



Care of people who may be suicidal

Rapid review

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1 Executive summary

Background

The purpose of this review is to summarise the evidence for several aspects of care of people who may be suicidal. Building on the work of the Agency for Clinical Innovation's (ACI's) Suicide Care Pathways Evidence Check (2022) the review addresses the following questions:

1. What does the evidence tell us about the value of screening for suicidality within mental health services?
2. What does the evidence tell us about the use of clinical assessment versus standardised tools for suicide risk assessment?
3. Is there any new evidence that substantially changes the conclusions of the 2014 Sax Institute report 'Management of suicidal behaviour – evidence for models of care'?
4. What are the core and adaptable elements of effective clinical suicide care pathways?
5. How does the current evidence advance our understanding of best practice for different populations who are placed on suicide care pathways (e.g., age, gender, LGBTIQ+ people, Aboriginal and Torres Strait Island people, culturally and linguistically diverse people, people with co-occurring disorders)?
6. What is the evidence for alternative post-discharge follow-up protocols, including alternative time frames and modalities?

Methods and limitations

This review was undertaken as a pragmatic rapid review, summarising international and Australian research and evaluation evidence on suicide prevention programs. The main sources of evidence used were existing systematic reviews of the literature and primary trials or evaluations of in scope interventions, including grey literature.

There is a lack of high-quality research on many of the questions this review aims to answer. We did not explicitly assess the quality of each piece of evidence but note that much of it is limited to grey literature.

Key findings

The key findings of the review are noted below against each research question.

Question	Key findings
What does the evidence tell us about the value of screening for suicidality within mental health services?	Screening tools can increase risk detection beyond self-disclosure or clinical judgment. However, screening tools should not be used alone to allocate or determine treatment.
What does the evidence tell us about the use of clinical assessment vs standardised tools for suicide risk assessment?	For treatment, in addition to screening, there needs to be a comprehensive clinical assessment of each patient's situation and needs. There is growing consensus that clinical assessment should be focussed on treatment planning not prediction or risk stratification. Successful transition from traditional risk stratification approaches to comprehensive clinical assessment of suicide risk requires an all of health approach, where all staff are competent to conduct collaborative suicide risk assessment rather than relying on screening tools.
Is there any new evidence that substantially changes	The conclusion of the 2014 Sax Institute report is not invalidated by any literature covered in this report. It remains valid to say that:

Question	Key findings
<p>the conclusions of the 2014 Sax Institute report ‘Management of suicidal behaviour – evidence for models of care’?</p>	<p><i>Moving away from screening checklists towards a more comprehensive clinical assessment, as the first step in clinical assessment of patients with suicidal ideation and behaviours, would provide a more clinically useful basis for decision-making in relation to management, as well as a more tailored or individual-oriented treatment pathway.</i></p> <p><i>Optimal management entails the provision of a range of clinical services and development of policies for certain clinical problems. Best practice involves general mental health practices, and not merely those focused on suicide and related self-harm behaviours (Sax, 2014).</i></p> <p>New evidence highlights the importance of responding to both severe and complex mental illness as well as to those presenting with suicidality but not severe and complex mental illness. This shift towards universal suicide care has led to clinicians delivering suicide care to a much higher number of consumers and a broader range of consumers – particularly given recent spikes in presentations of people with mental health crisis linked to natural disasters and COVID. Some argue that more resources are needed for the health system to deliver both universal evidence-based suicide care and general mental health practices.</p>
<p>What are the core and adaptable elements of effective clinical suicide care pathways?</p>	<p>As noted in the ACI’s Suicide Care Pathways Evidence Check (2022), the core and adaptable elements of effective clinical suicide care pathways are:</p> <ul style="list-style-type: none"> ▪ Risk assessment and/or risk formulation ▪ Safety planning ▪ Lethal means counselling ▪ Face to face follow-up after discharge ▪ Care transition (e.g. warm-handover to ongoing aftercare). <p>Further research and evaluation of suicide care pathways is needed. Preliminary evidence, however, suggests that how the components of care are delivered impacts efficacy. From a provider perspective, culture, leadership, training and resourcing are critical elements of effective implementation of suicide care pathways in practice.</p> <p>Establishing trust and connection in the delivery of care to a person who is suicidal or has self-harmed is important. From a workforce perspective, therefore, all staff should be trained so that they are competent at connecting with individuals and collaboratively assessing suicide risk.</p> <p>Trust and connection are foundational aspects of a peer worker’s role, and peer support may be able to supplement and/or support clinical care when it is constrained by resources, availability or location. To support the peer-workforce, ideally guidelines on clinical care pathways will be complemented by guidelines for non-clinical workers and promote integration between clinical and non-clinical care.</p>
<p>How does the current evidence advance our understanding of best practice for different populations who are</p>	<p>We did not find any studies explicitly examining the effectiveness of suicide care pathways for priority populations. These material gaps highlight the need for more rigorous evaluations of suicide care pathways and how they need to be adapted to deliver compassionate, helpful and effective care to different priority populations.</p>

