Older People's Aftercare Service Delivery Model Report: Summary

I am pleased to provide an overview of the *Older People's Aftercare Service Delivery Model Final Report* commissioned by NSW Health and produced by the University of NSW, along with report's executive summary.

NSW and national suicide prevention policies and plans in Australia recognise the importance of postvention in overall suicide prevention efforts. Postvention, is a strong element of a systems-based approach informing the *Fifth National Mental Health and Suicide Prevention Plan*, and the *National Mental Health and Suicide Prevention Agreement*. Postvention programs and services which are "co-designed, inclusive, coordinated and integrated" are included under one of the five goals of the *Strategic Framework for Suicide Prevention in NSW 2018–2023*, along with suicide prevention and intervention initiatives. Aftercare is an important element of postvention and features in the *NSW Towards Zero Suicides Initiatives* contributing to the Premier's Priority goal of reducing suicide rate by 20% by 2023.

In May 2021, the NSW Ministry of Health commissioned the University of NSW to deliver an aftercare service delivery model that is informed by the evidence about suicide in older people, current and preferred pathways of accessing care and support, and suicide prevention interventions that are effective for and acceptable to older people. The project also sought to identify how the recommended model may be implemented through adaptation of existing aftercare models or through other service delivery approaches.

One key output from this work was a systematic review of evidence-based aftercare for older adults following self-harm which was published in the *Australian and New Zealand Journal of Psychiatry.*[1] The project team also consulted with a wide range of key stakeholders including:

- older adults with lived experience of suicide crises
- clinicians from older people's mental health (OPMH) teams
- General Practitioners
- Emergency Department health professionals and
- aftercare researchers and service providers

The project report draws on the published evidence base and consultation with people with lived experience and key stakeholders. The report proposes a valuable human rights approach to care that seeks to deal with barriers to care and support for older people in suicidal distress including access, ageism, stigma and the pathways into care. The report emphasises a number of core principles that will support services seeking to improve the outcomes of older people experiencing suicidal distress and reduce the number older people who die by suicide in our community.

Key findings and recommendations of the report include:

Key findings

- There is poor representation of older people when included within the broad remit of all-age adult aftercare programs. Older people who have self-harmed or experienced suicidal crisis have different needs to the broader adult population, just as youth have differing needs to adults, requiring adaptation of existing standalone approaches to aftercare.
- Review of the current evidence base indicates that a discrete aftercare service model is not fit-for-purpose for older people.
- A systemic approach to aftercare and suicide prevention for older people and a more holistic pathway to care approach are needed.

[1] Wand AP, Browne R, Jessop T, Peisah C. A systematic review of evidence-based aftercare for older adults following self-harm. *Australian & New Zealand Journal of Psychiatry*. January 2022. doi:10.1177/00048674211067165

Key recommendations

- A low threshold for referral for aftercare for older people is supported – any older person presenting with self-harm or suicidal crisis in any setting should be referred for aftercare (*see Figure 2, Executive Summary*).
- Early referral to specialist older people's mental health (OPMH) services for any older person at the time of presentation with any self-harm/suicidal crisis regardless of setting is recommended.
- Regular assertive aftercare follow-up by OPMH services and other providers of individualised psychosocial support (which may include community aged care providers and Primary Health Network-commissioned psychosocial support providers) is recommended.
- Care navigators for older people presenting with self-harm/suicidal crisis should be considered.
- The report also recommends stakeholder-specific education and training on suicide and self-harm in older adults, clear communication across services/supports including for transitions across services, and collaborative safety planning with the older person and their family and carers, with documentation and sharing of the plan.

I hope that this report focusses attention on suicide in older people, and the impacts such deaths have on those who know and care about each person. It offers guidance to efforts to improve the outcomes of older people who have self-harmed or experienced suicidal crisis that has the potential to contribute to reducing suicide deaths of valued members of our communities.

