such as Public Service Announcements (PSAs), posters, flyers, billboards, information tables, advertisements and print materials, or online and/or social media messages. As stated in the NSSP "… the dissemination of positive messages that focus on recovery and hope can help reduce the biases and prejudices associated with mental and substance abuse disorders and with suicide. Using these interventions can increase understanding of the barriers to seeking help and provide information that will empower individuals to take action."[9(p32)]

Recent suicide prevention efforts are focusing on the development of safe messages that promote specific actions and are integrated into a comprehensive plan.[6,9] One of the Action Alliance's priorities aims to change the national narratives around suicide and suicide prevention to ones that promote **hope**, **connectedness**, social support, resilience, treatment, and recovery"[ddd] which reflects the Core Values and is a welcome shift from prior narratives that (unintentionally) focused on darkness, despair, "failure," "committing suicide," death, or graphic details. The voices of attempt survivors are essential for advancing Action Alliance priorities such as promoting Zero Suicide in Health and Behavioral Health Care and changing the public conversation around suicide and suicide prevention. To further support appropriate or recommended practices, it will be helpful for suicide prevention organizations and mental health consumer organizations to publicly recognize and commend media groups that use exemplary policies or practices.

[ccc] http://www.suicidepreventionmessaging.org

[ddd] http://actionallianceforsuicideprevention.org/priorities

Recommendation 6.2 – Policy: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Objective 2.1 of the NSSP is to "develop, implement, and evaluate communication efforts designed to reach defined segments of the population" using evidence-based practices from communications and social marketing.[9(p33)] In accordance with those practices, attempt survivors should be included in the formative research phase of communications efforts, be considered a specific audience to receive messages, be featured messengers in media or materials, and be partners in the evaluation of the campaigns. Additionally, the call to action in campaigns should consider ways to help achieve or support Core Values and further engage attempt survivors in seeking help.

Recommendation 6.3 – Practice: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

It is understandable that most people do not discuss their past suicidal experiences, often due to the fear of discrimination or interpersonal rejection in both personal and professional settings.[98,182] As noted in one report, it takes "incredible courage and commitment to the well-being of others to share their stories of pain and hope."[74(p8)] Yet, when people stay silent it allows the stereotype of the suicidal person as a severely ill outcast to continue unchallenged, perpetuating stigma, and discrimination. To enhance impact and effectiveness, efforts aimed at training and education should engage people with lived experience of a suicidal crisis, as well as their family and friends, as part of presentations.[98]

The more people speak out, the broader the public image of "suicidal person" becomes, eventually crushing the stereotype.[98,182] Disclosure is not something that should be taken lightly, but it is the most effective way to combat stigma and discrimination. A recent study also found that disclosure had beneficial effects, reducing loneliness and countering suicidal feelings.[75] Additionally, research suggests that telling others about a traumatic experience can have health benefits.[183] As noted under Recommendation 1.14 (page 31), additional guidance about self-disclosure is needed, but new resources are emerging. A promising initiative called "Sound Out for Life" is developing a speakers' bureau of attempt survivors with a particular focus on challenging suicide-related stigma while providing participants with guidance about public disclosure as attempt survivors.[eee] The project builds on prior work with mental health speakers' bureaus including "Sharing Our Lives, Voices and Experiences (SOLVE)"[fff] and "Coming Out Proud."[ggg]

[eee] http://dignityandrecoverycenter.org/center-programs/transforming-suicide-prevention/
[fff] http://dignityandrecoverycenter.org/program/solve-sharing-our-lives-voices-and-experiences-2/
[ggg] http://www.stigmaandempowerment.org/resources

Research

Recommendation 6.4 – Program: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

A network of academic and research professionals with lived experience from a suicidal crisis could develop and advocate for projects and guidelines that follow the Core Values. Developing the research network would support NSSP Objective 12.4 to “increase the amount and quality” of suicide prevention and aftercare research.[9(p70)] It would also help address a key question in the Prioritized Research Agenda for Suicide Prevention (Research Agenda)[hhh] which inquires about needs for “new and existing research infrastructure.” Additionally, evaluation of programs and supports, including cost benefit or cost effectiveness, helps further NSSP Goal 13 to “evaluate the impact and effectiveness” of interventions.[9(p71)]

However, more funding is needed for suicide prevention research. While suicide is the 10th leading cause of death in the U.S.[184], only $37 million went to the National Institute for Mental Health (NIMH) grants for suicide studies in fiscal year 2013 ($21 million for suicide prevention)[185]. For comparison, Transmissible Spongiform Encephalopathy (e.g., Creutzfeldt-Jakob or “mad cow” disease) received $35 million in Fiscal Year 2013[185], while having 224 cases reported worldwide between 1996 and 2011[186].

While not specifically focused on suicide, the Lived Experience Research Network (LERN) might be a source of ideas or partners in developing research from an attempt survivor perspective. Among other tasks, LERN seeks to “build research and evaluation capacity among [peers]” and “contribute to the development and evaluation of alternatives to mainstream intervention and mental health services that promote the empowerment, recovery, and community integration of [peers].”[iii]

The Task Force submitted ideas for future research to NIMH as part of a Request for Information (RFI) response (See Appendix D). In brief, the submission focused on four domains, presented in Table 3 (below) alongside relevant questions in the Research Agenda.

[hhh] http://actionallianceforsuicideprevention.org/task-force/research-prioritization
[iii] http://www.lernetwork.org/

Table 3. Task Force Research Interests compared with the National Prioritized Research Agenda

Task Force Research Interests	Prioritized Research Agenda
Examine negative stereotypes, prejudice, discrimination, shame and social exclusion as related to suicide, suicide attempts, diagnoses, seeking services, including emergency care and mental health treatment.	Aspirational Goal 10 is to "increase help-seeking and referrals for at-risk individuals by decreasing stigma."
Investigate the etiology of suicide attempt behaviors and the role of protective factors in preventing both initial attempts and further attempts, as well as avenues for developing and supporting the promotion of protective factors through public education.	Aspirational Goal 1 is to "know what leads to, or protects against, suicidal behavior, and learn how to change those things to prevent suicide."
Explore the experience of attempt survivors with intervention and treatment approaches, and their explanation of the relationship of this intervention/treatment experience to further attempts (or prevention of further attempts). Areas for research and evaluation should include peer-delivered programs, self-help approaches, and technology-based supports.	Key Question 3: "What interventions are effective? What prevents individuals from engaging in suicidal behavior?" Key Question 4: "What services are most effective for treating the suicidal person and preventing suicidal behavior?" Key Question 5: "What other types of preventive interventions (outside health care systems) reduce suicide risk?"
Explore the effects of suicidal crises, as well as the impact of interventions, on family and significant persons after a suicide attempt. Also explore the primary and secondary positive outcomes from interventions as indicators of effectiveness.	<Not specifically addressed in the Research Agenda>

Section 3: Appendices, Glossary, and References

Appendix A: Recommendations

Recommendations by Part

Part 1: Attempt Survivors as Helpers – Self-Help, Peer Support, and Inclusion

Recommendation 1.1 – Practice: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Recommendation 1.2 – Practice: Provide information about self-advocacy to every attempt survivor.

Recommendation 1.3 – Practice: Encourage attempt survivors to participate in community activities.

Recommendation 1.4 – Practice: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Recommendation 1.5 – Practice: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

Recommendation 1.6 – Program: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Recommendation 1.7 – Policy: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Recommendation 1.8 – Policy: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Recommendation 1.9 – Program: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

Recommendation 1.10 – Program: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

Recommendation 1.11 – Policy: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Recommendation 1.12 – Practice: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Recommendation 1.13 – Practice: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

Recommendation 1.14 – Program: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

Recommendation 1.15 – Policy: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Recommendation 1.16 – Policy: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

Part 2: Family, Friends, and Support Network

Recommendation 2.1 – Practice: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Recommendation 2.2 – Practice: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Recommendation 2.3 – Program: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Recommendation 2.4 – Practice: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

Part 3: Clinical Services and Supports

Recommendation 3.1 – Practice: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Recommendation 3.2 – Policy: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

Recommendation 3.3 – Practice: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Recommendation 3.4 – Practice: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

Recommendation 3.5 – Policy: Behavioral health systems should make suicide prevention a core component of care.

Recommendation 3.6 – Practice: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

Recommendation 3.7 – Practice: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

Recommendation 3.8 – Practice: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Recommendation 3.9 – Policy: Protocols for addressing safety and crisis planning should consider be based on principles of informed and collaborative care.

Recommendation 3.10 – Practice: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

Recommendation 3.11 – Practice: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Part 4: Crisis and Emergency Services

Recommendation 4.1 – Policy: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

Recommendation 4.2 – Practice: Crisis center and hotline staff should review the “Lifeline service and outreach strategies suggested by suicide attempt survivors”.

Recommendation 4.3 – Program: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Recommendation 4.4 – Practice: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

Recommendation 4.5 – Policy: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.6 – Program: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

Recommendation 4.7 – Policy: Promote use of mobile crisis teams including a peer specialist who can use his or her lived experience as an asset during interventions.

Recommendation 4.8 – Policy: Law enforcement agencies should provide training about behavioral health emergencies to all officers; with a minimum requirement to have a specialized response team that is easily identified by community members.

Part 5: Systems Linkages and Continuity of Care

Recommendation 5.1 – Policy: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

Recommendation 5.2 – Program: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Recommendation 5.3 – Practice: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

Recommendation 5.4 – Policy: Hospitals and clinics should establish formal relationship with community support organizations or groups to facilitate continuity of care.

Recommendation 5.5 – Program: Develop coordinated care systems that can ensure continuity of care, particularly during high risk periods for suicide.

Recommendation 5.6 – Policy: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

Recommendation 5.7 – Practice: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

Recommendation 5.8 – Practice: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Part 6: Community Outreach and Education

Recommendation 6.1 – Policy: In accord with the Action Alliance Framework for Successful Messaging, communications campaigns should focus on successful recovery and hope.

Recommendation 6.2 – Policy: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Recommendation 6.3 – Practice: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

Recommendation 6.4 – Program: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

Recommendations by Type of Activity

Practices

Recommendation 1.1: Develop, evaluate, and disseminate self-help materials for persons who have lived through a suicidal crisis.

Recommendation 1.2: Provide information about self-advocacy to every attempt survivor.

Recommendation 1.3: Encourage attempt survivors to participate in community activities.

Recommendation 1.4: Explore religion and spirituality as potential resources in collaboration with the attempt survivor and his or her support network.

Recommendation 1.5: Encourage attempt survivors to participate in exercise and physical activity when it can enhance wellness and recovery.

Recommendation 1.12: Train agency/organizational leaders and managers working with persons with lived experience of a suicidal crisis on protecting confidentiality and privacy while also facilitating support for their employees.

Recommendation 1.13: Engage attempt survivors as partners in behavioral health and suicide prevention efforts.

Recommendation 2.1: Every attempt survivor should define a support network for himself or herself; people can assist in the process but not insist on persons to include or exclude.

Recommendation 2.2: Offer training and/or educational materials to people identified by the attempt survivor as supports.

Recommendation 2.4: Expand programs and projects that provide support for families coping with mental health concerns to explicitly address issues related to suicidal crises.

Recommendation 3.1: Agencies and organizations providing clinical services should consider the Core Values as ways to improve care for all patients, including attempt survivors.

Recommendation 3.3: Professional clinical education should include training on providing treatment to someone in a suicidal crisis, or recovering from crisis.

Recommendation 3.4: Clinical professionals should collaborate with a person to understand his or her suicidal experience and specifically address suicide risk.

Recommendation 3.6: At the beginning of care, professionals should inform patients about their approach to working through crisis situations.

Recommendation 3.7: Behavioral health providers should integrate principles of collaborative assessment and treatment planning into their practices.

Recommendation 3.8: Behavioral health professionals should complete a comprehensive assessment that goes beyond suicide risk as soon as it is feasible to do so, acknowledging that a person has a life beyond the crisis.

Recommendation 3.10: Consider the Core Values as essential aspects of care and/or outcomes to achieve in all treatment (including outpatient and inpatient) to help in a suicidal crisis.

Recommendation 3.11: Use a collaborative approach to prescribing medication that discusses multiple options, respects informed choices, and is monitored and modified as needed.

Recommendation 4.2: Crisis center and hotline staff should review the "Lifeline service and outreach strategies suggested by suicide attempt survivors".

Recommendation 4.4: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.

Recommendation 5.3: Suicide prevention and mental health advocacy groups should use public recognition to highlight exemplary school policies and programs.

Recommendation 5.7: All agencies, organizations, and groups providing support for attempt survivors should consider ways to use technology to facilitate timely access to care.

Recommendation 5.8: Conduct research and evaluation studies to examine and improve technology-based supports like online forums and self-help resources.

Recommendation 6.3: Encourage individuals with personal experience from a suicidal crisis to share their stories of recovery, offering appropriate support and recognition for those who do.

Programs

Recommendation 1.6: Develop, evaluate, and promote support groups specifically for persons who have lived through a suicidal crisis; such groups are encouraged to use a peer leader or co-facilitator.

Recommendation 1.9: Develop certified peer specialist positions that are specific to lived experience of a suicidal crisis.

Recommendation 1.10: Develop a national technical assistance center focused on helping individuals with lived experience of a suicidal crisis.

Recommendation 1.14: The Task Force should work with key partners to assemble a diverse workgroup to develop guidance for meaningful inclusion of attempt survivors in suicide prevention and behavioral health efforts.

Recommendation 2.3: Develop, evaluate, and promote programs specifically intended to help the family and friends of attempt survivors.

Recommendation 4.3: Develop and promote crisis respite care centers, especially ones that employ peer providers.

Recommendation 4.6: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.

Recommendation 5.2: Develop and promote peer specialist programs to provide students who are coping with suicidal thoughts or behavioral health challenges with support and connections to resources.

Recommendation 5.5: Develop coordinated care systems that can ensure continuity of care, particularly during high risk periods for suicide.

Recommendation 6.4: Develop a network of professionals with lived experience to conduct research and evaluation studies on supports for individuals who have survived a suicidal crisis.

Policies

Recommendation 1.7: Establish training protocols and core competencies for peer supports around suicidal experiences, and methods for assessing them.

Recommendation 1.8: Provide warm line staff with basic training for working with suicidal callers, including how to refer or transfer callers to crisis services.

Recommendation 1.11: Train human resources staff at agencies and organizations that hire disclosed persons with histories of mental health challenges or suicidal experiences in best practices for supporting those employees.

Recommendation 1.15: Every Task Force of the Action Alliance should recruit attempt survivors as members. This will demonstrate that the suicide prevention community values them and their expertise.

Recommendation 1.16: Agencies and organizations at all levels (federal, state, community, etc.) should explicitly endorse, or require, inclusion of attempt survivors in suicide prevention efforts.

Recommendation 3.2: Organizations involved in suicide prevention should have formal statements of support for helping attempt survivors.

Recommendation 3.5: Behavioral health systems should make suicide prevention a core component of care.

Recommendation 3.9: Protocols for addressing safety and crisis planning should consider be based on principles of informed and collaborative care.

Recommendation 4.1: Crisis and emergency services should be expanded and improved to ensure capacity and competence for helping suicidal individuals.

Recommendation 4.5: Emergency departments should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.

Recommendation 4.7: Promote use of mobile crisis teams including a peer specialist who can use his or her lived experience as an asset during interventions.

Recommendation 4.8: Law enforcement agencies should provide training about behavioral health emergencies to all officers; with a minimum requirement to have a specialized response team that is easily identified by community members.

Recommendation 5.1: Colleges and university should develop policies that promote help-seeking and foster a supportive campus environment.

Recommendation 5.4: Hospitals and clinics should establish formal relationship with community support organizations or groups to facilitate continuity of care.

Recommendation 5.6: Hospitals should work with crisis centers, peer professionals, and outpatient healthcare providers to establish formal strategies for transitions from emergency or inpatient services to community supports.

Recommendation 6.1: In accord with the Action Alliance Framework for Successful Messaging, communications campaigns should focus on successful recovery and hope.

Recommendation 6.2: Engage attempt survivors throughout the process of developing, implementing, and evaluating suicide prevention communications strategies.

Appendix B: Task Force Member Bios and Perspectives

John Draper, PhD – Co-Lead; Project Director, National Suicide Prevention Lifeline, has nearly 25 years of experience in crisis intervention and suicide prevention work, and is considered one of the nation's leading experts in crisis intervention and hotline practices. Since 2004, he has been the Director of the National Suicide Prevention Lifeline (800-273-TALK). He is also the President of Link2Health Solutions, a wholly owned subsidiary of the Mental Health Association of New York City, and has a private mental health practice.

Eduardo Vega, MA – Co-Lead; Executive Director, Mental Health Association of San Francisco. Over twenty years, Eduardo has worked in five states as a leader in transformative mental health programs and practices, including: national, state and regional technical assistance; research and training projects and major policy initiatives in suicide prevention; stigma and discrimination reduction; consumer rights and empowerment and community integration, self-help and peer support for mental health consumers. He is also Director and Principal Investigator for The Center for Dignity, Recovery, and Empowerment.

Lilly Glass Akoto, LCSW, Looking In ~ Looking Out, LLC, is a passionate advocate for basic human rights and has been involved as a professional in the mental health world since 1989. She has a private mental health practice, and is developing a program to help professionals to work through mental health challenges without threat of losing their employment. She serves on numerous speakers' bureaus and advisory boards, and speaks about depression, suicide, racism, adoption, self-worth, identity issues, advocacy, recovery and healing.

Cara Anna is a journalist and former foreign correspondent, and she edits Talkingaboutsuicide.com and Attemptsurvivors.com. She was co-chair of the task force that established the Attempt Survivor / Lived Experience Division within the American Association of Suicidology (AAS). She looks forward to the day when we ask in amazement, "Why did we ever whisper about this?"

Heidi Bryan is currently the Senior Director of Product Development at Empathos Resources. She has been active in the suicide prevention field since 1999 after losing her brother to suicide and struggling with depression and suicidality herself. Heidi created Feeling Blue Suicide Prevention Council, a nonprofit organization based in Pennsylvania and co-founded the Pennsylvania Adult/Older Adult Suicide Prevention Coalition. She is the author of the booklet, *After an Attempt: The Emotional Impact of a Suicide Attempt on Families* and has been a keynote speaker for numerous national conferences and organizations.

Julie Cerel, PhD, is a licensed clinical psychologist and Associate Professor in the College of Social Work at the University of Kentucky. Her research has focused on suicide bereavement and suicide prevention. She is currently the Principle Investigator (PI) of the Military Suicide Bereavement study funded by the Military Suicide Research Consortium from the U.S. Department of Defense. Dr. Cerel is a Board member and former chair, Kentucky Suicide Prevention Group; and Editorial Board Member, Suicide and Life-

Threatening Behavior. She has served as the Research Division Director and is currently the Board Chair for the American Association of Suicidology.

Mark Davis is the leader of the Pink and Blues GLBT Mental Health Consumer Support group. Mark is Founding President of the Pennsylvania Mental Health Consumers' Association (PMHCA est. in 1987). Mark also serves on the National Suicide Prevention Lifeline (1-800-273-TALK) Consumer Survivor Subcommittee (CSS). Since 2003, he has facilitated Pink & Blues Philadelphia, a weekly peer-run social network and support group and safe space for sexual and gender minority people living with mental health and co-occurring conditions to achieve recovery.

Linda Eakes, CMPS, is a suicide attempt survivor as well as a Certified Missouri Peer Specialist. She manages a Drop-In Center for Truman Medical Center Behavioral Health in Kansas City, MO called New Frontiers.

Barb Gay, MA, is the Executive Director of Foundation 2, Inc., a crisis response non-profit agency located in Cedar Rapids, Iowa. Barb has been able to use her personal experiences to help guide programs that work to save lives and improve access to care. Through this project and other collaborations, Barb has been able to offer her voice as a suicide attempt survivor to help move forward the work of suicide prevention. Barb has her MA degree in Health Education from the University of Northern Iowa. She has been working in human services since 1993.

Leah Harris, MA, writes and speaks nationally about her own experiences of trauma and recovery, as a psychiatric survivor, suicide attempt survivor, and survivor of her mother Gail's death by suicide in 1996. She works to promote peer-developed crisis alternatives at the National Empowerment Center, consults on trauma-informed practice for the National Center for Trauma-Informed Care (NCTIC), and is helping to develop an attempt survivors' speakers' bureau training for the Mental Health Association of San Francisco. Leah is a trainer in Emotional CPR (eCPR), a program that teaches skills for supporting persons in crisis. She is technical director at Madness Radio and is a storyteller in the Washington, DC, area.

Tom Kelly, CRSS, CPS, Former Manager, Recovery and Resiliency, Magellan Health Services of Arizona. Tom Kelly has twelve years of experience working in public mental health. His experience includes coaching and training staff in recovery principles and the use of strength-based and person-centered planning principles. Tom was employed with Magellan as the Manager for Recovery and Resiliency. An attempt survivor and a person who has received services, Tom has presented at national, state, and local conferences on suicide prevention, homelessness, trauma informed care and mental health recovery.

Carmen Lee is a consumer activist who directs and founded, in 1990, Stamp Out Stigma - a well-known speaker's bureau composed of all clients, survivors, and consumers faced with mental health challenges. Since that time, SOS has delivered over 2600 public presentations to local, national and international audiences, directly reaching 400,000 people. The main focus of SOS is to put a human face on mental health problems and dispel the myths that greatly hinder recovery. Carmen is both a suicide attempt survivor and a suicide loss survivor, with her brother having died by suicide at 37 years old.

Stanley Lewy, MBA, MPH, is a survivor of his son David's suicide, several attempts by his wife, and his own passive attempt and suicidal ideation. He is a passionate advocate for suicide prevention at local, state and national levels, and co-authored the State of Illinois' Suicide Prevention, Education, and Treatment Act (PA 093-0907). He founded the Chicago/Midwest Chapter of the American Foundation for Suicide Prevention and the Suicide Prevention Association.

