

Evidence Brief

Focus Area 4: Providing accessible, comprehensive and compassionate care.

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Definition and scope of this focus area

Providing accessible, comprehensive, and compassionate care is about offering timely, tailored interventions to individuals who are experiencing suicidal ideation or engaging in self-harm. Health and mental health care services are necessary for responding to acute distress, but the service system requires a more compassionate, coordinated and integrated approach to linking consumers and their carers with ongoing clinical and non-clinical support services that address underlying drivers of distress (e.g., economic, legal, interpersonal, mental/physical health).(1, 2)

What are the key issues?

- 1. People with lived experience of suicide or self-harm do not consistently have access to timely care.(3)
- 2. Suicide prevention care should be inclusive and appropriate for all people who need them including populations disproportionately impacted by suicide (e.g., people who are First Nations, LGBTIQ+, CALD, men, youth, residents in rural and remote locations, refugees, employed in high-risk forces, in contact with the justice system).(3)
- 3. People with lived experience of suicide or self-harm report that care is not routinely compassionate, person-centred, coordinated and/or holistic.(3)

What is currently happening (in Australia)?

From a public health perspective, indicated interventions target people who are already suicidal or self-harming and are usually delivered in clinical settings.(4)

In Australia, suicide prevention, self-harm and mental health interventions are accessed via Commonwealth, State and Territory, and Non-Government Organisation (NGO) programs and services.(5) Commonwealth Government funded health care is provided through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) and State/Territory health care is provided through hospitals. Interventions delivered by NGOs range from crisis telephone support services, such as Lifeline Australia, to those providing tailored interventions for priority populations.(6)

An environmental scan of suicide prevention activity in Australia identified a range of suicide prevention specific interventions funded by the Commonwealth.(6) Key among these are:

- the National Suicide Prevention Leadership and Support Program (NSPLSP), introduced in 2017, and currently funding 40 projects to provide sector leadership, reform, advocacy, research and translation, and services targeting people who are disproportionately impacted by suicide.(7, 8)
- Australia's 31 Primary Health Networks (PHNs) commissioning suicide prevention and mental health services in their local areas (as part of a stepped care model), with around two-thirds of PHNs (21) having also participated in Suicide Prevention Trials initiatives.(9, 10, 11)
- innovative service delivery models such as:
 - digital mental health and suicide prevention services and programs which are delivered remotely via telephone, videoconference, online chat, online course (self- or therapist-guided), secure mobile messaging (SMS) or mobile applications (apps);
 - peer-based interventions delivered by people with lived experience of suicide or self-harm;

Where should efforts be focused (in Australia)?

Missed opportunities to detect and reduce suicide risk in the health system have the largest potential to reduce the suicide rate.(12) This finding is based on a best evidence modelling exercise conducted by the American Foundation for Suicide Prevention as part of Project 25 (which aims to reduce the US suicide rate by 20% by 2025).(13) These opportunities involve health system change and training health care professionals to detect and reduce suicide risk.(12)

The need for health system reform is supported by the Productivity Commission Inquiry into Mental Health Accessibility highlighting the necessity to improve access to timely and effective services and better resource ambulatory services across Australia to be able to meet population needs.(14) The Final Advice also made recommendations about service accessibility noting limited availability (geographically, hours of operation, and access) and more barriers experienced by populations disproportionality impacted by suicide.(2)

Because suicidality is a complex and unique experience, individually tailored responses are critical. The Final Advice recommended shifts in how suicide prevention supports are delivered, calling for connection and compassion. The aim of this shift is for supports to work collaboratively with individuals and their support people to reduce distress, build a sense of connection and strengthen hope. To achieve this shift, it is essential that service providers are supported to engage compassionately and collaboratively and that they are equipped to identify and respond to diverse drivers of suicidal distress.

This shift involves more comprehensive and better coordinated responses across services and sectors. This means building upon mental health treatment options, to equip our mental health system to also provide a lead role in care coordination which integrates health, education, justice and social service supports.

FOCUS AREA 4 OBJECTIVES AND ACTIONS

Objective 1

Improve the accessibility of timely and appropriate suicide prevention services.

Australian Institute of Health and Welfare (AIHW) data highlight that not everyone who suicides uses the health system, suggesting there may be missed opportunities to prevent suicide in other sectors with which people disproportionately impacted by suicide are in contact (e.g., housing, employment and income support, family services etc.) as outlined in the evidence brief for Focus Area 2.(15)

Conversely, the same data show that accessing the health system does not in itself prevent suicide.(15) To improve the accessibility of timely and appropriate suicide prevention services, structural barriers to help seeking in general and (mental) health service use need to be addressed. Barriers include service costs for those who are unable to afford them, limited hours of service operation, lack of awareness of services and how to access and navigate the service system, inability to travel to services, lack of service availability (particularly in rural and remote locations), siloed services, lack of care coordination and workforce issues.

