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Guide for developing a suicide care pathway

For local health districts and specialty health networks

June 2022

Zero Suicides in Care is a NSW Health Towards Zero Suicides initiative

NSW GOVERNMENT
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Content warning

While the authors do not anticipate that this content will cause distress, we encourage you to consider not reading it if you think you may become distressed. If you find yourself becoming distressed, please seek support and exercise your self-care strategies.

Introduction

This guide was developed as a part of the NSW Health Zero Suicides in Care initiative. The suicide rate in Australia has increased over the past decade. Suicide is the leading cause of death for people aged 15 to 44 years.[1]

Towards Zero Suicides is a priority of the NSW Premier that aims to address the key initiatives in the *Strategic Framework for Suicide Prevention in NSW 2018-2023* and reduce the rate of suicide deaths by 20% by 2023.[2]

One of the initiatives within the broader Towards Zero Suicides program is the Zero Suicides in Care initiative. It supports suicide prevention in mental health services within inpatient and community care settings. This aligns with priority area three of the strategic framework, supporting excellence in clinical services and care. NSW Health has adopted the internationally accepted *Zero Suicide Framework* as the foundation of the NSW Health approach to reducing suicides in NSW through the Zero Suicides in Care initiative.[3]

The *Zero Suicide Framework* consists of seven essential elements: lead, train, identify, engage, treat, transition and improve.[3] The NSW Health Zero Suicides in Care initiative has adopted these seven elements and framed them into four focus areas, each led by one of the NSW Health pillar agencies. The focus areas are lead, train, suicide care pathway and improve (see Table 1). This collaborative approach has been guided by the NSW Ministry of Health Mental Health Branch and the Zero Suicides Institute of Australasia.

Table 1: NSW Health pillar agencies Zero Suicides in Care leadership

Zero suicide framework element	NSW Health pillar agency
Lead	Clinical Excellence Commission
Train	Health Education and Training Institute
Suicide care pathway (identify, engage, treat, transition)	Agency for Clinical Innovation
Improve	Clinical Excellence Commission

The Agency for Clinical Innovation (ACI) is leading the suicide care pathway component that includes the elements of identify, engage, treat, and transition. The ACI has developed the NSW Health suicide care pathway (see Appendix A) to address these elements.[4] It guides clinicians to provide best-practice methodologies when caring for individuals who have suicidal behaviour, based on current research. It also addresses how to prevent future suicidal behaviours.

Support to develop a local suicide care pathway

NSW Health local health districts (LHDs) and specialty health networks (SHNs) are encouraged to develop a local pathway. This document, *Guide for developing a suicide care pathway: for local health districts and speciality health networks,* provides a step-by-step approach. It outlines how to review current practices and the pathway for suicide care and align it to best practice. It includes sound methodology and principles to assist LHDs and SHNs to co-design, collaborate and engage local stakeholders.

This ACI *Guide to developing a suicide care pathway* contains advice, checklists, and other tools to support you to develop a suicide care pathway to best suit your local requirements.

Commitment to continual system improvement is vital to ensure the suicide care pathway is current and relevant to your local situation. Improvement should be guided by data, with systems developed for regular monitoring and review of the pathway.

This document can be used in collaboration with the *Suicide Prevention Quality Improvement Toolkit*, developed by the Clinical Excellence Commission (CEC).[5] The CEC's toolkit provides comprehensive information, resources and quality improvement tools for monitoring and reviewing suicide care pathways.

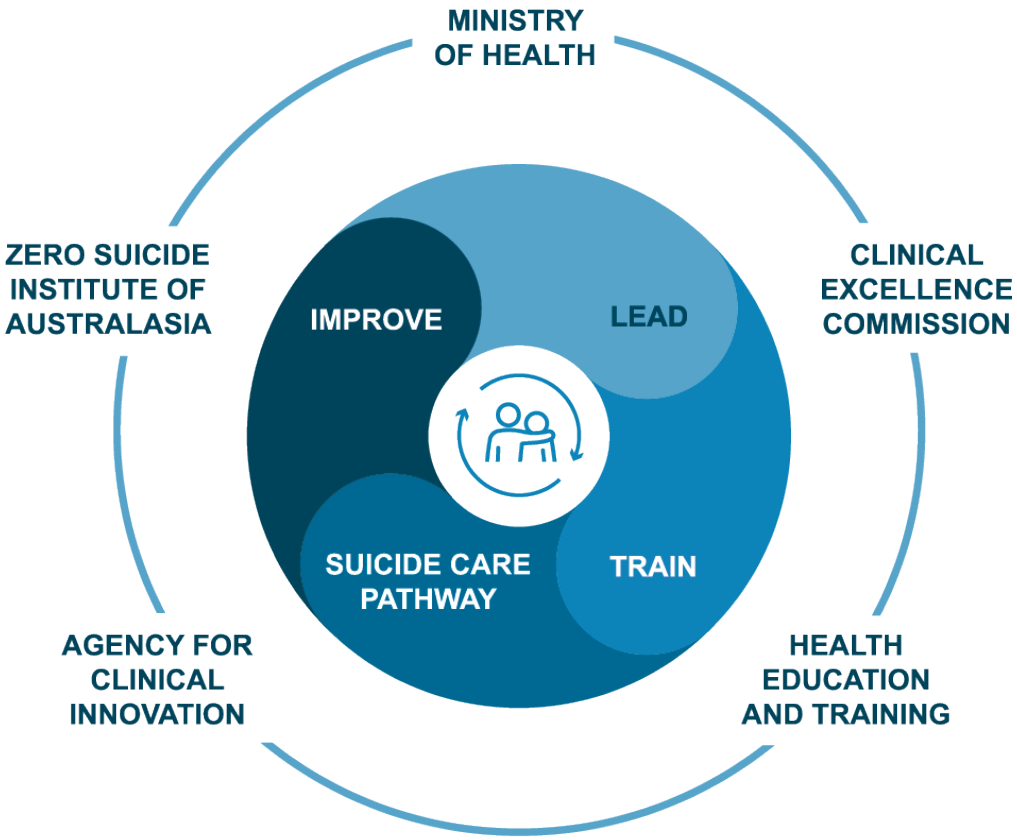


Figure 1: NSW Health Zero Suicides in Care collaborative approach

What is a suicide care pathway?

Clinical care pathways are an important tool that are widely used in health services to systematically guide evidence-based healthcare.[6] Clinical care pathways typically possess three defining characteristics. They:

- are used to translate guidelines or evidence into local structures
- detail the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol, or other inventory of actions
- standardise care for a specific clinical problem, procedure or episode of healthcare in a specific population.[7]

A suicide care pathway within a health service is a clinical care pathway for the clinical care of people presenting with suicidal behaviours.

Purpose of a suicide care pathway

- It outlines the course of care that has been established in an LHD or SHN for an individual who has suicidal behaviours. Suicidal behaviours is the collective term used when a person has suicidal ideation or has tried to take their own life.
- The pathway provides a structured approach to care and aims to reduce unnecessary, or unwanted variation, in service delivery.
- It aims to enhance teamwork, interdisciplinary care and facilitate smooth transition within the service and for referral outside the LHD or SHN.
- It is based on best practice and the latest available evidence.
- It is a fluid (living) document that can be altered and adapted as new services are developed or when new evidence and best practices emerge.

