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Universal Aftercare Service Delivery Model

ACI Mental Health Network

December, 2024

Agency for Clinical Innovation

NSW GOVERNMENT

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About This Resource

What is Universal Aftercare?

Aftercare services are non-clinical services that provide rapid and assertive follow-up of people after they have experienced a suicide attempt or suicidal crisis. Aftercare is a service for people wanting support to address their drivers of suicidality and reduce their suicidal risk. For priority populations at increased risk of suicide, and where service capacity allows, this may also include providing early intervention to people with suicidal ideation and self-harming behaviours.

Universal Aftercare is the provision of inclusive and responsive Aftercare services to any person needing support, regardless of gender, age, sexuality, religion, ethnicity, disability and impairment and culture. Access to Universal Aftercare is identified as a core area of work in the Strategic Framework for Suicide Prevention in NSW 2022-2027.

Who is this resource for?

This resource – a service delivery model – has been developed for Aftercare service providers, key partners, service managers and workforce to provide guidance on the delivery of universal aftercare services within NSW.

The resource contains information about:

- Effective and safe service delivery of aftercare services.
- Support for priority populations at an increased risk of suicide.
- Suggested governance structures and processes to support service delivery.
- Workforce development and support.

What is a Service Delivery Model?

A service delivery model focuses on the broader governance of a service, and considers managerial involvement, local governance and partnerships. It is targeted at service providers, those who deliver care and those involved at a broader stakeholder level.

A service delivery model differs from a model of care, which is a hands-on tool used by care providers to guide the day-to-day, localised delivery of services to consumers. This service delivery model provides overarching guidance, allowing for flexibility for various models of care, and does not replace current or future models of care.

Why is this resource needed?

This resource provides state-wide guidance on the delivery of Universal Aftercare services within NSW.

The need for a Universal Aftercare system has been recognised by both the National Suicide Prevention Advisor Final Advice and the Productivity Commission Inquiry into Mental Health. Following these recommendations for a Universal Aftercare system, State, Territory and Commonwealth Governments have subsequently committed to implementing a Universal Aftercare system through bilateral funding schedules of the National Agreement on Mental Health and Suicide Prevention.

NSW Aftercare services will be expanded and new services established through the transition to a Universal Aftercare system. These will extend aftercare referral pathways across all of NSW. Universal Aftercare aims to deliver improved outcomes for all people experiencing suicidal ideation, crisis or a recent attempt, with a focus on priority groups at increased risk of suicide.

Underpinning Principles

The NSW Universal Aftercare Service Delivery Model seeks to provide guidance on the effective, safe, inclusive, responsive and sustainable delivery of Aftercare services. The guidance provided in this resource is underpinned by four core principles, that care is:

- Person centred and person led
- Trauma informed
- Human rights based
- Recovery orientated

These principles should be applied in the NSW Universal Aftercare Service Delivery Model within services, workforce and communities.

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- Primary Health Network (PHN) groups:
    - PHN Suicide Prevention Community of Practice
    - NSW/ACT PHN Mental Health Network

Glossary

Aboriginal People

In recognition of Aboriginal people as the first inhabitants of NSW, this resource respectfully refers to Aboriginal and Torres Strait Islander people as Aboriginal people.

Key Terms

Below are definitions of key terms used throughout this resource. These have been defined in the context of how they have been used, and should be interpreted, in this resource.

Aftercare: Support provided to people after they have experienced suicidal thoughts, behaviours or attempts, focused on long-term recovery through personalised, non-clinical and community-based services that seek to address the drivers of suicide.

Care Coordinator: Aftercare worker who provides comprehensive non-clinical psychosocial support to consumers, collaborating with peer workers and other providers to deliver tailored, holistic services.

Cis or cisgender: The term "cis" is short for "cisgender." It describes people whose gender identity matches the sex they were assigned/presumed at birth. For example, if someone is assigned/presumed female at birth and identifies as a woman, they are cisgender.

Clinical Care: Involves the provision of diagnosis and treatment by qualified mental health professionals.

Clinical Governance: A framework to ensure safe, high-quality care through monitoring and improvement of clinical practice.

Clinician: A qualified health professional who provides clinical support, assessment and treatment to consumers. Depending on the profession this may mean Australian Health Professional Registration Authority (AHPRA) registration, eligibility to join the Australian Association of Social Work (AASW) or Djirruwang trained.

Cognitive Disability: Refers to a range of conditions (such as intellectual disability, developmental disability, dementia, acquired brain injury, autism spectrum disorder or other neurodevelopmental conditions, and severe and persistent mental illness) that can impact on a person’s ability to communicate, remember, learn, concentrate, and make everyday decisions.

Consumer Care Review: A process to review the nature of support provided by a service with respect to a consumer’s needs and safety.

Consumer: A person who accesses aftercare services following suicidal ideation, crisis or an attempt.

Co-production: A collaborative approach to service design in which consumers, service providers, key partners, policy makers and family, carers, friends and kin work together to design and implement a service that meets the needs of the community.

Diagnostic Overshadowing: The wrongful attribution of a consumer's symptoms to an existing condition, leading to misdiagnosis or overlooked health issues.

Endosexism: Treating endosex bodies and people as valid, and people with innate variations of sex characteristics as disordered or in need of 'fixing'.

Group Debriefing: Structured group discussion and opportunity to talk about challenges, successes and stressors in relation to supporting consumers in their recovery.

Heteronormative: Preferential cultural attitudes that heterosexuality is the preferred or normal sexual orientation.

Intersectionality: How various aspects of a person's identity, such as culture, beliefs and life experiences, intersect to influence their experiences, perceptions and treatment within society.

Lateral Violence: Internal violence that appears when people or a community feel oppressed, displaced, unsafe and have no safe frameworks to guide them. Lateral violence is not just an individual's behaviour. It often occurs when a number of people work together to attack or undermine another person or group. It can also be a sustained attack on people, families or groups.

Lived and Living Experience: Knowledge and insights gained by people through their personal experiences of mental health challenges, trauma or suicidal crises. This includes both consumers or family, carers, friends and kin.

Neurodivergence: variation in neurocognitive functioning among people. It includes several conditions such as autism, attention-deficit/hyperactive disorder (ADHD), Tourette syndrome, dyslexia and other learning difficulties.

Non-clinical care: Supportive services that focuses on psychosocial needs and empower consumers to establish ongoing community support in a non-acute setting.

Older people: People aged 65 years and above. Aboriginal people aged 50+ are eligible to access Older People's Mental Health services.

Operational governance: A framework that ensures effective management, communication and collaboration among service partners to enhance quality and sustainability of aftercare services.

Peer Worker: Aftercare workers who draw on their personal lived and living experience of suicide or psychological distress to provide authentic engagement and support for people accessing aftercare services.

Person-centred care: Care that respects and responds to the preferences, needs and values of people. Person-centred care treats each person respectfully as an individual human being, and not just as a condition to be treated.

Person-led care: Care that supports the person to lead their own care and be treated as a person first. The focus is on the person and what they can do, not their condition or disability.

Psychosocial support: Non-therapeutic support given to help meet the mental, emotional, social, and spiritual needs of consumers.

Reflective Practice: A process that focuses on the needs and wellbeing of the employee and is an opportunity to reflect on professional practices, successes and challenges.

Recovery-oriented: Approach to recovery understands that each person is different and should be supported to make their own choices, listened to and treated with dignity and respect. Each person is the expert of their own life and support should assist them to achieve their hopes, goals and aspirations.

Support Plan: A personalised plan that outlines a consumer's individual recovery goals, strategies and support systems to foster long-term mental health and wellbeing.

Safe storytelling: The practice of sharing personal experiences of suicide and psychological distress in a supportive environment that ensures people feel respected and safe in discussing their mental health journey.

Safety Plan: A collaborative, person-centred and person-led process that creates a personalised tool to help consumers manage suicidal thoughts and urges by identifying coping strategies, support resources and action for crisis situations.

Service Mapping: The process of identifying local services within an area to enhance referral options, highlight service delivery gaps, and foster collaboration for improved care access.

Stakeholder Mapping: The process of identifying key organisations or individuals that should be considered in building local partnerships and engagement.

Team Leaders: Aftercare workers who oversee and coordinate aftercare services and ensure the service provides evidence-informed care that is innovative and tailored to the community they support.

Therapeutic Nihilism: The view that treatment is of limited or no benefit to consumer.

Transgenerational Trauma: the trauma effects passed down through generations, influencing the mental health and wellbeing of people who may have not directly experienced the original traumatic event.

Trauma Informed Care: An approach to care that recognises the enduring impacts of trauma on people and ensures services are delivered in a safe, supportive and empowering environment.

Universal Aftercare: The provision of inclusive and responsive Aftercare services to any person need support, regardless of gender, sexuality, religion, ethnicity, ability and culture.

Virtual Care: The provision of services involving any interaction between a consumer and care provider(s), or between care providers, that occurs remotely using technology.