Evidence and things we can build upon

There are opportunities to leverage several mental health service system components or points of entry to address barriers to accessibility of timely and appropriate suicide prevention services including navigation tools or resources that facilitate finding appropriate services, warm referrals to optimise service uptake, co-responder models for managing suicidal crises, digital services which address multiple service access barriers, and enhanced risk assessment and care pathways in ambulatory care given this service type is commonly accessed pre-suicide.

Importantly, people experiencing suicidal distress also access the service system via non-mental health (e.g., peer-led safe spaces, primary care, social prescribing) and non-health sector (e.g., education, social welfare, justice) entry points, which will be discussed in relation to Objectives 2 and 3.

Service navigation

Service navigation is a type of care coordination that aims to resolve barriers and facilitate access to mental health and suicide prevention services.(16)

A scoping review of current models of mental health service navigation in 25 studies (published from 2000-2019) found that navigation programs target diverse populations and are delivered in person, by telephone, and online.(16) Navigators included peers, paraprofessionals, clinicians, teams, and web applications. Only 11 studies were randomised controlled trials. Common features of navigation programs included engagement, assessment, service identification, referral, and monitoring/follow-up. The authors concluded that although current evidence for mental health service navigation is promising, more evidence from randomised controlled trials is needed.

A systematic review of eight studies evaluating outcomes of various mental health service navigation models for young people concluded that system navigation is a promising method for improving service use and called for future research examining effectiveness and implementation including processes contributing to better outcomes.(17) Future research could explore the effectiveness of online navigation tools tailored for other subgroups disproportionately impacted by suicide.

A US study found that issues with data availability and accuracy (e.g., insufficient, incorrect or out-of-date information in search results) in online navigation tools are a major barrier for finding timely and appropriate mental health services, especially for individuals seeking care on behalf of a family member. (18) These findings highlight the importance of ongoing monitoring and maintenance of up to date information in online navigation tools. In Australia, Head to Health is a key example of an online navigation tool that aims to help users find digital mental health (including suicide prevention) services from trusted mental health organisations. An independent evaluation of the Head to Health gateway reported it has been used by a substantial number of people and has potential to be cost effective, but needs to be more widely promoted and user experiences can be improved.(19) This platform has been redeveloped as the National Mental Health Platform which aims to facilitate navigation of all mental health services irrespective of delivery mode, and is currently being trialled on the recommendation of the Productivity Commission into mental health.(14) The new platform includes an optional decision support tool (adapted Link-me)(20) to tailor service recommendations based on type and intensity of user needs, but which does not specifically assess suicidality. The new platform is also linked with telephone service navigation from the National Head to Health Assessment and Referral Phone Service (Monday to Friday, 8.30am to 5pm, except public holidays). Associated with the Adult Head to Health Centres and satellite network (formerly Adult Mental Health Centres and HeadtoHelp), this navigation service aims to be a front door to the mental health system, facilitating collaboration, coordination and integration of holistic care. It uses the Initial Assessment and Referral Decision Support Tool to help the trained intake team tailor service offerings to meet individual needs.(21) The new platform needs to be evaluated including determining which of its components (web platform, phone service, Link-me, IAR-DST) produce observed outcomes.

Another example of an online navigation tool is Health Pathways, which originated in New Zealand to support a whole-of-system approach to patient-centred care, and has been adapted by other countries including Australia.(22) It provides clinicians localised evidence-based physical and mental health information to help them make the right decisions, together with consumers during consultations. In Australia, HealthPathways programs are developed by PHNs in every state and territory and registration is required to enable user access.(23) Multiple studies have examined HealthPathways with a published review reporting that awareness and use are the most commonly reported.(24) This review also reported that the impacts and outcomes of HealthPathways are difficult to measure,(24) which is applicable to evaluating navigation systems more broadly. Specifically, the extent to which navigation tools are used as intended (meaning whether consumers go on to use services identified using online navigation) is unknown. Innovative and rigorous evaluation designs could be used to explore the effect of HealthPathways on suicide prevention.

Warm referrals

Warm referrals (or handoffs) facilitate service uptake and support service integration by enabling a three-way connection between the consumer, the referring service provider, and the service to which the consumer is referred.(25) An effective warm referral involves considering the individual's capacity to take up the referral, explanation for the referral, and

monitoring by the referring provider – and not just contact or provision of background information from the referring service provider.(25) Quality improvement methods have been shown to increase warm referrals.(26) Evidence regarding the effectiveness of warm referrals is limited but one (non-suicide specific) literature review reported that three studies showed increases in service uptake following warm referral compared to control groups.(27) More research is needed to determine the effectiveness of warm referrals for managing suicidal distress.

Co-responder suicide crisis management

The role of first responders (police or ambulance) is vital in managing suicidal crises and facilitating appropriate care and follow-up, but their most common care pathway response involves transportation to emergency departments (EDs) even though there is no evidence that this is the best response.(28) An alternative care pathway that has received increasing attention is the co-responder model, which involves first-responders responding to crisis calls with a mental health clinician, peer, or social services staff. A scoping review of 23 academic and grey literature published between 2009 and 2019, and supplemented by consultations with experts, found that co-responder models were associated with reduced hospital use and police detentions but none of the studies examined longer-term impact on suicidality.(28) The long term impact of co-responder models on suicidality needs to be investigated.

