Suicide Prevention Australia

Right from the start

Report on the design of Australia's universal aftercare system

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About Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 380 members representing more than 140,000 workers, staff and volunteers across Australia, we provide a collective voice for service providers, practitioners, researchers, local collaboratives and people with lived experience.

Over 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Almost 7.5 million Australians have been close to someone who has lost their life to, or attempted, suicide.[1] Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

Executive Summary

A previous suicide attempt is the strongest risk factor for a subsequent suicide death. While effective aftercare has been found to address this risk, many people discharged from hospital following an attempt do not receive treatment. This number is even larger for those who are not admitted to an Emergency Department following a suicide attempt.

The sector has welcomed over $300 million in Commonwealth, State and Territory commitments to a universal aftercare system as part of the new National Agreement on Mental Health and Suicide Prevention. This follows recommendations from the Final Advice of the Prime Minister's National Suicide Prevention Advisor and Productivity Commission.

An effective universal aftercare system can arrest recent increases in suicides and suicidal behaviour and support efforts towards zero suicides nationally. To be truly universal, it should ensure all individuals who have experienced a suicide attempt or suicidal crisis have access to, and are supported towards, compassionate, effective and appropriate services.

This report brings together insight and advice from individuals and organisations with lived experience of suicide and expertise in delivering and evaluation aftercare models in Australia (see full list **Appendix A**). This includes an unprecedented level of insight and advice from organisations and individuals who have accessed, delivered and/or evaluated nine different aftercare services across Australia over the past decade. In developing a universal aftercare system, Governments have a unique opportunity to be guided by this first-hand experience.

The title of the report is *Right from the Start*. This title was chosen for two reasons. At the individual level, we know if we support people 'right from the start' of a crisis or attempt, we can prevent suicide and save lives. At the community level, what you're working on is a once-in-a-generation opportunity to build this system and get it 'right from the start'.

To do so, this Report recommends seven key design features as part of a universal aftercare system: multiple service types; broad eligibility; comprehensive service range; immediate and long-term support; extensive referral pathways; reaching support networks and person-centred service delivery.

The Report further recommends seven key enablers of a truly universal aftercare system: addressing data gaps; workforce development; best practice commissioning; standardised data collection; service and community capacity; research and evidence; quality and safety.

Case for reform

A previous suicide attempt is the strongest risk factor for a subsequent suicide death and the risk for suicide after an attempt is significantly elevated compared to the general population.[2] The relative risk for suicide after attempted suicide is between 20 to 40 times higher than in the general population.[3]

Between 15% and 25% of people who make a suicide attempt will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[4] The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'.[5]

While coordinated aftercare has been found to reduce future suicide attempts by 19.8%[6], around half of people discharged from hospital following an attempt do not receive follow up treatment.[7] For those who attempt suicide, but not admitted to hospital and many priority at-risk populations, the rate of access to aftercare and other supports is significantly lower. For example, while an estimated 393,700 reported self-harm over a 12 month period there are only 29,900 self-harm hospitalisations.

Accordingly, efforts to significantly reduce suicide rates in Australia and 'shift the dial' towards zero suicides rely on addressing existing gaps to aftercare services. Both increased and universal aftercare, has been an ongoing sector priority which has been advanced by people with lived experience, advocacy bodies, researchers and service providers in recent years.

Context and opportunity

The Final Advice of the National Suicide Prevention Advisor and Productivity Commission Inquiry into Mental Health both recommended universal aftercare for those who have attempted suicide. This has been followed by commitments from State, Territory and Commonwealth Governments in successive budgets and as part of the new National Agreement on Mental Health and Suicide Prevention.

Analysis of all eight bilateral agreements under the National Agreement shows over $300 million in contributions towards a universal aftercare system between now and 2025-26.

Bilateral Agreement (with CTH)	Commitment
New South Wales	$121.3 million
Tasmania	$5.2 million
Western Australia	$40.4 million
Australian Capital Territory	$6 million
Queensland	$78.6 million
Victoria	$41.9 million
Northern Territory	$9.3 million
South Australia	$13.7 million (election commitment not bilateral)

A range of aftercare services currently operate in different parts of Australia (see **Appendix B**) and the evidence base on their effectiveness continues to grow (see **Appendix C**). Despite commitments to universal aftercare, most bilateral agreements include no agreement on particular service models beyond 30 June 2023 (**Appendix D**).