Desired outcomes

- Mental health staff directly treat suicidality in a way that is co-designed, collaboratively developed, culturally safe, evidence based, inclusive, and equitable
- Decreased unwanted variation in the clinical care of suicide
- Each person, their family and carers experience collaborative, culturally safe and integrated care
- Mental health staff actively manage referrals and communicate around transitions
- All health staff within the LHD or SHN have an awareness of the process of care for people who present with suicidal behaviours, along with avenues for referral to mental health services.

Benefits

- Offers a structural preventive process that standardises suicide prevention care for all people with identified suicide behaviour. This addresses the paradox of prevention: that more lives will be saved with a universal intervention compared to current practice that focuses resources on those people considered to be at high risk
- Provides a care journey for a person with suicidal behaviours within the LHD or SHN that is easy for staff to understand
- Improves communication between different service providers and reduces unwanted variation
- Provides clear guidance on the transfer of care, either within a service, or during external transfers. This is well-known as a vulnerable time in a person's suicide care journey. A clearly documented protocol embedded in a defined pathway can help to minimise loss of information and ensure a warm handover is achieved
- Promotes improved engagement and outcomes by supporting a compassionate and person-centred holistic assessment
- Lowers the risk of adverse incidents, supports staff in understanding how to respond to suicidality and creates a common language and understanding
- Offers potential benefits to the community, including increased knowledge regarding access points into the LHD or SHN for suicide care and referral pathways from the LHD and SHN to external providers

- Potentially benefits the person and their carers via an increased understanding of the person's journey within the LHD or SHN and what to expect at each point of care. Clearly documented contact information may also improve communication between the person, their family and carers and services in the LHD or SHN.

Audience

The pathway is a useful guide for different audiences. It enables each group to understand the various components of care and what is required from them. For example, the pathway provides:

- **clinicians and service providers** with a structured and standardised evidence-based and policy-supported guide on the care required for people with suicidal behaviour. This can assist clinicians in their decision making and support their referral to other teams or external services.
- **the person, their family and carers** with a comprehensive communications mechanism. It enables them to understand the steps in the care of an individual. The service contact details are also embedded in the pathway. Together these elements can empower them with the knowledge necessary to undertake collaborative decision-making with service providers.
- **the general community** with knowledge and awareness of services available to the public and increases the community's capacity to assist someone who has suicidal behaviours.

Components of a suicide care pathway

These components provide a clear path for where, when and how a person accesses each level of care within an LHD or SHN service. This may include:

- the points of contact with the LHD or SHN, including entry, telephone triage and referral, and intake. It also includes details of the components of care within the LHD or SHN. These could include assessment, treatment and care, and transition of care to services external to the LHD or SHN.
- details and contact information for specific services or teams within the person's journey on the pathway. This may be recorded in an accompanying reference document if there is not enough space on the pathway document. It is important to note that service contact details may often change, and these will need to be reviewed and updated regularly. A link to online service contacts may be easier to update.
- LHD, SHN and NSW policies and procedures that impact on components of the pathway.
- types of assessment forms used and how they are documented. For example, a safety plan might be entered in the person's electronic medical record (eMR). This may be best recorded in a reference document accompanying the pathway, including a note of the alignment of relevant policy or procedure with clinical care.
- details of the clinician or staff member responsible for a given task or component of care at a given point in the pathway. For example, the emergency department clinical nurse consultant or duty registrar.

Types of pathways

There are many types of pathways that can be used to document suicide care in LHDs and SHNs. Each has their positives and negatives. It is best to base the type of pathway you select on the purpose of the document and the audience for whom it is written.

Purpose of a pathway

Different pathways can convey different types and different amounts of information (see Table 2). If the purpose of a pathway is to provide a great deal of information or a detailed rationale for each step of a pathway, a narrative style pathway may be appropriate. If the purpose is to provide an understanding of the journey a person undertakes within a service, it may be better to use a pathway in the style of a flow chart.

Audience of a pathway

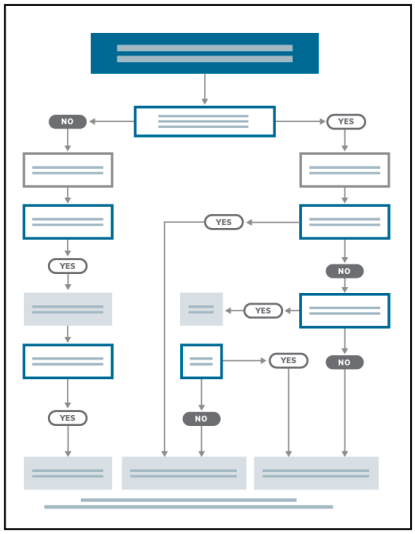
A key factor in deciding the best pathway is to use the format that will be accepted by the people who will use it. If the pathway is not accepted by its users, it will not be effective. To prevent this from happening, identify key stakeholders and engage with them early.

To standardise the pathway, consider ensuring consistency in design and format for each of the different pathways documented for different services or population groups within the LHD and SHN.

Table 2: Types of pathways – purpose and benefits

Type of pathway	Purpose	Benefits
Flow chart	• Useful for documenting the individual steps in each person's journey through the clinical system • Provides a clear outline of the decision or referral points during care	• Simple outline of movement of a person • Indicates the role of stakeholders • Easy to read and use in a clinical setting for busy clinicians • Can be translated into an easy-to-read version for the person, their family and carers • Highlights the referral and transition points of care
Narrative	• Provides detailed information to support interventions or actions in a pathway	• Allows extra information or explanatory notes to be provided to support components of the pathways • Enables more written information to be conveyed in a single page document
Swimlane	• Outlines all key stakeholders in a clinical journey • Provides the steps or actions occurring concurrently by different stakeholders over time or throughout the person's journey	• Clearly delineates the role of stakeholders during a person's journey • Allows comparison of the roles of stakeholders at a given point in time or across the person's journey • Outlines possible connections, handovers, and communication opportunities between stakeholders to increase effectiveness and efficiency

Flowchart pathway[9]



Narrative pathway[10]

Swimlane pathway[11]

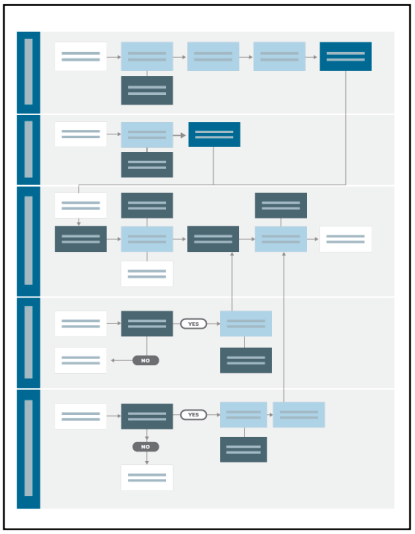


Figure 2: Examples of three types of pathway

Redesign methodology approach to developing a pathway

Redesign methodology is an evidence-based framework to support initiatives that aim to deliver better care integrated within the system.[8] It also helps to ensure the changes are sustainable. Redesign methodology provides a broad outline to undertake a redesign project from the initiation and diagnostics stages to solutions, implementation, and sustainability. It offers a range of tools, fact sheets and resources to support each of the stages in the redesign process. The *Redesign model* gives an overview of the key components of redesign incorporating redesign, as well as participatory, collaborative and co-design concepts (see Figure 3).[9]

