Evidence Brief

Focus Area 5: Supporting long-term wellbeing.

Dr Bridget Bassilios[1*], Dr Karl Andriessen[1*], A/Prof Amy Morgan[1], Dr Angela Nicholas[1], Dr Anna Machlin[1], Dr Lennart Reifels[1], Dr Bridget Kenny[2], Dr Angela Clapperton[1], Dr Jaelea Skehan OAM[3], Dr Karolina Krysinska[1], Dr Danielle Newton[1], Dr Anna Ross[1], Prof Nicola Reavley[1], Prof Jo Robinson[2], A/Prof Dianne Currier[1].

*Co-lead authors.

[1] Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, [2] Orygen, Centre for Youth Mental Health, University of Melbourne, [3] Everymind.

Definition and scope of this focus area

People who have attempted suicide are at greater risk of re-attempting and dying by suicide,(1) yet many people are without follow-up mental health care.(2) The risk is particularly elevated in the first three to six months following an attempt.(3) Although experiences vary, for some people suicidal ideation may be enduring and persist for many years.(4) Effective suicide prevention requires services and systems which do not just focus on episodic interventions to alleviate immediate distress, but which ensure continuity of care and aim to restore long-term mental health and wellbeing. Systems and service providers must be equipped to provide effective ongoing support to anyone who has experienced suicidal crisis and their families and carers, including connecting people with ongoing coordinated psychosocial support.

What are the key issues?

- There are few services with capacity or service models designed to support longer-term, less acute distress through to a state of wellbeing.(5)
- Aftercare services involving provision of (risk management and psychosocial) support within 24 hours of discharge from hospital/emergency departments (EDs) following a suicide attempt, and provided for around three months, may offer a foundation from which to build longer-term care options with greater continuity.
- Family, friends, and caregivers are often left unsupported in their role caring for loved ones.(6)
- In providing support beyond alleviating suicidal crisis to restoring wellbeing, there is a role for less formal community-based supports to complement more formal clinical support.

What is currently happening in Australia?

Policy reform

The need for coordinated psychosocial support and integration of care for individuals experiencing a suicidal crisis and their families and carers is recognised in the state and territory and Australian Government strategies, the National Mental Health and Suicide

Prevention Agreement (National Agreement), the joint Primary Health Network (PHN) regional plans, and focus population strategies.(5) At the PHN region level, work on developing care navigation and care pathways for people experiencing suicidal crisis to coordinate support is underway.

Aftercare

There are several aftercare services currently available in Australia.(7) Aftercare services aim to prevent future suicidal behaviour for people who have been admitted to an ED or hospital due to suicidal behaviour by increasing access to and engagement with care in the critical period post-discharge.(7, 8) Aftercare typically involves ongoing risk management, safety planning, treatment adherence strategies, training in problem-solving skills, and assistance with psychosocial needs.

Key examples include Beyond Blue's The Way Back Support Service (TWBSS) which is transitioning to national Universal Aftercare[1] and the Hospital Outreach Post-Suicidal Engagement (HOPE) program in Victoria. There is significant government support to expand these aftercare services.

Beyond Blue created TWBSS to provide non-clinical care and practical support in the critical period following a suicide attempt.(9) It provides a support coordinator who initiates contact with the individual and tailors a program for up to three months built upon personal connection and integration with community services. Since its beginning in 2014, TWBSS has expanded nationally to 38 sites across Australia. In 2021, the Australian Government committed to Universal Aftercare and all states and territories (except South Australia) have committed to funding aftercare services for every Australian discharged from hospital following a suicide attempt. Beyond Blue plans to transfer support of its sites in mid-2023 to the Australian, state and territory governments and PHNs. National Best Practice Guidelines for the enhancement and establishment of aftercare services are currently under development.(10)

HOPE is a hospital-based service that offers clinical (mental health clinician) and non-clinical (peer support and wellbeing workers) assertive outreach support to people who have experienced a suicidal crisis and their support networks.(11) It aims to identify and build protective factors against suicide, providing up to 90 days of psychosocial care after discharge to individuals who do not meet the entry requirements for specialist public mental health care. HOPE has been piloted in selected Victorian health services. The Victorian Royal Commission recommended recurrently funding all area mental health services to offer the HOPE program.(12) From mid-2023 all TWBSSs in Victoria will transition to the HOPE model of care.

Support for caregivers

In terms of initiatives aimed at caregivers of people who have attempted suicide, Minds Together is an example of a new digital program that aims to build skills, knowledge, and confidence of caregivers.(13) Key crisis telephone and other digital support services, such

[1] The Australian Government refers to aftercare services for all people who have made a suicide attempt as the 'Universal aftercare services' initiative. However, according to the public health model of suicide prevention, 'universal' interventions target the whole population; 'selective' interventions, people who are at risk of suicidal ideation or behaviours; and 'indicated' interventions, people who are already suicidal or self-harming. Therefore, consistent with this model, aftercare services – even if they target all people who have made a suicide attempt – are an indicated intervention.

as Lifeline Australia and the Suicide Call-back Service, explicitly recognise people who are worried about someone who is suicidal as one of their target groups for counselling services and/or online resources.

What are the critical gaps in Australia?

Most aftercare services provide support following discharge from hospital after a suicide attempt. There is a recognised need to trial expanded referral pathways to reach Australians at risk who are not admitted to hospital.(14)

There is a need to develop tailored aftercare services for specific populations: children and young people; LGBTIQ+ people; and Aboriginal and Torres Strait Islander people.(14, 15, 16) There is a lack of data on whether aftercare services are meeting the needs of people experiencing a borderline personality disorder or people from CALD backgrounds.(14)

Often, family and caregivers are left out of safety planning and discharge planning and their role in supporting their loved one's long-term wellbeing beyond the point of crisis is not recognised. They are also rarely offered information, practical or emotional supports to manage the impacts of the caregiving role on their own wellbeing.(6)

Furthermore, services typically involve formal health or mental-health based support options. To support long-term wellbeing, it is critical that in addition alleviating the suicidal crisis, the role of complementary less formal community-based supports in restoring wellbeing (through increasing connectedness and support networks) should be considered.

