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RESEARCH ARTICLE

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A qualitative study of multiple voices to inform aftercare services for older persons following self-harm

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Abstract

Objectives: Self-harm and suicide are closely related in older adults, highlighting the opportunity for Aftercare interventions in targeted suicide prevention. The study aims were to explore strengths and shortfalls of current Aftercare services for older adults from the perspective of key stakeholders and researchers; and inform a set of guiding principles for older persons' Aftercare.

Methods: Semi-structured interviews were undertaken with a convenience sample of older people with lived experience of self-harm, clinicians and suicide researchers (n = 22). Interviews were focussed on current practice (strengths and limitations), potential improvements, and identifying the core components of an acceptable Aftercare model. Interviews were audio-recorded, transcribed and subjected to a reflexive thematic analysis grounded in interpretive description.

Results: Current practice strengths included validation, a person-centred approach and optimising aftercare delivery. Limitations included ageism, practical limitations (lack of service awareness, fragmented service provision, barriers to access, and traumatising approaches), and limited services, funding and training. Overarching themes included anti-ageism; anti-stigma; empowerment and agency; conveying hope; patience and pace; accessible; and finding purpose: connections and meaningful activity.

Conclusions: Older people who have self-harmed have complex, individualised needs. They sit within intersecting systems traversing healthcare, support services, family, and the social environment. Systemic, coordinated Aftercare founded upon core principles of anti-ageism, anti-stigma, partnership, empowerment, accessibility and provision of connections and meaning are needed.

KEYWORDS
aged, improvement, prevention, self-harm, suicide

Key points

- Older people who have self-harmed need a dedicated, evidence-based approach to Aftercare.
- Key stakeholders and researchers value Aftercare which is person-centred, validating, and optimises service delivery.
- Identified limitations of current Aftercare services include ageism, practical limitations, and limited services, funding and training.
- The derived core principles for Aftercare include anti-ageism, anti-stigma, empowerment and agency, conveying hope, patience and pace, accessibility and finding purpose.

1 | INTRODUCTION

Older adults, particularly men over 85 years, have the highest rates of suicide across the lifespan in many countries.[1,2] Yet this is not well publicised and there are relatively few interventions targeting older adults for suicide prevention,[3] of which Aftercare is a core component. Aftercare, the coordinated follow-up and management following self-harm or attempted suicide,[4] has been associated with reduced risk of repeat suicidal behaviours.[5,6] There is a close relationship between self-harm and suicide in older adults. Therefore, in this paper Aftercare refers to care following self-harm of any intent, including suicide attempts.

A recent systematic review revealed few empirical studies evaluating Aftercare interventions for older adults of mostly low levels of evidence.[7] Most effective Aftercare interventions were older-adult specific and adopted a multifaceted, assertive follow-up approach accompanied by systemic change. The review highlighted gaps in the Aftercare literature and opportunities for dedicated older-adult research, including a need for qualitative research with older adults, their families, and clinicians, to understand why Aftercare interventions do or do not work.[7,8] Qualitative research can provide insight into how clinical interventions are experienced or work in the real world and how various systems and services interact.[8,9] It examines the nuances of clinical interactions and explores meaning with those directly involved.[9] Such knowledge is essential to informing evidence-based interventions for older persons' Aftercare with the ultimate aim of preventing suicide.[10]

Too often, older people and other crucial stakeholders are told what is best for them in relation to service provision. However, these stakeholders hold rich experiential knowledge of user needs. A variety of perspectives must be considered regarding Aftercare for older adults, including key stakeholders: that is, older people with lived experience of self-harm, their carers, clinicians across healthcare settings (e.g., emergency care, primary care, specialist services), and researchers (describing and evaluating new initiatives for Aftercare). Accordingly, this study aimed to (i) qualitatively examine current strengths and shortfalls of Aftercare for older adults from these different perspectives; and (ii) use these insights to inform a set of guiding principles for older persons' Aftercare.

2 | MATERIALS AND METHODS

2.1 | Sample

The study was conducted in New South Wales (NSW), Australia. Key stakeholders relevant to Aftercare of older people were identified; older people with lived experience of self-harm, Older Peoples' Mental Health Clinicians, General Practitioners (GPs), and Emergency Department (ED) clinicians. Researchers implementing initiatives for suicide Aftercare were also included to provide perspectives on how older adults are considered (or not) and related strengths and shortfalls in emerging approaches to implementation of Aftercare initiatives, given the implications for translation to clinical contexts.

Relevant organisations or team clinical leads were asked to introduce the study to their members/professional group via email invitation. Anyone interested was encouraged to contact the research team. There was no limitation on the number of participants. Participants were offered an individual or group interview with common stakeholders, according to preference given the sensitive nature of inquiry. We approached a national organisation of people with lived experience of suicide (Roses in the Ocean) regarding recruiting older people with lived experience of suicide. They utilised their network to contact members who were of the target age group and provided mentors (peer support) for their participating members. Mentors provided dedicated support for older adult participants before and after their participation in the interview to anticipate and address any emergent distress.

