Zero Suicide Healthcare

EVALUATION FRAMEWORK

Outcomes, Actions & Measures

Zero Suicide Institute of Australasia

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Contents

1. Program Theory and Evaluation

Program Theory is used to design evaluations that match the purpose, intended outcomes, scope and limitations of a program. Relevant and reliable evaluation of programs needs this level of design.

Clear program theory and design is essential for evaluation and monitoring to be well-aligned to what is intended and to test what is happening in the implementation and operation of a program. Without a clear articulation of program purpose, rationale, intended outcomes and the linkages between activities to achieve these outcomes, it is difficult to undertake program evaluation in a robust and reliable way.

Program Theory involves six fundamental components, which are categorised within the Theory of Change and the Theory of Action, as shown in the table below:

Components of Program Theory[1]

Theory of Change	Situational Analysis: identification of problem, causes, opportunities consequences	Focusing and scoping, setting the boundaries of the program, linking to partners	Outcomes chain: the centrepiece of the program theory, linking the theory of change and the theory of action
Theory of Action	Desired attributes of intended outcomes, attention to unintended outcomes	Program features and external factors that will affect outcomes	What the program does to address key program and external factors

Theory of Change is used to describe what change the program is seeking to achieve, for whom, and the extent to which it operates within a context or limitations to do so. Theory of Change addresses the following three elements:[2]

- **Situational Analysis**; the identification of the problem that the program is addressing, its causes and the reasons why solving this problem generates benefits of value;
- **Scoping**: setting the boundaries of the program and identifying its response to the problem(s) it is addressing;
- **Outcomes**: creating a chain of outcomes to organise in a logic sequence the relationships between immediate, intermediate and longer-term outcomes – the assumptions about the interactions between outcomes are made explicit so that they can tested and evaluated.

Theory of Action goes into the detail of the results or observable attributes of program outcomes, describes the program features (delivery mechanisms and capabilities) that will support the achievement of these outcomes, and the ways in which the program addresses external factors or barriers to its operation, as intended.

[1] Funnell, S.C. & Rogers, P.J. 2011. *Purposeful Program Theory*. Jossey Bass, USA. Page 150.
[2] Funnell, S and Rogers P 2011 *Purposeful Program Theory*. Jossey Bass. USA.

2. Zero Suicide Healthcare as a Program

Zero Suicide Healthcare may be regarded as a program. It is a multi-faceted combination of practice, service delivery, consumer engagement and organisational change activities that together create greater effectiveness in healthcare settings to prevent suicides by those in care of health services. The seven parts of Zero Suicide Healthcare are as follows:

1. **Lead** – instilling the belief that suicide can be prevented
2. **Train** – developing the skills for a standardised approach to suicide prevention practise
3. **Identify** – developing a centralised, consistent and systematic identification of suicide risks
4. **Engage** – developing practices and processes for effective engagement with suicidal persons
5. **Treat** – providing effective and proven treatment of suicidal ideation and behaviours directly
6. **Transition** – transferring of persons out of healthcare with follow up care and support
7. **Improve** – developing continuous improvement based on lessons learnt

Diagram provided by the US Zero Suicide Institute, Education Development Centre Washington DC

3. Theory of Change for Zero Suicide Healthcare

This identifies the problem that Zero Suicide Healthcare is seeking to address, the causes of the problem and the ways in which the program addresses these causes.

Situational Analysis

Suicidal behaviour can be difficult to detect, and suicidal persons similarly may be hard to reach. Australian research has identified that up to half of those who attempt to end their lives have contact with health services in the period immediately prior.[3] However, this contact may not be about their suicidality. Accordingly, suicide prevention faces a fundamental challenge: how to use the health system to identify and engage with those persons who may take action to end their lives.

Health and hospital service practices in response to suicidal persons and those who have presented for medical attention following a suicide attempt do not always reflect appropriate and best practice. This can result in treatment that is not directly and effectively addressing the person's suicidality and therefore fails to ensure that suicidal behaviour is prevented during the period of healthcare. In Australia this has been recognised as a priority policy reform to be addressed on a national basis.[4]

Those persons who have attempted suicide are highly vulnerable to re-attempt and to die by suicide, especially in the period immediately following a suicide attempt. One study estimates a 20-40 times higher risk of suicide for those who have previously attempted suicide. For those suicidal persons who do have contact with health services prior to or after a suicide attempt, attention to engagement, follow up and aftercare is regarded as a high priority to facilitate suicide prevention.[5]

Program Scope

The core principle of Zero Suicide Healthcare is that suicide deaths for people receiving healthcare are preventable, and the program goal is that no deaths by suicide occur amongst persons receiving health care – viewing this is an aspirational challenge that health systems should accept.[6]

Zero Suicide addresses the above challenges in suicide prevention within health care systems.

This is reflected in the four clinical elements of the ***Suicide Prevention Pathway*** for Zero Suicide Healthcare:

- Systematically identifying and assessing suicide risk [in all people presenting for care]
- Ensuring every person [receiving care] has a suicide Care Management Plan
- Using effective evidence-based treatments to directly target [person] suicidality
- Providing continuous contact and support [to engage with suicidal persons and their carers]

Zero Suicide Healthcare draws on the techniques of quality management and continuous improvement in its design and implementation. It implicitly assumes that suicide prevention can be addressed in health care settings in the same way, and with the same absolute improvements, as has been done in wound management, infection control and medication management.

To be effective, Zero Suicide Healthcare requires organisational, workplace and professional cultures that support continuous improvement and better practice in suicide prevention. The concepts of a ***Just and Learning Culture*** are an essential characteristic of Zero Suicide Healthcare.

