Collaborating to Enhance Suicide Prevention in Western Australia

SafeSide Prevention and Western Australian Mental Health Commission Partnership: Explore Phase Findings Report

September 2024

SafeSide PREVENTION

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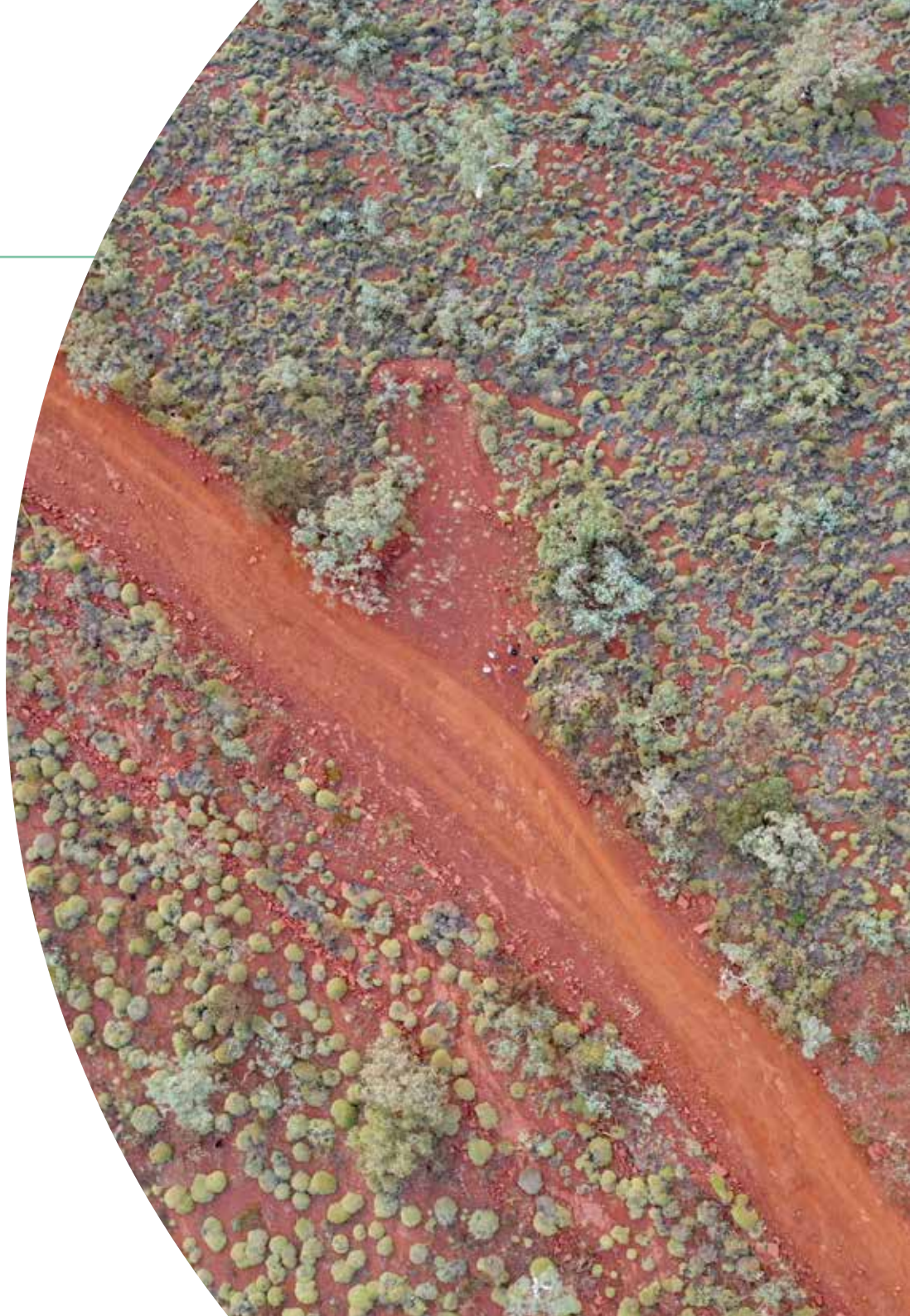


Acknowledgements

SafeSide Prevention acknowledge the Traditional Custodians of the land on which our workshops and events have taken place. We honour the ancestors of yesterday, the custodians of today, and those of tomorrow. We recognise the continuing connection to land and waters and how culture is held, nurtured, and shared.

SafeSide Prevention recognise the individual and collective expertise of those with living and lived experience of mental health, alcohol and other drug issues and suicidal crisis, including their families and carers. Insights from those with a living and lived experience are essential in shaping SafeSide Prevention's goals and strategies.

By incorporating firsthand knowledge of health systems and services, SafeSide Prevention works towards implementing meaningful changes in the field.

Foreword from Professor Tony Pisani

Suicide prevention is complex, requiring a multifaceted response tailored to community needs. This report details the initial phase of our work exploring how SafeSide Prevention's approach might enhance suicide prevention efforts in Western Australia, reflecting its diverse communities' unique voices, experiences, and needs.

This phase of work provided multiple opportunities for people to experience and respond to SafeSide Prevention's programs and assess the fit and potential value. We are grateful for the enthusiastic participation of individuals, organisations, and communities across the State in such a short timeframe, and look forward to broader and deeper engagement in the future.

Participants provided rich, voluminous, and detailed feedback, as this report reflects. Overall, participants expressed a strong desire to do more in suicide prevention and to see strong cross-sector collaboration. Survey data and participant discussions converged to suggest that SafeSide Prevention's research-based approaches, in their current or adapted form, could strengthen and complement the excellent work already underway in Western Australia.

We accomplished a great deal together in a short period of time. We are grateful for the opportunity to work with the Commission and give special thanks to the Communications team for their expertise and collaboration. I would also like to extend my thanks to the SafeSide Prevention team for their dedication and the results achieved.

We remain dedicated to working collaboratively towards our shared goal of reducing suicide and improving mental health and wellbeing for all Western Australians.

Anthony R. Pisani, Ph.D.

Professor, Psychiatry and Pediatrics

Center for the Study and Prevention of Suicide

University of Rochester Medical Center

Founder and Chief Scientific Advisor,
SafeSide Prevention

Executive Summary

The Mental Health Commission of Western Australia (the Commission) engaged SafeSide Prevention (SafeSide) to explore how its programs and services could complement existing suicide prevention efforts in the state. This report presents findings from the 'Explore' phase of the project, conducted from April to July 2024.

Key activities:

- Stakeholder engagement sessions and workshops with over 250 participants.
- Sample workshops and feedback sessions of SafeSide Prevention's programs and offerings: Connect, SafeSide Program, and Restore Network.
- Consultation with lived experience advocates, first responders, mental health professionals, and leaders across various sectors.
- Engagement with leaders via private interviews, Public Sector Leadership Council, and a large cross-sector Leadership event and workshop.

Key findings:

1. Healthy Resilient Workforces:
    - Strong interest in the Connect Program for first responders.
    - Potential applicability to other government and non-government workforces.
2. Ready to Respond:
    - SafeSide Program well-received across Mental Health, Youth Services, and Alcohol and Other Drugs (AOD) sectors.
    - Participants reported increased knowledge, self-efficacy, and motivation to apply learnings.
    - Need for customisation to Australian context and integration with existing systems.
3. Supported when Suicide Occurs:
    - Keen interest in implementing Restorative Just and Learning Culture (RJLC) practices.
    - Desire for a whole-of-government approach to suicide prevention and response.
4. Consultation and Collaboration:
    - Strong emphasis on authentic lived experience engagement.
    - Need for culturally appropriate and region-specific consultation.

Challenges:

- Limited engagement from the primary care sector.
- Insufficient time to gain meaningful engagement and representations from regional, remote, culturally diverse and Aboriginal and Torres Strait Islander communities.
- Time constraints affecting participant recruitment and data collection.

Actions for Consideration:

1. Establish a diverse advisory structure to guide project-wide engagement.
2. Implement Connect Program across first responder workforces.
3. Customise and roll out the SafeSide Program to Commission-funded services.
4. Develop a Restore Network for Western Australia (WA) Health and the Department of Justice, starting with those involved in incident review processes relating to suicide.
5. Create evaluation frameworks and address practical implementation considerations.

Next steps:

SafeSide will provide a proposal for thoughtfully building the necessary structures and implementation strategies to ensure a unified approach to suicide prevention, cultural relevance, and long-term sustainability. The focus will be on fostering collaboration and creating a foundation for lasting impact in WA communities.

Actions for Consideration

Based on the findings and insights gained during this exploratory phase and detailed below, SafeSide offers the following actions for consideration.

Consultation and Collaboration	• Establish a diverse advisory board with lived experience advocates and key stakeholders to guide project-wide engagement. Incorporate region-specific consultation, engage expert organisations like Roses in the Ocean, and align with existing local lived experience frameworks. • Consult with Aboriginal and Torres Strait Islander organisations to ensure cultural safety and explore their recommendations and feedback on SafeSide's programs or services. • Explore with other government departments via the Public Sector Leadership Council work they may want to undertake with SafeSide.
Healthy Resilient Workforces	• Take preparatory steps to invite and encourage first responder workforces (initially identified as police, fire and emergency services, and paramedics) to implement the Connect Program. • Explore the utility of the Connect Program in other relevant or interested Departmental workforces outside of first responders. • Consider selecting priority groups based on available data and evaluating the program with these groups to contribute to the evidence base.
Ready to Respond	• Customisation of the SafeSide Program for Mental Health and Youth Services - including customised scenarios and lived experience interviews where required. • Customise the Primary Care adaptation to ensure relevance for a non-clinical audience working in suicide prevention. • Develop implementation plans and roll out the SafeSide Program to Commission-funded Mental Health, Youth Services and AOD Services in both Non-Government Organisation (NGO) and WA Health in the first instance. Explore using the SafeSide Program and Framework with other relevant Government departments such as Education. • Leverage and resource existing networks and structures for the rollout of this training, such as Suicide Prevention Coordinators and WA headspace network. • Explore system and policy integration needs across services and sectors. Participants suggested that the SafeSide framework should be integrated with current local policies, procedures, and documentation standards to enhance its relevance and applicability. • Explore the utility of the Collaborative Assessment and Management of Suicidality (CAMS) to ensure people with suicide ideation have access to evidence based treatments.

Supported When Suicide Occurs	• Develop a Restore Network for WA Health and the Department of Justice, starting with those involved in incident review processes relating to suicide. • Expand the Restore Network to include Work Health and Safety (WHS) and Human Resources (HR) leaders from across the Government and encourage the continuous adoption of restorative practices statewide. • Deliberately learn from Network members about resource and policy development needed to support the application of RJLC practices across services and sectors.
Measuring Impact	• Development of a project-wide logic model in consultation with the Commission and advisory group/s. • Establish an evaluation plan for each program component, including agreed-upon metrics and roll-out strategies. Scope for consideration includes evaluation of adaptation and co-design customisations to content, educational outcomes and impact, change in care delivery and outcome for consumers and families. • Develop an inventory of currently available data sources and identify what additional data sources might be needed to measure the agreed outcomes. • Consider how to properly resource project partners for engaging in high quality evaluation.
Project-Wide Considerations	• Develop advisory group and its governance structure. • Develop overarching and program-specific communications plans. • Address technical compatibility issues and determine necessary steps and funding for implementation. • Explore how SafeSide could advise or assist in developing the next WA Suicide Prevention Framework.

About SafeSide Prevention

SafeSide Prevention works towards a vision of a world where every person is respected, connected, and giving to others.

Our challenge is to engage, unite, and support a diverse workforce, serving diverse populations in diverse and remote locations to think, act, and communicate with a common set of principles and best practices.

We deliver a systems-based approach to suicide prevention and provide leadership consultation and workforce education for health, mental health, educational, and governmental organisations seeking to unite and inspire their mental health and primary care workforces to prevent suicide.

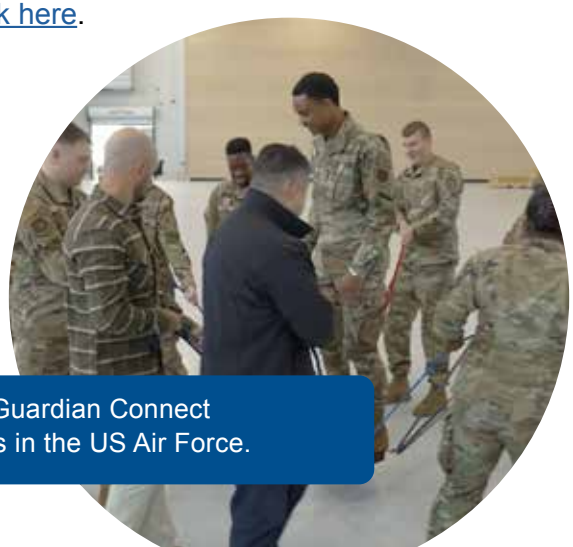
Our programs cultivate a healthy, resilient workforce that is ready to respond and supported when a suicide occurs.

Explore an overview of Suicide Prevention in Systems (Pisani, Moutier, & Stahl, 2021; Pisani & Boudreaux, 2023), how this relates to Zero Suicide, and the programs SafeSide offers to advance this approach in Appendix A.

The SafeSide team - Dan Mobbs, Tony Pisani, Jamie Thompson, Mel Clark, Kim Borrowdale, Alicia Visser, Annie Lewis, Tiyana Gostelow

The Connect Program

The Connect Program is an upstream prevention program proven to increase team cohesion, improve mental health, and reduce suicide risk. It is currently adaptable for military and police units. Evaluations are underway in healthcare, religious communities, and youth sports. The program includes six hours of interactive training designed for groups of 25-40 focusing on the four cores of Kinship, Purpose, Guidance, and Balance, as well as text messages and video follow-ups for six months. Participants see improved mental health, reduced suicide risk and depression symptoms, reduced occupational problems, and increased social bonds and cohesion. For more information and to explore the evidence, click here.



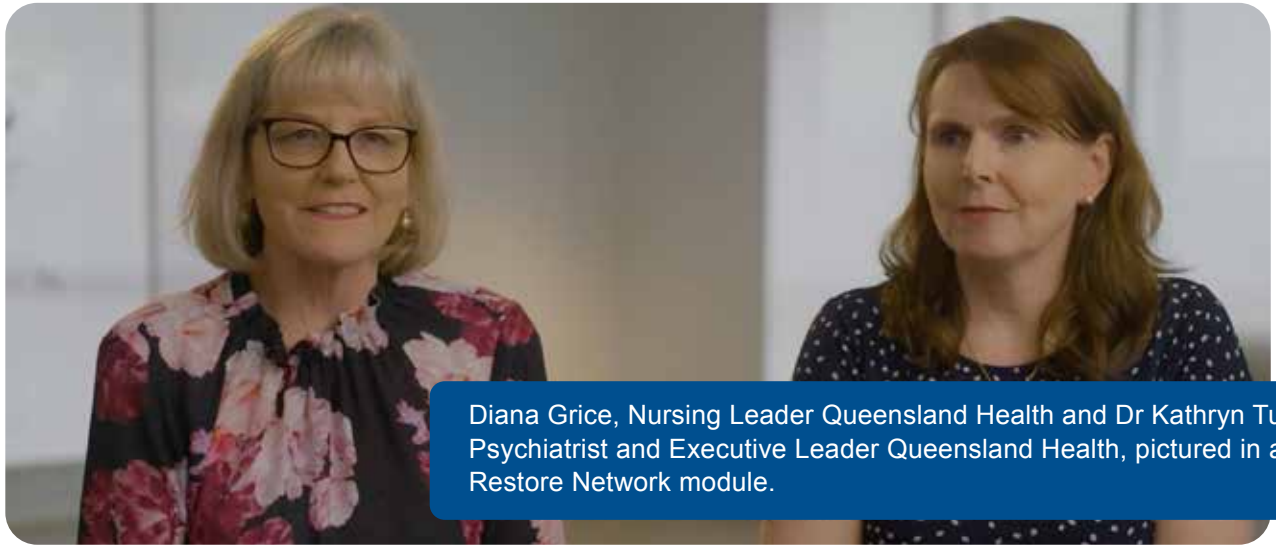
Wingman Guardian Connect participants in the US Air Force.