FOCUS AREA 5 OBJECTIVES AND ACTIONS

Objective 1

Resource the service system to enable assertive follow-up for all individuals following a suicidal crisis including suicide attempt.

Define objective

There is a need to extend the scope of care beyond alleviating the immediate suicidal crisis to include support to maintain longer-term wellbeing. A service system that provides best-practice aftercare support for people following a suicide attempt or suicidal crisis may reduce the likelihood of a future attempt.

Describe range of issues or barriers potential action must address

Workforce issues will need to be addressed to support the scaling up of aftercare service provision, particularly in rural and regional Australia.

Aftercare service models must be culturally appropriate and safe for population groups such as First Nations Australians and LGBTQI+ Australian's among others.

Things we can build on

Aftercare services may offer a foundation from which to build longer-term care options with greater continuity for people who have experienced a suicidal crisis and their support networks.

Types of aftercare models

Different models of aftercare, including non-clinical and community-based services, are being delivered in Australia.(7) Three types of aftercare models have been identified with variation within each type (7):

1. **Assertive aftercare** involving a case manager who proactively maintains contact (via home and other off-site visits, telephone calls and texts) rather than relying on the person to contact the service. Rapid follow-up, case management and motivational support are provided. TWBSS, Universal Aftercare and HOPE are examples of assertive aftercare.

2. **Brief contact interventions** providing supportive messages via postcard, text message or letter (not therapy).

3. **Brief interventions** providing sessions that are limited either in number (usually fewer than six) and/or duration (10-20 minutes) and typically provided over the telephone. Case management is not a feature and therapy is not typically provided.

Evaluation of TWBSS and HOPE

In Australia, aftercare services are relatively new and there has been limited evaluation of their effectiveness,(11, 17, 18) although modelling has suggested that they could prevent 20% of suicide attempts and may be cost-effective.(8, 19, 20) An independent evaluation of TWBSS showed evidence of short-term benefits but it did not examine long term outcomes, such as suicide reattempts.(14, 21, 22) However, TWBSS significantly reduced psychological distress and suicidal ideation, and increased emotional wellbeing up to one to four months after using the service. Preliminary findings from an uncontrolled study have shown that HOPE improves subjective wellbeing.(11) Another small study found that around the 6-month follow-up, HOPE significantly reduced suicidal ideation and distress and increased coping self-efficacy, hope and well-being, with staff identified as a key component contributing to recovery.(23)

Aftercare effectiveness review

The promising aftercare findings shown in the above single studies are supported by a rapid review brokered by the Sax Institute for the NSW Ministry of Health.(7) This review concluded that the impact of aftercare on preventing suicide is unclear. However, it found that **assertive aftercare models** and **brief interventions** seem to reduce the proportion of people who re-attempt suicide compared with a control condition (mostly treatment as usual).(7) **Brief contact interventions** reduce the incident rate of repeat suicide attempts or self-harm, but not the proportion of people who attempt suicide.(7)

Although the review did not find research that explicitly examined aftercare intervention components that produce positive outcomes, effective models were likely to involve:

- Rapid follow-up with greater frequency in the first month post-discharge;
- A strong focus on therapeutic alliance, engagement and care continuity;
- Providing the first session face-to-face if the follow-up service is delivered by telephone; and
- Addressing a wide range of psychosocial needs, involvement of a support person and integration with clinical care.

A systematic review of aftercare for older adults following self-harm (including with suicidal intent) concluded that multifaceted, assertive follow-up approached coupled with systemic change are promising but require further evaluation.(24) It also highlighted that assessment and referral pathways were inconsistent, with many people not referred to any form of community follow-up care.

Adapting aftercare models

Adaptations of aftercare services are being developed for specific population groups. Child and youth specific models of aftercare services are being developed and trialled in Victoria (adapting the HOPE program in four health services across Melbourne(25) and New South Wales (i.am, adapting TWBSS in four sites).(26) North Western Melbourne PHN is designing and piloting training for HOPE clinicians in Victoria to make the service safer and more inclusive for LGBTIQ+ people.(27) The Commonwealth 2022-23 Budget allocated funding to implement culturally sensitive, co-designed aftercare services with Aboriginal and Torres Strait Islander organisations.(28) Evaluation of a South Australian Aboriginal and Torres Strait Islander co-designed aftercare service that was part of the National Suicide Prevention Trial found a decrease in re-presentations due to repeat suicide attempt for clients of the aftercare service, and clients reported improvements in adherence with medication and better engagement with services.(29) Based on analysis of limited routinely collected data, participants in a trial of aftercare incorporating peer support (Murrumbidgee TWBSS site) were more likely than those without peer support to complete treatment and remain in the service for a longer period.(22) Another trial of an aftercare service 'Next Steps' incorporating peer workers is underway in the Illawarra/Shoalhaven region of NSW.(30, 31)

The NSW, QLD, ACT and Victorian governments are funding the trial of expanded referral and entry pathways to aftercare services from other settings, such GPs, emergency services, alcohol and other drug services and community-based health services.(32)

Expert consultation views concurred with current best-practice approaches for aftercare services. They also emphasised the importance of the non-clinical components of aftercare and that aftercare be more widely available.

Actions

1) Expedite the trial, evaluation and scaling up of universal assertive aftercare services (through the National Mental Health and Suicide Prevention Agreement) with the aim of achieving immediate aftercare services that are available for at least 12 weeks with flexibility around commencement and access to ongoing, less intensive support available longer-term and the ability to re-refer.