Digital services

Digital services improve access to timely care by overcoming barriers including (physical/psychological) inability to travel to services, lack of service availability in rural and remote locations, and consumer out-of-pocket costs. Digital services offer a range of service delivery models (e.g., staff-supported, self-directed) and modalities (phone, online, apps, SMS), many are available 24 hours 7 days or operate 365 days and/or offer extended hours, which means people can get the care they need when they need it and where they need it. Their reach is significant, and those for which evaluations are publicly available show that digital services are valued by users and effective (i.e., improve wellbeing and increase help seeking).(6, 29)

An independent evaluation of three key Australian digital mental health services targeting people with depression and anxiety and using different models of online service delivery, with the option of self-directed or therapist-supported course completion, showed that they are producing significant clinical improvement for consumers.(29) The magnitude of improvement produced, especially by therapist-supported treatment, is comparable with more resource intensive face-to-face treatment options. The evaluation concluded that digital services have the potential to be scalable and good value for money but are not intended to serve Australia's entire help-seeking population, which may be better served through other components of the mental health system.

To improve quality and protect people from harm, the Australian Commission on Safety and Quality in Health Care has received Commonwealth funding to implement the accreditation assessment scheme for the 2020 National Safety and Quality Digital Mental Health Standards.(30, 31)

Several peer-reviewed systematic reviews have specifically investigated the effects of digital services on suicidality. For example, one reviewed the impact of telephone crisis services on suicidal users and found that most of the included 18 studies (published from 1966 to 2015) reported positive effects on immediate and intermediate degree of suicidal urgency and depressed mood, and positive user and counsellor experiences.(32) However, the authors

noted their findings were limited by inconsistencies in defining suicidality across studies, and lack of long-term follow-up and controlled studies.(32) Future research of digital interventions for suicidality should consistently define suicidality and investigate long term outcomes.

Another meta-analysis focusing on self-guided online or app interventions included 14 articles (16 studies published from 2012 to 2019) and concluded that those directly targeting suicidality significantly reduced suicidal ideation immediately post-intervention, but those indirectly targeting suicidality, such as those targeting depression, did not.(33)

Ambulatory care

Ambulatory care is care that is provided to hospital patients who are not admitted to the hospital (e.g., in EDs and outpatient clinics) or patients of community-based (non-hospital) health-care services.(34)

AIHW data show that in their last year of life, among people who suicide: both females (90% v 59%) and males (79 v 48%) were much more likely to have used MBS services than hospital services (for any reason); both females (30% v 13%) and males (19% v 6%) were much more likely to have been admitted to hospital for mental health problems than intentional self-harm; females were more likely than males to have used MBS (57% v 37%) and PBS (71% v 50%) mental health services and prescriptions; and 11% did not access any health services.(15)

Similarly, a Canadian study of 2,835 people who suicided in Toronto from 1998 to 2011 found that in the previous 12 months, around 92% had any type of health care contact, 66% had a mental health care contact, and 25% had only non-mental health contacts.(35) The most common type of mental health contact was an outpatient primary care visit (54%), followed by an outpatient psychiatric visit (40%), an ED visit (31%), and a psychiatric hospitalisation (21%). The median time from last mental health contact to death was 18 days (interquartile range 5-63). The authors concluded that predominance of ambulatory mental health care contacts, often close to the time of death, underscores the critical need to embed risk assessment and care pathways into all routine primary and specialty clinical care, and not only acute care settings.

Importantly, findings from a systematic review show that there is insufficient evidence for the effectiveness of standalone risk assessment (either using structured tools or clinician assessment) in predicting or reducing suicide.(36) Therefore, safety planning alongside risk assessment is essential, with findings from a meta-analysis demonstrating evidence for its effectiveness in preventing suicidal behaviour (but not suicidal ideation).(37) This suggests that safety planning is an essential element for inclusion in risk assessment in all settings.

Expert Consultation findings relevant to Objective 1

Expert Consultation supported that:

- accessibility of mental health and suicide prevention supports and services must be improved (e.g., need for increased availability of bulk-billing services and services that provide 24-hour support); and
- digital mental health services and programs should be a key priority, particularly in relation to meeting the needs of people in regional areas.

There should be a focus on the availability of non-stigmatising, timely and affordable youth-specific support from youth-specific trained workforce. This may include expanding on

current services or creating new youth-focused services that include a mix of face-to-face and digital interventions.