2.2 | Procedures

Interviews were conducted via videoconferencing by the same facilitator (RB) between August-September 2021. Two semi-structured interview guides were used; one for key stakeholders (clinicians and people with lived experience), and one for researchers, reflecting different contexts. These were informed by the study aims, our systematic review of older persons' Aftercare interventions following self-harm[7] and our previous qualitative research on late life self-harm.[11–13] Topics covered included the

parameters of Aftercare, lived experience of Aftercare and identified strengths and weaknesses, and suggestions for improvement and training. Researchers were asked about the inclusion of older adults in their initiatives (in co-design or as participants), older adult feedback, and suggestions for improvement and training. Given the sensitive topics for discussion, additional ethical safeguards were implemented. Participants could choose not to respond to questions or to take breaks (but did not elect to). The interviewer (RB) reminded participants of avenues for support in the case of any emergent distress. The two senior psychiatrist clinician researchers (AW, CP) were available if needed. The project manager (TJ) provided contact details for follow-up questions or concerns. Interviews were audio recorded and transcribed. Simple demographic data were recorded for each participant (i.e., stakeholder group or researcher and gender).

The study was funded by the Mental Health Branch of the NSW Ministry of Health to develop a model of Aftercare Service Delivery.[14] Capacity Australia provided additional funding for the research. Ethical approval was given by the University NSW Human Research Ethics Committee (HC220094).

2.3 | Data analysis

Transcript data were analysed using reflexive thematic analysis,[15] grounded within an interpretive description framework[16–18] (Box 1). Interpretive description keeps the generation of clinically- and practice-relevant knowledge at the centre of analysis, utilising practical knowledge to guide service design rather than generating primarily theoretical contributions.[19,20] Given the study focus on informing components of good quality Aftercare, this practice-oriented approach was considered most appropriate for framing the thematic analysis.

3 | RESULTS

Individual (n = 6) and group interviews (n = 6) were conducted (duration 30–60 min). The 22 participants included older people with lived experience (4), Older Peoples' Mental Health clinicians (hereafter termed Mental Health Clinician) (5), GPs (3), ED clinicians (3), and suicide prevention researchers (7).

BOX 1 Data analysis and methodological rigour

Detailed data analysis

The study sample size was determined by the number of interested participants rather than saturation of themes. Data were collected, included and analysed in the same way for all stakeholder groups.

Transcript data were cleaned and de-identified and codes were attributed to each participant. Data were then uploaded to NVivo 12 as individual transcripts. The primary coder (AK) read and re-read transcripts and coded them line-by-line, iteratively revising themes as subsequent transcripts were analysed. A primarily inductive approach was taken to coding themes, acknowledging that meaning arises from the interaction between coder and text. Analytic categories and predominantly semantic themes were initially generated, to stay close to the experiences described by the participants. Categories were created to respond to each discussion point. Semantic codes were coded as a means of grouping congruent experiences described in the data, and these groupings were refined using the process of constant comparison between codes and data while examining more latent themes.[15]

Methodological rigour

(i) Reflexivity

AW (study lead), CP, (senior co-investigator) (both old age psychiatrists), AK (primary coder, clinical psychologist), RB (facilitator, occupational therapist and provisional psychologist) are clinicians, while TJ (Project Coordinator) is a senior research scientist and academic, all with experience in older persons' mental health. While having commonalities in expertise, the wide variety of work settings, professional backgrounds and experience of the researchers enhanced the capacity for reflexivity, which included considering the funding mandate to develop a pragmatic service model while still capturing the voice of participants. Such reflexivity was facilitated by documentation of observations and reflections during and after interviews, and upon coding and thematic analysis.[16,18] The clinical expertise of the interviewer (RB) enabled sensitive and empathetic facilitation of discussion of the sensitive subject matter (suicide Aftercare), while acknowledging potential power imbalances between researcher and participant, and provided a direct link to supports when needed.

(ii) Member checking

AK was the primary coder, however emerging codes were checked and compared with the experiences of the interviewer (RB) and the project coordinator (TJ), and the other investigators to ensure all reflections and feedback were incorporated into the coding structure in a process of member checking. Any disagreements in coding were discussed with all authors until consensus was reached.

Emergent themes are presented in relation to strengths and limitations of current Aftercare approaches for older people from a collective thematic analysis of all interview transcripts (i.e., all viewpoints considered together), with discrete analysis of each stakeholder group and the researchers precluded by small numbers. Notwithstanding this, where commonalities did emerge (e.g., traumatising responses in Aftercare), they are noted.

3.1 | Strengths of current provision of aftercare for older adults

Three broad themes emerged regarding strengths of current Aftercare for older adults, namely (i) validating and hearing the person; (ii) person-centred Aftercare; and (iii) optimising Aftercare delivery.

3.1.1 | Validating and hearing the person

Participants outlined the core desired components of engagement with older people following self-harm as listening and validation.

