NSW Health

Older People's Suicide Prevention Pathway Project

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Evaluation Report

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ACKNOWLEDGMENTS

This work was completed by ARTD Consultants and Taylor Fry with the assistance of the Older People's Mental Health Policy (OPMH) Unit in the Mental Health Branch of the NSW Ministry of Health.

We would also like to thank the key informants from the Local Health Districts (LHDs) involved in the pilot, and the consultants from the clinical redesign consultants. We thank them for their time and insights and trust that their views are adequately represented in this report.

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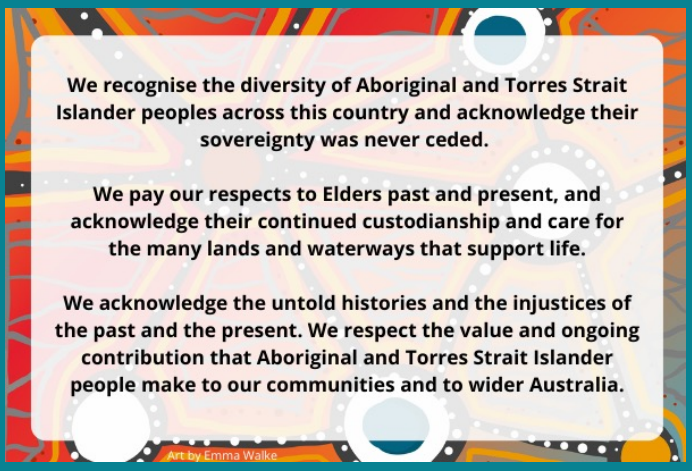

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Produced by: NSW Ministry of Health

The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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SHPN (MH) 230819
ISBN 978-1-76023-646-5 (print); 978-1-76023-647-2 (online)

October 2023

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Foreword

Older people are special in many ways. They use health and mental health services differently to younger people, and combine both resilience and vulnerability. One outcome associated with this which is not often discussed, is that Australian men aged 85 and above consistently have the highest rate of death by suicide in Australia.

The Older People's Suicide Prevention Pathway Project is one key NSW Health initiative intended to improve local pathways to care for older people experiencing suicidal distress. This report summarises the evaluation findings and recommendations from the project.

In December 2021, the NSW Ministry of Health commenced this project in collaboration with 4 Local Health Districts (LHDs), supported by clinical service redesign consultants. Participating LHDs were:

- Illawarra Shoalhaven LHD
- Nepean Blue Mountains LHD
- Western Sydney LHD
- Western NSW LHD

The aim of the project was for these LHDs to build on the Agency of Clinical Innovation's suicide care pathways framework and develop a locally relevant suicide care pathway specifically for older people, supported by experts in clinical service redesign. The project also built on work by the University of NSW commissioned by the Ministry to develop an evidence-based aftercare model for older people in suicidal distress. The model emphasised the importance of a systemic approach to aftercare and suicide prevention for older people and a more holistic pathway to care approach.

Importantly, each local pathway was guided by the key principles distilled from the older people's aftercare model and NSW Health's targeted older people's suicide prevention efforts:

- **Early identification** is needed to support older people at risk of suicide.
- A **low threshold for referral to specialist OPMH services** is supported.
- Accessing **timely, and appropriate specialist OPMH care** and support as early **as possible** are critical.
- **Inclusion of the older person and their family and carers** in care planning and decision-making enables collaborative safety and care planning.
- **Rapid assertive follow-up** of all older people identified as at risk of suicide, ideally face-to-face within 24-48 hours is recommended. Follow-up should reinforce connectedness between consumers and care providers and be linked with a higher intensity of scheduled care contact in the initial weeks after the presentation.
- **Continuity of care** should be maintained wherever possible, with a clinician or peer worker assigned, or if not possible, ensuring a thorough handover of information.
- **Specific education and training** on identifying suicide and self-harm in older people will support the effectiveness of targeted suicide prevention efforts.
- **Clear communication** across services and supports, including transitions across services is critical.
- **Enhanced transfer of care** should include a warm handover and follow-up appointment scheduling before transfer.

This evaluation report on The Older People's Suicide Prevention Pathway Project provides a summary of the pathways design process as well as the implementation and early outcomes of the pathways. The evaluation highlights a number of opportunities and challenges in the process. However, staff and stakeholders agreed that early pathway implementation has had two clear outcomes for older people at risk of suicide.