Question	Key findings
placed on suicide care pathways?	<p>The available evidence does, however, highlight important factors that need to be considered in the best practice care of people who may be suicidal within priority populations. Section 3.5 summarises this evidence.</p> <p>Note this evidence is insufficient to support clinical recommendations and/or guidelines and is only included to highlight different factors which need to be considered.</p>
What is the evidence for alternative post-discharge follow-up protocols, including alternative time frames and modalities?	<p>There is a lack of high-quality evidence on what elements of aftercare are most effective. Programs involving a range of modalities have been successful. Person-centred, clinically integrated care consistently appears as an element of successful aftercare. But not all aftercare services are effective. Brief contact therapy is not effective alone.</p> <p>A range of timeframes are being used in aftercare services, with rapid follow-up within 24 hours to 72 hours of discharge and ongoing follow-up in the first month post discharge appearing most commonly. There is, however, a lack of high-quality evidence regarding how the timeframe of initial follow-up impacts consumer outcomes.</p> <p>More research and evaluations are needed to ensure aftercare services are effective and to understand what works best.</p> <p>In the absence of strong evidence to set time protocols for aftercare, providers could aim to follow-up and connect people to aftercare as soon as reasonably possible following discharge.</p> <p>Further research is also required to strengthen understanding of patient prioritisation rules for aftercare. Black Dog (2017) is one example of literature suggesting ways that services can prioritise those people who require more rapid, assertive follow-up.</p> <p>Finally, as many people drop out of aftercare, providers should maintain an ongoing focus on trying to keep people in aftercare until they have received adequate care.</p>

2 Introduction

2.1 Background

The purpose of this review is to summarise the evidence for several aspects of care of people who may be suicidal. Building on the work of the Agency for Clinical Innovation's (ACI's) Suicide Care Pathways Evidence Check (2022) the review addresses the following questions:

1. What does the evidence tell us about the value of screening for suicidality within mental health services?
2. What does the evidence tell us about the use of clinical assessment vs standardised tools for suicide risk assessment?
3. Is there any new evidence that substantially changes the conclusions of the 2014 Sax Institute report 'Management of suicidal behaviour – evidence for models of care'?
4. What are the core and adaptable elements of effective clinical suicide care pathways?
5. How does the current evidence advance our understanding of best practice for different populations who are placed on suicide care pathways (e.g., age, gender, LGBTIQ+ people, Aboriginal and Torres Strait Island people, culturally and linguistically diverse people, people with co-occurring disorders)?
6. What is the evidence for alternative post-discharge follow-up protocols, including alternative time frames and modalities?

2.2 Methodology

This review was undertaken as a pragmatic rapid review, summarising international and Australian research on elements of care for people who may be suicidal. The main sources of evidence used are existing literature (including systematic reviews of the literature and primary trials of relevant interventions) and publicly available evaluations of trials of relevant interventions. Evidence was sourced in three stages:

- The evidence referenced in the ACI's Suicide Care Pathways Evidence Check (2022) was reviewed
- Additional papers recommended by members of the Ministry of Health's Towards Zero Suicides Evaluation Expert Panel who were provided with the six questions
- Database searches, using Scopus, with key terms:
 - Screening & suicid* & review (searches for documents where screening and suicid* and review appear together or separately in the title or keywords)
 - "Clinic* assessment" & suicid* (searches for documents where clinical/clinician assessment and suicid* appear together or separately in the title or keywords)
 - {Suicide Care Pathway} (searches for documents where Suicide Care Pathway appear together in the title or keywords)
 - Post-discharge follow-up & suicid* (searches for documents where Post-discharge follow-up – punctuation ignored) and suicid* appear together or separately in the title or keywords)
 - Aftercare & suicid* (searches for documents where Aftercare and suicid* appear together or separately in the title or keywords).

Searches were undertaken in April 2022. Search was limited to papers written in English language, published from 2019 to present. We prioritised inclusion of large systematic meta-analyses¹ if available.

¹ Evidence hierarchies that prioritise systematic reviews of RCTs are limited in scope and so are not suited to evaluating the evidence from suicide prevention programs and strategies (Dudgeon et al. 2021a).

2.3 Limitations

This review did not set out to provide a comprehensive review of the evidence on best practice in caring for people who may be suicidal but aims to provide a balanced assessment of what is known.

The focus of this report is on universal approaches to suicide prevention, rather than specific approaches for issues such as, for example, chronic suicidality or treatment resistant depression.

There is a lack of high-quality research on many of the questions this review aims to answer. We did not explicitly assess the quality of each piece of evidence but note that much of it is limited to grey literature. The findings of this review support the strong need for more robust research into the most effective care for people who may be suicidal.

3 Rapid review

3.1 What does the evidence tell us about the value of screening for suicidality within mental health services?

Brief screening tools are an effective way to identify individuals at risk for suicide who require further assessment and care. Universal suicide risk screening as part of routine care is feasible, and if implemented properly has been shown to lead to material increases in risk detection (Boudreaux et al. 2016). This includes suicide risk screening for children and adolescents (Newton et al. 2017; Ambrose et al. 2018). Where evidence has not been found for the benefit of screening, screening has not been shown to have any adverse effects (O'Connor et al. 2013).

In the US, the Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above (The Joint Commission, 2019)². Examples of validated screening tools include the PHQ-9, and the Columbia-Suicide Severity Rating Scale. When using validated screening tools, organizations should not change the wording of the questions because small changes can affect the accuracy of the tools (The Joint Commission, 2019)².

Although screening is useful, it is not sufficient and should never be used to determine treatment or risk on its own (Wilson et al. 2020; Turner et al. 2021; Miller et al. 2017). The limitations of screening tools including risk scales in clinical practice are well documented (for example in Wyder et al. 2021; Chan et al. 2016). A comprehensive review of screening tools ('risk scales') assessed the ability of the tools to predict who would repeat self-harm. Overall, no suicide risk screening tool was sufficient to be recommended for routine clinical use (Quinlivan et al. 2016); the tools with high sensitivity had low specificity and poor positive predictive values.

For treatment the clinical focus should be on 'conducting comprehensive clinical assessments of each patient's situation and needs' (Quinlivan et al. 2016) and not on the categorisation of patients into high-risk and low-risk categories (Wyder et al. 2021). Guidelines from the American Zero Suicide Institute recommend screening followed by a suicide risk assessment, while the UK National Institute for Health and Care Excellence also recommends screening but notes that tools should not be used in isolation (i.e. without accompanying clinical assessment) to determine treatment.