DeQuincy Lezine, PhD, is a suicide attempt survivor who has been active in national suicide prevention efforts since 1996, including roles in the development of national and state suicide prevention plans. Dr. Lezine has worked with organizations including Suicide Prevention Action Network (SPAN) USA, National Alliance for the Mentally Ill (NAMI), Oklahoma Suicide Prevention Council, the National Suicide Prevention Lifeline (NSPL), and the Suicide Prevention Resource Center (SPRC). He is the author of *Eight Stories Up: An Adolescent Chooses Hope Over Suicide* (Oxford University Press, 2008). Dr. Lezine is President & CEO of Prevention Communities, focusing on suicide prevention and mental health promotion. He was the primary wrtier for *The Way Forward* and the inaugural Chair of the Attempt Survivor and Lived Experience Division of the American Association of Suicidology.

Jennifer Randal-Thorpe is CEO of MR Behavior Intervention Center, and has worked in The Juvenile Continuing Education Program(JCEP) in St. Martin Parish. She was also Staff Development Specialist at Our Lady of Lourdes Hospital in Lafayette, Louisiana. Ms. Randal-Thorpe has worked in both mental health services and substance abuse treatment services.

Shari Sinwelski, MS/EdS, is the Associate Director of Quality Improvement for the National Suicide Prevention Lifeline. Working in suicide prevention for 20 years, Shari has served as a director at several crisis centers across the country and trained many populations in suicide assessment and intervention. Shari created one of the nation's first support groups for Suicide Attempt Survivors at the Didi Hirsch Suicide Prevention Center. Shari is an AAS certified crisis counselor and a Training Coach and safeTALK instructor with Living Works Education.

Sabrina Strong, MPH, ADS is the Executive Director of Waking Up Alive, Inc., a nonprofit that provides suicide prevention education and advocacy across the state of New Mexico. She uses her experiences as a mental health consumer and a suicide attempt survivor to help ease the stigma associated with suicidal ideation.

CW Tillman, is a Consumer Advocate that has been active in disability rights advocacy for over 14 years. He has been active as a suicide attempt survivor on the planning committee of the First National Conference for Survivors of Suicide Attempts, Healthcare Professionals, Clergy and Laity held in Memphis, TN in 2005 and as a speaker on the first ever Suicide Attempt Survivor plenary session at the AAS Conference in 2011. He's also spoken at local and state conferences about his experiences as a suicide attempt survivor. CW is the Board President for the disAbility Law Center of Virginia (the designated Protection and Advocacy agency).

Stephanie L. Weber, MS, LCPC, is the Executive Director of Suicide Prevention Services, Inc., a non-profit organization headquartered in Kane County, Illinois. Stephanie founded Survivors of Suicide, a self-help group that has been going for over 30 years. For the past 8 years she has run Survivors of Suicide

Attempts support groups. She is the founder and director of the Crisis Line of the Fox Valley. She is a former member of the AAS board of directors also served as a former Survivor Chair. Ellen Weber, Stephanie's widowed mother, took her own life in 1979. Stephanie has been a featured presenter at forums and meetings held across the United States. She has also appeared on numerous radio, television programs, and talk shows.

Staff Support:

Melodee Jarvis is a suicide prevention specialist at the Mental Health Association of San Francisco, where she promotes and advocates for innovative suicide prevention projects and strategies dedicated to advancing wellness, recovery, and social justice practices. Melodee previously worked at San Francisco Suicide Prevention, where she managed all administrative, development, and training aspects of the crisis line program. As a suicide prevention professional with lived experience of her own suicidal thoughts and actions, Melodee believes that the most effective suicide prevention efforts must directly incorporate lessons learned from the expertise of those who have personal connections to suicide.

Angela Mark is a Public Health Advisor in the Suicide Prevention Branch, Center for Mental Health Services, at the Substance Abuse and Mental Health Services Administration (SAMHSA). Angela serves as a Grant Project Officer and is responsible for managing Garrett Lee Smith Youth Suicide Prevention State/Tribal grants. After losing several close friends to suicide, she uses her personal experiences to help move forward the work of suicide prevention. She believes that reducing stigma as well as engaging and learning from suicide attempt survivors is essential to saving more lives and vital to the suicide prevention movement.

Appendix C: Resources

Disclaimer: The following resources were identified during the process of developing *The Way Forward* and are included here to provide specific examples of approaches described in *The Way Forward*. The list of resources is not intended to be comprehensive and inclusion of specific programs or practices does not constitute an endorsement by the Suicide Attempt Survivors Task Force or the National Action Alliance for Suicide Prevention.

Part 1: Attempt Survivors as Helpers – Self-Help, Peer Support, and Inclusion

Resource	Location	Notes
Blogs / Websites		
Live Through This	http://livethroughthis.org/	"*Live Through This* is a collection of portraits and stories of suicide attempt survivors, as told by those survivors. The intention of *Live Through This* is to show that everyone is susceptible to depression and suicidal thoughts by sharing portraits and stories of real attempt survivors—people who look just like you."
Reasons to Go On Living	http://thereasons.ca/	The group is "collecting the stories of people who have attempted or seriously contemplated suicide but now want to go on living. The Project will study and share these anonymous stories for research, education and inspiration."
Talking About Suicide	http://talkingaboutsuicide.com/	This site features about 60 interviews with attempt survivors about their experience, their recovery and their decision to speak openly.
What Happens Now	http://attemptsurvivors.com/	"This site was launched by the American Association of Suicidology, in the first such effort by a national organization... We want to show that this can happen to anyone and that it's possible to recover, or learn to manage, and move on."

Resource	Location	Notes
Books		
- **Susan Rose Blauner:** ***How I Stayed Alive When My Brain Was Trying to Kill Me*** - **Heidi Bryan:** ***Must Be the Witches in the Mountains*** - **James Clemons (Ed.):** ***Children of Jonah*** - **Richard Heckler:** ***Waking Up Alive*** - **Kevin Hines:** ***Cracked, Not Broken: Surviving and Thriving After a Suicide Attempt*** - **Kay Redfield Jamison:** ***Night Falls Fast: Understanding Suicide*** - **DeQuincy Lezine:** ***Eight Stories Up: An Adolescent Chooses Hope Over Suicide*** - **Craig Miller:** ***This is How it Feels: A Memoir of Attempting Suicide and Finding Life*** - **Joshua Rivedal:** ***The Gospel According to Josh: A 28-Year Gentile Bar Mitzvah*** - **Brent Runyon:** ***The Burn Journals*** - **Kevin Taylor (AKA Ken Tullis):** ***Seduction of Suicide: Understanding and Recovering from Addiction to Suicide*** - **David Webb:** ***Thinking about Suicide: Contemplating and Comprehending the Urge to Die*** - **Terry Wise:** ***Waking Up: Climbing Through the Darkness***		
Peer Mentoring		
ASHA International	http://www.myasha.org/programs/peer-mentoring/	Peer specialists provide support, encouragement, and specialized services
Peer Specialists		
Certified Intentional Peer Support Specialist	http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/pdf/requirements-ipss.pdf	Peer support specialist training used in the state of Maine, and many other warm lines, crisis respites, and peer-operated services

Resource	Location	Notes
Certified peer specialist programs	http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/peer_support_consumer_run_services_peer_specialists/Certified_Peer_Specialist_Training_Program_Descriptions.pdf	Compilation of peer specialist training and certification programs
Certified Peer Specialist Whole Health and Resiliency Training	http://www.viahope.org/programs/training-certification	This is used by the state of Texas and other states for peer specialist credentialing
Pillars of Peer Support	http://www.pillarsofpeersupport.org/	Summit meetings and website designed to help foster the use of Medicaid funding to support peer specialists in providing mental health care
Peer Support Groups	http://attemptsurvivors.com/support-groups/	
Alternatives to Suicide	http://www.westernmassrlc.org/alternatives-to-suicide	A peer-led support group program by the Western Massachusetts Recovery Learning Community
Attempters Support Group	http://www.spsamerica.org/services/support-groups/	Suicide Prevention Services of America, Batavia, Ill. - an open, “confidential, educational, self-help group.”
Eden Program	http://www.suicideorsurvive.ie/services/the-eden-program	A support group for attempt survivors. The founder is an attempt survivor that has become a therapist, and at least some groups are co-facilitated by peers.
Suicide Anonymous	http://suicideanonymous.net	A peer-run support group, patterned after 12-Step / Anonymous substance abuse recovery meetings

Resource	Location	Notes
Suicide Attempter Support Group	http://www.didihirsch.org/node/32	Didi Hirsch Suicide Prevention Center, Los Angeles, CA - "for people who have had a suicide attempt or who are struggling with chronic thoughts of suicide."
Peer-run organizations		
International Center for Clubhouse Development	http://www.iccd.org/	Clubhouses are "community-based centers that offer opportunities for friendship, employment, housing, education, and access to services through a single caring and safe environment, so members can achieve a sense of belonging and become productive members of society."
Reports		
Suicide Prevention Dialogue with Consumers and Survivors: From Pain to Promise	http://store.samhsa.gov/product/Suicide-Prevention-Dialogue-with-Consumers-and-Survivors-From-Pain-to-Promise/SMA10-458	Report based on a dialogue meeting between SAMHSA representatives, suicide attempt survivors, suicide loss survivors, and representatives of hospital/medical systems.
Self-help		
A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department	http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355	Booklet specifically about emergency department care after a suicidal crisis.

Resource	Location	Notes
Finding Your Way Back	http://www.beyondblue.org.au/docs/default-source/default-document-library/bl1160-finding-your-way-back.pdf?sfvrsn=2	A resource for people who have attempted suicide (from Australia)
Stories Of Hope And Recovery: A Video Guide for Suicide Attempt Survivors	http://store.samhsa.gov/product/Stories-Of-Hope-And-Recovery-A-Video-Guide-for-Suicide-Attempt-Survivors/SMA12-4711DVD	DVD with series of video interviews with attempt survivors and resources from the National Suicide Prevention Lifeline.
Wellness Recovery Action Plan (WRAP)®	http://www.mentalhealthrecovery.com	An "evidence-based system that is used worldwide by people who are dealing with mental health and other kinds of health challenges. It was developed by a group of people who have a lived experience of mental health difficulties."
Warm Lines		
National Consumer Self-Help Clearinghouse – Warm Lines	http://www.mhselfhelp.org/	Technical assistance center includes several resources for locating warm lines, or operating them.
National Empowerment Center – Warm Lines	http://www.power2u.org/peer-run-warmlines.html	NEC maintains a resource page on peer-run warm lines.

Part 2: Family, Friends, and Support Network

Resource	Location	Notes
Booklets		
A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department	http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in-the-Emergency-Department/SMA08-4357	A brochure that provides family members with information about the likely assessment, treatment, and follow-up an attempt survivor will receive during and after his or her visit to the emergency department.
After an attempt: The emotional impact of suicide attempt on families	http://www.heidibryan.com/uploads/After_An_Attempt__2013_booklet_download.pdf	This booklet includes information on important do's and don'ts, dealing with a traumatic event, what to say to the attempt survivor, ways the family can communicate their feelings, how an attempt affects family members, and additional resources.
Supporting Someone After a Suicide Attempt	http://www.suicideline.org.au/content/uploads/supporting_someone_after_a_suicide_attempt.pdf	Family resource booklet from Australia.
Educational Programs		
ASIST	https://www.livingworks.net/	Applied Suicide Intervention Skills Training (ASIST) as well as safeTALK are community education programs that teach participants how to recognize signs of emotional distress, provide basic supportive intervention, and make appropriate referrals to additional care.
Families Healing Together	http://family.practicerecovery.com/	Interactive, self-paced classes, and a supportive community focused on recovery.

Resource	Location	Notes
Heidi's Hope for Families	http://www.mhawisconsin.org/heidis-hope.aspx	Support group for families of attempt survivors.
QPR	http://www.qprinstitute.com/	Question. Persuade. Refer. A community education program that teaches participants how to recognize signs of emotional distress, ask about potential suicidal thoughts, and refer someone to get help.

Part 3: Clinical Services and Supports

Resource	Location	Notes
General Resources		
Self-Harm: The Short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	http://www.nice.org.uk/Guidance/CG16	Guidance from the National Institute for Health and Care Excellence (UK) – describes the type of care that someone who self-harms may want to receive and what types of services might be most beneficial.
Suicide Prevention Resource Center – Providers Section	http://www.sprc.org/for-providers/	Fact sheets, tool kits, trainings, webinars, publications, and research specifically for primary care, emergency department professionals, and outpatient mental health care providers

Resource	Location	Notes
Psychotherapies		
Cognitive Therapy for Suicide Prevention	http://www.behavioralhealth-ctx.org/resources/Suicide_Prevention.pdf	Description and Randomized Controlled Trial for the cognitive therapy approach developed specifically for suicidal thinking and behavior.
Collaborative Assessment and Management of Suicidality	https://sites.google.com/site/cuajsplab/home	CAMS is an approach to suicide risk assessment and therapy that engages a person in a collaborative fashion and specifically works to address suicidal thinking and motivation
Dialectical Behavioral Therapy	http://behavioraltech.org/resources/whatisdbt.cfm	A cognitive behavioral therapy developed to treat chronic or ongoing suicidal thinking and behavior.
Safety Planning Intervention	http://www.suicidesafetyplan.com/	Website supporting the brief intervention using a prioritized list of coping strategies and resources to reduce suicide risk.

Part 4: Crisis and Emergency Services

Resource	Location	Notes
Crisis Respite Care		
A Peer-Run Respite **indicates that peers oversee staff, and operate the respite at all levels and that at least 51% of the Board of Directors identifies as peers.** A directory of peer-run crisis respites currently in operation can be found here: http://www.power2u.org/peer-run-crisis-services.html		

Resource	Location	Notes
Afiya	http://www.westernmassrlc.org/afiya	Afiya strives to provide a safe space in which each person can find the balance and support needed to make meaning out of a crisis and turn it into a growth opportunity. It is available to anyone ages 18 and older who is experiencing distress and could benefit from being in a short-term, 24-hour peer-supported environment.
Rose House	http://www.integration.samhsa.gov/images/res/PDF/PSWRC.pdf	Services are designed to help 'at risk' individuals to break the cycle of learned helplessness and recidivism. In addition, a continuum of crisis services is available, including: warm Line, In-Home Peer Companionship, Social Structure (Nights Out), and peer advocacy.
Hybrid Crisis Respite: A Hybrid indicates that although the respite is attached to a traditional provider organization and/or the Board of Directors is comprised of less than half peers, the director and staff of the respite do identify as peers.		
Leeds Survivor Led Crisis Service	http://www.lslcs.org.uk/	Center provides services which are an alternative to hospital admission and statutory provision for people in acute mental health crisis.
Parachute Program NYC	http://www.nyc.gov/html/doh/html/mental/parachute-respite.shtml	Centers offer voluntary services for individuals in crisis but not at imminent risk of harming self or others, and do not have acute medical needs. The program focuses on helping with acute symptoms of psychosis for stays of one night to two weeks.

Resource	Location	Notes
Provider-run Respite		
Accalmie	www.accalmie.ca	The mission of Accalmie is to help suicidal people in a difficult time by providing transitional housing and allowing them a chance to step back and regain some control over their lives. Meeting and connecting with other resources/agencies is given priority to ensure continuity of services.
Columbia Care	http://www.columbiacare.org	Crisis Resolution Centers are local, home-like environments with 24 hour specialized staff. They promote quick connection and return to home and community services. Strong collaborative relationships exist with local Mental Health Services and hospitals assisting with smooth transitions. They offer crisis respite, diversion, and step down care (transitioning when not safe to go home yet).
Maytree respite centre	www.maytree.org.uk	Maytree offers a sanctuary for people in a suicidal crisis aiming to help through a calm and peaceful environment in which trusting relationships can be developed, and guests can feel listened to and understood. The program reaches people at significant risk and has demonstrated significant reductions in distress levels and longer-term benefits.

Resource	Location	Notes
Crisis Intervention Teams (CIT) and Alternative Crisis Interventions		
CIT International	http://www.citinternational.org/	Organization designed to “facilitate understanding, development and implementation of CIT programs… to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness.
Emotional CPR (eCPR)	http://www.emotional-cpr.org	This public health education program, developed by persons with lived experience of crisis and distress, teaches how to effectively support persons in crisis. A program that has been successfully paired with CIT training.
NAMI CIT Center	http://www.nami.org/template.cfm?section=cit2	National Alliance on Mental Illness (NAMI) promotes the expansion of the use of crisis intervention teams (CIT) and provides assistance and up-to-date information about implementing CIT programs.
Overcoming The Darkness	http://overcomingthedarkness.com/	Suicide attempt survivor and former police officer, Eric Weaver now trains law enforcement in crisis response through his organization. A possible addition to CIT training.

Part 5: Systems Linkages and Continuity of Care

Resource	Location	Notes
Continuity of care		
The Baerum Model	http://www.biomedcentral.com/1471-2458/11/81	A rapid-response intervention for someone who has attempted suicide and occurs as collaboration between the general hospital, the municipal suicide prevention team, and community health and social services located in the municipality.
NYAPRS Peer Bridger Project	http://www.nyaprs.org/peer-services/peer-bridger/	Persons who are successfully managing their own recovery from a psychiatric disability and have completed the requisite Peer Bridger Training Program help individuals being discharged from psychiatric hospitals to return to community life.
Suicide Prevention Centre of Quebec - CPSQ	http://www.cpsquebec.ca/le-cpsq/services-offerts/ (Website in French)	Integrated Service Liaison, Support and Recovery (SILAR) is a service that is for people who have attempted suicide or who have presented in a hospital emergency center due to a suicidal crisis. This service provides telephone and face-to-face support with individuals and also their relatives.
Vancouver's S.A.F.E.R.	http://www.vch.ca/403/7676/?program_id=78	Suicide Attempt, Follow-up, Education and Research (SAFER) provides a broad range of services associated with suicide prevention, intervention and postvention. SAFER consists of a team of mental health professionals who provide short-term intervention and therapy that is individualized and client centered.

Resource	Location	Notes
Technology-based Supports		
Real Time Crisis	http://www.realtimecrisis.org/	Toronto-based service, a collaboration between a street nurse and a police officer, engages people in crisis on social media in an effort to divert them from the criminal justice system and into proper care.

Part 6: Community Outreach and Education

No additional resources.

Appendix D: Task Force Response to National Institute of Mental Health (NIMH) Request For Information (RFI) on Suicide Research

Suicide Attempt Survivor and Loss Survivor Perspectives on Research Needs in Suicide Prevention

In collaboration with international experts and research faculty the Suicide Attempt Survivor Taskforce has explored recommendations for research in core areas related to attempts, reattempts and suicide death prevention. In addition to the proposed Roadblocks treatment, our recommendations focus on three (3) domains that have the potential to fill crucial information gaps and thereby provide directions for future suicide prevention efforts:

1. Stigma, bias, shame, self-stigma and discrimination as related to suicide itself, surviving an attempt, mental health conditions and mental health treatment generally
2. Etiology of suicide attempt behavior including the role of protective factors and avenues for develop and support of these through educational or other public efforts
3. Interventions and perceptions of treatment as related to re-attempt

Stigma, prejudice, discrimination, self-stigma/shame and social exclusion as related to suicide, suicide attempts, diagnoses, seeking services including emergency care and mental health treatment

- Many studies suggest that stigma decreases help seeking and is related to the continuation or increase of mental health problems, and that stigma is a cross-cultural phenomenon.

- The definition of stigma is often considered separate (or competing) with the effects of stigma, presenting the potential problem, especially in cross-sectional studies, of having multicolllinearity (i.e., several variables from a common construct). For example, stigma is often tested as an independent variable that is competing with concepts such as help-seeking attitudes, trust, confidentiality, fear, loss of esteem, seeing help seeking as weak or failure, reluctance to admit having a mental illness, denial, concerns about disclosure (e.g., Gould, 2012; Bruffaerts, 2011). However, all of the aforementioned variables may be related to stigma, either as part of the construct or as an outcome of stigma.

  It would be useful to determine the joint effects of stigma and related elements as one unified construct, or alternatively to study the downstream effects of stigma. For example, one prospective study showed that self stigma was not predictive of suicidal behavior (Yen, 2009), but more studies are needed to determine whether or not there were moderators involved. For example, do suicide attempt survivors experience more stigma or self-stigma than people with mental illness in general, and could that be related to future behavior? Additionally, there is evidence that many general awareness campaigns are not effective at increasing help seeking or decreasing suicidal behavior (Dumesnil, 2009). It may be useful to clarify what types and components of stigma targeted by interventions may have significant effects on outcomes such as help-seeking and repeat attempts.

On this topic, one contributor noted that some of the components of stigma could include label avoidance (I don't want to seek out help so I am not labeled mentally ill) and self-stigma. However, one of the barriers to additional research is being able to separate out effects of stigma such as low morale from the symptoms of mental illness such as depression.

- Studies about actual versus perceived public stigma could be helpful in identifying contributors to suicidal behavior or help seeking behavior.
- The notion of access to care is often cited as a barrier to help seeking; however there is less study of the actual accessibility of services. How much of the issue is access to services as opposed to perceived access to services? Is perceived access related to stigma? For example, perhaps people are willing to seek help in private, non-psychiatric settings, in nontraditional hours, or more confidential locations as against other forms of help seeking.
- Studies suggest that the stigma about suicide may be higher than it is for other forms of injury or death (Sveen, 2008), and the effects of that stigma carry-over from the attempt survivor or death by suicide to the family, and perhaps friends of those individuals. The field currently knows little about the effects of that stigma carried over.
- At least one published study has indicated that suicide attempt survivors and their family may experience stigma and discrimination from health care providers (Cerel, 2006). We know less about the effects of this felt stigma and discrimination on subsequent suicidal behavior, continuity of care, or future help seeking. Additionally, even with their advanced training, many healthcare providers avoid mental health care for themselves because of stigma (Wallace, 2010). Do interventions designed to increase awareness, knowledge, and skills have an effect on stigma (for patients and for the healthcare staff themselves)?
- There appears to be little research[1] about the actual and perceived impacts of involuntary rescue, voluntary versus involuntary hospitalization, and self disclosure about being a suicide attempt survivor or having experienced suicidal ideation - particularly as these variables might affect protective factors such as connectedness and risk factors such as social isolation (or burdensomeness, lower belonging) and willingness to seek services in the future.
- There has been little study of the effects of permanent injury or disfigurement that results from a suicide attempt in terms of the effects on self-esteem, self-perception, shame, and re-attempts (or deaths) in the future.