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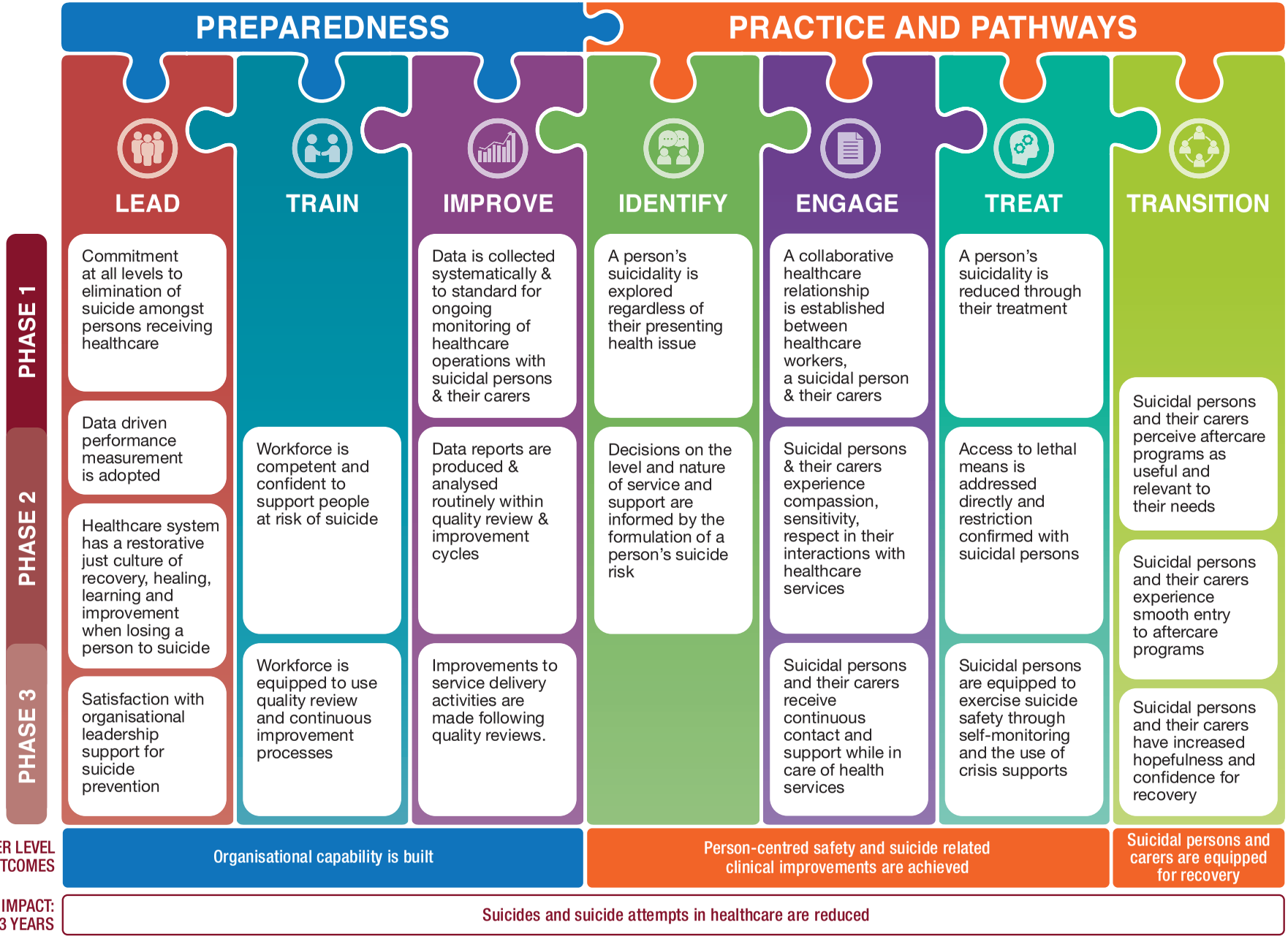
[3] Shand F, Christensen H, al. E. Care After a Suicide Attempt. Sydney, Australia: National Mental Health Commission; 2015.

[4] Commonwealth of Australia 2017 The Fifth National Mental Health and Suicide Prevention Plan.

[5] Shand F, Woodward A, McGill K, Larsen M, Torok M et al. Suicide aftercare services: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2019.

[6] Zero Suicide Multi-Site Collaborative Factsheet, Clinical Excellence Division, Queensland Health

Zero Suicide Healthcare: Theory of Change



4. Theory of Action

Theory of Action is about the program execution – what is done to achieve changes the program is seeking. It is concerned with what the program will do, what it won't and how it will go about it. The Theory of Action identifies program management choices on priorities, resource allocation and the approach with which actions will be undertaken – characteristics, by whom and in what manner.

For a program such as Zero Suicide Healthcare, the Theory of Action is an essential translation of the broader strategic intent contained in the Theory of Change into the operational practices, processes, techniques and devices used to achieve individual, organisation and systematic improvements for suicidal persons and their carers. It is how the 'rubber hits the road.'

The Outcomes Chain Statements represent the Theory of Action for Zero Suicide Healthcare. They expand on the Outcomes Chain created for the Theory of Change by describing the specific change and practice to be adopted towards the achievement of each intermediate outcome, the key activities to be undertaken to generate that change or practice, and the 'inputs' i.e. the knowledge and skills, the personnel, the financial, intellectual and other resources required.

Accordingly, the Outcomes Chain Statements provide an opportunity to examine more closely how activities relate to the stated program outcomes and to check for their alignment and feasibility to deliver the results intended.

The Theory of Action should enable an alignment to the program with operational plans and budgets – to signal when, how and with what resources program activity will occur. In doing so, the Theory of Action creates the level of detail in the Evaluation Framework that will support process evaluations and the application of continuous improvement techniques to monitor the progression towards changes and practice adoptions that will achieve results. It is through the attention to components within the Outcome Chain Statements that a mix of process and outcome evaluation activities can be designed and conducted.