Restore Network

The Restore Network provides leaders with a trusted network for collaboration with external organisations dedicated to fostering a RJLC. This network engages those most affected to identify human needs and hurts, providing a path to healing, growth, and continuous improvement through shared learning. It is designed for leaders responsible for reviews and responses to suicide-related incidents. It includes meetings every one to two months with others in the Restore Network at various stages of leading change in their organisations and access to a curated and growing library of resources.

Implementing a RJLC offers benefits, including improved experiences for families and teams. As the reviews are led by those providing care, they are also given the opportunity to suggest improvements

For more information and to explore the evidence informing the Restore Network, click here.



Diana Grice, Nursing Leader Queensland Health and Dr Kathryn Turner, Psychiatrist and Executive Leader Queensland Health, pictured in a Restore Network module.

The SafeSide Program

The SafeSide Program is built around the SafeSide Framework for Suicide Prevention, which presents four core tasks for suicide prevention: Connect, Assess, Respond, and Extend (see Appendix B). Adopting the Safe-Side Framework aims to enhance suicide prevention across all settings.

Four adaptations of the SafeSide Program are tailored to different workforces:

- **Mental Health:** For psychiatrists, psychologists, counsellors, allied health professionals, social workers, and non-clinical colleagues, including peer workers who work with adults and children in mental health or other clinical settings.
- **Primary Care:** For general practice and community sector professionals such as GPs and allied health professionals who work in healthcare and support services and with people in settings such as GP clinics or disability support services.
- **Youth Services:** For clinical and non-clinical roles in an organisation that provides youth services, such as schools, community-managed organisations, and justice health, for children and adolescents through to age 25.
- **Alcohol and Other Drugs:** For psychiatrists, psychologists, counsellors, allied health professionals, social workers, and peer workers in Alcohol and other Drugs services working with people who have substance use and suicide concerns.

The SafeSide Program is delivered through InPlace® Learning, which provides Video Guided InPlace® Workshops, Office Hours, an online Community of Practice, and regular micro-learnings. It is co-led by expert clinicians and instructors with lived experience. Participants demonstrate increased confidence, consistency, and efficacy in asking about suicide concerns with the use of prevention-oriented risk formulation, and patients and consumers benefit from recovery-oriented care.

Once someone has completed the initial SafeSide Program, we also offer an Advanced Risk Formulation workshop, where learners have the opportunity to take a deeper look at Prevention-Oriented Risk Formulation. Within this advanced workshop is a violence supplement module that describes how to apply the Prevention-Orientated Risk Formulation when assessing and formulating the risk of violence.

For more information and to explore the evidence, click here.

InPlace® Learning

Blending the convenience, fidelity, and sustainability of online training with live group interaction and on-going consultation, updates, and refreshers to keep learning and growing.

Video-Guided InPlace® Workshop

Teams work together through specially designed video modules that teach, demonstrate, and prompt group interaction - a systematic framework and common language to unite your teams.

Office Hours & Community of Practice

SafeSide faculty and subscribers around the world interact in life Monthly Office Hours and an online Community of Practice. Get answers, share ideas, and build your professional network.

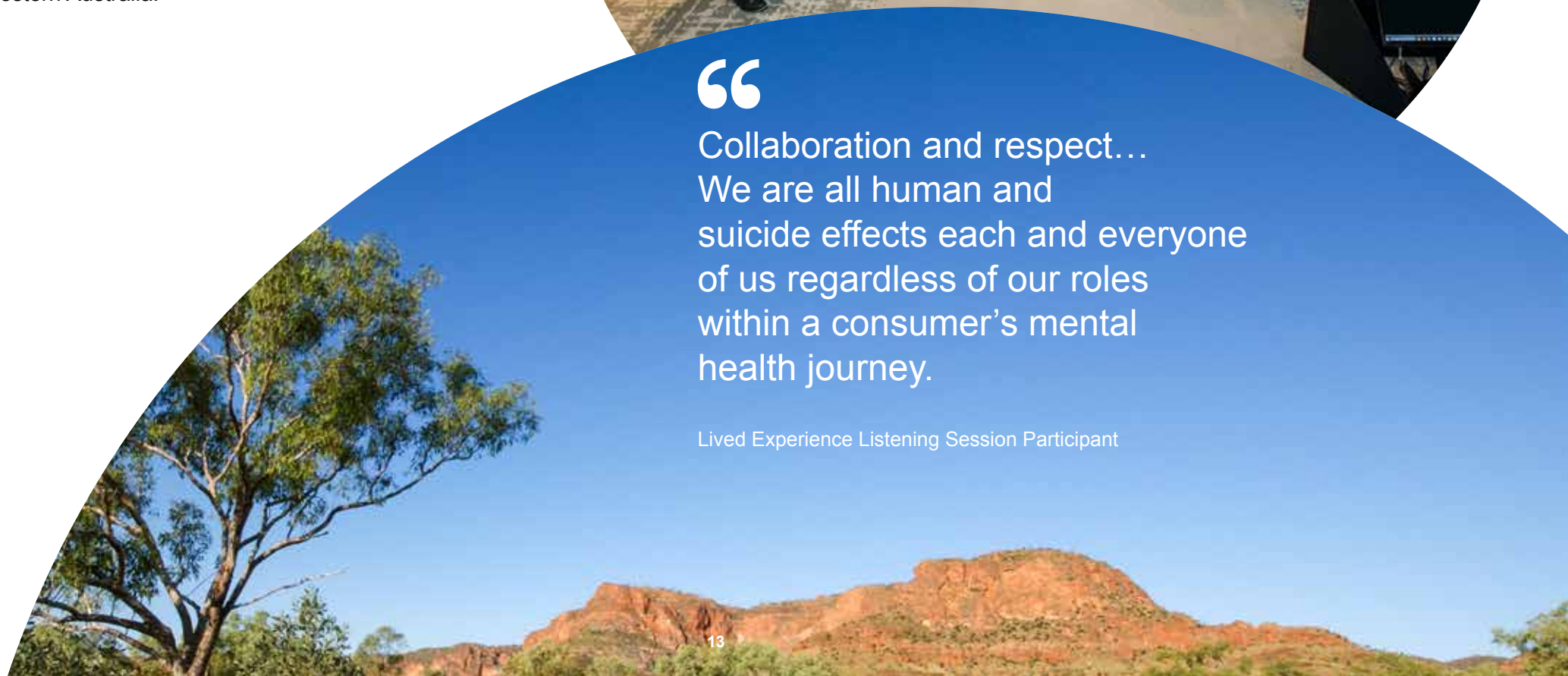
Tools & Refreshers

Stay current with advances in zero suicide care through regular updates, new modules, and quick refreshers throughout the year.

Project Activities at a Glance: Explore Phase

The Mental Health Commission of Western Australia engaged SafeSide Prevention to explore how its programs and services may complement existing local services, systems, and communities. From April to July 2024, SafeSide and the Commission rapidly and successfully initiated stakeholder engagement, listening events, workshops, and an event with more than 150 key leaders invited with representation across Western Australia.

> “Collaboration and respect… We are all human and suicide effects each and everyone of us regardless of our roles within a consumer’s mental health journey.
>
> Lived Experience Listening Session Participant



Listening Events and Engaging Key Stakeholders

130+ attendees at the SafeSide Prevention Leadership Event

130+ people attended InPlace® Workshops on Mental Health, Youth Services, Primary Care and AOD

Only 2% of participants across all workshops anticipated that applying the SafeSide Framework would take too much energy away from their work

150+ Tier 1 Government and non-government organisation leaders advised about the SafeSide Prevention and WA Mental Health Commission Partnership Project

160+ Tier 2 Government, non-government, and private sector organisations invited to participate in the listening sessions and workshops

Weekly meetings with the Commission's Operational Team

Additional consultations across sectors including with WA Child and Adolescent Health Services, Suicide Prevention Coordinators, the WA Primary Health Alliance, and the Lived Experience Steering Committee

Most participants thought the SafeSide Framework would help communication, improve care, and increase hope

57 attendees across the Lived Experience, Protecting our Protectors and Reviewing and Responding to Suicide Listening Sessions

Q&A

SafeSide presented and held a Q&A at the July Public Sector Leadership Council Meeting

EPIS Framework

SafeSide employed the Explore, Prepare, Implement, Sustain (EPIS) Framework (Aarons, et al., 2011) for this project and engagement. This model helps us to explain and review our evidence-based programs against the unique needs and conditions of the WA context.

SafeSide hosted a series of events to gather insights from service providers, people with lived experience of suicide, and community leaders. These events focused on the ongoing efforts in Western Australia and how SafeSide's training and systemic approach could support and enhance these services. We explored the benefits, adaptability, and potential of SafeSide's programs and services to complement the existing work in the region.

For a full list of roles and organisations represented at the workshops and listening sessions, and a project timeline, see Appendix C, Appendix D and Appendix E.

SafeSide recognises that this is just the start of these conversations and thanks everyone who has contributed so far. Further work in WA will include continued stakeholder engagement to expand on initial conversations.

Consultation and Collaboration: Hearing from People at the Heart of the Issue

> “Collaboration and communication between services – connect the dots.”
>
> Lived Experience Listening Session Participant

> “Remove the biomedical approach – doctors are not the expert – the person is. See the person and not the issue.”
>
> Lived Experience Listening Session Participant

Consultation and Collaboration: Hearing from People at the Heart of the Issue

Overview of Sessions

The voices of lived experience must be central to suicide prevention efforts and strategies.

SafeSide invited community members with lived experience of suicide to be part of the consultative process to ensure the actions for consideration for suicide prevention strategies and approaches were informed by and reflected the needs and wishes of people with lived experience.

This session explored three areas: an overview of the SafeSide co-design approach to education, feedback on the overall status of service provision, and the engagement of lived experience in this process. It also focused on how we can meaningfully engage and collaborate with those with Lived Experience of suicide in future co-design and consultation efforts.

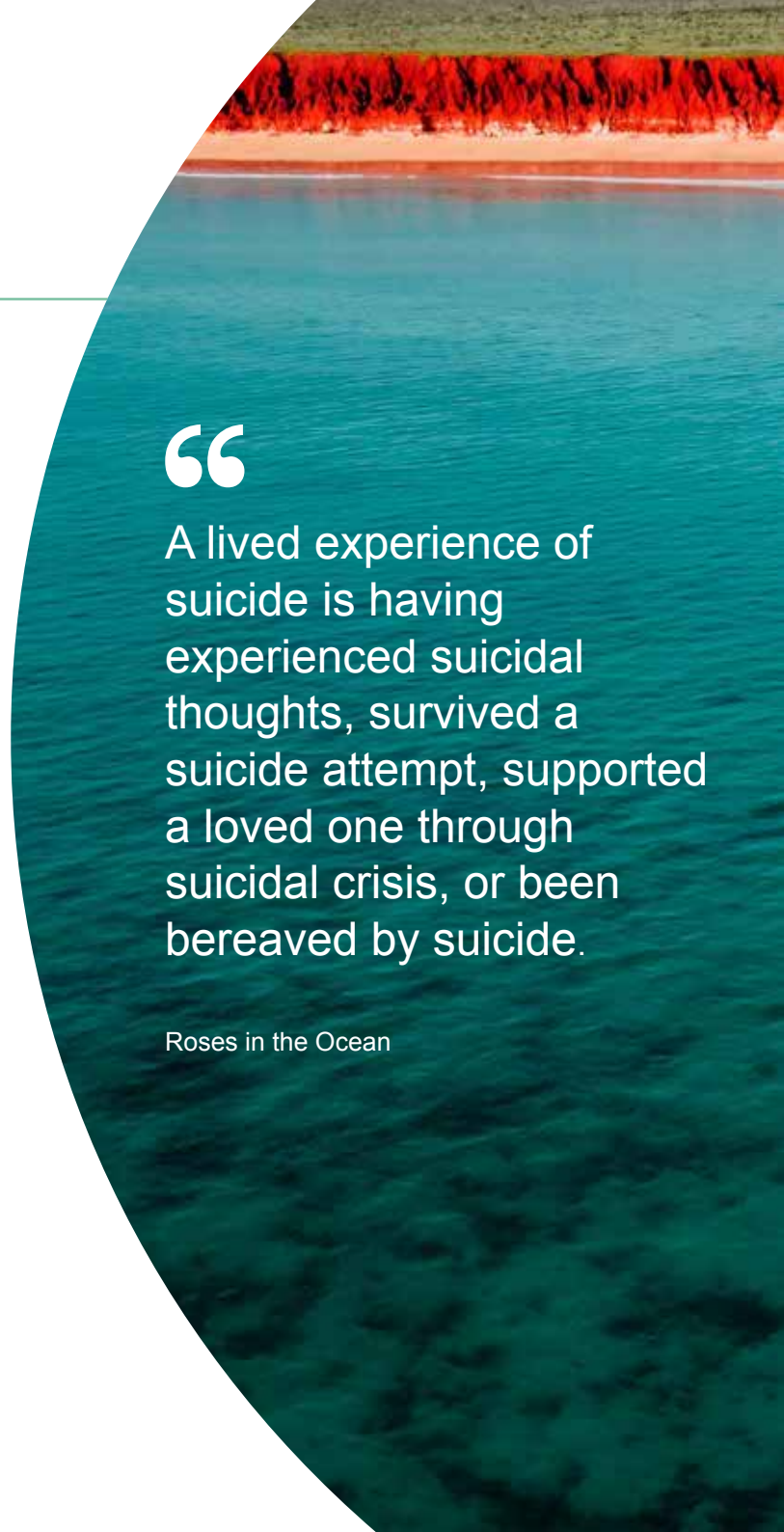
There were a total of 18 attendees across two sessions. Nine of these had experienced suicidal thoughts or behaviours themselves and had also been a carer or family member of someone experiencing this, four were family or carers, and two had personal experiences.

The information from these sessions was shared with leaders, and further insights were gathered at the workshop portion of the Leadership event on July 31, 2024. A summary of all of these insights is outlined below.