2) Expand referral criteria for aftercare services to include ambulatory presentations.

3) Subject trial evaluation findings, expand referral pathways to aftercare services.

4) Support the development and evaluation of integrating suicide prevention peer workers into aftercare service delivery.

5) Support the development and evaluation of tailored aftercare services for specific populations e.g., children, young people, Aboriginal and Torres Strait Islander people, LGBTQI+ people.

Objective 2

Build the capability of services supporting an individual who has experienced a suicidal crisis to include family and carers and resourcing to enable direct supports for family and carers.

Define objective

Family and carers have an important role in supporting individuals who have experienced suicidality, particularly when engagement with formal care services ceases. Services should provide support to chosen family and carers to alleviate distress, identify support needs, provide information and strengthen their ability to effectively support their loved one in their recovery and to assist in the prevention of further suicidal crises.

Describe range of issues or barriers potential action must address

Healthy reactions from family and carers toward a loved one following a suicide attempt can help to reduce symptoms of depression, facilitate future disclosures of suicidal crises, and reduce risk factors for future suicidal attempts.(33, 34) The responses of family and carers following a suicidal crisis are therefore integral to their loved one's recovery and treatment process and can reduce the likelihood of further crises. However, family and carers can lack the knowledge and skills to provide positive support and they can inadvertently carry out behaviours with the potential for harm.(35) Despite a need for a healthcare system that supports family and carers to provide care following a suicide attempt, some research has shown that family and carers can receive inadequate education and communication from healthcare providers to assist them in identifying future suicidal crises, safety planning to keep their loved one safe, and to provide family and carers with the knowledge and skills to provide their loved one with good care. (36, 37, 38)

Furthermore, despite their support being integral to their recovery process, family and carers often describe feeling 'invisible' to health professionals and the system.(6) Family and carers are often excluded from discharge planning, despite them taking on the role as primary caregiver following discharge,(39) and they can feel they are not being taken seriously by healthcare professionals or even stigmatised by them.(40) Aftercare services aim to increase links to supportive networks, and people with lived experience of suicide attempt have argued strongly that family and caregivers need greater involvement.(6)

In addition to the requirement of education and support so that family and carers can facilitate the recovery of their loved one, family and carers experience their own stress and distress (sometimes called 'caregiver burden') following the suicide attempt.(39) The time of discharge from inpatient healthcare services can be a particularly anxious time for family and carers as they can fear for the safety of their loved one and lack confidence in their own ability to provide good care.(38) Therefore, family and carers also require support options to maintain their own health and wellbeing while they provide care and beyond.(39) Improving the confidence of family and carers to support their loved one after suicide attempt,

confidence that their loved one is receiving good healthcare, and the support received by the carer themselves have all been shown to reduce 'caregiver burden'.(39)

Things we can build on

A report prepared for the National Suicide Prevention Advisor and National Suicide Prevention taskforce recommends the following supports for carers of people experiencing a suicidal crisis: psycho-education tools and therapeutic support that increases their understanding about suicide and supports their own wellbeing (Recommendation 2); training for health professionals about how to include carers in treatment and discharge planning (Recommendation 3); and routinely including the needs of carers in suicide prevention strategies (Recommendation 4).(32)

Support for carers

Caregivers need access to resources that provide holistic, practical, and accessible information at the time of crisis and throughout recovery,(33) as well as to options to support their own wellbeing. This support needs to be age and developmentally appropriate for children of parents experiencing suicidality. It should also include postvention support as appropriate (refer to Focus Area 3: Empowering earlier intervention).

Programs and services

Minds Together is a new digital program developed by Everymind that aims to build skills, knowledge, and confidence of caregivers of people who have attempted suicide.(13) The online program consists of two modules about supporting the care recipient and the caregiver's own wellbeing, and a series of optional in-depth topics (e.g., suicide, stigma, safety plans, hypervigilance) delivered over eight weeks. Participants can also access an online forum to anonymously share their story, questions, and comments with other caregivers. Everymind is currently evaluating whether caregivers engage with and benefit from the program and associated online social support forum.

Key telephone and other digital support services acknowledge that support people need guidance and support in their caring role. Below are some of many examples of support lines and other services available to carers:

- Neami National. List of state and national resources and organisations to support carers https://www.neaminational.org.au/get-support/carers-and-family/useful-supports-for-carers/
- Beyond Blue: Talk to a counsellor 24/7 (phone or online): Talk or chat online to a counsellor - Beyond Blue
- SANE. Friends, family and carers forum: Mental health support for family, friends & carers (saneforums.org)

Family and carers may benefit from ongoing individual or family counselling services to manage their own mental health and wellbeing. Beyond Blue provides a useful guide on how to access a mental health professional: Beyond Blue - Find a mental health professional

Online information and resources

Many Australian not-for-profit mental health and suicide prevention organisations have online resources to help those supporting a person in a suicidal crisis. These may be especially useful for learning warning signs of suicide risk and having conversations about

suicide with a person who might be at risk. Others focus on self-care throughout the caring journey or information on suicide bereavement. The following are some of many examples:

- Conversations Matter. Fact sheet and short podcasts about how to talk to someone thinking about suicide: When someone is thinking about suicide - Conversations Matter
- Beyond Blue. Self-care when caring for someone with mental health difficulties and suicidal thoughts: Look after your mental health as a supporter - Beyond Blue
- SANE. How to care for a carer of someone who has made a suicide attempt: Caring for a carer (sane.org)
- Open Arms. Suicide bereavement information: Suicide bereavement | Open Arms