The Theory of Action also incorporates Assumptions and External Factors or Implementation Factors that are beyond the program's control that may affect both the activities and the results for the program. It is important to address these in program evaluation, as they may be pertinent to interpretation of the data and results – no program operates in isolation.

The Assumptions and External Factors are described for the Zero Suicide Healthcare program as follows:

Assumptions

- The accountabilities of the healthcare organisation will align with the requirements of Zero Suicide Healthcare improvements.
- For the Australian context, the 'Healthcare System' incorporates all services that are called 'health services' in the Fifth National Mental Health and Suicide Prevention Plan, i.e. public hospitals, community mental health services, allied health, funded NGOs, peer support programs. That is, it does not include primary health care services.
- Australian healthcare systems have quality and continuous improvement processes already in place.
- CEO or equivalent has delegated authorities that will enable changes in practice with suicidal people and their carers for the health care system involved.
- Leadership from senior managers for the adoption of changes in practices to proceed (and to achieve engagement with the workforce and key stakeholders), i.e. assumption that the people reporting to the CEO want to make the changes.

- The operating environment (budget, cost structures, workloads, reporting arrangements, staffing, professional development/training) will allow implementation of Zero Suicide in Healthcare improvements.
- Government requirements on systems or other external governance on the collection and use of data associated with services and practices will enable use of data for quality improvement.
- Organisations have data systems that are suitable, to a standard of privacy and functionality and capable of collating and reporting data required for service and practice improvement monitoring.
- Personnel at the frontline and their managers are willing and equipped with skills to collect data routinely and reliably.
- A workforce to adopt specialist suicide-related clinical treatments is available or can be developed.
- The workforce itself will be open to learning and developing new skills.
- Organisations are culturally open and sufficiently responsive in their operating processes to make continual changes for improvement to services and practices.
- There is agreement among health clinicians and key stakeholders on the evidence based and most suitable suicide screening and assessment tools to enable consistency of approach across a healthcare system.
- Collaborative engagement with suicidal persons and their carers is supported in principle and practice by the funders and operators of health service systems, especially through critical processes such as communication, case planning and management, information provision and sharing, decision making and resource allocation, and in feedback mechanisms and service quality assurance.
- Suicide safety planning and management is widely accepted as an effective technique and a proper response by health service systems to the collaborative management of suicide with persons.

External Factors

- Community expectations, legitimisation and stigma-orientation regarding health care system responses to suicidal people.
- Consumer and carer comfort regarding the privacy and ethics issues in the data systems being utilised for evidence based care and care transitions.
- For the Australian context, Medicare items and subsidies that enable access to suicide related treatments, especially pharmacological, clinical and psychological services.
- Government and organisational policies that are barriers to implementation of Zero Suicide Healthcare, e.g. pricing structures for services under hospital agreements.
- Related services such as emergency services, community mental health (NGOs) and allied health professionals interact with the healthcare system in ways that are consistent with Zero Suicide Healthcare.
- Healthcare workers beyond the organisation making the improvements are broadly supportive of Zero Suicide Healthcare, especially in the way they respond to suicidal people and their carers.
- Healthcare systems capability to collect and transfer data through internet connections and technologies – for the Australian context this especially applies in rural and remote locations.
- Performance measurement and monitoring being undertaken across multiple sites being subject to standards and processes set by a central review unit or similar.
- Financial incentives and efficiency measures that cross or minimise quality in service delivery.

Implementation Factors

- Zero Suicide Healthcare is introduced to a healthcare system as a specific program for quality and performance improvement in suicide prevention. It is to be incorporated into routine or ‘business as usual’ operations following introduction.
- Zero Suicide Healthcare is to complement and be integrated to existing quality improvement systems for the healthcare system.
- Consumer and carer feedback and input to the improvement of a healthcare system for suicide prevention is an essential element of quality in service.
- Legal reviews of aspects of the Zero Suicide Healthcare are undertaken to identify potential liabilities, impacts on existing risk profiles and mitigation strategies, relevance to existing health care legislation and case law.

Outcome Chain Statement – Preparedness #1

Outcome – Organisational Capability is Built			
Framework - Lead			
Intermediate Outcome: *Commitment at all levels to elimination of suicide amongst persons receiving healthcare*	***Intermediate Outcome:*** *Data Driven Performance Measurement is Adopted*	***Intermediate Outcome:*** *Healthcare system has a just culture of recovery, healing, learning and improvement when losing a person to suicide*	***Intermediate Outcome:*** *Satisfaction with organisational leadership*
Change/Practice Adopted Healthcare workers are responsive to changes in their workplace systems and practices to eliminate suicide in healthcare.	**Change/Practice Adopted** Performance measures aligned to the Zero Suicide Healthcare Framework are in place.	**Change/Practice Adopted** Just culture and learning processes are adopted when losing a person to suicide in healthcare	**Change/Practice Adopted** Health system leaders actively strive towards Zero Suicide Healthcare and make decisions to enable its implementation.
Key Activities Case for Change – benefits for healthcare workers are presented and accepted. Professionalism Appeal – linking healthcare ethics and values to the improved outcomes for suicidal people and their carers.	**Key Activities** ZSH Performance Measures are identified – and targets for local context are set. Data specifications are determined for monitoring performance of healthcare services within ZSH Framework. Report formats are prepared for monitoring and trend analysis. Data reports are routinely generated.	**Key Activities** Overhaul of Root Cause Analysis procedures, including provisions for immediate reviews of critical incidents at a team level so recommendations for immediate improvement can be made. Training throughout the workforce on Just Culture – principles, practices and processes. Provision of 'postvention' supports for healthcare workers impacted by the loss of a person to suicide.	**Key Activities** Case for Change – business case supporting this – are presented and adopted. Accountability for performance of the healthcare system across various structures and leadership positions is defined regarding suicide prevention. Leader work with various service and functional units to set a pace for implementation and adoption of ZSH. Implementation stages are planned. Communication related to ZSH implementation is delivered by CEO or equivalent.