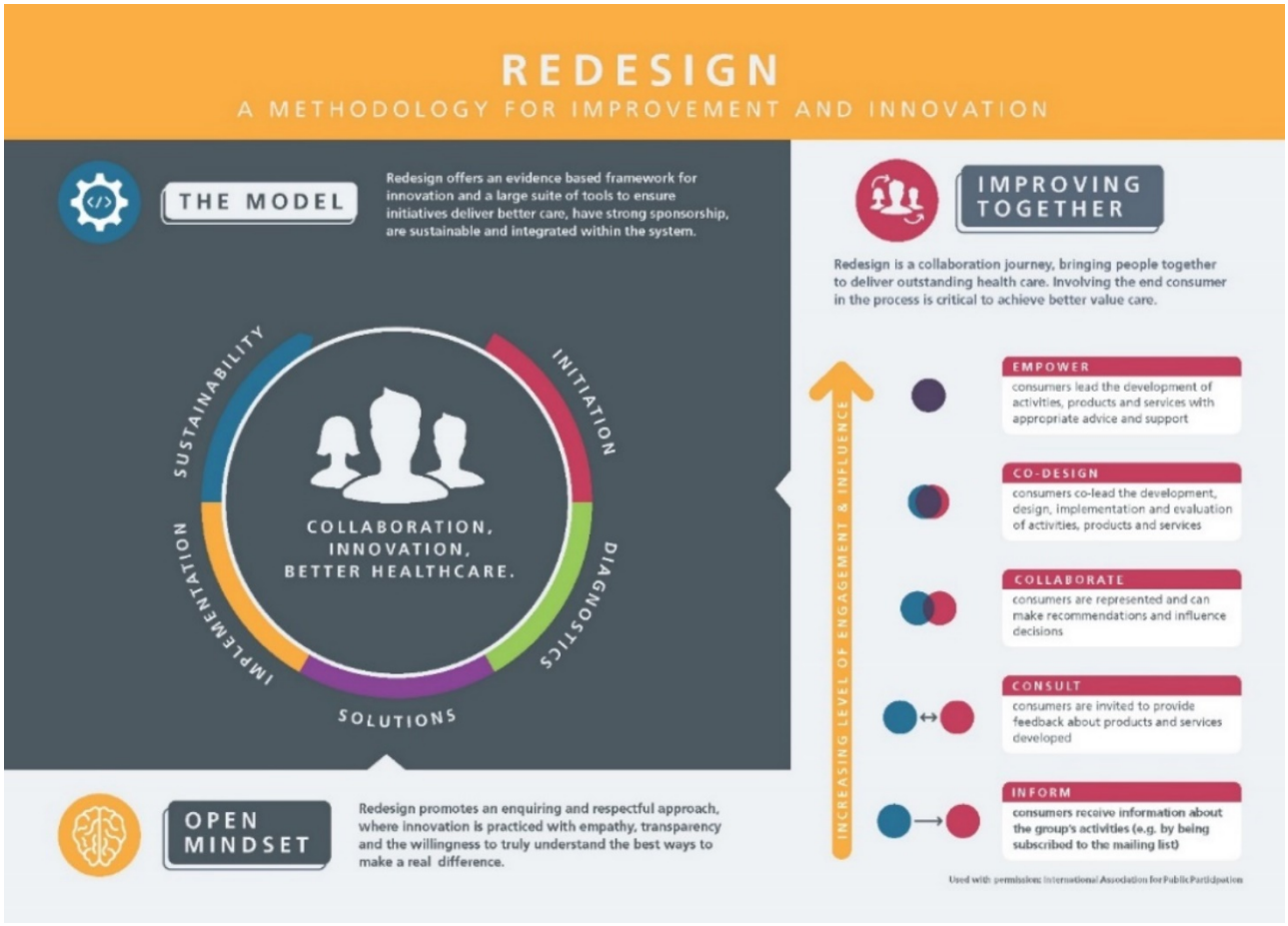


Figure 3: Redesign model - a methodology for improvement and innovation

When developing a local LHD or SHN suicide care pathway using redesign methodologies, collaborative and co-design approaches is fundamental. It is essential to collaboratively engage all people who use and deliver the service in the development and decision making of the new pathway. Engaging people early reduces possible knowledge gaps at points on the pathway. It ensures the pathway matches the local context and provides cohesion across the service. Involving relevant members of a service also fosters a sense of ownership and increases the potential that recommended practices will be adopted.[10]

Ensuring people who have lived experience provide input in all steps of the pathway may greatly enhance access to – and acceptability of – the care journey. Including lived experience is vital in a suicide care pathway. The core rationale is to offer a service that is open, accessible to a range of different groups of people and caters for these people. Including lived experience is the best way to ensure the services will be acceptable.

You can find resources on the ACI website that can be used to embed a co-design and participatory and collaborative approach. They include *A Guide to Build Co-design Capability* and the web-based *Co-Design Toolkit* and *Working with Consumers*. [11-13] Also refer to Appendix B for a Checklist for developing a suicide care pathway.

Steps for developing a suicide care pathway

Establish an LHD or SHN suicide care pathway working group

The working group undertakes the lead role in developing, documenting and implementing a local suicide care pathway.

- **Purpose:** outline the purpose or goal to provide a clear understanding of what the working group hopes to achieve within a specified time. The goal can include the specific scope of work and the areas of scope for the working group.
- **Membership:** there needs to be about 6 to 10 members, including senior clinicians and people with lived experience. It is best to include at least two people with lived experience. There also needs to be service managers and staff from specific units or wards who may benefit from the development of a unit-specific pathway. This may include non-mental health staff, such as those from an emergency department or representatives from alcohol and drug services. It is also worthwhile to include general practitioners, staff from primary health networks and other non-government representatives. Co-design and collaboration and engagement is important in developing a suicide care pathway. Including people with lived experience in the working group when you begin (*Start up and engage)* will ensure they help shape the pathway and the decision-making processes.[14]
- **Frequency of meetings:** the timing of meetings depends on the capacity of the working group's members. Regular, frequent meetings may be required early in the process and become less frequent as work progresses. Discuss the possibility that work will be required outside of set meeting times and document this. Consider flexible meeting approaches to ensure people with lived experience can be involved in a way that respects their time and trauma. For example, meetings could be held at different times of day and virtually, so people don't have to revisit sites that can be triggering.
- **Roles and functions:** outline the role of the working group, as well as the role and responsibilities of individual members to achieve the group's goal. To ensure a clear understanding, outline the expected time commitment involved. This may include the expectation that members will develop or review some work between meetings.

TIP: Think through how your team will work together and what *capabilities they need for co-design*.[15]

- **Governance and reporting structure:** outlining the governance structure (including a project sponsor) and obtaining executive sign-off will enhance support that may be required for later sign-off and executive agreement of the pathway. Provide transparency by providing a timeline for reporting, based on a specified time frame or dependent on delivery of specific outputs. It ensures executives and all staff are aware of the progress and actions being undertaken by the working group.

TIP: Refer to the ACI guidance for executives involved in co-design in *A Guide to Build Co-design Capability.*[11]

Terms of reference for the working group are essential to outline and document all the necessary components of the working group. It is a valuable reminder of the agreed parameters and scope of the working group and keeps individuals and the group accountable to the purpose and outcomes previously agreed. It may be useful to develop an agreed statement about how the *Mental Health Act*, clinical policies and evidence-based guidelines will impact proposed activities.[16] It is also worthwhile discussing what can be realistically delivered to manage the expectations of members.

