

# Zero Suicides in Care initiative



18 March 2020

Stephen Scott

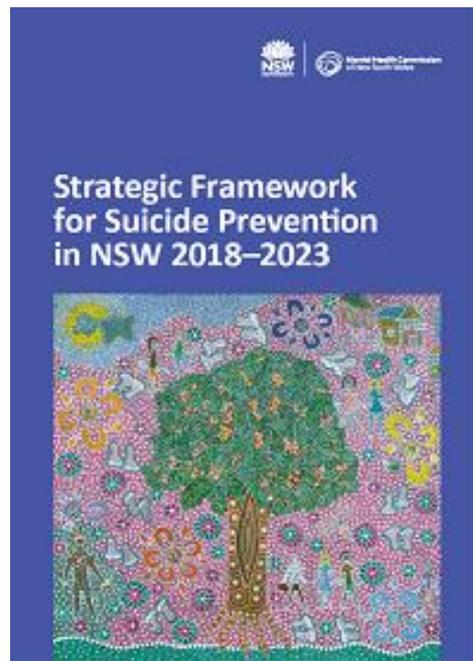
Principal Policy Officer, Mental Health Branch

# Towards Zero Suicides Premier's Priority

Target: Reduce the rate of suicide deaths in NSW by 20 per cent, from 10.9 per 100,000 population in 2017 to 8.7 per 100,000 population by 2023



- Fifteen initiatives to make an unprecedented impact on the suicide rate.
- Derived from the *Strategic Framework for Suicide Prevention in NSW 2018-23*.
- New investment of \$87 million from 19-20 to 21-22 – scale up to full implementation in 20-21.