People Involved Frontline healthcare workers Unit Managers of healthcare workers, e.g. DONs Support function managers, e.g. human resources, legal, finance, IT, communications, facilities Representatives of workers, e.g. unions, professional associations.	**People Involved** Chief Executive Officers or equivalent Senior executive team Risk managers and quality assurance specialists. IT and Data Personnel (including data analysts) Unit Managers of healthcare workers, e.g. DONs	**People Involved** Chief Executive Officers or equivalent (critical) Senior executive team Unit Managers of healthcare workers, e.g. DONs Lead human resources professional on organisational development (or equivalent) Sydney Dekker (or equivalent inspirational coach)	**People Involved** Chief Executive Officers or equivalent Senior executive team. Lived experience leadership Clinical and workforce leadership
Knowledge Attitude & Skills Healthcare workers believe that they can achieve elimination of suicide through continual improvement. Knowledge of relevant system and practices in their role that will make a difference towards elimination of suicide in health care. Skills in safer suicide care	**Knowledge Attitude & Skills** Knowledge of the basis for performance measures for ZSHC. Knowledge of related external requirements on performance measurement, e.g. Health Safety and Quality Standards. Skills in specifying data requirements and definitions against performance measures. Knowledge of technology required to fulfil data requirements and reporting capabilities.	**Knowledge Attitude & Skills** Knowledge about just culture principles and their translation into healthcare operations and practices. Skills in leading organisational development and culture change. Skills to apply just culture, e.g. analytical skills, technical translation of improvements, interpersonal skills for shared learning, communication skills. Cultural attributes are based on learning and opportunity instead of blame and retribution.	**Knowledge Attitude & Skills** Leadership reinforces that evidence based treatments, clear clinical pathways and collaborative care management for suicide care is consistent with standards of care for other health conditions. Knowledge of what works for suicide prevention in healthcare settings. Skills in communicating the benefits, the sustainability and the results of ZSH.
Resources Data on the case for change; examples of achievements with the changes (peer or like organisations); feedback from lived experience. Key positions are given work-time and 'licence' to participate in the changes being introduced.	**Resources** ZSHC suite of standardised performance measures. IT Systems (operations support). Budget for data system refinements, e.g. integration, linkages.	**Resources** Just Culture Principles and Theory. Funding for training – skills development. Budgets for time-related activities to implement Just Culture.	**Resources** Local data for the Case for Change. Financial modelling for local situation - applied to local budget. Evidence surrounding suicide prevention in a hospital and health care setting. Lived experience insights on service provision. Pathways and protocols are embedded in clinical care as routine practice.

Outcome Chain Statement – Preparedness #2

Outcome – Organisational Capability is Built

Framework - Train

Intermediate Outcome: *Workforce is competent and confident to support people at risk of suicide*	***Intermediate Outcome:*** *Workforce is equipped to use quality review and continuous improvement processes*
Change/Practice Adopted All members of the workforce are assessed for their knowledge, skill and attitudes commensurate with the roles and responsibilities that they will perform in supporting people at risk of suicide.	**Change/Practice Adopted** All members of the workforce understand how they can contribute to processes of continuous improvement of services for suicidal persons and their carers.
Key Activities Specifications on the level and nature of competency for all job roles Workforce survey to quantify current workforce status regarding competency levels and degrees of confidence and comfort with regard to services for suicidal people and their carers. Health service staff are trained, in line with their roles and responsibilities, and are competent and confident to work with suicidal persons and their carers. Workforce development plan that identifies areas of need for training and development.	**Key Activities** Guidelines for service provision to suicidal people and their carers are integrated to existing quality improvement processes. Liaison with Centre for Clinical Excellence and other agencies to set training for quality improvement managers to incorporate suicide prevention. Just Culture training delivered widely to the workforce.
People Involved Senior Human Resources Management professional, with expertise in workforce learning and development. Senior clinician, who can define the levels of clinical knowledge, skill and attitudes (competency) required for specific clinical services for suicide prevention. Providers of training (internal and external), including trainers and persons with lived experience as facilitators of learning. Clinical mentors and coaches as appropriate. Frontline healthcare workers across the workforce, including peer workers. Unit Managers of healthcare workers, e.g. DONs Representatives of workers, e.g. unions, professional associations.	**People Involved** Healthcare service Quality Improvement Manager, or equivalent. Frontline healthcare workers across the workforce, including peer workers. Unit Managers of healthcare workers, e.g. DONs

Knowledge Attitude & Skills Workforce planning knowledge Knowledge of the availability and relevance of workforce training programs Skills in designing and administering assessments of competency (knowledge skills and attitudes) across a workforce with different roles and structures. Skills in observing and analysing comfort and confidence levels about providing services to suicidal persons and their carers.	**Knowledge Attitude & Skills** Knowledge of the principles and techniques of quality and improvement – as applied to the healthcare system context and services provided for suicidal persons and their carers – commensurate with job roles and responsibilities. Skills in the selection and/or design of quality improvement education programs for the healthcare workforce. Attitudinal acceptance across the organisation of the relationship between Just Culture practices and quality improvement for services provided for suicidal persons and their carers.
Resources Budget for workforce planning activities and subsequent training.	**Resources** Just Culture theory and principles. Quality Improvement Program as utilised by the organisation. Budget for training development and delivery.