Training for health professionals

Health professionals involved in the acute care and discharge planning of a person who has experienced a suicidal crisis and those involved in their longer term care can facilitate good ongoing care of the person in crisis by considering family and carers as a central part of the care team.(38) To do this, these health professionals require their own training in how to empower family and carers to provide care to their loved ones and to support their own mental health and wellbeing. Support, education, communication and involvement of family and carers in ongoing care planning should consider (36, 38):

- Caring and empathetic actions toward family and carers while the person in suicidal crisis is in acute care (e.g., in emergency care after a suicide attempt) and upon discharge. These are times of extreme stress for family members and carers.
- Provision of education for family and carers in recognition of warning signs of suicidal crisis and safety planning to increase their confidence and skills in their ability to assist their loved one to stay safe upon discharge to the home.
- Involvement of family members and carers in discharge and longer-term plans for ongoing mental health care.
- Education and skills training in how to provide longer-term support to the loved one in crisis.
- Provision of support and information for carers on how to access supports for their own wellbeing, such as those listed above.

Routinely including carers in suicide prevention strategies

Suicide prevention strategies must take a multi-level and multi-sectoral approach to integrating care of family and other carers of those in suicidal crisis in all aspects of suicide prevention, intervention and postvention. Due consideration should be given to accessing family and carers and providing them with resources and support at all opportunities available through their contact with the healthcare system and through their own help-seeking. To achieve optimal outcomes for family and carers, suicide prevention strategies need to incorporate training required for health professionals to include family and carers as appropriate as central members of the care team of the person at risk, and to support their own mental health and wellbeing.

Actions

1) Expand aftercare service models of care to include chosen family and carers in support interactions

2) Provide direct support to chosen family and carers

3) Trial integration of suicide prevention peer workers to support chosen family and carers in aftercare services

4) Prioritise the trial (and expansion) of new mechanisms for supporting chosen family and carers

5) Provide accessible information and resources to empower chosen family and carers to be confident and effective in their support role

Objective 3

Address systems barriers to the provision of longer-term coordinated care for people who have previously experienced a suicidal crisis to support restoring and maintaining long-term mental health and wellbeing.

Define objective

Objectives 1 and 2 focus on leveraging aftercare services to provide intensive support for people including families and carers following self-harm. Objective 3 focuses on service system shifts needed to better support longer term care and strengthen a genuine effort to support people to restore wellbeing (not just reduce crisis).

Some of the health service system barriers described in Evidence briefs for Focus Area 4 (Providing accessible, comprehensive and compassionate care for individuals who are experiencing suicidal ideation or engaging in self-harm) and Focus Area 2 (Mitigating the impact of drivers of distress in the general population) are also relevant when considering longer term coordinated care and support to restore and maintain long term mental health and wellbeing. Examples include affordability of services, lack of awareness of services and how to access and navigate the service system, siloed services, lack of care coordination and workforce issues.

Describe range of issues or barriers potential action must address

Existing support options for ongoing mental health and wellbeing are typically not designed to be available in the long term, which reflects the underlying relatively short-term funding cycles and the lifecycles of government policy and strategies.(5) Existing short-term support options lack integration and coordination, which means that people with complex and/or long-term support needs underlying their suicidal distress are left to navigate individual short-term supports by themselves. The fragmentation of the mental health and suicide prevention service sector and workforce capacity and distribution impact on the ability to support ongoing, coordinated care models.

Things we can build on

Types and modalities of care

A range of care types and models should be funded to meet the needs of people who have experienced a suicidal crisis and their support networks at various stages of their recovery trajectory from acute crisis to longer term recovery, and in accordance with their preferences. These include clinical, non-clinical and community-based supports that are delivered in person or remotely using a range of digital options (telephone, online etc.).

It is critical that people who have self-harmed or experienced a suicidal crisis receive clinical care by a mental health professional. The UK National Institute for Health and Care Excellence recommends that a mental health professional conducts a psychosocial assessment at the earliest opportunity after an episode of self-harm, and that an evidence-based psychological treatment is offered.(41) Clinical care is provided in emergency departments (EDs), hospital and community settings. Examples of frameworks that can be used to provide clinical support for suicide prevention have been described in Focus Area 4 (Providing accessible, comprehensive, and compassionate care).

Peer-led support, such as Safe Haven Cafes (an alternative to EDs), is a key example of non-clinical care that has been receiving increased attention in policy reform. (42) Although peer-led models of care seem promising, the evidence for their impact on suicide is yet to be established. A recent scoping review of peer support programs for suicide prevention identified seven programs that used different designs and included a variety of settings (schools, communities, rural and online).(43) 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. These findings, particularly the need for more rigorous evaluation of acceptability and effectiveness, are supported by another scoping review.(44)

Expert consultation affirmed that increased support for and investment in community-based peer recovery services is needed. Those consultations likewise identified a need for building the research evidence on the effectiveness of peer recovery services in a range of age groups (including youth and adult) to determine which types of approaches are most effective.

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.

Other non-clinical or community-based interventions focus on promoting 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 effectiveness of community development and investment to increase informal community supports (e.g., Men's Sheds) and increasing mechanisms to facilitate a person's connection to these modes of support could be explored.

As outlined in the Evidence brief for Focus Area 4 (Providing accessible, comprehensive and compassionate care), digital services play in important role in overcoming barriers to timely care 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).(5, 46)

Chronic and recurrent suicidality

Current treatment models and research mainly focus on acute episodes of suicidal crisis, whereas *chronic* suicidal ideation "may represent a stable condition that likely requires long-term management" as opposed to acute and immediate interventions.(47) Moreover, it is well established that suicidal ideation is episodic and commonly reoccurs (3, 48) Chronic suicidality is most often discussed in the context of ongoing mental illness, particularly borderline personality disorder, treatment-resistant depression, and PTSD, although recurrence of suicidality has been observed in individuals with a broad range of psychiatric diagnoses.