Actions

- 1) Improve service navigation and referral pathways to ensure connection with appropriate services by:
 - a. Building on and promoting existing navigational tools (such as the Head to Health website and Phone Service and HealthPathways) to help people to find appropriate local supports. Ongoing evaluation of different navigation models is needed to ensure they are meeting diverse user needs including consumers disproportionately impacted by suicide, their support people and service providers. Ongoing maintenance of these tools is required to ensure information is up to date. Ongoing promotion of navigation tools is needed to ensure people who need them are aware of them.
 - b. links between crisis lines and PHN area-based HealthPathways to support individuals navigating locally available services and facilitating warm referrals where required.
 - c. Design, trial and evaluate clinician-emergency service co-responder service models.
 - d. Develop nationally consistent standards for "no wrong door" service responses.
- 2) Continue to improve efficient and timely service delivery through strategies including:
 - a. Continued integration and promotion of digital care, with a focus on improving access in regional and remote areas.
 - b. Continued evaluation of therapist-supported and self-guided digital services and tools.
 - c. Reduction of out-of-pocket costs of mental health and suicide prevention care for people in the lowest socio-economic quartile.
 - d. Embed risk assessment, safety planning and care pathways into all health care settings – primary (GPs, community health centres, allied health services), secondary (specialist and ambulatory) and EDs. Evaluate effectiveness of these pathways in all settings.

Objective 2

Ensure provision of compassionate, person-centred care.

The Final Advice identified several barriers relating to the (negative) process and outcome of contact with the service system including dissatisfaction with (or trauma experienced from) ED responses to suicidal crisis, inability to access clinical services due to complicated eligibility criteria, and long waiting lists for public and private clinical services.(3) The Final Advice also acknowledged that these barriers contribute to carers experiencing anxiety while trying to keep someone safe.(3) Furthermore, a rapid review of the lived experience

perspective of suicide (prepared for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce) indicated that both consumers and carers are excluded from treatment decisions.(38)

Evidence and things we can build upon

There are opportunities to improve the non-clinical and clinical suicide prevention service system, including building workforce capability, and to involve carers.

Non-clinical care models

Because of the above barriers, the Australian Government has recently increased its focus on the role of community-based (or non-clinical) suicide prevention programs. A key example is the National Safe Spaces Network model proposed by a consortium of national suicide prevention and lived experience organisations.(39) The model involves people with lived experience and peer workers providing support in safe settings ranging from libraries, coffee shops, hairdressers, community centres or other services with gatekeeper trained staff, PHN commissioned services, Safe Haven Cafes (an alternative to EDs) to residential safe houses where people in crisis can stay for several days.(39) When measured, outcomes have been mixed for safe haven cafes (or similar) in Western Australia providing psychosocial support involving a peer component. (40) Example positive system outcomes include diversion from ED, and reduced hospitalisations, length of admissions, interactions with police and rates of incarceration. Example positive individual outcomes include improved social connections, service experience, confidence to address welfare-related needs, self-advocacy skills, and access to services; and reduced suicidality and distress. However, some groups of people disproportionately impacted by suicide were often ineligible for services or there was limited information about how their needs would be met by the service.

A UK safe haven café case study showed a one third reduction in mental health hospital admissions in a seven-month period (41) and people with lived experience value safe havens and peer support groups because they provide an opportunity connect with peer workers or others with a shared lived experience of suicide and mental illness.(38) Although the safe haven café model of care seems promising, the evidence for its impact on suicide is yet to be established.

A recent scoping review of peer support programs for suicide prevention identified eight publications about seven programs that used different designs and included a variety of settings (schools, communities, rural and online).(42) Only three programs contained data on effectiveness, reporting improvements in domains such as experiencing a sense of community, understanding reasons for suicidal thoughts, reducing intensity of suicidal thoughts, and emotional support. Overall, the review noted an evidence gap in research knowledge regarding program design, implementation, and effectiveness. The review highlighted the need to define peer support and lived experience, improve our understanding of the types of peer support programs available to those experiencing suicidality, and rigorously evaluate peer support suicide prevention programs led by people with lived experience.(42) These findings, particularly the need for more rigorous evaluation of acceptability and effectiveness, are supported by another scoping review.(43) A scoping review to examine the evidence for peer support for youth suicide prevention is currently in progress.(44)

It is likely that the need for more robust evidence for peer support programs explains mixed (but more favourable) **Expert Consultation** views about whether people with lived experience

should be utilised as paid peer workers in settings such as primary care, community health care services dealing with high-risk populations, training organisations and other settings.

Work is in progress by the Australian Commission on Safety and Quality in Health Care to define and develop common standards for what constitutes an Alternative to ED Service. This work will contribute to building the evidence base by facilitating better identification of recognised Alternative to ED interventions and collaboration with mental health services. **Expert Consultation** corroborated that there is a need to expand the availability and accessibility of alternatives to the ED for people experiencing suicidal distress but did not specify whether these alternatives ought to be clinical or non-clinical.

A scoping review of suicide prevention interventions for men reported that other non-clinical interventions that promote social interaction (e.g., sports based activities, social media, community-based informal support centres) are highly valued by men (45) but their effectiveness for suicide prevention is yet to be established. The review also identified that placing mental health initiatives in informal settings could improve men's help seeking.

Clinical care models

In addition to building the evidence base for alternative or non-clinical models of care, improving compassionate and person-centred care in EDs and other clinical and non-clinical settings is needed. Various models and frameworks for suicide prevention in clinical settings have been developed that may contribute to more compassionate service provision.