Outcome Chain Statement – Preparedness #3

Outcome – Organisational Capability is Built		
Framework - Improve		
Intermediate Outcome: *Data is collected systematically to a standard for ongoing monitoring of healthcare operations with suicidal persons and their carers*	***Intermediate Outcome:*** *Data reports are produced and analysed routinely within quality review and improvement cycles*	***Intermediate Outcome:*** *Improvements to service delivery activities are made following quality reviews*
Change/Practice Adopted Continuous improvement systems have data that allows monitoring of quality and performance.	**Change/Practice Adopted** Data reporting is included in meetings, quality review processes and decision making on service and practice improvements.	**Change/Practice Adopted** Decisions are taken and acted upon to implement improvements arising from quality reviews.
Key Activities Data specifications are determined for monitoring quality and performance of healthcare services for suicidal persons and their carers. Data is routinely collected, collated and analysed, on an automated or procedural basis. Data custodianship and accountability for data use is determined.	**Key Activities** Data reports are compiled to meet the needs of those involved in their analysis with presentation of data results relating to the measures of service performance, variation indicators and quality standards. Meeting agendas, information for reviews, management reports incorporate the data reports. Meeting minutes, notes and documentation records the interpretation and implications of the data reports to feed into decision processes.	**Key Activities** Recommendations for service and practice improvements are prepared with reference to data results and reports. Appropriate decision-making and governance processes within an organisation are used to consider the recommendations and make determinations. Implementation of decisions includes consideration of the resources, budget, personnel and change management factors required to achieve successful change. Accountability for the service and practice improvements being effectively implemented is assigned and progress is monitored.
People Involved Chief Operating Officer (or equivalent) IT and Data Personnel (including data analysts) Frontline healthcare workers Unit Managers of healthcare workers, e.g. DONs	**People Involved** Chief Operating Officer (or equivalent) Quality Improvement Officer (or equivalent) Unit Managers of healthcare workers, e.g. DONs Clinical specialists	**People Involved** Chief Operating Officer (or equivalent) Risk manager and legal officers. Quality Improvement Officer (or equivalent) Unit Managers of healthcare workers, e.g. DONs Clinical specialists Frontline healthcare workers

Knowledge Attitude and Skills Knowledge of data needs/skills in specifying data requirements. Knowledge of technology required to fulfil data requirements and reporting capabilities. Skills in data collection, standards and data management. Skills in data analysis and reporting.	**Knowledge Attitude and Skills** Knowledge of data analysis and performance measures for services and practices relating to suicide prevention in healthcare. Skills in translation of data results into improvement techniques for services and practices. Attitude towards data-informed service improvement.	**Knowledge Attitude and Skills** Knowledge of the dynamics of burnout, compassion fatigue and vicarious trauma as they can affect service performance. Skills in decision making and implementation of service improvements in organisational settings, depending on job roles and responsibilities. Attitudes generally towards positive improvements to services and practices.
Resources IT Systems (operations support) Data ethics and standards relevant to healthcare provision Budget for data system refinements, e.g. integration, linkages	**Resources** IT Systems (operations support) Data reporting formats and configuration that relates to user needs/specifications Distribution of data reports in a routine way within organisational systems.	**Resources** Budget for service and practice improvements. Authorisation of personnel to make changes and to implement decisions. Knowledge of implementation practices by key personnel.

Outcome Chain Statement – Practice #1

Outcome – Person Safety and Suicide Related Clinical Improvements are Achieved	
Framework - Identify	
Intermediate Outcome: *The suicidality of people is explored regardless of their presenting health issues.*	***Intermediate Outcome:*** *Decisions on the level and nature of service and support are informed by the formulation of a person's suicide risk.*
Change/Practice Adopted Screening tools for suicidality are consistently utilised with all persons in healthcare services.	**Change/Practice Adopted** Suicide risk formulation tools are utilised alongside clinical judgement with people at risk of suicide.
Key Activities Selection of screening tools for the health care services and facilities – relevant to context. Protocol on universal application of suicide screening tools across health care services and with people of all ages, cultures and circumstances. Training in the administration of and interpretation of screening tool data. Integration of screening tools and data collection to existing care data systems and health care planning or case management. Guidelines and examples of how screening tool results are to be utilised in health care responses and referrals for suicidal persons.	**Key Activities** Selection of suicide risk formulation tools e.g. SafeSide, or Screening Tool for Assessing Risk of Suicide (STARS); or Chronological Assessment of Suicide Events (CASE). Selection of imminent suicide risk tools, e.g. brief and crisis interventions. Selection of suicide safety planning tools, e.g. BeyondNow. Selection of tools to Prevent Access to Lethal Means. Communication and engagement with personnel and stakeholders including persons with lived experience of suicide and carers in co-design comprehensive assessment protocols. Formalisation and budgetary allocations to support service and support responses based on a person's need – with associated decision making delegations and authorisations. Training in the administration, purpose and interpretation of comprehensive suicide risk formulation assessments, alongside clinical judgement. Training in related suicide safety planning, prevention of access to lethal means and crisis or brief interventions. Training in discussing results/formulation of risk/level of care with patient and carers to engage with a suicidal person around use of services.

People Involved Front line health service personnel. Qualified health professionals, i.e. nurses, doctors, social workers, psychologists, allied health workers. Related health and social services, notably Alcohol and Other Drugs, Psychosocial Support Services. Nursing Unit Managers, team leaders, clinical leads/ directors. Service improvement and quality assurance managers.	**People Involved** Qualified health professionals, i.e. nurses, doctors, social workers, psychologists, allied health workers. Related health and social services, notably Alcohol and Other Drugs, Psychosocial Support Services. Peer workers. Families, carers, spiritual & support workers. Nursing Unit Managers, team leaders, clinical leads/ directors. Service improvement and quality assurance managers. Senior managers and finance managers in a health care system. Health system funding managers.
Knowledge Attitude & Skills Knowledge of validated and reliable suicide screening tools to be used in different settings. Skills in the use of suicide screening tools in a way that engages with the person to obtain accurate data. Attitude towards the use of screening tools to maximise person benefit and improved care.	**Knowledge Attitude & Skills** Knowledge of the distinction between suicide risk formulation and suicide risk prediction including crisis or imminent risk assessment. Skills in the use of suicide risk formulation – comprehensive suicide assessment tools – in a way that collaboratively and respectfully engages with the person and their carers. Attitude towards service response decisions based on identified need.
Resources Licence fees for selected screening tools. Training for personnel in the administration, interpretation and use of screening data. IT Systems for integration of screening data.	**Resources** Licence fees for selected assessment tools and related intervention and safety planning tools. Training for personnel in the administration, interpretation and use of assessment data and decision making on service and support responses. Training for personnel is the use of related intervention and safety planning tools. IT Systems for integration of assessment tools and data collection and for integration of comprehensive assessments into service responses, care plans and case management.