We found no published research on the role of life stressors with respect to chronic suicidal ideation, but there is some evidence that life stressors may play a role in recurrence, although studies generally find that it has a lesser impact than mental illness or that mental illness mediates the effect.(3, 48, 49)

In terms of managing chronic suicidality, there is evidence for efficacy for pharmacological approaches such as lithium in bipolar disorder and clozapine in schizophrenia, and psychotherapeutic approaches such as Cognitive Behavioural Therapy and Dialectical Behavioural Therapy – the latter particularly for suicidality in the context of borderline personality disorder.(50) Research specifically examining approaches to managing chronic suicidality outside of evidence-based treatment guidelines for various mental health disorders is scant. The Veterans Administration in the United States recommends that long-term treatment approach for chronically suicidal individuals should include "regular mental health follow-up, a well-articulated safety plan, routine suicide risk screening, coping skills-building, and management of co-occurring psychiatric symptoms."(51)

Care coordination

Care coordination involves two or more participants (including the patient) purposefully organising a person's health and social care needs across multiple service providers responsible for different care needs and requires resources and information exchange.(52)

The Australian Government Department of Health and Age Care has developed national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness.(53)

Effective care coordination can 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.(53) However, a meta-review has reported 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 comparing outcomes of different care coordination models.(54)

Key enablers of care coordination are relationships, service knowledge, colocation and full integration of multiple service providers types.(55, 56) 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.(55) Appropriate resourcing that incentivises collaborative care is also essential to enable coordinated supports and consumer engagement.

Technology has the potential to play a significant role in facilitating care coordination. An Australian modelling study showed that benefits of technology-enabled care coordination exceed those that would be produced by targeting individual components of the mental health system (e.g., increasing service capacity growth rate by 20% or standard telehealth).(57) The authors recommend new models of care and the digital infrastructure to support them and their integration. Technology could also be harnessed to help identify and provide pathways for people who have previously self-harmed or attempted suicide.

Barriers to care coordination include fee-for-service models; mental ill-health stigma; a complex, unnavigable and hierarchical service system; (55) excessive caseloads; and data management responsibilities.(56)

Assertive aftercare services can be leveraged to facilitate care coordination including linkage to a range supports that address longer-term social and economic stressors.

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.(58)

Mental health service navigation programs target diverse populations and are delivered in person, by telephone, and online and navigators include peers, paraprofessionals, clinicians, teams, and web applications.(58) Common features of navigation programs include engagement, assessment, service identification, referral, and monitoring/follow-up.(58) Although evidence for mental health service navigation is promising, more evidence from randomised controlled trials is needed.(58)

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.(59)

Head to Health is an online navigation tool that aims to help users find digital mental health (including suicide prevention) services. It needs to be more widely promoted and user experiences can be improved.(60) The 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.(61) The new platform includes an optional decision support tool (adapted Link-me)(62) 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, which 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.(63)

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.(64) 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.(65)

Assertive aftercare services can be leveraged to facilitate navigation of services providing a range supports that address longer-term social and economic stressors.

Care pathways

Drawing on the Zero Suicide framework, NSW Health and QLD Health have published care pathways for individuals at risk for suicidal behaviour.(66, 67) The Victorian Department of Health provides general information on care for at-risk individuals on their website as well as more formal clinical practice guidelines for EDs and mental health services.(68) These pathways and guidelines are not service directories or referring guides but, rather, serve to educate and inform clinicians and health services on best-practice care of individuals potentially at risk for suicidal behaviour.(69) The pathways offer guidance on how to identify, assess, intervene, and transition care for these individuals. Specific services are not referenced in the pathway documents; however, NSW Health provides a toolkit for local health districts and specialty health networks to develop detailed localised pathways that include service details.(70)

Nationally, the Australian Government Department of Health has produced guidance for PHNs to help with implementing a stepped primary mental health approach. This guidance describes the Initial Assessment and Referral Decision Support Tool (IAR-DST)(63, 71, 72) for mental health care. The IAR-DST is intended to complement clinical judgement and includes a domain related to risk of harm, to be considered together with seven other domains in determining referral pathway and level of care (on a scale ranging from 1: self-management to 5: specialist and acute services).(73) Again, this tool does not provide referral details for specific services.

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.(74) However, there are also opportunities to develop cross-sector partnerships to better and more inclusively respond to suicidal distress and social and economic stressors and strengthen protective factors in the long term (e.g., housing, education, employment etc.). The recent environmental scan found that while the cross-sector concept has started to be increasingly mentioned in contemporary suicide prevention policy documents, there seems to be a lag in practice. (5)

Expert consultations reiterated the importance of considering social determinants and addressing factors that can contribute to an increased risk of suicide including access to affordable housing, financial distress, and so on. They recognised that cross-portfolio action was needed to accomplish this.

There are several mechanisms that can be used to facilitate the development of cross-sector partnerships that have been detailed in Focus Area 4 (Providing accessible, comprehensive and compassionate care). Briefly, these include applying cross-government conceptual frameworks and developing suicide prevention workplans that commit government portfolios to specified actions.(75, 76, 77) Existing frameworks promote

collective learning for effective cross-sector partnerships and emphasise the need for dynamic leadership and resourcing a supporting ('backbone') agency to develop and implement cross-sectoral committees and actions.(75, 76, 77)

One 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.(78) 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.(79)

Increased investment in research is needed to improve understanding of the long-term support needs of people who experience suicidality and effective approaches to meet these needs. This includes looking at needs across the lifespan and for different subgroups (such as gender diverse groups), understanding the episodic and fluctuating nature of suicidality, as well as identifying novel approaches to long-term support.