3.1.1 Gaps in the evidence

As there are a wide range of screening tools used across a wide range of settings, the evidence on how specific tools perform in different settings, for different sub-populations varies. For example, there is a lot of research on alternative screening tools for young people (such as Aguinaldo et al. 2020 and Milliman et al. 2020) but limited evidence on the use of screening tools for other sub-populations.

3.1.2 Discussion of key findings

While some screening tools can increase risk detection beyond self-disclosure or clinical judgment, there is a consistent message in the literature that screening tools should not be used alone to predict self-harm or allocate or determine treatment. For treatment, in addition to screening, there needs to be 'comprehensive clinical assessments of each patient's situation and needs' (Quinlivan et al. 2016).

² The US Joint Commission issues annual reports on National Patient Safety Goals and requirements for accredited hospitals and behavioural health care organizations. suicide risk assessment. Requirements are based on extensive literature review and the technical advice of experts panels.

3.2 What does the evidence tell us about the use of clinical assessment vs standardised tools for suicide risk assessment?

Standardised tools on their own are not sufficient for risk assessment. They can however assist with clinical assessment through information gathering and inquiry (Barzilay et al. 2019; University of Manchester 2018). Given the limitations of standardised tools in determining treatment (discussed in Section 3.1 and in Carter et al. 2016 and Turner et al. 2021), clinical assessment has a clear role in risk assessment with the support of standardised tools.

Patients have reported that standardised tools alone can feel impersonal (University of Manchester 2018), highlighting a need for compassionate, collaborative clinical assessment in addition to the use of standardised tools. Patient experience matters and research reinforces the importance of preventing negative experiences with hospital and health services, and the benefits of engagement with people who can demonstrate non-judgemental, compassionate and helpful attitudes towards a person who has survived a suicidal crisis (Sax 2019).

The limitations of standardised tools versus comprehensive clinical assessment hold across sub-populations. For example, Leckning et al. (2020) developed guidelines for the culturally responsive assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts via the Delphi method. 286 statements across all relevant areas of clinical practice were derived from the literature and tested with a panel³; no statements covering the use of structured screening tools were endorsed.

Current thinking supports the result presented in Sax (2014) that clinical assessment should:

- Be based on a comprehensive clinical interview by a skilled clinician
- Encompass a detailed evaluation of suicidal behaviour and ideation, and a full psychiatric diagnostic assessment and determination of the psychosocial circumstances of the individual
- Involve carers if possible and when appropriate.

Since 2014, further emphasis has been placed on understanding that the purpose of clinical assessment is not prediction but to support treatment planning (Large 2018). Pisani et al. (2016) propose suicide ‘prevention-oriented risk formulations’ which synthesize data into four distinct judgments to directly inform intervention plans:

- Risk status (the patient’s risk relative to a specified subpopulation)
- Risk state (the patient’s risk compared to baseline or other specified time points)
- Available resources from which the patient can draw in crisis
- Foreseeable changes that may exacerbate risk.

This is one example of a framework for synthesising suicide risk information gained during a clinical assessment in a way that articulates a consumer’s immediate distress and resources at a specific time and place so a helpful treatment plan can be formed. Collaborative assessment and management of suicidality (CAMS) and chronological assessment of suicide events (CASE) are others. Existing research supports the CAMS as a well-supported therapeutic framework for suicidal ideation (Swift et al. 2021).

The CASE approach (Shea et al. 1998) is an interviewing strategy for uncovering withheld intent through specific validity techniques and a collaborative, non-judgemental stance. Gold Coast Mental Health and Specialist Services (GCMHSS), and other Hospital and Health Services across Queensland, have replaced risk categorisation with a combination of CASE and Prevention-Oriented Risk Formulation (Turner et al. 2022). At GCMHSS the transition from traditional risk stratification to this model achieved results in a

³ With clinical, community-based and lived experience in Aboriginal and Torres Strait Islander mental health and/or suicide prevention

relatively short timeframe. Within a few months of implementation, strong fidelity to the new model enabled the elimination of ‘low’, ‘medium’ or ‘high’ risk in clinical documentation; and a 35% reduction in suicide attempt re-presentations was observed after shifting to prevention-oriented risk assessment in combination with safety planning, consumer and carer education, and assertive follow-up (Turner et al. 2022).

Staff need to be trained in how to assess, formulate, and manage suicide risk; and on-going supervision should be available to support consistency of approach (Sax 2014; University of Manchester 2018). The limitations of screening tools necessitates that this capability exists across all staff. Staff should be comfortable asking patients about suicidal thoughts (University of Manchester 2018). But measuring the confidence of clinicians in their ability to assess the risk of suicide is difficult (Airey & Iqbal 2022). There is some evidence of the benefit of clinical judgement, specifically the emotional responses to patients, in contributing to risk assessment (Barzilay et al. 2019).

3.2.1 Gaps in the evidence

The need for mental health workers and the broader workforce to deliver non-judgemental, compassionate and helpful attitudes towards a person who has survived a suicidal crisis (Sax 2019) and to practice cultural safety (McGough et al. 2018) is vital to improve outcomes. But there is limited knowledge on how to best support the workforce to do this. This is discussed further in Section 3.4.

Also, best practice clinical guidelines for assessment for high-risk populations, such as Aboriginal and Torres Straight Islanders⁵, have been proposed but not yet widely implemented and/or evaluated.