1. **More rapid access to support** – Previously older people would wait 1-2 weeks to receive follow up from the OPMH team. The pathway reduced this consistently to 24–48 hours.
2. **More emphasis on identifying the causes or triggers for suicidal distress** – Staff attributed this shift to both the pathway and the accompanying training and support.

I would like to congratulate and thank the staff of the four participating LHDs for their commitment to this challenging project and their ongoing efforts to support prevention of suicide in older people. I commend the report to other NSW Health local health districts and anyone who wishes to progress suicide prevention initiatives for older people. This report highlights that a focused and specific local care pathway can improve the responsiveness of services to older people in suicidal distress.

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The Older People's Suicide Prevention Pathway Project

Evidence shows that older people have a significant risk of suicide, and older men (over 85) have the highest suicide rates of all age groups. Older people need targeted supports as broader suicide prevention interventions are often not appropriate.

Between December 2021 and June 2022, the NSW Ministry of Health funded a project to support four Local Health Districts (LHDs) – Illawarra Shoalhaven, Western NSW, Western Sydney and Nepean Blue Mountains – to develop a local suicide care pathway specifically targeting older people. The four sites were selected through an EOI process. Funding was used to provide a range of supports for the process, including engaging a redesign consultant to support the four LHDs to develop the pathways.

Since completion of the redesign process, one site (Illawarra Shoalhaven) was able to commence implementation and the other three (Western Sydney, Nepean Blue Mountains and Western NSW) have gained endorsement for their pathways.

1.1 The Evaluation

ARTD consultants were engaged in December 2021 to undertake an evaluation of the project. This included:

1. The design an evaluation framework for the clinical redesign process, implementation of the pathways and outcomes that can be used for ongoing monitoring and evaluation.
2. The delivery of a formative and summative evaluation of the design process and early implementation of the pathways in the participating Local Health Districts (LHDs).
3. The identification of insights to inform further implementation of the pathways in the participating LHDs and expansion of the process to additional LHDs in New South Wales (NSW).

The evaluation included all four pilot sites. The evaluation drew on multiple data sources, including:

- Document scan – scan of key documents related to older people's suicide prevention and the redesign process
- Interviews with key stakeholders (project leads, executive sponsors, clinical redesign consultants and Ministry of Health leads)
- A survey of PUG members (n=31, 47% response rate)
- A lessons learned workshop
- Focus groups with staff implementing the pathway (n=2 workshops, 12 participants)
- Administrative data – deidentified data about 40 participants who had been supported through the suicide care pathway

The methods were implemented largely as intended and we have sufficient data to answer the key evaluation questions about the redesign process. For the implementation evaluation, we were unable to implement the original methodology due to the status of implementation. Instead, we focused on enablers and barriers to implementation across sites, how implementation was working in the one operating site and considerations for future implementation.

Key Findings

Overall, the redesign process achieved its purpose: all four LHDs developed a draft pathway. However, there were significant challenges in gaining endorsement and transitioning to implementation that can be learned from in future implementation.

2.1 Redesign

- Redesign is an appropriate methodology to develop a suicide care pathway for older people, provided it is based on timeframes recommended by the ACI (meaning, a 12 month process). This is because it takes significant time to engage with key stakeholders, and to achieve governance signoff for the pathway.
- One of the key challenges faced by the project leads was a lack of experience or expertise in redesign processes. To ensure the success of the process, staffing for the project should include:
  - clinicians with in-depth knowledge and relationships within the service
  - people who have training/ experience in redesign or AIM (even if the redesign consultants were engaged in future, this would still be needed to ensure a successful rollout as the level of support from the redesign consultants required for this project is not sustainable in the future)
  - involvement of Towards Zero Suicide or Zero Suicides in Care leads, to ensure that the process is informed by those with expertise in suicide prevention and to connect the process to other suicide prevention initiatives, in particular Zero Suicides in Care.
- It takes the time to effectively engage with people with lived experience and stakeholders who will be referring to the pathway, but this is essential to ensure the pathway design reflects the needs of individuals, is practical and able to be implemented and has buy in from key stakeholders.
- Governance should include all those who will be responsible for endorsing the pathway prior to implementation, to create buy-in and ensure the pathway is able to be endorsed.
- Leads appreciated the support provided to site leads throughout the process from the Older People's Mental Health Policy Unit (OPMHPU) team and from their fellow leads.
- Key success factors for the redesign process across the four sites were:
  - the Project User Group (PUG) collaboration – the value of the combined input of those involved in the PUG and the discussions that provided direction for the pathway
  - strong project management (dedicated role with appropriate experience and expertise)
  - the involvement of clinical redesign expertise and connection to Towards Zero Suicides (TZS)
  - the systems improvement orientation of the process
  - the pathway being locally developed to meet individual LHD needs and match the resourcing available.