One example is the Collaborative Assessment and Management of Suicidality (CAMS) therapeutic framework which adopts an empathic, non-judgmental approach involving consumer and mental health provider working together to assess suicide risk and develop a care plan. Involving consumers in their own treatment decisions increases their sense of agency and contributes to more positive service experiences.(38) A meta-analysis of nine studies concluded that CAMS is a well-supported intervention for suicidal ideation.(46) However, there was no difference in outcomes produced by CAMS and other interventions for suicide attempts, self-harm, other suicide-related correlates, or cost effectiveness.(46) Furthermore, effect size differences favouring CAMS were significantly smaller for males and military personnel/veterans.(46) Preliminary findings from a small pilot study suggest that CAMS for teens is acceptable, appropriate and feasible, and reduced suicidal ideation.(47) However, larger randomised controlled trials are needed to establish efficacy.

Another example is the Zero Suicide framework for creating a systematic approach to suicide prevention and quality improvement in the healthcare system with the goal that no suicides should occur when a person is in contact with the health system. It proposes seven essential elements for effective coordinated care, four of which relate to clinical care (Identify, Engage, Treat, Transition) and three to implementation factors (Lead, Train, Improve).(48) The clinical care elements include: quidelines for evidence-based screening and assessment of suicide risk (Identify), pathways to care for people at heightened risk including the development of an individual Suicide Care Management Plan (Engage), use of evidence-based, suicide-specific interventions (Treat), and emphasis on continuity of care and close monitoring between clinical contacts and during care transitions (e.g., hospital or ED discharge, etc.) (Transition). The implementation elements focus on the need to: engage leadership and administration to create a culture change to suicide prevention being everyone's responsibility within an organisation (Lead), develop a competent suicide prevention workforce which includes training all staff (not just mental health professionals) in how to identify suicidal risk and how to effectively interact with people whose risk is heightened (Train), and for data-driven quality improvement (Improve). Organisations assess their current practices, attitudes, and training to determine needs and develop an implementation plan, and use systemic data collection to evaluate efforts, continually assess progress and model fidelity, encourage accountability, and inform revisions. The Zero Suicide framework has been widely adopted internationally particularly in the US and locally by the Gold Coast Mental Health Specialist Service and has shown promise in terms of reducing repeated suicide attempts after an initial attempt and a longer time to a subsequent attempt.(49, 50) However, there is a lack of robust evidence for its effectiveness.(51)

Expert consultations identified is a need to improve the experience of suicidal individuals who have contact with emergency departments including providing more training for staff and reducing wait times.

Expert consultations considered that aftercare involving post-acute crisis intensive support for people who have been admitted to an emergency department or hospital due to suicidal behaviour, should be a key focus and should include the provision of both clinical and non-clinical supports. Aftercare services are covered in more detail in Focus Area 5 (Supporting long-term wellbeing).

Finally, **expert consultations** suggested that to strengthen clinical workforce capability, comprehensive and trauma-informed suicide prevention and intervention training across all allied health, nursing and medical training programs should be included and potentially be made mandatory for accreditation.

Workforce compassion building

Ensuring compassionate, person-centred care could be facilitated by adapting some of the emerging workforce compassion building training such as the Compassionate Foundations: Suicide Prevention Capability Suite developed by the Australian Public Service Mental Health and Suicide Prevention Unit (52) or the training for frontline workers as part of the Distress Brief Intervention Trial. However, prior to adapting any existing training programs, their effectiveness needs to be evaluated.

Involving carers

Finally, irrespective of the suicide prevention setting (clinical or non-clinical), with consumer consent, it is important to consider the role of carers in assessment and treatment. Carers have a desire to be involved in treatment. (38) Involving carers could contribute to better outcomes if, for example, interventions improve negative family interactions that complicate the lives of people experiencing suicidal distress or involve collaborating with carers to develop and implement safety plans. (53) Furthermore, carers can potentially contribute vital assessment data that could reveal withheld intent (information not disclosed by the person experiencing suicidal distress). (53) The importance of involving carers in the receipt of services for people who have self-harmed or attempted suicide is covered in more detail in Focus Area 5 (Supporting long-term wellbeing). The evidence base for the involvement of carers needs to be bolstered.

Actions

 Design, trial and evaluate alternatives to ED services (e.g., Safe Haven Cafes) for crisis support that includes suicide prevention peer workers and other non-clinical service models.

- 2) Prioritise the work underway to develop national standards for alternatives to ED services through the Australian Commission on Safety and Quality in Health Care.
- 3) Improve assessment and management of suicidal crises in EDs and other clinical settings by trialling evidence-based models of care to improve processes and improve workforce capability (e.g., CAMS, compassion building training).
- 4) Design, trial and evaluate service models tailored for men.
- 5) With consumer consent, involve families and carers in care interactions and evaluate the effectiveness of this approach.
- 6) Use co-design and co-production principles and approaches for implementing the above actions and involve people with lived experience of suicide representing the diverse subgroups disproportionately impacted by suicide.

Objective 3

Configure the service system to provide more coordinated and holistic care.