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[1] Statements about scarcity of studies reflect the published research known to the members of the Task Force.

- There has been little study of the thought processes related to stigma formation and its effects, which could guide the development of interventions. For example, there is some research that says that suicide attempt survivors may be seen as more responsible for their outcomes than people with other health conditions or issues (Lester, 1996). Additionally, family members have often been considered responsible for suicidal behavior. The assignment of responsibility could be studied in a manner that is consistent with cognitive science and cognitive psychology (e.g., attribution errors, schemas).

- Research that develops a model connecting stigma to suicidal behavior would be useful in determining targets for intervention. Key elements might include, in temporal order, the formation of stigma → level of stigma → stigma effects (as described above) → mental health behaviors (e.g., help-seeking) → suicidal behavior. A critical review could examine and summarize each of those linkages to suggest pathways connecting stigma to suicidal behavior, and identifying intervention points. A stronger evidence base could use a prospective design given the temporal relationships. However, studies conducted in a short timeframe could use of Structural Equation Modeling (SEM) or Mixed Effects Modeling could also strengthen the knowledge about the (potential) role stigma plays in suicidal behavior.

- It is noted in a review[1] that at least some public-level media interventions that have been successful at reducing suicide deaths have included aspects of stigma reduction, particularly with regard to increasing help seeking. In addition, those broad-based efforts have achieved success for suicide reduction where simultaneous stigma-reduction and suicide prevention messaging has occurred, and that such effects are significantly improved compared to the presence of only one or the other 'campaign'. However the stigma reduction element has received less attention than other parts of interventions such as the USAF Program (Knox, 2003) or the national suicide prevention program in England (Paton, 2001) and the causal link or interaction between suicide prevention and stigma-change remains unclear.

Etiology

- Studies that inquire about the decision-making involved in suicide, specifically choice of method, might be useful. What role do personality, disorder, access to means, and psychological needs play in suicidal planning?

- There is a lack of studies that have examined the relationship between onset of suicidal behavior in adolescence (as opposed to in adulthood) and future reattempts or death by suicide. This type of longitudinal or prospective research would be in line with Joiner's concept of capability for suicidal behavior.

- There is also little research about resilience factors, beyond protective factors, that help people to recover after a suicide attempt or after experiencing serious suicidal ideation.

Interventions

- There has been little, if any, study of peer supports as an intervention for suicidal individuals (e.g., support groups, peer specialists, etc.). Although consumer-run services including peer support programs have been established as evidence-based by SAMHSA, we do not have an evidence base around the feasibility, safety, acceptability, and efficacy of peer provided services for suicidal individuals. It may be useful to examine which components of existing interventions (that have been efficacious in reducing suicidal ideation and behavior) could be replicated or enhanced by employing peer providers. One example design for experimentation would be treatment as usual or waitlist vs. clinician led groups vs. peer led groups.

- The experiences that people who attempt suicide have in the services milieu can be a significant factor in how or whether they follow up with treatment recommendations, seek or avoid services in the future and, prospectively, the likelihood of future attempts or death. In one study both attempt survivors and relatives reported very negative experiences in relevant emergency room services (Cerel, 2005). Additionally many studies of service recipients have reported negative experiences in psychiatric emergency and inpatient psychiatric settings, including demeaning treatment, abuse and severe trauma (Cusack, et al, 2003; Robins, et al, 2005). However no studies have been conducted into the relationship between personal treatment experiences generally and outcomes for suicide death or reattempt.

- Some studies suggest that help-seeking is hindered by perceived need for treatment, with individuals often minimizing symptoms or preferring approaches they classify as "self-help" Gould, 2012; Bruffaerts, 2011). What do suicidal individuals consider “self-help”? What do they see as the most acceptable or desirable forms/channels for help? Interestingly, there is evidence that people unwilling to seek ‘traditional’ help sometimes call the National Suicide Prevention Lifeline (Gould, 2012). What is the feasibility, acceptability, and effectiveness of engaging suicide attempt survivors through 24-7 telephonic, computer or other mobile communications devices?

- Would changing the diagnostic codes or billing/reimbursement codes increase service provision for suicidal individuals or the accuracy of their clinical care?

- There was a suggestion of developing more interventions based on Shneidman’s psychache theory and Joiner’s Interpersonal Theory of suicidal behavior.

- What are the effects of family (and significant persons) education and involvement in clinical care? Are there effects on social connectedness or social loss, and eventually does this have an impact on reattempts?

Outcomes / Measures of effectiveness

- Some contributors asked for additional research on the impact of suicidal behavior on family and significant person survivors. While there is no a great amount of study on the effects of suicide on siblings, friends, colleagues, or patients, there are far fewer studies that examine the experience of the family and significant persons of suicide attempt survivors.
- Some studies have examined the mental health impact of suicide on loss survivors (e.g., complicated grief and bereavement, depression, and increased risk of suicidal behavior), and some cross-sectional research has indicated that adolescents who are exposed to a suicide or that attempt suicide are more likely to be involved in substance abuse, violence, and low family connectedness (e.g., Cerel, 2005). We know little about the potential positive effects of suicide prevention programs for the family and significant persons for suicide attempt survivors (or individuals at risk for suicide). Are there secondary benefits that accrue from suicide prevention interventions? Do participants share information with others? Do family/friend attitudes change when they see successful interventions? Does their emotional distress decrease?
- More generally, research might be improved by including positive outcomes from interventions such as improved mental health and wellness, increased hope or optimism, and increased skills.

Roadblocks

- There appear to be some barriers related to the IRB process, in particular, beliefs about what increases suicide risk (e.g., Does asking questions about suicide increase risk?). Given that IRBs are often regulated by NIH, perhaps there could be an education campaign for the IRBs that offers clear guidance on what is known about iatrogenic effects (or lack thereof) of asking about suicide. Are researchers avoiding the topic of suicide to preempt IRB (or grant reviewer) concerns or delays? Similarly, the field might benefit by having some clear guidelines around including suicidal people or people with a history of suicidal behavior in research studies.
- In general, there is little study of the actual thought process that is involved in suicidal decision-making or suicidal ideation, as opposed to a study of general risk or contributing factors. Due to multiple factors that influence and relate to the development of suicidal ideation and behavior, this has posed difficulties for research. It may be useful to examine methods that have been used in cognitive science and neuroscience that could be applied to the process of suicidal thinking.
- A major roadblock to studying the community level affects of interventions is the delay in having access to suicide and suicide attempt data (though this may be a suggestion more relevant to the Data and Surveillance Task Force).
- Methods are needed for measuring intermediate community or group outcomes from large interventions (universal or selective). For example, what type of interventions actually increase

connectedness, improve the dialogue around suicide and comfort with discussing suicide and related topics (as a counter to stigma), or improve the social climate and culture around mental health in general? Additionally, methods or indicators are needed for examining the effect that leaders and institutions have on mental health and suicidal outcomes when they prioritize and promote (or hinder and hide) mental health issues.

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Appendix E: Expert Interviewees, Reviewers, Funding Organizations

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- Madge Tullis, Co-founder, Tennessee Suicide Prevention Network

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Prevention Communities

Substance Abuse and Mental Health Services Administration

Suicide Prevention Resource Center

Glossary

Accessibility (of care) – the location, hours, and placement of care which facilitates or inhibits individuals from getting care.

Assertive Community Treatment (ACT) – a team approach to intensive, comprehensive, community-based treatment and support for individuals with chronic or persistent mental health challenges.

Attempt survivor – see suicide attempt survivor

Behavioral health—a state of mental/emotional being and/or choices and actions that affect wellness.

Behavioral health challenges – issues, problems or challenges including mental and substance use disorders, severe psychological distress, and suicidal thinking or behavior.

Behavioral health care – clinical services that promote mental or emotional health, seek to prevent or treat behavioral health challenges, and/or support recovery

Bibliotherapy – the use of self-help materials or recommended reading as a way of helping a person cope with mental health challenges

Care plan – a collaborative and comprehensive plan for treatment and/or support

Cognitive behavior therapy for suicide prevention (CBT-SP) – an evidence-based form of therapy or treatment that specifically focuses on the thoughts and behavior that challenge suicidal individuals

Connectedness – relationships between individuals, groups, and/or organizations that are experienced as positive, satisfying, helpful, or supportive

Continuity of care – an approach to treatment or support that ensures that a person and his or her clinical records can go from one provider to another with few (if any) delays

Core Value – a concept describing a perspective and/or belief that attempt survivors identified as factors that make care both helpful and preferable for a person experiencing, or recovering from, a suicidal crisis

Crisis respite – a facility that provides an individual with a supportive environment that promotes recovery from acute distress or crisis, when a person is not in immediate danger

Crisis support – care or services specifically aimed at helping individuals in mental or emotional distress

Dialectical behavior therapy (DBT) – an evidence-based form of therapy or treatment that specifically focuses on controlling chronic or long-term suicidal thoughts, feelings, and behaviors

Dignity – value and respect, concern for a person’s needs and feelings, and avoiding the use of labels and stereotypes

Ecological model (Social Ecological Model) – a framework for examining the factors that influence an issue that encompasses attitudes and behaviors at the individual, relationship or group, community, and social or cultural levels

Evaluation – systematic investigation of program or practice value, process, and/or impact

Evidence-based – practices or programs that have scientific research or evaluation results demonstrating that the desired outcome can be achieved

Federally qualified health centers – health care organizations that serve an underserved area, provide comprehensive services, and receive special Medicare and Medicaid funding

HIPAA – the Health Insurance Portability and Accountability Act issued standards and safeguards about the use and disclosure of individual health information, privacy rights, and control of information

Inclusion – meaningful engagement of persons from a specified group in the initiation, development, dissemination, promotion, implementation, and/or evaluation of activities

Informed care decision – choices about treatment and support to promote health and well-being that are based on a clear understanding of the risks and benefits of available options

Lethal means – instruments, objects, or materials used for suicidal behavior that have a high rate of death

Lived experience – first-person knowledge about suicidal thinking and/or behavior from having lived through one or more suicidal experiences

Lived expertise – the combination of lived experience and relevant training or practice that enables a person to apply personal knowledge to professional activities

Mental health (see also behavioral health) – a person's capacity to fully use his or her mental abilities, experience social and cognitive development, interact with others, and experience well-being

Mental health challenges (see also behavioral health challenges) – the temporary or long-term symptoms, problems, concerns that cause a person distress and/or disrupt his or her life, which includes traditionally defined 'mental illness.'

NSSP – the National Strategy for Suicide Prevention finalized in 2012

Peer – a person who has lived experience from mental or behavioral health challenges, particularly experience from a suicidal crisis

Peer respite – crisis respite that is operated by peers, or includes significant numbers of staff who are peers

Person-centered approach – an approach to treatment that is guided by an individual's needs, wishes, strengths, values, resources, and goals

Policy – a written or formal statement intended to guide the actions of governments, organizations, or individuals

Practice – a process, method, technique, approach, procedure or other behavior that occurs on a regular basis

Primary care – clinical services that are aimed primarily at general or physical health and well-being

Program – a specific intervention, therapy, treatment, campaign, course, workshop, or other activity or resource designed to support or help someone

Protective factors – characteristics, situations, or other elements in a person's life that make it less likely that he or she will develop a disorder or experience a suicidal crisis

Recovery – a concept of living a hopeful, meaningful, and fulfilling life in spite of behavioral health challenges

Recovery practices (Recovery-oriented services) – support or clinical practices and services that aim to support recovery

Research – systematic investigation of a concept, theory, program, practice, or policy to increase general knowledge and understanding of its components, mechanisms, outcomes, or other qualities

Resilience/Resiliency – a person's capacity for positive outcomes and/or protection from negative outcomes in spite of challenges

Risk factors – characteristics, situations, or other elements in a person's life that make it more likely that he or she will develop a disorder or experience a suicidal crisis

Self-advocacy – the process of asserting one's rights and/or informing service or support providers about one's needs, wishes, strengths, values, resources, and goals

Self-care or self-help – information a person acquires and/or actions a person takes to maintain or improve his or her health and well-being

Self-management – self-care that is specifically aimed at modifying, coping, or tolerating behavioral health challenges

Self-stigma – negative perceptions of oneself based on beliefs about a condition, disorder, or circumstance

Stigma – the combination of bias, negative stereotypes, fear, avoidance, shame, discrimination, and/or abuse that is associated with a labelled condition or circumstance

Suicide – death caused by self-inflicted injury, poisoning, or suffocation; a fatal suicide attempt

Suicide attempt – a self-inflicted injury, poisoning, or suffocation with some intent to die

Suicidal behavior – a suicide attempt and/or actions preparing for a suicide attempt

Suicidal crisis – a situation when a person is experiencing suicidal thoughts, feelings, and/or impulses, which may involve suicidal behavior

Suicide attempt survivor – a person who survived a prior suicide attempt

Suicide prevention supports – actions and activities that have the potential to prevent, intervene, or assist recovery from a suicidal crisis

Support network – the persons identified by an individual as potential or active providers of tangible, social, emotional, or psychological support

Trauma informed care – support or services that is aware of a person's potential history of sexual, physical, or emotional abuse, traumatic service experiences, and how such life experiences can impact behavioral health challenges and care

Warm line – a pre-crisis telephone-based service that provides supportive listening, social support, and/or advice about coping that is often staffed by peers or paraprofessionals

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The National Action Alliance for Suicide Prevention is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) (http://actionallianceforsuicideprevention.org/NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance envisions a nation free from the tragic experience of suicide. For electronic copies of this paper or for additional information about the Action Alliance and its task forces, please visit http://www.actionallianceforsuicideprevention.org.

NATIONAL Action Alliance FOR SUICIDE PREVENTION

The Relationship Between Suicidal Behaviors and Zero Suicide Organizational Best Practices in Outpatient Mental Health Clinics

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Objective: This study tested the hypothesis that fidelity of clinics to Zero Suicide (ZS) organizational practices is inversely related to suicidal behaviors of patients under clinical care.

Methods: Using cross-sectional analyses, the authors examined the fidelity of 110 outpatient mental health clinics to ZS organizational best practices and suicidal behaviors of clinic patients in the year before a large-scale Zero Suicide implementation. Fidelity to ZS organizational best practices was assessed over a 1-year period with an adapted version of the ZS Organizational Self-Study instrument (17 items self-rated on a Likert scale of 1–5). Suicidal behaviors of patients were identified by extracting information on suicide attempts and deaths from a mandated statewide incident-reporting system database. Clinics were dichotomized into any or no suicide incidents during the year of observation. Logistic regression analyses were used to adjust for clinic census and population type (majority child or adult).

Results: The clinics (N=110) served 30,257 patients per week. Clinics' total average fidelity score was 3.1±0.6 (range=1.41–4.12). For each point increase in fidelity, clinics had a significantly reduced likelihood of having a suicide incident (adjusted odds ratio=0.31, 95% confidence interval=0.14–0.69). Exploratory analysis identified significant differences for seven of 17 ZS organizational practices, with the largest effect sizes for suicide-specific quality improvement policies and activities (η^2=0.097) and lethal means reduction (η^2=0.073).

Conclusions: These findings support an association between clinics' use of ZS organizational best practices and lower suicidal behaviors of patients under their care. Findings also support the validity of the ZS Organizational Self-Study instrument.

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Suicide is a growing public health crisis. Since 1999, the national prevalence of death by suicide has steadily increased (1). In 2017, it was the 10th leading cause of death in the United States for all age groups and the second for ages 10–44 years (2). Most individuals (83%) who died by suicide accessed general medical or mental health care in the year before their death (3, 4), and suicide and intentional self-harm were the fastest-growing reasons for psychiatric emergency room visits between 2010 and 2014 compared with all other mental health- or substance use–related reasons (5). These facts suggest that health care systems could reduce suicide by improving identification and treatment of individuals at increased risk.

Encouraging health care systems to provide safer, more effective care of suicidal patients has become a national priority (6, 7). In 2012, the Office of the Surgeon General and the National Action Alliance for Suicide Prevention (NAASP), a public-private partnership dedicated to reducing

HIGHLIGHTS

- A cross-sectional study of 110 mental health clinics found that clinics with higher fidelity to Zero Suicide (ZS) organizational best practices were less likely to have a suicide incident among patients.
- For each point increase in fidelity to ZS organizational best practices, clinics had a significantly reduced likelihood of having a suicide event.
- Higher fidelity to seven organizational best practices was significantly associated with a history of no suicide incidents, with the largest effect sizes for suicide-specific clinic quality improvement activities and reduction of lethal means.
- The ZS Organizational Self-Study instrument had strong psychometric properties.

suicide, released a broad national suicide prevention strategy (6). The NAASP Clinical Care and Intervention Taskforce focused on recommendations that were targeted specifically to health care settings (8) and based on an environmental scan of large-scale suicide prevention efforts, including the U.S. Air Force Suicide Prevention Program (9), the quality improvement initiative of the Henry Ford Health System's Perfect Depression Care (10, 11), Central Arizona Programmatic Suicide Deterrent System, the National Suicide Prevention Lifeline, and others (12). These programs provided compelling evidence that health care systems can reduce suicide through a bundled set of interventions coupled with intentional and sustained leadership and continuous quality improvement activities. The taskforce named this approach Zero Suicide (ZS) to reflect an aspirational goal of preventing all suicides by patients in health systems and to provide a framework for suicide prevention within health care settings. A similar national effort targeting health services in the United Kingdom reduced suicide deaths and, importantly, found that mental health services with a more comprehensive approach had greater reductions, underscoring the need for developing and implementing a systematic model (13). Early adopters of the ZS framework, including Centerstone, a behavioral health system in Tennessee, and the Institute for Family Health, a large federally qualified health center primary care network in New York, observed reductions in suicide incidents of >50% within 3 years (12). The ZS Toolkit was informed by these early adopters and was developed by the Suicide Prevention Resource Center to support large-scale implementation (12, 14), and randomized controlled trials of ZS are under way (15–17).

Hogan and Goldstein Grumet (12) have defined seven core components of the ZS model to improve the identification and treatment of individuals most at risk for suicide. Three of these components address administrative best practices in managing change, including leadership, training, and measuring outcomes and conducting quality improvement. Four additional components reflect established best practices in suicide care, namely, suicide screening and risk assessment (18–21); use of systematic suicide care protocols that include safety planning and lethal means reduction (22–29); evidence-based treatment to address suicidal thoughts and behaviors directly, in addition to other mental health issues (30–34); and provision of support during care transitions, with follow-up after discharge from acute care settings such as "caring contacts" (35–37).

Further highlighting the growing national consensus around these core suicide safer care practices, two national accrediting organizations, The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities, have recently amended their accreditation standards to include suicide screening, risk assessment, and follow-up care after discharge, listing ZS among suggested resources (38, 39). The ZS Toolkit provides tools to assist providers and health care systems in implementing model practices, including the ZS Organizational Self-Study, which assesses fidelity to ZS organizational best practices (40).

Growing support for the model has led to implementation projects across diverse health care systems, states, and tribal nations in the United States (16, 17). Understanding the relationship between fidelity to ZS organizational practices and suicide-related outcomes is critical to support ongoing ZS implementation and research efforts (41–43). The current study examined the relationship between fidelity to the organizational best practices promoted by the ZS model and suicidal behaviors in the year preceding a statewide implementation of ZS in mental health clinics. We expected that clinics with higher fidelity would be less likely to have had patients with suicidal behaviors during the previous year. In addition, we examined the ZS Organizational Self-Study tool's psychometric properties to support the large-scale implementation project and to inform future use of this instrument.

METHODS

Setting

The study focused on community-based mental health clinics not affiliated with hospitals in New York State (NYS) in the year before large-scale ZS implementation. The Suicide Prevention Continuous Quality Improvement (SP-CQI) project was launched in 2017 to support ZS model implementation in outpatient mental health clinics and was a collaborative effort between the NYS Office of Mental Health (NYSOMH) Bureau of Evidence-Based Services and Implementation Science and Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) (44), the NYSOMH Suicide Prevention Office (45), and the Center for Practice Innovations at the Columbia University Department of Psychiatry, NYS Psychiatric Institute (NYSPI) (15, 46). The institutional review boards of the Nathan Kline Institute for Psychiatric Research at the NYS Office of Mental Health and NYSPI determined that the study project did not meet the definition of human subjects research.

Sample

All non–hospital-affiliated, community-based, and NYS-licensed mental health clinics (N=321) were invited to participate in the SP-CQI project. Moreover, state-run psychiatric hospital clinics were required to participate but were excluded from this study because of concerns about bias (due to a centralized governing structure mandating participation) and generalizability (NYS is one of the few states to operate a large-scale network of psychiatric hospitals). The study sample included clinics voluntarily enrolled as of April 1, 2017 (N=134 clinics, a 42% recruitment rate), that completed their baseline ZS Organizational Self-Study (N=131, 98%), and were open 6 months before and after the observation period. The final sample included 110 clinics. In preparation for the study, we compared the sizes (number of patients in a sample week) of participating and nonparticipating clinics and client characteristics, including age, race, Medicaid insurance, serious mental illness, and comorbid substance use. Chi-square analysis using the 2015 Patient Characteristics Survey (PCS) data, a biennial NYSOMH survey of mental health programs, detected no statistically significant differences.

Measures and Data Sources

Clinic and client characteristics. All clinic and client characteristics were extracted from the 2017 PCS (47), including clinic size (number of patients served during the PCS sample week), and clinic type (whether >50% of population served at the clinic served were children).