3.2.2 Discussion of key findings

There is growing consensus that clinical assessment should be focussed on treatment planning not prediction⁶. The transition from traditional risk stratification to prevention-oriented risk assessment can deliver a reduction in suicide attempt re-presentations when used in combination with safety planning, consumer and carer education, and assertive follow-up (Turner et al. 2022). It requires an all of health approach, where all staff are competent to conduct collaborative suicide risk assessment rather than relying on screening tools.

3.3 Is there any new evidence that substantially changes the conclusions of the 2014 Sax Review?

In 2014, the NSW Ministry of Health commissioned a review to assess the evidence for identification and management of people presenting to health services with suicidal behaviour or ideation. This review concluded:

Moving away from screening checklists towards a more comprehensive clinical assessment, as the first step in clinical assessment of patients with suicidal ideation and behaviours, would provide a more clinically useful basis for decision-making in relation to management, as well as a more tailored or individual-oriented treatment pathway.

Optimal management entails the provision of a range of clinical services and development of policies for certain clinical problems. Best practice involves general mental health practices, and not merely those focused on suicide and related self-harm behaviours (Sax, 2014).

The two main components of the conclusion (screening and clinical assessment, and broader guidelines for clinical care of people who may be suicidal) are addressed separately below.

⁵ See Leckning et al. 2020

⁶ This is linked to the widespread acceptance that screening tools should not be used to predict self-harm or allocate or determine treatment (see for example, Wyder et al. 2021; Large et al. 2016).

3.3.1 Screening and clinical assessment

The evidence summarised in Section 3.1 and Section 3.2 fully supports the conclusions of Sax (2014) on the use of screening and clinical assessment. As discussed above, new evidence strengthens the findings of Sax (2014) with numerous studies released since 2014 highlighting the prevention paradox in suicide – where most suicides come from a population assessed as ‘low’ or ‘moderate’, and only a minority of cases come from the high-risk population (Queensland Health, 2022). This paradox makes prediction futile for the purposes of determining treatment; so clinical assessment should be focussed on treatment planning not prediction (Pisani et al. 2016; University of Manchester 2018).

3.3.2 Guidelines for the clinical care of people who may be suicidal

Evidence reviewed for this paper still supports a view that best practice involves general mental health practices, as well as those focused on suicide and related self-harm behaviours.

Public healthcare systems have historically focussed on (a) identifying mental illness in those presenting with suicidality, (b) assessing a level of risk and (c) treating mental illness in those assessed as high risk (Queensland Health 2022). Recent evidence, as outlined in Sections 3.1 and 3.2, shows that screening and risk assessment cannot predict who will die by suicide, so categorical assessments of risk should not be used to allocate resources to individuals or determine treatment.

This has led to a paradigm shift, and there has been a shift away from predictive risk assessment to evidence-based brief interventions for all people presenting with suicidality. For example, Brodsky et al. (2018) outline the Assess, Intervene and Monitor for Suicide Prevention model (AIM-SP) as a guide for implementation of evidence-based and best practices in clinical settings.

- “Assess” refers to the use of systematic screening and comprehensive risk assessment to identify at-risk patients.
- “Intervene” consists of conducting suicide-specific brief and psychosocial interventions.
- “Monitor” provides strategies for ongoing monitoring and increased contact during known high risk periods.

Brodsky et al. (2018) propose ten basic steps for clinical management, designed to be easily incorporated into standard clinical practice. These steps are to enhance suicide risk assessment, provide brief interventions to increase safety and teach coping strategies and to improve ongoing contact and monitoring of high-risk individuals during transitions in care and high-risk periods. Other evidence-based brief interventions and suicide care pathways are discussed in Section 3.4.

Despite the shift towards universal approaches to suicide care, there remain individuals (e.g. those with severe mental illness) who also require a strong clinical focus on diagnosis, formulation, treatment of mental health and clinical aftercare (Queensland Health 2022). A balanced approach is needed, incorporating suicide specific care and non-clinical care **as well as** diagnosis of underlying mental health conditions and clinical care. Almost all state and territory health departments recommend that a comprehensive mental health status examination and psychiatric assessment accompanies a suicide risk assessment (Queensland Health 2022, Victorian Department of Health 2022, Sax 2014).

3.3.3 Gaps in the evidence

The evidence is clear on the need for both evidence-based brief interventions, and clinical care for those with mental health treatment needs.

3.3.4 Discussion of key findings

A paradigm shift has occurred in suicide care, with widespread recognition of the importance of responding to both severe and complex mental illness as well as to those presenting with suicidality but not severe and complex mental illness. The shift has led to clinicians delivering suicide care to a much higher number of consumers and a broader range of consumers, particularly given recent spikes in

presentations of people with mental health crisis linked to natural disasters and COVID. Some argue that more resources are needed for the health system to deliver both evidence-based suicide care to everyone who may be suicidal *and* general mental health practices (Queensland Health 2022).

3.4 What are the core and adaptable elements of effective clinical suicide care pathways?

Many organisations and health services have guidance on pathways for suicide care, most with common elements. As noted in the ACI's Suicide Care Pathways Evidence Check (2022)⁷, the core and adaptable elements of effective clinical suicide care pathways are:

- Risk assessment and/or risk formulation⁸
- Safety planning
- Lethal means counselling
- Face to face follow-up after discharge⁹
- Care transition (e.g. warm-handover to ongoing aftercare)⁹.

There is limited but growing evidence for the effectiveness of suicide care pathways at reducing re-presentation and subsequent attempts. For example, Stapelberg et al. (2020) found that the Zero Suicides framework and suicide care pathway within Gold Coast Mental Health and Specialist Services (GCMHSS) delivered a reduction in repeated suicide attempts and a longer time to a subsequent attempt for those receiving multi-level suicide care.