Actions

1) Resource the service system to enable access to ongoing care and choice in support mechanisms for people who have previously experienced a suicidal crisis or self-harmed through:
    a. Changing the structure of mental health funding through Medicare/ commissioning agencies to ensure ongoing, affordable care.
    b. Funding a variety of support mechanisms (e.g., clinical, non-clinical, peer, self-guided) to enable people to access support in a way that works for them.
    c. Building the infrastructure, processes, and culture across the service system to enable coordination and collaboration in delivering care beyond acute care settings.
    d. Effective triage systems that expediate care for people who experience repeated suicidal crisis.
    e. Dedicated ongoing community case management roles to coordinate support needs, provide a consistent contact point and provide motivational support for individuals that experience suicidality.
    f. Service models and partnership agreements that facilitate collaborative care planning and coordinated service delivery.
    g. Service funding and worker role requirements that enable time for workers to participate in case conferences, build relationships with other service providers, and maintain knowledge of local supports and best practice.
    h. Information systems that enable timely sharing of information.
    i. Online guidance (e.g., care pathways) to support service providers to deliver best practice care and to help individuals to navigate service systems to connect with relevant supports e.g., HealthPathways.

2) Include input from suicide prevention experts and apply a suicide prevention lens to social and economic policy making.

3) Increased investment in research is needed to improve understanding of the long-term support needs of people who experience suicidality and effective approaches to meet these needs. This includes looking at needs across the lifespan and for different sub groups (such as gender groups), understanding the episodic and fluctuating nature of suicidality, as well as identifying novel approaches to long-term support.

References

1. Demesmaeker A, Chazard E, Hoang A, Vaiva G, Amad A. Suicide mortality after a nonfatal suicide attempt: A systematic review and meta-analysis. Australian & New Zealand Journal of Psychiatry. 2022;56(6):603-16.
2. Spittal MJ, Shand F, Christensen H, Brophy L, Pirkis J. Community mental health care after self-harm: A retrospective cohort study. Aust N Z J Psychiatry. 2017;51(7):727-35.
3. Kapur N, Cooper J, King-Hele S, Webb R, Lawlor M, Rodway C, et al. The repetition of suicidal behavior: a multicenter cohort study. Journal of Clinical Psychiatry. 2006;67(10):1599-609.
4. Geulayov G, Casey D, Bale L, Brand F, Clements C, Farooq B, et al. Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study. Lancet Psychiatry. 2019;6(12):1021-30.
5. Bassilios B, Dunt D, Currier D, Krysinska K, Machlin A, Newton D, et al. Environmental scan of suicide prevention activity in Australia: Summary report. Melbourne: Centre for Mental Health, University of Melbourne; 2023.
6. National Suicide Prevention Adviser. Compassion First: Designing our National Approach from the Lived Experience of Suicidal Behaviour. Canberra: Australian Government; 2020.
7. Shand F, Woodwards A, McGill K, Larsen M, M. T, Petheridge A, et al. Suicide aftercare services: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health. 2019.
8. Pirkis J, Robinson J, Gunnell D, Hawton K, Hetrick S, Niederkrotenthaler T, et al. Understanding Suicide and Self-harm. Melbourne: Centre for Mental Health, University of Melbourne; 2022.
9. Beyond Blue. The Way Back Support Service 2023 [Available from: https://www.beyondblue.org.au/mental-health/suicide-prevention/after-a-suicide-attempt/the-way-back-support-service.
10. North Western Melbourne Primary Health Network. Universal co-design: Development of national best practice guidelines for aftercare, postvention and distress brief support 2023 [Available from: https://nwmphn.org.au/news/universal-co-design-development-of-national-best-practice-guidelines-for-aftercare-postvention-and-distress-brief-support-services/.
11. Williamson P, Hope J, Segal J, Gill L, Orr M, Trevorah B, et al. A critical review of the first six months of operation of a trial Hospital Outreach Post-suicidal Engagement (HOPE) service in Australia. Australas Psychiatry. 2021;29(3):315-21.
12. Health Do. Suicide prevention in Victoria Melbourne: Victorian State Government; 2022 [Available from: https://www.health.vic.gov.au/prevention-and-promotion/suicide-prevention-in-victoria.
13. Everymind. Minds Together 2023 [Available from: https://mindstogether.org.au/.
14. Nous Group. The Way Back Support Services Evaluation | Final Evaluation Report. 2022.
15. State of Victoria. Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Part Paper No. 202, Session 2018-21 (document 1 of 6). Victoria: Victoraian Government; 2021.
16. State of Victoria. Royal Commission into Victoria's Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Part Paper No.202, Session 2018-21 (document 4 of 6). Victoria: Victorian Government; 2021.
17. Kehoe M, Wright AM, Lee SJ, Rylatt D, Fitzgibbon BM, Meyer D, et al. Provision of a Multidisciplinary Post-Suicidal, Community-Based Aftercare Program: A Longitudinal Study. Community mental health journal. 2022:1-12.
18. Wright AM, Lee SJ, Rylatt D, Henderson K, Cronje H-M, Kehoe M, et al. Coordinated assertive aftercare: Measuring the experience and impact of a hybrid clinical/non-clinical