Fidelity to ZS organizational practices. Fidelity to ZS organizational practices (ZS fidelity) was assessed before the SP-CQI project implementation with the ZS Organizational Self-Study instrument (40), which was administered to point persons of clinical projects (clinic leadership or quality improvement staff) via SurveyMonkey between February and May 2017 to inform project planning. The tool includes 17 quantitative items (rated on a 5-point scale, with 5 indicating the highest fidelity) and six descriptive questions (excluded from this analysis). Adaptations to the instrument reflected commonly used language in NYS's clinics and project requirements (see online supplement to this article). The 17 quantitative items were averaged to compute a total ZS fidelity score for each clinic (48, 49).

Suicidal behaviors in the previous year. Data on suicidal behaviors—specifically, suicide attempts and deaths—were extracted from a state administrative database, the NYS Incident Management Reporting System (NIMRS) (50). NIMRS is a mandatory reporting system for all adverse incidents (e.g., medication reactions and violence) for NYSOMH-licensed programs. All suicide attempts and deaths are required to be reported within 24 hours of discovery. Because the count of suicidal behaviors was highly skewed, study clinics were dichotomized into two groups: no patients with suicidal behavior incidents (N=40) or one or more patients with suicidal behaviors (N=70). In the year of observation (April 2016–2017), most clinics (N=70, 64%) had reported at least one suicide attempt or death incident among their patients (mean±SD=3.1±4.9, median=1, range=0–27), with 22 clinics (20%) reporting one or more deaths (0.25±0.55, range=0–3).

Data Analysis

Statistical analyses were conducted with SAS, version 9.4, and SPSS, version 25; all statistical tests were two-tailed.

Relationship between ZS fidelity and suicidal behaviors among clinic patients. A logistic regression was conducted to test whether clinic ZS fidelity was associated with patients' suicidal behaviors in the previous year. We adjusted the model for clinic size by using 2017 PCS data on the number of patients served in the clinic during a sample week (larger clinics are more likely to have a suicide incident) and by clinic type (mostly child services vs. adult services) because of differences in the prevalence of adolescent versus adult

TABLE 1. Characteristics of participating clinics and patients served[a]

	Clinics or patients	
Characteristic	N[b]	%
Clinic		
Most patients are children (>50% served are ≤17 years)[c]	22	20
Urban (≥50,000 people)	77	70
Rural (<50,000 people)	33	30
Federally qualified health center	8	7
One or more suicide-related incident in the previous year[d]	70	64
Patients served per week per clinic (median)[e]	233	
Patient	M±SD	Range
% of patients served by clinic in a typically week		
Children (≤17 years)	30±30	0–98
Older adults (≥65 years)	7±10	0–83
Racial-ethnic minority groups	44±26	0–97
Non–English-speaking preference	10±14	0–66
Veteran	2±2	0–9
Medicaid recipient	77±15	25–100
Serious mental illness or serious emotional disturbance	90±9	58–100
Alcohol or substance use disorder	13±14	0–70
Intellectual disability	12±6	0–34
Competitive and integrated employment	<1±<1	0–1
Criminal or juvenile justice status	.1±.1	0–1
Past-year clinic suicide incidents[d]		
All suicidal behaviors	3.11±4.94	0–27
Suicide attempts	2.88±4.64	0–25
Suicide deaths	.25±.55	0–3

[a] Data on patients served were from the biennial Patient Characteristics Survey (PCS) of all New York State Office of Mental Health–licensed programs during a single week of observation.

[b] Data are shown for 110 clinics, except for non–English-speaking preference (N=96), veteran (N=105), Medicaid recipient (N=107), serious mental illness or serious emotional disturbance (N=108), competitive and integrated employment (N=105), and criminal or juvenile justice status (N=99).

[c] Number of patients served during PCS assessment week and majority adult- or child-serving clinic based on PCS reporting in which the two clinic characteristics were adjusted for in logistic regression analysis.

[d] Data on suicide-related incidents (including attempts and deaths) were obtained from the New York State Incident Management Reporting System, a mandatory reporting system for all adverse incidents for New York State Office of Mental Health–licensed mental health programs.

[e] M±SD=275.1±226.6, range=10–1,314.

suicide attempts (51). Exploratory analyses with analysis of covariance examined differences in fidelity for individual ZS practices among clinics with and without a suicide incident in the previous year and controlled for clinic size but not clinic type (because of parsimony considerations and lack of a finding in hypothesis testing).

Psychometric properties of the ZS fidelity assessment. We examined the psychometric properties of the ZS Organizational Self-Study instrument because no previously published findings exist. The ZS Organizational Self-Study had high internal consistency (α=0.90). A principal component analysis (PCA) was conducted by using varimax rotation and the Kaiser criterion to identify whether the instrument had any meaningful subscales. Suitability for PCA was tested with the Kaiser-Meyer-Olkin (KMO) test for sampling adequacy, Bartlett's test of sphericity, and a correlation matrix review. The study data were suitable for PCA; all 17 items were correlated with at least one other item in the scale ($r>0.37$). The KMO measure was 0.85, with individual item measures ranging from 0.60 to 0.93, and Bartlett's test of sphericity was statistically significant ($p<0.001$). The item with the lowest KMO also had the lowest mean score and assessed the inclusion of suicide attempt survivors in clinic policy (item 3). Excluding this item did not change the overall findings. PCA identified four principal components (with eigenvalues >1), which together accounted for 61.4% of the total variance (26.0%, 14.0%, 11.3%, and 10.1%,). However, the grouping of items was inconsistent (e.g., related practices were not grouped together with frequent cross-loading); therefore, the interpretability criterion was not met. This lack of interpretability suggested that the ZS fidelity instrument is best interpreted as a single scale (see online supplement).

RESULTS

Characteristics of the study clinics and their patients are presented in Table 1. Most clinics were located in urban settings (70%), and 80% predominantly served adults. The participating clinics served 30,257 patients during a typical week.

ZS Fidelity for All Clinics in the Year Before Large-Scale ZS Implementation

Clinics' ZS fidelity assessed with the ZS Organizational Self-Study instrument ranged from very low to high (1.4–4.1 of 5.0), with a mean±SD of 3.1±0.6, reflecting moderate fidelity. Examining individual organizational practice items, we found that the highest rated item was safety planning (item 12), with a mean of 4.1±0.9, followed by screening using a validated instrument (item 8, 4.0±1.3) and routine suicide screening (item 7, mean of 3.9±0.8) (Table 2). The lowest rated items were policy input from suicide attempt survivors (item 3, 1.2±0.6), assessment of staff suicide care confidence and skills (item 4, 1.8±0.9), identifying and measuring suicide death rates (item 19, 2.5±0.9), and lethal means reduction (item 13, 2.6±1.2). Similarly, a high proportion of clinics reported high fidelity (i.e., scored 4 or 5) on safety planning (78%), but few reported high fidelity to lethal means reduction (16%).

Association Between ZS Fidelity and Suicidal Behaviors Among Patients

Results of the logistic regression model are presented in Table 3. After adjusting for patient census and population type served, we found that clinics with higher ZS fidelity had 0.31 lower odds of having a client with suicidal behavior during the previous year (adjusted odds ratio=0.31, 95% confidence interval=0.14–0.69). In other words, for each unit increase (i.e., one point on a 1–5 scale) on the ZS fidelity scale, clinics were significantly less likely to have any patients with suicidal behaviors. The model explained 33% (Nagelkerke R^2) of the variance in suicidal behaviors.

Differences in ZS Organizational Practices Between Clinics With and Without Suicidal Incidents

A statistically significant difference between clinics with and without a suicide incident was observed for total average fidelity scores and for seven of the 17 organizational practice items (Table 2). Medium effect sizes were observed for two items: quality improvement activities focused on suicide prevention (item 20) and lethal means reduction (item 13) (η^2=0.097 and 0.073, respectively). Examination of the proportion of clinics who achieved high fidelity (i.e., scored 4 or 5 on the ZS Organizational Self-Study instrument) on these two items identified marked differences for clinics with and without a suicide incident. Nearly half (45%, N=18) of clinics without a suicide incident reported that they met the quality improvement criteria compared with fewer than a quarter (23%, N=16) of clinics with an incident in the previous year. Small but statistically significant effects were observed for five other ZS fidelity organizational practice items: leadership commitment (item 1), assessments of confidence in suicide care and of skills among staff (item 4), suicide risk assessments (item 10), engaging hard-to-reach and no-show patients (item 16), and following up with patients who have been discharged from acute settings (item 17).

DISCUSSION

To our knowledge, this is the first study that reports an association between greater fidelity to ZS organizational practices and lower risk for suicidal behaviors. Specifically, after adjusting for patient census and population type served (adult vs. child), we found that the results supported the hypothesis that clinics with higher fidelity to the organizational practices promoted by the ZS model were less likely to have suicidal attempts or deaths among their patients. This finding was observed before a large-scale ZS implementation and extends preliminary research suggesting that the

TABLE 2. Baseline fidelity to Zero Suicide (ZS) organizational practices among 110 participating mental health clinics with and without a past-year suicide event

Item no.[a]	Item	All clinics (N=110)		No suicide event (N=40)		Suicide event (N=70)			
		M	SD	M[b]	SD	M[b]	SD	F[c]	η^2
1	Leadership commitment to suicide-specific policies	3.4	.9	3.6	.9	3.3	.9	5.70*	.051
2	Leadership commitment to dedicated staffing	2.7	1.0	2.6	1.1	2.7	1.0	.53	.004
3	Survivors have input into clinic policy	1.2	.6	1.2	.5	1.2	.6	.61	.006
4	Staff assessment	1.8	.9	2.1	.9	1.6	.8	4.23*	.038
5	Staff training	3.2	1.3	3.5	1.4	3.0	1.2	2.96	.027
7	Suicide screening protocol	3.9	.8	4.1	.7	3.9	.8	3.58	.032
8	Use of validated screening tool	4.0	1.3	4.1	1.2	3.9	1.3	3.23	.029
10	Suicide risk assessment	3.4	1.1	3.7	1.1	3.3	1.1	5.28*	.047
11	Suicide care pathway for patients at risk	3.2	1.0	3.4	1.1	3.2	1.0	1.49	.014
12	Safety planning	4.1	.9	4.3	1.0	4.0	.9	2.88	.026
13	Lethal means reduction	2.6	1.2	3.0	1.3	2.3	1.1	8.38**	.073
14	Suicide-specific treatment	2.9	.8	3.0	1.0	2.9	.8	.90	.008
16	Outreach after missed appointments	3.4	1.0	3.6	1.0	3.2	1.0	4.18*	.038
17	Acute care transition support	3.7	.9	3.9	.9	3.6	.9	4.78*	.043
18	Reviewing suicide deaths	3.0	1.2	3.3	1.4	2.8	1.1	6.17	.055
19	Measuring suicide deaths	2.5	.9	2.7	0.9	2.5	.9	2.13	.019
20	Suicide-specific quality improvement activities	3.0	1.0	3.3	1.1	2.8	.9	11.48**	.097
Total ZS fidelity score[d]		3.1	.6	3.2	.7	2.9	.6	9.44**	.080

[a] Item number in the ZS Organizational Self-Study adapted from the New York State Office of Mental Health Suicide Prevention Continuous Quality Improvement project. This instrument is a 23-item survey with 17 quantitative items; its six qualitative items (6, 9, 15, and 21–23) were excluded from the analysis. Items were rated on a 5-point Likert scale, where 1 indicates the lowest and 5 the highest fidelity.

[b] Unadjusted means are presented for clinics with and without a suicide event in the previous year.

[c] Clinics with and without a suicide event were compared by using analyses of covariance controlled for clinic size (number of patients seen during the sample week of the New York State Office of Mental Health 2017 Patient Characteristics Survey). df=1, 107.

[d] The 17 quantitative items were averaged for a total ZS fidelity score.

**$p<0.01$, *$p<0.05$ for mean difference between groups.

TABLE 3. Associations between clinic characteristics and history of suicide incident[a]

Clinic characteristic	β	SE	AOR[b]	95% CI	p
Zero Suicide fidelity[c]	−.1.16	.40	.31	.14–.69	<.01
Clinic size[d]	.007	.002	1.01	1.00–1.01	<.001
Clinic type (reference: adult-serving clinic)[e]	−.42	.58	.49	.21–2.06	.472

[a] Full model results χ^2=30.06, df=3, $p<0.001$.

[b] We adjusted the model for clinic size (median of 233 patients served per week) because larger clinics were more likely to have a suicide incident. We also adjusted the model for clinic type because of differences in the prevalence of adolescent versus adult suicide attempts. No other variables were included.

[c] Fidelity was measured on a scale from 1 to 5. For each 1-point increase on the Zero Suicide fidelity scale, clinics were significantly less likely to have any patients with suicidal behaviors.

[d] Clinic size was defined as the number of patients served in the sample week as assessed in the New York City Office of Mental Health 2017 Patient Characteristics Survey (PCS).

[e] On the basis of the PCS, clinics were categorized as serving predominantly adults (>50% served were ≥18 years old) or children (>50% patients served are ≤17 years old).

comprehensive approach encapsulated within the ZS framework is associated with fewer suicidal behaviors among those under care (10, 11). In addition, our findings suggest that specific ZS practices may be important priorities for suicide prevention efforts, particularly initiating suicide-focused quality improvement processes and reducing lethal means.

The study results indicate that the ZS Organizational Self-Study instrument has high internal consistency and concurrent validity. Specifically, the instrument could distinguish between clinics with and without suicide incidents. The instrument is brief, accessible, and in the public domain, and it does not require special training or expert raters (40). Self-assessment is important because it allows clinical programs to use the instrument in order to support internal quality improvement processes and offers a feasible approach to examining fidelity in large-scale implementation initiatives (52, 53).

As described above, the ZS framework was based on innovative quality improvement projects that identified death by suicide as a problem within health care systems and leveraged leadership commitment to monitor and reduce such deaths among individuals under care (9, 11, 54). It is noteworthy that among the 17 ZS organizational practices, the quality improvement infrastructure item had the highest effect size. Organizational best practices for suicide-specific quality improvement were defined as having suicide care embedded in the medical chart, written clinical workflows for suicide care, and data collection and review by clinical teams (e.g., data on the quality of patient suicide care plans). Nearly half (45%) of clinics without a suicide incident reported that they met the quality improvement criteria compared with fewer than one-quarter (23%) of clinics with an incident in the year before.

These findings underscore the importance of developing a sustainable data-monitoring and quality improvement infrastructure to support suicide prevention efforts.

In exploratory analyses, lethal means reduction also emerged as an important ZS practice, with the largest mean difference between clinics with and without a suicide incident. Achieving high fidelity to the lethal-means-reduction item requires documentation in safety plans as a standard practice, in addition to policies addressing clinician training, family inclusion in means reduction, and confirmation of means reduction. Interestingly, in this sample, most clinics (78%) reported high fidelity to safety planning, but few (16%) reported high fidelity to lethal means reduction, even though most safety planning interventions are supposed to include lethal means reduction. These findings suggest that staff may require additional training in lethal means reduction and safety planning to be comfortable and effective in these integrated practices. Safety planning interventions that incorporate lethal means reduction are associated with a 45% decrease in suicidal behaviors over 6 months (27). Moreover, clinic policies clarifying expectations for patients, their families, and staff to implement and confirm means reduction may be required to maximize the benefits of safety planning and means reduction counseling. These findings align with literature highlighting the role of lethal means reduction in reducing suicide (22, 23, 55). Future research may examine whether large-scale interventions, such as the SP-CQI initiative, can increase fidelity to lethal means reduction and other best practices and can decrease suicidal behaviors.

This study had several strengths and limitations. Its strengths included data from 110 mental health clinics serving a large and diverse population and the use of state-mandated reporting data as an objective measure for suicidal behaviors. Limitations included the following. First, our findings may not generalize to other treatment settings or patient populations. Second, we did not differentiate between suicide attempts and deaths. Third, the ZS Organizational Self-Study is a self-reported instrument, which may introduce bias. The role of self-reported fidelity has been debated in the literature but can offer a reliable, valid, and cost-effective method in specific contexts (41, 52, 53, 56, 57). Moreover, NIMRS, the resource we used for data indicating suicidal behaviors, is a state administrative database for monitoring serious incidents and adverse incidents and was not designed for research purposes. We could not include unreported suicidal behaviors, such as incidents of which the agency was unaware or suicidal behaviors that did not meet reporting criteria. In addition, although the size of the data set allowed for adjustment for clinic size and type, it did not have the statistical power to enable adjustment for other clinic- and patient-level characteristics that may affect organizational practices and outcomes, an important area for future study.

This cross-sectional study examined suicidal behaviors in the year before the fidelity assessment; the optimal period of such observations is unclear, given the evolution of organizational practices over time. Longitudinal study is needed to investigate fidelity over time and the relationship between gains in fidelity to changes in suicide outcomes. Finally, the exploratory analyses did not account for multiple comparisons, increasing the chance of type I errors, and ceiling effects for select organizational practice items (e.g., safety planning) may have introduced type II errors.

CONCLUSIONS

The findings of this study suggest that high fidelity to ZS organizational best practices in outpatient mental health clinics may reduce suicidal behaviors among patients. Exploratory analyses suggested that clinic engagement in suicide-specific quality improvement activities and in strategic development of effective policy- and protocol-based lethal means reduction may be particularly important for reducing suicide risk. Our findings also indicate that the ZS Organizational Self-Study instrument has high internal consistency and concurrent validity with patients' suicidal behaviors, suggesting it is a useful tool for health care systems.

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Restorative Just Culture: a Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust

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ABSTRACT

Restorative justice is an approach that aims to replace hurt by healing in the understanding that the perpetrators of pain are also victims of the incident themselves. In 2016, Mersey Care, an NHS community and mental health trust in the Liverpool region, implemented restorative justice (or what it termed a 'Just and Learning Culture') to fundamentally change its responses to incidents, patient harm, and complaints against staff. Although qualitative benefits from this implementation seemed obvious, it was also thought relevant to identify the economic effects of restorative justice. Through interviews with Mersey Care staff and collecting data pertaining to costs, suspensions, and absenteeism, an economic model of restorative justice was created. We found that the introduction of restorative justice has coincided with many qualitative improvements for staff, such as a reduction in suspensions and dismissals, increase in the reporting of adverse events, increase in the number of staff that feel encouraged to seek support and a slowing down of the upward trend in absence due to illness. It also improved staff retention. The economic benefits of restorative justice appear significant. After corrections for inflation, acquisitions and anomalies, we found that the salary costs averaged over two fiscal years were reduced by £ 4 million per year, coinciding with the introduction of a just and learning culture in 2016. In addition, Mersey Care reaped around £ 1 million in saved legal and termination expenses. We conservatively attribute half of these savings to the introduction of a just and learning culture itself, and the other half to non-related factors. Using this assumption, we estimate the total economic benefit of restorative justice in the case of Mersey Care NHS Foundation Trust to be about £ 2.5 million or approximately 1% of the total costs and 2% of the labour costs.[*]

Keywords: Restorative Justice; Economic Benefits; Health Care.

1. INTRODUCTION

In this paper, we report on the practical and economic effects of implementing a restorative just culture in a medium sized NHS (National Health Service) trust in the north of England. Mersey Care is a community and mental health trust providing care for a population of over 11 million service users/patients in the North West of England and beyond. It is the largest provider of forensic learning disability services and is one of the major providers of high secure services in England. It employs about 8,000 staff members across more than 80 sites. In 2014, the disciplinary actions pertaining to employee-relations at Mersey Care was notably high, and during this time, the

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[*] Trust turnover at the time was £ 260 million; in April 2018 this has grown to £ 360 million.

organization was focused on the disciplinary processes and intended to make them better and faster. To this end, the emphasis was also given to increasing HR training within the organization. However, by 2015, realizing that their current managerial and supervisory practices were not leading to desired improvements (like reduction in disciplinary actions or the time-taken), Mersey Care decided to fundamentally alter the way it responded to incidents (including suicides), patient harm, violence and complaints made against staff. Responses had previously been driven by human resource & patient safety policies and practices that mostly (if unwittingly) followed a retributive just culture script—organized around rules, violations and consequences. This was replaced, over a period of 18 months, with restorative justice focused on understanding, healing and learning.

In a retributive just culture, the questions that are asked centre around culpability: it assesses how bad ("reprehensible") staff errors are; and accordingly administers proportional consequences (Marx, 2001; Reason, 1997; Wachter & Pronovost, 2009). Such an arrangement has been shown to put downward pressure on people's willingness to come forward with bad news, and to change what people share and how they tell their stories when they do (Dekker & Hugh, 2010; Dekker & Laursen, 2007); it elides issues of substantive justice by ignoring broad staff support and the fairness of the rules applied (Dekker & Breakey, 2016); it leaves the age-old procedural question of 'who draws the line' fundamentally unresolved (Dekker, 2009); and is linked less to justice than to organizational power: one's position in the medical competence and managerial hierarchies co-determines whether retributive responses are seen as 'just' (Dekker & Nyce, 2013; von Thaden, Hoppes, Yongjuan, Johnson, & Schriver, 2006).

Restorative just culture, originating in a variety of ancient traditions, and with recent applications to justice in for example schools and juvenile offending (Barton, 2003; Mulligan, 2009; Weitekamp, 1999; Zehr & Gohar, 2002), asks very different questions: who is hurt; what do they need; and whose obligation is it to meet those needs? The success of restorative responses hinges on getting the community involved in collaboratively resolving those questions and arriving at a solution that is respectful to all parties (Braithwaite, 1989), such as, patients, families, caregivers, organizational representatives, regulators and legal and union representatives. It considers accountability in a forward-looking (rather than punitive, backwards-looking) manner, asking who needs to do what now, given their role and the expectations that come with it (Sharpe, 2003, 2004). Practices that reflect confession and repentance (e.g., reporting, disclosure, apology) can precede forgiveness and re-engagement (Berlinger, 2005). In restorative justice, an account is not seen as something that needs to be settled or paid, but as something that is told, shared and learned from (Dekker, 2016). The goals of restorative justice include moral engagement of stakeholders, reintegration of the caregiver into the community of practice, emotional healing of those affected by the incident, and, ultimately, organizational learning and improvement.