Establish stakeholder consultation groups

Identify and document key stakeholder groups during the establishment phase. It is important to engage these stakeholders early, so they are included in the design process. It will increase the chances of the pathway being implemented successfully and sustainable. Stakeholders may include general practitioners and local primary health networks, community mental health teams, safe havens, emergency departments, residential aged care providers, private psychologists, and non-government organisations.

Purpose of stakeholder consultation

You can collaborate with these groups to test your thinking and ideas. They can make sure you think of all avenues. They can also provide insight into what is required at each point of the pathway. Obtaining agreement from stakeholders and groups associated with a particular stage along the pathway will be vital in finalising an agreed pathway of care. It will also ensure its use in the future.

Develop a work plan

Developing a plan for the working group can be useful in documenting the overall project goal and the desired outcomes, as well as the specific activities required to achieve these outcomes.

TIP: Redesign methodology can help you to step through planning.[12]
Your working group may also find it useful to document a clear plan on how and when you will work with more people than just those in the group. Try documenting a people partnership plan to support your co-design and collaboration approach.

Key performance indicators can ensure activities are completed. They should be documented in the work plan. Documenting the people responsible for specific activities can make members accountable for key tasks. Including time frames will provide a timeline for activities and a guide for completing tasks and achieving outcomes.

It may also be useful to develop a simple process evaluation to determine whether the activities of the plan have been implemented as intended. See Appendix C for an example of a simple pathway development work plan.

Document current local services and relevant policies

One of the first steps in developing an LHD or SHN suicide care pathway is to document the services available in the local area. This includes specific local services, local non-government community-based services and national help lines. The following may be useful when documenting services:

- types and roles of different services
- current practice and procedures, including documentation, referral processes, transfer of care processes, etc.

- service eligibility criteria
- service contact details and hours of operation
- state and LHD and SHN policies and procedures impacting service delivery
- current assessment tools and documentation procedures, including eMR, where relevant
- baseline data on presentations to services, re-presentation within 28 days, number of suicides, percentage of people with a formulative suicide prevention assessment, percentage of people with a safety plan, people experience and staff experience. See the section on page 23, Monitoring, review and system improvement, for a more comprehensive list of data parameters.

The information can be documented in a format that is most useful to the LHD or SHN. This may be in the form of a table. Or it could be incorporated into a flow chart that outlines the journey of the person through different services in the LHD or SHN.

The NSW Health policies and guidelines that may be relevant to the development of a local suicide care pathway include:

- *Clinical Care of People Who May Be Suicidal* (PD2016_007)[17]
- *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045)[18]
- *Mental Health Triage Policy* (PD2012_053)[19]
- *Call Handling Guidelines for Mental Health Telephone Triage Services* (GL2012_008)[20]
- *Triage of Patients in NSW Emergency Departments* (PD2013_047)[21]
- *Departure of Emergency Department Patients* (PD2014_025)[22]
- *Emergency Department Patients Awaiting Care* (PD2018_010).[23]

TIP: These *fact sheets and resources* may be helpful to understand the current situation.[24]

Mapping services

Learn about the services that are being provided because this assists you to identify issues or gaps that need to be addressed. Several approaches can be adopted:

- ***Process mapping (current state)*** provides a graphical representation of a set of steps or functions in the delivery of a service from start to finish, including the people involved in each step.[25]
- ***People journey mapping (current state)*** outlines all steps the person takes, how they feel and the touch points they experience.[26] It should tell you how the person experiences the current system. Here is a useful *step-by-step guide* to follow when undertaking journey mapping.[27]

The following steps using the PAS-DS-GROD method may be considered (see Table 3) if you undertake a mapping exercise.

The guide on *How to process map* provides useful and practical methods to develop a process map, including how to run a facilitated session.[28] The CEC has developed the *QIDS platform* that has a function for documenting a process map.[29] Your local LHD or SHN redesign lead can also assist you.

Table 3: PAS-DS-GROD method

Steps	Considerations
1. Purpose	Why are we doing this mapping exercise?
2. Audience	Who will need to use this mapped out process or service?
3. Standards	What standards and symbols will we use?
4. Detail	How detailed should we be?
5. Scope	Where are the boundaries for this process or service?
6. Gathering information	How will we get the information we need to produce the process or service map?
7. Recording	What method will we use to produce the process or service map?
8. Other data	What performance measures and other data should we capture?

Gap analysis

Undertaking a gap analysis helps to identify the main gaps, and opportunities, against a desired future state. Overlaying the people journey map over the process map (the steps undertaken when mapping your current services) can assist in highlighting key areas of concern particularly related to the person's experience. The gap analysis can also assist in prioritising the issues to address.

Developing your local suicide care pathway is an opportunity to ensure best practice care methodologies and procedures are incorporated in the care provided. You can review your current care and processes by using your current state process map. Compare your map against the key elements of the NSW Health suicide care pathway.[4] It is also important to engage key stakeholders to diagnose or identify aspects of care that work well and components of care that don't work with the current pathway.

Key elements to consider include:

- early identification and engagement that is developmentally informed across the life span
- assessment
- formulation
- brief intervention, including preventing access to lethal means, the person's and carer's education, safety planning, and rapid follow up
- treatment, including treatment for suicidality, addressing drivers of suicidality, addressing modifiable suicide risk factors, and providing recovery-oriented, trauma-informed, holistic support
- transition of care.

These key elements are considered best practice in the delivery of suicide care and should be addressed in every suicide care pathway. As a part of the gap analysis, a review of each element may consider:

- the person who is responsible for delivery of an element
- where an element is carried out
- how consistently this element is carried out
- what the process is for documenting this element and where the documentation is held
- what the local policies or procedures are to support this element.

If there are not clear protocols, policies, or documentation for each of these key elements within an LHD, SHN or individual service, this may be reviewed by the working group to ensure these are addressed.

As an LHD or SHN may have several pathways for different groups or locations within its area, each pathway should be assessed against the key elements and documented accordingly.

See Appendix D for a suicide care pathway gap analysis tool to assist you to undertake your local gap analysis.

Prioritising key components

The gap analysis might reveal areas for improvement or further investigations. A prioritisation process may be necessary to determine which key element or issue to address first if there are competing demands. Engaging key stakeholders in this process is important. The *Prioritising key issues fact sheet* provides advice on consulting with key stakeholders and reviewing literature to determine a list of priorities.[30] Grouping issues together may be a useful process when determining when to prioritise action. For example, the headings could be document review, staff awareness, local data collection or local policy review and development. These priorities can then be plotted on an impact and influence matrix which considers high versus low influence priorities against high versus low impact priorities (see Figure 4).