2.2 Implementation

Key enablers for implementation included:

- **Pre-existing work** – in Illawarra Shoalhaven, the existing implementation of a suicide care pathway as part of the Zero Suicides in Care initiative allowed the broader system to understand the concept and language; the design of the pathway also used existing systems, processes and ways of working, facilitating implementation.
- **The localised approach** – allowing each site to decide on an implementation approach enables them to effectively respond to local context and resourcing.
- **Leadership** – support from LHD level leaders and senior management engagement who were essential in developing buy in from key stakeholders and gaining endorsement for implementation
- **Tension for change** – buy-in from core teams about the need for specialist responses to older people at risk of suicide was important to overcoming challenges and barriers to change.
- **Staffing** – continuity and seniority of staff in the older people's mental health team at Illawarra Shoalhaven facilitated faster transition to implementation.

Key barriers included:

- time spent navigating and delays due to slow governance processes within LHDs
- lack of support from leaders and other staff
- a broader lack of tension for change within the system due to ageism and a lack of knowledge about older people's high rates of suicide
- resistance to change and concerns about workload among staff
- the challenge of non-crisis response teams having to adapt to a rapid, time bound response model
- ongoing staffing shortages, exacerbated by increasing demand for mental health and suicide prevention services and supports

Five core aspects have been identified as core to successful pathway implementation in future.

Alignment with Zero Suicides in Care

- Alignment is critical to avoid gaps or duplication in caring for older people at risk of suicide, and in supporting service delivery of the pathways. This should not mean subsuming the work into the broader program, as the pathway for older people will require targeted support, given the additional complexity involved and the need for specialist support for older people at risk of suicide

Having the right leads

- An older people's mental health clinician supported by the TZS lead
- The personal qualities, passion and connections of the individuals)

Leveraging existing work

- Including an established adult suicide care pathway and existing systems, processes and ways of working

Creating tension for change

- Increasing awareness of suicide rates for older people

Involving engaged executive sponsors

- overcoming the inherent challenges in undertaking the design and implementation of a suicide care pathway (for any cohort) will be best supported by an actively involved executive sponsor who has sufficient influence within the broader system

Recommendations for Sites Considering Commencing the Redesign Process

The following recommendations are useful to consider for any site considering developing a suicide care pathway and have particular relevance to those considering developing a pathway for older people.

Overall

- **Alignment with Zero Suicides in Care**
  - Ensure that any redesign process is aligned with the broader Zero Suicides in Care initiative but that there continues to be a dedicated focus for older people's pathways, given the need for specialist support for older people at risk of suicide.
  - Redesign and implementation of older people's suicide care pathways should occur in sites with established adult suicide care pathways to leverage existing work and ensure a consistent approach and facilitate implementation.

Redesign

- **Timeframe**
  - Ensure that any future redesign processes use the ACI timeframes, balancing the need for momentum with the time required to enable effective engagement with all stakeholder groups and for endorsement through LHD processes.
- **Leverage existing work**
  - Align the redesign process with ACI methodology and the state-wide suicide care pathway supporting information.
  - Encourage redesign processes to focus on designing pathways that are consistent with existing ways of working a to minimise the need for new systems and processes.
  - Encourage future redesigns to focus on responses that can be delivered within existing resources, as this is more likely to produce pathways that can be implemented and sustained.
- **Lead role**
  - Consider a lead model for the process that includes:
    - clinicians with in-depth knowledge and relationships within the service
    - people who have training/ experience in redesign or AIM
    - involvement of Towards Zero Suicide or Zero Suicides in Care leads
- **Stakeholder Engagement**
  - Ensure that any future redesign process actively plans for and includes engagement with people with lived experience throughout the entire process in a way that aligns with best practice.
  - Consider expanding the scope of any future redesign process to explicitly integrate aged care and primary health stakeholders.
  - Ensure that any future redesign process actively plans for and includes engagement with Aboriginal communities and Aboriginal Community Controlled Health Organisations (ACCHOs).
- **Governance**
  - Ensure that governance of future redesign processes is representative of broader services within the LHD and stakeholders outside of the LHD.
  - Support LHDs to appoint project sponsors at the right level, and with a clear understanding of the level of engagement expected.