> Often all you need is to be listened to and validated that your feelings are right, that it's okay to have the feelings you've got and then to ask, "Is there something else that we can do for you?" and to listen to what the answer might be. **AC06 (F, Lived Experience**)

Implicit in validation and empowerment is assisting the person to identify strengths:

> …things that have changed my life was someone who worked with me…. They saw some things in me that were good, tried to exaggerate and help me to see those things, encouraged me around the things that I was strong in … to help them build up self-esteem. That's one thing the psychologist did for me. **AC01 (F, Lived Experience**)

3.1.2 | Individualised person-centred care

Individualised person-centred care comprised comprehensive initial assessment for 'good fit' care; holistic care; personalised safety plans; matched therapy; and follow-up with reassessment. The key to 'good fit' individualised Aftercare plans were those informed by initial comprehensive assessments which established the older person's background, supports, and context of the crisis to enable identification of specific risk factors to be targeted and goals developed.

> … doing a thorough assessment; not just on risk but their whole lifestyle and how they live and what supports they have. [Assessing] the precipitant before the attempt, whether that situation is still the same or has it changed or what we need to do in order to ensure minimal risk. Getting other people involved if possible; family, GPs, other services; psychologists…. Making goals with the person. **AC08 (F, Mental Health Clinician)**

Allocating Aftercare support services to match the older person's experience, engagement style and specific needs/goals were valued. Accordingly, Aftercare needs to have a broader focus beyond mental health:

> We think about the person, their physical health, their mental health, their social health, the context that they're in. **AC10 (F, Mental Health Clinician)**

> It [Aftercare] would be around reconnecting into community groups or the cohort that I've worked with is significantly isolated after the death of the long-term spouse or estranged from family and friends for various reasons. **AC02 (F, Researcher**)

Participants appreciated health professionals assisting them to develop insight into their self-harm and become empowered to recognise their own warning signs.

> A psychiatrist … helped me a lot by giving me a little [safety planning] program of six things to think about… I know when I'm in bad shape because I hide in my room. I know when I'm getting better, when I start to think about going out and chatting to somebody. … So there's six stages and if I keep those in mind, I know where I am, and that I need to change something… **AC04 (F, Lived Experience**)

A variety of treatment interventions were highlighted as useful components of Aftercare, including group/day programs, telehealth psychology and acceptance and commitment therapy, according to consumer preference. For example, identified benefits of group therapy included trusting others with similar experience and teaching coping skills while building social connections.

> They headed me in a direction of acceptance and commitment therapy…. I went through their standard course which was 10 weeks or so. Then I joined a group that was a year-long and it was the most fantastic thing……. Since then, I've had a relapse… and I've continued on with ACT treatment and I haven't had a readmission in six years. **AC05 (M, Lived Experience**)

Participants acknowledged the potential for telehealth to overcome physical barriers to accessing Aftercare relevant for some older

adults, although the need to retain in-person options was raised for those uncomfortable with or unable to access online technology.

> I lived [in a remote area], and I was very depressed… I had a psychologist on the phone every day… until I was able to get to town to get some physical help… I was teetering on the edge and instead of four sessions, she spoke to me every day for a week until I was able to get some help [in person]. **AC01 (F, Lived Experience**)

An approach to Aftercare which involves follow-up and reassessment, which is dynamic and responsive to the older person's individual changing needs and goals, was promoted:

> …reassessing, upgrading, downgrading, depending on the risk and what we have before us, and …eventually working towards getting them to a point that they're back on track… sort of slow and steady process; always checking in with the client. **AC08 (F, Mental Health Clinician)**

> I think the aftercare is also about working with the client and their goals to sort of rebuild. **AC08 (F, Mental Health Clinician)**

3.1.3 | Delivery of aftercare

Strengths of Aftercare delivery included crisis stabilisation facilities away from ED, going to the person, primary care access points, and care coordinators. Various preferred alternatives to ED for suicidal crises in adults of all ages were suggested. Although not specifically evaluated for older adults, the perceived possible advantages of these alternatives to ED were a homely, non-threatening environment and calm and comfortable space.

> [ED] is sometimes a complex environment, just from a sensory point of view from a frailty point of view. It's a loud, busy, bustling and possibly confusing environment… diversion away from ED to things like crisis stabilisation facilities might be a massive positive step to having people go to a place that's comfortable for them and may feel it's safer sometimes. **AC18 (F, Researcher)**

Participants highlighted the value of Aftercare being delivered in the older person's home, allowing for more holistic assessment of their environment. It was also seen as facilitating access to care and providing holding, support and demonstrating the older person's value (that services would come to them).

> Just someone going to the person, no expectation that [the client] have to go and be somewhere or use some type of technology or something to fit into the service, [instead] making the service suit them. **AC10 (F, Mental Health Clinician)**

General Practitioners were referred to as a reliable, central connection points for older people, especially for those with long-standing relationships. Accordingly, the GP can tailor appropriate supports or referrals that might need to be made:

> I was very lucky. … I had the same GP for almost 20 years …. he was the first to see there was something wrong with me. I went to see him about a sore foot or something and he goes, "Are you okay? You're not your normal cheeky self. Let's make another appointment and have a chat" and then I finally opened up to him, "I can't get out of bed in the morning. I don't go to work. I'm picking fights with people that I never used to" and he said, "Right. I have a friend who's a psychiatrist." He had confidence in him and said, "It's someone I trust" so I trusted him because of that. **AC05 (M, Lived Experience**)

General Practitioners also play important roles in ensuring ongoing care, support, and adherence to therapy:

> So the follow-up can start from the hospital and then of course the GP as well with counselling the patient, seeing the patient regularly, monitoring him… **AC21 (F, GP)**

A support coordinator was identified as beneficial to provide a central point of contact and liaison for the older person's Aftercare. Such a role would facilitate connections between the intersecting services and health systems an older person may need and reduce the likelihood of re-traumatisation for the older person by not having to repeat their history to multiple care providers.