This presents a unique opportunity for Commonwealth, State and Territory Governments to draw on lived experience as well as service provider and research expertise in the design a universal aftercare system. In developing what will become this new universal aftercare system, there is a window to put in place the right foundations and get it 'right from the start'.

This opportunity occurs at a critical juncture with the latest data suggesting increasing rates of suicidality and distress. While data from 2020 and 2021 shows relatively stable suicide deaths, 2022 data suggests the number of suicides, suicidal behaviour and personal distress is increasing nationally.[8] This is consistent with evidence from natural disasters and other crises that suicide rates tend to increase 2-3 years after a crisis.[9]

An effective universal aftercare system can arrest any increase and support efforts towards zero suicides nationally. To be truly universal, an aftercare system should ensure all individuals who have experienced a suicide attempt or suicidal crisis have access to, and are supported towards, compassionate, effective and appropriate services.

Key Design Features of a Universal Aftercare System

1. Multiple service types

Evidence to date suggests a one-size-fits all approach to aftercare will not be effective. Suicide is complex human behaviour and the causes and risk factors of a suicide attempt are varied. Different aftercare services appear to work for different individuals or cohorts in different circumstances and at varying times.

No single aftercare model should be adopted, rather a range of aftercare services should be commissioned and available within a universal aftercare system. This will ensure individuals have access to services that support them when, how and where they need it and suitable to their local context and in a culturally-responsive way. It could include a combination of aftercare services throughout an individual's healing journey.

2. Broad eligibility

At its centre, universal aftercare should support those who have attempted suicide or experienced suicidal crisis. The majority of existing aftercare models currently support both those who have attempted suicide or experienced suicidal crisis. This should continue given the benefit of early intervention, evidence from existing models that attempts are problematic for the purpose of referrals and also that there are ongoing data gaps around self-harm and suicidal behaviour. Suitable referral and service pathways should support individuals towards an appropriate service response.

3. Comprehensive service range

A universal aftercare system needs to provide individuals access to a range of supports. This involves a person-centred approach with flexibility within services to address an

individual's needs through clinical, non-clinical and peer supports. Across all support types a compassionate, trauma-informed approach is critical.

Clinical

Clinical supports that should be available include post-crisis clinical care, safety planning, clinical group support and any psychiatric, psychological or other medical support. Clear clinical governance, escalation and referral protocols should be considered as part of implementation planning.

Non-clinical

Non-clinical supports that should be available within a universal aftercare system include:

- Case management and service navigation
- Psychosocial and community connection assistance
- Group work and group therapy
- Cultural connection programs
- Self-assessment and development tools
- Assistance to overcome stigma
- Supports to address factors contributing to suicidal behaviour (e.g. welfare, employment, family and relationship services, education and training, housing)
- Support connecting and engaging with aspects of clinical care
- Long-term recovery planning and transition to community life

Peer support

Peer supports within a universal aftercare system can drive better outcomes. A peer-based enhancement to the Way Back Service in Murrimbidgee showed those who accessed support were more likely to continue in the program. The presence of a peer worker with a lived experience of suicide at the start of the process has been found to be effective in multiple service models. Suicide-specific lived experience is essential, including experience of suicidal distress.

Ensuring peer representation from groups less likely to access existing services, including older persons, males, Aboriginal and Torres Strait Islander people and LGBTQI+ and culturally and linguistically diverse communities, will help best connect those most at-risk to aftercare support.

4. Immediate and long-term support

While the risk of suicide is highest in the first three months following a suicide attempt, an increased risk of suicidality can be long-lasting. The majority of existing services include support for approximately 12 weeks and some offer ongoing, less intensive support beyond that.

While intensive support should be prioritised for a three-month period, some lasting, lower cost and intensity services should be available longer-term (e.g. access to support groups, text message, postcard follow-ups, connections to 'warm lines' and peer forums).

