Suicide Prevention Australia

Policy Position

Aftercare

January 2023

Position

1. Any person who attempts suicide or experiences suicidal crisis should have access to quality, suitable and accessible aftercare support as part of a universal aftercare system.
2. Commonwealth, State and Territory Governments should implement the following key design features as part of a universal aftercare system:
    a. Multiple service types through a range of services and models
    b. Broad eligibility including people who have attempt suicide or experienced suicidal crisis
    c. Comprehensive services range including clinical, non-clinical and peer supports
    d. Immediate and long-term support with flexibility around commencement
    e. Extensive referral pathways including the health and mental health system; community and social services; personal support networks and self-referral
    f. Reaching support networks including family, friends and carers
    g. Person-centred service delivery through various locations, times and modality
3. Commonwealth, State and Territory Governments should address the following key enablers of a national universal aftercare system:
    a. Address gaps in data on suicide attempts and behaviour by increasing 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
    b. Increase focus on workforce development by growing, retaining and developing the clinical, non-clinical and peer suicide prevention workforces required to deliver universal aftercare
    c. Utilise best practice commissioning by funding multiple service types and contracts for the delivery of aftercare services for a minimum of four years, with clear performance and outcome indicators including requirements for collaboration and service referral
    d. Develop standardised data collection and data linkage across the universal aftercare system and with related services, helping address data gaps and ensure outcomes can be effectively measured
    e. Enhance service and community capacity by addressing existing gaps in support services and building community capability for suicide prevention which will drive better outcomes.
    f. Invest in research and evaluation on aftercare and be prioritised throughout the development of a national universal aftercare system, including in commissioning aftercare services.
    g. Ensure aftercare programs are accredited, or registered to work towards accreditation, under the Suicide Prevention Australia Standards for Quality Improvement.

Context and Commentary

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 comparted to the general population.[1] The relative risk for suicide after attempted suicide is between 20 to 40 times higher than in the general population.[2]

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.[3] 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'.[4]

While coordinated aftercare has been found to reduce future suicide attempts by 19.8%[5], around half of people discharged from hospital following an attempt do not receive follow up treatment.[6] 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.

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 in 2022. 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.

What does effective aftercare look like?

In 2022, we undertook consultation with our Lived Experience Panel and our members with expertise and lived experience of aftercare and suicide prevention to develop a set of key design features of a universal aftercare system.[7] We believe effective aftercare should include:

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.

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.

[1] Shand, F, A Woodward, K McGill, M Larsen, and M Torok. 2019. Suicide aftercare services: an Evidence Check rapid review. brokered by the Sax Institute for the NSW Ministry of Health
[2] Sax Institute. (2019). Suicide aftercare services, Evidence Check, available online: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf.
[3] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf
[4] Australian Institute of Health and Welfare. (2021). Psychosocial risk factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide.
[5] Krysinska, Karolina & Batterham, Philip & Torok, Michelle & Shand, Fiona & Calear, Alison & Cockayne, Nicole & Christensen, Helen. (2015). Best strategies for reducing the suicide rate in Australia. The Australian and New Zealand journal of psychiatry. 50. 10.1177/0004867415620024.
[6] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf
[7] Suicide Prevention Australia. (2022). Right from the start: Report on the design of Australia's universal aftercare system, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2022/12/Right-from-the-Start-Final-Report.pdf.

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.

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.

- 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.[9]

[8]Suicide Prevention Australia. (2022). Right from the start: Report on the design of Australia's universal aftercare system, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2022/12/Right-from-the-Start-Final-Report.pdf.
[9] Inagaki M, Kawashima Y, Kawanishi C, Yonemoto N, Sugimoto T, et al. Interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for a suicide attempt: a meta-analysis. Journal of Affective Disorders. 2015;175:66-78.
[10] Australian Institute of Health and Welfare. (2022). Patterns of health service use in the last year of life among those who died by suicide, available online https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/health-service-use-in-the-last-year-of-life.
[1] Australian Institute of Health and Welfare. (2022). Patterns of health service use in the last year of life among those who died by suicide, available online https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/health-service-use-in-the-last-year-of-life.

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.

- 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, safes paces/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.

- 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.

- 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 to a universal aftercare system in Australia for State and Territory Governments to address

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

Acknowledgements Statement

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If you or someone you know require 24/7 crisis support, please contact:

Lifeline: 13 11 14
www.lifeline.org.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

For general enquiries