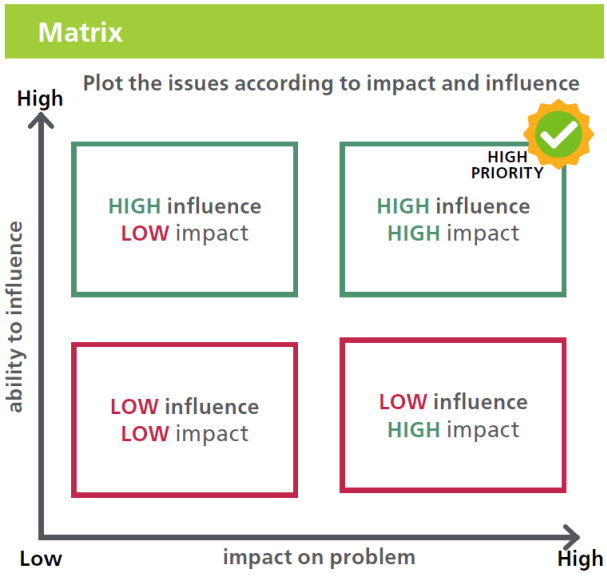


Figure 4: Impact and influence matrix

Another method for prioritising the key components is to consider already determined solutions and plotting these on a solutions prioritisation matrix (see Figure 5) by ease of implementation versus impact. Further advice on this method can be found in the *Solutions prioritisation fact sheet*.[31]

A *Driver diagram* is another useful tool that can assist a team to understand the factors, or drivers, that need to be addressed to achieve a specific goal.[32] The CEC's *QIDS platform* has a function for documenting a driver diagram for your LHD, SHN or local service.[29] *Pareto charts and the 80-20 rule* may be another useful method to demonstrate the relative importance of issues and can be accessed via the CEC website.[33]

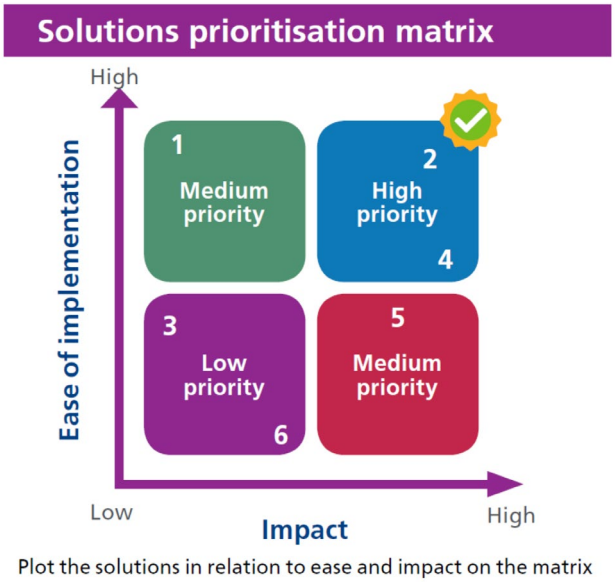


Figure 5: Solutions prioritisation matrix

Design and document your local suicide care pathway

Based on the research and work conducted in the mapping exercise above, LHDs and SHNs will be well placed to document their future (desired) state pathway, ensuring each of the components are included. The *step-by-step guide* for future state mapping may provide some guidance for this activity.[27] It is important to undertake this collaboratively using co-design and other helpful engagement and participation approaches. If you are not confident in drafting a local pathway using co-design or engagement and participatory design approaches, consider asking for an experienced facilitator to help you.

Draft the prototype suicide care pathway on paper or a whiteboard, or use software such as Publisher, Visio or PowerPoint for electronic versions. If you use a software program, ensure it is accessible later in case updates to the pathway are required.

The LHD and SHN working group will need to consider the type of pathway that best suits their local requirements. Refer to page 9, Types of pathways, to determine the best visual layout for your pathway. It is important that the pathway is simple to read but has the capacity to convey all the pertinent information outlined.

An effective pathway for an LHD or SHN suicide care pathway is a people flow chart. It clearly documents the entry points, the journey within the LHD or SHN and the exit points for the person. Against the various journey points, LHDs and SHNs can document who is responsible, the assessments required and the eligibility criteria. These journey points can also be documented against the key components of the NSW Health suicide care pathway as seen below in Figure 6.

Suicide care pathway emergency department presentation

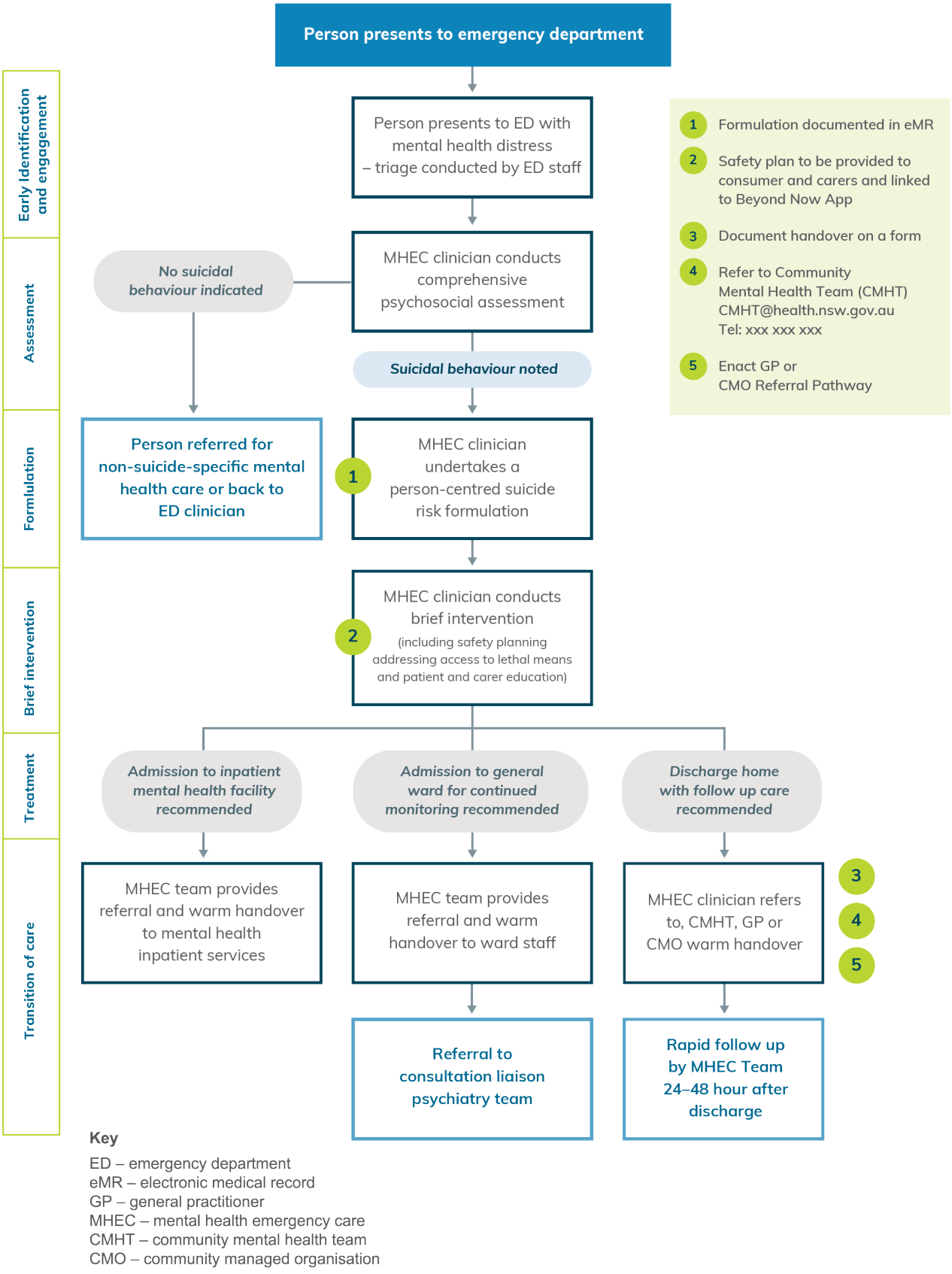


Figure 6: Example of LHD or SHN suicide care pathway flow chart

A narrative document may be required to accompany a flow chart style pathway to ensure all details of the suicide care pathway are clearly documented and easy to read. This narrative document can provide further explanatory notes for each journey point. It is also an opportunity to incorporate policies, procedures, and more detailed elements of the NSW Health suicide care pathway. The narrative document may include detailed contact information for various points in the pathway as these may not fit within a simple flow chart style pathway.