post-suicidal assertive outreach team. Journal of Affective Disorders Reports. 2021;4:100133.
19. Krysinska K, Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N, et al. Best strategies for reducing the suicide rate in Australia. Aust N Z J Psychiatry. 2016;50(2):115-8.
20. Le L. Modelling the cost-effectiveness of brief aftercare interventions following hospital-treated self-harm. . Submitted.
21. Nous Group. The Way Back Support Services Interim Evaluation Short Report Canberra: Australian Government Department of Health and Aged Care; 2021.
22. Nous Group. The Way Back Support Services Evaluation: Final Report. Melbourne: Beyond Blue; 2022.
23. Kehoe M, Wright AM, Lee SJ, Rylatt D, Fitzgibbon BM, Meyer D, et al. Provision of a Multidisciplinary Post-Suicidal, Community-Based Aftercare Program: A Longitudinal Study. Community mental health journal. 2023;59(4):680-91.
24. Wand AP, Browne R, Jessop T, Peisah C. A systematic review of evidence-based aftercare for older adults following self-harm. Australian & New Zealand Journal of Psychiatry. 2022;56(11):1398-420.
25. Victorian Department of Health. Interim Recommendation 3: Expansion of Hospital Outreach Post-suicidal after Engagement (HOPE) 2022 [Available from: https://www.health.vic.gov.au/mental-health-reform/interim-recommendation-3.
26. NSW Health. Youth Aftercare Pilot 2022 [Available from: https://www.health.nsw.gov.au/towardszerosuicides/Pages/youth-suicide-aftercare-pilot.aspx.
27. NWMPHN. The Hospital Outreach Post-Suicidal Engagement service and LGBTIQ+ community 2023 [Available from: https://nwmphn.org.au/our-work/suicide-prevention-intervention/hospital-outreach-post-suicidal-engagement-hope/.
28. Care DoHaA. New national approach to local suicide prevention 2022 [Available from: https://www.health.gov.au/ministers/the-hon-david-coleman-mp/media/new-national-approach-to-local-suicide-prevention.
29. Muyabi K WS, Carter M, Gilliam M, Jones M,. Evaluation of an aftercare service model in an Aboriginal Community Controlled Health Organisation. Wyalla: Country South Australia Primary Health Network; 2020.
30. Bliokas VV, Hains AR, Allan JA, Lago L, Sng R. Community-based aftercare following an emergency department presentation for attempted suicide or high risk for suicide: study protocol for a non-randomised controlled trial. BMC Public Health. 2019;19(1):1380.
31. Health GP. Next steps: Suicide prevention aftercare program.
32. Commonwealth of Australia. The National Mental Health and Suicide Prevention Agreement Canberra: Australian Government; 2022 [Available from: https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement.
33. Frey LM, Hans, J. D., & Cerel, J. Suicide disclosure in suicide attempt survivors: Does family reaction moderate or mediate disclosure's effect on depression? . Suicide and Life-Threatening Behavior. 2016;46(1).
34. Frey LM, & Fulginiti, A. Talking about suicide may not be enough: family reaction as a mediator between disclosure and interpersonal needs. Journal of Mental Health. 2017;26(4):366-72.
35. Nicholas A, Pirkis J, Jorm A, Spittal MJ, Reavley N. Helping actions given and received in response to suicide risk: Findings from an Australian nationally representative telephone survey. SSM - Population Health. 2019;9:100483.
36. Grant C, Ballard ED, Olson-Madden JH. An Empowerment Approach to Family Caregiver Involvement in Suicide Prevention:Implications for Practice. The Family Journal. 2015;23(3):295-304.

37. McLaughlin C, McGowan I, Kernohan G, O'Neill S. The unmet support needs of family members caring for a suicidal person. J Ment Health. 2016;25(3):212-6.
38. Wayland S, Coker S, Maple M. The human approach to supportive interventions: The lived experience of people who care for others who suicide attempt. Int J Ment Health Nurs. 2021;30(3):667-82.
39. Maple M, Wayland S, Sanford RL, Bhullar N. Predictors of Caregiver Burden Among Carers of Suicide Attempt Survivors. Crisis. 2023;44(1):41-8.
40. Cerel J, Currier GW, Conwell Y. Consumer and family experiences in the emergency department following a suicide attempt. J Psychiatr Pract. 2006;12(6):341-7.
41. National Institute for Health and Care Excellence (NICE). Self-harm: assessment, management and preventing recurrence UK: NICE; 2022 [Available from: https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm.
42. KPMG. National Safe Spaces Network Scoping Study. Canberra: Commonwealth Department of Health; 2020.
43. Schlichthorst M, Ozols I, Reifels L, Morgan A. Lived experience peer support programs for suicide prevention: a systematic scoping review. International Journal of Mental Health Systems. 2020;14(1):65.
44. Bowersox NW, Jagusch J, Garlick J, Chen JI, Pfeiffer PN. Peer-based interventions targeting suicide prevention: A scoping review. American Journal of Community Psychology. 2021;68(1-2):232-48.
45. Struszczyk S, Galdas PM, Tiffin PA. Men and suicide prevention: a scoping review. Journal of Mental Health. 2019;28(1):80-8.
46. Bassilios B, Ftanou M, Machlin A, Mangelsdorf S, Tan A, Scurrah K, et al. Independent evaluation of supported digital mental health services: Phase 2 final report. Melbourne: Centre for Mental Health, University of Melbourne; 2022.
47. Garakani A, Buono FD, Larkin K, Polonsky M, Goldberg JF. Development and validation of a new scale to measure chronic suicidal ideation: The Chronic Suicidal Ideation Inventory-5 (CSI-5). Journal of psychiatric research. 2022;150:160-4.
48. Ten Have M, Van Dorsselaer S, Verdurmen J, Van't Land H, De Graaf R, Vollebergh W, et al. Incidence and course of suicidal ideation and suicide attempts in the general population. Canadian Journal of Psychiatry. 2009;54(12):824-33.
49. Zhang Y, Law C-K, Yip PS. Psychological factors associated with the incidence and persistence of suicidal ideation. Journal of affective disorders. 2011;133(3):584-90.
50. Rudd MD, Craig JB, David AJ, Seth F, David C. A Standard Protocol for the Clinical Management of Suicidal Thoughts and Behavior: Implications for the Suicide Prevention Narrative. Frontiers in Psychiatry: Frontiers Media S.A.; 2022.
51. US Department of Veterans Affairs: Rocky Mountain Mental Illness Research Education and Clinical Centre for Suicide Prevention. Therapeutic Risk Management of the Suicidal Patient 2022 [Available from: https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf.
52. McDonald KM, Sundaram V, Bravata DM, Lewis R, Lin N, Kraft SA, et al. Definitions of care coordination and related terms. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol 7: Care Coordination): Agency for Healthcare Research and Quality (US); 2007.
53. Australian Government Department of Health. National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness - March 2022. Canberra: Australian Government; 2022.
54. Gaebel W, Kerst A, Janssen B, Becker T, Musalek M, Rössler W, et al. EPA guidance on the quality of mental health services: A systematic meta-review and update of recommendations focusing on care coordination. European Psychiatry. 2020;63(1):e75.