Acronyms

ABS: Australian Bureau of Statistics

ACCHO: Aboriginal Community Controlled Health Organisation

ACCO: Aboriginal Community Controlled Organisation

AH&MRC: Aboriginal Health and Medical Research Council

ASIST: Applied Suicide Intervention Skills Training

CAMHS: Child and Adolescent Mental Health Services

CBPATSISP: The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

CMO: Community Managed Organisation

CoP: Community of Practice

ED: Emergency Department

K10: Kessler Psychological Distress Scale

KPIs: Key Performance Indicators

LGBTIQ+: Lesbian, Gay, Bi+, Trans, Intersex and Queer individuals

LHA: LGBTIQ+ Health Australia

LHDs: Local Health Districts

LRG: Local Response Group

MDS: Minimum Data Set

MSC: Most Significant Change

NACCHO: National Aboriginal Community Controlled Health Organisation

NDIS: National Disability Insurance Scheme

PHNs: Primary Health Networks

PREMs: Patient Reported Experience Measures

QOLS: Quality of Life Scale

RE-AIM: Reach Effectiveness Adoption Implementation Maintenance Framework

SHN: Specialty Health Network

SIDAS: Suicidal Ideation Attributes Scale

SPOT: Suicide Prevention Outreach Teams

STARTSS: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

TAFE: Technical and Further Education

THMC: Transcultural Mental Health Centre

Service Delivery

This section addresses the key components of Universal Aftercare service delivery. This includes:

1. Broad and inclusive referral pathways, with inbound referrals extending beyond LHD/SHN services and Emergency Departments.
2. Timely, responsive services, that focus on building rapport from first contact.
3. Service delivery and care that is underpinned by a person-centred, person-led, trauma-informed, human-rights and recovery-oriented approach.
4. Inclusive and responsive services, regardless of gender, sexuality, age, religion, ethnicity, impairment or disability, and culture.
5. Flexible services (program length and mode of delivery) to meet the individual needs of the consumer.
6. Promotion of and support for the involvement of family, friends, carers and kin, with consent.
7. Organised and gradual transition from Aftercare services, in consultation with the consumer and their support network.

Entry to the Program

Referral Pathways

Broadening referral pathways supports the goal of universal access to Aftercare services. Inbound referrals to the Aftercare program should be widened to extend beyond LHD/SHN services and Emergency Departments (ED).

As detailed in Governance, each provider should undertake service mapping in their local area. This will identify services for both inbound and outbound referrals. Consideration should be given to accepting referrals from:

- Self-referrals and referrals from family, carer, friends and kin.
- Local Health Districts (LHDs) and Specialty Health Networks (SHNs)
    - Hospital and community services
    - Drug and alcohol services
    - Mental health services (including Towards Zero Suicides initiatives e.g. Safe Havens, SPOTs)
    - Aboriginal Mental Health Clinical Leaders and/or District Coordinators
    - LHD/SHN Aboriginal Health Units
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- Mental Health Community Managed Organisations (CMOs)
- Private mental health providers

- General Practitioners (GPs)
- Social services (e.g. family violence, financial counselling, housing, and employment)
- Cultural services (e.g. settlement services, Aboriginal Community Controlled Organisations (ACCOS) and other Aboriginal support services).
- Other priority population support services (e.g. disability, NDIS services, LGBTIQ+, youth, men).
- Services or facilities that support older people (e.g. aged care assessment services, community and residential aged care facilities and services).
- Educational facilities (e.g. schools, TAFEs and universities).

Operationalising referrals from health and non-health services may be specified in service agreements, as outlined in the Governance section of this resource. The Aftercare service should ensure that referral criteria and referral processes are understood by inbound referring services through service agreements, local governance groups and other forms of ongoing communication. When accepting referrals from non-clinical services, Aftercare providers need to ensure that appropriate clinical support is in place for consumers where required, e.g. a GP, the acute care team or a community based mental health team.

Referral Criteria

Suicide Attempt and Crisis

Evidence shows that early intervention is effective in suicide prevention[1].

People who have experienced a recent suicide attempt or crisis are eligible for referral to the Aftercare program. Evidence shows that aftercare is more effective when offered to consumers following their first suicide attempt[2]. Priority should be given to those with recent suicide attempt. Where capacity allows – and with consideration for the appropriateness of the service for the consumer – referrals for people experiencing suicidal crisis should be accepted.

Flexibility for Priority Populations

The transition to Universal Aftercare in NSW aims to deliver improved outcomes for all people experiencing suicidal crisis, with a focus on priority groups at increased risk of suicide.

Consumers at an increased risk of suicide may benefit from earlier intervention and lower thresholds to enter the Aftercare program. Aftercare providers are encouraged to consider accepting referrals for consumers experiencing suicidal ideation who may be at higher risk of suicide, or who may have limited access to alternate suicide prevention services (e.g. Safe

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[1] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].
[2] Ibid.

Havens or SPOTs) due to rurality, accessibility or other barriers. To better understand who may benefit from lower threshold, please see Priority Populations.

It is important to support system change that focuses on proactive suicide prevention, as opposed to reactive. Whilst expanding the referral criteria may have implications for service demand and referral pathways, it is an essential element of universal access. For more information on how to manage referrals when service is at capacity, see Service Capacity.

Age

Aftercare services should accept referrals for consumers aged 16 and older (with the exception of specialist services e.g. ACON and i.am youth pilot) and consider accepting referrals for consumers as young as 14, if they have been assessed to have capacity for consent. For more information, see consent for Minors.

Please note, if working with under 18-year-olds, all service providers are required to obtain a working with children check and consider mandatory reporting requirements.

Alternate care for Minors

If a referral is declined based on age, the below services may be alternative care options:

- Safeguards
- Child and Adolescent Mental Health Services (CAMHS)
- Star4Kids
- New Horizons 'i.am'
- NSW Health Child and Family Counselling Services
- Head to Health Kids Hub

Consent and Confidentiality

Consent and confidentiality are critical considerations in Aftercare and healthcare more broadly. They protect consumer autonomy, public confidence and the integrity of the system. Consumers have the right to choose who has access to their health information, and breaches of confidentiality can cause harm. It is essential that Aftercare providers – and all involved stakeholders – understand consent and confidentiality in the context of Aftercare service delivery. This is particularly applicable to instances of sharing information with other services and with carers, family, friends and kin, sharing of safety and support planning, involvement in care and notification of escalating suicide risk.

Consent is dynamic and can be given or withdrawn throughout the course of the Aftercare program. It is important for Aftercare providers to regularly check in with the consumer about their consent preferences.

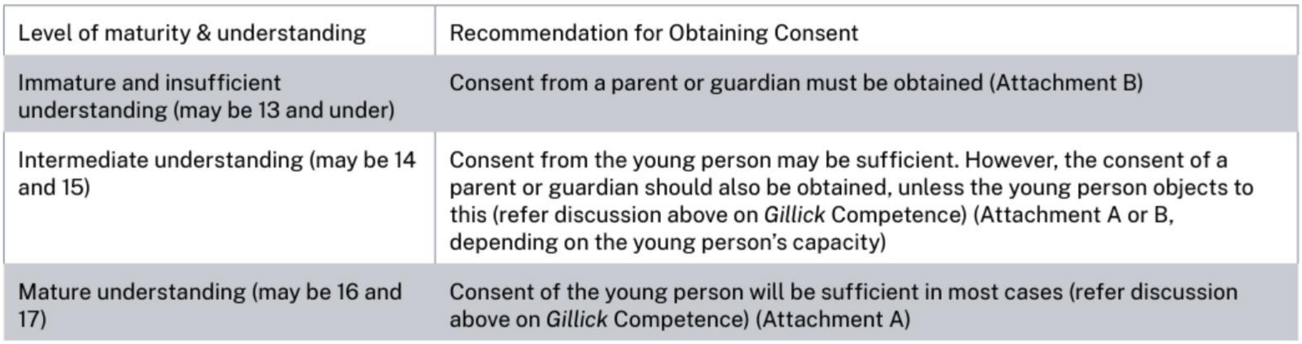
The below seeks to provide some guidance and clarity on key considerations, laws and processes for gaining consent and maintaining confidentiality. Please note, the below resources have been provided as a guide and in some instances are applicable to clinical

NSW Health services; whilst Aftercare is a non-clinical service some principles and guidance are applicable in the context of Aftercare.

Minors

NSW health guidance states that those aged 16 and above have the capacity to consent. However, for younger people aged 14 to 16 years, the Gillick Case is a relevant factor in assessing if a minor has capacity for consent. The Gillick case holds that a child's capacity increases as they approach maturity, or in other words, the authority of a parent decreases as their child's capacity increases[3]. The NSW Health 'Consent to Medical and Healthcare Treatment Manual' provides a guide for assessing a minor's capacity to consent to medical treatment. Whilst Aftercare services are not considered medical treatment, the principles outlined in this policy can be applied to the context of aftercare. Table 1 provides a guide to assessing a minor's capacity to consent to care.

Table 1: Maturity Guide for Minor's Capacity to Consent to Treatment



Level of maturity & understanding	Recommendation for Obtaining Consent
Immature and insufficient understanding (may be 13 and under)	Consent from a parent or guardian must be obtained (Attachment B)
Intermediate understanding (may be 14 and 15)	Consent from the young person may be sufficient. However, the consent of a parent or guardian should also be obtained, unless the young person objects to this (refer discussion above on *Gillick* Competence) (Attachment A or B, depending on the young person's capacity)
Mature understanding (may be 16 and 17)	Consent of the young person will be sufficient in most cases (refer discussion above on *Gillick* Competence) (Attachment A)

Reduced capacity for consent

Some Aftercare consumers may have reduced capacity to consent, for example in the instance of cognitive or developmental disability or age (younger or older people). There are a range of considerations to ensure fair and effective engagement with people who have reduced decision-making capacity. The Information and Privacy Commission NSW guide 'Privacy and persons with reduced decision-making capacity' suggests best practice tips for agencies when collecting, using and disclosing personal and health information about people with reduced decision-making capacity.

Family, Carers, Friends and Kin

Consent from the consumer is essential before any contact is initiated with carers, family, friends or kin. It is the right of the consumer to not give consent for contact to be made, or information to be shared, with their support networks. This may be for a myriad of reasons, such as relational dysfunction, privacy, shame and stigma, or safety concerns (e.g. domestic

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[3] **NSW Health.** Consent To Medical And Healthcare Treatment Manual [Internet]. Sydney (AU): NSW Health; 2024 [cited 25 Sept 2024]. Available from: https://www.health.nsw.gov.au/policies/manuals/Documents/consent-section-8.pdf

and family violence). No matter the reasoning, decisions around consent must be respected. Providers should obtain written consent from the consumer for any communication between Aftercare workforce and identified support networks.