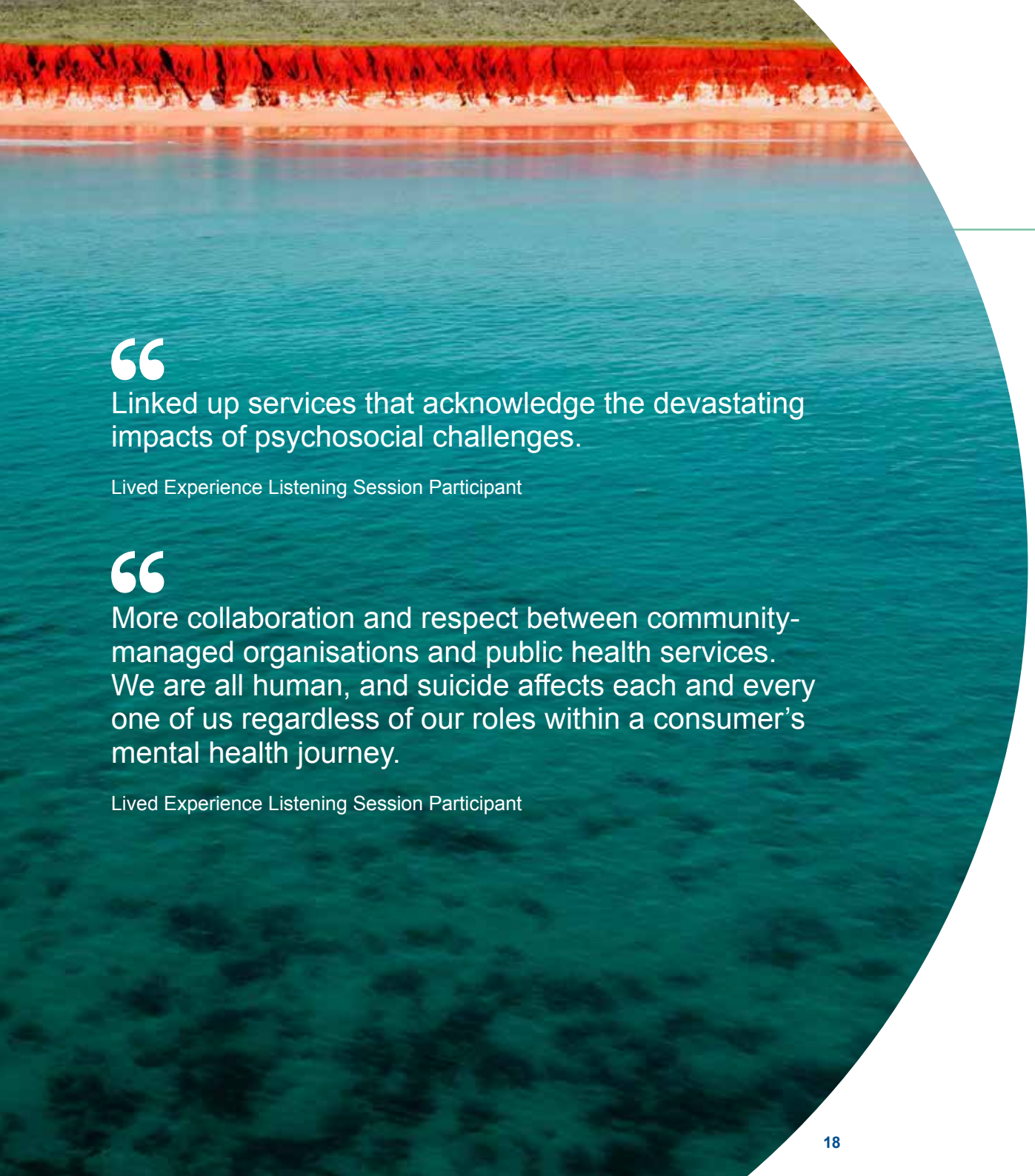
Key Insights

Existing strengths in the suicide prevention sector identified by participants:

- Increased recognition and integration of lived experience in various roles and advisory groups.
- Capacity building and training initiatives for the lived experience peer workforce.
- Improved collaboration through community-based suicide prevention networks.



> “A lived experience of suicide is having experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or been bereaved by suicide.
>
> Roses in the Ocean



> Linked up services that acknowledge the devastating impacts of psychosocial challenges.
>
> Lived Experience Listening Session Participant

> More collaboration and respect between community-managed organisations and public health services. We are all human, and suicide affects each and every one of us regardless of our roles within a consumer's mental health journey.
>
> Lived Experience Listening Session Participant

- Enhanced accessibility with diverse support options, including alternatives to traditional clinical services and the use of various platforms such as virtual and text-based services.
- Greater awareness of cultural impacts and diverse communities' needs.

Challenges in the sector:

- Lack of integration and coordination between organisations, sectors, and regions.
- Need for cultural competence in clinical systems.
- Resistance to non-clinical perspectives and lived experience inclusion.
- Limited mental health service accessibility, especially in regional areas.
- Prioritisation of service policies over individual needs.
- Frustration with ineffective consultations.
- Crisis-oriented and reactive approaches with a need for upstream prevention.

Needs and opportunities:

- **Integrated Approach:** Develop a more compassionate, person-centred strategy leveraging lived experience.
- **Staff Development:** Provide ongoing staff training in trauma-informed approaches, lived experience engagement, and cultural competence.
- **Authentic Involvement:** Include people with lived experience in service design, delivery, and review.
- **Improved Coordination:** Enhance communication among service providers to address complex needs.
- **Flexible Support:** Offer 24/7 availability and services for non-English speakers.
- **Person-Centred Care:** Shift towards more empowering approaches in mental health care.
- **Advisory Group:** Establish a new group for ongoing collaboration with the lived experience community.
- **Engagement Strategies:** Leverage existing networks, utilise community call-outs, and provide compensation for advocates.
- **Continuous Improvement:** Regularly evaluate and improve services based on community feedback.
- **Sustainable Funding:** Improve funding structures for grassroots organisations and lived experience initiatives.
- **Community-Driven Strategies:** Develop prevention strategies with, not just for, communities and services.
- **Diverse Consultation:** Ensure various perspectives, including those of non-peer workers with lived experience.
- **Awareness of Services:** Improve advertising and information dissemination about available services.
- **Cultural and systemic change:** Ensure services are inclusive and responsive to diverse cultural backgrounds.

Participants were asked: what is the most important changes you want to see in suicide prevention services and support?

- Person-centred and trauma-informed care
- Lived experience integration and coordination across the entire journey of care
- Lived experience involvement in the development, implementation, and leadership of services
- Training and education of staff to ensure the best quality care
- Increased cultural competence and diversity

Who completed the surveys?

- 15 of the 18 participants, 12 were lived experience workers, and three were community members.
- Most were located in the Perth Metropolitan area, with two from the South-West and one from the Goldfields.
- No attendees identified as Aboriginal or Torres Strait Islander origin.

Collaboration

13 out of 15 stated that they would like to collaborate or consult with SafeSide and the Commission in the future.

8 out of 13 would like to see a new advisory group established for this collaboration.

11 out of 13 respondents said they would prefer to collaborate face to face or use a hybrid model.

Initial Findings, Key Observations and Actions for Consideration

Initial Findings: Consultation with people with lived experience and people disproportionately affected by suicide about how SafeSide's Programs would be tailored and implemented has only just begun.

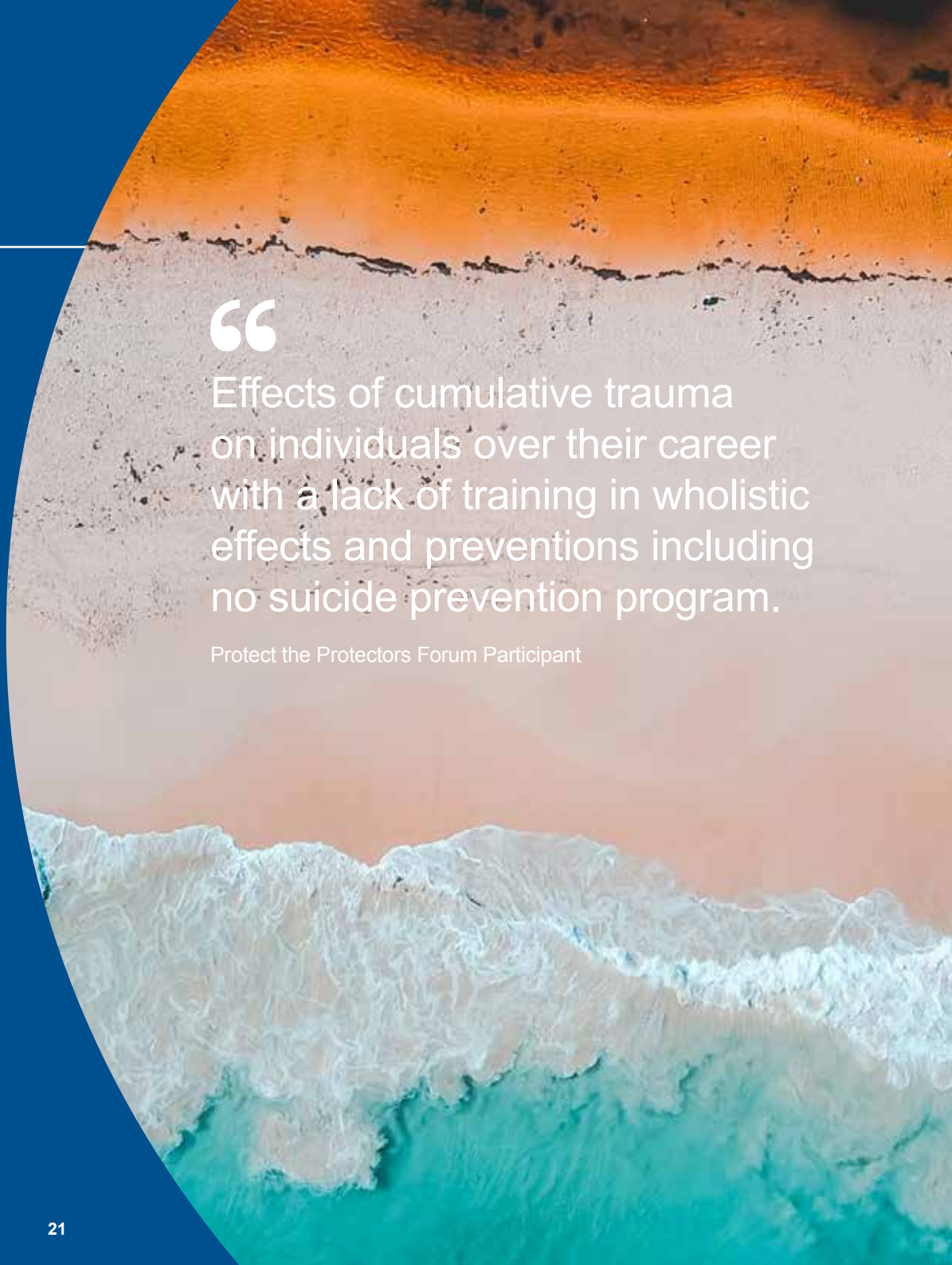
Key Observations:

- There was broad interest in both Government and non-government organisations to use SafeSide Programs.
- The central theme was the need for genuine consultation and collaboration while acknowledging consultation fatigue in the sector.
- There is a need for place-based, regional and culturally appropriate consultation.
- Specific engagement is required with those disproportionally affected by suicide.
- Where possible, align with existing advisory groups and structures.
- There was an emphasis on long lead-in time for consultation and ensuring authentic, trauma-informed and supportive consultation.

Actions for Consideration:

1. Establish a diverse advisory board with lived experience advocates and key stakeholders to guide project-wide engagement. Incorporate region-specific consultation, engage expert organisations like Roses in the Ocean, and align with existing local lived experience frameworks.
2. Consult with Aboriginal and Torres Strait Islander organisations to ensure cultural safety and explore their recommendations and feedback to SafeSide's programs or services.
3. Explore with other government departments via the Public Sector Leadership Council work they may want to undertake with SafeSide Prevention.

Healthy Resilient Workforces: Introducing the Connect Program for First Responders



> “Effects of cumulative trauma on individuals over their career with a lack of training in wholistic effects and preventions including no suicide prevention program.

Protect the Protectors Forum Participant

Healthy Resilient Workforces: Introducing the Connect Program for First Responders

Overview

As part of the Prevention/Early Intervention stream of the Suicide Prevention Framework 2025, reducing distress and strengthening protective factors across the population is a pressing issue. This is also a key priority of the new National Suicide Prevention Strategy.

SafeSide's Alicia Visser presenting Connect Program feedback on behalf of, Steve Wickham, Manager Department of Fire and Emergency Services, Wellness Branch.

Frontline services are exposed to significant psychosocial risk factors while on the job, with 5% of police and emergency services experiencing suicidal ideation in the previous 12 months (Case, et al. 2020). Case et al. (2020) found that there is limited evidence as to the effectiveness of suicide prevention programs targeting specific occupations.

SafeSide was engaged to introduce WA first responders to the Connect Program, a universal upstream career enhancement program proven to increase team cohesion, improve mental health, reduce suicide risk, and improve occupational functioning among military personnel (Wyman, et al., 2020, 2023), and validated with police departments (Pisani et al., under review). The program involves six hours of interactive group training for work teams. It is followed by short boosters embedded in ordinary work to foster positive bonds, enabling them to confront adversity as a cohesive and resilient workforce.

Session Details

The 'Protecting Our Protectors' forum was hosted on June 11, 2024, and aimed to better understand the current status of upstream mental health and suicide prevention in Western Australia for the first responder community.

There were 18 attendees, represented by the Western Australia Police Force, the Department of Justice, and the Department of Fire and Emergency Services.

Session outline:

- Key issues surrounding mental health and suicide, current practices, strengths, and protective factors within respective services were examined to identify existing and emerging needs of workplace prevention services.
- The Connect Program and approach were presented to consider their potential utility and implementation in the Western Australian context.

- Attendees shared their thoughts on the program's applicability, identified enablers and barriers to its implementation, and expressed their ideas for mental health and suicide prevention efforts in Western Australia.

On June 13, 2024, an additional presentation providing an overview of the Connect program for First Responders to the First Responder Working Group was conducted.

This included representatives from the Western Australia Police Force, the Department of Biodiversity, Conservation, and Attractions, and St John of God Western Australia, who could not attend the forum.

Lastly, the feedback from these sessions was shared with further insights gathered at the workshop portion of the Leadership event. A summary of all of these insights is outlined below.

> Capitalising on small team dynamics within the workplace and developing strong relations outside the workplace so people have meaningful support.
>
> Protecting our Protectors Forum Participant

> Normalisation. Conversation. Organisational Support. Cultural Acceptance.
>
> Protecting our Protectors Forum Participant

Key Insights

Existing strengths in upstream prevention for first responders identified by participants:

- **Multi-faceted approach:** Services offer peer support, psychological services, Employee Assistance Programs, chaplaincy, wellness officers, and critical incident response.
- **Organisational strategies:** Mental health strategies, health and wellbeing programs, and training packages have been developed and implemented.
- **Co-design principles:** Programs are starting to be created using lived experience and co-design principles, focusing on preventative approaches.
- **Reduced stigma:** Leadership separates organisational performance from mental health services, reducing stigma around seeking support.

Challenges in upstream prevention for first responders:

- **Inconsistent training:** Lack of regular training to normalise mental health discussions within organisations.
- **Mentoring gaps:** Formal mentoring structures are absent, limiting support for first responders.
- **Reactive focus:** Existing programs emphasise intervention over preventative strategies.
- **Implementation struggles:** Organisations find it challenging to implement mental health strategies effectively.
- **Inadequate trauma management:** Particularly concerning the cumulative nature of trauma exposure and unique experiences of first responders.
- **Insufficient suicide response:** Current approaches for managing suicide incidents are perceived as inadequate.
- **Internal motivation needed:** There is a need to foster an internal drive for well-being among first responders.
- **Community building:** Insufficient emphasis on building a sense of community among first responders.

Needs and opportunities in upstream prevention for first responders:

- **Systemic Approach:** Shift from individual resilience to organisational responsibility for mental health.
- **Customised Training:** Develop service-specific, relatable training materials.
- **Leadership Engagement:** Improve communication and support from leadership.
- **Destigmatisation:** Encourage open conversations, normalisation, and cultural acceptance of mental health.
- **Team Cohesion:** Enhance team dynamics through shared values and connection.
- **Early Education:** Integrate mental health resources in initial training programs.
- **Evidence-Based Approaches:** Utilise long-term data and studies for engagement.
- **Contextual Awareness:** Acknowledge WA's diverse regional needs.
- **Comprehensive Support:** Strengthen internal and external support systems.