55. Williams B. Collaborative and coordinated care: An investigation of the enablers and barriers for adults who experience mental ill health in Eastern Melbourne: EMHSCA Care Coordination Research Summary. Melbourne: Eastern Mental Health Service Coordination Alliance; 2019.
56. Friedman A, Howard J, Shaw EK, Cohen DJ, Shahidi L, Ferrante JM. Facilitators and Barriers to Care Coordination in Patient-centered Medical Homes (PCMHs) from Coordinators' Perspectives. J Am Board Fam Med. 2016;29(1):90-101.
57. Iorfino F, Occhipinti J-A, Skinner A, Davenport T, Rowe S, Prodan A, et al. The Impact of Technology-Enabled Care Coordination in a Complex Mental Health System: A Local System Dynamics Model. J Med Internet Res. 2021;23(6):e25331.
58. Waid J, Halpin K, Donaldson R. Mental health service navigation: a scoping review of programmatic features and research evidence. Social Work in Mental Health. 2021;19(1):60-79.
59. Stafford E, Brister T, Duckworth K, Rauseo-Ricupero N, Lagan S. Needs and Experiences of Users of Digital Navigation Tools for Mental Health Treatment and Supportive Services: Survey Study. JMIR Ment Health. 2021;8(6):e27022.
60. Bassilios B, Ftanou M, Machlin A, Mangelsdorf S, Banfield M, Tan A, et al. Independent evaluation of the Head to Health Digital Mental Health Gateway: Final report. Melbourne: Centre for Mental Health, University of Melbourne; 2022.
61. Productivity Commission. Mental Health, Report no. 95. Canberra: Australian Government; 2020.
62. Fletcher S, Spittal MJ, Chondros P, Palmer VJ, Chatterton ML, Densley K, et al. Clinical efficacy of a Decision Support Tool (Link-me) to guide intensity of mental health care in primary practice: a pragmatic stratified randomised controlled trial. The Lancet Psychiatry. 2021;8(3):202-14.
63. Australian Government. Initial Assessment and Referral Decision Support Tool Canberra: Commonwealth of Australia; 2022 [Available from: https://docs.iar-dst.online/en/latest/index.html#.
64. HealthPathways Community. What is HealthPathways? New Zealand: Canterbury District Health Board, and Streamliners 2022 [Available from: https://www.healthpathwayscommunity.org/About.
65. HealthPathways. What is HealthPathways? Melbourne2022 [Available from: https://melbourne.communityhealthpathways.org/43160.htm.
66. NSW Government and Agency for Clinical Innovation. NSW Health suicide care pathways 2022 [Available from: https://aci.health.nsw.gov.au/networks/mental-health/suicide-care-pathway#evidence.
67. Clinical Excellence Queensland MHAaoDB. Suicide Prevention Practice: Queensland Health Guideline October 2021 2021 [Available from: https://www.health.qld.gov.au/system-governance/policies-standards/guidelines.
68. Victorian Department of Health. Suicide risk - treatment and care of people at risk 2015 [Available from: https://www.health.vic.gov.au/practice-and-service-quality/suicide-risk-treatment-and-care-of-people-at-risk.
69. Agency for Clinical Innovation. Suicide care pathways. Evidence Check. NSW Ministry of Health; 2022. Contract No.: 9 November 2022.
70. NSW Health. NSW Health suicide care pathway toolkit: NSW Ministry of Health; 2022 [Available from: https://aci.health.nsw.gov.au/networks/mental-health/suicide-care-pathway.
71. Australian Government. Initial Assessment and Referral Decision Support Tool v1.05 Canberra: Commonwealth of Australia; N.D. [Available from: https://iar-dst.online/#/.
72. Department of Health. National PHN Guidance: Initial assessment and referral for mental health care. Canberra: Australian Government; 2020.
73. Department of Health. National PHN Guidance, Initial Assessment and Referral for Mental Healthcare - Version 1.04. Canberra: Australian Government; 2020.

74. National Suicide Prevention Project Reference Group. National Suicide Prevention Strategy for Australia's Health System 2020-2023. Melbourne: Department of Health and Human Services, Victorian Government; 2020.
75. de Montigny JG, Desjardins S, Bouchard L. The fundamentals of cross-sector collaboration for social change to promote population health. Glob Health Promot. 2019;26(2):41-50.
76. Gale MM. Cross-sectoral suicide prevention implementation post-disasters in Canterbury, Aotearoa New Zealand. 2022.
77. HM Government. Cross-Government Suicide Prevention Workplan. UK; 2019.
78. Bell ON, Hole MK, Johnson K, Marcil LE, Solomon BS, Schickedanz A. Medical-Financial Partnerships: Cross-Sector Collaborations Between Medical and Financial Services to Improve Health. Academic Pediatrics. 2020;20(2):166-74.
79. Nelson KL. Associations Between Cross-Sector Partnerships and Local Health Department Participation in Population-Based Activities to Prevent Mental Health Conditions. American Journal of Public Health. 2020;110(S2):S225-S31.