10 July 2012

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The Hon Kevin Humphries, MP
Minister Mental Health
Minister for Healthy Lifestyles
Minister for Western Sydney
Level 31 Governor Macquarie Tower
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Attn: Jennifer Nobbs, Senior Policy Advisor
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Subject: Improving 'Open Disclosure' processes following a suicide whilst in care/post discharge and moving to a more effective, accountable, collaborative model of care for people at risk of suicide.

Dear Minister,

In response the sector's concerns regarding suicide rates of people in care and post discharge, the need for improved implementation of the 'Open Disclosure' policy and greater accountability to be built into service systems, MHCC have reviewed NSW Health's Policy Directive, Standards and Guidelines on Open Disclosure, and whilst on paper the policy covers the principles, procedures and mechanisms necessary to deal with an adverse event, Open Disclosure may still remain somewhat aspirational. Idiema et al., (2008, p.430)[i] write: *lest Open Disclosure policy fail its health reform objectives, more insight into what works for consumers involved in adverse events is essential, requiring institutional support for practice-based research into consumers' experiences of existing approaches to adverse event management.*

In 2008, an Australian study was conducted in four states including NSW that investigated patients' and family members' experiences of open disclosure following adverse events including suicide and self-harm.[ii] Twenty three people were interviewed who had been involved in adverse events and incident disclosure. The methodology used was a thematic discourse analysis. The participants were recruited as part of an evaluation of the Australian Open Disclosure pilot commissioned by the Australian Commission on Safety and Quality in Health Care. Whilst all participants (except for one) appreciated the opportunity to meet with staff and have the adverse event explained to them. Their accounts revealed a number of concerns about how open disclosure is enacted e.g., disclosure not occurring promptly or too informally; disclosure not being adequately followed up with tangible support or change in practice; staff not offering an apology, and disclosure not providing opportunities for consumers to meet with the staff originally involved in the adverse event. Analysis of participants' accounts suggests that a combination of formal open disclosure, a full apology, and an offer of tangible support has a higher chance of gaining consumer satisfaction than if one or more of these components is absent.

It was clear from the findings it is necessary for staff to become more attuned in their disclosure communication to the victim's perceptions and experience of adverse events, to offer an appropriate apology, to support victims long-term as well as short-term, and to consider using consumers' insights into adverse events for the purpose of service improvement.

Action has been proposed on a number of fronts to bolster the 'Open Disclosure' initiative. Legal reform may promote collaborative principles to govern lawyers' roles in negotiating adverse events,[iii] make tangible support a standard component,[iv] and strengthen clinicians' accountability for (appropriate) disclosure.[v] Training provided to clinicians and managers should encompass response procedures to adverse events, emphasise disclosure communication that includes apologising and listening to consumers/ carers and give prominence to the need to take account of the consumer/ carer experience to improve the disclosure process. Most important is that health facilities accord consumers/ carers a voice in how adverse event responses are to be structured.

MHCC suggest that what is missing that would improve accountability is workforce capacity building to move policy objectives from well-intentioned directives to meaningful practice. For this to occur, scenario-based surveys confirming consumers' in-principle preference for disclosure [vi] need to be complemented with a practice-based model such as that described following (p. 3) in the "Choose Life: A National Strategy and Action Plan"[vii] an initiative to prevent suicide in Scotland in order to determine best practice in error response processes and to make sure this is delivered to every patient.

The Commonwealth Government have acknowledged in their National safety priorities in mental health: a national plan for reducing harm that, *suicides in mental health service settings may indicate a catastrophic system failure and can undermine public confidence in the mental health care system.*[viii] They are not only tragic events causing much grief and distress for families and friends, but are traumatising for mental health professionals and other workers involved in their care, and for other consumers within the mental health service. Whilst suicides of people in the care of mental health services are not always preventable, it is acknowledged that there is scope for reducing tragic events through improved systems of care.[ix]

Health Ministers agreed that *'suicide of a patient in an inpatient unit'* is a sentinel event in health care, to be publicly reported by jurisdictions as one of a number of nationally agreed core sentinel events (see National MH Strategy, 2005:appendix 8).[x] This data was included in the National Sentinel Event Report released by the Australian Council for Safety and Quality in Health Care in 2005. Unfortunately (we understand partly due to delays in the Coroners Court) no more recent figures than 2009 identify suicides whilst in care in NSW. This makes it difficult to assess whether there are any significant changes to outcomes. We propose that a study is necessary to identify the extent to which NSW policy directives have reduced adverse events and initiated improved services responses to meet targets for improved outcomes.

In addition to suicides in inpatient units, adverse events also include suicides occurring while consumers are on day leave, are absent without leave, or in the days and weeks immediately following discharge. This recognises that preventable suicides can occur as the result of omissions in care, for example as a result of lack of follow-up and continuity of care post-discharge. It is also argued that suicides occurring for periods up to a year following discharge from an inpatient unit are also serious events, particularly where consumers are in the care of community mental health services. Such suicides are often perceived by members of the community as a failure of the health care system.[xi]

Suicides are often preceded by suicide attempts and/or other acts of deliberate self-harm. Whilst acknowledging that not all self-harm behaviour is suicidal behaviour or related to suicidal thinking, improved systems of assessment and management of deliberate self-harming behaviours may help to reduce suicides. A systems oriented approach to reducing suicides, suicide attempts and deliberate-self harm is needed, along with a non-punitive

culture that rewards incident reporting and supports its use in continuous quality improvement.