Implementation

- **Education and training**
  - Prioritise the roll-out of education and training (Older People's Gatekeeper Suicide Prevention) to increase skills and confidence of staff involved in implementation, both in referring to and delivering the pathway.
- **Staged approach**
  - Use a staged approach to implementation, to allow for processes to be bedded down and staff confidence increased before increasing the number of referrals.
- **Monitoring and evaluation**
  - Ensure that redesign and implementation processes include monitoring and evaluation component (see monitoring and evaluation plan for support).

Case Study – Illawarra Shoalhaven LHD

The Illawarra Shoalhaven LHD project was led by a Mental Health Nurse Practitioner in the OPMH Service (community) and supported by the Zero Suicides in Care lead (funded through TZS).

4.1 Context

Illawarra Shoalhaven is the only LHD with a dedicated Zero Suicides in Care lead, and the lead was involved throughout the process. It is also a Lifespan trial site, with an established suicide prevention collaborative.

4.2 Design Process

Illawarra Shoalhaven LHD's older people's suicide care pathway was developed through the clinical redesign process between January and June 2021, supported by redesign consultants. The redesign was informed a Project User Group (PUG) that included comprehensive representation from:

- OPMH
- mental health
- geriatrics
- Aboriginal mental health
- TZS
- medical and nursing
- primary health and aged care (including Veterans affairs).

Illawarra Shoalhaven LHD reported that they had significant support from the redesign consultants to identify the right people for the PUG, while their success in engaging a range of stakeholders was largely due to the project lead drawing on personal networks of connections. Strong support from the redesign consultants to undertake the redesign process was important given that the project lead did not have re-design expertise.

4.3 Pathway Design

The pathway design involves four stages – identify, engage, treat and transition. The emphasis is on ensuring that older people at risk of suicide: are identified early on, using an evidence-based and person-centred approach to risk formulation; and have an immediate brief intervention, ensuring appropriate follow up within 48 hours and the involvement of the OPMH team in their care. For detail, see the flowsheet in Appendix 6.

4.4 Implementation

Illawarra Shoalhaven LHD's pathway was endorsed immediately after the redesign phase, and both the Illawarra and Shoalhaven teams started implementation of the pathways in July 2022.

4.4.1 Staged Roll-out

The LHD took a staged approach to implementation, opening up initially to referrals from EDs and acute care service of community mental health only (though they don't reject referrals from other sources). This was based on staged implementation of the adult suicide prevention pathway, which expanded as teams built confidence in the process.

The site is planning to extend their referral pathways during May/ June 2023 to include referrals from generalist hospital wards via psychiatry liaison services. If that expansion is successful, the teams will further expand to begin accepting referrals from anywhere in the LHD.

4.4.2 Support For Implementation

The LHD took a staged approach to implementation, opening up initially to referrals from EDs and acute care service of community mental health only (though they don't reject referrals from other sources). This was based on staged implementation of the adult suicide prevention pathway, which expanded as teams built confidence in the process.

The site is planning to extend their referral pathways during May/ June 2023 to include referrals from generalist hospital wards via psychiatry liaison services. If that expansion is successful, the teams will further expand to begin accepting referrals from anywhere in the LHD.

Overall, staff and other stakeholders were positive about the implementation of the pathway in Illawarra Shoalhaven LHD – reporting it has been implemented as intended. The team have made a number of adjustments to existing systems and processes to support implementation of the pathway, including:

- a **team roster** developed for those working on the pathways
- adjustments to **an existing referral system** (through the acute team) to refer directly to the team delivering the care, which enabled the response to be made within 48 hours (the acute team previously managed referrals and these would be responded to within 1–2 weeks)
- changes to **key roles within the team** and existing workloads to deliver responses to referrals within 24–48 hours – specifically, by ensuring that on certain days of the week a member of the team is not booked into appointments so that they are able to respond to referrals received within the last 24-48 hours.