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Older Peoples Aftercare Service Delivery Model (OPASDM)

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Executive summary

Older adult men (aged 85+) have the highest rates of death by suicide in the Australian population (Australian Bureau of Statistics, 2020), yet the issue is not well publicised and there are few efforts to specifically target older adults in suicide prevention initiatives (McKay et al., 2021). Aftercare is a key component of suicide prevention, and is especially pertinent to older adults, for whom there is a very low ratio of self-harm to suicide (Chiles et al., 2019). Accordingly, any self-harm in an older person must be regarded as a red flag heralding the need for assertive aftercare, regardless of stated intent (Wand et al., 2019b). Aftercare refers to planned coordinated support and follow-up after a suicide attempt or crisis (Shand et al., 2018). There is poor representation of older people when they are included within the broad remit of all-age adult aftercare implementation programs (Wand and McKay, 2021). The reasons for this are poorly understood but have been postulated to include ageism, barriers to access (e.g. requirements for suicidal intent behind self-harm, language, communication, cognitive impairment and limitations on physical access), inadequate training of clinicians regarding the needs of older adults and vulnerabilities for suicide, and not recognising the pivotal role of primary care (Wand and McKay, 2021). Combined with research demonstrating differences in the risk factors and reasons for suicide between older and younger adults (Adamek and Kaplan, 1996; Chiles et al., 2019; De Leo et al., 2001; Sinyor et al., 2016), these issues highlight the need for a dedicated older persons aftercare service delivery model (OPASDM).

Key to delivering effective aftercare to older people following a suicidal crisis, is addressing potential barriers to care. Older adults may face the double stigma of ageism and mentalism (discrimination on the basis of mental health conditions) (O'Cionnaith et al., 2021). The connections between suicide, human rights violations and ageism have previously been considered (Van Orden and Deming, 2018; Wand et al., 2021c). In particular, the risk factors associated with suicide in older people may be caused or exacerbated by human rights violations and represent downstream effects of ageism (Wand et al., 2021c). The OPASDM directly incorporates the evidence regarding ageism, stigma, and human rights violations in addressing specific aftercare needs. Accordingly, the OPASDM is guided by several core principles of care; awareness (to combat ageism and stigma), person-centred and trauma informed care (paced and meaningful), and connection and collaboration (accessible, hopeful, empowered and in partnership).

The OPASDM is founded upon evidence derived from research conducted with older adults with lived experience of self-harm/suicidal crises and their carers specifically. Simply extrapolating research findings from the general adult literature was recognised as inadequate and potentially another form of ageism, denying the unique identities and needs of older people (Wand et al., 2021c). Nonetheless, where resonances exist between the evidence gathered for the OPASDM and current aftercare initiatives such as the Way Back Support Service (Beyond Blue, 2020) and Towards Zero Suicide initiatives (McKay et al., 2021) they are emphasised. In line with the literature demonstrating the close link between self-harm and suicide in older adults, aftercare was defined as the care of an older person after self-harm regardless of intent. Recognising the specific complex and inter-agency presentations and needs of older people, key stakeholders informing development of the OPASDM included older people with lived experience of self-harm and their carers, emergency and crisis workers, Emergency Department staff, hospital services (medical and psychiatric wards), primary care, residential aged care facilities, outpatient mental health and aged care services and non-clinical community services.

Accordingly, the methodology used to develop the OPASDM had two sources of evidence: a novel systematic review of the international literature and a thematic analysis of consultations with older people with lived experience and key Australian stakeholders about older persons aftercare using individual interviews and focus groups. Three fundamental components of aftercare were evaluated during the data gathering phase: (i) referral pathways for aftercare; (ii) assessment tools and safety planning, and (iii) strategies for effective engagement and intervention; and educational interventions to support non-clinical workers regarding suicidal behaviours in older persons. To complement this existing published research evidence and 'dig deeper', consultations with older people with lived experience and other key stakeholders explored (i) the gaps and problems with current aftercare services and (ii) aspects of aftercare which are valued, work well or are proposed solutions. Data from this variety of sources were triangulated to derive an aftercare service delivery model based upon evidence, which was tailored to and informed by older persons' needs. The proposed recommendations for implementation and evaluation measures developed in the OPASDM directly arose from these data. This robust methodology, in particular targeting the evidence-base specific for older adults and triangulating findings, revealed synergistic themes supporting the validity of the OPASDM.