1.1. The Changes at Mersey Care

Through detailed in-person interviews conducted on-site, researchers were able to find common themes pertaining to the culture at Mersey care prior to the implementation of restorative justice practices. Subsequently, the changes implemented 2015 onward were also identified along with the commonly perceived effects of these implementations. The interview method is elaborated in chapter 2.

Prior to the introduction of restorative justices at Mersey Care, staff reported a major fear of being blamed for adverse events. Staff were not always telling the truth, and half of the clinical staff acknowledged that they felt inhibited to speak out about adverse events. There was a sense among staff that the organization was solely target-oriented and lacked openness and compassion. Many incidents led to suspensions pending an investigation (sometimes leading to an employment tribunal). The primary aim of the investigation was perceived to be to find a root cause which was followed by a disciplinary investigation, suspension and dismissal or sanction. Suspension was intended as a none-prejudicial act and as a measure to reduce risk pending an investigation but was perceived by staff as punishment. Costs associated with suspensions were rising, as were legal costs, agency costs for backfill absenteeism and staff turnover.

Over a period of 18 months, Mersey Care developed and implemented the following changes:

- From investigations of supposed offenders to restorative conversations between all stakeholders in the incident. This also involved a focus on myth/rumour busting by making factual information available sooner to other staff, where previously it was common not to share information during the investigation period.
- Freeze of staff suspensions unless contraindicated by evidence of threat.
- Culling judgmental language about staff performance from HR policies and procedures and patient safety post-incident reviews. Reviewing them (invitation to all staff for feedback) for clarity and necessity, and critically assessing them for the extent to which they actually empower and enable staff.
- Appointment (through self-nominations) of Just and Learning Culture lead to drive the organisational agenda, represent and advocate restorative justice and recruit ambassadors across the footprint.
- Appointment (through self-nominations) and training of just-culture ambassadors to represent and advocate for restorative justices across the trust's multiple sites.
- Revitalization of staff support through better advertising (like promotional banners, weekly CEO blogs), psychological first aid, debriefings and follow-up. This included 72-hour reviews (previously 5 working days), internal staff counselling services enabled to meet and connect with teams (also via telephone) following a serious incident.
- Sharing good practice stories (which are found by encouraging the staff to share their experiences) through a new internal 'just and learning culture' microsite—including not only clinical or operational successes but also lessons learnt, confessions made and gratitude extended.
- Encouraging the trickle-down of restorative just culture into everyday organizational life, including back-office and administrative work.
- Promoting just culture awareness through internal communication to affirm that things will be dealt with differently now.

These changes have been the subject of workshops at Mersey Care and also documented in various policy documents. This report is not intended to provide ways to achieve a cultural change. It, however, focuses on the effects of these interventions and highlights the various benefits.

1.2. HR and other Policy Documents

Mersey Care – like all large institutions – relies on written procedures and policies for much of its processes. These procedures generally serve five main purposes (Hale & Borys, 2013):

- They are a memory aid for steps, especially in emergency situations
- To facilitate coordination between multiple actors
- As a basis for training
- As organisational memory, for example as the starting point for innovation – "how did we do that again?"
- To enable the monitoring and checking of behaviour (for example to prevent High Impact - Low-Frequency events)

Procedures are static but need to provide guidance under the varying circumstances of day-to-day work. On the one hand, they need to offer sufficient guidance for practitioners, but on the other hand, the number of rule of exceptions (“non-compliances” or “violations”) that they provoke needs to be minimised to retain credibility. We have looked at the following procedures:

- HR01 – Disciplinary Procedure
- HR07 – Management of attendance
- HR37 – Supporting Colleagues
- SA03 – Reporting, Management & Review of Adverse Incidents

Whereas judgmental language (holding staff strictly accountable by procedure and compliance standards) was still present throughout Trust documentation, almost all procedures and policies now explicitly refer to or attempt to embody the values of a just and learning culture. Particularly the **HR37** (Supporting Colleagues) policy is one that has been established as a result of the just and learning culture and this change in reflected in the simple language of the policy and a high emphasis on supporting staff. The organisation has refreshed all their organizational values to embody the Just and Learning language and has introduced a new value of ‘Support’ which specifically asks staff to raise concerns.

2. METHOD

The evaluation reported in this paper was conducted immediately after the implementation period of restorative justice (which had lasted 18 months). The researchers had no role in the operationalization of a ‘just and learning culture’ nor its practical implementation. They became involved—for the purpose of this paper—to assess its effects.

Over two separate periods of in total nine full days, researchers were present at trust headquarters as well as various sites. They were given unfettered access to accounting records, policies and procedures, as well as staff members themselves. Staff interviewed included Mersey Care’s CEO, Executive Director of Workforce, Head of Health and Well-Being, Deputy Director of Workforce, Head of the Finance team, Business Intelligence team, Strategic Advisor Digital Programmes, Staff Side Chair, Deputy Medical Director, Strategic Organizational Effectiveness Lead and Head of Organizational Effectiveness and Learning. The aforementioned staff includes members who worked directly worked with the sharp-end of the organization before and during the implementation of restorative practices. Also included are those that recognized the retributive culture and those who instigated and drove this cultural change within the organization. During these interviews, the researchers focused on understanding the organization’s journey through an (ongoing) cultural change and its perceived effects by the staff. The data analysis of staff absenteeism, disciplinary cases etc. was performed after correcting the data for known changes in the organization (such as acquisitions) to make the yearly numbers comparable. The costs analysed were based on annual accounts split per division and corrected for inflation and for acquisitions. The cost model was validated with Mersey Care staff before the savings calculations were made. The associated costs for making the changes have been included as part of the total operating costs of the organization and are therefore reflected in the economic analysis. The policies assessed for this study were HR01 Disciplinary Procedure; HR07 Management of Attendance; HR37 Supporting Colleagues; and SA03 Reporting, Management and Review of Adverse Events.

3. RESULTS

3.1. Staff Experience

During the interviews with Mersey Care staff, and following up with the analysis of the data such as disciplinary cases, incident reporting etc., we were able to identify numerous intangible benefits resulting from the implementation of the just and learning culture at Mersey Care. Below are examples of staff experience benefits that have been instigated or enabled by the organizational culture change:

- Increase in good faith and sensemaking
- Building trust within the different levels of the organization and also for the system
- Staff feel more enabled and are aware that the system should be in place to enable them to perform their best
- Awareness of a just and learning culture within the organization helps diffuse stressful situations and restore calm as staff knows things are changing
- An understanding that there is no compassion for patients without compassion for staff
- Increase in compassionate leadership
- Increase in psychological safety within teams
- Increase in understanding the relationship between teams' psychological safety and patient safety
- No knee-jerk reaction to unexpected events
- Prioritizing safety, physical and psychological, over all else (while “safety first” is a common notion in high-risk places, a culture that truly accommodates for it is a different goal)
- Reduction in psychological stress
- Staff feels more engaged, open and able to speak up
- Increased motivation
- Changing perspective around accountability and human error
- Tendency to find a local resolution
- Increased sense of personal learning among staff
- Increased staff engagement with senior leaders
- Recognizing 2nd victims and providing support
- Unblocking specific barriers that were affecting the staff's ability to work in-line with Mersey Care's leadership programs
- Making the process of special payments faster, thereby reducing psychological stress for the involved parties
- An open and accommodating work environment that facilitates honestly and learning
- Increase in morale and job satisfaction

While not all, many of the above benefits can be substantiated by (cost) data analysis to demonstrate the tangible and economic benefits generated by restorative practices. The next sections detail the same. In these descriptions we have endeavoured to report relative rather than absolute numbers to nullify scaling effects. Financial data has been corrected for acquisitions and inflation. In other cases, we assume that the volume of staff and activities during the represented time-period stay more-or-less the same.

3.2. Tangible (non-economic) Effects of Restorative Practice

All the data was corrected for known changes in the organization, like acquisition of several smaller institutions through the years. This was done to make the yearly data comparable against constant staff numbers to assess the effects of restorative interventions.

The implementation of restorative practice at Mersey Care has improved the quality of employment for many staff members. The just and learning culture has had a strong downward effect on the number of suspensions and disciplinary cases. In the period from April 2014 until March 2018, the disciplinary and suspension cases for the two operational units at Mersey Care was reduced from 66 before to 37 after the introduction of restorative practice. The just and learning culture has also led to an increase in reporting adverse events of between 7% and 18% per year from 2014 to 2017. We assume that the actual number of incidents occurring during the represented time-period stays more-or-less the same so that the increase in reports signals a more open and trusting culture.

In a just and learning culture where trust, compassion and good faith have increased it is expected that employees feel more encouraged to seek help. An increase in staff coming in for support for face to face counselling has been determined after the introduction of restorative justice: from an average of 283 requests per year in 2014 and 2015 to an average of 378 per year for 2016 and 2017. Similarly, in the last two years after restorative practices were introduced, there is a reduction in issues presented regarding bullying, career, formal procedures, health, job situation, employment, trauma and violence/assaults.

Absence due to illness includes work-related and personal reasons for reporting absence. In a just and learning culture, we expect three effects that influence absenteeism:

- Less work-related pressure and more support from staff due to the trust and compassion, possibly leading to a reduction in stress-related absenteeism.
- Less reluctance to report sick for work when justified due to less work-related pressure and more trust leading to an increase in justified absenteeism.
- More support from the employer to reduce the duration of the absence, leading to a reduction in absenteeism.

The net effect is expected to be a reduction in absenteeism. Indeed, with the introduction of a just and learning culture, we see that there is a drop-in absence due to illness and the previously increasing trend decelerates. The total effect is initially 0.5% point and grows to 1% point in 2017. This data has been corrected for acquisitions as well as seasonal trends exhibited by sickness reports which are mainly during the winter months. We have excluded maternity leave, (un)authorized absence and other types of absences unrelated to sickness.

It is expected that as a result of the roll-out of the just and learning culture, staff retention is improved, and turnover is reduced. The data on staff turnover is quite volatile but since early 2015 the reduction is visible, as shown in Figure 1.

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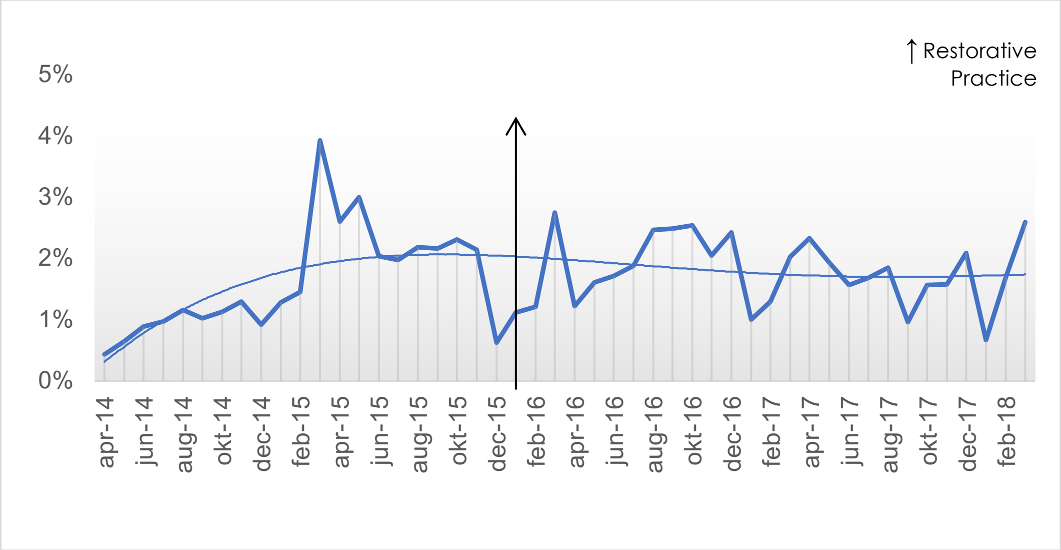

Figure 1: Total staff turnover rate

This data excludes all retirements and has not been corrected for acquisitions. Note that Mersey Care Trust is participating in the NHS Retention programme and has already been focused on improving staff retention.

3.3. Economic Effects

As shown above, the implementation of restorative practices at Mersey Care has generated various benefits. The total cost base of Mersey Care in fiscal year 2017/2018 is approximately £ 250 million[†]. Of this around 70% are costs for salaries. To enable a fair comparison with preceding years the following corrections have been made:

- Acquisitions have been excluded that Mersey Care has acquired over the last few years.
- The costs have been corrected for inflation using the Consumer Price Index (CPI) in the United Kingdom.

Table 1 shows the corrected total costs and salary costs for the past four fiscal years at Mersey Care.

Table 1 Total costs and salary costs – raw data and corrected data

	2014/2015	**2015/2016**	**2016/2017**	**2017/2018**
TOTAL OPERATING COSTS	£ 204 mio	£ 211 mio	£ 256 mio	£ 272 mio
TOTAL SALARY COSTS	£ 150 mio	£ 151 mio	£ 163 mio	£ 198 mio
% SALARY COSTS OF OPERATING COSTS	74%	72%	64%	73%
TOTAL OPERATING COSTS (corrected for acquisitions)	£ 204 mio	£ 211 mio	£ 228 mio	£ 216 mio
TOTAL OPERATING COSTS (corrected for acquisitions + inflation)	**£ 212 mio**	**£ 220 mio**	**£ 235 mio**	**£ 216 mio**
TOTAL SALARY COSTS (corrected for acquisition)	£ 150 mio	£ 151 mio	£ 139 mio	£ 154 mio
TOTAL SALARY COSTS (corrected for acquisition + inflation)	**£ 157 mio**	**£ 157 mio**	**£ 143 mio**	**£ 154 mio**
% SALARY COSTS OF OPERATING COSTS (corrected)	**74%**	**72%**	**61%**	**72%**
TOTAL OPERATING COSTS (corrected & 16/17 impairment costs smoothed out)	**£ 212 mio**	**£ 220 mio**	**£ 218 mio**	**£ 216 mio**
% SALARY COSTS OF OPERATING COSTS (corrected & 16/17 impairment costs smoothed out)	**74%**	**72%**	**66%**	**72%**

A one-time cost for impairment was taken as part of operational costs in the fiscal year 2016/2017 and is unrelated to labour costs and restorative practice and has therefore been smoothed out in the bottom two rows of the table. The salary cost is the annual gross basic pay with no employer contributions or employee deductions. This figure does not include annual leave allowance and neither does it account for allowances paid in addition to basic pay, which will include shift allowances and 'lead' payments payable to staff who work in secure settings. This data also excludes other indirect labour costs such as staff education and training etc.

The average salary cost in fiscal years 14/15 and 15/16 (£ 157 mio) is higher than the average in fiscal years 16/17 and 17/18 (£ 148 mio). This signifies a reduction of about £ 9 mio or £ 4 mio per year after correction of inflation, acquisitions and anomalies that coincides with the introduction of a just and learning culture in 2016. A general reduction may be expected due to productivity increases, and another part of this reduction is justified below for reduced illness leave and less 'suspension with pay'.

[†] In April 2018 this has grown to £ 360 million.

As explained above, an improvement in absence due to illness of at least 0.5% point has coincided with the introduction of a just and learning culture to at Mersey Care after correcting for acquisitions and seasonal trends. This should equal an economic value of 0.5% of the total labour sum or £ 500,000. However, the sickness cost data shows a slightly more nuanced picture, perhaps because the absence due to sickness shifts from lower paid wage scales to higher bands. These expenses are £ 87,000 more in the year 2015/2016 vs the previous year, whereas in the fiscal year 2017/2018 vs 2016/2017 we see total savings of £ 19,000. The difference according to this estimate amounts to about £ 110,000 rather than £ 500,000. The total trend for 'suspensions with pay' shows a clear reduction to coincide with the introduction of restorative practices as reported above, amounting to approximately £ 50,000 per annum.

Other savings that coincide with the introduction of a just and learning culture include legal costs and termination fees, which are additional to the savings in salary costs. There is a significant reduction in the number of disciplinary cases and suspensions coinciding with the introduction of a just and learning culture at Mersey Care, leading to a reduction in legal costs by £ 270,000 from 2016/17 to 2017/18, where previously legal costs were actually increasing. These include all expenditure on solicitors' fees across the organisation and corporate negligence costs. Similarly, termination costs have been significantly reduced by about £ 700,000 after the introduction of a just and learning culture, exclusive of Mutually Agreed Resignation Schemes costs.

In summary, after corrections for inflation and acquisitions, we have found that salary costs improved around 2016 when the just and learning culture was introduced. About £4 million per annum (2.2%. of total costs) savings were realized in staff costs, coinciding with the introduction of restorative practice. The savings are in part due to higher productivity, as well as reduced illness leave and less 'suspension with pay'. Additionally, savings of around £ 1 million in legal and termination costs have been identified to coincide with the introduction of the just and learning culture.

We conservatively attribute half of that savings to the introduction of a just and learning culture itself, and the other half to non-related factors. Using this assumption, we estimate the total economic benefit of restorative practice in the case of the Mersey Care NHS Foundation Trust to be about £ 2.5 million. This amounts to a meaningful saving as it is approximately 1% of the total costs and 2% of the labour costs. These estimates are based on a relatively short window after the introduction of restorative practice, and it remains to be seen whether these savings can be sustained.

4. DISCUSSION AND CONCLUSION

Implementation of restorative justice in Mersey Care has noticeable and apparently uniformly beneficial consequences for staff and organization alike, and also shows economic benefits. The intangible benefits include a downward effect (as expected) on the number of suspensions and disciplinary cases, an increase in staff coming in for support for face to face counselling, a reduction in absence due to illness, and improved staff retention. The economic effect is a meaningful saving of approximately 1% of the total costs and 2% of the labour costs. In the example of Mersey Care we see that after the move from a retributive just culture to a restorative justice, the initial reluctance on people to come forward with bad news is overcome, as was suggested by the literature (Dekker & Hugh, 2010; Dekker & Laursen, 2007).

While it would have been valuable to interview the sharp-end of the organization directly, the perspective from the managerial end is equally valuable especially in the case where the organization has recognized the gap between staff experience and the perception of it. These interviews accommodated for the staff to share their personal journey during the organizational culture change and speak openly about their experiences. Not only was this achieved, the interviewees appeared forthcoming, positive about the cultural change and motivated to continue. During the interviews, researchers were also able to identify some obstacles in the mobilization of this cultural change. These included an initial level of distrust from all staff to come forward and share their experiences without fear of blame. This was overcome by increased engagement of the managers with their staff, continued persistence and setting examples by doing things differently. Another obstacle was the involvement of middle-managers in the cultural change. While the researches did not investigate this further, it seemed to stem from the complicated tasks of middle-managers that include being a bridge of coordination between both ends of the organization.

The estimates of this study are based on a relatively short window after the introduction of restorative justice, and it remains to be seen whether these savings can be sustained for a longer period. Given the unique setting, no benchmark information is available to cross-check our estimates for the economic benefit of restorative practice. Some important goals of restorative justice, however, have already been achieved, including moral engagement of stakeholders, reintegration of the caregivers into his or her community of practice, emotional healing of those affected by the incident, and, ultimately, organizational learning and improvement.

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ORIGINAL ARTICLE

Restorative just culture significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses

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ABSTRACT

Objective: Matching safety and quality improvements to the complexity of healthcare, Gold Coast Mental Health and Specialist Services implemented a new response to clinical incidents: the Gold Coast Clinical Incident Response Framework (GC-CIRF). It utilises a Restorative Just Culture (RJC) framework and Safety II principles. This paper evaluates its impact.
Methods: Staff surveys measured perceptions of just culture and second victim experiences. Quality of recommendations were compared before and after implementation. For the 19 incidents that occurred after the implementation of GC-CIRF, audits of the review processes were undertaken, measuring several components.
Results: Results show significant improvement in staff perceptions of just culture and second victim experiences. Review of incident review data showed several shifts in line with Safety II and RJC. The process audit demonstrated inclusion of a broad range of stakeholders, and significant improvements in the quality and strength of recommendations.
Conclusions: Embedding RJC and Safety II concepts into the incident review process is associated with improved measures of culture and review outputs. The integration of Safety II concepts and support of cultural shifts will require further work and committed leadership at all levels.

Key Words: Restorative just culture, Just culture, Zero suicide framework, Clinical incidents, Safety II, Resilient healthcare, Complex systems, Second victim, Human error and patient safety, Root cause analysis

1. INTRODUCTION

Current approaches to improving healthcare safety and quality are not unequivocally successful.[1–3] One reason is that our growing understanding of the complexity of healthcare is yet to be adequately reflected in our approaches to adverse event investigation and in our safety and quality improvements.[4,5] Seeing complex systems as componential and linear ("Safety I"[6]), these approaches tend to reduce an ad-

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verse event to a "cause' or a broken part that can be fixed with a policy, rule or poster.[7,8] In mental health it can drive restrictive practices, risk secrecy and underreporting because of the backward-looking accountability of traditional, retributive just cultures that are organized around individual actions, transgressions and consequences.[9–12] In contrast, openness about potential harm and psychological safety allowing for all parties to tell their stories can provide a strong driver for learning and improvements[13] and has been found to be associated with lower mortality rates.[14]

Restorative Just Culture (RJC) sees safety ("Safety II") coming from the resilience and adaptations to respond to challenges[15,16] even if these fall outside the scope of design, training or quality initiatives.[17] Forward-looking accountability explores the impacts and needs that result from an incident, and the obligations on all stakeholders to improve safety according to their roles and responsibilities.[18] RJC promotes healing, learning and quality improvement by asking what needs to be done to set people up for success, including consumers, families, clinicians and organizational stakeholders.[19] It tends to capture the complexities of both "causes" and improvements because of the broader, forward-looking conversations it engenders.[20] This means understanding why things mostly go well even under varying conditions, and identifying and enhancing the adaptive capacities in people, teams and processes that make this possible.[21] For example, Turner et al.[22] outlined the benefits of a move away from traditional approaches of responding to critical incidents in the context of implementing a Zero Suicide Framework (ZSF) within a health setting,[23] which can increase ownership of the people involved in embedding solutions,[24,25] while also noting the broader applicability of RJC.