Outcome Chain Statement – Practice #2

Outcome – Person Safety and Suicide Related Clinical Improvements are Achieved		
Framework - Engage		
Intermediate Outcome: *A collaborative health care relationship is established between healthcare workers, a suicidal person and their carers.*	***Intermediate Outcome:*** *Suicidal persons and their carers experience compassion, sensitivity, respect in their interactions with health care services.*	***Intermediate Outcome:*** *Suicidal persons and their carers receive continuous contact and support while with health care services.*
Change/Practice Adopted Trust in the health care relationship is enabled through development of a Care Management Plan through open exchange of information, continuous communication and participative decision making.	**Change/Practice Adopted** Clinicians and other health workers hold beliefs and understandings of suicidal behaviour that underpin compassionate health care.	**Change/Practice Adopted** Follow up contacts are made routinely and at key points such as when appointments are missed or a referral to another service is made.
Key Activities Adoption of tools such as the Collaborative Assessment and Management of Suicide (CAMS) or similar as the basis for engagement and treatment planning with all suicidal persons and their carers. Training for all key personnel, such as care coordinators and clinicians in the skills required to build collaborative health care relationships. Preparation of the Care Management Plan includes education of person and carer on suicidality and its causes, and the health care services that relate to treatment and recovery.	**Key Activities** Frontline and professional health workers who are treating suicidal persons and their carers are recruited with suitable attitudes and personal attributes for the roles that they will perform. Frontline and professional health workers are trained in values based engagement with suicidal persons and their carers, e.g. Connecting With People. Clinical supervision and wellbeing support programs monitor for staff showing signs of burnout, compassion fatigue and vicarious trauma to intervene earlier and prevent impacts on services.	**Key Activities** Operationalisation of routine and 'key points' follow up contacts with all suicidal persons including protocols for responses to identified changes in needs and suicidal status. Creation of a service directory and referral protocols to a range of 'aftercare' and support services for suicidal persons and their carers, including lived experience and peer support programs. Integration of support service referrals and follow up contact activities to the care management plans and clinical review processes for a person.
People Involved Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Nursing Unit Managers, team leaders, clinical leads/directors.

Knowledge Attitude & Skills Knowledge of comprehensive psychosocial suicide risk assessment and management tools, such as Collaborative Assessment and Management of Suicide (CAMS) or similar. Attitudes that uphold participative and partnership-based treatments of suicidality, based on respect for a person's ability to recover. Skills in the creation of collaborative health care relationships through personal rapport generation, communication and negotiation.	**Knowledge Attitude & Skills** Knowledge of the concepts of psychological pain as it relates to suicide and suicidal behaviour. Non-judgemental and empathic attitudes towards a person experiencing suicidality and/or attempting to take their lives. Knowledge of the impacts of another's suicidality on carers/families. Listening skills.	**Knowledge Attitude & Skills** Knowledge of the personal and social factors of a non-health nature that affect a person's suicidality and recovery. Knowledge of support services outside of the health care system. Skills in use of care planning with persons and carers to promote support services. Skills in the use of brief follow up contacts to ascertain changes in person need or suicidal status. Attitudes that embrace total person care beyond health care system boundaries and enable productive interaction with other services.
Resources Licence fees for use of CAMS or equivalent. Education and training for key personnel. Education materials and programs for carers. Technology – integration of comprehensive psychosocial assessments to care management systems.	**Resources** Human resource management: recruitment, retention and clinical supervision protocols. Education and training for key personnel.	**Resources** Education and training for key personnel. Service and system development to support operationalisation of follow up brief contacts. Investments in creation and maintenance of support service directories.

Outcome Chain Statement – Practice #3

Outcome – Safety and Suicide Related Clinical Improvements are Achieved with Suicidal Persons

Framework - Treat

Intermediate Outcome:	***Intermediate Outcome:***	***Intermediate Outcome:***
A person's suicidality is reduced through their treatment.	*Access to lethal means is addressed directly and restriction confirmed with suicidal persons.*	*Suicidal persons are equipped to exercise suicide safety through self-monitoring and the use of crisis supports.*
Change/Practice Adopted Interventions that specifically address a person's suicidality are adopted in care and treatment plans as the primary course of action.	**Change/Practice Adopted** Lethal means counselling is offered routinely, with due consent, and integrated with suicide safety planning.	**Change/Practice Adopted** Suicide safety plans are formulated with all persons.
People Involved Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Nursing Unit Managers, team leaders, clinical leads/directors.
Key Activities Psychotherapy; psychology; psychiatric interventions that directly address suicidality are utilised, e.g. - CBT - SP - DBT - Psychotherapy - Psychoeducation - Pharmacotherapy - Psychiatric care - ECT - Chemical dependency treatment (substance abuse) Clinical governance and oversight of treatments for suicidality is exercised by expertise in suicide. Intersections between primary health care (GPs), community mental health and health system mental health and psychiatry are formed through care plans for suicidal persons.	**Key Activities** Selection of counselling and consent techniques on lethal means restrictions – informed by expertise. Training relevant staff in the use of these interventions. Legal review of aspects of lethal means restrictions to address potential liabilities.	**Key Activities** Selection of suicide safety planning techniques, e.g. Beyond Now – informed by expertise. Training relevant staff in the use of these techniques. Legal review of aspects of suicide safety planning to address potential liabilities.