Evidence suggests *how* the core elements of the suicide care pathway are delivered matters. For example, discussion of the implementation of the suicide care pathway within GCMHSS identified that the critical elements were:

- An **all-of-health approach** – rather than being limited to a single team, all staff were trained and involved in suicide prevention efforts
- **Restorative just culture** shift, including a focus on supporting staff and families following deaths of consumers by suicide (Queensland Health 2022).

Turner et al. (2021) highlights that the current use of algorithms and/or incident reviews to determine culpability following adverse incidents is flawed and can have devastating effects on staff and the broader healthcare community. They argue that restorative just culture is needed, to replace backward-looking accountability with a focus on the hurts, needs and obligations of all who are affected by critical incidents. At GCMHSS such a process has achieved a culture change required to support learning, improving and healing for consumers, their families and staff (Turner et al 2021). Kaur et al. (2019) also outlines the positive effects of implementing restorative justice in a UK setting¹⁰. They found that the introduction of restorative justice coincided with many qualitative improvements for staff, such as:

- Improved staff retention
- A reduction in suspensions and dismissals
- An increase in the reporting of adverse events

⁷ ACI's 2022 search found 15 pathways or frameworks described in the peer reviewed and grey literature. The evidence on suicide care pathways is generally descriptive. We believe the summary is comprehensive and have only noted *additional* findings here.

⁸ Discussed in detail in Section 3.2

⁹ Protocol for post-discharge follow-up is discussed further in Section 3.6

¹⁰ Mersey Care NHS Trust, who have implemented a Zero Suicides approach.

- An increase in the number of staff that felt encouraged to seek support
- A slowing down of the upward trend in absence due to illness.

Other studies also cite resourcing and effective implementation as enablers of effective clinical suicide care pathways in practice. For example:

- In the roll out of a collaborative care program for depression across New York, clinics that invested in staffing, resourcing and related structural reform were more like to sustain the program and have better long-term outcomes than those that did not. Moise et al. (2018) to conclude that ‘patient and provider engagement and care manager resources are critical factors to ensuring sustainability’.
- More broadly, many studies point the usefulness of implementation science to promote the systematic uptake and efficient translation of evidence-based suicide prevention initiative into practice and policy (Moise et al. 2018 and Reifels et al. 2022).

The literature also raises potential challenges to efficacy of suicide care pathways. Atkinson et al. (2019) find the efficacy of mental health service pathways, including delivery of low and moderate intensity services, relies on capacity being available within those parts of the system. Efficacy could be challenged by lack of capacity downstream to provide care or accept incoming referrals. Similarly, it is to be expected that increased demand or over-worked staff within ED and hospitals would reduce fidelity to the suicide care pathway (for example, lower completion of safety plans and/or follow-up), particularly if the health system is not able to adapt to these circumstances.

3.4.1 Gaps in the evidence

To date there have been very few rigorous evaluations of suicide care pathways, particularly compared to the strong evidence for and utilisation of pathways for chronic disease and other medical issues. There is also limited research that identifies which components of a suicide care pathway are most important to effective care¹¹.

3.4.2 Discussion of key findings

From a provider perspective, culture, leadership, training and resourcing are critical elements of effective implementation of suicide care pathways in practice.

Preliminary evidence shows that *how* the components of care are delivered matters. For example, establishing trust and connection in the delivery of care to a person who is suicidal or has self-harmed is important. Where practical, therefore, all staff should be trained so that they are competent at conducting comprehensive suicide risk assessments (and do not rely on screening tools alone).

Trust and connection are foundational aspects of a peer worker’s role, and peer support may be able to supplement and/or support clinical care when it is constrained by resources, availability or location. To support the peer-workforce, ideally guidelines on clinical care pathways will be complemented by guidelines for non-clinical workers and promote integration between clinical and non-clinical care.

But there is a need for ongoing evaluation and monitoring to determine the efficacy of suicide care pathways. Further research and evaluation of suicide care pathways should be supported and/or commissioned. Evaluation would be supported by standardised individual-level data on interactions along suicide care pathways, collected on individuals’ electronic medical records (e.g. data on completed safety plans, other services received from clinical and non-clinical staff, post-discharge follow-up timing and mode).

¹¹ Noting that many components of care pathways (such as screening, assessment, safety planning, lethal means restriction, and transition planning) each independently have evidence.

3.5 How does the current evidence advance our understanding of best practice for different populations who are placed on suicide care pathways?

3.5.1 Gaps in the evidence

We did not find any studies explicitly examining the effectiveness of suicide care pathways for priority populations including Aboriginal and Torres Strait Islander people, LGBTIQ+ people and older people.

3.5.2 Discussion of key findings

These material gaps highlight the need for more rigorous evaluations of suicide care pathways and how they need to be adapted to deliver compassionate, helpful and effective care to different priority populations.

The limited available evidence on factors that need to be considered in the clinical care of people who may be suicidal within priority populations are summarised below. Note this evidence is insufficient to support clinical recommendations and/or guidelines and is only included to highlight different factors which need to be considered.

3.5.2.1 Young people

There are some suicide prevention frameworks and pathways that have been adapted specifically for children, including in Australia¹². However, evidence on the effectiveness of alternative interventions for young people is still emerging. For example, the evidence on psychosocial interventions in children and adolescents who self-harm is uncertain (Witt et al. 2021).

There are, however, known barriers to implementing intervention strategies and facilitating engagement between young people and mental health services, including:

- Young people cite a preference for self-management as a major obstacle to help-seeking for self-harm from clinical services (Czyz et al. 2013)
- However, evidence also suggests that the more self-reliant a young person is, the higher their level of risk (Cleary et al. 2019)
- Young people are often reluctant to identify themselves as being at risk and service providers may be limited by a lack of youth specific specialist mental health care (Cleary et al. 2019)
- Stigma and negative beliefs (including family beliefs) towards mental health services and professionals (Velasco et al. 2020).