1.1 Gold Coast Clinical Incident Response Framework (GC-CIRF)

Gold Coast Mental Health and Specialist Services (GCMHSS) is a directorate within the Gold Coast Hospital and Health Service (GCHHS) and provides integrated mental health and drug and alcohol services across all ages to an estimated population of 600,000 people. Turner et al.[22] described the Gold Coast Clinical Incident Response Framework (GC-CIRF) using RJC and Safety II principles, structured around building culture, healing and "learning anything" rather than a narrow linear focus on cause close to the frontline or proximal to the incident, leading to recommendations of high quality and strength.[26] It asks stakeholders who is impacted, what do they need, and who has the obligation to meet that need. The following components of GC-CIRF were implemented at GCMHSS and are summarised in Figure 1:

- Responding to consumers, carers and families using the STARS Tool[27] (Sorry, Tell me about it, Answer questions, Response, Summarise);
- Responding specifically to staff[28] based on Scott's[29] three-tier model of volunteer peer support with psychological first aid, Denham's[30] 5 rights and the GRACE model of compassion;[31]
- Weekly triage process of clinical incidents to assess the need for formal review and through what methodology. Root Cause Analyses (RCAs) are typically avoided as they use a team entirely external to the treating team;
- Comprehensive Incident Review Process consisting of: (1) immediate response by the responsible consultant and team leader, (2) engagement with the family about their understanding, concerns, questions, and recommendations, (3) review of the "clinical care pathway" including timeline, work as done, areas of good practice, and interactions using a constellation diagram,[32] (4) validation of findings, lessons and recommendations, (5) reflection on feedback from leadership and to development of action, and (6) report endorsement and open disclosure with family;
- Training of clinicians, leaders and facilitators in incident review, RJC and disclosure;
- Guide provided to make recommendations SMARTER (Specific, Measurable, Accountable, Realistic, Timely, Effective/Evaluation, Reviewed) and strong (using hierarchy of hazard controls);[26]
- Continuous quality improvement[23] including assessment of all comprehensive reviews and recommendations;[33]
- Gathering feedback via semi-structured interviews from all stakeholders, including staff, family and carers.

2. METHODS

The GC-CIRF evaluation components are summarised in Figure 2. GC-CIRF was evaluated by seeking evidence of:

(1) Improvement in Just Culture and Second Victim experiences. Assessed via the Voice of Staff Survey, introduced at GCMHSS in 2016 (and repeated in 2017 and 2019). The survey was distributed to all clinical staff across Gold Coast Mental Health and Specialist Services. 2017 and 2019 included the Just Culture Assessment Tool[34] and Second Victim Experience and Support Tool.[35] Results of the Voice of Staff Survey were analysed, comparing outcomes from 2017 (N = 297, 45% of GCMHSS workforce) and 2019 (N = 315, 50% of all workforce).[36]

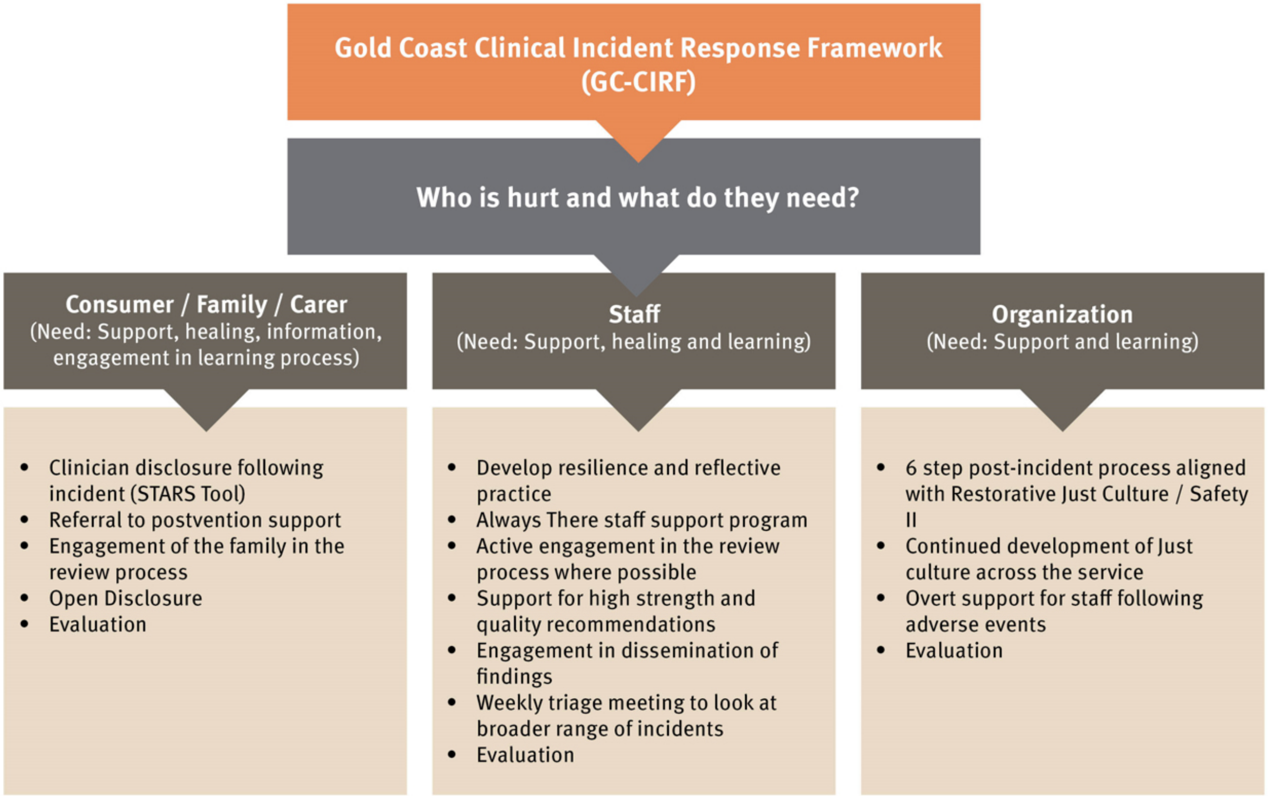

Figure 1. Gold Coast Clinical Incident Response Framework (GC-CIRF)

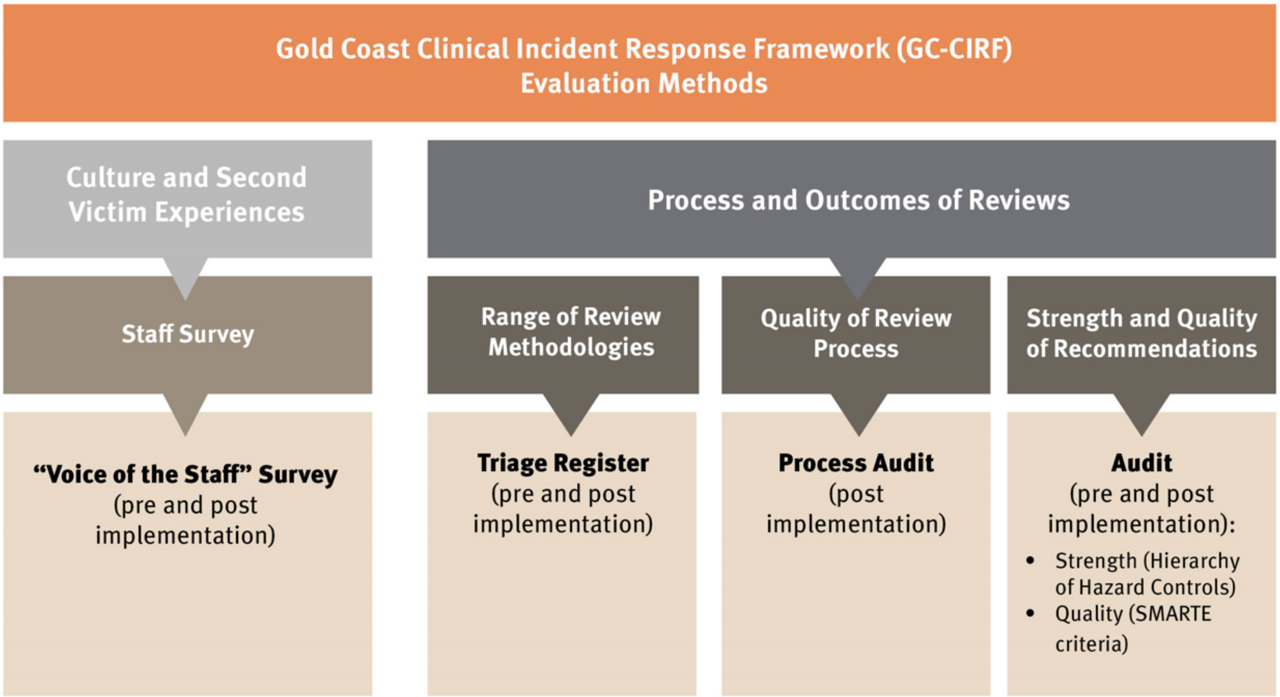

Figure 2. Gold Coast Clinical Incident Response Framework: Evaluation methods

(2) A service that is now learning from a wider range of incidents and with a greater inclusion of stakeholders. Assessed via a register at GCMHSS on all incidents discussed at weekly triage meetings with the leadership of GCMHSS, and records of the type of incident and review, inclusion of team members and leadership, and family or carer's input.

(3) The quality of the incident review process. There were 19 incidents that were reviewed in the 1 year post implementation of GC-CIRF. These were anlaysed using an adaptation of tool of the Dutch Healthcare Inspectorate,[33] which contained 44 questions on immediate response, review process, reconstruction, analysis, conclusions, recommendations, and follow through/close the loop.

(4) Improvements in the quality and strength of recommendations of post-incident reviews. An audit was undertaken to review the quality and strength of recommendations of all reviews in the two years prior to the implementation of GC-CIRF (October 2016 – October 2018; N = 39 incidents, producing 72 recommendations), and in the 12 months after (November 2018 – October 2019; N = 19 incidents, producing 75 recommendations).[37–40] The strength of recommendations was based on a hierarchy of hazard controls[41] and relates to the likelihood of its implementation preventing the unwanted event where "weak" relies on individual behaviour (policy, procedure, rules, warnings), "moderate" targets systems but remains reliant on individual vigilance (e.g. software enhancements, elimination of distractions, audits or increased staffing); and "strong" simplifies processes, strengthens clinical governance or standardises care. Quality was assessed using "SMARTE" criteria,[41] which included domains of specific, measurable, accountable, realistic, timely and effective/evaluated. Two auditors independently assessed 10 incident reviews, cross-collated results to establish inter-coder reliability and engaged a third auditor when the analysis was ambiguous.

Descriptive anlayses were performed for all four study components, and changes in the results between the period before and after the implementation of GC-CIRF were anlaysed using *t*-tests and Chi square tests. Statistical significance was set at $p < .05$. All analyses were conducted using the IBM SPSS 25.0.

3. RESULTS

3.1 Voice of the staff (VOS) survey

In 2017, 20% of GCMHSS staff felt blamed for adverse events, and 35% feared consequences of involvement in an event, which caused psychological and physical distress and feelings of inadequacies in patient care ability. A third of staff reported that the organisation did not show concern for their well-being following an incident.[36] Statistically significant changes were seen in the 2019 survey (at level of $p < .05$) including:

- Fewer staff reported being afraid of disciplinary actions (27.3% vs. 34.9%) or of being blamed when involved in an event (16.5% vs. 20.3%);
- More staff expressed trust in the hospital to handle these events fairly (40.3% vs. 25.3%) and believed that the hospital sees clinical incidents as opportunities for improvement (56.8% vs 43.2%);
- More staff felt that the organisation understands they may need help with effects of their involvement in incidents (61.1% vs. 54.9%), and agreed or strongly agreed that the organisation offers resources in overcoming these effects (62.2% vs. 42.2%); and
- 50.0% disagreed that the organisation does not show concern for the well-being of staff involved in incidents (increase from 39.3% in 2017).

Importantly, a statistically significant association was noted between the staff's ability to actively participate in the incident review process and more positive perception on all domains of just culture, less distress and negative impacts on their professional self-efficicacy following involvement in incidents, perceived higher levels of support from work and non-work related sources, and lower turnover intentions and reported absenteeism.[36]

3.2 Triage data

Prior to 2018, the primary focus of GCMHSS (in line with the broader health service) was on reviews of reportable events, and largely for consumers meeting the criteria of the suspected suicide of a person with a mental illness who is under the care of a mental health service. Gradually, from 2018, with the introduction of GC-CIRF, a larger range of incidents were considered to undergo a review and thus contribute to a learning process (see Table 1).

Since the implementation of GC-CIRF, just under half of reviewed incidents were classified as SAC1 (incident resulting in death/permanent harm), with the remaining ones classified as either SAC2 (21.1%) or Significant events (31.6%). "Significant Events" were defined by GCMHSS to include events that provided an opportunity for significant learning but were not reportable events and included but not limited to suicide attempts and "near misses". A decision to label an event as a Significant Event is made in the GCMHSS Triage Committee.

Table 1. Types of incidents and review methodologies, before and after the implementation of GC-CIRF

	Before GC-CIRF (Oct 2016 – Oct 2018) N = 39		**After GC-CIRF (Nov 2018 – Oct 2019) N = 19**	
	N	**%**	**N**	**%**
Event				
Death by suicide	34	87.2%	8	42.1%
Suicide attempt	2	5.1%	7	36.8%
Death - head injury	2	5.1%		
MHA breach			1	5.3%
Physical deterioration	1	2.6%		
Seclusion			1	5.3%
Unexplained death			1	5.3%
Violence incident			1	5.3%
Classification of Event				
SAC 1	39	100.0%	9	47.4%
SAC 2			4	21.1%
Significant event			6	31.6%
Review Methodology				
HEAPS	33	84.6%	1	5.3%
MHSS Comprehensive Review (Patient Safety facilitated)			14	73.7%
MHSS Comprehensive Review (MHSS facilitated)			4	21.1%
Root Cause Analysis (RCA)	6	15.4%		

Note. MHA – Mental Health Act; SAC – Severity Assessment Code; HEAPS – Human Error and Patient Safety incident review approach; RCA – Root Cause Analysis

The implementation of GC-CIRF also led to greater variation in the methodologies applied in incident reviews, with most reviews using the MHSS Comprehensive Review facilitated by Patient Safety (73.7%), followed by MHSS-facilitated Comprehensive Reviews, and only one incident undergoing the HEAPS review. No incidents were reviewed using the RCA methodology, compared to 15.4% in the period prior to GC-CIRF. Anecdotally, there had already been a deliberate and large move away from RCA approaches prior to 2017, in recognition of the limited learnings that were being identified in RCAs.

Since November 2018, reviews of all incidents included in this analysis produced recommendations (compared to 78.1% in the "before" period, Fisher test $p = .010$), and the average number of recommendations per incident was significantly higher than before the implementation of GC-CIRF (3.9 vs. 1.9; $t(56) = -3.47$, $p = .001$).

3.3 Process audit

Incidents reviewed in the period post implementation of GC-CIRF (N = 19) also underwent an audit of the review process examining 7 dimensions: Immediate response, Review process, Reconstruction, Analysis, Conclusions, Recommendations, and Follow through (see Appendix 1).

In the aftermath of the incident, Clinician Disclosure was offered in 17 and occurred in 15 out of 19 incidents, most commonly 1 or 2 days after the incident. In all incidents, staff were offered support following the incident. The review teams had good multidisciplinary representations, representations from relevant members of the clinical team, trained facilitator and peer clinical experts. Only 2 incidents out of 19 incidents included representatives from external organisations.

Just over half of incidents included in the audit (57.9%) had a record of seeking input from consumers or their carers, or subsequent consideration of their feedback. When feedback was sought, 100% agreed to it, and all reviews considered the feedback.

There is evidence of regular completion of different methodologies used to identify underlying causes or contributing factors of the incident, such as Chain of events, Human factors analysis or Diagramming. All incident reviews considered adherence to relevant guideline/protocols, and in 73.7%, reports articulated whether the care provided was in line with evidence-based practice.

Evaluation of conclusions confirmed that contributing factors, existing service developments aimed at addressing similar issues, and examples of high-quality care were identified in almost all incidents. Similarly, all incident reviews had articulated recommendations that followed the SMARTE framework.

In regard to “Follow through” actions, just under half of incident reviews were completed within the appropriate time frame, and in only 8 out of 19 cases, feedback on the incident review was provided to the consumers or their carers through the Formal open disclosure (FOD). While this accounted for less than half of reviewed incidents (42.1%), it is worth noting that FOD was offered to 100% of SAC1/reportable events (and all but one family accepted). On the other hand, none of the other incidents received FOD, which is due to the fact that at the time of conducting this study, processes were in place to support FOD for reportable events but not for the other Comprehensive Reviews (non-SAC1 incidents/events) undertaken. Processes have subsequently been updated to ensure FOD is also offered to consumers and families for non-SAC1 incidents.

3.4 Audit of recommendations

Quality of recommendations was assessed against the SMARTE criteria, as shown in Table 2.

Table 2. Quality of recommendations, before and after the implementation of GC-CIRF

	Before GC-CIRF (Oct 16 – Oct 18) N = 72		**After GC-CIRF (Nov 18 – Oct 19) N = 75**		**Difference (*p* value)**
	N	**%**	**N**	**%**	
Specific					
The aim of the proposed recommendation is clear.	56	78.9%	70	93.3%	.011*
Measurable					
The recommendation demonstrates an impact on process and outcomes.	48	67.6%	57	76.0%	.259
The recommendation includes a substantive measure of performance improvement.	0	0.0%	6	8.0%	.028*
The recommendation includes an aspirational target.	3	4.2%	3	4.0%	.945
Accountability					
There is a single point position of accountability responsible for follow-through of recommendation.	69	97.2%	74	98.7%	.528
Realistic					
Recommendation is achievable within available resources, is likely to be accepted and implemented.	65	91.5%	72	96.0%	.264
There is evidence from the narrative that there are issues identified that have not resulted in recommendations.	2	7.7%	4	25.0%	.120
These issues are being addressed by alternative means.	1	3.8%	4	25.0%	.096
There is evidence that review team did not propose a recommendation as they were inhibited by concern of the ability to implement.	0	0.0%	1	6.7%	.279
Timely					
Recommendation has a clear timeline for implementation.	68	95.8%	74	98.7%	.258
Effective/Evaluated					
Recommendation will actually make a difference to the identified issue.	46	64.8%	60	81.0%	.039
Evidence base for the recommendation is cited.	4	5.6%	8	10.7%	.268
There is a plan to determine if the recommendations are implemented.	46	64.8%	72	96.0%	< .001**
There is a documented plan to evaluate effectiveness of the recommendation to address the identified issue.	5	7.0%	17	22.7%	.008*
The evaluation embedded into business as usual.	4	5.6%	9	12.0%	.205

Note. * Statistically significant at level $p < .05$; ** Statistically significant at level $p < .001$

Results in Table 2 show that all indicators of the quality of recommendations have improved since the implementation of GC-CIRF, though not all reached a level of statistical significance. Most notable improvements are seen in the domain of Effectiveness/Evaluation, with 96.0% of recommendations including a plan to determine if the recommendation has been implemented (increase from 64.8%; $p < .001$), and a plan to evaluate the effectiveness of the recommendation (22.7% vs. 7.0%; $p < .05$). Further, auditors considered 81.0% of recommendations made since GC-CIRF as making a difference to the identified issue (increase from 64.8%; $p < .05$). The implementation of GC-CIRF has contributed to the development of more specific recommendations with clearer aims (noted in 93.3% of cases, increase from 78.9%; $p < .05$), and more measurable recommendations that included a substantive measure of performance improvement (noted in 8.0% of cases, but in no cases prior to November 2018).

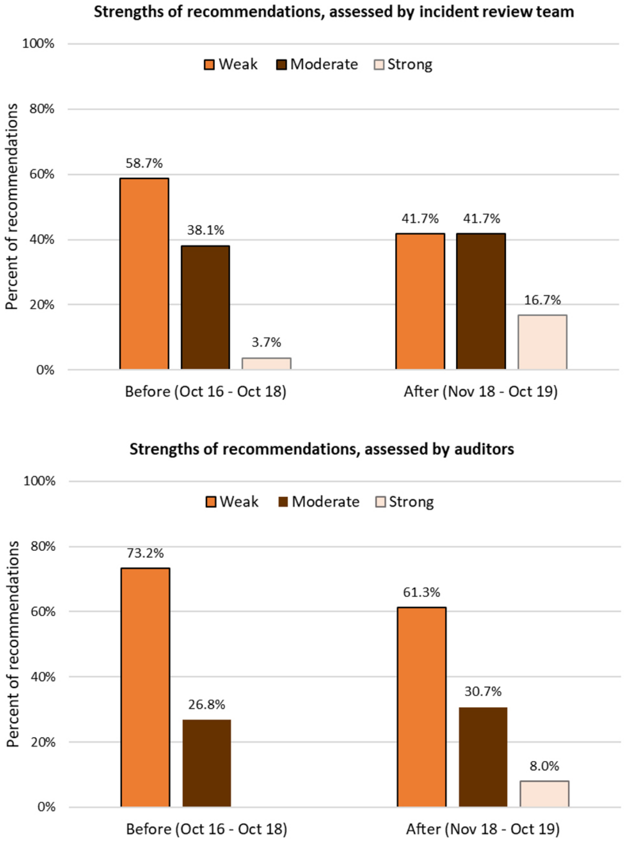

Figure 3. Strength of recommendations before and after the implementation of Clinical Incident Response Framework (GC-CIRF), as assessed by incident review teams and auditors

We also analysed changes in the strength of recommendations, as rated by the teams developing the recommendations as part of the incident review, and as rated by the auditors participating in this study (see Figure 1).