> …having that one support coordinator that [the older person] will work with who will liaise with everyone on their behalf really helps with not having to share their story as many times and repeat the same information. **AC03 (F, Researcher**)

3.2 | Limitations in provision of aftercare for older adults

Current Aftercare service limitations related to ageism, practical limitations, and limited services, funding and training.

3.2.1 | Ageism

Ageism manifested as a barrier to Aftercare provision in multiple ways. These included the neglect and invisibility of suicide in older people, with limited public awareness and consequently inadequate focus on prevention.

> Suicidal thoughts […] what would that look like for an older person? […] it's something that you just don't see or hear about. It's not in the media. **AC13 (F, Researcher)**

Ageism also manifested in the downplaying of the seriousness of self-harm in older people, and dismissal of mental illness as normative:

> There's this general ageism in our society that it's okay for older people to be depressed and anxious, and that that's a natural part of aging and, "Oh, well, you know, if you were 90 you'd probably want to die too"…. that's really harmful. **AC08 (F, Mental Health Clinician)**

Additionally, researchers identified that older people with lived experience of suicide may not be included in planning Aftercare services, quality assurance evaluations or research, although their contributions are important.

> Throughout my whole work here at the PHN [Primary Health Network] around mental health, you hardly ever see representation of older adults in any lived experience forum. **AC13 (F, Researcher)**

> If you've never felt that bad that it just wasn't worth living anymore, it is really hard to connect… Lived experience is important. **AC01 (F, Lived Experience**)

Finally, ageism was manifest through the lack of dedicated training, and specialised positions, for working with older people. This was acknowledged as a failure to privilege the experiences of older people as specialised knowledge.

> …upskilling the service providers that look after the older adult cohort. Even the podiatrist or the dietician, for all those professions to have that basic level of insight into older person's mental health and how it might present and what they potentially could deliver within their own service provision… being able to recognise someone's struggles or even provide the basic support for that person… that could potentially already have a high therapeutic value. **AC13 (F, Researcher)**

> And they actually were trying to source specific training… if they're presented with someone who appears to be in a suicidal crisis…something very specific for that older demographic, and to my knowledge that there wasn't actually anything. **AC02 (F, Researcher**)

3.2.2 | Practical limitations

Practical limitations included a lack of service awareness, fragmented service provision, barriers to access, and traumatising approaches to Aftercare service delivery.

Participants spoke of gaps in their knowledge regarding services for older persons' Aftercare, and eligibility.

> No, I don't know the mental health telephone number. **AC12 (F, GP)**

> I just know the support is there [but not how to access it]. **AC01 (F, Lived Experience)**

Service provision was experienced as fragmented, including the sense that older people were falling through service-imposed cracks and poor communication between services. Participants highlighted frustrating and -for the older person-invalidating 'turf wars' that exist in acute provision of older persons' Aftercare, especially for people with dementia. This lack of an integrated and person-centred approach to care resulted in delays and lack of continuity of care as well as missed opportunities to intervene effectively.

> My main issue is the people that have had such a long psych history. Then they get a new diagnosis of dementia and it seems like then they're in this no man's land then. And it's to-ing and fro-ing. That seems to be our biggest challenge…. **AC17 (F, ED)**

Age and accommodation setting were identified as barriers to accessing Aftercare services. Once aged over 65 some people may lose access to previously valued services, despite ongoing need. Older people residing in residential Aged Care facilities (RACF) were noted to be especially disadvantaged.

> The [aged care] residents can't see a private psychologist and get a Medicare rebate through the GP mental health plans which really disadvantages a lot of residents who might benefit. **AC09 (F, Mental Health Clinician)**

> So what I've noticed with some of the people that I work with that have had suicide attempts… and that

> are residing in aged care facilities…they don't have access to things like Suicide Call Back Service or Lifeline. It's not easily available for them to connect to those services unless they have mobile phones. **AC09 (F, Mental Health Clinician)**

General Practitioners noted an absence of established relationships with hospital-based healthcare professionals which led to superficial handovers in care transitions. Communication deficits were also noted in the flow of information from emergency or acute hospital care settings to GPs after self-harm.

> They say we're discharging this patient to your care and they send us a discharge summary… But in the process of the mental health treatment, we don't get any feedback or anything from them. **AC21 (F, GP)**

Various barriers to accessing services were identified. Just as facilitated access was identified as a strength, conversely, delays accessing appropriate support services at the crucial time were a weakness.