Care should be designed with these barriers in mind. For example, interventions could support young peoples' desire for self-management¹³ of problems by providing access to self-guided websites or apps with varying levels of involvement from mental health professionals, depending on readiness to engage (Czyz et al. 2013). More generally, care that employs digital support options complimentary to face-to-face treatment (e.g. self-guided websites or apps) has been shown to be effective in addressing suicidal thoughts and/or symptoms of mental health conditions (Black Dog 2020).

¹² See for example [Generation Zero Suicide, Children's Hospital of Philadelphia](#)

¹³ Self-management can be defined as taking responsibility for personal wellbeing and behaviour. For example, using unguided self-help interventions (Bennett et al., 2019).

3.5.2.2 Older people

Suicide care should consider the systemic differences in healthcare utilisation by older people. More specifically, McKay et al. (2021) note that suicide care for older people should consider:

- For older people, most mental healthcare is delivered outside of specialist mental health services. Within state-funded hospitals, mental health-related admissions and community contacts reduce markedly with age in specialist mental health settings but increase in non-specialised settings (such as General Practitioners (GPs)) and to Emergency Departments. However, older people have very low use of Medicare-funded psychological services.
- Physical conditions and disability are major modifiable contributors to suicide for older people.
- Facilitation of engagement in meaningful activities and reducing social isolation is important and provides an opportunity for risk identification.

A recent systematic review (Laflamme et al. 2022) found that primary-care-based collaborative management was associated with reduced self-harm (composite measure of suicide attempt and suicide ideation) and reduced suicidal ideation in older people. This finding could be because older people often have physical and mental health symptoms or conditions that need to be addressed, which are optimally addressed and treated in a collaborative, holistic team approach.

These findings highlight a need for GPs and other staff outside of specialist mental health services to be well prepared and trained to recognise and respond to suicide risk. In addition, physical conditions, disability and/or social isolation need to be addressed in a treatment plan if they are relevant factors for an older person.

3.5.2.3 LGBTIQ+ people

LGBTIQ+ people have a higher risk of suicidal behaviour than their peers. Yet very little is known about the different treatment needs, preferences, and best practice suicide care pathways for LGBTIQ+ persons. Reporting by LGBTIQ+ Health Australia (2021) highlights that:

- Compared to the general population, LGBTIQ+ people are more likely to attempt suicide, have thoughts of suicide, have engaged in self-harm in their lifetime, or experience and be diagnosed with a mental health condition. The extent of this differs between sub-groups within the LGBTIQ+ population.
- A third of LGBTIQ+ people aged 16 to 27 who had not used a crisis support service during their most recent personal or mental health crisis indicated that their decision was due to anticipated discrimination.

The NSW LGBTIQ+ Health Strategy 2022-2027 proposes the need for suicide prevention initiatives to be informed by people with lived experience of mental and emotional distress and targeted towards the entire community. It also aims for awareness of and access to inclusive mental health services to increase.

3.5.2.4 Aboriginal and Torres Strait Island people

Aboriginal and Torres Strait Islander people view health in the context of a holistic, collective, social and emotional wellbeing (SEWB) model of community healing (Dudgeon et al. 2021a). It is therefore critical to consider the complex interplay of social, political and historical forces, as well as individual circumstances, that contribute to Aboriginal and Torres Strait Islander suicidal behaviour (Dudgeon et al., 2022; Hunter and Harvey, 2002). In many cases these inequities are compounded by ongoing experiences of discrimination and racism across the healthcare system (Lavery et al., 2017). It is hardly surprising then that clinical mental health services are often experienced by Aboriginal and Torres Strait Islander people as unhelpful and inappropriate (Dudgeon et al., 2014).

Best practice approaches to suicide care for Aboriginal and Torres Strait Islander people were explored in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). ATSISPEP (2016) focussed on Indigenous community-led suicide prevention and was based on:

- Twelve Indigenous community, risk group and subject-matter-specific suicide prevention Roundtable Consultations that took place across Australia over March 2015 – April 2016
- A literature review on what works in community-led Indigenous suicide prevention
- An analysis of 69 previous consultations on Indigenous suicide prevention that took place across Australia between the years 2009 and 2015, and that involved 1,823 participants
- Plus analysis of other credible and relevant sources, including the Access to Allied Psychological Services (ATAPS) Operational Guidelines for Indigenous Suicide Prevention Services, and state and territory general population suicide prevention strategies.

A potential set of success factors was identified from the above activities. For individuals challenged by suicide ideation, or who have recently attempted suicide, preventative interventions are required. ATSISPEP (2016) notes that the following features of care are critical:

- Clinical mental health services delivered in culturally safe service environments with access to Indigenous and/or culturally competent non-Indigenous staff
- Availability 24 hours a day, 7 days a week, and in a timely manner.

In addition, a common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This ensures cultural and ‘lived experience’ considerations are reflected in care, but also empowers communities, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time (ATSISPEP 2016).

The following table outlines other success factors for Indigenous suicide prevention, with those identified in the meta-evaluation of evaluated community-led Indigenous suicide prevention programs in blue font.