Comparison of the ratings between the two groups shows that in both time periods, the incident review teams assessed recommendations as being stronger than those of auditors. Before the implementation of GC-CIRF, review teams considered 58.7% of recommendations to be of weak strength (compared to 73.2% according to auditors' rating), and after GC-CIRF, teams assessed 16.7% of recommendation as strong (which was double the percentage of recommendations rated as strong by the auditors); however, these differences were not statistically significant. The implementation of GC-CIRF has had a significant impact on improving the strength of recommendations, when assessed by both the review teams ($\chi^2(2) = 7.976$, $p = .019$) or study auditors ($\chi^2(2) = 6.644$, $p = .036$). It is worth noting, however, that despite these improvements, the majority of recommendations made after November 2018 (61.3%) continues to be rated as weak by the auditors, with a very low percentages considered to be strong (8.0%).

4. DISCUSSION

Results demonstrated improved just culture and second victim experiences, performance of reviews of a much larger range of incidents and near misses, a deeper understanding of what is going well (in line with Safety II), improved stakeholder engagement (in line with RJC), and an increase in number, strength and quality of recommendations. This occurred in the context of a move away from RCAs and greater involvement of the treating team, and following the introduction of a staff peer responder program, "Always There".[28] This aligns with findings and recommendations from a recent review of the personal and professional impacts of loss through suicide.[42]

There were, to our knowledge, no other policy changes, adoptions or cultural shifts that may have occurred and could account for the effects we have observed.

The staff survey currently used at GCMHSS comes from traditional Just Culture principles rather than RJC.[34] This calls for an updated survey, which should also better capture second victim experiences and support.[35]

Notwithstanding significantly improved quality and strength of recommendations after the implementation of GC-CIRF, few were classified as "strong". Yet there were substantial changes away from modifying procedures and rolling out education, and towards more resilient responses such as enhancing team coordination, engaging with families, and simulation exercises to understand work as done.[43] While these may not be deemed "strong" within a hierarchy of controls framework, they can be much more desirable given our complex systems. Combinations of several weaker recommendations may also be beneficial but could not be identified through from the individual ratings of the present study.

The "learn anything" principle aligned with feedback from families about the review process. Families frequently raise issues about care and engagement, or suggest improvements to the system that may appear unrelated,[4] but can address issues including demand and capacity misalignments which could have proactively reduced risk rather than only responding once harm had occurred.

The audit tool, although adapted from Leistikow et al.'s[33] original format, still proved limited in its consideration of Resilient Health Care (RHC) or Safety II principles. Yet, it was a useful quality improvement tool in identifying gaps in performance, such as the recognition for the need for open disclosure following non-SAC1 reviews. Additional specific Safety II and RJC approaches should be further embedded into GC-CIRF review processes, such as those previously noted by Anderson and others.[4,43] This literature identifies issues such as increasing staff awareness of the concepts of Safety II and RJC; remaining open to a range of possible learnings and actions; improving understanding of the misalignments between demand and capacity and work as done, and trade-offs and adaptations, including what is working well and what might be adding risk; supporting actions that will enhance team work, coordination, and diversity of opinions; and considering whether findings are applicable to other areas of the organization.

The process audit tool applied for the purposes of this evaluation, is used as part of routine quality improvement typically completed by only one rater. We acknowledge this to be a limitation, which was partly mitigated by the fact that the same person completed all process audits included in our study and they were an experienced clinician. Also, the process audit tool allowed for a measurement of the presence of processes felt to be important in implementing this new approach to responding to incidents, however it does not give us a comparison with processes that were occurring prior to the implementation. While this would have added further valuable information, performing those audits on past reviews was outside of the scope and resources of this evaluation.

As described, there are limitations to the effective measurement of quality and strength of recommendations, with some differences in their description in the literature. A more standardised approach was achieved through the use of brief descriptors for the domains and sub-domains of quality, and a process of development of inter-coder reliability for the auditors.

Further limitation of our study is the absence of a measure of perceptions of GC-CIRF processes by families and carers. While anecdotal feedback has suggested that this process was well received, it is important for any future studies in this area to systematically collate and evaluate experiences of all stakeholders.

5. CONCLUSIONS

Bringing about cultural change including a Just Culture is recognised to be very challenging.[44] While this paper describes an evaluation of the impacts of implementing a range of components of this framework, with demonstrated improvements in culture and other measures, it gives little insight into any critical success factors in terms of the implementation processes or leadership actions that supported these changes. There is of course no substitute for continued advocacy towards all levels of leadership, providing support and endorsement for approaches to incidents that incorporate Safety II and restorative just culture approaches.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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“Zero Suicide” – A model for reducing suicide in United States behavioral healthcare

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Abstract

Suicide is a serious public health concern in the US, especially for those served in outpatient behavioral health. Over the past decade, there has been a dramatic increase in US suicide rates, and a significant proportion of those dying by or attempting suicide were treated in outpatient behavioral healthcare within the prior year. In response, the US Action Alliance released the National Strategy for Suicide Prevention in 2012, a key tenet of which is the “Zero Suicide” (ZS) model. ZS provides resources for administrators and providers to create a systematic approach to quality improvement for suicide prevention in healthcare systems via seven essential elements (Lead, Train, Identify, Engage, Treat, Transition, Improve). In this paper, we describe the ZS model, as well as our operationalization of the model in an NIMH-funded study in ~170 free-standing New York State outpatient behavioral health clinics, serving >80,000 patients. This study is the largest implementation and evaluation of the ZS approach ever conducted in outpatient behavioral health. Evaluation of ZS implementation in “real-world” clinical settings will provide crucial insight regarding broader dissemination and inform how to best adopt empirically-supported care for suicidal patients in outpatient behavioral health, thereby reducing tragic and preventable loss of life.

Keywords

Zero Suicide; implementation; clinical best practices; outpatient behavioral health

Worldwide, someone dies by suicide every 40 seconds. More than 800,000 people die by suicide annually, and for every death there are an additional 10-25 attempts (World Health

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Organization [WHO], 2017). In the United States, suicide is the 10th leading cause of death, and suicide rates are 22% higher than global averages (Center for Disease Control and Prevention [CDCP], 2017). U.S. suicide rates increased a staggering 25% over the past decade while other leading causes of death declined (CDCP, 2016). In 2016 alone, nearly 45,000 Americans died by suicide and one million made attempts (CDCP, 2017). Given the scope of this public health issue, the need for prevention has been repeatedly affirmed (U.S. Department of Health & Human Services [U.S. DHHS], 2011; 2012).

In response to this enormous public health issue, the National Action Alliance for Suicide Prevention (NAASP) was established in 2010. The National Action Alliance is a public-private partnership advancing the National Strategy for Suicide Prevention, a report published in 2012 by the U.S. Surgeon General and partnerships with the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, the Suicide Prevention Resource Center, and a task force consisting of national and international suicidology experts (U.S. DHHS, 2012). While the National Strategy for Suicide Prevention advocates a comprehensive approach to suicide prevention involving community, school, primary care, emergency departments, inpatient units, and outpatient behavioral health settings, the National Action Alliance has identified healthcare systems as particularly critical venues for suicide prevention because suicidal patients often receive services in the period leading up to their attempt or death, providing an opportunity for identification and connection to treatment (U.S. HHS, 2012).

Unfortunately, suicidal patients often “fall through the cracks,” due in part to a fragmented American healthcare system (SPRC, 2017). Unlike in Norway, healthcare is not typically provided or overseen by the government in the United States (except for persons with significant disabilities or those living in poverty and requiring government assistance), and the majority of healthcare facilities are independent and privately-run. The majority of individuals pay for their health insurance premiums out-of-pocket, either through state-specific or federal insurance marketplaces or through group plans administered by private insurance companies that are offered and subsidized by their employers. While the Affordable Care Act of 2010 mandated that all Americans must carry health insurance, millions of individuals still struggle to access adequate, affordable healthcare (American College of Emergency Physicians, 2017). Further, idiosyncratic variations exist in insurance coverage, and different often-unaffiliated facilities are responsible for the care of physical, behavioral, and substance-related concerns; as a result, poor continuity of care and communication among providers is common (U.S. DHHS, 2011).

Even those receiving care often do not receive what is required to prevent or resolve suicidal crises. Between 20-80% of all persons dying by suicide in the U.S. accessed care in the year prior to their death (Ahmedani et al., 2014; Luoma, Martin, & Pearson, 2002), and nearly half within 30 days (Ilgen et al., 2012; a finding that has been replicated in other nations; Isometsa et al., 1995). While many reasons exist why people receiving services still die by suicide, three potential causes were identified by the National Strategy for Suicide Prevention: 1) detection of suicide risk is inadequate; 2) evidence-based, suicide-specific interventions are not deployed; and 3) intensity of care is not increased during high risk periods (U.S. DHHS, 2012). While great strides have been made in the past ten years in identifying “best practices” for suicide prevention (Brown et al., 2005; Fowler et al., 2012; Jobes et al., 2005; Michel et al., 2017; Michel & Gysin-Maillart, 2015; Linehan et al., 2006; Luxton et al., 2013; Pisani et al., 2016; Posner et al., 2011), a striking gap remains between the development of these innovations and what services the majority of suicidal individuals in the U.S. actually receive. Experts in suicide prevention have long recommended universal screening with validated measures at regular intervals across varied settings to better identify those who may be at-risk for suicide, but the majority of individuals seen in healthcare settings do not receive any screening, let alone frequent screenings using standardized metrics (Posner et al., 2011). The field has also moved away from prediction of who will engage in suicidal behaviors, and shifted to a prevention-oriented approach in which those who are identified as being at elevated risk receive comprehensive suicide risk assessments that weigh distal and proximal risk and protective factors to identify potential fluctuations in suicide risk over time and inform subsequent treatment planning and interventions (Jobes et al., 2005; Pisani et al., 2016). However, the majority of clinicians are not trained in this orientation, many systems rely on risk status for triage, and even those patients who are effectively identified as being at high risk often do not receive specialty or more intensive mental health care.

Beyond best practices in assessment, research has also shown that better understanding of the suicidal state and suicide-specific interventions have shown significant promise in resolving suicidal urges, whereas treating underlying diagnoses alone does not typically resolve suicidal ideation and behaviors (Brown et al., 2005, Linehan et al., 2006; Michel & Gysin-Maillart, 2015). Unfortunately, despite the development of evidence-based, suicide-specific treatments and clinician guidelines (AESHI Working Group, 2018), the majority of clinicians working with suicidal individuals do not have sufficient training in how to provide these interventions or build strong, collaborative relationships with suicidal patients (Brown et al., 2005, Linehan et al., 2006; Michel & Gysin-Maillart, 2015; Michel & Jobes, 2010). In response to these gaps between science and practice, the National Action Alliance sought to provide recommendations for improving suicide care in healthcare systems, especially in regard to adequate procedures for detection of suicide risk, use of evidence-based, suicide-specific interventions, and greater intensity of care, monitoring, and patient engagement during their highest risk periods (U.S. DHHS, 2012). A key method of disseminating best practices in suicide care was the “Zero Suicide” Initiative (ZS; Suicide Prevention Resource Center, 2017; zerosuicide.sprc.org).

The “Zero Suicide” Initiative

ZS is a key component of the National Strategy for Suicide Prevention and priority of the National Action Alliance that aims to bridge gaps in practice. ZS is a strategic framework for creating a systematic approach to suicide prevention and quality improvement in the healthcare system with the aspirational goal of "zero suicides.” The foundational belief of ZS is that suicide deaths for individuals receiving care within health and behavioral health systems are preventable.[1] The few healthcare systems that have implemented and evaluated ZS-like approaches demonstrated notable reductions in suicide deaths (Centerstone, 2016; Hampton, 2010). It must be noted these studies were correlational and preliminary; it is extremely challenging to prove that a reduction of suicides is causally related to a specific suicide prevention effort, and only large-scale, controlled evaluations of ZS procedures will establish their effectiveness. However, reductions of greater than 70% in the year after unveiling ZS interventions are certainly promising. The ZS model provides guidance on how to best implement "best practices" in "real-world" settings. ZS is comprised of seven essential elements for an effective, coordinated system for suicide care; four of these elements focus on how the patient should be treated and the remaining three relate to implementation factors (see Table 1).

The first implementation element, *Lead*, emphasizes the need to engage leadership and administration to create a culture change about suicide prevention. The onus is placed on leadership to put policies in place that foster a transparent, blame-free environment where suicide prevention is a systems issue and not the personal responsibility of individual staff members. This shifts emphasis away from liability or fear toward a safety-focused team approach, wherein identification and improvement of barriers to optimal care are everyone's responsibility. The second implementation element, *Train*, highlights the importance of developing a competent suicide prevention workforce. The ZS model stresses that every member of the workforce (not only mental health professionals) should receive training on the signs of suicide risk and how to interact with suicidal individuals effectively, with different staff roles requiring different competencies. Lastly, the final implementation element, *Improve*, emphasizes the need for data-driven quality improvement. Before implementing new procedures, organizations assess their current clinical practices, attitudes, and training to determine needs and knowledge/practice gaps. Leadership then develops an implementation plan based on identified needs, and employs systemic data collection to evaluate efforts, continually assess progress and model fidelity, encourage accountability, and inform revisions.

In addition to implementation elements, the ZS model also recommends four clinical elements. The *Identify* element provides guidelines for evidence-based screening and assessment of suicide risk for all patients at intake and regular intervals. The *Engage* element ensures pathways to care for patients at elevated risk, and recommends the creation of a personalized Suicide Care Management Plan that includes frequent reassessment, specialized treatment, and greater intensity of clinical contact. The *Treat* element stresses the importance of using evidence-based, suicide-specific interventions, including brief interventions to maintain immediate safety (such as safety planning and means reduction counseling[2]), and longer-term interventions to directly target suicidal thoughts and behaviors. Lastly, the *Transition* element highlights continuity of care and close monitoring

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[1] The authors recognize that the name of the "Zero Suicide" Initiative is somewhat controversial. The initial intent of the National Action Alliance and Suicide Prevention Resource Center in selecting such a moniker was to inspire hope and optimism, and convey the belief that suicide deaths *could* be prevented within healthcare systems. This goal is clearly aspirational and limited to the prevention of suicide within healthcare systems only. Some have raised the concern that the name "Zero Suicide" could foster misconceptions amongst the public or policy makers, who may inaccurately perceive that aspirational goal as being readily attainable, and thus set expectations unrealistically high. Others have suggested that the title could convey the perception that all suicide deaths (not just those occurring outside in healthcare systems) should have been prevented, which could increase guilt and stigma for survivors who have lost loved ones. While these concerns are valid, the "Zero Suicide" Initiative has already been widely disseminated across the United States and internationally (see zerosuicide.org and zerosuicide.sprc.org for more information on the history of ZS). As such, the authors continue to use the ZS name in this manuscript.

[2] The Zero Suicide Academy considers safety planning and means reduction counseling to be engagement strategies used as part of a Suicide Care Management Plan. However, the co-developers of the Safety Planning Intervention (Stanley and Brown, co-authors on this manuscript), considered these brief interventions used to improve engagement and maintain safety throughout treatment.

of suicidal individuals, both between clinical contacts and during care transitions (e.g., hospital or ED discharge, etc.). For more detail, see: http://zerosuicide.sprc.org/toolkit.

A Large-Scale Implementation of Zero Suicide in Outpatient Behavioral Health

While emergency departments (ED) and inpatient units have historically been settings associated with crisis care, outpatient behavioral health is increasingly recognized as a critical venue for improved suicide care. In the United States, outpatient behavioral health clinics are typically freestanding entities that focus on mental health or substance abuse treatment. While these clinics may be in the same healthcare system as primary care or hospital providers, many are independent public or private organizations. While individuals may receive inpatient or residential treatment for particularly severe presentations or times of acute crisis, the majority of care for mental disorders is provided in outpatient behavioral health settings. Suicide rates in these settings are 100 times higher than those of the general population (Brown et al., 2000). At any time, ≈15% of outpatient behavioral health patients endorse suicidal ideation in the past week (Trivedi et al., 2013), 55% report lifetime suicidal ideation, and more than 25% made a suicide attempt (Harkavy-Friedman, 1993). These high rates are particularly alarming since outpatients experiencing suicidal ideation or attempt are more likely to eventually die by suicide (Wenzel et al., 2011). Given that behavioral health patients are seen over a longer period of time than inpatient or ED patients, the opportunities to intervene are greater; thus, improving prevention practices in outpatient behavioral health holds promise for reducing suicide.

As the ZS model is being promoted nationally, the National Institute of Mental Health (NIMH) funded grants evaluating the effectiveness of ZS interventions. Herein, we describe our implementation of the ZS model in New York State (NYS) behavioral healthcare clinics, the largest implementation and evaluation of the ZS model ever conducted. This implementation is a continuous quality improvement project undertaken by the NYS Office of Mental Health Bureau of Evidence Based Services and Implementation Science, with funding from the NIMH to test and evaluate implementation strategies (NIMH grant #: R01-MH112139; PI: Stanley).

NYS as a test system for outpatient ZS implementation

NYS is a strong location for testing implementation efforts, because the state’s size, regional and population diversity, and established administrative databases allow for a large-scale, generalizable evaluation of ZS. While the suicide rate is relatively low, NYS ranks 5th in the nation for number of deaths (CDCP, 2017) given the population density. The suicide rate is also markedly variable across the state – while rates of suicide death are lower than the national average in the populous New York City metropolitan region, almost 50% of counties in NYS have suicide rates higher than the national average, especially in rural northern and western upstate regions. Rates among outpatient behavioral health patients climb even higher (58/100,000 in some counties; NYS Office of Mental Health, 2015). Nearly 45% of those dying by suicide in NYS were seen within a month of their death in an outpatient behavioral health clinic (NYS Office of Mental Health, 2016). The quality of care in New York is also representative of outpatient care across the United States, in that most clinicians have little or no specialized training in suicide-specific interventions, few clinics have established systematic protocols for identifying, treating, and monitoring patients at elevated suicide risk, and no universal system for documenting and sharing information is in place across treatment settings (NYS Office of Suicide Prevention, 2016). Thus, we have aimed to address all of these deficits through our implementation of the ZS model.

Participating clinics

As of April 1, 2017, 177 licensed freestanding or state-operated mental health clinics were participating in this project. Clinics represent 90 provider agencies, over 3500 clinicians, and serve approximately 86,000 Medicaid-enrolled patients each year (see Table 2 for patient characteristics). Clinics elected to participate through a statewide continuous quality improvement project led by the NYS Office of Mental Health Bureau of Evidence Based Services and Implementation Science program and receive a small Medicaid claims-rate incentive (~4%).

AIM-SP clinical procedures

All participating clinics agreed to implement our operationalization of the ZS clinical procedures, called the *Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP;* Stanley, 2017) program of suicide-safer care (see Figure 1). AIM-SP strives to provide a basic level of care for all patients, including universal screening and comprehensive risk assessment on a regular basis for all patients, and engagement of high-risk patients on a Suicide-Safer Care Pathway (SSCP) with specialized care and increased contact.

Assessment for all patients—All patients are screened for suicide risk at intake, quarterly treatment plan review, and as clinically-indicated (i.e., whenever there is an abrupt change in clinical status or if the clinician is concerned) using the highly-validated *Columbia Suicide Severity Rating Scale (C-SSRS*; Posner et al., 2011). At intake, the C-SSRS asks about both lifetime and recent suicidal thoughts and behaviors; subsequent timeframes are since the last administration. Patients also receive a comprehensive suicide risk assessment at intake, after positive screens, or as clinically-indicated, providing broader case conceptualization and creating an individualized profile of chronic/distal and acute/proximal risk and protective factors. Risk assessment is completed in the same session as a positive screen or shortly thereafter.

Intervention and monitoring for patients on the SSCP—If a patient is deemed to be high-risk during assessment, they are placed on the SSCP, a package of enhanced outpatient care that involves frequent reassessment and monitoring, greater intensity of clinical contact, and specialized interventions. Patients are placed on the SSCP if they endorse suicidal intent, plan, or behavior within the past 90 days (i.e., a “Yes” response to any of questions 4-6 on the C-SSRS screener); patients may also be placed on or removed from the SSCP based on clinical judgment. SSCP designation is clearly denoted in the medical record.

Before the patient leaves the initial clinical interaction, clinicians must determine which actions must be taken immediately to keep the patient safe until the next session. This includes administering the 6-step *Stanley-Brown Safety Planning Intervention* (which includes provision of crisis information and means reduction counseling), and may involve including friends or family, if appropriate. Clinicians also provide psychoeducation about the nature of suicide risk, and brief the patient regarding the requirements of treatment on the SSCP and the rationale for these interventions. In subsequent sessions, clinicians construct a treatment plan that directly addresses suicidal thoughts and behavior. If clinicians are trained in suicide-specific interventions, these approaches are recommended; alternatively, clinicians can utilize their existing orientation and skillset to directly target modifiable risk factors and enhance protective factors, as informed by comprehensive suicide risk assessment. Clinicians maintain at least weekly sessions with all patients on the SSCP, re-screen patients at each session, and revise the safety plan as needed.

If patients miss scheduled appointments, clinicians make outreach contact to ensure safety and maintain continuity of care. This contact likely consists of a phone call, but could take the form of text messaging, emails, or home visits based on clinic policy. When making outreach contact, the purpose is to show concern over the patient’s absence, assess mood state and current suicide risk, review the safety plan and crisis resources, problem-solve barriers to using the safety plan and attending treatment, and re-engage by scheduling an appointment as soon as possible. When patients on the SSCP have an ED visit or hospitalization, they are prioritized to receive an appointment within 72 hours of discharge (a particularly high-risk period for suicide). Clinicians strive for contact with other treatment providers to ensure “warm handoffs” and continuity of care during care transitions. Patients are eligible to exit the SSCP after 90 days free from suicidal intent, plan, behavior, ED visits, or inpatient hospitalizations or should the clinician determine that the level of care is no longer indicated.