Participant Feedback on the Connect Program

Applications

- Integration with recruit training programs
- Enhancement of peer-based support programs

Barriers

- Need for high-level organisational support
- Requirement for Australian voices and language in content
- Financial constraints
- Resource management in an already stretched workforce

Broader consideration

- Recognition of mental health challenges beyond first responders (e.g., education, health, transport sectors)

Evaluation Data

Who completed the surveys?

- 19 post-forum surveys were completed, by three clinicians, nine managers, and seven general workforce.
- 15 participants were from Perth Metro, two from South West, and two from Wheatbelt regions.
- One participant identified as Aboriginal, and two participants identified as Torres Strait Islander.

31% of respondents indicated that their workforces did not have high morale

Only half of the respondents indicated that their workforce had the coping strategies to meet the challenges of their work

More than half of the respondents indicated they would be interested in learning more about the Connect Program for their workplace

87.5% of respondents stated that they believed the Connect Program could enhance protective factors within their workforce

Team connection and cohesion was seen as important to their workforces resilience to adversity by 68% of respondents

Initial Findings, Key Observations and Actions for Consideration

Initial Findings: There was a strong initial indication that the upstream Connect Program could enhance protective factors in the first responder workforce.

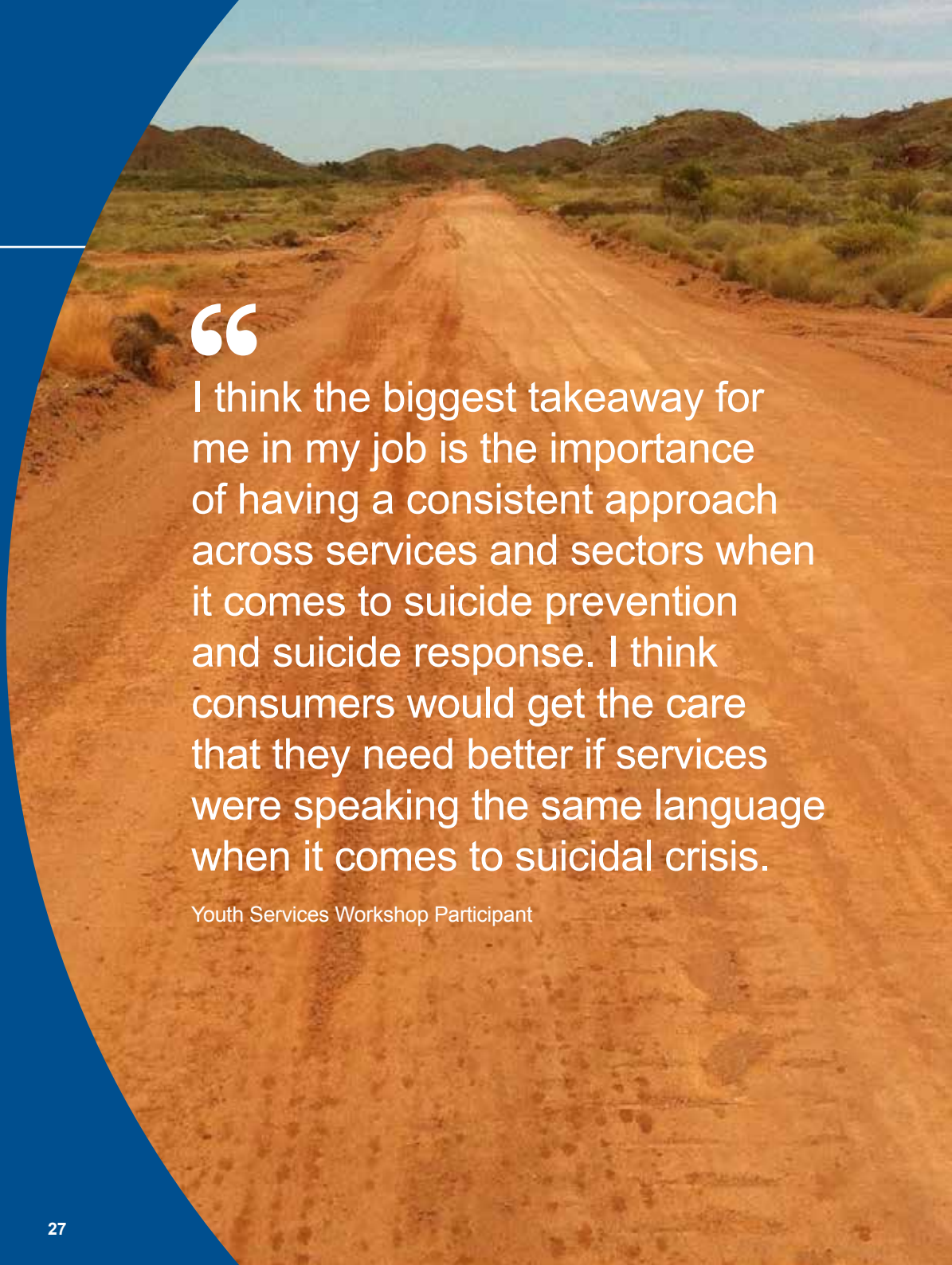
Key Observations:

- There was keen interest in the Connect Program Upstream prevention for First Responders.
- Workplace Health and Safety and Human Resources representatives from other government departments and NGO expressed interest in introducing the Connect Program to their workforces' resilience and team-building efforts.
- Participants encouraged local facilitation of the Connect Program where possible because the program involves team cohesion and group dynamics.
- Participants appreciated the strong evidence base supporting this program.

Actions for Consideration:

1. Take preparatory steps to invite and encourage first responder workforces (initially identified as police, fire and emergency services, and paramedics) to implement the Connect Program.
2. Explore the utility of the Connect Program in other relevant or interested Departmental workforces outside of first responders.
3. Consider selecting priority groups based on available data and evaluating the program with these groups to contribute to the evidence base.

Ready to Respond: Introducing the SafeSide Program for Workforce Educations



> “I think the biggest takeaway for me in my job is the importance of having a consistent approach across services and sectors when it comes to suicide prevention and suicide response. I think consumers would get the care that they need better if services were speaking the same language when it comes to suicidal crisis.
>
> Youth Services Workshop Participant

Ready to Respond: Introducing the SafeSide Program for Workforce Education

Overview

The SafeSide Program supports learners to apply the SafeSide Framework and has been adapted for Primary Care, Mental Health, Youth Services and Alcohol and Other Drug settings.

Service responses to suicide risk have been dominated by medical models that stratify suicide risk as high, medium or low in an effort to predict the likelihood of suicide.

The SafeSide Framework for Suicide Prevention was developed to provide a map of best practices, including the shift away from outdated modes of assessment to prevention-oriented assessment (Pisani et al., 2016).

More than 160 WA government and non-government organisations and their staff working in services across Primary Care, Mental Health, Youth, and Alcohol and other Drugs were invited to experience the SafeSide InPlace® Workshop.

InPlace® Learning includes an interactive video workshop, co-led by clinical and lived experience expertise, completed as a group with multiple sections for discussion.

SafeSide Program Sessions

SafeSide Program - Mental Health Sessions

Sessions	**Three Mental Health Sessions were conducted** 1. In-Person - All staff on 25th June 2024. 2. In-Person - Leaders on 2nd July 2024. 3. Videoconference- All staff on 9th July 2024.	
Attendance (N = 68)	**Representation from:** • Mental Health • Youth Services • AOD	• Primary Care • First Responders • Other
Post survey responses (N = 44)	**Roles:** • Clinicians: 28 • Managers: 10 • Support Worker: 1 • Other roles: 10	No respondents identified as Aboriginal or Torres Strait Islander

SafeSide Program - Alcohol and Other Drug Sessions

Sessions	**Three Alcohol and Other Drug Sessions were conducted** 1. In-Person - All staff on 26th June 2024. 2. In-Person - Leaders on 3rd July 2024. 3. Videoconference - All staff on 10th July 2024.	
Attendance (N = 40)	**Representation from:** • Mental Health • Youth Services • AOD	• Education • First Responders • Other services
Post survey responses (N = 23)	**Roles:** • Clinicians: 9 • Managers: 15 • Support Worker: 2 • Other roles: 1	Two respondents identified as Aboriginal

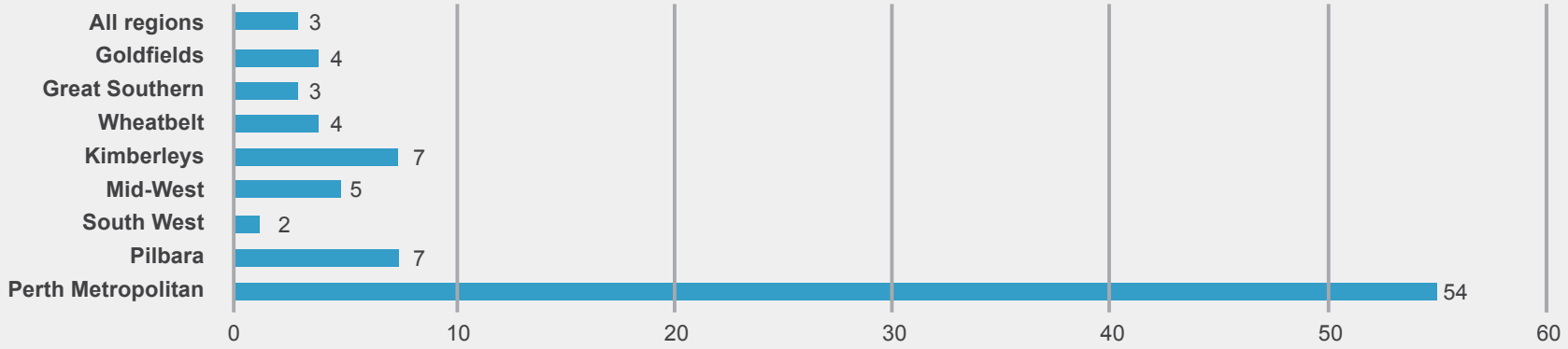
SafeSide Programs - Youth Services Session

Sessions	One Youth Services - Video Conference Session was conducted on 18th June 2024.	
Attendance (N = 14)	**Representation from:** • Mental Health • Youth Services • AOD	• Justice • First Responders
Post survey responses (N = 7)	**Roles:** • Clinicians: 3 • Support Worker: 2 • Peer Worker: 1 • Other roles: 1	No respondents identified as Aboriginal or Torres Strait Islander

SafeSide Programs - Primary Care Session

Sessions	One Primary Care - Videoconference Session was conducted on the 19th June 2024.	
Attendance (N = 11)	**Representation from:** • Mental Health • Youth Services • Primary Care	• Education • First Responders
Post survey responses (N = 9)	**Roles:** • Managers: 3 • Peer Worker: 3 • Other roles: 3	No respondents identified as Aboriginal or Torres Strait Islander

Regional representation



Evaluation Data

Knowledge improvement

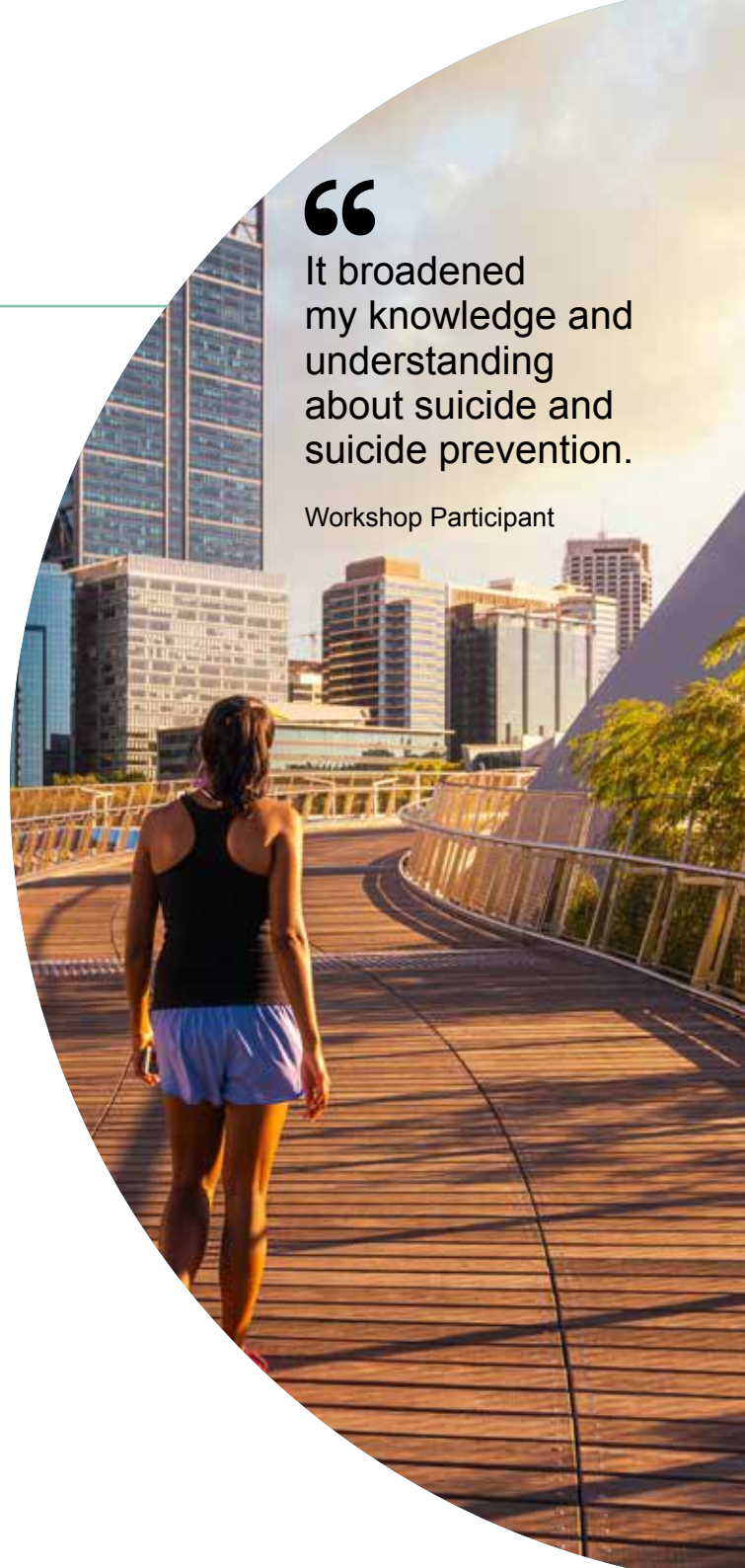
Across all SafeSide Program sessions, knowledge improved in key aspects of each of the four tasks in the SafeSide Framework. The average improvement was from 3.24 to 3.57 out of 4. The most significant change in knowledge was for participants in the AOD Program (average increase from 2.95 to 3.55). It should be noted that these items are not highly sensitive to change as participants typically enter the workshop with base knowledge in suicide prevention. This was the case for this cohort, particularly for Mental Health, Youth Services, and Primary Care.

Self-efficacy

Self-efficacy is when someone believes they can successfully do a particular task. Studies have shown that after training, people with higher self-efficacy are more likely to change their behaviour based on what they learned.