The Final Advice highlighted problems with integration and communication between services resulting in consumers having to re-tell their stories to multiple health care providers.(3) It also noted consumer distress due to navigating siloed referral systems between organisations managing overlapping issues with lack of coordination between services (e.g., housing, mental health, alcohol and other drugs, education, work and finances).(3)

Evidence and things we can build on for Objective 3

There are several models of care that have the potential to promote better coordination and holistic care including care coordination, social prescribing, integrated ambulatory care and cross-sector partnerships. Each of these is elaborated below.

Care coordination

There are over 40 definitions of care coordination and it is often confused with many related terms (e.g., collaborative care, continuity of care, disease management, case management, care management, and care or patient navigation), which poses challenges for conducting research and synthesising evidence.(54) The US Government Agency for Healthcare Research and Quality defines care coordination as "the deliberate organization of patient care activities between 2 or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care."(54) A common definition of care coordination can enable building the evidence base for its effect on suicide prevention.

Policy and research have tended to focus on care coordination for mental health problems and not specifically for suicide prevention.

A systematic scoping review of health care coordination frameworks (55) reported that a 2018 framework by Weaver and colleagues (56) – addressing context, locus, and design domains, as well as service delivery, leadership and governance, and workforce domains – is the most useful for investigating the effectiveness of primary care coordination

approaches. The framework aims to examine factors leading to improved patient outcomes by differentiating relationships between coordination mechanisms, processes, integrating conditions, and outcomes across multi-team systems. The review also identified three frameworks that focused on implementation locus (e.g., setting, level, purpose) and design (e.g., personal, relationship-oriented, technical) elements of implementation, which could be useful for implementing care coordination. More consistent use of these frameworks in the design and evaluation of coordination approaches may increase their consistent implementation and measurement, enabling identification of factors and mechanisms that contribute to outcomes.

The Australian Government Department of Health has developed national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness, summarised in Box 1.(57) Extensive consultation and consensus-based processes were used to develop the guidelines which include special considerations for working with specific population groups. For example, in response to Recommendation 9, Child Link in Victoria is a web-based register, implemented to facilitate information sharing between a range of services and sectors (health and support services, public hospitals, early childhood education care providers and schools) with the aim of promoting children's wellbeing and safety.(57) Correspondingly, the National Children's Mental Health and Wellbeing Strategy also notes the importance of care coordination between diverse groups of stakeholders (e.g., medical professionals, allied health professionals, educators and families) for supporting children's mental health.(58)

Box 1: National guidelines to improve coordination of treatment and supports for people with severe and complex mental illness (57)

- 1. Clarify the function and role of each stakeholder
- 2. Ensure there is a care coordinator to navigate and coordinate support for consumers
- 3. Ensure multiagency care planning is consumer-led and recovery oriented
- 4. Develop and implement practices that support communication and information sharing
- 5. Establish and support safe transitions of care
- 6. Ensure Aboriginal and Torres Strait Islander services are involved and available
- 7. Promote and strengthen innovative leadership
- 8. Ensure workforces are equipped to deliver effective coordination
- 9. Commit to improve and increase the use of data and technology in care coordination

Effective care coordination is thought to improve consumer, carer and community experiences; quality of life; family engagement; clinical outcomes; and productivity; as well as reduce hospital admissions and provide economic benefits.(57) However, a meta-review conducted by the European Psychiatric Association found limited evidence that some concepts of care coordination improve the effectiveness and efficiency of mental health services and consumer outcomes and called for more evidence to improve understanding of the impacts of different care coordination models.(59)

One systematic review investigated the impact of brief acute care suicide prevention interventions.(60) Three of the 14 included studies incorporated care coordination (as one of multiple intervention components) and were associated with linkage to follow-up care and reduced subsequent suicide attempts and depression symptoms at follow up. Additionally, a systematic meta-narrative review of research in community mental health care planning and care coordination including 50 studies from the UK, Australia and USA published in 1990-2018 identified a gap between personalised care planning and coordination policy and real-world practices and experiences of service users and carers.(61) Policy mechanisms can be leveraged to improve the gap between policy and practice.

Key enablers of care coordination are relationships and service knowledge.(62) These are supported by a gentle and flexible service environment (including compassionate and capable service providers and outreach where appropriate), user-friendly service navigation tools and roles, clear communication mechanisms, funded cross-sector training to standardise workforce knowledge of health and community service providers, staff networks and alliances, and policy reform that stabilises health and community sector workforce to maintain networks and alliances.(62) Appropriate resourcing that incentivises collaborative care is also essential to enable coordinated supports and consumer engagement. Barriers to care coordination include fee-for-service models; mental ill-health stigma; and a complex, unnavigable and hierarchical service system.(62)

A study of the experiences of care coordinators in US Patient-centered Medical Homes identified similar and additional enablers and barriers.(63) Functionality of clinical information technology; the availability of community resources; interactions with clinicians and other health care facilities; interactions with patients; and self-care practices for mental health and wellness were named as both enablers and barriers. Colocation and full integration into practices were other key enablers, whereas excessive caseloads and data management responsibilities were experienced as important barriers.