Note: you may require a different flow chart for different services, locations, or population groups, depending on your specific LHD or SHN requirements and evidence. For example, it is recommended that LHDs and SHNs seek to develop a separate local pathway for older people as distinct from an adult and young person's pathway. This is supported by evidence such as:

- men over 80 have the highest suicide rate in the population
- suicide attempts in older people are more likely to be lethal with a clear link to self-harm. Early intervention, follow-up and aftercare are critical.
- there are acknowledged barriers to care for older people. These include less mobility, reduced independence, isolation, they do not present to care as readily, can be invisible in society and face ageism that can normalise low mood and distress.

Testing the pathway in the system

Once a protype pathway is documented, provisional endorsement of the pathway by the working group should be obtained. The working group can determine the solution direction and period for testing and strengthening the pathway. The next step is to consider how it may be use in the LHD or SHN. Consider the PDSA cycle (Plan, Do, Study, Act – see Figure 7) as a way of testing certain parts of the pathway, or the entire pathway, in specified locations. The *Prototyping and testing fact sheet* provides general advice on testing a solution and building staff buy-in.[34]

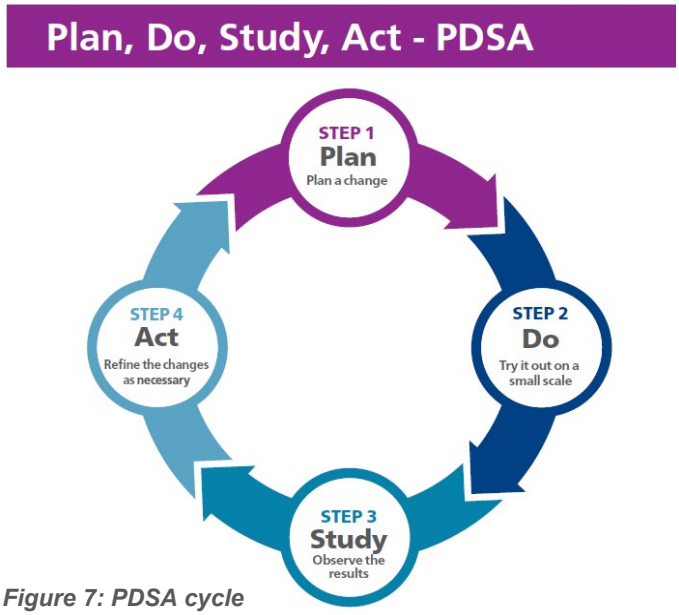


Figure 7: PDSA cycle

Several steps may be considered when testing and piloting your suicide care pathway in the local system.

- Test the pathway in the LHD or SHN in specific locations or services. Consider testing in a couple of identified teams or locations most relevant to the pathway developed. For example, this could be emergency department clinical nurse consultants and community teams, if the pathway identifies the emergency department as the intake point with direct referrals made to community teams. Or it may be specific to a population group, such as older people. Therefore, testing would involve the older people's mental health team.

  Present the pathway to the relevant staff and people by walking them through the pathway and asking for feedback via group discussions or interviews. Ask what works well, what could be improved, and what hasn't been covered.

  When evaluating the pathway in the testing sites, you may also wish to consider the following aspects:
  - How do staff access the pathway? Is it printed and placed on a wall? Do staff access the pathway via a computer or mobile device?
  - How and why is the pathway being used? Do staff use it to inform their practice? Do staff use it with the person to inform the next steps of care? Do staff use it to inform themselves about where to refer an individual? Do staff use it to confirm a policy related to their practice?
  - Does the pathway provide all relevant information or is there information missing?
  - What consideration is there for people who do not enter a service via the pathway or who may drop out of the pathway during care? What review process is in place to monitor access to the pathway?
  - Are there any issues or situations identified that require an alternative pathway of care?
- Consult with your stakeholder consultation groups, or any stakeholders who have not previously engaged in the drafting of the prototype pathway, to obtain their feedback. Questions to consider include, would you adopt the pathway? Why or why not? What would you need for this to work well for you?
- Review current local policies to ensure the elements of the pathway are included in relevant policies. This will assist in increasing local use of the pathway as per the local policy directive. Consider developing new policies or procedures where required.
- Using the results of the testing phase, changes to the pathway can be made prior to piloting the pathway in real time in an identified location.
- **Pilot the pathway** in an appropriate location over a specified time. Develop a framework for collecting feedback and evaluating the pilot site. You can ask similar questions to those asked in the testing phase regarding what works well, what could be improved and what has not been included.
- Review all feedback and evaluation of the pathway in the pilot phase and revise pathway.

Endorsement of the LHD or SHN suicide care pathway

Each LHD and SHN will have different methods or processes to endorse service specific or LHD- or SHN-wide documents and policies. The designed suicide care pathway should undergo these local processes for endorsement.

It is vital that endorsement is gained by those services who feature on the pathway or will use the pathway. This is to ensure it aligns with their service policies, current capacity to deliver services and the ability to refer individuals as outlined in the pathway.

Implementation

The purpose of implementation is to effectively implement change, so it becomes the new way of working and is embedded as business as usual.

A change facilitation approach is an effective method for implementing your local suicide care pathway. To support the successful implementation of your new way of working, the key factors that you need to consider include:

- defining the change. This includes what is changing, what are the benefits of changing, what are the consequences of not changing and what are the measurements of success
- developing an implementation plan and schedule
- obtaining the necessary support from your executive, clinicians, people involved and other stakeholders.

Communications

To support the implementation of your pathway, you will need to develop a communications plan to ensure that the necessary staff, services, and partners are aware of the change. This includes when the pathway will come into effect and how it will impact their work. It may be helpful to work alongside your local communications team to develop a strategy, and to leverage existing processes and tools.

Some things you may need to consider in this plan include:

- your audience
- the date you will go live
- the platforms will you use to communicate and promote the change
- ensuring your sponsors and implementation champions are aware of the communications plan
- the support that will be available to staff after the go-live date
- the training staff will need before and after the go-live date.

This guide does not provide a complete outline of the steps required to implement your local pathway. For further information on implementing innovative solutions in your LHD or SHN, please consider the ACI's *Implementation guide: putting a model into practice* and the *ACI redesign methodology implementation fact sheets*.[35,36] Support can also be obtained by contacting the *ACI Implementation Team* who specialise in supporting clinicians and managers to implement healthcare improvements and innovations into everyday practice.[37]

Training staff

It is important that all LHD and SHN staff are aware of the suicide care pathway and the key components of suicide care. Although many staff members may have been involved in the development or testing of the pathway, not all staff will have had exposure to it. It is important to outline a training schedule to ensure all staff understand the pathway and are comfortable using it. Consider drafting a training schedule early in the planning phase of the project.