> There's often a ginormous gap between the assessment of need and when they're actually going to receive [the supports] ….. it can be significant in that Aftercare phase. **AC09 (F, Mental Health Clinician)**

> In an ideal world, wouldn't it be lovely to have somebody pick them up and take them home and settle them in …..make sure they're okay… once they've had that acute crisis?… But in reality… no one's contacting them for 24–48 hours and they're home alone. **AC17 (F, ED)**

Assumptions about technological proficiency were further barriers to access:

> It really is a form of discrimination because the more we become technologically dependent, the more we're discriminating, not just against older people but people with disabilities and people who are vulnerable and who may have some cognitive deficits. **AC01 (F, Lived Experience**)

Finally, various triage services were experienced as inconsistently helpful, despite mandates to centralise information.

> My Aged Care's very difficult to deal with…. But it's also about knowing what's on offer…. to some extent it depends on the knowledge and enthusiasm of the person on the other end of the phone. **AC07 (M, Mental Health Clinician)**

The approach to Aftercare service delivery could also be traumatic. Notably this emerged from thematic analysis of data derived from people with lived experience and researchers alike. Participants described traumatic experiences of frustration and disempowerment that the automatic response of acute care professionals responding to self-harm was often to enact involuntary hospitalisation due to perceived risk without first engaging the older person to understand their individual situation and existing supports.

> …if I ever mentioned to anyone that I was feeling suicidal or life was getting me down …. there would be knock on my door and the police would arrive. **AC05 (M, Lived Experience**)

There was a perception of clinicians from crisis services taking coercive approaches to 'cover themselves' rather than engage in therapeutic interventions to mitigate suicide risk.

> …there's an over-emphasis on supposed duty of care. Everyone is concerned if after they leave you, if you self-harm, they will be blamed… So the fact that they've entered my space means at the end of the day, they control me… I didn't think they had the right to do it… I was always worse after those incidents. **AC05 (M, Lived Experience)**

3.2.3 | Limited services, funding and training

Participants described service limitations, including Aftercare experiences that were lacking in holistic care, support for families, and much-needed male-specific interventions (e.g., men's sheds) given the higher rates of suicide in older men.

> [We need] phone support for family members to debrief or to ask questions, to have anything to look at what they might be able to do to support their loved one. **AC01 (F, Lived Experience**)

> The grief-stricken man sitting at home on his own, still in that dark tunnel, won't come out of it. I find men are a lot harder to help. **AC16 (F, ED)**

Workforce in this area was perceived as too few and poorly renumerated. Inadequate training across settings intersected with stigma about suicide:

> I think people are just afraid of asking those question if they're worried about someone, you know, "Oh, you seem like you're really withdrawn and you're really low. Are you feeling depressed? Are you feeling like

> you want to end your life?" I think people are afraid of words like suicide. **AC11 (F, Mental Health Clinician)**

Practical issues such as inadequate numbers of specialist clinicians limited provision of older peoples' Aftercare.

> The challenge for us is probably not enough staff. Staffing numbers in the community. They're really run off their feet… they need more funding. **AC16 (F, ED)**

Healthcare professionals are not remunerated for Aftercare work such as communicating with other clinicians; a barrier to sharing and coordinating care.

> The psychologist has to write to us after a few sessions and sometimes we have a telephone call…. If I'm worried about the person, I will ring the psychologist. She doesn't get paid for that. I don't get paid for that. **AC12 (F, GP)**

Combining the collective perspectives of these key stakeholders and researchers, a set of core principles was derived to guide older persons' Aftercare. The overarching themes for provision of Aftercare for older people included anti-ageism; anti-stigma; empowerment and agency; conveying hope; patience and pace; accessible; and finding purpose: connections and meaningful activity (Table 1).

4 | DISCUSSION

To the best of our knowledge, this is the first qualitative study exploring the perspectives of a broad range of key stakeholders and researchers regarding older adult Aftercare following self-harm. Emergent themes pertaining to strengths of current approaches included an approach to Aftercare that is person-centred, validating, and optimises delivery. Limitations included ageism, lack of service awareness, fragmented provision, barriers to access, limited services, traumatising approaches, funding shortfalls and gaps in workforce training. These themes informed development of guiding principles for older persons' Aftercare: anti-ageism; anti-stigma; empowerment and agency; conveying hope; patience and pace; accessible; and finding purpose through connections and meaningful activity.

The participant-identified strengths of current approaches to Aftercare align well with the literature regarding self-harm in older adults, which highlights the myriad individual reasons for self-harm and the need for sensitive responses.[21–23] Following self-harm, comprehensive assessment is essential, but the *process* is particularly important as this clinical encounter may be the first (and only) opportunity for engagement, with validation and listening highly valued by stakeholders. Indeed, other qualitative work suggests that perceptions of invalidation and rejection may underlie self-harm in older people.[11,12,21] Reflective listening may facilitate a personalised approach by highlighting needs identified by the older person him/herself, which can be matched to safety planning and intervention, rather than utilising checklist suicide screening tools to make safety plans.[24,25] Key stakeholders and researchers elaborated the benefits of 'good fit' care which is strengths-based, person-centred, holistic and links the older person with the right case manager, service and therapy, supporting previous findings.[2,7,26] Further, Aftercare services which stay involved, reassess and then respond flexibly to changes in the older person's needs, including type and intensity of follow-up were valued. Clinical guidelines for managing self-harm similarly concluded that a multifaceted, multilevel approach which incorporates the full spectrum of suicidal behaviours is needed for older adults.[27]