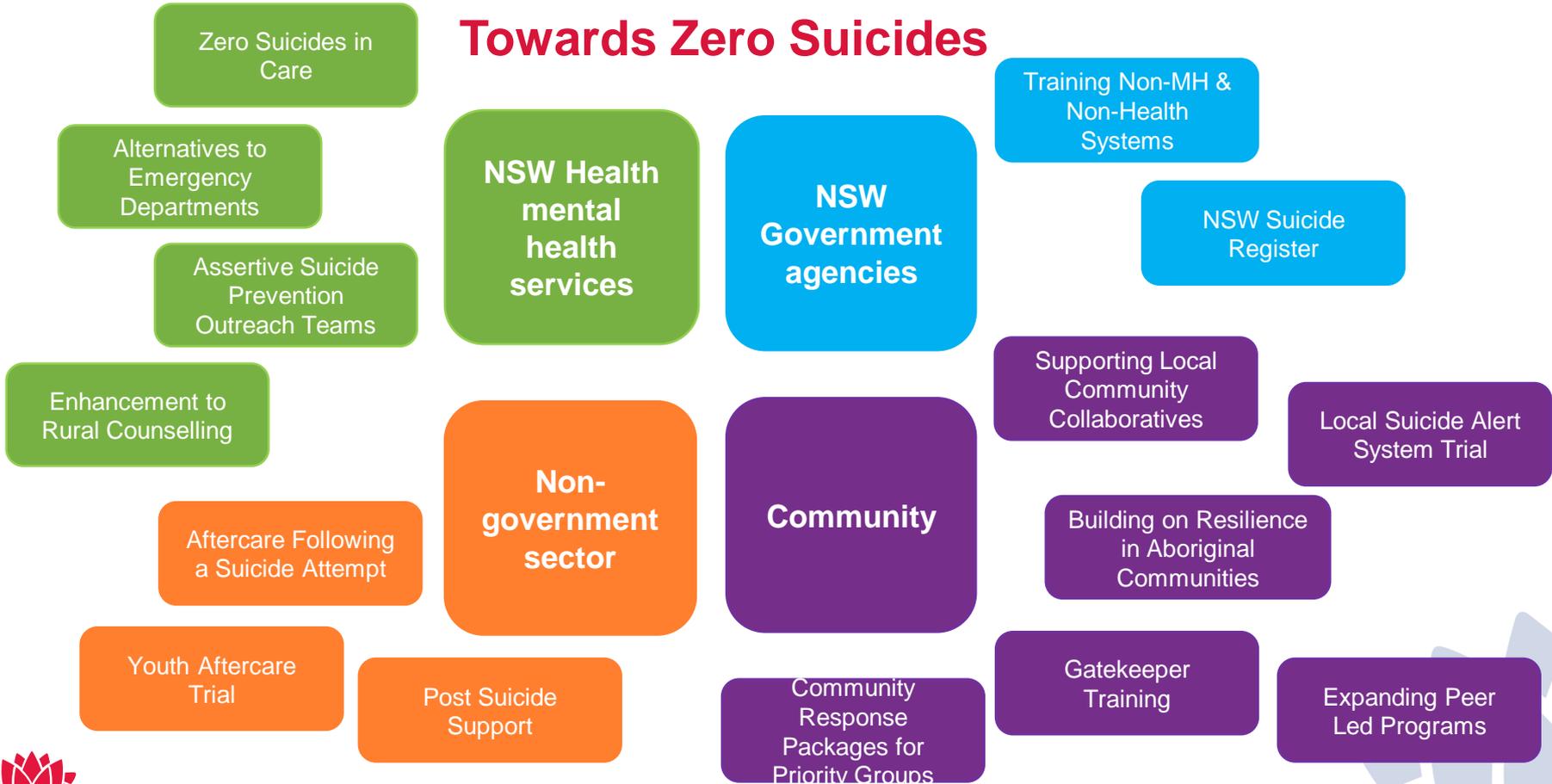


Towards Zero Suicides  
Premier's Priority

\$87 million investment from  
2019-20 to 2021-22

*Strategic Framework for  
Suicide Prevention in NSW  
2018-2023*

# Towards Zero Suicides



## Zero Suicides in Care

- ▶ Implementing a NSW version of the Zero Suicides Healthcare approach to prevent suicides and suicide attempts in mental health inpatient and community settings
- ▶ Cultural change management
  - ▶ Attitudinal shift that does not accept suicide as inevitable among people with mental illness
  - ▶ Suicide prevention specific clinical training and care pathways
  - ▶ Learning environment that responds supportively to risks and critical incidents
  - ▶ Improved engagement with people with lived experience including bereaved families
  - ▶ Just and restorative service culture led by executives and managers
- ▶ Linked with Assertive Suicide Prevention Outreach Teams to support community focus – consistency of approach
- ▶ Workshop held in October, guidance material forthcoming – local co-design workshops
- ▶ Coordination position funded



# Using co-design for improvement

## Zero Suicides in Care Initiative

18 March 2020

Margaret Kelly | A/Manager Patient Experience & Consumer Engagement | ACI

Stephen Adei | Peer Support Worker | Eastern Suburbs Mental Health

Carrie Lumby | Lived Experience member, Illawarra Shoalhaven Suicide Prevention Collaborative

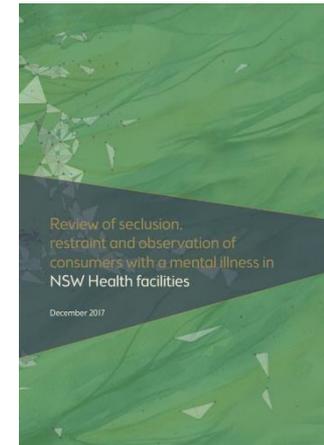
Presenter: Margaret Kelly

## ACI Mental Health (MH) Network

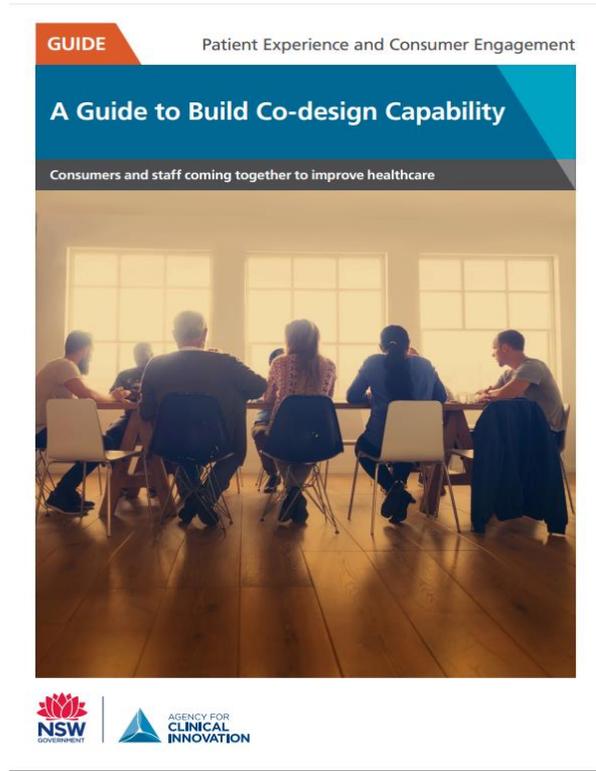
- Works collaboratively with clinicians, managers, consumers and carers to promote improved consumer engagement and outcomes in mental health service delivery.
- Three Co-Chairs, MH Network Executive Committee and broader Network.
- Works closely with the Mental Health Branch (MoH) to partner on key initiatives.