There are existing examples where immediate intensive support has been followed by lasting, less intensive models, for example, individuals transitioning from Hospital to Recovery to Eclipse. Longer-term non-clinical support is also consistent with the approach of effective postvention models currently in operation. This builds on evidence that effective and evidence-based suicide aftercare can have an impact for at least 12 months.[10]

Aftercare should be available immediately following an attempt or suicidal crisis. However, it should be recognised that some individuals may not wish to immediately participate in aftercare services and flexibility is needed to allow individuals to begin access to aftercare supports when they are ready. Consultations suggest initial contact could be made and if an individual is not ready to participate, permission could be sought to check in a month later.

5. Extensive referral pathways

There can be 'no wrong' door to access aftercare support. While many people who attempt suicide will be admitted to hospital, limiting referral to emergency departments will exclude many people at-risk. Only half of those who die by suicide had any contact with an emergency department in the 12 months prior to their death.[11]

Bilateral commitments to increased aftercare for those discharged from an Emergency Department are welcome but need to be matched with more extensive work on, and effective resourcing for, community-wide referral pathways.

Referrals to aftercare services should include hospitals; schools and universities; police and emergency services; families and carers; suicide prevention services including networks, safe spaces/safe havens and crisis lines; mental health services including psychologists, psychiatrists, and Head to Health; community and peer groups; social services and general practitioners.

Referrals from support networks and self-referrals should be permitted, provided there are intake and referral mechanisms to ensure safety and appropriateness of aftercare.

6. Reaching support networks

While aftercare services are delivered to those who have experienced a suicide attempt or crisis, these individuals can often be supported through their family, carers and friends. Lifting the rate of individuals accessing services will require more proactive outreach including through their individual support networks. This can help individuals and their support network navigate aftercare and related supports.

Additional supports for carers and loved ones of those who attempt suicide should be addressed more broadly and will have a positive impact on suicide prevention outcomes.

7. Person-centred service delivery

Aftercare should be available in a range of locations and delivered flexibly. After hours supports, accessible locations and culturally appropriate services should be considered. Evaluations suggest aftercare can be effectively delivered in face-to-face and online settings with different modalities suitable to different individuals. Individual choice is important from initial contact through to delivery, for example young people may not answer phone calls but could be engaged through text or other outreach methods (within privacy restrictions).

Key Enablers of a Universal Aftercare System

1. Addressing data gaps

Major gaps in data on suicide attempts and behaviour require urgent action. Concerted efforts are required to fill data gaps including to understand suicidality identified by police and emergency services; general practitioners; psychologists and psychiatrists; private hospitals; state and local government mental health services; community services and improved collection of data in Emergency Departments. This will require additional training and resources across the workforce to build capability in reporting and usage.

2. Workforce development

Delivery of a universal aftercare system requires increased focus on growing, retaining and developing the clinical, non-clinical and peer suicide prevention workforces that will deliver aftercare. Increased suicide prevention training in the clinical workforce and social sector will support those likely to reach those who have attempted suicide or experienced suicidal crisis including through an increased focus on suicide prevention capability in higher education curricula across social work, allied health and other care disciplines.

In addition, given the risks of vicarious trauma on staff working in aftercare, there should be funding for staff to help avoid burnout and unnecessary turnover in aftercare services. These should be progressed as part of the planned National Suicide Prevention Workforce Strategy, including with specific priorities for the lived experience and peer workforce, for example, development, registration and training priorities. While this Strategy is developed, a Workforce Capability Framework could be put in place in the interim and provide guidance on attracting, developing and retaining the workforce.

3. Best practice commissioning

Evaluations and the Productivity Commission have confirmed short-term funding arrangements impede the delivery of aftercare services and limit referrals. Funding certainty is required in the delivery of universal aftercare and funding agreements should be commissioned for a minimum of four years with clear performance and outcome indicators.

As part of commissioning a range of services, it is critical requirements for collaboration and service referrals are built into contracting arrangements. This should include specific guidance on collaboration between aftercare services and other broader support services. This commissioning of services should reflect the local service need and in partnership with those who have lived experience.