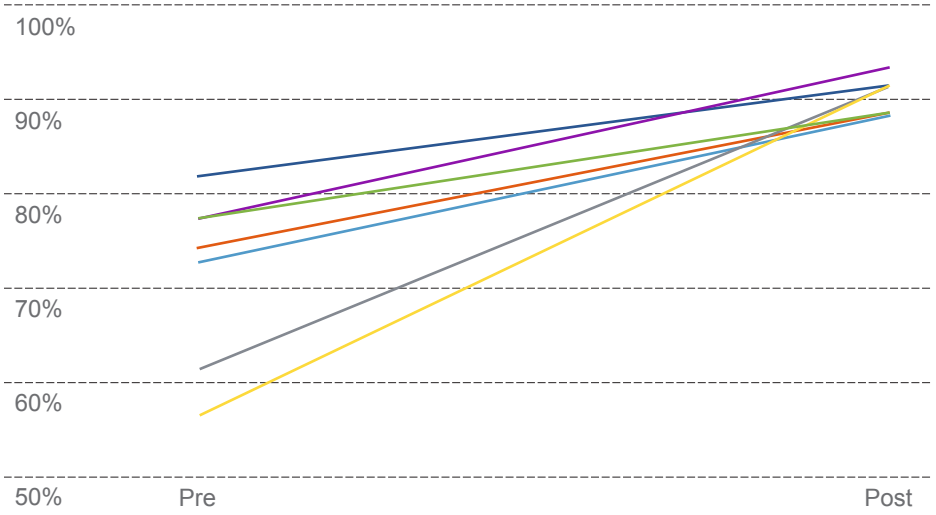
After completing the workshop, overall staff confidence in their ability to use suicide prevention skills across the four core tasks of the SafeSide Framework (Connect-Assess-Respond-Extend) was 86% or higher. The greatest increases in confidence were seen in linking risk assessments to person-specific plans and developing person-specific safety plans. There was also a notable boost in confidence regarding how to extend support to people at risk beyond the immediate interaction.

When broken down by SafeSide Program, these percentages indicate substantial growth in self-efficacy across several areas, especially for Youth Services and Primary Care. There was also significant improvement for Mental Health and AOD in developing person-specific safety plans and extending support.

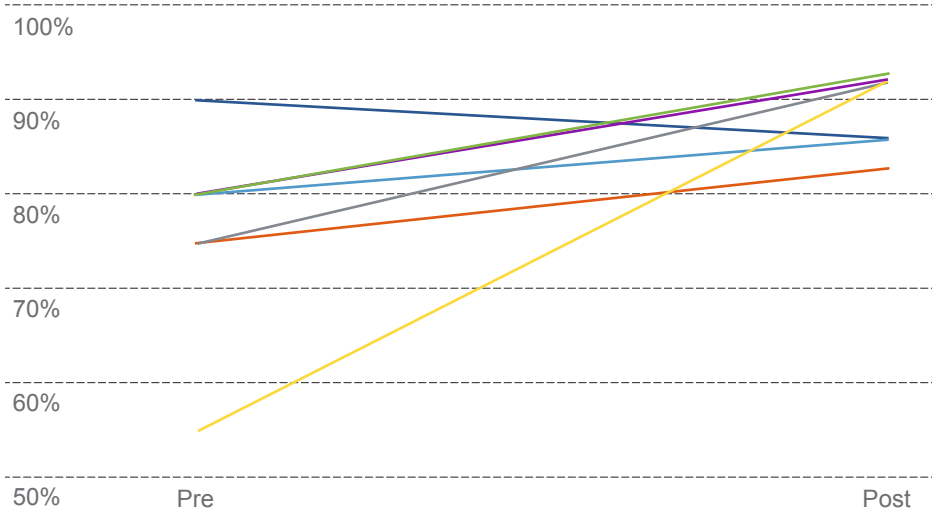


Change in Self-Efficacy Pre-Post Workshop (% Agree/Strongly Agree)

Mental Health

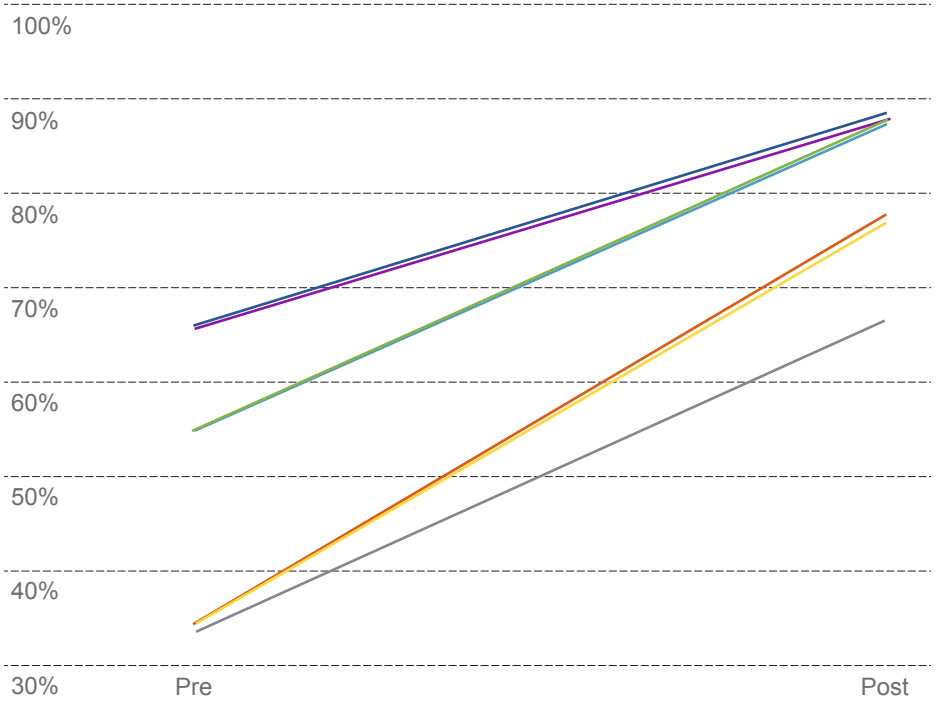


Alcohol and Other Drugs

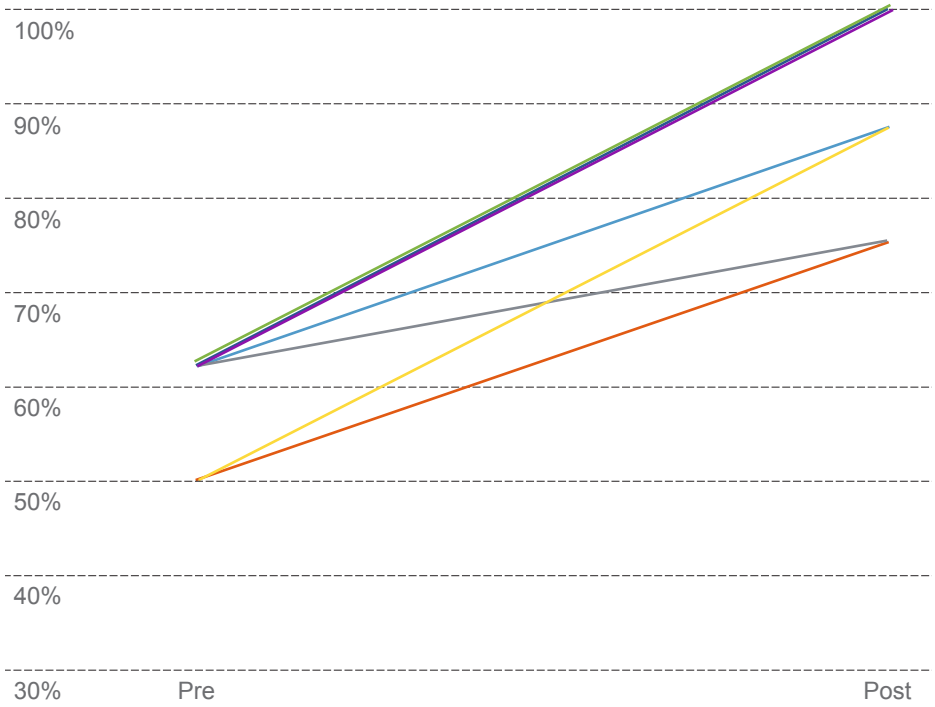


- Asking about suicide in a way that encourages openness
- Linking risk assessments to person-specific plans
- Contributing to suicide risk assessments
- Developing person-specific safety plans
- Extending Support
- Knowing what to do
- Maintaining a hopeful stance

Youth Services



Primary Care



- Asking about suicide in a way that encourages openness
- Linking risk assessments to person-specific plans
- Contributing to suicide risk assessments
- Developing person-specific safety plans
- Extending Support
- Knowing what to do
- Maintaining a hopeful stance

Learning transfer

Learning transfer is the perception of participants' ability to transfer what they have learnt into everyday practice. High ratings of learning transfer immediately after training have been shown to predict behaviour change. Participants expressed a strong motivation and capacity to apply the key suicide prevention skills learnt in their day-to-day work with people at risk.

Participants felt that the workshop:

- Was directly applicable to their work (70%)
- Demonstrated understanding of how they would use it in their work (74%)
- Provided examples that were relatable and closely resembled those they encounter in their jobs (78%).

Concerns about the time and resources required to use the new skills were minimal, with an average of 2.25% feeling it would take too much away from their other work.

These findings increase confidence that the workshop enables staff to be able to immediately apply concepts and skills learnt in the program.

The learning transfer data is particularly encouraging, as only 49% of participants viewed the situations used in the workshops to be very similar to those they encountered on the job. This means that the discussions and practice exercises helped support learning transfer even when situations in the workshop were different from those they encountered on the job. SafeSide is well-versed in customisation to help improve this metric for broader adoption.

Share one thing you'll take into your everyday work…

- Using the framework
- Identifying foreseeable changes with consumers and helping them plan for those changes
- Use of mini-interventions
- Using family support plans
- Framing of risk status and risk state
- Focusing on building trust and connection
- Using supportive language
- Integrating into current practices and procedures
- Being proactive in asking the right questions
- Using more standardised measures for safety planning and risk assessment
- Integrating the framework to enhance consistency and collaboration with colleagues
- Identifying strengths and protective factors earlier

80% **agreed or strongly agreed that they planned to integrate what they learned into their work**

70% **agreed or strongly agreed that what was taught would help them do their jobs better**

Impact

Participants indicated that the workshop had an impact on how their work in suicide prevention. They expressed a desire to immediately integrate the learnt skills and approach into their work and to engage in ongoing training and opportunities for connection to further upskill in suicide prevention.

Overall satisfaction with the SafeSide Program was high, with an average rating of 3.96 out of 5. Across all workshops, participants were particularly satisfied with the quality of teaching (82%) and group discussions (85%).

Participants also indicated a strong belief that everyone had a role to play in preventing suicide and addressing risk with many highlighting the importance of a coordinated approach across various services and sectors. The current lack of common language and approach and the potential harm this can cause to those they support were identified as major areas of concern.

These reflections suggest that the workshop has the potential to bring about meaningful changes in how participants approach their work.

- **56% of participants** stated that the workshop impacted their perception of their role in suicide prevention, a high number given that most participants were working in this space.
- **35% of participants** planned to attend Office Hours.
- **56% planned** to use the Community of Practice, SafeSide's online membership forum.
- **90% of participants** agreed or strongly agreed that people in our regions suffer when systems and teams do not share a common approach.
- **However, only 46%** agreed or strongly agreed that different systems and teams currently share a common language and approach.

What Participants had to say About the Workshops

I feel confident in my ability to ask about suicide in a way that encourages people to respond in an open and honest manner.

Primary Care Workshop Participant

Wish I was taught this when I started in Mental Health.

Mental Health Workshop Participant

I think the biggest takeaway for me in my job is the importance of having a consistent approach across services and sectors when it comes to suicide prevention and suicide response.

Youth Services Workshop Participant

It should be more widely available because I thought it made sense. It's backed by evidence and it was fairly structured.

AOD Workshop Participant

The framework was of use to me or value to me. Just be something that I can easily refer to.

Primary Care Workshop Participant

It was refreshing to see that the voice of the family and the supports were part of this framework. We live in a state where our resources are thin... So the idea that we bring the family and supports along with the journey is something that we know.

Mental Health Workshop Participant

I've done some other suicide prevention workshop or training programs before that were so confusing. I liked how simple this was.

Youth Services Workshop Participant

Overall framework helps break things down and slow it down to create a safe environment. There are other complementary tools you can use to maintain people's safety. I do think this is a more humanistic way of managing risk and assessing risk and for that I applaud it.

AOD Workshop Participant

Participant Feedback on how SafeSide Program Could Enhance Service Delivery

Participants in the sessions were asked how the SafeSide Program could potentially enhance and complement existing service delivery in suicide prevention in WA. Five key themes were identified.

Common framework and language

Participants noted the benefits to establishing a consistent approach across various services and sectors for effective suicide prevention and response.This consistency ensures that consumers receive the care they need more effectively when services speak the same language during a suicidal crisis.

The Safeside Framework was viewed to support a consistent approach to suicide prevention, creating a common language and understanding within teams and across different services, facilitating team discussions and enhancing communication and collaboration in suicide prevention efforts, and essentially making it easier for different roles and services to come together.

Participants felt that using the SafeSide Framework would improve their service delivery

- **74%** stated that it would help their teams communicate about risk and responses
- **71%** indicated it would improve care or services provided

> “Overall framework helps break things down and slow it down to create a safe environment.
>
> AOD Workshop Participant

Enhanced self-efficacy and confidence

The SafeSide Program was perceived to improve self-efficacy and confidence in suicide prevention skills.

Participants noted that the training:

- Increased their confidence in engaging in suicide prevention tasks
- Enhanced their ability to develop safety plans and link risk assessments to person-specific plans
- Provided clear guidelines that help both new and existing staff feel more assured in their roles
- Boosted their readiness to address suicide concerns effectively.

Framework usability

The SafeSide Framework was the most frequently endorsed enhancement for service delivery.

Participants stated that the framework:

- Uses simple and easy to use visual aids, practical tools and follow-up communication strategies
- Helped to solidify existing practices
- Provides a structured way to approach suicide prevention
- Uses a clear, easy to follow model that could be utilised across various roles, experience levels, and sectors.

> “The fact that the limited predictive ability of suicide was acknowledged in the framework and that the focus is on planning and support. I really like that... And I also liked in the framework where risk is sort of relative to self and others rather than that static low medium high because it is relative.
>
> Mental Health Workshop Participant

Collaborative and person-centred approach

The framework was viewed as helping services focus on client-centered approaches and emphasising the individual behind the risk and their unique journey.

Participants appreciated the how the framework is:

- Aligned with a holistic approach, integrating family and community voices and support, which is essential in resource-thin areas.
- Trauma-informed, emphasising planning over prediction and involving support persons in the process.
- Client-centred and humanistic in its approach, helping professionals remember the person behind the suicidal ideation and focusing on protective factors.
- Validating of the individuals' experiences rather than jumping to solutions.

Addressing gaps

The SafeSide Program was viewed as having the potential to address gaps in existing training by:

- Providing a more detailed and structured approach to suicide prevention
- Providing a universal system language and focusing on extension of care
- Being easily integrated into existing training frameworks to provide a more comprehensive learning experience.

Suggestions for Program Customisation

SafeSide works with organisations to customise the SafeSide Program to local needs. We sought feedback from participants to see if they believed this was required and what they thought should be customised.

Localisation

Adapt the content to reflect Australian terminology, healthcare settings, and cultural nuances, specifically Primary Health, Youth Services, and Mental Health which do not have Australian adaptations. This includes changing references to American systems and statistics to Australian equivalents.

Increase representation of specific cohorts

Participants noted that there were opportunities to increase the representation of various groups within the SafeSide Programs including:

- Range of age groups, particularly wider age range of youth and older adults
- Complex presentations
- Emergency response teams
- Rural/remote communities
- Non-clinical, peer support roles and community-based settings.

The SafeSide Program includes a broad range of learning engagement opportunities such as video refreshers, advanced workshop modules, and additional resources and updates. These learning resources could be leveraged alongside other program customisations to address this representation need.