Technology has the potential to play a significant role in facilitating care coordination, as demonstrated by an Australian study using system dynamics modelling for the North Coast NSW population.(64) This study showed that technology-enabled care coordination was forecast to deliver a reduction in self-harm hospitalisations and suicide deaths by 6.71% (95% interval 5.63%-7.87%), mental health-related ED presentations by 10.33% (95% interval 8.58%-12.19%), and the prevalence of high psychological distress by 1.76 percentage points (95% interval 1.35-2.32 percentage points). These benefits exceeded those that would be produced by targeting individual components of the mental health system (increasing service capacity growth rate by 20% or standard telehealth). The authors advise against investing in more of the existing types of services instead, urging for new models of care and the digital infrastructure to support them and their integration.

Policy mechanisms can be leveraged to develop infrastructure for minimising barriers (funding models, unnavigable service system) and enhancing enablers (e.g., resourcing, technology, cross-sector workforce capability) of care coordination.

Social prescribing

Social prescribing is a model of integrated care that has recently proliferated, with the aim of linking primary care patients with community (non-clinical) support to improve their holistic health and wellbeing (social, mental and physical) and relieving some of the pressure on primary care providers.(65, 66, 67, 68) Care integration is the result of partnerships between health and social care providers.(68) Much of the evidence about social prescribing is based on studies conducted and/or programs delivered in the UK.

Types of social prescribing interventions are diverse, ranging from targeted lifestyle interventions aiming to prevent or slow progression to chronic disease (e.g., physical activity, healthy eating or cooking, group mentoring) to those focusing on the social determinants of health (e.g., income support, leisure, social support).(66)

Social prescribing interventions also differ in terms of intensity or duration of support, and whether and how link worker support is provided.(66) A link worker is a non-health or social care professional based in primary care practices or community and/or voluntary organisations. At minimum, link workers match service users with local community

activities.(68) However, link workers can also develop individual action plans, set goals, provide ongoing support and communication, and accompany the patient to their first sessions.(68) Link workers are essential for providing integrated care.(68)

Social prescribing originally focused on people residing in low socioeconomic areas (66) and there is now a focus on older adults because of their increased risk of experiencing social isolation and loneliness.(69, 70)

At least two systematic reviews have demonstrated that although positive outcomes of social prescribing have been reported in individual studies or evaluations, conclusions are limited because studies are low-quality with a high risk of bias.(65, 71)

This evidence suggests that further research with more rigorous design is needed to determine the effectiveness (and cost-effectiveness) of social prescribing. Based on findings from another systematic review highlighting the benefits of co-design and co-production for social prescribing,(67) future research should use these processes for intervention development (and research). Furthermore, the effect of social prescribing for people experiencing suicidal distress has not been examined, although one study of the feasibility of adapting digital social prescribing for suicide bereavement support has identified challenges.(72)

Integrated ambulatory care

A scoping review that included 34 articles published between 2000 and 2019 identified the three most common models of ambulatory care internationally are: transfer from hospital to community settings, relocation of specialist care venue from outpatient clinics to primary care or telehealth without changing the people who deliver the service, and joint working/liaison between specialists and primary care providers or within primary community care providers.(73) The review showed that integrated care models can increase access and convenience for patients, but there was insufficient evidence of clinical and economic outcomes. Barriers to implementing integrated ambulatory care identified included: lack of ongoing funding; lack of infrastructure; lack of confidence, trust and communication between providers; increased workload; and time and knowledge and skills gap to perform new roles.(73) Additionally, the review emphasised the need for an appropriate location for services, committed leadership, development of a governance group representing different provider groups, strong communication mechanisms, new workforce skills and overall change management. Notably, this review did not focus specifically on suicide prevention or even mental health.

Chain of care is an integrated model which links and coordinates primary care, hospitals and community services and professionals through local pathways for the identification, treatment and management of health problems. (74) The evidence on chain of care, which operates in Norway, for preventing suicide is scarce and heterogenous. (75).

The collaborative care model integrates mental health care in primary care settings, with care provided by an interdisciplinary team including a (nurse) care manager, a primary care doctor and a consultant psychiatrist.(76) Collaborative care aims to improve the physical and mental health of people with mental illness and strengthen relationships between primary and specialist care.(77) A meta-analysis found that the most effective collaborative care framework for reducing suicidal ideation is primary care-based collaborative care with an embedded psychological intervention, and that consumers aged over 65 benefit the most.(76)

Further research is needed to identify models of integrated ambulatory care that are effective for managing suicidal distress.

Cross-sector partnerships

The above sections have mainly focused on evidence for improving coordination, collaboration and integration in the health sector, which is appropriate given that suicide prevention should be led by the health portfolio.(78) However, there are also opportunities to develop cross-sector partnerships to better and more inclusively respond to suicidal distress. For example, it would be appropriate to form cross-sector partnerships between health, education and social welfare at minimum when focusing on children (79), and between health and justice when focusing on people in the judicial system.