## NSW Seclusion and Restraint review

- Triggered in May 2017 by NSW Coroner's release of CCTV footage of mistreatment and events contributing to the death of Ms Miriam Merten.
- Scope covered acute mental health units and declared emergency departments.



# The resource.....



Available at

[https://www.aci.health.nsw.gov.au/\\_data/assets/pdf\\_file/0013/502240/Guide-Build-Codesign-Capability.pdf](https://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0013/502240/Guide-Build-Codesign-Capability.pdf)

# Why co-design?

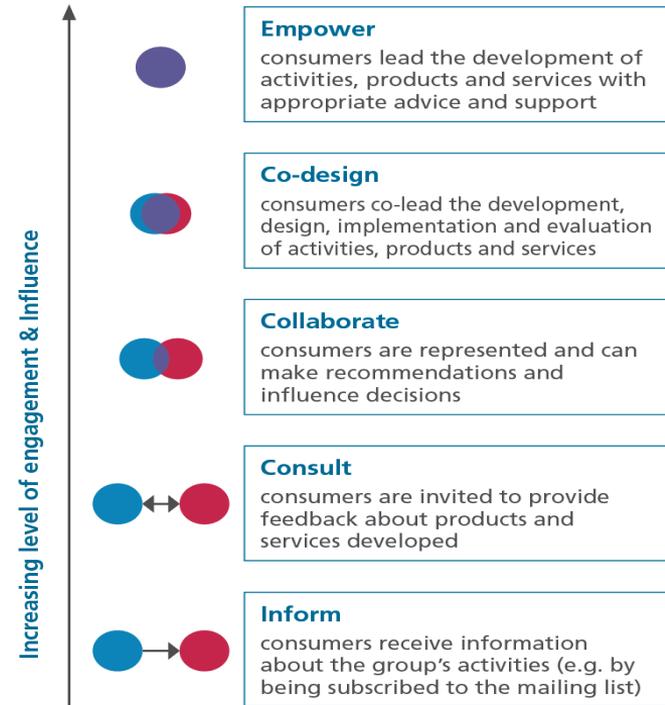
*Co-design is important in mental health services because it challenges the status quo, addresses well known power imbalances that exist across many levels and ensures the voice of people with lived experience is a co-driver of change, innovation and leadership. The evidence shows that using co-design creates safer, higher quality and more efficient care*

Workshop participants  
involved in creating the ACI  
co-design capability guide

# A few definitions...

**Co-design:** A participatory process which brings together people with lived experience, and people with professional or technical expertise, in equal partnership, to solve problems or design services.

**Experience-Based Co-design (EBCD):** A specific co-design methodology often used to co-design health services, with a particular focus on understanding and improving the patient journey.



Source: Adapted by the ACI with permission from the International Association for Public Participation (IAP2)