Once the pathway is completed and endorsed, initial introductory sessions may be required to educate clinical staff, managers, peer workers and executives. Training sessions may also need to be delivered to other service providers of the pathway. The endorsed pathway can also be included in annual or regular

mandatory training for relevant staff and stakeholders. This will maintain awareness of the pathway and inform staff of any changes or updates to it.

Incorporating the LHD or SHN suicide care pathway as a part of orientation or introductory training will ensure that new staff are informed of the processes within their LHD or SHN. It will also give them access to the pathway to use in their everyday practice.

Monitoring, review and system improvement

The suicide care pathway provides an opportunity to measure the success of suicide care by referring to key points in the pathway. It is important to determine the measurement parameters and the review process of the suicide care pathway during the early development phase. Embedding measurement and data collection processes will enable data to be collected once implementation commences.

Key points to consider when reviewing a suicide care pathway and the delivery of suicide care should include measures consistent with the elements of the NSW Health suicide care pathway (see Table 4).[4]

Table 4: Measures consistent with the elements of the NSW Health suicide care pathway

Pathway element	Review
Early identification and engagement	All people presenting to health services describing mental health problems are asked directly about suicide
Assessment	Comprehensive mental health assessments documented on the mental health current assessment module and the mental health review module in eMR
Formulations	Suicide risk formulations are completed to the agreed process or standard
Brief interventions	Access to lethal means is addressed; the person, family and carer education conducted; safety plans completed and rapid follow up within 24-48 hours as indicated
Treatment	The following are addressed: suicidality and its drivers, modifiable risk factors, treatment of psychiatric disorders and strengthening recovery and protective factors
Transition of care	Warm handovers are conducted and recovery-oriented holistic supports are engaged

Process measures

Suggested process measures to evaluate the use and effectiveness of the suicide care pathway may be undertaken by file audits (or other data collecting processes). These measures can be found on the CEC *QIDS platform.*[29]

The measures include the number of people accessing mental health services and the percentage of people who have mental health issues and who are under the suicide care pathway who have:

- suicidal behaviours identified for suicide care following a comprehensive assessment
- a mental health care plan developed
- a formulative suicide risk assessment
- had documented advice provided on reduction to lethal means
- a safety plan documented
- received rapid follow up within the specified time
- been receiving evidence-based treatments for suicide behaviour
- referrals made
- missed an appointment and received contact within an agreed time frame.

Outcome measures

The overall goal for suicide care in an LHD or SHN is that individuals are less likely to die by suicide when they enter a service. The outcome measures may include:

- reduced suicide deaths for people accessing mental health services
- reduced suicide attempts for people accessing mental health services, including:
  - rate of emergency department presentation for suicide attempt or self-harm
  - rate of emergency department presentations for any reason for people accessing mental health services
  - rate of acute mental health unit admissions for people accessing mental health services
  - time to next emergency department presentation after first emergency department presentation for suicide attempt (index presentation).

When developing performance measures, consideration should be given to using existing key performance indicators, for example, follow-up time frames and 28-day readmission rates.

Continuous improvement

One of the principles for the Zero Suicide in Care framework is a focus on continuous improvement. The CEC has developed the *Suicide Prevention Quality Improvement Toolkit*.[6] It provides a comprehensive guide for collecting and using data to measure and review LHD and SHN suicide care pathways using the Improvement Science methodology.[38]

The toolkit is a useful guide to support LHDs and SHNs to understand if a change leads to an improvement. It is recommended when LHDs and SHNs are developing their monitoring and review processes for their local pathway.

Ongoing review of the suicide care pathway

Ensuring local policies and procedures are current is an ongoing task within LHD and SHN clinical services. The LHD and SHN suicide care pathway should be regularly reviewed in line with local LHD and SHN policy reviews.

Responsibility for the review of the suicide care pathway, and the relevant local policies and procedures, should be allocated to an appropriate lead staff member. For example, this could be a service development manager or a community nurse unit manager. A review timeline should be determined in line with the current LHD and SHN process.

The service, LHD or SHN suicide care pathway should be monitored, reviewed, and improved through governance systems. These could include the quality and safety committee, morbidity and mortality meetings, mental health safety dashboard and other safety intelligence data.

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- Zero Suicide Institute of Australasia

Glossary

Carer: Any person who provides paid or unpaid care and support to a relative or friend who has a disability, a mental illness, a chronic health condition, a terminal illness, drug or alcohol issue or who is elderly and frail.

Clinical care pathways: Tools used to guide evidenced-based healthcare by translating clinical practice recommendations into a clinical process of care. Each pathway details the steps in a course of treatment or care. The aim is to standardise care for a specific clinical concern, procedure, or episode in a specific population.

Collaborative: We work with each other to achieve the best possible outcomes for our patients who are at the centre of everything we do. In working collaboratively, we acknowledge that every person working in the health system plays a valuable role that contributes to achieving the best possible outcomes.

Mental health: A positive concept relating to resilience, enjoyment of life and social connection. This state of wellbeing increases the person's ability to realise their own abilities, cope with the normal stresses of life, work productively and contribute to their community.

Recovery: The person is able to create and live a meaningful life, contribute to the community that they choose with, or without, mental health issues.

Recovery-oriented: The principles of this approach include understanding that each person is different and should be supported to make their own choices. The person should be listened to and treated with dignity and respect. They are the expert in their own life and support should assist them to achieve their hopes, goals, and aspirations. Recovery will mean different things to different people.[39]

Respectful: Respecting the abilities, knowledge, skills, and achievements of all people who work in the health system. It is coupled with a commitment to provide health services that acknowledge and respect the feelings, wishes and rights of the person and their carers.[40]

Self-harm: Any behaviour that involves the deliberate causing of pain or injury to oneself. Self-harm is usually a response to distress – often the distress associated with mental illness or trauma. In the short-term, some people find that it provides temporary relief from the psychological distress they are experiencing. While people who self-harm do not necessarily mean to kill themselves, it often becomes a compulsive and dangerous activity, and requires careful professional help.

Suicide: An act of intentionally terminating one's life.

Suicidal attempt: Self-initiated, potentially injurious behaviour with the intent to die that does not result in a fatal outcome.

Suicidal behaviours: Thinking or talking about suicide, planning a suicide, or taking actions related to ending one's own life.[41]

Suicide care pathway: A clinical care pathway that details the steps for evidence-based care to be taken by clinicians to ensure all people experiencing suicidal behaviours who access a health service receive standardised care.

Suicidal ideation: Thoughts about wanting to be dead or killing oneself.

Treatment: Specific physical, psychological, and social interventions provided by health professionals aimed at reducing impairment and disability, and/or the maintenance of current levels of functioning.