Participants highlighted the relevance of context and setting for Aftercare which encompassed a range of access points including crisis services, primary care, and mental health services. Both positive and negative experiences were described regarding access to, and the appropriateness of, emergency services following self-harm. While researchers noted the potential for crisis stabilisation facilities outside of ED, these have not yet been designed or tested with older adults. Home-based (in-reach) Aftercare services were preferred; although if home was a RACF, this was reportedly less likely, suggesting enhanced communication, service partnerships and staff education are needed. Aftercare care-coordinator roles were noted as beneficial in navigating across services and reducing the likelihood of re-traumatisation through repeating personal stories. Care navigators for suicide Aftercare have been proposed, with roles such as advocacy, facilitating linkage to services, and hopeful engagement with the older person to match care needs.[28]

Many of the themes regarding deficiencies in older persons' Aftercare have been raised before. Ageism was an especially pertinent barrier to delivery, which has been linked to suicide in older adults.[10,29] Stakeholders and researchers alike spoke of invisibility of older people in general, exemplified by the lack of awareness of suicide in older people (men, in particular) as a public health concern, the absence of older people with lived experience in service planning, deficits in training for all healthcare professionals about the specific needs of older adults,[30] and shortfalls in specialist services. Added to this was ageism in healthcare professionals manifest by dismissing mental illness in older people as 'normal' or 'understandable' and minimisation of the seriousness of older adult suicide attempts.[12,31,32]

Multiple limitations to accessing appropriate and responsive services were identified. Barriers included lack of awareness of services (such as mental health triage), sometimes arbitrary eligibility criteria based on age or type of residence (e.g., exclusion of RACF residents) rather than need, and rejecting those with complexity (e.g., co-morbid dementia). Provision of holistic Aftercare may be stymied by delays in accessing essential services such as home care packages, resulting in ongoing unmet need and, for some, premature admission to a RACF, both associated with self-harm.[12,33] Lack of standardised pathways for older adults

TABLE 1 Overarching themes for provision of Aftercare for older people

Theme	Description and elaboration
Anti-ageism	Ageist attitudes identified include that older people's lives are considered less valuable than younger people due to shorter life years remaining or perceived lesser contribution to society, the invisibility of older adult-specific needs and roles and their holistic nature and clinician dismissal of self-harm as 'less serious' (e.g., motivated by gaining attention or due to dementia-related processes). Other manifestations of ageism include relative absence of older people in service planning and few dedicated training opportunities and positions in older persons' health, all of which discount their lived experience. An ageist approach is discriminatory, undercuts the humanity and value of the older person, and likely leads to further isolation and trauma.
Anti-stigma	Multiple kinds of stigma exist in older persons' aftercare, including self-stigma, cultural stigma, and at the societal level. Public health messaging can help address invisibility, stigma, and ageism. Community and aftercare services should publicise and destigmatise mental health issues in older people, including openly and sensitively talking about suicide and self-harm and building clinician comfort asking about and discussing it. Clinician responses in aftercare need to be mindful that many older people fear they will be judged or treated punitively (including involuntary psychiatric admissions) when disclosing self-harm/suicidal ideation. Non-clinicians may feel burdened and uncertain with how to respond to suicidal disclosures from older people, necessitating development and promotion of clear pathways of referral.
Empowerment and agency	Agency, autonomy, and self-determination are key human rights. Aftercare services that support empowerment and the agency of the older person are valued and needed, aligned with holistic person-centred aftercare responsive to the persons' needs, will and preferences. A collaborative approach to assessment following self-harm/suicidal crisis and care provision may facilitate engagement and recovery. Involving people with lived experience back into the cycle of service provision must involve genuine partnerships in the development and evaluation of aftercare initiatives, at individual or group levels, thereby flattening the power differential.
Conveying hope	Instilling a sense of hope that things can change and improve is an essential element of aftercare services for older persons. This must be about more than safety, and facilitated by having clear, achievable goals identified collaboratively with the older person and following up with ongoing support. The identified gaps in clinician knowledge and skills regarding older adults may be addressed through education, training and facilitated access to specialist services (such as older peoples' mental health).
Patience and pace	Taking the time to listen to and validate the experiences of older adults who have self-harmed is pivotal. This should include allowing sufficient time to explore the factors contributing to self-harm and explaining available aftercare services. To facilitate this, the consultation must be of adequate duration and not condensed into a standard primary care physical health consultation, for example, The approach to aftercare should be paced and matched to the older person's acuity, cognitive ability, and needs.
Accessible	Enhancing access to aftercare goes hand in hand with agency, empowerment, and inclusion. Access to aftercare might be facilitated by addressing identified barriers including delays accessing services, limited round-the-clock support, hard to navigate crisis and referral lines, siloing of healthcare and support services, unclear pathways for aftercare in the private healthcare sector, technological limitations (e.g., access to devices or limited skills), and poor communication between different services, older people, their families, and primary care.
Finding purpose: Connections and meaningful activity	A loss of reasons to live, perceived role and connectedness to others may underpin self-harm and suicidal crises in older people, especially older men. As part of holistically addressing needs, aftercare services should include activities- both individual and within groups- such as shared meals, intergenerational connections, life promotion activities and hobbies (clubs, committees, courses). Finding purpose should be considered alongside other key principles of aftercare such as empowerment and agency and conveying hope, as individualised approaches are needed which match the older persons' needs, will and preferences to opportunities for activities and connectedness. There is no one size fits all solution. Suggestions included facilitating companionship through someone visiting the older person regularly and spending time helping them with practical tasks, but also taking part in shared social activities together. Measures to help overcome isolation, promote purpose and agency, and a sense of social connection, can also be incorporated into aftercare services.