There has also been a focus on delivering training and support to support awareness and implementation, including:

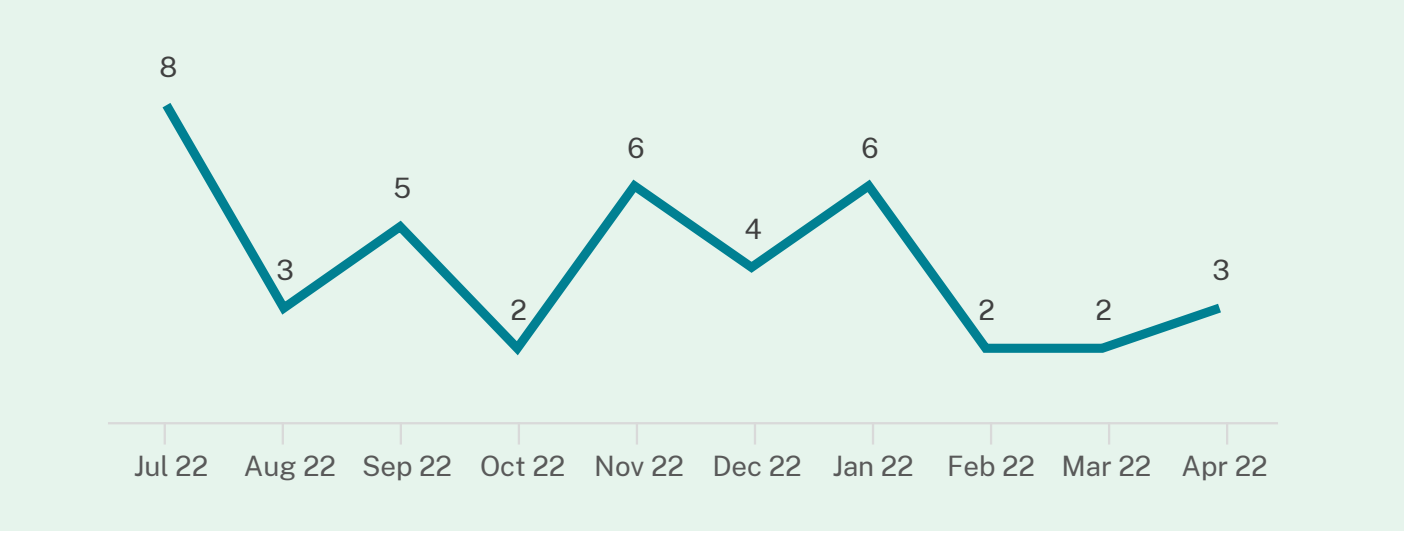
- **training and resources** (e.g. infographic of the traffic light response) prior to the pathway program being implemented, which were useful in building staff awareness and confidence
- a **peer support worker**, who has been involved in the hospital as well as in the community and other advocacy activities, to support clinical staff with their confidence in working with at risk individuals
- **training focusing on suicide prevention for older people**, which has been revised and delivered as a priority to key staff delivering the care to older people
- **education and training** of clinical staff in Nowra and delivery of TZS Gatekeeper training to increase awareness about the pathway and how it works.

4.4.3 Reach

Between July 2022 and mid-April 2023, the Illawarra Shoalhaven LHD pathway reached a total of 40 older people at risk, aged between 68 and 91 (n=22 with data about age and gender). Most participants were aged between 75 and 84 (11 out of 22), with 7 aged 65–74 and only 4 over 85.

It is positive to see that most pathway participants were men (14 out of 22), because this is consistent with rates of suicide by gender, although not commonly achieved in suicide prevention programs.

Figure 13. Pathway Participants By Month



Source: Illawarra Shoalhaven program participant spreadsheet, July 2022-April 2023

The number of participants per month varied, with higher numbers initially, and over the holiday period. The drop off in early 2023 may be due to a temporary reduction in staffing over that period.

The majority of pathway participants were experiencing thoughts of suicide or self-harm, with only three having made an attempt.