It is important to differentiate between an Aftercare provider sharing information and receiving information. An Aftercare provider listening to family, carers, friends or kin who choose to share information does not breach confidentiality.

Helpful Resources:

- NSW Health Patient Privacy
- NSW Health Privacy Manual for Health Information. Of note:
  - Section 11 - Using and disclosing personal health information
- NSW Health Consent to Medical and Healthcare Treatment Manual
- Information and Privacy Commission NSW. Of note:
  - Consent Checklist and Fact Sheet
  - Privacy and persons with reduced decision-making capacity
  - Access to Health Information for Health Care Consumers
  - Providing access to health information - guidance for health care providers

Service Capacity

Prioritisation

There needs to be an established procedure for prioritising referrals based on local priority cohorts, accessibility and need. This procedure can be determined through local governance groups.

Aftercare services should prioritise people who have had a recent suicide attempt or are experiencing suicidal crisis. If capacity allows, services should consider referrals from those experiencing suicidal ideation who are at a higher risk of suicide with limited access to other suicide prevention services (e.g. Safe Havens or SPOTs). The prioritisation process should involve phone contact with the consumer – preferably by a peer worker – to understand their circumstances and suicidal risk.

Alternate Care / Declining Referrals

If the Aftercare service is at capacity and unable to accept new referrals, or the referral does not meet the eligibility criteria, the following steps should be taken within two business days from receipt of the referral:

- Communicate outcome back to referring provider/person.
- Direct consumers at high suicide risk to alternative services such as Safe Haven, the emergency department or emergency services.

- Suggest an alternative pathway of care. An alternative pathway may be a Safe Haven or safe space, or Lifeline's Eclipse Group support, along with help-line support (Service mapping – as detailed in Governance – should identify alternate referral pathways).

Initiation of Care

The period following a suicidal crisis is a time of heightened vulnerability for further suicide attempts. Providing timely access to high-quality follow-up and aftercare support can reduce the risk of further attempts and deaths[4]. The Sax Institute[5] found that rapid initiation of care was a key factor amongst effective Aftercare programs with some providers initiating care whilst the consumer was still in a tertiary setting. There has been a reported range of initiation of care taking place in the first 24 hours up to the first week[6]. Warm handover is recommended best practice, and Aftercare providers are encouraged to work and communicate with referring providers to facilitate a warm handover.

Timeframes for Contact

From receipt of referral, Aftercare programs should engage with consumers in the first two business days. Should providers have the capacity, contact should be initiated within one business day, or where relevant, commence while the consumer is still in hospital. Where workforce allows, it is encouraged that first contact is conducted by a peer worker[7].

If services are unable to respond within two business days, this should be communicated back to the referrer so alternate care can be arranged or current supports maintained until the Aftercare provider has capacity to initiate care.

For guidance on how to handle inbound referrals when Aftercare services are at capacity, see Service Capacity.

First Appointment

Care may be delivered via telephone, video conference, or face-to-face as part of a home, community or hospital-based visit. The person’s preferred mode of delivery should be discussed with them during the initial contact. There is evidence that contact made face-to-face is likely to improve engagement[8] and is therefore encouraged as the preferred mode for initial contact. For more information, see Modes of Delivery.

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[4] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

[5] Ibid

[6] Ibid.

[7] **Folk, Roses in the Ocean.** Lived Experience Of Suicide Service Guidelines: Aftercare. Sydney (AU): Roses in the Ocean; 2024 [cited 25 Sept 2024]. Available from: https://rosesintheocean.com.au

[8] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

Providing Care

Scope of Care

Aftercare services are non-clinical services that provide rapid and assertive follow-up of people after they have experienced suicidal crisis, behaviours or attempts. Aftercare is a service for people who want support to address their drivers of suicidality and reduce their suicidal risk.

Aftercare services are delivered in partnership with the consumer and should incorporate frequent risk assessment and safety planning, care coordination and navigation and support to follow a recovery plan. Aftercare provides psycho-social support with a problem-solving or solution-focused approach[9]. Aftercare services also connect the consumer with community-based services and other supports, through outbound referrals.

Aftercare services do not provide clinical treatment; however, clinical care may be part of the consumer's care plan and consumers should be encouraged to continue or commence clinical treatment where assessment indicates it is needed. This treatment can be received in parallel with Aftercare services and should be coordinated by the Aftercare services, where required.

Aftercare services should employ a person-centred and person-led approach to ensure the consumer's needs are met.

Roles and Functions

The roles and responsibilities of the Aftercare workforce – and how they function together – have been outlined in detail in Workforce. The Aftercare workforce includes peer workers, care coordinators, team leaders, and in some alternate models of care, mental health clinicians.

Peer workers draw upon their personal lived and living experience of suicide to provide authentic engagement and support for people accessing Aftercare services. Peer workers can bridge the gap between services and the consumer, through their understanding of isolation, shame and stigma following a suicide attempt or crisis.

Care coordinators provide comprehensive non-clinical psychosocial support to consumers and work collaboratively with peer workers to provide tailored, holistic and comprehensive support to consumers throughout service delivery.

Team leaders oversee and coordinate Aftercare services and ensure the service provides evidence-informed care that is innovative and tailored to the community they support. Team

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[9] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

leaders guide and support staff, while managing consumer care reviews, service demand and risk and escalation policies and procedures.

Program Duration

Individuals are at the greatest risk of suicide in the three-month period following a suicide attempt[10], although for some people the risk extends for a longer period. In Australia, Aftercare services have typically been offered as a 12 week intervention. Evidence from the Sax Institute[11] shows that the average duration for effective Aftercare services is longer than this, and it must be acknowledged that some people will need support beyond 12 weeks. For some consumers, the full 12 weeks will not be required.

Aftercare services should be focused on the needs of the person; being flexible around service length is an example of person-centered care.

Key Performance Indicator (KPI) requirements should not influence the duration of a consumer's care. For more information, see Performance Indicators.

People accessing services should be offered 12 weeks of support at a minimum, recognising that this is the period of greatest vulnerability to further suicide attempts following suicidal crisis.

Early Transition

If the consumer wishes to transition from the program prior to 12 weeks of care, providers should undertake the following before services cease:

- Discussion between the consumer and the peer worker or care coordinator, with team leader guidance, to ensure:
    - Safety and support planning has been reviewed.
    - Identified supports are available (e.g. family, carer, friend and kin support).
    - Other clinical or psychosocial support is available.
- Transition from the program has been communicated to the primary care provider(s) or referring service provider.
- The consumer understands they can re-enter the program should they need to.
- Regular contact has been planned at intervals that the consumer prefers, until the cessation of the 12 week period.

The flexibility to receive less than 12 weeks aftercare must be driven by the consumer accessing services and is not a means for Aftercare providers to increase service capacity.

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[10] **Australian Government.** National Mental Health And Suicide Prevention Plan [Internet]. Canberra (AU): Australian Government; 2021 [cited 25 Sept 2024].

[11] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

If more than 12 weeks is required

Evidence[12] shows that effective Aftercare services have – on average – a duration longer than 12 weeks. Every consumer's needs will be different, and some people will require support beyond a 12 week period.

Each service should develop criteria or guidance to support decisions and approval requirements about extending care beyond 12 weeks. Criteria may include consumers with more complex or multiple psychosocial needs (e.g. substance misuse, social isolation, housing problems or unemployment), those who have not been able to secure ongoing care where it is indicated, or those who experience a significant life stressor in the latter half of the program that has not resolved by the end of the 12 week period.

If suicidal crisis persists or escalates at the 12 week period, further support should be considered. To support transition from the program, and in the interests of the consumer's recovery and autonomy, the additional aftercare support should have an increasing focus on support planning and establishing support networks with:

- Family, carers, friends and kin
- Community networks or services
- Psychosocial services
- Primary care services

Modes of Delivery

Modes of delivery will change depending on the service type, consumer location and preference, and model of care. Modes of delivery should be flexible to adapt to the needs of the consumer and reviewed on an individual basis, in partnership with the consumer. Never make assumptions about a consumer's preference – check in and ask what will work best for them.

Considerations for appropriate modes of engagement for different populations have been further detailed within Supporting Priority Populations.

Face-to-Face

Face-to-face engagement should be made available for consumers if this is their preferred method of engagement (noting exceptions for alternate Models of Care that are virtual care based). Face to face contact may be particularly appropriate for:

- Consumers with limited access to technology or internet
- Consumers without access to a safe and private space
- Consumers who are comforted by known processes

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[12] Ibid.

- Consumers – particularly from priority populations – who may benefit from initial face to face engagement to help build rapport and trust.

Workforce Safety Considerations

When delivering offsite face-to-face care, providers should implement policies and procedures to ensure workforce safety. This is particularly applicable to providers who may be travelling longer distances to remote locations to support rural or remotely based consumers.

Key considerations may include:

- Safe driving practices and appropriate hours to travel (i.e. not at dawn and dusk).
- Travelling in pairs if appropriate.
- Ensure staff have appropriate resources to safely carry out duties.
- Agreed methods of communication and check ins.

Virtual Care

What is Virtual Care?

Virtual care involves any interaction between a consumer and care provider(s), or between care providers, that occurs remotely using technology[13]. You may have heard it referred to as ‘telehealth’, but virtual care is the more appropriate language as it encompasses more than just telephone. Virtual care can include:

- Videoconferencing
- Telephone
- Case conferencing with other providers
- Virtual triage
- Use of mobile phone apps
- Text messaging

Aftercare and Virtual Care

Virtual care can be a safe mode of Aftercare that complements in-person connections. Consumers may prefer to engage via virtual care, and this should be supported where appropriate. This may be due to reasons such as:

- Work and school commitments
- Avoiding the need for travel
- Preferring the anonymity of virtual care (i.e. don’t want to attend clinic in person due to concerns around shame, stigma and privacy).