Table 1: Subset of the recommended features of suicide care for Aboriginal people in ATSISPEP (2016)

INDICATED – AT RISK INDIVIDUALS	Clinical elements	<ul style="list-style-type: none"> • Access to counsellors/mental health support • 24/7 availability • Awareness of critical risk periods and responsiveness at those times • Crisis response teams after a suicide/postvention • Continuing care/assertive outreach post ED after a suicide attempt • Clear referral pathways • Time protocols • High quality and culturally appropriate treatments • Cultural competence of staff/mandatory training requirements
	Community leadership/cultural framework	<ul style="list-style-type: none"> • Community empowerment, development, ownership – community-specific responses • Involvement of Elders • Cultural framework
COMMON ELEMENTS	Provider	<ul style="list-style-type: none"> • Partnerships with community organisations and ACCHS • Employment of community members/peer workforce • Indicators for evaluation • Cross-agency collaboration • Data collections • Dissemination of learnings

Note: the recommended features of suicide care identified in the meta-evaluation of evaluated community-led Indigenous suicide prevention programs in blue font (ATSISPEP 2016).

Leckning et al (2020) used the Delphi method to derive a set of over 200 endorsed statements which informed the development of a set of underlying principles of culturally competent practice and recommendations for processes of effective and appropriate engagement; risks, needs and strengths to be assessed; formulation of psychosocial assessment; and recommendations specific to children and young people. The recommendations cover all aspects of clinical practice relevant to psychosocial assessment in the context of evaluating self-harm and suicidal thoughts by Aboriginal and Torres Strait Islander people. The guidelines are based on recommended principles including:

- Culturally competent practice relevant to making psychosocial assessment more responsive to the cultural needs and strengths of patients
- Strategies relating to interpersonal and communication skills (to ensure more effective and appropriate engagement of Aboriginal and Torres Strait Islander people during the assessment process)
- That a comprehensive set of risks, strengths and needs to be considered during assessment – as this informs more culturally appropriate clinical formulation.

3.5.2.5 Intersectionality

These priority populations also need to be considered together, as many people belong to one or more of the groups and this intersectionality can lead to different needs and experiences within healthcare.

For example, Uink et al. (2020) note that emerging literature has begun to identify that for people who are both Aboriginal and Torres Strait Islander and LGBTIQ+, suicidality is a primary health concern, consistent with research into these groups separately. However, they also identify that there is a set of health-related concerns which are unique to being Aboriginal and Torres Strait Islander and LGBTIQ+. Aboriginal LGBTIQ+ people may need to negotiate ‘added layers of identity’ when presenting at services, and for workers too, there is a juggling of competing priorities in determining what should be at the centre of a person’s care (Hill et al. 2022). There have been calls to adopt ‘affirming’ care models in practice that recognise and respond to the diversity of gender and sexual orientations of Aboriginal and/or Torres Strait Islander people seeking support and who are LGBTIQ+ (Hill et al. 2021). More research is needed, however, to understand the needs of this group in relation to their specific risk for suicide (Dudgeon et al. 2015) and to evaluate the outcomes of applying an intersectional approach in healthcare (Uink et al. 2020).

As noted above, there is a lack of rigorous evidence on how to adapt suicide care pathways for priority groups, including those who belong to multiple groups. Some adaptations of clinical care pathways, however, may benefit multiple groups. For example, digital mental health services and tools may be used to support and complement traditional face-to-face treatments, which can strengthen the relationship between patient and healthcare professional (Black Dog 2020). This may be appropriate for groups who indicate a desire for self-management, such as young people, or for those with less access to in-person services, such as people living in remote areas.

3.6 What is the evidence for alternative post-discharge follow-up protocols, including alternative time frames and modalities?

The risk of repeated self-harm or suicide attempts following discharge for self-harm or attempted suicide is substantially increased in the days, weeks and months following a suicide attempt (Goldman-Mellor et al. 2019; Luxton et al. 2013). This reinforces the need for post-discharge follow-up and care after a suicide attempt.

Post discharge follow-up varies in modality and frequency, and a variety of protocols have been found to reduce the incidence of repeat self-harm or suicide attempts (Shand et al. 2019; Inagaki 2019). Additionally, participants engaging with post discharge care in Australia have reported improved subjective wellbeing (Williamson et al. 2020; Nous Group 2021) and a reduction in ED presentations for any reason (Wright et al. 2021).

Although a range of protocols of different frequencies and modalities have been found to be effective, there is a lack of research (including a lack of RCTs) exploring which features of post-discharge care are most effective (Shand et al. 2019; Luxton et al. 2013). Additionally, not all aftercare services are effective. For example:

- Brief contact interventions (supportive messages sent via postcard, text message, or letter) do not offer therapy and may reduce the incident rate of repeat suicide attempts or self-harm but do not reduce the proportion of people who have a suicide attempt (Shand et al. 2019)
- One assessment of an implementation of The Way Back service found no impact on readmission rates. The authors note this may be because of a lack of consumer engagement with the service after discharge despite a proactive engagement process (where people were met in hospital before discharge), and a potential lack of access to clinical evidence-based treatments (McGill et al. 2022).

On the other hand, the Nous mid-term evaluation of The Way Back (2021) showed a significant reduction in psychological distress and suicidal ideation and significant improvement in emotional wellbeing on average but did not assess the impact on readmissions. While the effectiveness of this aftercare service is still unclear, the interim evaluation found that trust and connection with support coordinators was the foundational mechanism that enacts change for participants (Nous 2021). Together these findings highlight the role of both non-clinical and clinical care in aftercare services.

The common elements of programs that have been found to be effective in available literature include:

- Trust and rapport with support coordinators (Nous Group 2021)
- Rapid follow-up with greater frequency in the first month post-discharge (Shand et al. 2019)
- A strong focus on therapeutic alliance, engagement, and continuity of care (Shand et al. 2019)
- Providing the first session face-to-face (where telephone follow-up is part of the service model) (Shand et al. 2019)
- Addressing a wide range of psychosocial needs, involvement of a support person and integration with clinical care (Shand et al. 2019; Nous Group 2021)
- Hospital liaisons and the relationships between providers and referrers (Nous Group 2021).