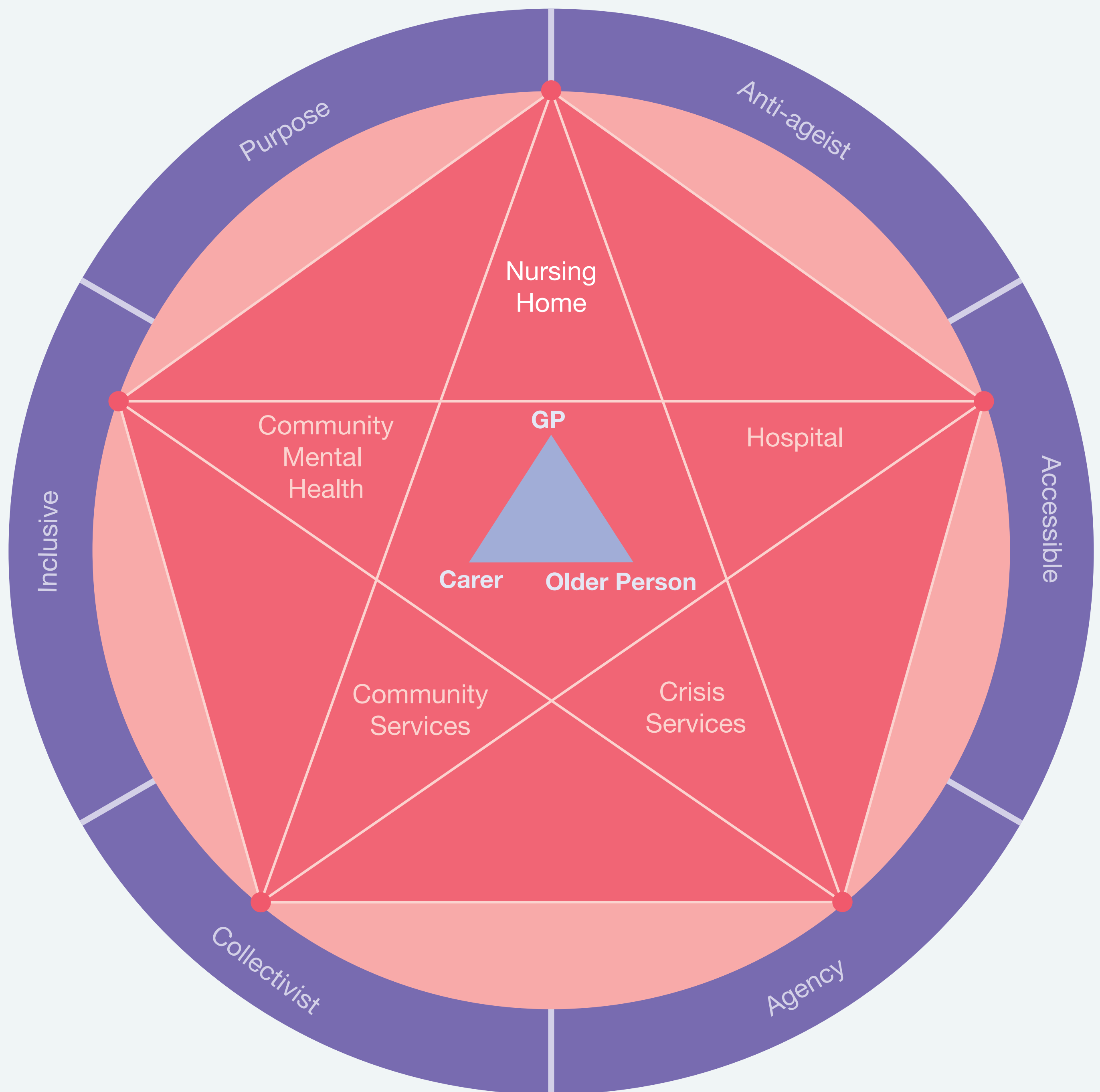

Figure 1. Systems and principles of the OPASDM

The OPASDM espouses a recovery-oriented approach which recognises individual circumstances and needs. The key principles derived from the aforementioned evidence-base which underpin this model are:

1. Anti-ageist
2. Accessible
3. Giving Agency
4. Collectivist
5. Inclusive
6. Giving Purpose

There are multiple intersecting stakeholders, systems and services surrounding the older person after a suicide crisis (see Figure 1). Recognising the complex and variable needs of older people, these systems span the home and social environment, family, primary care, physical and mental healthcare community services, support services for activities of daily living, crisis services, Emergency Departments, hospital-based care, the general community, and wider society. Open and clear communication between all these components is needed to deliver collaborative holistic aftercare and achieve optimum outcomes. At the heart of the triad is the older person experiencing the suicidal crisis, their family/carer, and the GP. Based on the gathered evidence, the OPASDM proposes targeted recommendations for implementation and evaluation of aspects of aftercare for each of these services/systems.

Built into the OPASDM are measures to enhance sustainability spanning workforce development and training, making strong connections between systems and services, community (aspects of public health promotion and inclusion), and governance and leadership.