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[13] **NSW Agency for Clinical Innovation.** Virtual Care in Practice: About [Internet]. Sydney (AU): NSW Agency for Clinical Innovation; 2023 [cited 25 Sept 2024]. Available from: https://aci.health.nsw.gov.au/virtual-care-in-practice/about

- Improved accessibility for themselves and family, carers, friends and kin.

Consumer Considerations

When considering virtual care, Aftercare providers and consumers should discuss the safety and appropriateness of this mode of delivery. Key considerations include:

- Consumer preference and consent.
- Access to internet and technology.
- Digital literacy and supports.
- Language or translator requirements.
- Privacy and safety – e.g. children or partners who may overhear (domestic and family violence concerns).
- Availability of family, carers, friends and kin to support consumer during or after engagement.
- Necessary adjustments to risk escalation processes to consider distance and availability of local services and supports.

Useful Resources

The ACI has developed a suite of resources aimed at clinicians and consumers to support the delivery of virtual care. Whilst this is a resource written for NSW Health clinicians, the principles apply in the context of Aftercare.

Aftercare providers are encouraged to familiarise themselves with the below if supporting consumers via virtual care:

- Virtual Care in Practice Guide
- Resources for providers and consumers
- Virtual Care Principles

Safety and Support Planning

Safety Planning

A safety plan equips the consumer with tools and strategies to manage suicidal thoughts and behaviours. Safety planning helps people reduce the immediate risk of suicidal behaviour and has been evaluated as effective in several research papers[14] [15]. It is important to identify social determinants of suicide that may be impacting on the consumer's wellbeing, this may

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[14] **Ferguson M, Rhodes K, Loughhead M, et al.** The Effectiveness Of The Safety Planning Intervention For Adults Experiencing Suicide-Related Distress: A Systematic Review. Arch Suicide Res. 2022 Jul-Sep;26(3):1022-1045. doi: 10.1080/13811118.2021.1915217. Epub 2021 Apr 29. PMID: 33913799

[15] **Abbott-Smith S, Ring N, Dougall N, et al.** Suicide Prevention: What Does The Evidence Show For The Effectiveness Of Safety Planning For Children And Young People? – A Systematic Scoping Review. J Psychiatr Ment Health Nurs. 2023 Apr 13. doi: 10.1111/jpm.12928.

include housing, financial stress and barriers, family and domestic violence, relationship breakdown, social isolation and loneliness, employment, physical health and spiritual needs. A safety plan aligns to a human rights approach and must support the consumer to identify coping and help-seeking strategies that are tailored to their needs, circumstances and personal relationships.

Safety planning should be considered in line with risk monitoring and escalation policies and procedures, as detailed further below and in Clinical Governance.

With consumer consent, best practice recommends the inclusion of carers, family, friends and kin in the development of safety plans. It is important to note that the safety plan belongs to the consumer, and consent is required from the consumer before services share this with other services and carers, family, friends and kin.

Developing a New Safety Plan

Safety planning must be person-centred and person-led, collaborative and tailored to the consumer's specific needs. Feedback from people with lived and living experience tells us that consumers want the plan developed *with* them, not *for* them[16].

In developing a safety plan, workers should discuss and agree with the consumer:

- Ownership of the plan (the consumer).
- Pros and cons of sharing it with others (e.g. health professionals, other services, family, carers, friends or kin).
- If they have used a safety plan before and what strategies were helpful.
- Timeframes and processes for review.

It is the consumer's choice to create a safety plan, and it must be developed with their consent. If the consumer does not wish to create a safety plan, it is still important to begin a conversation about their early warning signs, reasons for living and current coping strategies. These can be documented on the consumer's file and translated into a safety plan, if the person is willing, in a later session. It may also be useful to understand the barriers to creating a safety plan by asking open-ended questions about this.

The Beyond Now website is a useful tool in guiding consumers and workforce on the development of a safety plan.

Existing Safety Plans

If the consumer already has a safety plan, with their consent, this should be carefully reviewed to ensure it is current and effective.

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[16] **Ferguson M, Rhodes K, Loughhead M, et al.** The Effectiveness Of The Safety Planning Intervention For Adults Experiencing Suicide-Related Distress: A Systematic Review. Arch Suicide Res. 2022 Jul-Sep;26(3):1022-1045. doi: 10.1080/13811118.2021.1915217. Epub 2021 Apr 29. PMID: 33913799

As detailed in Governance, opportunities to reduce the burden on consumers by streamlining safety plans should be explored. When safety plans are developed, these should be shared (with permission) across the care team to allow for consistency of care and to reduce burden on the consumer to develop duplicate plans.

Support Planning

A support plan is associated with recovery goals and is more focused on a consumer's plan to stay connected and supported in their recovery. Whilst this may overlap with a safety plan, it is important to recognise this as a separate plan with a different focus.

Like safety plans, providers should explore opportunities to share support plans (with consent) to reduce the burden on the consumer in duplicating these and ensure consistency of care.

Risk Monitoring and Escalation

The presence of suicidal thoughts and behaviours, and the consumer's ability to manage these, should be reviewed at each meeting with the consumer. Where the consumer reports ongoing or re-emerging suicidal thoughts, their safety plan and coping strategies should be discussed. This may assist in confirming the level of support required, i.e. are they able to use their own internal coping strategies or do they need additional support?

For further detail on responding to escalated suicide risk, see Clinical Governance.

Supporting Autonomy

Working with consumers who experience suicidal thoughts and behaviours means addressing both autonomy and safety. These goals are not mutually exclusive.

Supporting consumer autonomy can increase safety through:

- Improved engagement with services and their staff.
- Support to disclose suicidal thoughts.
- Encouragement to identify, develop and practice their self-directed coping strategies.
- Reducing re-traumatisation through use of minimally restrictive practices.

Collaborative safety planning (*see above*) aligns with both goals and is an important part of supporting autonomy.

Working with Care Providers

Effective aftercare involves the collaboration of a variety of care providers and services, as identified in service and stakeholder mapping. Working collaboratively with all involved parties is imperative to supporting Universal Aftercare.

For more detail on who to be engaging, methods to engage and ways in which all key partners can work together, see Operational Governance.

Communication

Effective methods of communication with key identified partners and services should be determined at the Aftercare provider level, in collaboration with other partners. As detailed in Operational Governance, formalisation of partnerships is an opportunity to detail what this working relationship looks like.

Other key considerations for agreements with providers include:

- Warm handover.
- Shared duty of care.
- Communication touchpoints.
- Key contacts.

Outbound Referrals

A key challenge identified by Aftercare providers during consultation[17] was the limited capacity of other services and providers to accept referrals from Aftercare services.

As detailed in Operational Governance, Aftercare providers are encouraged to undertake service and stakeholder mapping. Services and partners identified in these exercises may be appropriate to refer to when other services do not have capacity.

Concerns about service capacity and inaccessibility can also be escalated through established local governance groups to identify local solutions in partnership with key stakeholders.

Family, Carers, Friends and Kin

Family, friends, carers and kin may include partners, parents, siblings, chosen family, extended family, housemates, colleagues and other relationships. Please note children or young adults may also be taking on caring roles within their families.

The support that family, friends, carers and kin can provide to someone following a suicide attempt or suicidal distress is critical. Some people may use the term 'carers' to describe this support role, others do not. Different members of a consumer's support network may have different caring roles and Aftercare providers should recognise these roles are dynamic and may look different in other circumstances.

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[17] **NSW Agency for Clinical Innovation.** NSW Universal Aftercare Project: Consultation Findings. Sydney (AU): NSW Agency for Clinical Innovation; 2024 [cited 25 Sept 2024].

The level of support family, friends, carers and kin provide is contingent upon their personal resources which may be impacted by factors such as:

- The chronicity and severity of the consumers' suicidal distress.
- The closeness of the relationship between the consumer and family, friend, carer or kin.
- Additional stressors such as maintaining employment responsibilities, financial difficulties, other caring responsibilities (e.g. children, elderly parents, people with disabilities) or social isolation.
- The accessibility of individual and structural supports, including from health professionals, other organisations, or other family and friends.

Identifying Supports

The identification of family, carers, friends and kin should be collaborative and undertaken with the consumer. Identification should include discussion of the pros and cons of involving specific people in their support network. Consumer consent should always be obtained before approaching support people or sharing confidential information. Once support people have been identified it is preferable that a joint discussion occurs with the consumer and their identified support(s) to understand and agree expectations. The priority of family, friends, carers and kin involvement is to support the consumer, and not to obtain collateral information.

If the consumer is reluctant to identify a support network, review the barriers together. If the barrier is dysfunctional relationships within family, carer, friend or kin structures, then discuss other people who may be more supportive and/or appropriate.

If the consumer is unable to identify anyone supportive in their network, this might indicate a need to connect them with social groups as part of their care. If the barrier is shame about their suicidality or mental health, connection with a peer support group may be helpful, alongside discussion about that shame and options for self-disclosure and seeking support.

Recognising 'chosen family'

It is important to acknowledge the complexities and dynamic nature of family and kin systems. The identification of a support network for consumers may not always include immediate family members. For example, for many LGBTIQ+ people there may be conflict or disconnection with family of origin, and it is important to recognise the importance of chosen family for these communities.

Promoting involvement of family, friends, carers and kin

The inclusion of family, friends, carers and kin in aftercare can improve outcomes for consumers[18] [19]. Where appropriate, the involvement of family, friends, carers and kin should be encouraged and accommodated by Aftercare providers.