## Not all consumer engagement is co-design

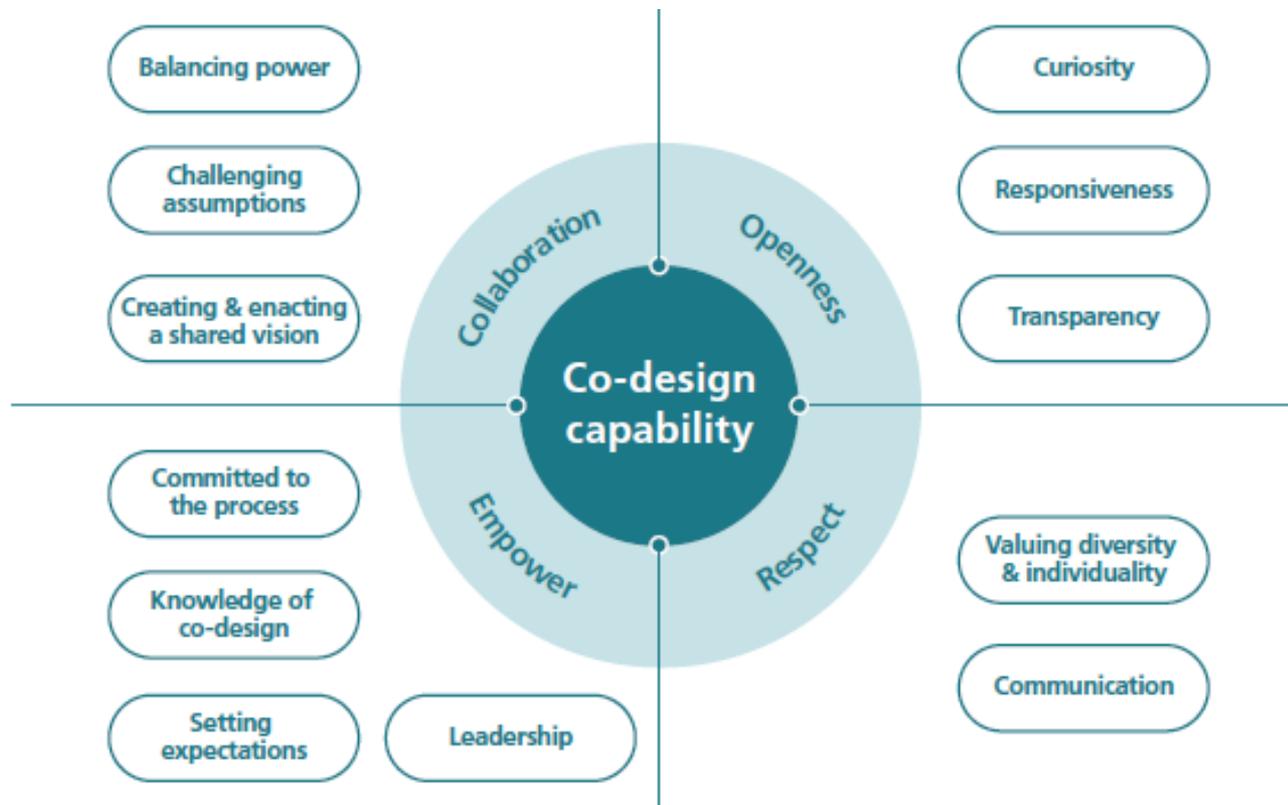
- Having one or two consumers on a committee, distributing a feedback questionnaire, or sending a document to consumers for review, would not be considered co-design.
- Co-design is about sharing power and making decisions together.
- Co-design usually requires partnering with consumers *from the outset* of the project, before project aims and scope have been finalised.

# The principles of co-design

- Equal partnership
- Openness
- Respect
- Empathy
- Design together



# Capabilities



- A culture that recognises engagement and participation is everyone's responsibility.
- Strong leadership.
- Being brave & courageous.
- Development of infrastructure support.
- Continuous evaluation.

- How will you contribute to the success of this work?
- What are you doing and saying that will let others know that you support this work?
- What do you need to be successful?
- Barriers that you may face and how to overcome them

This is a practical kit that lays out the why, when and how for different tools that can be used when improving health services and provides templates

- Personas
- Storyboards
- Five Whys
- Empathy Maps
- Experience Map
- Experience Questionnaire
- How Might We...?
- Journey Map



Available at

<https://www.aci.health.nsw.gov.au/networks/peace>

# Useful resources to support co-design

- Dimopoulos-Bick, T.L., et al (2019) ““Anyone can co-design?”: A case study synthesis of six experience-based co-design (EBCD) projects for healthcare systems improvement in New South Wales, Australia,” Patient Experience Journal: Vol. 6: Iss. 2, Article 15
- ACI experience based co-design (EBCD) toolkit:  
<https://www.aci.health.nsw.gov.au/networks/peace>
- Consumer Health Forum of Australia’s EBCD toolkit: <https://chf.org.au/experience-based-co-design-toolkit>
- The Point of Care Foundation’s EBCD toolkit:  
<https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/>
- Commissioning Mental Health Services: A Practical Guide to Co-design  
<https://www.cesphn.org.au/preview/our-region/1270-commissioning-mental-health-services-a-practical-guide-to-co-design-august-2016/file>

Presenter: Stephen Adei

- Key Principles and Concepts
  - Mutuality and Respect
  - Trauma informed practice
  - Reducing power imbalances and tokenism
  - Appropriate recovery focused language
  - Ability to work with people at any stage of recovery
  - Practical examples

- In previous slide key word was with, not for
- Mutuality
  - Working together both researchers clinicians and individuals with lived experience have something to offer
  - People are more than the sum of their diagnoses
  - Don't be condescending or create bias based on the fact that the person may have mental distress or a diagnosis
- Respect
  - Treating the person just as any other
  - DBAD – The “Don't be a Dick” principle

- Trauma informed practice – What is it
  - **Trauma-Informed Practice** is a strengths-based framework grounded in an understanding of and responsiveness to the impact of **trauma**, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010)
- Key Principles and Concepts
  - Safety
  - Choice
  - Collaboration and Mutuality
  - Transparency and Trustworthiness
  - Empowerment

- Reducing power imbalances and tokenism
  - Always going to be a level of power imbalance – key is minimising it
  - Practical example of peer work – patients sometimes realize you have pass to facilities and freedom to come and go and are paid by hospital so get that out of the way up front and focus on commonalities
  - Not making decisions for – but with (key)
  - Comes back to the human values of respect and that they have something to offer
  - Tokenism – appreciate what they have to say – even when it may not be what you want to hear or something you had not thought of but relevant to their experience
  - Not being dismissive of the input of consumers with lived experience.