following presentation for self-harm leads to ad hoc and missed referrals.[7] Participants noted this was especially true for older persons utilising private healthcare. The delivery of holistic Aftercare was also hampered by poor inter-service communication, a major concern for primary care, who may not receive warm handovers from acute services to continue Aftercare, leaving GPs feeling isolated, unsupported and nihilistic regarding management of older adults following self-harm.[13,28] The specific value/roles of carers in Aftercare did not emerge in the interviews. However, stakeholders and researchers identified lack of support for families and carers as a major gap, resonating with previous qualitative work on late life self-harm revealing emotional distress and burden amongst carers.[11,12]

Perhaps most stark were experiences that healthcare services continue to traumatise older people with lived experience of suicide. Participants spoke of an overemphasis on measures perceived to mitigate risk, such as involuntary hospitalisation, sometimes even without discussion or further assessment of suicidal statements. Such knee-jerk responses to disclosures of suicide were not only perceived as traumatising, invalidating and disempowering, but a deterrent to seeking help. These responses may reflect a lack of training and understanding about older persons' suicide[34] and over-emphasis on 'tick-box' approaches to screening and risk assessment, rather than contemporary evidence-based methods of individualised assessment and management of people in suicidal crises.[25]

4.1 | Implications for older persons aftercare services

The thematic analysis informed a set of overarching principles for older persons' Aftercare. Additionally, perspectives of the different stakeholder groups and researchers revealed that the older person who has self-harmed sits within a core triad involving his/her carer and GP, surrounded by interacting services and settings of care (see Figure 1). This model is a visual representation of the derived themes, with the older person at the centre of intersecting systems and services. Figure 1. Reflects the complexity of meeting the diverse personalised needs of older people following self-harm and highlights the importance of good communication across systems. This is especially important given that the older person may present to various settings for Aftercare and move between services and supports. These evidence-derived principles also reflect why older people need a dedicated Aftercare approach,[35] not a one-size fits all model of adult Aftercare.[36] Ageism has been blamed for the failure to identify and understand the specific needs of older people[37] and may even contribute to suicide.[10] Knowledge gaps regarding older adults are pervasive across healthcare[37] and may fuel stigma and ageist attitudes.

The core principles for older persons' Aftercare derived from these stakeholder and researcher interviews are especially relevant for primary care and mental health services, specifically Older Peoples' Mental Health (OPMH). A point of difference between older and younger adult Aftercare is the greater likelihood of a connection with

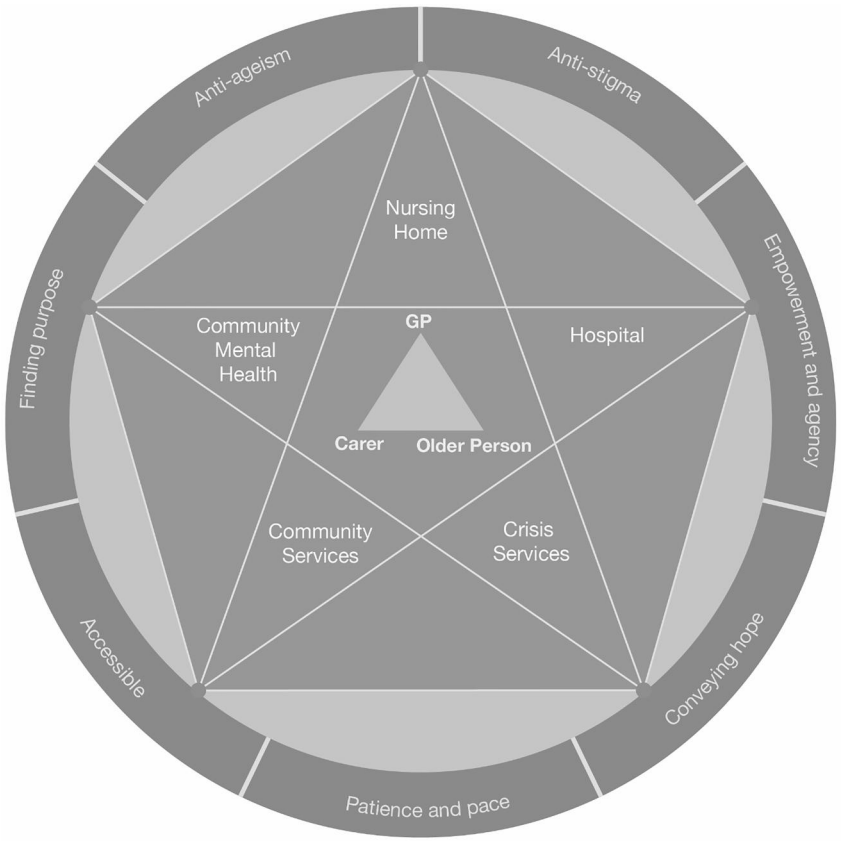

FIGURE 1 Principles and interacting systems of older persons' Aftercare.