As detailed in Operational Governance, representation of family, friends, carers and kin should also be considered in local governance groups to inform service delivery and embed the voices of people with lived and living experience in governance structures.

Support for family, friends, carers and kin

While family, friends, carers and kin play a key role in recovery and suicide prevention, they frequently experience emotional strain and elevated risks to their own wellbeing. Incorporating carer support into aftercare is crucial, for their own mental health and wellbeing, and to improve the support they provide to consumers.

Support for the family, friends, carers and kin was identified as an important gap in existing Aftercare services by people with lived and living experience[20]. If capacity allows, psychosocial education could be provided by the Aftercare provider.

Many family, carers, friends and kin who provide support do not identify as carers and, as such, potentially miss out on supports available to them. In these circumstances the Aftercare provider should provide them with information about the support they can access.

The *Minds Together* program addresses this gap by offering a free, evidence-informed, self-paced online program specifically for family, friends, carers and kin supporting someone following a suicide attempt or experiencing suicidal distress. Informed by and including people with lived and living experience, it helps carers manage the emotional demands of their role while enhancing their knowledge and skills. The program connects users with essential resources, supporting their mental health and increasing their capability to provide effective care. Carer Gateway is an Australian Government program providing free emotional and practical services and support for carers, family, friends and kin. The program includes counselling, coaching, peer support, respite and carer directed support packages. Aftercare providers are encouraged to refer family, friends, carers and kin to the Minds Together and Carer Gateway as part of standard practice.

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[18] **NSW Health.** Mental Health Services For Families And Carers [Internet]. Sydney (AU): NSW Health; 2023 [cited 25 Sept 2024]. Available from: https://www.health.nsw.gov.au/mentalhealth/Pages/services-family-carer.aspx

[19] **Mental Health Coordinating Council.** Carers Of People With Mental Health Conditions: Overview [Internet]. Sydney (AU): MHCC; 2023 [cited 25 Sept 2024]. Available from: https://mhrm.mhcc.org.au/chapters/9-carers-of-people-with-mental-health-conditions/

[20] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

Supporting People from Priority Populations

A key element of Universal Aftercare is ensuring services are inclusive and responsive to all people who require support, regardless of gender, age, sexuality, religion, ethnicity, impairment/disability and culture. The transition to Universal Aftercare in NSW aims to deliver improved outcomes for all experiencing suicidality, with a focus on priority groups at increased risk of suicide.

It is important that Aftercare services are flexible to adapt their service delivery to best meet the needs of the consumer. For example, methods of communication, the environment, using appropriate assessment tools and tailored resources.

For an in-depth overview of each priority population, additional risk factors and challenges they may experience, key considerations for supporting these consumers and links to helpful resources, see Supporting Priority Populations.

Culture Care Connect

Culture Care Connect is an Aboriginal specific Aftercare program that integrates suicide prevention and holistic aftercare with cultural sensitivity and community empowerment[21]. It is a federally funded program developed by NACCHO. The Culture Care Connect program is delivered by more than 40 ACCHOs across Australia, and 11 within NSW.

Aboriginal people have a right to choice

All Aboriginal people have a right to choice and may prefer to access Aftercare services (or any service for that matter) from a mainstream provider. It is important not to assume that an Aboriginal person will seek their care from an ACCHO.

Some reasons why Aboriginal may not wish to access care from an ACCHO include:

- Difficulty maintaining privacy at local ACCHOs
- Not wanting to identify
- Complicated kinship and familial relationships

It is likely that Culture Care Connect is delivered by the local ACCHOs in your region. The presence of such services does not remove the responsibility for Aftercare providers to provide culturally inclusive and responsive services to Aboriginal people.

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[21] **National Aboriginal Community Controlled Health Organisation.** Culture Care Connect [Internet]. Canberra (AU): NACCHO; 2023 [cited 25 Sept 2024]. Available from: https://www.naccho.org.au/culturecareconnect/

Cultural Humility

Murray PHN’s Cultural Humility Framework outlines initiatives for building and strengthening the capacity of the workforce to work in partnership with Aboriginal people to deliver culturally informed, responsive and safe services, that are free of racism.

Transition from the Program

Not all consumers will progress through the Aftercare program at the same pace. Transition from Aftercare services must be well-organised and supported in consultation with the consumer and their support network.

The Agency for Clinical Innovation has developed the ‘Key principles for transition care’ to support clinicians and healthcare services improve the transition from youth to adult services. Whilst this has been developed in a clinical context, the principles can be applied in the Aftercare context. These key principles emphasise the importance of:

- Formal transition processes
- Early preparation
- Empowering and encouraging consumers
- Good communication and shared responsibility
- Individualised transition plans
- Follow up

Gradual Transition

As the consumer becomes well throughout the duration of the Aftercare program, it may be beneficial to reduce the frequency of engagement to support their gradual transition out of the service. This should be discussed with the consumer and align with their needs.

The final two meetings with the consumer should include:

- Review of safety and support plans.
- Confirmation of ongoing care plan.
- Communication with care team/referring provider regarding the transition out of the Aftercare service (with consent).
- The involvement of family, carers, friends or kin (with consent).
- Consideration for gradual transition, caring contact or re-entry if required.
- Celebrating successes and achievements – planning for a “good” goodbye
- Storytelling and capturing the consumer experience in a person-centred manner (for more information, see Informing Best Practice).

Unplanned Transition

Instances of unplanned discontinuation of the program may occur with consumers for a range of reasons. It is important that Aftercare providers have guidelines around what to do in this instance. This process can be discussed and determined with local governance groups and communicated to consumers at service onboarding. Consideration should be given to:

- What length of no contact is considered an instance of unplanned discontinuation.
- How long to continue attempts to contact.
- Ongoing caring contacts.
- Process for closing file.
- Communication required with other care providers or family, carers, friends and kin (if consumer consent was provided).
- The process for re-entry to the program should the consumer wish to resume services.
- Data collection that may inform retention/engagement rates.

Caring Contacts

Consumers may benefit from brief caring contacts (e.g. texts, calls, postcards or letters) at the end of the Aftercare program. This may be for a period up to 12 months, or less, as determined by the needs of the consumer and in the context of service capacity. Evidence demonstrates that caring contacts can reduce re-presentation to hospital for self-harm[22] and re-occurrence of suicide attempts [23] in the 12-18 months following an initial suicide attempt.

Re-Entry

Consumers should be able to access Aftercare services again if required. Previous access to Aftercare services does not preclude consumers from re-entering the program. The process to re-enter the program should follow referral pathways as outlined in Entry to the Program. Individual services should manage this according to service capacity and may choose to track these trends to inform service delivery.

Frequent program access may indicate the need for an alternative approach, and the Aftercare provider should have a conversation with the consumer about the appropriateness of the service for them and if the program is meeting the consumer's needs.

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[22] **Stevens GJ, Sperandei S, Carter GL, et al.** Efficacy of A Short Message Service Brief Contact Intervention (SMS-SOS) In Reducing Repetition Of Hospital-Treated Self-Harm: Randomised Controlled Trial. Br J Psychiatry. 2024 Mar;224(3):106-113. doi: 10.1192/bjp.2023.152. PMID: 38083861; PMCID: PMC10884824.

[23] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

Priority Populations

This section addresses the key components of supporting priority populations to access Universal Aftercare which are:

- Inclusive and responsive Aftercare services, regardless of gender, sexuality, age, religion, ethnicity, impairment or disability, and culture.
- An open-minded Aftercare workforce, who are aware of unconscious biases, and create a safe space, free of prejudice and discrimination.
- Understanding and recognition of the role of intersectionality, and how this influences the experiences of a person.
- Recognition of consumers as people, with unique experiences, characteristics, preferences and strengths.
- Not making assumptions about consumers based on the priority population they may identify with.
- Service delivery is adjusted to best suit the needs of the consumer, including use of specified resources and tools.

Supporting Priority Populations

The transition to Universal Aftercare in NSW aims to deliver improved outcomes for all people experiencing suicidal crisis, with a focus on priority groups at increased risk of suicide including Aboriginal people, rural and remote communities, Culturally and Linguistically Diverse Communities, LGBTIQ+ people, older people, younger people and men.

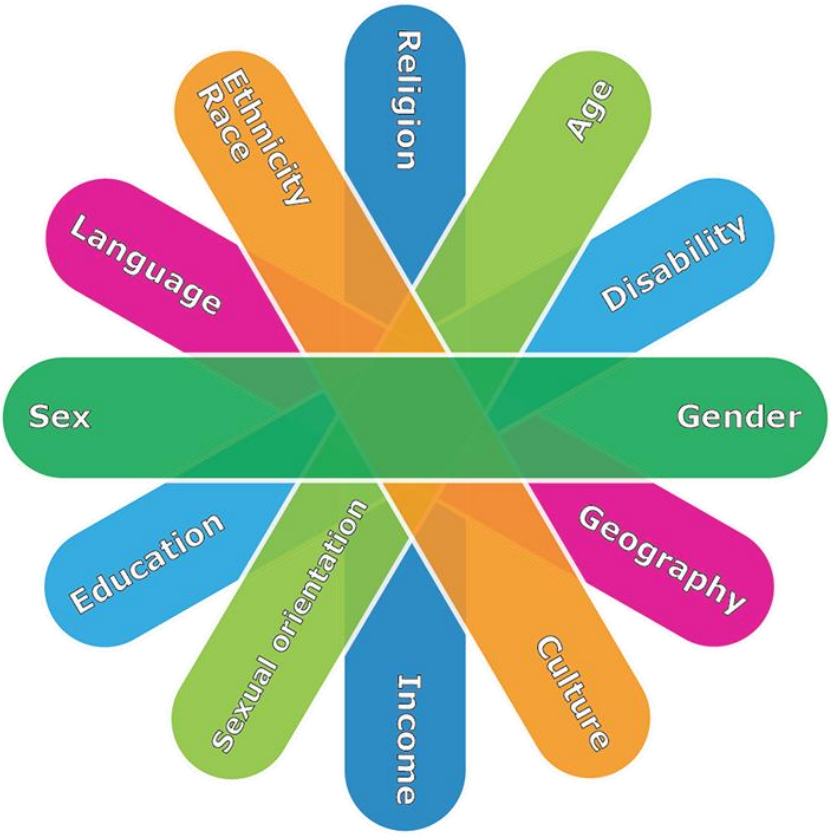
The importance of adapting care to meet the needs of the local community and priority populations has been spoken about throughout this resource. This section aims to focus in more depth on populations that are at higher risk of suicide and provide practical considerations for ways to ensure Aftercare services are responsive to the needs of these populations.