- Language around suicide
  - Absence of suicide language and conversation is a major contributor to the stigma people face in the community – (bereaved)
  - Suicide not a crime or religious overtones and compassion rather than judgement or condemnation
  - “Attention seeking” when looking for attention or comfort when distressed
  - Examples of appropriate language

## Appropriate words

- Died by suicide
- Took his or her life
- Ended his or her life
- Non-fatal attempt at suicide
- Attempt to end his or her own life

## Worn-out words

- Committed suicide
- Successful suicide
- Completed suicide
- Failed attempt at suicide
- Unsuccessful suicide

- Important to be able to work with consumers at any stage of recovery from their mental distress.
  - The consumers do not necessarily have to be many years removed from period of self harm or suicidal ideation.
  - Many of the best insights come from people with recent lived experience.
  - Decisions as to consumers to use for input should be based more on their desire to contribute their lived experience.
  - Example around using people 3 months to 5 years removed from emotional distress.

Presenter: Carrie Lumby

# Some considerations for LHDs

# 'Lived experience of suicide' in the context of LHD

## Zero Suicides initiatives



Necessary to ensure people with relevant lived experience are involved, including:

- people who have had significant exposure to ED and hospitals for suicidality or with suicidality.
- people who don't traditionally access services.
- people whose distress is created or compounded by systemic oppression and discrimination.

The need for power sharing *between* clinicians and consumers in co-design is now commonly acknowledged, but often not *within* lived experience cohorts

# Essential elements of a local co-design process

- ✓ Commitment to the iterative nature of the process.
- ✓ A rich and diverse range of perspectives actively incorporated.
- ✓ Paid participation of lived experience participants.
- ✓ Decision-makers develop a genuine understanding of co-design and commits to its core principles.
- ✓ Clear communication by commissioning agencies about the hard boundaries of the project upfront to all participants.
- ✓ Co-facilitation of all co-design training and participant workshops by people with relevant lived experience.
- ✓ The final service or service improvement must accurately reflect the service model blueprint borne out of the co-design.

# When there isn't a commitment to co-design values and principles

*A lived experience participant said they felt “swindled” by not having the hard boundaries of the project communicated upfront.*

*A lived experience participant who had felt “shut down and ignored” by the health system was re-traumatised by having their expectations raised, then finding out the service model didn't reflect the ideas generated through the designing phase.*

# Questions for LHDs to consider before undertaking local co-design

- ✓ Do participants (including LHD staff and management) have a shared understanding of what co-design is, and what a local co-design process involves?
- ✓ Is there sufficient time, energy and other resources to commit to the iterative nature of a co-design process?
- ✓ Are the hard boundaries of the project known and will they be clearly communicated upfront to all co-design participants?

# Rewards for LHDs in undertaking co-design with a commitment to its values and principles

- Fosters cooperation and trust between local service providers and service users that has meaning and value beyond the co-design process.
- Encourages a sense of collective ownership and community ‘buy-in’ of local services.
- Potential problems are more likely to be raised and addressed before service models or improvements are implemented.
- When done well, the evidence shows that it’s more likely to produce services that are efficient, effective and sustainable.

## What Ann says about working collaboratively

“The Collaborative is not just about collecting data. They really value our input as people with a lived experience...I feel like my voice matters as much as anyone in the room, even if they have degrees as long as their arms!”

- Ministry of Health will support use of co-design in LHDs/SHNs for the initiative
  - Sue Murray [suem@zerosuicide.com.au](mailto:suem@zerosuicide.com.au)
  - Stephen Scott [Stephen.Scott@health.nsw.gov.au](mailto:Stephen.Scott@health.nsw.gov.au)
  - Tegan Cotterill [Tegan.Cotterill@health.nsw.gov.au](mailto:Tegan.Cotterill@health.nsw.gov.au)
- Deborah Howe ACI Mental Health Network Manager  
[Deborah.Howe@health.nsw.gov.au](mailto:Deborah.Howe@health.nsw.gov.au)
- The ACI is currently developing a co-design capability toolkit which will be tested with people with lived experience and staff.
  - For enquiries email [ACI-PEACE@health.nsw.gov.au](mailto:ACI-PEACE@health.nsw.gov.au)

# Any Questions?



**Thank You**



[aci.health.nsw.gov.au](http://aci.health.nsw.gov.au)