The recent environmental scan found limited suicide prevention initiatives in other sectors (e.g., in the Departments of Justice, Education and Training, and Transport) rather than cross-sectoral partnerships.(6) Although the cross-sector concept has started to be increasingly mentioned in contemporary suicide prevention policy documents, there seems to be a lag in practice.

Applying a conceptual framework has the potential to promote effective cross-sector partnerships. Canadian academics have proposed a framework for cross-sector collaboration to promote population health based on previous research and practice-based knowledge. The framework comprises three key dimensions for collective impact: the collaborative engagement process itself; motivation for collaborative engagement; and the capacity for collaborative action and adaptability.(80) Collective learning overlaps the three dimensions and is central to effective cross-sector initiatives because of its critical role in adapting strategies to complex and unpredictable socio-ecological systems.(80)

Collective Impact Suicide Prevention is a cross-sector suicide prevention framework, developed in New Zealand based on a qualitative study of cross-sectoral suicide prevention in a post disaster context.(81) It can be applied at a local, regional and national level. The framework highlights the need for dynamic leadership and resourcing a supporting ('backbone') agency to develop and implement cross-sectoral committees and actions. This study found that cross-sectoral suicide prevention enhanced the wellbeing of participants, hastened learning, supported innovation and raised awareness across sectors. It also identified the following enablers of cross-sectoral suicide prevention: effective communication; creating cross-sectoral action plans to facilitate motivation and evaluation of outcomes, cross-sectoral suicide prevention committees' ability to support the wellbeing of managers of mental health and wellbeing organisations, ensuring indigenous Māori and Pacific partnership and participation; and considered processes to support the inclusion of people with lived experience.

Another example of an innovative cross-sector partnership initiative is Medical-Financial Partnerships (MFPs) in the US, involving collaborations between the health sector and financial services organisations to improve health by reducing patient financial stress mainly in low income communities.(82) Examples of financial services provided by MFPs include individually tailored financial coaching, free tax preparation, budgeting, debt reduction, savings support, and job assistance. Three different models are used to provide these financial services: full-scope on-site service partnerships; targeted onsite service partnerships; and partnerships facilitating referral to off-site financial services. MFPs have been shown to improve finances and, in the few studies available, health outcomes.(82) Overall, the success of MFPs is attributable to strong administration-level buy-in and staff support, adaptation to overcome health system logistical challenges, and alignment with

existing clinical social needs screening and referral programs for sustainability but there are nuances based on which of the three models is used.

Findings from another US study suggest that cross-sector partnership activity to prevent mental health problems is facilitated by shared personnel or resources, written agreements, and regular meetings.(83)

To facilitate cross-sector efforts, the UK has produced a cross-government suicide prevention workplan which commits each government portfolio to taking action on suicide and outlines deliverables and timeframes for monitoring progress against commitments.(84) Australia could consider implementing a similar mechanism.

Actions

- Apply existing frameworks and consistent definition of care coordination to design, trial and evaluate its effectiveness for preventing suicide and identify which components of care coordination contribute to observed outcomes.
- 2) Apply evidence-based frameworks (e.g., collaborative care model) and consistent definition of integrated care to design, trial and evaluate its effectiveness for preventing suicide and identify models of integrated care that are effective.
- 3) Design, trial and evaluate an integrated care pathway model for ambulatory and inpatient settings that:
 - a. Is housed within mental health service settings, but plays a care navigator role with the capacity to coordinate across non-mental health services including alcohol and other drug, homelessness, employment, and social service supports.
 - b. Has staff embedded in EDs and manages referrals received from primary care settings to ensure the pathway is engaged from point of entry into care.
 - c. Is supported by access to information systems across services (e.g., similar to roles of child wellbeing units in NSW for child protection).
- 4) Prioritise implementation of the following actions from the National Children's Mental Health and Wellbeing Strategy:
 - a. Establish model of integrated child and family care networked across Australia that provides holistic assessment and treatment for children 0-12 years old and their families (action 2.1.c.).
 - b. Provide specific funding for care coordination to be available to children and families with complex needs, offered at key points of contact with services (action 2.4.a).
- 5) Design, trial and evaluate a tiered model of social prescribing in primary care settings, including: social prescribing by GPs (tier 1), and social workers (or other allied health care professionals) embedded in primary care to provide navigation of social and economic support options (tier 2).

- 6) Apply evidence based-frameworks to prioritise the development and evaluation of cross-sector partnership models (e.g., health-justice models) through co-funding arrangements between health and relevant non-health government portfolios to promote collaboration, mutual capacity building and the availability of cross-sector service delivery.
- 7) Identify and leverage mechanisms to create solid infrastructure that minimises barriers and enhance enablers of care coordination, integration and cross-sector initiatives (e.g., technology-enabled care coordination, workforce capability, adequate remuneration for health providers to participate in care coordination and case conferencing, change management, cross-government suicide prevention workplan), and reduces gaps between policy and practice.
- 8) Use co-design and co-production principles and approaches for implementing the above actions and involve people with lived experience of suicide representing the diverse subgroups disproportionately impacted by suicide.

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