It is important to recognise the resilience and strength of priority populations, which are demonstrated through strong community bonds, cultural preservation, and adaptive strategies developed in the face of systemic challenges, discrimination and prejudice.

Intersectionality

Intersectionality is a term used to describe the different ways a person understands themselves, is perceived by others, and treated due to their identities in society. It is important to understand the different aspects of a person's identity and how these can expose them to overlapping forms of discrimination and marginalisation[24]. Figure 1 shows the range of factors that may shape and influence how a person understands their own experience of the world.

Figure 1: Intersectionality factors



Recognising the intersectionality of different identities is important when supporting Aftercare consumers. It helps to inform the context of a consumer's mental health. It's also essential in demonstrating respect for the whole person and understanding the intersecting ways that stigma and discrimination might impact an individual's mental health[25].

Whilst specific risk factors, challenges and considerations have been outlined under each priority population, these may also apply across populations. It is acknowledged that consumers may experience some, none or all of these and the Aftercare workforce is implored to consider how any of these factors may impact on, or apply to, consumers.

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[24] Victorian Government. Understanding Intersectionality. Melbourne: Victorian Government; [cited 29 Nov 2024]. Available from: https://www.vic.gov.au/understanding-intersectionality

[25] **NSW Agency for Clinical Innovation.** CAMHS LGBTIQ+ Resource for Change. Unpublished. Sydney (AU): NSW Agency for Clinical Innovation; 2024 [cited 25 Sept 2024].

Aboriginal and or Torres Strait Islander People

Overview

Aboriginal and or Torres Strait Islander people (herein respectfully referred to as Aboriginal people, in recognition that Aboriginal people are the first inhabitants of NSW) are significantly overrepresented in rates of suicide across NSW and Australia. Data from the Australian Bureau of Statistics indicates that the rate of deaths by suicide is approximately two and a half times higher among Aboriginal people compared with non-Indigenous Australians[26]. In 2022, suicide was the fifth leading cause of death among Aboriginal people[27].

At a system level, there is an urgent need to actively engage with Aboriginal communities to better understand these issues and to develop solutions together to prevent deaths by suicide amongst Aboriginal people[28]. At an individual level, Aftercare services present an opportunity to safely and meaningfully engage with Aboriginal consumers to support them in their recovery.

Risk Factors and Challenges

Experiences of racism, trauma, grief, loss and lack of autonomy collectively contribute to an increased risk of suicide for Aboriginal people[29]. The factors that place Aboriginal people at higher risk of suicide are highly complex and interwoven.

The below provides an overview of some common risk factors, however, is by no means exhaustive, nor will it be the experience of every Aboriginal person.

- Continued injustice caused by colonisation, including the forced removal of communities from Country and of children from their families, genocide and dispossession[30].

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[26] **Australian Institute of Health and Welfare.** Suicide Among Indigenous Australians [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians

[27] **Indigenous Mental Health and Suicide Prevention Clearinghouse.** Suicide Prevention: Indigenous Mental Health [Internet]. Canberra (AU): Indigenous Mental Health and Suicide Prevention Clearinghouse; 2023 [cited 25 Sept 2024]. Available from: https://www.indigenousmhspc.gov.au/topics/suicide-prevention#aboutthistopic

[28] **Heard TR, McGill K, Skehan J, et al.** The Ripple Effect, Silence And Powerlessness: Hidden Barriers To Discussing Suicide In Australian Aboriginal Communities. BMC Psychol. 2022;10:23. doi: 10.1186/s40359-022-00724-9

[29] **Heard TR, McGill K, Skehan J, et al.** The Ripple Effect, Silence And Powerlessness: Hidden Barriers To Discussing Suicide In Australian Aboriginal Communities. BMC Psychol. 2022;10:23. doi: 10.1186/s40359-022-00724-9.

[30] **Gibson M, Stuart J, Leske S, et al.** Suicide Rates for Young Aboriginal And Torres Strait Islander People: The Influence Of Community Level Cultural Connectedness. Med J Aust. 2021;214(11):514-518. doi: 10.5694/mja2.51084.

- Cultural devastation including loss of connection to Country, loss of identity, loss of language and loss of spirituality.
- Distrust of, and negative experiences with, the health system and services.
- Higher prevalence of disease burden and drug and alcohol misuse.
- Overrepresentation in the justice system.
- Overrepresentation in domestic and family violence.
- Transgenerational trauma.
- Impacts of overt and covert racism, and systemic racism and discrimination
- Lateral violence.
- Experiences of trauma, grief and loss.
- Social isolation and loneliness
- Colonial load
- Additional social determinants of health such as poverty, housing security and physical health.

Considerations

When supporting Aboriginal consumers, it is important to be aware of cultural practices and protocols and ensure you are providing care in a culturally safe way (see Cultural Capability in Workforce).

Before engaging with Aboriginal consumers, the Aftercare worker needs to:

- Have undertaken cultural capability training (see Workforce).
- Recognise the consumer's right to choice. Whilst there may be a local Culture Care Connect program available, not all Aboriginal people will choose to receive their care from the local ACCHO. Ask the consumer their preference.
- Speak with local Aboriginal stakeholders or representatives if guidance is needed, particularly around any key cultural considerations to be aware of (e.g. local Sorry Business). These organisations will have been identified in service and stakeholder mapping and may include the local Aboriginal Mental Health Clinical Leader/District Coordinator, LHD/SHN Aboriginal Health Unit, ACCHO, ACCO or Aboriginal organisation about any key cultural considerations to be aware of (e.g. local Sorry Business).
    - If the above are not available in your area, consider contacting the local Suicide Response Groups as these will have an Aboriginal representative.

Key considerations include:

- Giving consumers choice in terms of mode of delivery (some may prefer to meet in person) and location. Let consumers identify a space they feel safe.
- Ask permission before using names like Aunt or Uncle.

- Be aware of kinship structures and how this impacts their support networks. Ask who their support person(s) is.
- Ask them if they prefer to talk to an Aboriginal person.
- Be aware of language barriers – not all Aboriginal people speak English as a first language.
- Age – it might not be respectful or appropriate for a younger peer worker/care coordinator to support an older person and vice versa. Ask consumers what they are comfortable with.
- Cultural considerations regarding men's and women's business – it might not be respectful or appropriate for a female peer worker/care coordinator to support a male and vice versa. Ask consumers what they are comfortable with.
- Be curious – Ask about traditional language if it is being used by a consumer to describe their experiences.
- Be aware of Sorry Business protocols and how this may impact your engagements with the consumer
- Minimise the need for the consumer to repeat their story, acknowledging the emotional burden of this.
- Cultural load – it is your responsibility to educate yourself. Lean on your partnerships with local ACCHO, ACCOS, Aboriginal Mental Health Clinical Leader/District Coordinator, LHD/SHN Aboriginal Health Unit, or other Aboriginal organisations (see Local Partnerships).
- Check in on the person's decision to access mainstream services. Whilst the consumer may have chosen to receive aftercare from a mainstream provider instead of the local Culture Care Connect program, this may change throughout the course of the program. Check in and ask them about their choice.
- Understand the intersectionality with LGBTIQ+SB/LGBTIQSB+: Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Sistagirl, Brothaboy.
    - Sistagirl: is a term used by Aboriginal people to describe gender diverse people who identify as having feminine spirit, who align with a sense of womanhood and take on female roles in community. It can also be used in contexts to describe kin/known groups of Aboriginal women.
    - Brothaboy: is a term used by Aboriginal people to describe gender diverse people who identify as having masculine spirit, who align with a sense of manhood and take on male roles in community. It can also be used in contexts to describe kin/known groups of Aboriginal men.

Helpful Resources

- NACCHO's Culture Care Connect
- WellMob

- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP)
- CBPATSISP's Manual of Resources for Aboriginal & Torres Strait Islander Suicide Prevention
- NACCHO
- 13YARN
- AH&MRC (including social and emotional wellbeing resources)
- Yamurrah (for workforce support, education and training)
- Conversations Matter
- Kimberley Aboriginal Suicide Prevention Plan, 2021- 2025
- Cultural Humility Framework

Culturally and Linguistically Diverse Communities

Overview

Australia has a large culturally and linguistically diverse population. Refugee and humanitarian entrants, and other permanent migrant Australians form part of the larger culturally and linguistically diverse communities within Australia[31]. There are an estimated 7.3 million migrants living in Australia[32]. It is important to understand that each multicultural community is unique and has diverse experiences and cultural practices.