Cultural relevance & sensitivity

Tailoring the SafeSide Program and SafeSide Framework to be relevant for specific demographics was seen as an important consideration. This included:

- Incorporating culturally appropriate content that addresses the specific needs and cultural sensitivities of:
  - Aboriginal and Torres Strait Islander populations
  - Culturally and Linguistically Diverse groups.
- Tools and approaches that are validated and effective for these communities and that involve community representatives in the program design.

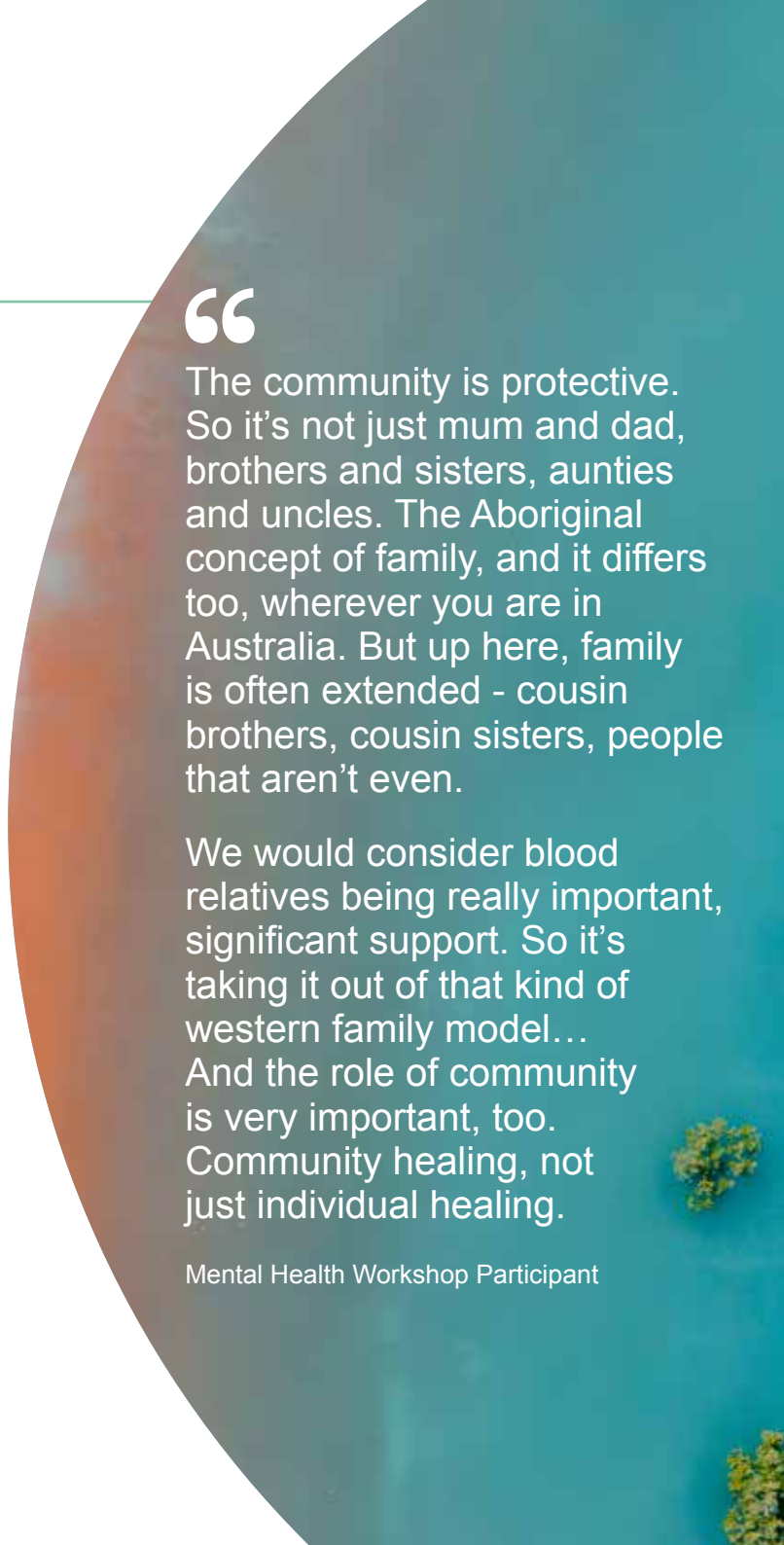
Sam Kilby from Open Minds gets ready to film for an introduction customisation project.

Additional Insights from Leaders

The feedback and evaluation data from these sessions was shared with further insights gathered at the workshop portion of the Leadership event on July 31, 2024.

Key insights included:

- Importance of a consistent approach across the state and the need for a balance between consistency and adaptability for effective statewide implementation.
- A desire for integrated support addressing suicidality and mental health and AOD combined with a recognition of the interconnected nature of these issues and the need for holistic care approaches.
- Need for comprehensive training across the sector, with clinical and non-clinical services.
- Recognition of many different approaches applied in dealing with suicide escalation across mental health and AOD services coupled with a call to cross-pollinate those learnings and put it into a framework benefiting all sectors.
- Want to see examples or case studies of successful approaches and SafeSide implementations.
- Acknowledgment of specific needs of Young People and suicide prevention.



> “The community is protective. So it’s not just mum and dad, brothers and sisters, aunties and uncles. The Aboriginal concept of family, and it differs too, wherever you are in Australia. But up here, family is often extended - cousin brothers, cousin sisters, people that aren’t even.
>
> We would consider blood relatives being really important, significant support. So it’s taking it out of that kind of western family model… And the role of community is very important, too. Community healing, not just individual healing.
>
> Mental Health Workshop Participant

Implementation Enablers and Barriers for Future Consideration

Enablers

1. **Adaptability:** Framework suits various contexts, including AOD services and diverse demographic groups.
2. **Flexible hosting:** Training can be conducted internally, in small groups, or online to fit organisational needs.
3. **Evidence-based:** Program is built on a strong foundation of research and evidence.
4. **Current best practices:** Framework incorporates emerging evidence and best practices in the field.
5. **Ongoing engagement:** Participants have access to continued learning through Community of Practice, Office Hours, newsletters, and resources.

Barriers

1. **Resource constraints:** Cost and staff time may be barriers, especially for organisations with limited budgets.
2. **Relevance concerns:** Content may not be suitable for all settings, particularly non-clinical or peer support roles.
3. **Resistance to change:** Experienced professionals may be reluctant to adopt new practices.

Considerations

1. **Support structures:** Clear documentation is needed to support implementation and align with existing policies.
2. **System integration:** Framework should be incorporated into electronic records, forms, and audits for increased uptake.
3. **Leadership support:** Strong executive backing is crucial for successful implementation.
4. **Accreditation options:** Explore potential accreditations with relevant organisations and governing bodies in the field.
5. **Funding support:** Investigate funding opportunities to assist with implementation costs.
6. **Training integration:** Align SafeSide with existing training programs to ensure seamless integration.

Initial Findings, Key Observations and Actions for Consideration

Initial Findings: The SafeSide Program - Mental Health, Youth Services, and Alcohol and Other Drugs - were well received along with a desire to see greater representation of the people and contexts of WA.

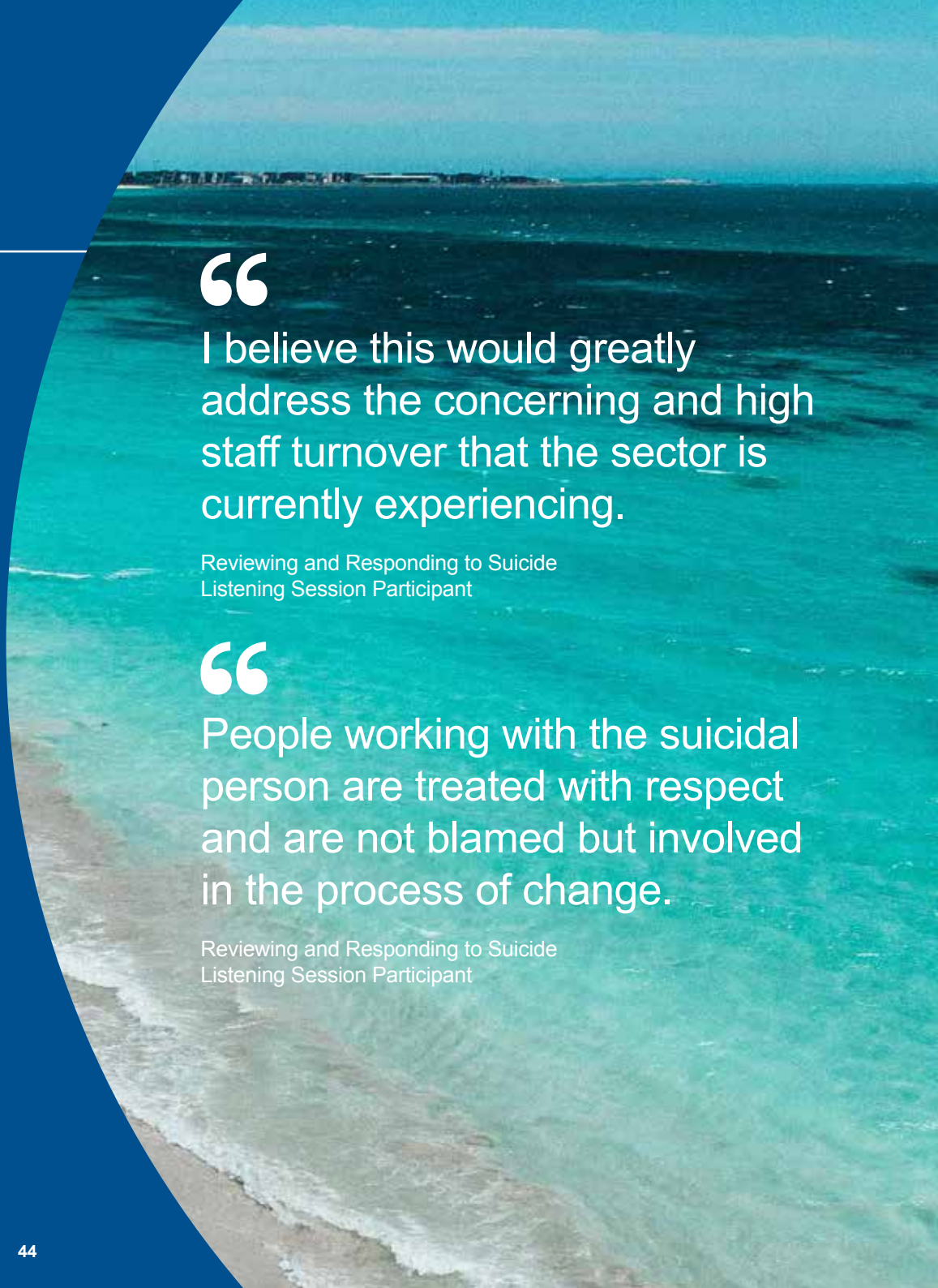
Key Observations:

- The SafeSide Framework was viewed to support a consistent approach to suicide prevention, creating a common language and understanding within teams and across different services.
- Participants who completed the SafeSide Program reported knowledge improvement, increased self-efficacy, and motivation and confidence to apply learnings.
- Participants in the leadership event who had not completed the SafeSide Program advised that they would like to see and hear more about how the SafeSide Framework works in practice
- Participants indicated a need for customisation of the training to an Australian context.
- The majority of workshop participants felt the training delivery model of co-designed clinical and lived experience instruction and practical exercises fit their services and facilitated learning integration.
- There was a strongly identified need for integration of the SafeSide Framework and Risk Formulation at a systems and process level.
- There is an opportunity to explore how SafeSide's supplementary modules can further enhance service delivery in suicide prevention. For eg: The Advanced Risk Formulation workshop, in which there is a violence supplement module that describes how to apply the Prevention-Orientated Risk Formulation when assessing and formulating risk of violence.

Actions for Consideration

1. Customisation of the SafeSide Program for Mental Health and Youth Services - including customised scenarios and lived experience interviews where required.
2. Customise the Primary Care adaptation to ensure relevance for a non-clinical audience working in suicide prevention.
3. Develop implementation plans and roll out the SafeSide Programs to Commission-funded Mental Health, Youth Services and AOD Services in both NGO and WA Health in the first instance. Explore using the SafeSide Program and Framework with other relevant Government departments such as Education.
4. Leverage and resource existing networks and structures for the rollout of this training. Eg: Suicide Prevention Coordinators and WA headspace Network.
5. Explore system and policy integration needs across services and sectors. Participants suggested that the SafeSide framework should be integrated with current local policies, procedures, and documentation standards to enhance its relevance and applicability.
6. Explore the utility of the Collaborative Assessment and Management of Suicidality (CAMS) to ensure people with suicide ideation have access to treatment that works.

Supported when Suicide Occurs: Introducing the Restore Network for Reviewing and Responding to Suicide Incidents



> “I believe this would greatly address the concerning and high staff turnover that the sector is currently experiencing.
>
> Reviewing and Responding to Suicide Listening Session Participant

> “People working with the suicidal person are treated with respect and are not blamed but involved in the process of change.
>
> Reviewing and Responding to Suicide Listening Session Participant

Supported when Suicide Occurs: Introducing the Restore Network for Reviewing and Responding to Suicide Incidents

Overview

Many of those working in the suicide prevention sector know the pain and hurt when suicide occurs in a professional setting.

When calling people to the bold goal of suicide prevention and implementing comprehensive, system-wide approaches, we must also support those affected when a suicide occurs.

Leaders representing 15 organisations across WA Departments and Services attended the “Reviewing and Responding to Suicide” session hosted on the June 11, 2024. The session explored the processes and practices for responding to and reviewing suicide-related incidents among service leaders in WA.

Participants explored the concept of a Restorative Just and Learning Culture (RJLC) including transparency, healing connections, and addressing power dynamics between those impacted by suicide incidents. The session focused on understanding current practices, identifying gaps, and exploring potential improvements to create a more restorative, just, and learning culture.

This involved introducing the SafeSide Restore Network to explore how it could be adapted and applied across WA services, systems, and communities. The SafeSide Restore Network offers leaders a trusted network for collaboration with other external organisations and a suite of resources that can be used to move organisations towards a more RJLC.

The feedback from these sessions was shared with further insights gathered at the workshop portion of the Leadership event on July 31, 2024. A summary of all of these insights is outlined on the following pages.

Evaluation Data

Who completed the surveys?

- 21 post-forum surveys were completed.
- 18 were from Perth Metro, two from Wheatbelt, and one from Great Southern.
- One identified as Aboriginal, and one as Torres Strait Islande

Key Insights

Identified Strengths in WA's Review and Response Processes:

- **Multi-agency collaboration:** This significantly enhances the effectiveness of responses to suicide-related incidents.
- **Specific guidelines:** The London Protocol and similar guidelines ensure consistency in managing suicide-related events.
- **Support services:** Employee Assistance Programs and chaplaincy are available to assist affected individuals.
- **Regional models:** Some regions have developed effective collaborative approaches that could serve as models for others, e.g. the Wheatbelt Response Committee.

Challenges in review and response processes:

- **Inconsistent protocols:** These are applied unevenly across services and regions, leading to disparities in care and response.
- **Time pressure:** The 28-day investigation requirement in Western Australia Health Service puts undue pressure on staff.
- **Inadequate support services:** Many existing services fail to address the complex needs of specialist staff adequately.
- **Resistance to change:** Organisational resistance often undermines the implementation of more effective response strategies.
- **Lack of evaluation:** Current supports and services need proper assessment to determine effectiveness.
- **Cultural insensitivity:** Many existing approaches lack inclusivity, potentially alienating diverse populations affected by suicide-related incidents.
- **Reactive focus:** There is an overemphasis on responding to incidents rather than preventing them.
- **Underutilised resources:** Valuable resources such as pastoral care and peer support are often overlooked or underused.