Additionally, implementation must be supported and flexibly adapted according to local resources. There are some common elements of the OPASDM across services and systems including (i) Stakeholder-specific education and training on suicide and self-harm in older adults, (ii) Clear communication across services/supports including for transitions across services, (iii) Collaborative safety planning with the older person and their carer for each services/system, with documentation and sharing of the plan, (iv) Prompt referral to specialist Older Persons Mental Health (OPMH) services at the time of presentation with any self-harm/suicidal crisis regardless of setting (v) Regular assertive aftercare follow-up by OPMH and other providers of individualised psychosocial support, and (vi) Evaluation of implemented recommendations. Areas for new or enhanced funding are highlighted. An overview of the clinical components of the OPASDM pertaining to OPMH, the final common pathway for all older people following a suicidal crisis, are outlined in Figure 2.

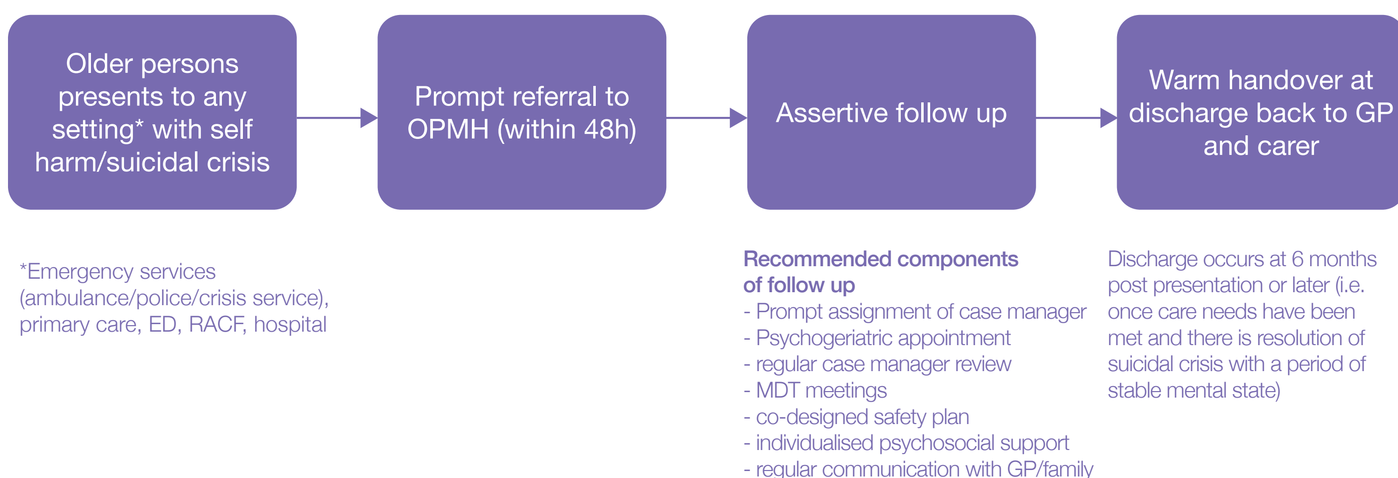

Figure 2. Overview of clinical components of the OPASDM pertaining to OPMH

Key stakeholders provided high-level feedback in a workshop discussing priorities and strategies to support implementation of the OPASDM. Workshop participants highlighted the challenges of establishing a centralised service model where State and Commonwealth services and funding must intersect and build capacity within multidisciplinary workforces, including people with lived experience. Accordingly, inclusion of people with lived experience in the development and governance of the OPASDM from the outset was highlighted as key to implementation. An identified priority for implementation included general community and bespoke clinician/service provider education and training, with a fundamental message of early referral to OPMH for any older person with self-harm/suicidal crisis. Strategies to raise awareness of the issue and combat ageism were emphasised.

The proposed 'service navigator' role was identified as key target to facilitate matching of the older person with self-harm/suicidal crisis to have their individualised care and social needs met. Opportunities for improved communication between different services and settings, including carers of people with lived experience, were reiterated, especially between hospital and primary care, private and public sectors, and all sectors with carers. The current absence of remuneration of such critical liaison contacts was identified as a priority area to be addressed. Finally, opportunities for the provision of non-clinical, peer and volunteer support as part of older persons' aftercare were suggested as priorities for delivery of social support. Potential value was identified through exchanging sympathy for empathy and providing safe, understanding and supported environments with adequate time for listening to the older person with lived experience of a suicidal crisis as essential components of aftercare.