4. Service and community capacity

Capacity within the aftercare system and related service systems is a key enabler. Better outcomes rely on both capacity of aftercare services, health services and broader social services including service waitlists and supports to address social and economic risk factors. Particularly in rural and regional communities, addressing existing gaps across the social services system will be required. Moreover, ongoing efforts to build community capacity for suicide prevention to address stigma, raise awareness and develop skills are needed.

5. Standardised data collection

Standardised data collection and a linked data system should be developed across the universal aftercare system and could include the extension of existing data monitoring systems. For example, any data system used or developed under the Targeted Regional Initiatives for Suicide Prevention being rolled out across all Primary Health Networks.

6. Research and evidence

Aftercare is a relatively new service and the evidence on what models work for whom, when and where continues to emerge. Early and ongoing investment in research and evaluation on aftercare should be commissioned throughout the development of a national universal aftercare system and should be a priority in future suicide prevention research funding allocations.

7. Quality and safety

All aftercare services should be safe, quality and effective. Aftercare services within the universal aftercare system should be accredited, or registered to work towards accreditation, under the Suicide Prevention Australia Standards for Quality Improvement. Several existing aftercare services have attained accreditation and support should be provided through the commissioning process to help other programs towards meeting these standards.

Recommendations

Commonwealth, State and Territory Governments should implement the following key design features as part of a national universal aftercare system:

1. **Multiple service types**: a range of aftercare services and models should be commissioned in a person-centred universal aftercare system
2. **Broad eligibility:** aftercare should be available to all those who have attempted suicide or experienced suicidal crisis
3. **Comprehensive service range:** an extensive range of clinical (e.g. clinical care and support, safety planning and medical support); non-clinical (e.g. case management, group therapy and work; psychosocial, community and navigation support) and peer support services (e.g. peer workers, lived experience from priority groups) should be available according to an individual's needs and recovery journey
4. **Immediate and long-term support:** immediate aftercare services should be available for at least 12 weeks with flexibility around commencement and access to ongoing, less intensive support available longer-term and the ability to re-refer
5. **Extensive referral pathways:** referrals should be available including through the health and mental health system (e.g. hospitals, General Practitioners, mental health services); community and social services (e.g. police, emergency services and community groups); personal support networks (e.g. carers and family) and self-referral
6. **Reaching support networks**: aftercare providers should actively reach out to an individual's support networks (e.g. carers, family and friends) to increase awareness

of aftercare services and support those caring and assisting loved ones connect with the aftercare system

7. **Person-centred service delivery:** aftercare should be available at a range of locations, times and in both face-to-face and digital modes depending on individual needs and preferences

Commonwealth, State and Territory Governments should address the following key enablers of a national universal aftercare system:

1. **Addressing data gaps:** gaps in data on suicide attempts and behaviour should be addressed through increase data collected on suicidality and self-harm identified by police and emergency services; general practitioners; psychologists and psychiatrists; private hospitals; state and local government mental health services; community services and improved collection of data in Emergency Departments.
2. **Workforce development:** increased focus on growing, retaining and developing the clinical, non-clinical and peer suicide prevention workforces will be required to deliver universal aftercare
3. **Best practice commissioning:** multiple service types should be funded and contracts for the delivery of aftercare services should be for a minimum of four years with clear performance and outcome indicators plus include requirements for collaboration and service referral
4. **Standardise data collection:** standardised data collection and data linkage should be developed across the universal aftercare system and with related services, thelping address data gaps and ensure outcomes can be effectively measured.
5. **Service and community capacity:** addressing existing gaps in support services and building community capability for suicide prevention will drive better outcomes
6. **Research and evidence:** investment in research and evaluation on aftercare should be commissioned and prioritised throughout the development of a national universal aftercare system
7. **Quality and safety:** aftercare programs should be accredited, or registered to work towards accreditation, under the Suicide Prevention Australia Standards for Quality Improvement

Appendix A

Consultations on this report have included a broad range of individuals and organisations with expertise and lived experience of aftercare and suicide prevention. They include representatives from:

- Suicide Prevention Australia's Lived Experience Panel
- BeyondBlue
- Manna Institute
- KPMG
- Wesley Mission
- AnglicareSA
- Neami National
- Hospital Outreach Post-Suicidal Engagement
- Lifeline Australia
- LGBTIQ+ Health Australia
- YouTurn Limited and StandBy Support After Suicide
- Mind Australia
- Black Dog Institute

Appendix B

	Anglicare Suicide Prevention Service	Beyond Blue The Way Back Support Model	Neami The Way Back Support Service	Hospital Outreach Post-Suicidal Engagement (HOPE)	Child and Youth HOPE	Lifeline Eclipse	Wesley Lifeforce Aftercare	Lifeline Hospital to Recovery	Mind Australia LGBTQI+ Aftercare
Duration	3 months	3 months	3 months	3 months	3 months	8 weeks	10-14 weeks	Flexible	3-6 months with ongoing group drop-ins
Time after an attempt can an individual engage	Usually within the past 3 months, can be flexible	Up to 3 months	Designed for immediately after	Designed for immediately after	No cut off	No cut off	No cut off	No cut off	No cut off
Requirements for eligibility	Recent suicide attempt, secondary criteria of suicide ideation	Recent suicide attempt, secondary criteria of suicidal crisis and risk of suicide imminent	Recent suicide attempt, secondary criteria of suicidal crisis and risk of suicide imminent	Suicide attempt, or at-risk of suicide with serious planning or intent and/or repeated self-harm	Children and young people at significant risk of suicide following a suicide attempt or serious planning/intent	Attempted suicide but is not at imminent risk of suicide	Experiencing suicidal distress or self-harm behaviour	Suicide attempt (hospitalisation not required); Individuals may need to engage in another e.g. drug & alcohol rehab, inpatient facility	LGBTIQA+; suicidal thoughts or behaviours; over 13 with parental consent; ties to North West Melbourne
Referral processes	Hospital or health professional	Hospital or health professional	Hospital referrals only	Hospital or health professional	Hospital or health professional	Hospital, health professional, or self-referral	Hospital, health professional, or self-referral	NSW Health, mental health services, NGOs, community, self	Community members, self-referral, other organisations
Target cohort	No specific cohort	No specific cohort	No specific cohort	No specific cohort	Children and youth aged 0-25 years	No specific cohort	No specific cohort	No specific cohort	LGBTIQA+ people
Modes of service delivery	Face-to-face outreach support, phone or virtual support when appropriate	Primarily face-to-face, can also be provided via telephone and messaging services	Predominantly face-to-face, can be via video conferencing, telephone and messaging services	Assertive psychosocial support, plus contact via phone calls, telehealth, texts, emails or postcards	Face-to-face, telehealth, telephone, responsive outreach	Face to face, complemented by an online offering	Face-to-face, over the phone, individual and group methods	Peer-lead with face-to-face, online and phone access in clinical, NGO, community or home settings	Face-to-face; tele-health; online group; peer and psychologist support

Appendix C

The report draws on projects commissioned by the National Suicide Prevention Research Fund including:

- Lived experience of suicide
- Aboriginal and Torres Strait Islander lived experience
- Trauma-informed approaches to suicide prevention
- Youth suicide prevention and care pathways

Specific program evaluations and related research that has informed this report include:

- Eclipse
- National evaluation of The Way Back service expansion
- Co-creation of new knowledge: good fortune or good management?
- LGBTQI+ Aftercare evaluation

Appendix D

Bilateral Agreement	Aftercare model	No. of aftercare services	No. of services non-hospital admission
NSW/CTH	Not specified	35	2
VIC/CTH	HOPE	22 plus nine subregional outreach	2
QLD/CTH	Not specified	24	2
WA/CTH	Not specified	Not specified	1
SA/CTH	Not specified	Not specified	Not specified
TAS/CTH	Not specified	Not specified	Not specified
ACT/CTH	Not specified	Not specified	1
NT/CTH	Not specified	3	1

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As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of this report. Suicide Prevention Australia thanks all involved in this report including aftercare service providers, researchers, people with lived experience and priority cohort representatives. We acknowledge and thank KPMG Australia for their pro bono support in facilitating this project.

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