Culturally and linguistically diverse communities and refugees are identified as priority populations under the National Mental Health and Suicide Prevention Agreement. Whilst difficult to quantify, it is known that people from these communities experience higher levels of psychological distress compared to other Australians[33]. Data from 2007-2020 indicated that in Australia, refugees and asylum seekers experienced 1.7 times the rate of suicide compared to other permanent migrants[34]

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[31] **Australian Institute of Health and Welfare.** Suicide Among Refugee And Humanitarian Entrants And Other Permanent Migrants [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-among-refugee-and-humanitarian-entrants-and-other-permanent-migrants

[32] **Pham TTL, Berecki-Gisolf J, Clapperton A, et al.** Definitions Of Culturally And Linguistically Diverse (CALD): A Literature Review Of Epidemiological Research In Australia. Int J Environ Res Public Health. 2021 Jan 16;18(2):737. doi: 10.3390/ijerph18020737. PMID: 33467144; PMCID: PMC7830035.

[33] **Suicide Prevention Australia.** Stats And Facts: CALD Communities [Internet]. Sydney (AU): Suicide Prevention Australia; 2023 [cited 25 Sept 2024]. Available from: https://www.suicidepreventionaust.org/news/statsandfacts#cald

[34] **Australian Institute of Health and Welfare.** Refugee And Humanitarian Entrant Health [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/reports-data/population-groups/cald-australians/refugee-and-humanitarian-entrant-health

Risk Factors and Challenges

People from culturally and linguistically diverse communities may be exposed to additional risk factors for suicide, which also pose as barriers to accessing Aftercare services. These may include:

- Adjusting to a new culture
- Religious and cultural beliefs of mental health and suicide supports
- Experiences of stigma and discrimination
- Changes in social and family support networks
- Communication and language barriers
- Increased social isolation
- Navigating different cultural identities (particularly amongst youth)

Additionally, culturally and linguistically diverse Australians who are refugees or humanitarian entrants may experience trauma from[35]:

- Persecution or human rights abuses within their country of origin.
- Exposure to war, violence or atrocities.
- Separation from family and friends.
- Asylum seeking or migration process.
- Time spent in immigration detention or processing centres.
- Difficulty in accessing service and supports including NDIS and Medicare.
- Difficulties obtaining and maintaining employment, particularly for refugees who had professional qualifications that aren't recognised in Australia.

Considerations

- Be curious – take the time to learn about the person's culture and background. This can be effective for feelings of isolation and connecting meaningfully (Transcultural Mental Health Centre have developed community mental health profiles that may assist).
- Have information available in the person's language- these are available here.
- Cultural practices or beliefs around gender and age – e.g. is it appropriate for males to support female consumers, and vice versa? Is it appropriate for younger staff member to support an older consumer, and vice versa?
- Cultural and religious beliefs about mental ill health and suicide- are there better ways to discuss wellbeing and illness that avoid issues of stigma, shame or taboos?

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[35] **Forum of Australian Services for Survivors of Torture and Trauma (FASSTT).** Never Turning Away: Australia's World-Leading Program Of Assistance To Survivors Of Torture And Trauma [Internet]. Sydney (AU): FASSTT; 2018 [cited 25 Sept 2024]. Available from: https://www.fasstt.org.au

- Recognise their family, carers, friends and kin structure may look different to others. This may be a large, multigenerational support network or they may have experienced separation from family during migration or asylum process.
- Make sure translators are available, and check with the consumer if they would like to have a translator available. For small community cultural groups, there may also be issues in finding a translator that is unknown to the person.
- Do not rely on family, carers, friends and kin to be translators. They are there as supports. It can be distressing or burdensome for them to translate, and information and nuances may get lost in translation back to the consumer.
- Do not use machine translation (such as google translate) to provide information.
- Check in with the consumer – ask them how they like to communicate and work together.
- Reach out to Transcultural Mental Heath Centre, NSW Refugee Health Service or STARTSS (for torture and trauma survivors) for support.

Helpful Resources

- Transcultural Mental Health Line- 1800 648 911
- Transcultural Mental Health Centre
- NSW Refugee Health Service
- Blue Knott (the National Centre of Excellence for Complex Trauma)
- Embrace Multicultural Mental Health
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTSS)
- Conversations Matter

LGBTIQ+ Communities

Overview

In this section, 'LGBTIQ+' is used to denote the experience of lesbian, gay, bi+, trans, Intersex and queer individuals. LGBTIQ+ is the acronym used by NSW Health and defines the populations that are the focus of funding under the NSW LGBTIQ+ Health Strategy 2022-2027[36].

LGBTQ+ is used below where the content is talking about experiences that do not necessarily include people who are Intersex. This difference is important, because often people with

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[36] NSW Health. LGBTIQ+ Health Strategy 2022-2027; 2022. [cited Sept 2024] Available from: https://www.health.nsw.gov.au/lgbtiq-health/Pages/lgbtiq-health-strategy.aspx

innate variations of sex characteristics (intersex) are not included in research and often do not identify as part of LGBTQ+ communities[37].

The inclusion of LGBTIQ+ people as a priority population in Universal Aftercare acknowledges the higher risk of suicidal behaviours amongst this population, compared to the broader population[38].

Data presented by LGBTIQ+ Health Australia (LHA) [39] indicates that:

- LGBTIQ+ young people aged 16 to 27 are five times more likely to have attempted suicide compared to the general population.
- Transgender people aged 14-25 are fifteen times more likely to have attempted suicide compared to the general population.
- In the largest national survey of LGBTIQ+ Australians, 57% of participants reported high or very high psychosocial distress in the previous four weeks, compared to only 13% of the general community.

Risk Factors and Challenges – LGBTIQ+

Table 2 below outlines some common risk factors and challenges that LGBTIQ+ people may experience, and examples of what this looks like in practice. This is not an exhaustive list of risks, challenges, or how these can manifest.

Table 2: Risk Factors and Challenges

Risk or Challenge	What this can look like
Stigma and discrimination	▪ Not recording LGBTIQ+ experience in data collection processes eg. intake forms. ▪ Refusal to use correct name and pronouns ▪ Homophobia and transphobia
Gatekeeping of services	▪ Restricting access to supports and services based on gender and sexual identity (e.g. gender affirming care)
Past negative experiences or trauma	▪ Experiencing homophobia, transphobia or endosexism[40] when accessing health services by health professionals. ▪ Experiences of conversion practices.

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[37] **NSW Agency for Clinical Innovation.** CAMHS LGBTIQ+ Resource for Change. Unpublished. Sydney (AU): NSW Agency for Clinical Innovation; 2024 [cited 25 Sept 2024].

[38] **Life in Mind Australia.** LGBTIQA+ Communities: Priority Populations In Suicide Prevention [Internet]. Newcastle (AU): Life in Mind Australia; 2023 [cited 25 Sept 2024]. Available from: https://lifeinmind.org.au/suicide-prevention/priority-populations/lgbtiqa-communities

[39] **LGBTIQ+ Health Australia.** National LGBTIQ+ Mental Health And Suicide Prevention Strategy 2021-2026. Sydney (AU): LGBTIQ+ Health Australia; 2021 [cited 29 Sept 2024]. Available from: https://www.lgbtiqhealth.org.au

[40] Endosexism means treating endosex bodies (bodies which are not intersex) as valid, and bodies with innate variations of sex characteristics as disordered or in need of 'fixing'. See: https://www.health.nsw.gov.au/lgbtiq-health/Pages/language-and-terminology.aspx

Application of restrictive practice in health settings	Use of seclusion or restraint under the guise of care or protection that is not in accordance with the principles and mandatory requirements outlined in 'Seclusion and Restraint in NSW Health Settings' (PD2020_004).
Isolation	Due to sustained exposure to stigma and discrimination, LGBTIQ+ people can experience higher rates of isolation from family and friends. This can impact the experience of forming and maintaining future relationships due to fear of further rejection or judgement.
Assumptions	▪ Assuming sexual identity on presentation at health service. ▪ Sexual orientation, innate variation of sex characteristics or gender identity is viewed as a mental illness.

Considerations

When supporting LGBTIQ+ consumers, it is important to be aware of your language, approach and consumers' personal experiences.

Some key considerations include:

- Use correct pronouns and name. Ask the consumer how they would like to be referred to and what their pronouns are, and then use them.
- Create a safe, welcoming environment (e.g. flags or inclusive language/posters).
- Validate experiences of stigma, discrimination and stereotyping.
- Be clear on consent and privacy, to abate fears of being prejudiced for identity or being 'outted' if not already out to family, friends, carers or kin.
- For people living with an innate variation of sex characteristics, their experience might not be necessary to disclose. If a person chooses to disclose, respect consent, and confidentiality agreements about how they want to be understood.
- Flexibility and openness to adapt service delivery to the needs of the consumer (modes of delivery, length of sessions, see above notes on neurodiversity).
- Recognise and value the chosen family and support people that consumer identifies – recognising that for many LGBTIQ+ people there may be conflict or disconnection with family of origin. Recognising the importance of chosen family for these communities.
- Don't make assumptions about relationships, avoid cis heteronormative thinking (e.g. acknowledging polyamorous relationships).
- Don't assume that a consumer's sexuality, gender or sex characteristics are related to their experience of suicidality or need to be a focus of their support – ask what is important for them.
- Respect the person's right to choose how they live their life, be professional, respectful and kind

- Be clear, transparent and follow through on what you say you'll do – building trust is vital. There can be fear and a lack of trust between LGBTIQ+ people and health services due to previous negative experiences.
- Be aware of the potential impact of police and justice services due to previous negative experiences due to over policing of community[41]. If utilising emergency services due to mental health crisis, e.g. try to engage SPOT if this is an option.