Knowledge Attitude & Skills Clinical expertise and research evidence to inform the selection of interventions in treatment plans. Clinical and health care skills in identification of interventions and mix of treatments for suicidal persons. Clinical workforce with skills to deliver treatments for suicidality. Attitudinal acceptance of suicidology as a discrete body of knowledge with specialist clinical and health treatments.	**Knowledge Attitude & Skills** Expert knowledge of techniques for requesting consent and use of lethal means restriction protocols. Skills in the performance of lethal means counselling. Attitudinal acceptance of ethical dilemmas arising in discussions on lethal means.	**Knowledge Attitude & Skills** Expert knowledge of techniques for developing suicide safety plans with suicidal persons. Skills in the development of suicide safety plans. Attitudinal acceptance of a suicidal person's ability to self-monitor and address elevations in their suicidal state. Attitudinal acceptance that person's suicidal state may wax and wane and that these cycles may be manageable rather than resolvable.
Resources Public health subsidies or provision of treatments, pharmaceutics and programs to support treatment of suicidality. Licence rights for treatment programs. Workforce acquisition and professional development. Data systems and technology supports for the operationalisation and clinical review of treatment programs.	**Resources** Licence rights to counselling programs on lethal means. Training for key personnel. Data systems and technology supports for the operationalisation and review of lethal means restriction programs.	**Resources** Licence rights to suicide safety planning tools and techniques. Training for key personnel. Data systems and technology supports for the operationalisation and review of suicide safety planning.

Outcome Chain Statement – Pathways

Outcome – Suicidal Persons and Carers are Equipped for Recovery		
Framework - Transition		
Intermediate Outcome: *Suicidal persons and their carers perceive aftercare programs as useful and relevant to their needs*	***Intermediate Outcome:*** *Suicidal persons and their carers experience smooth entry to aftercare programs*	***Intermediate Outcome:*** *Suicidal persons and their carers have increased hopefulness and confidence for recovery*
Change/Practice Adopted Aftercare programs are integrated with hospital-based health care for suicidal persons.	**Change/Practice Adopted** Care transitions for suicidal persons and their carers occur in a planned way.	**Change/Practice Adopted** The provision of healthcare instils a recovery outlook within suicidal persons and their carers.
Key Activities Creation of service directories and referral protocols to aftercare services, e.g. Beyondblue The Way Back Support Service; Eclipse Suicide Survivor Support Groups, Life Clinic. Education and training for key personnel in the benefits of and facilitation of suicide aftercare programs. Carers are routinely educated about the care, safety management and support that is available for them during healthcare periods and prior to transitions out of healthcare. Systematic referrals for aftercare programs occur for every suicidal person.	**Key Activities** Formulation of checklists, guides and authorisations for discharge plans relating to suicidal person. Training for key personnel in use of templates for discharge planning relating to suicidal person. Discharge plans for suicidal persons are finalised ahead of actual departure from the hospital and specialist health care environment.	**Key Activities** Recovery objectives are developed for every suicidal person as part of the clinical care planning process. Training for key personnel in positive communication and messages to encourage a recovery outlook. Use of peer workers and informal supports to enable recovery orientation.
People Involved Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Nursing Unit Managers, team leaders, clinical leads/directors.	**People Involved** Care coordinators/case managers. Clinicians, i.e. mental health nurses, psychologists, psychiatrists. Related health and social services, notably social workers, alcohol and other drugs workers, counsellors and psychosocial support coordinators. Peer workers, carers, informal and volunteer support people

Knowledge Attitude & Skills Knowledge of available aftercare programs and their type, purpose and application for suitable participants. Knowledge of referral processes including information and assessment provision to facilitate entry to aftercare programs. Skills in collaboratively developing plans for aftercare programs with persons and carers. Skills in negotiating placements and referral pathways for persons to enter aftercare programs. Attitudinal acceptance of concepts of total person care that includes attention to the post-specialist service care arrangements.	**Knowledge Attitude & Skills** Knowledge of discharge planning techniques and use of templates. Skills in engagement with persons and carers on discharge actions. Attitudinal acceptance of responsibilities within hospital and specialised health care services to complete discharge planning properly prior to person release.	**Knowledge Attitude & Skills** Knowledge of principles and practice of recovery in suicide prevention Skills in engagement with persons and carers on a recovery orientation Skills in motivation and problem solving through incidental contact with others Attitudinal embrace of positive and constructive provision of supports for those recovering from suicidal crisis Attitudinal acceptance of the potential for recovery from suicidal crisis
Resources Training for key personnel. Education and information resources for suicidal persons and carers.	**Resources** Training for key personnel. Operationalisation of discharge plans for suicidal persons through IT and systems technologies.	**Resources** Education and professional development for key personnel Education and information resources for suicidal persons and carers.

5. Data Measures

The Evaluation Framework for Zero Suicide Healthcare outlines the outcome chains across the framework for adoption of a comprehensive approach to suicide prevention in healthcare systems. These outcomes relate to practice changes, processes and workforce development.

Data measures as outlined below will support data collection within the Evaluation Framework across these levels of operation and results monitoring. These data measures will also feed quality review and continuous improvement processes.

The Data Toolkit available online through the US Zero Suicide Institute contains some data measures – the Evaluation Framework extends these. Those data measures that are from the Data Toolkit are shown in green highlight.