MHCC propose that the Ministry review the Scottish 'Choose Life' strategy which was established in 2002 to combat the high statistics of suicide (which are double that of the UK and Wales in terms of males between 15-34 years). The second phase evaluation has provided evidence of marked improvement towards national and local milestones, based on local coordinators' satisfaction with national action towards milestones.[xii]

The over-riding theme of the Choose Life strategy is collaboration: a collective, concerted effort required from all groups in society – health, human services, health professionals, communities, voluntary and statutory agencies and organisations, parents, friends and neighbours, combined with an integrated and co-ordinated approach across all government departments.

There are five principles which guide the implementation of the Choose Life Strategy and Action Plan:

Shared responsibility
Responsibility for addressing suicidal behaviour cuts across all departments, sectors, agencies (public, private and community) and organisational boundaries. All need to share a sense of collective responsibility and ensure that actions work in partnership. This requires harnessing the energy of the voluntary and community sectors and utilising their experience of working with local community interests and networks, alongside those of statutory agencies. This partnership working and shared responsibility also applies to sharing decisions about the investment and targeting of resources to achieve national and local objectives.

Effective Leadership
Both locally and nationally, effective and sustained leadership must be established to achieve a balance between 'bottom up' and 'top down' initiatives and actions which maximise ownership and commitment by all parties.

A Person-Centred Approach
In addressing complex issues, there must be recognition of the range of influences, events and experiences that shape a person's life at different stages, especially at critical points in their lives, for example, leaving school, becoming a parent, loss of employment, losing a loved one or colleague. All of these experiences shape a person's outlook and experience. This requires a people-centred approach – seeing people as individuals, with their own strengths, abilities, desires and wishes. It is important that this is a strengths-based approach and that in supporting and responding to people, that hope, understanding and empathy are offered to support the process of recovery which will be different for each individual. It is a recovery based approach.

Focus on Priority Groups
Suicide affects all parts of society. To ensure change occurs in both the short and longer term, a focus must centre on priority risk groups without losing sight of the broader needs of society as a whole.

Continuous Quality Improvement
A strategic approach to suicide prevention has to be informed by drawing on, and developing, better information and evidence of what works. Outcomes must be identified that can be measured and monitored to constantly evaluate progress and make the necessary

adjustments to confirm that our actions are being effective and take the necessary actions to improve future work.

The Choose Life strategy set out to achieve a 20% reduction in suicide over 10 years. MHCC propose that the Ministry similarly set a stated target to reduce suicides in NSW. This will require immediate and longer-term action and investment by a variety of agencies nationally and locally.

In order to achieve a significant targeted reduction and ensure change in the short and longer term, it will be important to focus actions and efforts on a number of priority groups which particularly include people with mental health problems (in particular those in contact with mental health services) and those with a severe mental illness experiencing chronic depression and/or severe anxiety disorders, people who experience psychosis, are delusional or hear voices, people experiencing complex trauma, people who attempt suicide, people affected by the aftermath of suicidal behaviour or a completed suicide, people who abuse substances and people in prison and people experiencing difficulties as a consequence of psychosocial disability and depravation.

It is also important to focus on people recently bereaved, who have recently lost employment, people who have been unemployed for a period of time, people who live in isolated or rural communities, people who are homeless and people of Aboriginal descent, refugees and young people identified at risk. There may also be local priority groups for action, and community planning partnerships will be necessary to identifying these and establishing the appropriate investments and actions to be taken.

The Choose Life model is recovery orientated approach that requires a quality response from services that focuses on the identification of those at risk and assessment of their needs and treatment, and the care coordination required across the mental health, health, psychosocial service domains as well as focus on the prevention, early intervention and supporting the recovery journey through care and support from services such housing, employment, education and the criminal justice system. The relationship between these factors and suicidal behaviour is complex and should not be addressed in isolation.

Following on from the national Inquiry into Suicide and Homicide by people with mental illness, an inquiry initiated by the Healthcare Quality Improvement partnership in the UK, Twelve points to a Safer Service[xiii] were recommended. These points focus on policy and practice in mental health that addresses concerns in relation to improving responses to reduce suicide events, particularly for people engaged with mental health services.

The ‘Twelve points to a Safer Service’ list identifies the most important recommendations intended as a checklist for local services;-

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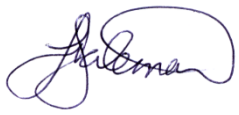
1. Staff training in the management of risk – both suicide and violence –every 3 years
2. All patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care
3. Individual care plans to specify action to be taken if patient is noncompliant or fails to attend service
4. Prompt access to services for people in crisis and for their families
5. Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients
6. Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with “typical” drugs because of side-effects

7. Strategy for co-existing conditions such as covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service
8. In-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails
9. Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months
10. Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks
11. Local arrangements for information-sharing with criminal justice agencies
12. Policy ensuring post-incident multidisciplinary case review and information to be given to families of involved patients.

MHCC acknowledge the whole of government approach outlined in the NSW Suicide Prevention Strategy 2010-2015 and the strategic directions toward a whole of community response. However we can find little evidence of improved outcomes, since we are unable to source suicide data since 2009, and in any event earlier data does not identify deaths in care. In our view it is necessary, at this point in time to review policy implementation across the NSW strategic directions, and evaluate the policy directives in relation to open disclosure. Likewise it is important to review the NSW broad based approach in relation to the Choose Life model and investigate how improvements can be made by up-skilling the workforce to meet the challenge of reducing suicides in NSW.

MHCC thanks the Minister for his interest and express their willingness to discuss the matter in greater detail with you and the department and would welcome an opportunity to assist in any way to progress a review process.

Yours sincerely



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