> "Having a set process and procedure that is available after a death is extremely important to make the process easier, to ensure we are supporting the best we can.
>
> Listening Session Participant

> "Where people are at the heart of it, where professionals are trauma informed and have done their own work on their own challenges and understand that this is complex and we are all in it together, learning how to respond with heart not just heads.
>
> Listening Session Participant

- Legal constraints: Operating within an adversarial legal system while promoting openness and learning presents challenges.

Needs and opportunities:

- **Increased funding:** This is needed to dramatically improve service delivery and resource allocation.
- **Sector-wide protocols:** Implement and rigorously evaluate these to ensure consistent, high-quality responses.
- **Enhanced collaboration:** Improve cooperation among stakeholders and funding bodies to optimise resource utilisation.
- **Tailored support services:** Significantly improve these for staff and those affected by suicide, addressing specific needs.
- **Holistic approaches:** Develop and implement culturally inclusive and trauma-informed care strategies.
- **Continuous improvement:** Foster a robust culture of learning within organisations.
- **Strong leadership:** Strengthen this to drive positive organisational change and overcome resistance.
- **Effective resource use:** Utilise pastoral care and peer support more effectively, recognising their unique benefits.
- **No-blame investigations:** Conduct thorough inquiries to identify systemic issues and drive quality improvement.
- **Prevention focus:** Develop and implement strategies to reduce suicide incidents.
- **Integrated response:** Improve inclusion and communication among all services for a more cohesive system.
- **Family inclusion:** Involve families and carers from the start after a sudden death, recognising their valuable input.
- **System accountability:** Frankly acknowledge system failures while balancing accountability and support.

What participants said about RJLC:

- **Resource concerns:** Funding and resource issues were raised, particularly for regional and remote areas.
- **Information needs:** More details are required about legislation and organisational requirements.
- **Organisational barriers:** Higher-level organisational and systems support is needed.
- **Integration benefits:** RJLC could provide a more robust, person-centred process focused on learning and supporting clinicians.
- **Top four enablers to changing practice:**
  - Funding and resources.
  - Leadership and organisational culture.
  - Interagency collaboration.
  - Support structures and governance.

Initial Findings, Key Observations and Actions for Consideration

Initial Findings: Participating health services are keen to implement practices that promote healing, learning and improving after suicide.

Key Observations:

- Services responding to suicide incidents could significantly benefit from a more restorative and inclusive approach to incident reviews and responses.
- Call for a whole of government approach to reduce fragmentation in suicide prevention and response efforts.

95% indicated they would consider implementing a RJLC in their organisation.

81% were interested in further information on becoming part of SafeSide's Restore network.

Although some organisations already use RJLC, **48% of participants** somewhat or strongly agreed it would improve their response to suicide-related incidents.

- Recognition that effective action requires coordination across various agencies and sectors.
- A strong emphasis on responses being culturally informed, contextual and responsive.
- There is a strong desire for group learning opportunities and a collaborative environment that advances local and state objectives while promoting peer-to-peer collaboration.
- There is a need for improved engagement of staff and family/carers impacted by suicide in the review and response process to enhance learning and facilitate change.
- Those impacted by suicide need access to effective and trauma-informed support.

Actions for Consideration

1. Develop a Restore Network for WA Health and Department of Justice starting with those involved in incident review processes relating to suicide.
2. Expand Restore Network to include WHS/HR leaders from across Government and encourage Statewide continuous adoption of RJLC.
3. Deliberately learn from Network members about resource and policy development needed to support the application of RJLC practices across services and sectors.

> Shared resources, shared knowledge and experience.
>
> Reviewing and Responding to Suicide Listening Session Participant

> Mutually beneficial for families, workplaces, and communities bereaved or impacted by suicide.
>
> Reviewing and Responding to Suicide Listening Session Participant

Engaging with Leaders

An initial presentation outlining the project to key stakeholders in WA was held on 18 April 2024. Sector leaders from the Commission, mental health and alcohol and other drug peak bodies, Health Service Providers, advocacy peaks, primary health peaks, and lived experience representatives attended. This presentation provided an overview of the Explore phase of the EPIS framework and reviewed stakeholder requirements for engagement.

Communication about SafeSide and the Commission partnership, including details about the engagement and planned events was sent by the Commission team in May 2024.

An email outlining the project, providing details about the listening events and workshops, and inviting participation was sent in mid-May 2024. 160+ Tier 2 Government and NGO leaders identified as key stakeholders for the project by the Commission received this correspondence.

Hon. Amber-Jade Sanderson

Tony Pisani, Maureen Lewis, Deb Roberts, Tegan Cotterill and Susanne Sharp

SafeSide also presented to 15+ members of the Public Sector Leadership Council before hosting a short Q&A on July 23, 2024. Key points from Professor Pisani's presentation included:

- A short introduction to SafeSide, its programs and the evidence behind them.
- Initial feedback from stakeholders, including first responders, healthcare providers, and individuals with lived experience, highlighted the strengths, challenges, and needs in suicide prevention in WA.

Members include Sharyn O'Neil, Commissioner, Public Sector Commission; Kylie Maj, Acting Director General, Department of Justice; Anthony Kannis, Director General, Department of Planning, Lands and Heritage; Commissioner Col Blanch, WA Police Force; and Dr Shirley Bowen, Director General, Department of Health.

These measures were implemented to ensure leaders were well-informed throughout the process and included before being asked to take action or commit to any future proposals.

SafeSide General Manager Jamie Thompson

Clinical Nurse Specialist Tendai Makanyanga and SafeSide's Daniel Mobbs.

Roses in the Ocean's Sam Phipps, Bronwen Edwards and Sasha Baker with SafeSide's Melanie Clark (second from right).

Commissioner Maureen Lewis

Attendees at the Leadership Event shared their insights into the initial findings.

Leadership Event

More than 150 Tier 1 and Tier 2 Government and NGO leaders were invited to attend the SafeSide Prevention Leadership event on July 31, 2024.

Attendees shared insights which have been combined into the data and findings for each section.

Some of the key messages from those in attendance included:

- The need to keep the momentum after this first stage of engagement and exploration.
- A desire for a clear call to action for those involved in the process to date and moving forward.
- Follow-up communications that clearly outlined SafeSide's programs and offerings including method of delivery, evidence base and target audience.
- Calls for mental health programs which don't overly rely on personal resilience and shifting away from placing burden solely on individuals to cope with workplace stressors.
- A desire for integrated support addressing suicidality and mental health and AOD combined with a recognition of the interconnected nature of these issues and the need for holistic care approaches.
- Calls for a whole of government approach to reduce fragmentation in suicide prevention and response efforts. Recognition that effective action requires coordination across various agencies and sectors.
- Recognition that effective suicide prevention strategies must be developed with, not just for, communities and services.

The SafeSide Prevention Leadership Event on July 31.

Additional Considerations

In addition to the findings and actions discussed above, any project pursuing these goals should establish robust evaluation frameworks and address practical considerations. Some of these are outlined below.

Measuring impact:

- Develop of a project-wide logic model in consultation with the Mental Health Commission and advisory group/s.
- Establish an evaluation plan for each program component, including agreed-upon metrics and roll-out strategies. Scope for consideration includes evaluation of adaptation and co-design customisations to content, educational outcomes and impact, change in care delivery and outcome for consumers and families.
- Develop an inventory of currently available data sources and identification of what additional data sources might be needed to measure the agreed outcomes.
- Consider how to properly resource project partners for engaging in high quality evaluation.

Further project considerations:

- Define project scope.
- Develop overarching and program-specific communications plans.
- Address technical compatibility issues and determine necessary steps and funding for implementation.
- Explore how SafeSide could advise or assist in the development of the next Western Australian Suicide Prevention Framework.

Closing Statement

Meaningful and deep consultation takes time, and what we have accomplished is just the beginning of exploring how we might work together to enhance suicide prevention efforts in WA.

The hearts and minds dedicated to the sector should have access to the latest evidence in suicide prevention that not only complements the excellent work already underway but also truly reflects the unique voices, experiences, and needs of Western Australia's diverse regions and communities.

Throughout this Exploration Phase, we have seen a strong desire for collaboration, for breaking down stigmas, and for creating a shared language and approach that can unite efforts across sectors. The enthusiasm for adapting and adopting evidence-informed programs and best practices gives us hope for the future.

However, a critical message we heard loud and clear is the importance of maintaining momentum. Stakeholders expressed concern about initiatives that come and go, potentially discouraging leaders and the workforce if concrete action is not taken. It is crucial that we honour the time and insights shared by taking decisive steps forward while remaining flexible and responsive to emerging needs and data.

As we move forward, it's essential that we stay in step with the evolving landscape of suicide prevention in WA. The data and learnings gathered during this exploratory phase should inform not only the implementation of SafeSide Prevention's programs but could also contribute to the broader state plan for suicide prevention. This approach ensures that our efforts remain aligned with and supportive of the state's overall strategy.

The proposal will outline how we can thoughtfully build the structures and implementation strategies necessary for long-term impact and sustainability. It will detail how both the Commission and other WA Government departments can collaborate with SafeSide to enhance suicide prevention efforts, creating a unified approach that is culturally relevant and fosters ongoing collaboration.

As we look to the next stage of this partnership, it is important to remember that every small act of care has the potential to save a life. In the words of one participant, "Sometimes small actions can make a big impact. It doesn't always have to be very clinical or academic, but just being human and showing that you care can already make a big difference."

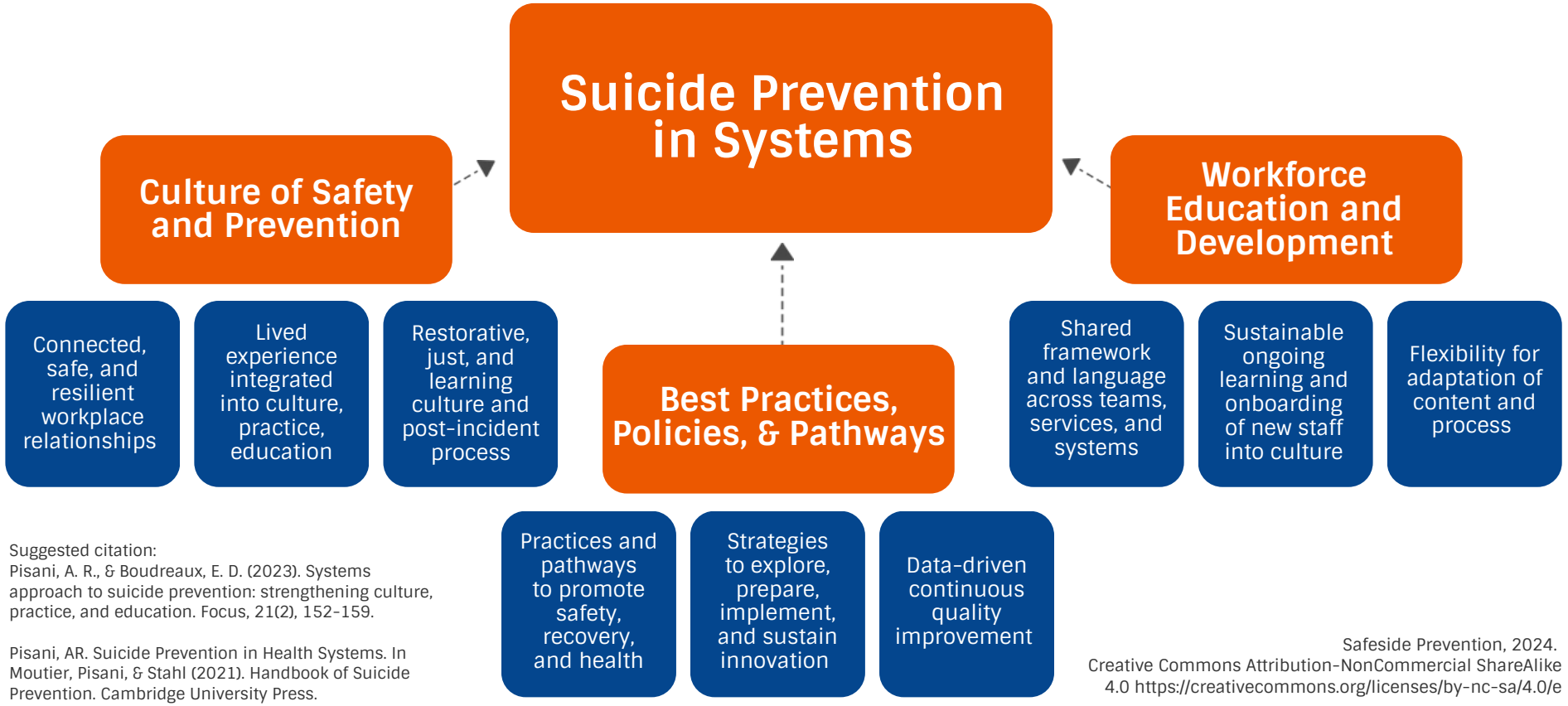
With continued collaboration, ongoing learning, and a steadfast commitment to centring the voices of those with lived experience, we move closer towards our shared vision of a WA where every person is respected, connected, and contributing to their community.

Jamie Thompson

General Manager, Australia
SafeSide Prevention

Appendices

Appendix A: Suicide Prevention in Systems

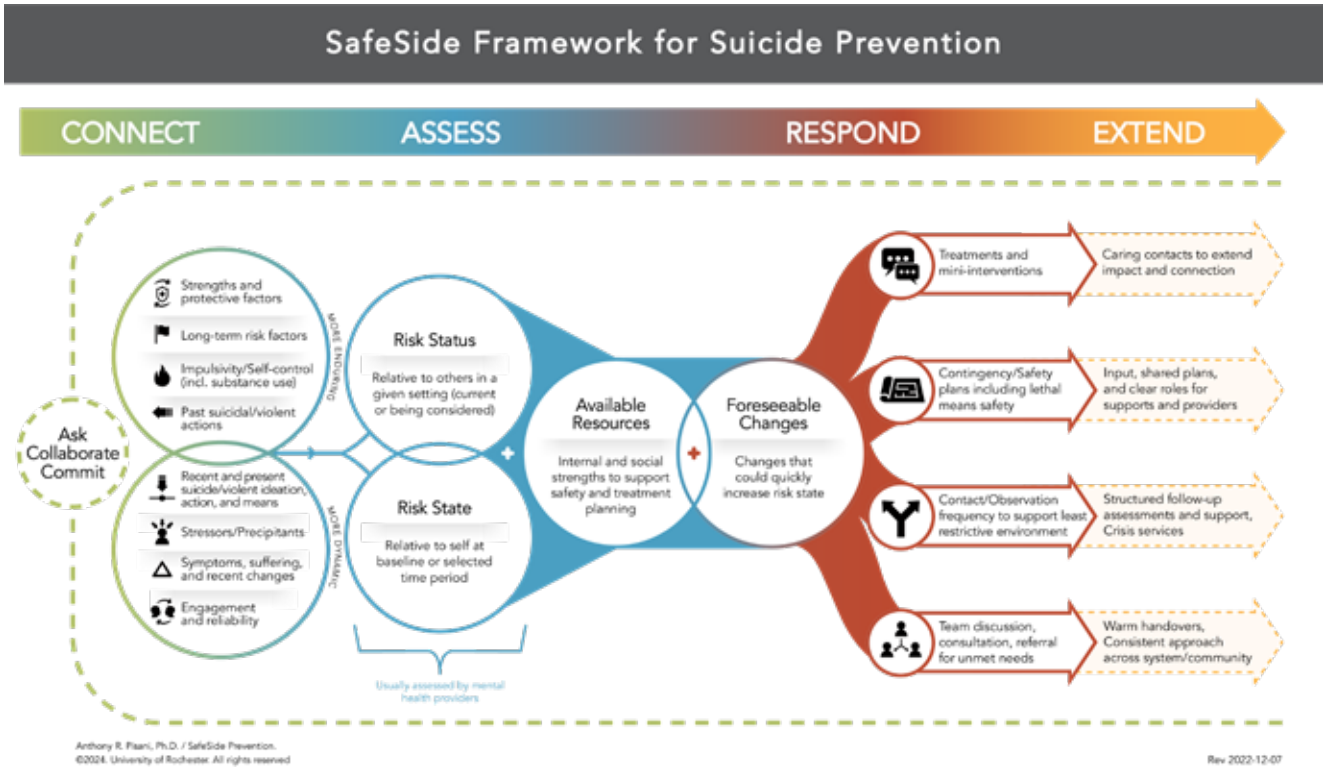


Suggested citation:
Pisani, A. R., & Boudreaux, E. D. (2023). Systems approach to suicide prevention: strengthening culture, practice, and education. Focus, 21(2), 152–159.