primary care, often due to age-related medical comorbidities.[28] Therapeutic relationships with GPs were highlighted strengths, identified previously,[13] although this might be hampered by lack of relationships and communication between primary and tertiary care, a recurrent identified need for service improvement.[12] Clinical care from OPMH should be timely, holistic in scope (matching services/supports to address needs), accessible and coordinated. Participants identified the core roles of OPMH as comprehensive specialist assessment, individualised safety planning, providing continuity of care (case management), follow-up and re-evaluation, and coordinating care (including liaison between services). Although this makes intuitive sense for OPMH services,[38] there is scant data evaluating the outcomes of such an approach for self-harm. However, the Elderly Suicide Prevention Programme, a dedicated holistic Aftercare intervention in Hong Kong which adds volunteers, non-psychiatric care and gatekeeper training to the above core OPMH roles, demonstrated a reduction in suicide rates when compared to an historical control,[39] albeit with some methodological limitations.[7] The implications of this qualitative study for other health and community sectors such as Emergency Departments, inpatient settings and community (non-clinical) services are further elaborated in the related Aftercare Service Delivery Model report.[14]

Important practical aspects of delivering older persons' Aftercare were highlighted. Ensuring older people have access to comprehensive Aftercare regardless of the setting in which they first present and whether public or private is a priority. Clearly articulated pathways from self-harm to prompt specialist assessment and follow-up are needed.[7] Dedicated training and upskilling of all who have contact with older persons in a suicidal crisis is required. This includes clinicians,[34] gatekeepers who may opportunistically intervene such as police,[22] pharmacists,[40] crisis supporters[41] and nursing home staff[42]; and non-clinical services who meet needs for social connection, meaningful activity and purpose,[28] all key to suicidal prevention.[22]

Telehealth can be both a barrier to and facilitator of Aftercare. Certainly, its greater use necessitated by the COVID-19 pandemic has seen a concerted effort to both maximise its use and address barriers identified here.[43] Rather than giving up with ageist assumptions that older people cannot, or do not want to learn how to engage with technology, active measures might be pursued to support the use of technology with either skill-based learning, adapting technology to suit the needs of older people or promoting use of existing telephone-based counselling (e.g., through Lifeline).

4.2 | Limitations

Although recruitment for this study prioritised canvassing a variety of stakeholder viewpoints, not all were represented, for example, family/carers, ambulance, police, geriatricians, aged care workers. Moreover, the sample size was determined by the number of interested participants available for interviews rather than theme saturation.[44] While the study objective was to include the voices of a diverse range of stakeholders groups and researchers, including older adults with lived experience often precluded from research and service design, only four out of 22 participants were older adults, possibly attributable to the sensitive nature of the issue at hand. This limitation was addressed by privileging the voices of those with lived experience where possible. Consequently, some themes may not have been fully explored, other relevant themes may not have emerged, and comparison between groups was not feasible. Further, researcher participants, who are not considered stakeholders in older persons' Aftercare, comprised a comparatively larger group than any of the key stakeholder groups, potentially influencing the emergent themes. Although contributing useful perspectives, researcher views are not equivalent to those of key stakeholders who are part of the Aftercare system. A larger study which achieves data saturation could elucidate whether key stakeholder (older people and their carers, and a more diverse range of clinicians) and researcher perspectives align. The choice of individual or focus group interview, provided for ethical reasons and to encourage participant engagement, may have resulted in less robust discussion. However, the themes that emerged are rich and informative to Aftercare service planning. Finally, although a reflexive approach was taken,[16] the research perspectives relating to Aftercare of study leads (AW, CP) may have been known to some participants and potentially influenced responses (e.g., providing expected or socially-sanctioned comments). However, the breadth of responses, in particular regarding problems with current approaches, suggests otherwise.

5 | CONCLUSION

We can do better with Aftercare for older adults. In this study we hear from the people receiving, delivering, and those developing and studying Aftercare services. The derived guiding principles for older persons' Aftercare support an assiduous approach to identifying individual will, preferences and needs, while promoting autonomy, dignity, empowerment, inclusivity, connection and relationships, which is entirely consistent with a human rights-driven approach, articulated in Articles 12, 19, 23 and 25 of the Convention on the Rights of Persons with Disabilities.[10,45] Future research can extend these insights by engaging with larger numbers of older people with lived experience and their carers and more diverse groups of clinicians across settings within the Aftercare system. Co-design of Aftercare services with older people with lived experience of self-harm is essential to inclusiveness and addressing the challenges identified here.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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