The most appropriate duration of care may differ between people. Many programs run for up to three months when the highest risk of readmission occurs, but there is some suggestion that care for longer than this may benefit some particular people (Shand et al. 2019; Wright et al. 2021).

Several organisations involved in the care of suicidal people have developed guidelines on the timing and modality of post-discharge follow-up. The frequency and modality of a range of aftercare services are detailed in Table 2.

Table 2 – Frequency and modality of follow-up procedures

Organisation	Follow-up procedure
The Black Dog Institute – Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute settings (2017)	<ul style="list-style-type: none"> ▪ Check progress of discharge plan and engagement with services ▪ Telephone reminders of appointments ▪ Assertive follow-up for priority populations, with first contact within 24 hours. This should involve more frequent contact, home-visits, intensive case management and out-reach support.
Beyond Blue – The Way Back (2020)	<p>The Way Back service in Australia, a targeted minimalist standardised post-discharge pathway that rapidly returns most people to primary care and/or non-clinical care pathways.</p> <ul style="list-style-type: none"> ▪ Care available for up to three months

Organisation	Follow-up procedure
National Action Alliance for Suicide Prevention – USA (2019)	<ul style="list-style-type: none"> ▪ Frequency should be determined based on interaction with the client and their needs ▪ Primarily face-to-face, or via telephone or messaging services where the client prefers this or face-to-face is not possible. ▪ Call within 24 hours of discharge to check on recovery ▪ Ongoing caring contacts (via text, card, email), with the first occurring within seven days of discharge and continuing for 12 months or more ▪ Assertive and persistent follow-up on missed appointments <ul style="list-style-type: none"> – Firstly, via telephone, personal contact, mobile crisis outreach team – Then via the patient’s emergency contacts – Finally, via emergency welfare checks by first responders when available information indicates highly acute and potentially imminent risk for suicide.
Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework (Turner et al. 2021)	<ul style="list-style-type: none"> ▪ Patients given an appointment date and time for their follow-up within 48 hours, prior to leaving the ED ▪ Staff were provided a framework to support follow-up care in the community, spanning these steps: <ul style="list-style-type: none"> – Mood check and assessment of current suicidality – Review and revision of the safety plan – Creation or updating of a care plan – Ensuring communication with carers, family and other health professionals – Identification of other agencies required, and referral – Agreement on a plan and next appointment as well as identification of any barriers to treatment. ▪ The principle of ‘warm handovers’ was emphasised, where the consumer would ideally have had their first appointment with the next health provider prior to closure from the Gold Coast Mental Health Service.
Stanley-Brown (2018)	<p>This study shows Safety Planning plus post-discharge telephone follow-up (at least two calls) was effective at reducing repeat suicidal behaviour.</p> <ul style="list-style-type: none"> ▪ The Safety Plan combined evidence-based strategies to reduce suicidal behaviour through a prioritized list of coping skills and strategies. ▪ In telephone follow-up, patients were contacted at least 2 times to monitor suicide risk, review and revise the Safety Plan, and support treatment engagement. First contact was attempted within 72 hours of discharge.

Organisation	Follow-up procedure
	<ul style="list-style-type: none"> ▪ Calls continued weekly until the patient began treatment or withdrew from the program.

Further to these guidelines, the Black Dog Institute (2017) includes a set of characteristics of people who require more assertive follow-up. This includes people:

- With a suspected diagnosed mental illness
- At risk of becoming homeless
- In situation of domestic violence
- Who cannot be sure they can keep themselves safe
- Presenting for suicide risk for the first time
- With a poor history of treatment adherence.

These factors consider how at risk a person is upon discharge. They fit broadly into the categories used for risk formulation in the SafeSide framework (Pisani et al. 2016). That is, they consider if a person either has low available resources, or high foreseeable changes.

Finally, it is well known that many patients drop out of outpatient mental healthcare after only a few appointments before they receive minimally adequate care (Fernández et al. 2020). This highlights a need for those referring in to and providing aftercare to focus efforts on keeping people in aftercare, for example via warm transitions, education, building and maintaining rapport, and transparency.

3.6.1 Gaps in the evidence

Most of the robust research on aftercare has focused on its efficacy overall and not on which elements work best. However, a wide range of programs has been assessed, with many found to be effective. There are clear common elements amongst those that been successful, and these can inform best practice, as summarised below.

3.6.2 Discussion of key findings

There is a lack of high-quality evidence on what elements of aftercare are most effective. Programs involving a range of modalities have been successful. Person-centred, clinically integrated care consistently appears as an element of successful aftercare. But not all aftercare services are effective. Brief contact therapy is not effective alone.

A range of timeframes are being used in aftercare services, with greater follow-up in the first month post discharge and rapid follow-up within 24 hours to 72 hours of discharge appearing most commonly. There is a lack of high-quality evidence on how the timeframe of initial follow-up impacts consumer outcomes.

More research and evaluations are needed to ensure aftercare services are effective and understand what works best.

In the absence of strong evidence to set time protocols for aftercare, providers could aim to follow-up and connect people to aftercare as soon as reasonably possible following discharge. Services should also consider how to prioritise those who require more assertive follow-up. Black Dog (2017) find this includes people:

- With a suspected or diagnosed mental illness
- At risk of becoming homeless
- In situation of domestic violence
- Who cannot be sure they can keep themselves safe after discharge

- Presenting for suicide risk for the first time
- With a poor history of treatment adherence.

Finally, as many people drop out of aftercare, providers should maintain a strong focus on keeping people in aftercare until they have received adequate care.

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