Pisani, AR. Suicide Prevention in Health Systems. In Moutier, Pisani, & Stahl (2021). Handbook of Suicide Prevention. Cambridge University Press.

Learn more about Suicide Prevention in Systems and the evidence behind it here.

Appendix B: The SafeSide Framework



The SafeSide Framework for Suicide Prevention was developed to provide a map of best practices including the shift away from outdated modes of assessment to prevention-oriented assessment (Pisani et el., 2016).

In Australia, this framework was first adopted by the Gold Coast Hospital Health Services as part of implementing the Zero Suicide Framework, becoming a key practice change in their Suicide Prevention Pathway (Turner et al., 2020) which yielded a reduction in suicide re-presentations to the service (Stapelberg et al., 2020). The approach to risk is now embedded in suicide prevention clinical guidelines in Queensland and has grown in use in Australia and expanded to provide a comprehensive model of best practice in suicide prevention.

The SafeSide Framework has been adopted nationwide by the Australian Defence Force (Harvey and Mobbs, 2024), who won the ACT Suicide Prevention Australia 2024 LiFE Award in the category of Best Practice in Workplace Award for their work in suicide prevention.

Appendix C: Organisations represented at the workshops and listening sessions

1. Roses In The Ocean
2. Wesley Mission
3. Outcare
4. WA Health
5. Anglicare
6. Standby
7. Mates in Construction
8. Advocacy services
9. Government departments
10. Western Australia Police Force
11. Department of Emergency Services
12. Department of Justice
13. St Johns WA
14. Department of Biodiversity, Conservation and Attractions
15. South Metropolitan Health Service
16. Zonta House Refuge Association
17. Raphael Services SJOG Healthcare
18. Vinnies
19. St John of God Midland Hospital
20. St John of God Mental Wellbeing Services
21. Older Adult Mental Health
22. Holyoake
23. East Metropolitan Health Services
24. Life Without Barriers
25. Bentley Hospital
26. Wanneroo Adult Community Mental Health
27. Mental Health Commission
28. MercyCare
29. Great Southern Mental Health Service
30. RUAH
31. Armadale Health Service
32. Youth Futures
33. Kimberley Mental Health and Drug Service
34. Western Australia Country Health Service
35. Casson Communities/Casson Homes
36. Palmerston Association
37. Parkerville Children and Youth Care
38. Mind Australia
39. Goldfields Rehabilitation Service
40. Orchard Avenue Centre
41. WACC
42. Cyrenian House
43. Kimberley Community Alcohol & Drug Services
44. Derby Aboriginal Health Service
45. Yaandina Community Services
46. Tenacious House
47. Mission Australia
48. Youth Involvement Council
49. Pilbara Mental Health Service
50. Derbarl Yerrigan health services
51. Lamp Inc.
52. Mifwa
53. WA Primary Health Alliance
54. Nile Health
55. Yaandina Turner River Rehab
56. Department of Education

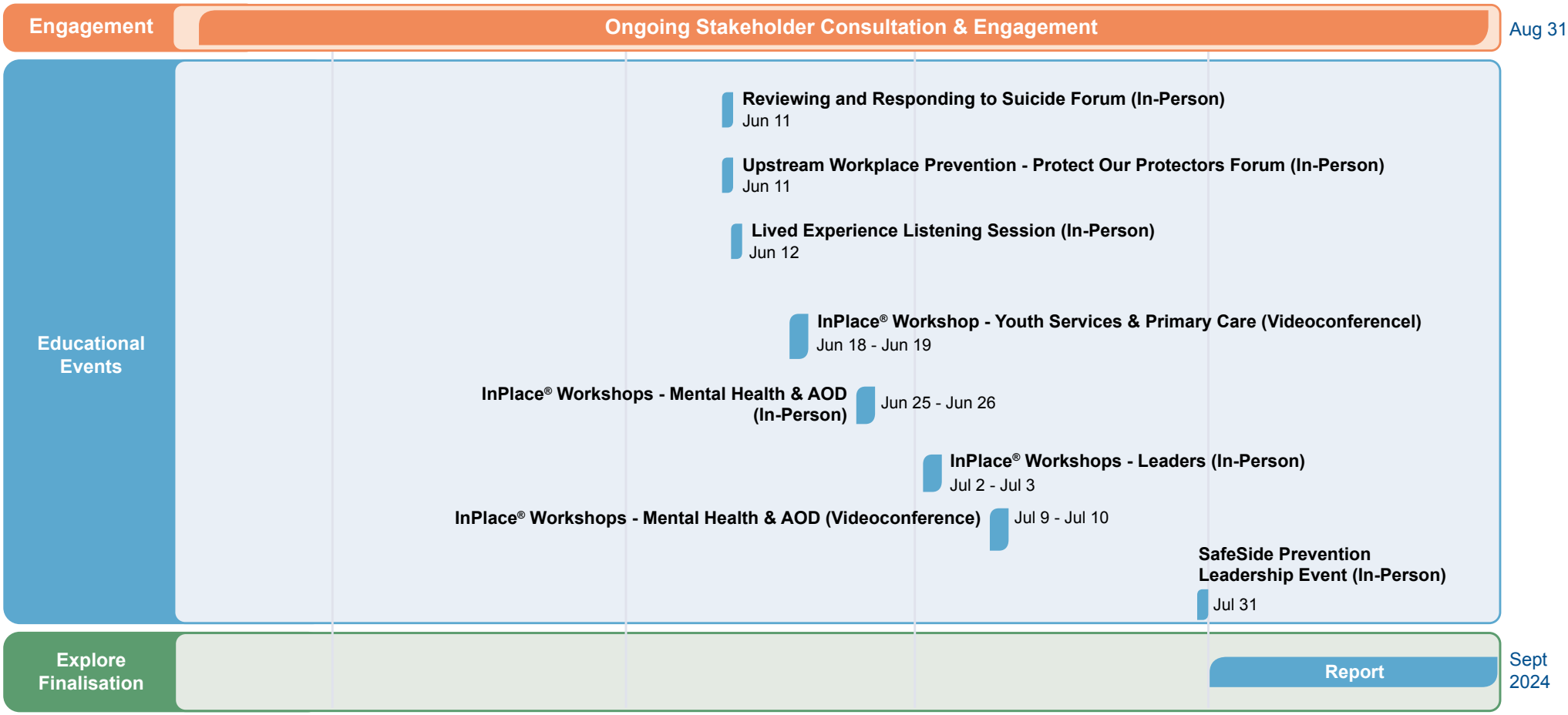
57. State Emergency Service
58. WA Association for Mental Health
59. Carnavon Family Support Services
60. This Working Life
61. Perth Inner City Youth Service
62. Neami National
63. North Metropolitan Health Service
64. Headspace National
65. Men's Health and Wellbeing WA
66. Wheatbelt Mental Health Service
67. Sobering up Centre - Carnavon
68. Department of Fire and Emergency Services
69. Moorditj Youth Foundation Aboriginal Corporation
70. 360 Health and Community Ltd
71. Pilbara Aboriginal Health Alliance
72. South Coastal Health and Community Services
73. St Patrick's Community Support Centre
74. HelpingMinds
75. Midland Women's HealthCare Place
76. Mental Health Advocacy Service
77. Community Outreach
78. 55 Central
79. Amana Living
80. LifeLine WA

Appendix D: Roles represented at the workshops and listening sessions

1. Senior Project Officer, Towards Zero Suicide
2. Support Coordinator
3. Clinical Coordinator and Occupational Therapist
4. Case Manager
5. Housing Plus Manager
6. Psychiatrist/Head of Department
7. Clinical Coordinator
8. Suicide Prevention Project Officer / Program Support Officer
9. Coordinator Mental Health Strategy
10. Mental Health Program Manager
11. Care Coordinator Community Mental Health
12. Clinical Nurse
13. Manager Community Support and Development
14. Senior Program Officer – Suicide Prevention
15. Aboriginal Outreach Youth Worker
16. Youth Mental Health Outreach Worker
17. Staff Development Educator
18. Counsellor
19. Mental Health Clinician
20. Coordinator of Nursing Mental Health
21. Regional Mental Health Nurse Educator
22. Community Services Officer/Office Administrator
23. Suicide Prevention Coordinator
24. Child and Family Advocate
25. Manager Suicide Prevention
26. Acting Assistant Director Strategic Management (Workforce)
27. General Manager
28. After Care Coordinator
29. Alcohol and Other Drug Prevention Coordinator
30. CEO
31. Service Manager
32. Workforce Development Officer
33. Outreach Youth Worker
34. Coordinator - Community Alcohol and Other Drugs
35. CDSW
36. SEWB Youth Worker
37. Program Coordinator / Counsellor
38. SEWB Clinical Lead
39. Team Leader
40. Residential Services Manager
41. Clinical Nurse Specialist
42. Senior Workforce Development Officer
43. Coordinator - Family Wellbeing Support Service
44. Peer Support Worker
45. Youth Support Services
46. Program Leader
47. Psychiatrist
48. Youth AOD Practitioner
49. Senior Youth Worker
50. Suicide Prevention Aftercare Worker
51. Suicide Prevention Community Liaison Officer

52. Carer Support
53. Peer Program Manager
54. Suicide Prevention Lead PHN
55. Culturally Diverse Psychological Service Admin and Intake Officer
56. Refuge Support Coordinator
57. Principal
58. Peer Support Team Leader
59. Student Well-being / Peer Support
60. Policy & Research
61. Managing Director
62. Domestic Violence Support
63. Youth Services Manager
64. Staff Development Nurse
65. State Manager, Be You headspace Schools and Communities
66. Suicide Prevention Coordinator
67. Program Manager Mental Health Strategy
68. Chair
69. Lived Experience Coordinator
70. Program Manager
71. Clinical Governance Manager
72. Senior Field Officer
73. Senior Mental Health Advocate - Adults and Older Adults
74. Assistant Director
75. Family Domestic Violence Case Manager
76. Director
77. Clinical Nurse Specialist - Safety Quality and Risk
78. State Mental Health and Well-being Coordinator
79. Employee Welfare Officer
80. DFES Chaplain
81. Psychologist
82. Chaplain
83. Sergeant – Injury Coordination Support Service
84. Corporate Health Coordinator
85. Corporate Health Officer
86. Manager Mental Health and Wellbeing
87. Prevention and Early Intervention Coordinator
88. Peer Support Officer - Probationary and Cadet Development Unit
89. First Responder Working Group Lead
90. Facility Manager
91. Field Officer
92. Individual Advocate
93. Senior Program Officer Lived Experience
94. Wellbeing Consultant
95. Safe Space Project Coordinator and Peer Support Worker
96. Project Officer and Peer Volunteer Support
97. Education Assistant/Volunteer Peer Care Companion
98. Trainer and Developer

Appendix E: Project Timeline



Appendix F: Data and Learning Parameters

This Explore Phase provided critical insights into the needs of suicide prevention in WA and how SafeSide programs and services may complement existing local services, systems, and communities.

During this phase, we identified several internal and external context factors influencing our work that impacted both the data collected and the conclusions we could draw from it. These factors shaped our understanding of the project's challenges and opportunities. This section will outline the key learnings derived from these contextual influences, offering valuable lessons for future phases of the project and similar initiatives.

Learnings

Timeframe

The project involved a rapid execution of the explore phase. This created several challenges that impacted on the other learnings detailed below, including:

- Insufficient leetime for recruitment and engagement of participants across sectors and organisations
- Limited opportunity to adequately prepare stakeholders and build relationships to increase engagement in the project.

Overall participant engagement and data collection

Over 250 participants registered for the SafeSide Program sessions, indicating a high level of interest. All registrants were allocated to a session based on their expressed preference and invited to attend. 158 registrants accepted the invitation to participate. Of this, 133 were able to attend one of the sessions. The challenges converting registration to attendance were:

- Registrant drop out from being unable to attend at short notice
- Registrants not confirming attendance following the invitation
- Leetime between invitation to attend and date of session.

Of the 133 participants who completed the SafeSide Program only 81 had matched pre-post survey data that could be utilised for analysis. It should be noted that qualitative data was obtained from all 133 participants during the sessions conducted.

Engagement with Primary Health Sector

The Primary Health Workshop hoped to gain insight into the suitability of the SafeSide Program for those working in this area. Attendees of the session however were primarily peer support and non-clinical roles rather than the primary care network. Consultation with representatives from the Western Australian Primary Health Alliance (WAPHA) identified the following challenges to engagement with this cohort:

- Duplicity and overlap with current training offered by WAPHA to their networks such as Black Dog Institute online suicide prevention training and Wesley Lifeforce training for practice staff.
- Time constraints of GP workforce and reimbursement requirements for GP engagement in training.
- Primary Health Alliance initiatives are Commonwealth funded and managed.
- Requirements for professional development to be recognised through the Australian Medical Association.

Lived experience consultation

Consultation for the Lived Experience Sessions was restricted by the following factors:

- The delivery timeline was insufficient to enable wider community member engagement.
- A framework for reimbursement was not put in place prior to the commencement of the engagement with lived experience networks.
- Members from remote and rural communities were not represented.
- Primary representation was from lived experience peer workforce.

Suggestions for improvement include:

- Utilisation of existing services such as Roses In The Ocean to facilitate Lived Experience consultation and engagement in a manner that reflects best practice.
- Reimbursement plan for those lived experience community members and service volunteers.
- Lived experience consultation across all regions acknowledging the diversity of service delivery and access to support both within and across the regions of WA.
- Minimum 6-8 week leetime between invitation to participate and consultation.

Regional and remote communities

The SafeSide Program In-Person Workshops were hosted in the Perth Metropolitan area. Given the limited number of sessions being conducted and the need of maximum engagement across the sector it was determined that conducting these sessions in regional and remote communities would potentially limit attendee numbers and restrict conclusions to those specific areas. It was anticipated that the videoconference sessions would provide adequate opportunity for those in regional and remote locations to attend. Whilst there was representation across all regions, this was limited and needs to be taken into consideration in relation to the applicability of the findings to more remote locations in Western Australia.

Cultural engagement

In this initial stage, our engagement with First Nations representatives and organisations has been guided by the Commission.

SafeSide hosted initial conversations with the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Aboriginal Health Council of WA. It was acknowledged that these relationships take time and respect to develop and SafeSide is continuing to build these in order to establish a solid foundation for any future work.

Representation of Aboriginal and Torres Strait Islander people across the listening events was minimal with a total of seven participants identifying as either Aboriginal or Torres Strait Islander in the survey data collected.

Data collected relating to the needs of First Nations people in WA was derived from those who worked with and supported these communities. We know that in this rapid initial Explore phase we haven't heard from all voices, and all experiences that would need to be consulted, and we are committed to broad and meaningful collaboration and co-design in the future.

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