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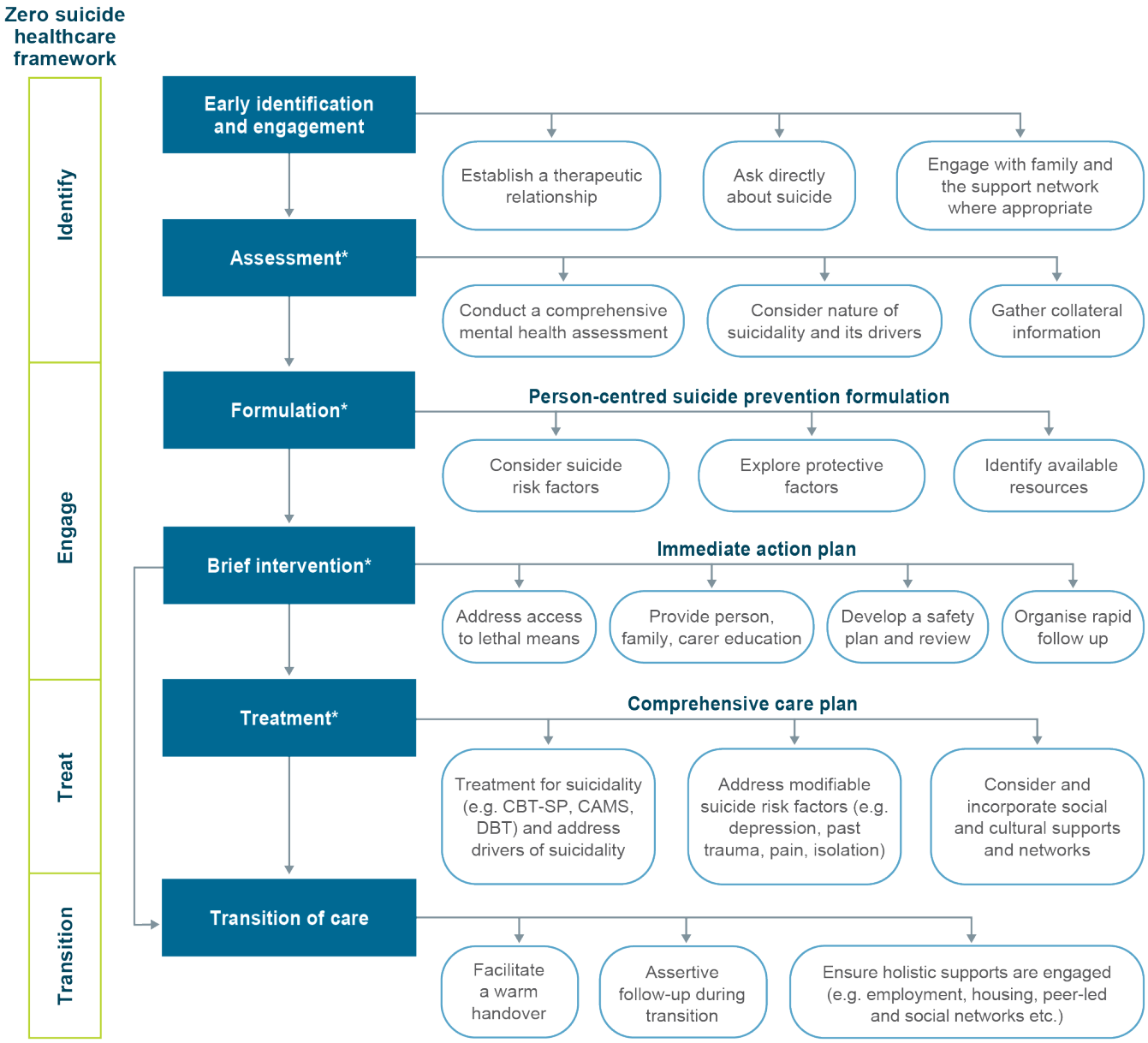
Appendix

Appendix A: NSW Health suicide care pathway



***Note:**
The pathway is not a fixed linear process. Movement between components of the pathway should occur in response to changes in the needs and circumstances of the person.

Glossary:
CBT-SP - cognitive behaviour therapy for suicide prevention
CAMS - collaborative assessment and management of suicidality
DBT - dialectical behaviour therapy

Appendix B:
Checklist for developing a suicide care pathway

Before you start	☐ Explore the *Redesign Methodology* framework
	☐ Review the CEC's *Suicide Prevention Quality Improvement Toolkit*
	☐ Review the *NSW Health suicide care pathway* document
Starting out	☐ Write down why you need to develop a suicide care pathway for your area
	☐ Identify benefits and potential outcomes of having a suicide care pathway
	☐ Outline the potential audiences for your local suicide care pathway
	☐ Review components of a suicide care pathway and the types of pathways best suited to your local situation
Establish a working group and stakeholder consultation groups	☐ Determine membership, including people with lived experience, service managers and senior clinicians
	☐ Develop terms of reference
	☐ Establish stakeholder consultation groups
	☐ Develop a workplan
Document current services	☐ Document current local and state services
	☐ Document relevant policies and procedures impacting service delivery
	☐ Collate baseline data on presentations to services, re-presentations, number of suicides, people and staff experience etc.
Map the current pathway	☐ Map the current local service – process map and/or people journey map
	☐ Conduct a gap analysis in line with the NSW Health suicide care pathway
	☐ Prioritise key components of work as identified by the gap analysis
Design future (desired) pathway	☐ Determine the type of pathway
	☐ Document the desired pathway
Test the pathway	☐ Identify the service or audience to pilot the use of the pathway
	☐ Pilot pathway
	☐ Collect feedback and evaluation data
	☐ Revise the pathway
Endorse the pathway	☐ Undertake local LHD or SHN processes for endorsement
	☐ Consider obtaining endorsement of the pathway from stakeholders not involved in the development of the pathway
Implementation	☐ Communications
	☐ Training staff
Review and monitoring of the suicide care pathway	☐ Identify process and outcome measures
	☐ Establish a monitoring and data collection system and process
Ongoing review of the suicide care pathway	☐ Establish a regular review process of the pathway in line with local processes
	☐ Embed pathway into local governance systems for continuous monitoring, review, and improvement

Appendix C:
Suicide care pathway development work plan

Goal	

Objective	Activities	Key performance indicators	Stakeholders	Timeframe and due date
Deliverable 1:				
1.1	1.1.1			
	1.1.2			
1.2	1.2.1			
	1.2.2			

Note: this is designed to be used as a digital document. You may not see all text in the editable fields if you print it.

Objective	Activities	Key performance indicators	Stakeholders	Timeframe and due date
Deliverable 2:				
2.1	2.1.1			
	2.1.2			
2.2	2.2.1			
	2.2.2			

Note: this is designed to be used as a digital document. You may not see all text in the editable fields if you print it.

Objective	Activities	Key performance indicators	Stakeholders	Timeframe and due date
Deliverable 3:				
3.1	3.1.1			
	3.1.2			
3.2	3.2.1			
	3.2.2			

Note: this is designed to be used as a digital document. You may not see all text in the editable fields if you print it.

Appendix D:
Suicide care pathway gap analysis tool

Service: ..... **Date:** .....

Element	Where does it occur?	Who is responsible for delivery?	How consistently is it conducted? *(verifiable data)*	Documentation of procedure *(including location of documentation)*	Local policies or procedures to support the element
Early identification and engagement					
Assessment					
Formulation					

Note: this is designed to be used as a digital document. You may not see all text in the editable fields if you print it.

Element	Where does it occur?	Who is responsible for delivery?	How consistently is it conducted? *(verifiable data)*	Documentation of procedure *(including location of documentation)*	Local policies or procedures to support the element
Brief intervention					
Treatment					
Transition of care					

Note: this is designed to be used as a digital document. You may not see all text in the editable fields if you print it.