Intervention and monitoring for patients not on the SSCP—Only patients at high risk are *required* to receive SSCP interventions; however, many patients at lower risk may benefit from certain SSCP interventions, and clinicians should use their judgment to select interventions as indicated. At minimum, patients not on the SSCP must be re-screened *at least* quarterly at treatment plan review, and any positive screen triggers comprehensive suicide risk assessment and SSCP determination. All patients, regardless of risk status, should be provided with crisis information during intake and at quarterly treatment review, including clinic off-hour/crisis numbers, local crisis support services (e.g., mobile crisis, ED, 911), and the National Suicide Prevention Lifeline (1-800-LIFELINE).

Training procedures

Agencies were assigned to one of two levels of implementation support, either *Basic* (BI) or *Enhanced* (EI) implementation. In the BI condition, large-group (~300 participants) webinars for clinic leadership are held monthly to assist with implementation of AIM-SP interventions, data reporting requirements, and training. In addition, all clinical staff in participating clinics (approx. 3,500) were required to take four hours of online distance-learning training on risk assessment, safety planning, the suicide-safer care pathway, and adaptations for children. EI procedures included all BI activities, but also included selection and utilization of site champions (i.e., clinic supervisors provided with advanced clinical training to serve as on-site resources for staff) and attendance at monthly small-group (approx. 10-15 people) learning collaborative meetings that addressed barriers and facilitators for implementing the ZS model. The additional resources required to implement the EI interventions were supported by the grant.

Evaluation procedures

During the *Preparation* phase, all measures and materials were prepared, clinics were enrolled, baseline data were collected, site champions were selected, clinical training of staff was initiated, and leadership and site champions began attending large-group webinars (BI) or small-group learning collaboratives (EI). The study employed an effectiveness-implementation Type 1 design (Curran et al., 2012) and cluster randomization (agencies) with stratification by geographic region and agency size (high vs. low annual patient census) to assign agencies to either BI or EI conditions.

During the *Implementation* phase, AIM-SP clinical procedures were implemented for all newly-enrolled patients, then extended to all patients at quarterly treatment plan review after six months. Clinic leadership and site champions continued to attend webinars (BI) or learning collaboratives (EI), data reporting began, and quality improvement information and technical support were provided. The data collection protocol tracks individual patient- and aggregate clinic-level data on the receipt of the AIM-SP clinical components as well as proximal outcomes (treatment attendance, emergency care, and hospitalization). Distal outcomes (suicide deaths/attempts) were obtained via statewide mandated reporting of all suicide attempts and deaths to the New York State Integrated Mandated Reporting System (NIMRS; NYS Office of Mental Health, 2016) and NYS Medicaid data. The 12 months after implementation is the *Maintenance* phase, during which clinics sustain performance without grant-funded technical, clinical, or implementation support, and the *Follow-up* phase is 12 months after maintenance concludes, used to assemble suicide data and query the National Death Index for deaths occurring outside NYS.

The implementation phase began in October 2017, so data are not yet available. The primary planned analyses include comparison of the effectiveness of EI and BI conditions in reducing suicidal behaviors (attempts and deaths), psychiatric hospitalizations, and ED visits. We will also conduct a historical control comparison analysis to compare outcomes within agencies before and after AIM-SP implementation, and a matched-cohort comparison analysis to compare outcomes between agencies who are and are not participating in the project. Further, we will use mixed qualitative-quantitative approaches to compare EI and BI conditions on implementation and sustainability of the ZS model, evaluating agency- and provider-level predisposing, enabling, and reinforcing factors affecting implementation success, as well as rates and quality of ZS components (process/impact evaluation) during implementation, maintenance, and follow-up periods.

Conclusions

Suicide is an enormous public health concern, and ZS has been promoted as a way to reduce suicides for those receiving services. Our study is the largest implementation and evaluation of the ZS approach in outpatient clinics ever conducted. Results from this study will provide crucial insight regarding how to best adopt and disseminate empirically-supported suicide-safe care, thereby reducing preventable loss of life.

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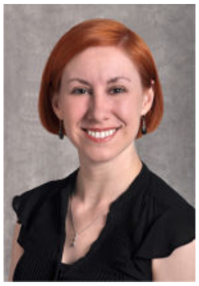

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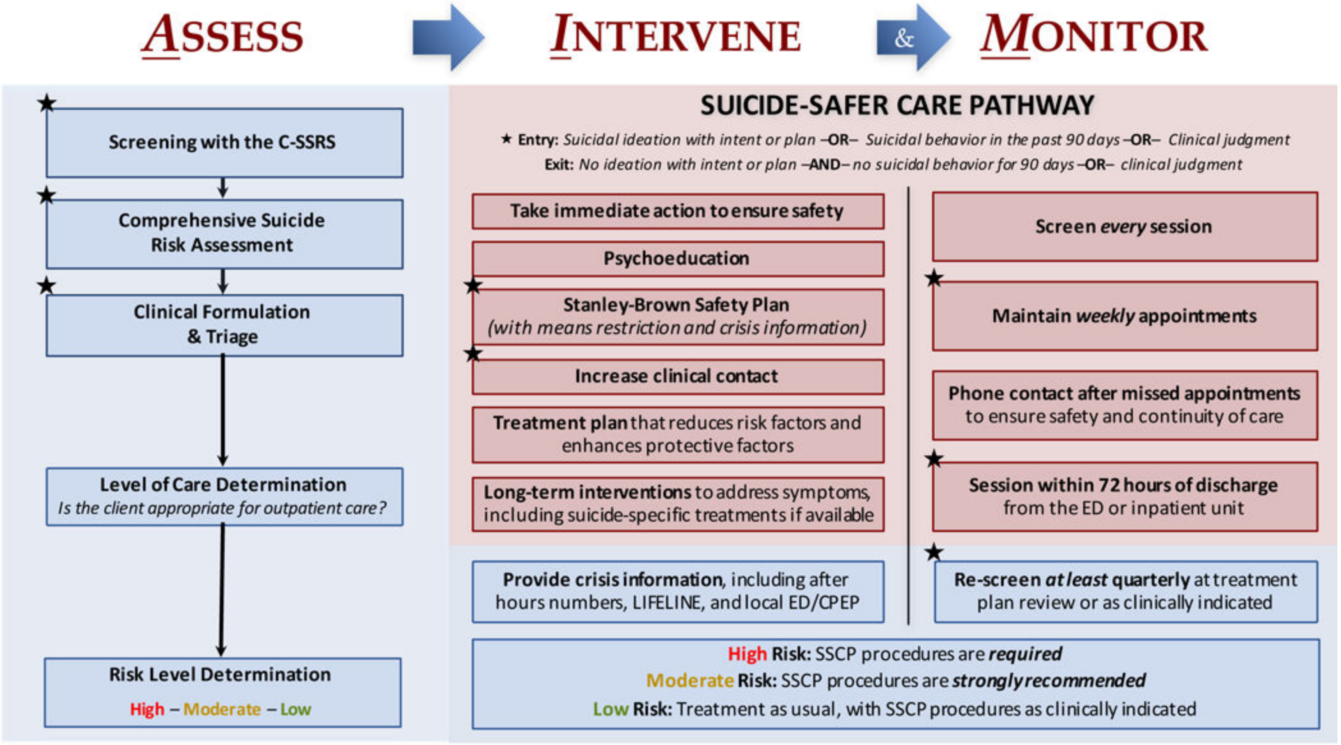


Note: Items in blue represent procedures for all clients, items in red represent enhanced care on the SSCP, and ★ denotes a measured index of the PSYCKES CQI project.

Figure 1.

Clinical procedures of the Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP) program of suicide-safer care, an operationalization of the Zero Suicide model for outpatient behavioral health clinics.

Table 1

ZS Elements and their descriptions

Element	Description
Implementation Elements	
LEAD	Create organizational culture change about suicide prevention
TRAIN	Develop a suicide prevention competent workforce
IMPROVE	Data-driven quality improvement
Clinical Elements	
IDENTIFY	Screening and assessment of suicide risk
ENGAGE	Ensuring pathways to care
TREAT	Using effective evidence-based best practices
TRANSITION	Continuing contact and follow-up

Table 2

Characteristics of Medicaid enrolled patients served in New York State participating clinics

Characteristics	Percentage *N*=73,732
Age	
Youth (<18)	29.6%
Adults (18+)	70.4%
Gender[1]	
Male	46.2%
Female	53.8%
Race and Ethnicity[2]	
Caucasian or White	51.0%
African-American or Black	23.3%
Hispanic or Latin	10.5%
Asian or Asian-American	2.1%
Other/Unknown	13.1%
Region[3]	
Rural	44.0%
Urban	56.0%
Primary Diagnoses[4]	
Depressive disorder	25.4%
Schizophrenia-spectrum disorder	16.0%
Externalizing disorder (ADHD or Conduct)	13.2%
Anxiety disorder	9.9%
Bipolar disorder	9.5%
Personality disorder	0.5%
Other[5]	25.5%
Comorbid substance treatment[5]	10.5%

Notes: This analysis includes Medicaid enrolled individuals, with one or more service at a participating mental health clinic (177 clinics, 90 provider agencies participating as of April 1, 2017) between November 1st, 2015 and November 1st, 2016 (*N*=86,080), excluding individuals over 64 years or without continuous Medicaid eligibility during the year of observation (*n*=73,732). All data is derived from Medicaid claims and encounters.

[1] Information on transgender and non-binary gender-identified individuals was not available from Medicaid databases.

[2] Information on race and ethnicity (i.e., White vs. Black Hispanic) was not available separately from Medicaid databases.

[3] A county was defined as urban if its population density was greater than 1,000 people per square mile according to the 2010 Census.

[4] Determined using the most prevalent diagnosis assigned to the individual in Medicaid claims during the year of observation.

[5] Includes all diagnoses with <0.5%.

[6] Includes those with any substance use service during the year.

Zero Suicide
The Dogged Pursuit of Perfection in Health Care

» David W. Covington, LPC, MBA, and Michael F. Hogan, PhD

“Is it rational to pursue zero suicide among patients in health care?” This question was posed by Mokkenstorm and colleagues[1] as they addressed objections that the science and published results aren’t yet in. Growing evidence, however, demonstrates remarkable success at reducing the number of lives lost to suicide in health care systems that have committed to the systematic “suicide care” approach known as “Zero Suicide.”

Psychiatric leadership is essential to the success of efforts toward zero suicide. More than a slogan, the approach applies evidence about what works in the detection, treatment, and management of individuals with intense suicidality within a culture determined to learn together and make a dramatic difference. Three essential steps—routinely asking about suicide, developing a collaborative crisis/safety plan including counseling on lethal means, and delivering direct treatment for suicidality for those at elevated risk—have produced exceptional results in several systems.

The concept of zero in quality improvement has been around for more than 50 years, with James Halpin introducing the zero defects movement in 1966. By 1976, the concept of “target zero” had moved to reducing accidents in Japan. In the 1980s, Dr Don Berwick and the Institute for Healthcare Improvement reached out to NASA for a dialogue about applying quality improvement to health care, ie, one small step for quality and one giant leap for health care safety. More recently, “Innovating to Zero” has been called one of the 10 megatrends for innovation.[2]

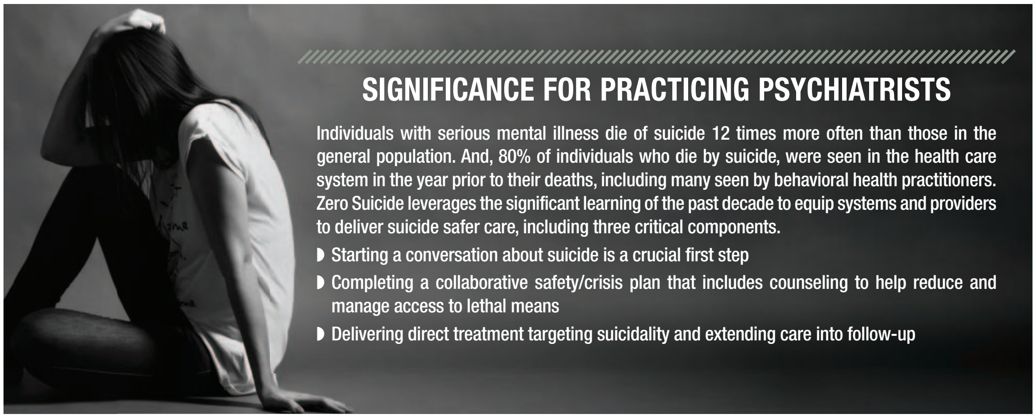
Efforts by the mental health system to realize zero suicide

Health care in the United States has focused on quality improvement since the 1960s, but it has only introduced the concepts of high-reliability science in the past 20 years. High-reliability organizations aggressively pursue perfection, an approach, for example, that has driven commercial aviation in the US to achieve remarkable levels of safety in air travel. This approach is characterized by a deference to front-line expertise, a preoccupation with learning about failures and “near misses” and a relentless focus on the target of zero defects.

The Henry Ford Health System (HFHS) in Detroit was the first to apply these concepts in behavioral health care, which focused on the relentless assessment of suicidality across their continuum of psychiatric care. The result was an audacious goal to achieve zero suicides in their mental health programs. The effort was labelled “perfect depression care.” In a 2015 National Public Radio story, Silberner wrote: “The story of the health system’s success is a story of persistence, confidence, hope, and a strict adherence to a very specific approach.”[3]

The population served by HFHS includes individuals with acute and serious mental illness whose hazard ratio suggests they are 12 times more likely to die of suicide than are those in the general population.[4] Nevertheless, HFHS reported a 75% reduction in the first 4 years of implementation of their perfect depression care model and zero deaths during all of 2009. Over the period of implementation, the effort succeeded in reducing suicide deaths among a population under psychiatric care to about the level in the general population.

This success did not occur in the context of the rigors of a funded research project but as part of an intensive “commitment to radical quality” within usual health care. The results are clearly impressive and demand attention. At the same time, the effort was not a randomized trial. Some have discounted the results, minimizing the approach as “clever sloganeering” and repackaging. One implication clearly is the need to complete the science and verify the results of applying new knowledge to the care of suicidal individuals.



SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS

Individuals with serious mental illness die of suicide 12 times more often than those in the general population. And, 80% of individuals who die by suicide, were seen in the health care system in the year prior to their deaths, including many seen by behavioral health practitioners. Zero Suicide leverages the significant learning of the past decade to equip systems and providers to deliver suicide safer care, including three critical components.

- Starting a conversation about suicide is a crucial first step
- Completing a collaborative safety/crisis plan that includes counseling to help reduce and manage access to lethal means
- Delivering direct treatment targeting suicidality and extending care into follow-up

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The US National Institute of Mental Health is doing this with a series of research awards. One is a 5-year grant to the HFHS and Brian Ahmedani to conduct a large-scale review of an implementation of Zero Suicide across most of the Kaiser Permanente Health System. Another is a grant to Barbara Stanley to evaluate enhanced versus routine implementation of Zero Suicide in over 160 mental health clinics in New York State.

Results are starting to emerge. In 2015, Centerstone partnered with the Suicide Prevention Resource Center and will soon submit its Zero Suicide results with the aim of publishing in a peer-reviewed journal, although reductions in the death rate at this large multistate nonprofit community mental health provider have been previously reported.[5] Centerstone achieved a 64% reduction in suicide deaths.

National Action Alliance for Suicide Prevention task force

In 2010, when a task force commissioned by the National Action Alliance for Suicide Prevention and Dr Richard McKeon of the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, studied the HFHS story, comprehensive evaluations of good suicide care were not yet available.[6] The task force quickly learned that usual care is disastrous when it comes to preventing loss of life by suicide. By 2010, striking evidence of the impact of good care was starting to emerge, such as the study by Motto and Bostrom[7] showing that “caring letters” to individuals who had been hospitalized following an attempt dramatically reduced subsequent attempts and deaths.

In 2010, *Forbes* magazine published an article asserting that few suicidal patients receive good treatment, a claim no one seemed to contest.[8] Few in the field escaped their criticism, including drug companies, the National Institutes of Health, therapists, and university clinical study review boards. At the time, Dr McKeon challenged our Action Alliance task force: “Over the decades individual clinicians have made heroic efforts to save lives, but systems of care have done very little.” His statement reveals one of the core challenges in suicide care: Individual clinicians (especially psychiatrists, often called on to make medicolegal decisions in the case of suicidal individuals) face great pressures, but institutions have not provided training, care pathways, and access to effective brief treatments and supports such as caring letters.

So, the task force reviewed the specific practices. What did the

HFHS actually do in their perfect depression care protocol? What did they do that might make care safer and might make it look and feel like care? We published the "Suicide Care in Systems Framework," and three specific research-informed and evidence-based approaches emerged as central to zero suicide efforts.[6]

Three approaches to reaching zero suicide

First, we need to routinely ask about suicide risk. In 2013, Simon and colleagues[9] concluded that the PHQ-9 question 9 regarding thoughts that you would be better off dead, or of hurting yourself, "identifies outpatients at increased risk for suicide attempt or death." They added: "This excess risk emerges over several days and continues to grow for several months," with an accuracy about twice as predictive of future suicide behavior as cholesterol scores are of future heart disease. Thus, a simple screening question (which obviously must be followed by a full clinical evaluation) matches effectiveness of a cardiac care metric widely acknowledged as significant and warranting care throughout the health care industry. Psychiatrists and others engaged in the delivery of mental health services are offered a great opportunity to positively affect the lives of those they serve through a relentless application of this question as part of their standard of care.t

Zero Suicide requires a standardized methodology for screening and assessing risk, and HFHS was relentless in its search of individuals in care who were at risk. Although science leading to better specificity in prediction is needed, we have the information we require to improve care today. Starting the conversation about suicide is a crucial first step. It creates connection, acknowledges the pain and distress individuals experience, and provides a foundation for effective emerging treatments.

Second, individuals at risk should complete a collaborative safety/crisis plan that includes counseling to help them reduce and manage access to lethal means. When we reviewed the HFHS practices in 2010, there were few research studies of safety planning. The findings of Bryan and colleagues[10] are promising, however. In the largest-scale study of crisis planning to date, the collaborative safety planning intervention by Stanley and Brown[11] reduced suicidal behavior by an extraordinary 50%. Use of this brief intervention for individuals with acute, elevated risk who are able to participate in it should be part of a new standard of care, as has been cited in a recent report from the Action Alliance.

Third, individuals at risk should receive direct treatment targeting suicidality and the care should extend into follow-up. The very significant suicide risks for individuals in the immediate aftermath of a psychiatric hospitalization have been carefully described by Olfson,[12] providing a clear message for the efficacy of universal and continuing interventions and support following hospital discharge. Yet, even when we know the practice works, HEDIS [Healthcare Effectiveness Data and Information Set] tells us that only about half of US patients receive any outpatient care during the first week after psychiatric hospital discharge and one-third receive no mental health care during the first month.

Let's rewind into the care itself. When acute or outpatient mental health care is received, the vast majority of individuals at risk do not receive any direct treatment for their suicidality. Dialectical behavior therapy, cognitive behavioral therapy, and the Collaborative Assessment and Management of Suicide have all been shown to reduce suicide risk. As well, new brief treatments are being developed, including the three-session ASSIP [Attempted Suicide Short Intervention Program] which reduced subsequent attempts by 80% compared with usual care.[13]

Outside inpatient settings, health care systems have simply not been accountable for suicide. Mental health professionals frequently report a complete lack of training to deliver interventions and care to prevent suicide.[14] These standard approaches came under criticism in the New Zealand national media in 2017.[15] The Minister of Health's response after studying Zero Suicide was to change the culture within the mental health workforce and galvanize society around known interventions. As Dr Jonathan Coleman explained: "It does seem that setting a goal, and it may be aspirational… actually just focuses efforts."[15]

A 2016 study by Erlangsen and Nordentoft[16] showed a lower risk of deliberate self-harm and general mortality for those who received psychosocial therapy. In fact, direct treatment of suicide is more effective and cost-efficient than statins are for the prevention of heart disease. (One fatal myocardial infarction is prevented for every 83 people treated with statins versus one self-harm episode prevented for every 44 people treated with psychosocial therapy.) When compared to this outcome of a well-established standard of care in the physical health world, we can clearly argue the case for direct care for suicidality becoming a standard practice expectation.

So, if we know that these three practices work and have increased and been repeatedly supported by research, why aren't they readily available?

The way forward

Zero Suicide attempts to break through these challenges of the status quo and forgotten patients. It states that the logic and the literature base on quality improvement suggests that we need a systematic, leadership-driven quality improvement approach for a "wicked problem" like suicide. The "Suicide Care in Systems Framework" report, recommending a systematic approach, was published at virtually the same time While and colleagues[17] were concluding that a systematic implementation of crisis intervention and other recommended steps in England and Wales saved hundreds of lives compared to incomplete implementation. Zero Suicide is also activated by a significant inclusion of the lived experience and expertise of those who have been there—that is, those who have made a suicide attempt but recovered and found some way forward.

The model is being implemented globally. More than 90 organizations and individuals have signed on to the Zero Suicide Alliance in the United Kingdom, including half of the National Health Service Trusts. In Queensland, Australia, 11 of 16 health districts are deploying the toolkit (available at ZeroSuicide.com) following the lead of Gold Coast Health. In 2017, hospitals in Ontario, Canada, published "Strengthening Suicide Prevention in Ontario Hospitals," which had as its top recommendation implementing the Zero Suicide model in hospitals across the province. As well, the fourth Zero Suicide International Summit with more than 100 leaders from nearly 20 countries was recently hosted in Rotterdam by 113 Suicide Prevention and Deloitte. The program also showcased their Supernet and Supranet Zero Suicide initiatives in Holland.

As a scientific matter, we need more data. As a public health and quality-of-care matter, the evidence is already in. The time is now. Together, we can, and must, do this. It is our hope that Zero Suicide motivates health care and other leaders to move from half measures to full measures in suicide prevention and better health care.

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