4.4.4 Early Outcomes For Older People

The team is not currently collecting data about outcomes for older people who access care through the pathway, and generally did not feel it appropriate to speak on behalf of older people about their experiences and outcomes.

However, staff and stakeholders agreed the pathway has had two clear outcomes for older people at risk of suicide.

1. **More rapid access to support** – Previously older people would wait 1-2 weeks to receive follow up from the OPMH team. The pathway reduced this consistently to 24–48 hours.
2. **More emphasis on identifying the causes or triggers for suicidal distress** – Staff attributed this shift to both the pathway and the accompanying training and support.

4.5 Learnings

4.5.1 Enablers To Successful Implementation In Illawarra Shoalhaven LHD

- Building on **pre-existing work and connections**
  - An adult suicide care pathway had already been developed and implemented between June 2021 and June 2022. This meant that the executives, managers and staff were already familiar with the concept of a suicide care pathway, which helped the older people's pathway gain broad engagement with the redesign process, achieve endorsement and progress with implementation.
  - More broadly, Illawarra Shoalhaven is a Lifespan[1] site with an established suicide collaborative, and this likely contributed to the success in involving PUG members from outside of the LHD because of those **existing connections related to suicide prevention**.
- The **design of the pathway** itself was a key enabler, as it was both simple and a formalisation of existing processes. Drawing on existing practice, meant the teams were able to respond through adaption of existing systems and processes.
- **The leaders and teams**
  - The *executive sponsor* at the LHD had been involved from the EOI stage, which ensured executive support for the pathway throughout the entire process.
  - The *project leads* had a combination of long tenure, seniority and an existing role leading the OPMH team, which was useful both in terms of design and transition to implementation.
  - The role of the *Zero Suicides in Care lead* supported the project lead throughout the process (Illawarra Shoalhaven is the only LHD with a dedicated lead in this position.
  - More broadly, the *teams implementing the pathways* in both Illawarra and Shoalhaven have had relatively stable and senior staff in their teams. This level of experience and continuity meant the team was well placed to take on older people who are at a high risk of suicide.
- Supporting OPMH staff and referring staff through **education and training** has raised awareness of the issues for older people at risk of suicide and enhanced the capability of the team to respond to older people at risk of suicide.

[1] Lifespan trials were a Black Dog initiative aimed at prevention suicide through better coordination and connection of existing programs and services for people at risk of suicide. For more detail, see the **Black Dog website**.

4.5.2 Barriers That The Illawarra Shoalhaven LHD Have Overcome

BARRIER	STRATEGIES
Staff concerns	
• Staff had some concerns prior to implementation of the pathway, including: – the concern that an increase in referrals would limit the capacity of clinical staff to effectively meet referral response deadlines (24–48 hours) – concerns about the time they needed to spend away from existing clinical work when delivering care to older people on the pathway	• To date, these concerns have been managed through a combination of: – staging the roll-out to limit the number of referrals by limiting the referral sources – communicating to the team the limited scale of potential referrals, based on data about actual numbers of older people at risk of suicide presenting at the service – drawing on casual staff to support service delivery while substantive staff are delivering pathway responses. • This strategy was enabled by having staff within the team leading the redesign and implementation as this meant that the team trusted their advice and approach. • Some concerns remain about the impact of increased demand as the team works toward expansion of the referral pathways.
Funding and staffing	
• Staffing issues have created difficulties in both meeting the 48-hour response timeframe and balancing existing clinical work with pathway responses. • The lack of funding to support implementation was consistently raised as a barrier.	• The team continues to manage by moving resources between different roles, but there is an identified need for more resourcing to support increased staffing, particularly as the pathway expands.
Engagement with ED	
• Consistent with feedback from other leads, engagement with EDs has been a challenge. To date, most of the referrals from the ED have been from Illawarra, and a much smaller number from Shoalhaven. Engagement with EDs is an issue for many suicide prevention initiatives, not just the pathway.	• Ongoing engagement and education are being undertaken to try to improve engagement with EDs.
Crisis care delivered by non-crisis response team	
• Accommodating a crisis or time bound response in a non-crisis support service was initially a significant challenge	• While managing the 48-hour response team is a challenge for the team, working with the acute team and rebalancing workloads has made this possible the majority of the time.

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