Processes marked with ** are listed on the US data elements worksheet found here: http://zerosuicide.edc.org/sites/default/files/ZS%20Data%20Elements%20Worksheet.TS_.pdf

Lead		
Outcomes	**Practice and Change**	**Processes**
% Healthcare workforce holding commitment to elimination of suicide Extent to which healthcare performance measures align to Zero Suicide Healthcare Culture review confirms existence of values of recovery, healing, learning and improvement Organisational wide feedback shows satisfaction with leadership	Feedback from healthcare workers shows support for changes to eliminate suicides Corporate and individual performance reviews apply measures from Zero Suicide Healthcare Corporate policy and procedure align to principles and practice of Just and Learning Culture Implementation decisions on Zero Suicide Healthcare are made in a timely manner	% Healthcare workforce is familiar with the Case for Change Data for performance measurement is collected and reported on. Workforce training in Just Culture is completed. Executives/leaders performance agreements contain measures on suicide prevention.

Train		
Outcomes	**Practice and Change**	**Processes**
Measured levels of knowledge, skill and confidence of healthcare workforce in providing support to people at risk of suicide Extent to which healthcare workforce is utilising quality and continuous improvement processes across discrete operational units	Extent to which healthcare workforce meets standards of knowledge, skill and attitudes on working with people at risk of suicide Extent to which healthcare workforce applies continuous improvement practices in routine service delivery	Workforce competency reviews completed Workforce training completed Guidelines and practice notes on continuous improvement for service provision to suicidal persons and their carers are adopted.

Improve

Outcomes	Practice and Change	Processes
Completeness of data to monitor healthcare for suicidal persons and their carers Quality review processes are utilising data on provision of healthcare to suicidal persons and their carers Evidence of improvements made following quality reviews	Data is made available for quality reviews Evidence of data reports setting quality review priorities and subsequent decisions on improvements	Data is collected according to specification Feedback from data users confirm satisfaction with quality of data and its utility in reports Quality reviews and improvement processes operate on the basis of data reports and analysis

Identify

Outcomes	Practice and Change	Processes
Universal screening for suicidality occurs across a healthcare system Suicide risk formulation is adopted in decision making on service levels and responses	Screening tools are consistently utilised in intake and care review operations Suicide risk formulation tools are adopted as standard operational requirements.	Workforce training in use of tools completed. Risk formulation results are incorporated into the care planning and budgetary decision processes. Proportion of clients who receive suicide screening during a reporting period. ** Proportion of clients screened positive for suicide risk that have a comprehensive risk assessment on the same day, during a reporting period. **

Engage

Outcomes	Practice and Change	Processes
Suicidal persons and their carers are satisfied with the level of collaboration in the relationship with healthcare workers Suicidal persons and their carers feedback meets expectations on compassion, sensitivity and respect shown by healthcare workers Suicidal persons and their carers report satisfactory contact and continuity of support during their period with health care services.	Evidence of the application of participative decision making tools and techniques Evidence that trust has been generated between suicidal persons, their carers and healthcare workers Extent to which healthcare workers demonstrate compassionate care Records of contact and continuity of follow up	Organisation-wide policy and standards on the use of collaborative techniques in the care of suicidal persons and with their carers Workforce training and professional development on compassionate care Adherence to supervision and support protocols to prevent burnout, compassion fatigue and vicarious trauma Records of brief contacts and follow up with suicidal persons and their carers Proportion of clients with a suicide care management plan who missed an appointment and who received contact within eight hours of the missed appointment, during the reporting period ** Proportion of clients who had been hospitalised or visited emergency department who were contacted within 24 hours of discharge during the reporting period. **

Treat		
Outcomes	**Practice and Change**	**Processes**
Measured reductions in suicidality for people undergoing treatment and healthcare Recorded adoption and adherence to lethal means management by people undergoing treatment and healthcare Quality and adoption of suicide safety management plans by people undergoing treatment and healthcare	Evidence based treatments are selected following an assessment of a person's needs regarding their suicidality Routine offering of lethal means counselling Routine formulation of suicide safety management plans	Treatments for suicidality are governed by clinical oversight and operate within professional standards Treatment selection is undertaken with the involvement of related health care providers, e.g. primary health care, community mental health Workforce training in lethal means counselling is completed Workforce training in suicide safety management planning is complete Privacy and consent protocols are formalised and utilised in all healthcare service provision. Proportion of clients with a safety plan developed the same day as screening, during the reporting period ** Proportion of clients who were assessed positive for suicide risk that were counselled for lethal means management the same day as assessment, during the reporting period. **

Transition		
Outcomes	**Practice and Change**	**Processes**
Suicidal persons and their carers outlooks on aftercare programs are generally positive Suicidal persons and their carers report smooth transition to aftercare programs Suicidal persons and their carers hold measurable increases in hopefulness and confidence for recovery	Hospital based care plans incorporate references to aftercare programs Transitions to aftercare programs occur using planned actions and clear handover pathways Proportion of healthcare plans that include collaboratively developed recovery objectives	Service directories and referral protocols for aftercare programs are in place and current Workforce familiarisation in aftercare programs is complete Discharge plans are completed to meet content and timeliness standards Peer workers and other informal supports are incorporated in the discharge and transitions activities during the period of healthcare

6. High Level Outcome Measures

Across the whole healthcare system, Zero Suicide Healthcare aims to eliminate suicide deaths. The following high level outcomes provide a mix of lead and lag indicators that relate to this objective.

These indicators are contained in the online Data Toolkit from the Zero Suicide Healthcare Institute.

- Rate of Deaths by Suicide Amongst all Clients of a Healthcare system **
- Rate of Deaths by Suicide Amongst all Clients of a Healthcare system with Identified Suicide Risk **
- Proportion of Clients Presenting to Emergency Department for Suicide Attempt Who Received a Suicide Care Management Plan **
- Proportion of Clients Admitted to Inpatient Unit for Suicide Attempt Who Received a Suicide Care Management Plan **
- Proportion of Healthcare Clients who Made a Suicide Attempt **
- Proportion of Healthcare Clients with Suicide Care Management Plan who Made a Suicide Attempt **

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