Helpful Resources

- ACON – NSW leading HIV and LGBTQ+ health organisation
- Interlink - brings people together to talk about living with innate variations in sex characteristics with the support of trained counsellors and intersex peer workers.
- Twenty10
- Here – ACON's digital suicide prevention hub
- Transhub
- LGBTIQ+ Health Australia
- NSW Health – LGBTIQ+ resource
- LGBTQ+ Inclusive and affirming practice guidelines
- Intersex Human Rights Australia

Men

Overview

Men are significantly overrepresented in deaths by suicide and are one of the most vulnerable populations to death by suicide. Australian males are three times more likely to take their own life compared to females[42]. It is known that men have higher rates of fatal suicide attempts compared to females[43], emphasising the importance of ensuring access to Aftercare services for males with suicide ideation or crisis, prior to a suicide attempt.

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[41] **Dwyer A, Ball M, Lee M, et al.** Barriers Stopping LGBTI People Accessing LGBTI Police Liaison Officers: Analysing Interviews With Community And Police. In: Dwyer A, Ball M, Lee M, editors. Sydney (AU): Taylor & Francis; 2021 [cited 25 Sept 2024].

[42] **Australian Institute of Health and Welfare.** Suicide And Self-Harm Monitoring Data [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data

[43] **Australian Institute of Health and Welfare.** Suicide And Self-Harm Monitoring Data [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data

Risk Factors and Challenges

Risk factors and challenges that are associated with male suicide include[44] [45]:

- Financial distress
- Unemployment or threat of job loss
- Housing insecurity
- Relationship conflict or breakdown
- Alcohol or drug misuse
- Gambling addiction
- Concerns about privacy – particularly in rural areas
- Shame and stigma surrounding men's mental health
- Difficulty or hesitancy in accessing services (if in full-time employment and services have limited service hours, or rurally based men in predominately agricultural jobs)

Considerations

- Acknowledge it may take men longer to open up - be patient and flexible in the ways you engage.
- Think about the type of activity when meeting – some men find it easier to communicate when multitasking. Some examples may include going for a walk with the dog, meeting in the park with a coffee or an outdoor activity.
- Think about the environment in which you meet – a consult room in a 1:1 environment may feel too intense for some men.
- Ask the consumer what they are comfortable with and what would they like to do.
- Privacy – some men may feel shame or embarrassment about seeking help. When meeting in public consider avoiding branded work uniforms or vehicles.
- Referral pathways should consider ways to engage men in the program, acknowledging low uptake of suicide prevention services amongst this population.

Helpful Resources

- Movember
- Men's Line Australia
- Doing it Tough?
- Headspace
- Mates in Construction
- Male Suicide Prevention Principles – Suicide Prevention Australia

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[44] **Seidler ZE, Dawes AJ, Rice SM, et al.** The Role Of Masculinity In Men's Help-Seeking For Depression: A Systematic Review. Clin Psychol Rev. 2016;49:106-118. doi: 10.1016/j.cpr.2016.09.002. PMID: 27664823.

[45] **Life in Mind Australia.** Men: Priority Populations In Suicide Prevention [Internet]. Newcastle (AU): Life in Mind Australia; 2023 [cited 25 Sept 2024]. Available from: https://lifeinmind.org.au/suicide-prevention/priority-populations/men

People with Cognitive Disability or Neurodivergence

We recognise that that not all cognitive impairment is associated with disability. People may also use different language to best describe their experience. For the purposes of this document, cognitive disability and neurodivergence have been discussed together as there is significant cross over in the risk factors for suicide, challenges experienced and considerations for adapting service delivery to better support consumers.

Overview

Cognitive Disability:

A person's cognitive disability might be because of conditions including intellectual disability, developmental disability, acquired brain injury and other neurodevelopmental conditions or severe persistent mental illness. A person with a cognitive disability may have trouble communicating, remembering, learning new things, concentrating, or making decisions that affect their everyday life[46] [47]. A person's experience of cognitive disability may be complex and affect them in different ways in different situations. Often, but not always cognitive disability can begin in childhood, affecting day to day function throughout a person's life.

People living with disability are one of the Australian government's priority populations for suicide prevention due to the high rates of suicide and self-harm among this population. People aged under 65 years, who used disability services between 1 July 2013 to 30 June 2018, died by suicide at a rate three times greater than the general population of the same age[48]. Forty percent of people with an intellectual disability will also experience a mental health problem, which places them at a further increased risk for death by suicide[49]

Neurodivergence:

Neurodiversity recognises that there is infinite neurocognitive variability across people, and that every person has a unique combination of abilities, needs and aspirations[50].

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[46] **NSW Health.** Responding to the health care needs of people with disability [Internet]. Sydney (AU): NSW Health; 2024 [cited 25 Sept 2024]. Available from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2024_030

[47] **NSW Health.** NDIS And Cognitive Impairment [Internet]. Sydney (AU): NSW Health; 2023 [cited 25 Sept 2024]. Available from: https://www.health.nsw.gov.au/disability/Pages/NDIS-and-cognitive-impairment.aspx

[48] **Australian Institute of Health and Welfare.** Deaths By Suicide Among People Who Used Disability Services [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/deaths-by-suicide-among-people-who-used-disability

[49] **NSW Mental Health Commission.** Living Well: A Strategic Plan For Mental Health In NSW 2014-2024 [Internet]. Sydney (AU): NSW Mental Health Commission; 2014 [cited 25 Sept 2024]. Available from: https://www.nswmentalhealthcommission.com.au/report/living-well-strategic-plan-mental-health-nsw-2014-2024

[50] **Neurodiversity Hub.** What Is Neurodiversity? [Internet]. Brisbane (AU): Neurodiversity Hub; 2023 [cited 25 Sept 2024]. Available from: https://www.neurodiversityhub.org/what-is-neurodiversity

Neurodivergence is an umbrella term that includes several conditions, such as autism, attention-deficit/hyperactive disorder (ADHD), Tourette syndrome, dyslexia and other learning difficulties such as dyscalculia, dysgraphia and dyspraxia/developmental coordination disorder[51]. Neurodivergent people may or may not also have an intellectual disability.

Neurodivergent people may describe their experience as a different way of processing thoughts and behaviour to the rest of the general population (described as neurotypical). This might include different ways of doing things or different sensory needs to help them to engage in the world[52].

Research[53] has shown that neurodivergent people are more likely to experience anxiety and depression and are at a higher risk of self-harm and suicide. While there is limited data on suicide deaths for neurodivergent people overall, it is known that people with autism are 7 times more likely to die by suicide than non-autistic people[54].

Risk Factors and Challenges

Neurodiverse people and people with cognitive disability face challenges that can put them at an increased risk of suicide but can also be barriers to accessing universal Aftercare services. These may include:

- Communication difficulties.
- Communicating distress through behaviour instead of language.
- The presence of mental health problems, chronic or complex physical health problems.
- Increased feelings of isolation.
- Stigma.
- Diagnostic overshadowing (when a consumer’s symptoms are wrongly attributed to an existing condition, leading to misdiagnosis or overlooked health issues).
- Previous negative experiences with health providers and others.

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[51] **R U OK?.** Neurodivergent: Resources And Support [Internet]. Sydney (AU): R U OK?; 2023 [cited 25 Sept 2024]. Available from: https://www.ruok.org.au/neurodivergent

[52] **headspace.** Neurodivergence As Defined By A Neurodivergent Person [Internet]. Melbourne (AU): headspace; 2023 [cited 25 Sept 2024]. Available from: https://headspace.org.au/headspace-centres/mount-druitt/neurodivergence-as-defined-by-a-neurodivergent-person/

[53] La Trobe University**.** La Trobe University Response To The Select Committee On Mental Health And Suicide Prevention [Internet]. Melbourne (AU): La Trobe University; 2021 [cited 25 Sept 2024].

[54] **Empowering Diversity in Neurodiversity Australia.** Autism And Suicide [Internet]. Sydney (AU): ED Neuro Australia; 2023 [cited 25 Sept 2024]. Available from: https://www.edneuroaus.com/autism-suicide

Considerations

When supporting consumers, it is important to be adaptive in the way you engage with them to improve the responsiveness of Aftercare services to their specific needs.

Key considerations include:

- If possible, plan the appointment in advance. Make sure you have access to a quiet space, some Easy-Read information, extra time and ask the consumer at the time of making the appointment what they might need to help them.
- Understand that neurodivergent people and people with cognitive disability may communicate differently, require more time to process information or formulate their thoughts. Consider planning for longer appointments.
- Use simple and clear communication.
- Be transparent and open about the care that will be provided.
- Don't assume everyone is the same, check in with consumers about what is working.
- Engage with both the consumer and any support people (including disability support workers) about what the consumer needs to help their communication and engagement.
- Ask the consumer how they like to best communicate and if they are comfortable for their support person to share examples of what works well.
- Make effort to connect and engage with the consumer about things that help them feel safer. This may include special interests or hobbies.
- Make available tools such as sensory aids and shared activities (such as walking, colouring or crafting) that the consumer can use whilst talking – this can aid effective and open communication by helping the consumer to regulate their nervous system.
- Recognise that emotional dysregulation or expression looks different for neurodivergent people and people with cognitive disability. Sensory overstimulation can be misinterpreted as distress, resulting in unnecessary and unhelpful escalation. Consider tools to support de-escalation.
- Be aware of common co-occurring conditions, such as obsessive-compulsive disorder, epilepsy and eating disorders.
- Make engagement structured and consistent to support feelings of safety and regulation (but be aware flexibility is still needed and ways you engage may change). If an appointment time or location needs to change, be clear about the reasons for the change and include the person in the decision-making process where possible.
- Discuss the mode of engagement (e.g. face-to-face or virtually). Ask the consumer what works well for them.
- Appropriate environments for engagement. For example, is the space accessible or can it be adapted to different sensory needs (e.g. low stimulus, dim lighting or comfortable seating).
- Consider accessibility of resources, for example, Easy-Read or visual aids.

Helpful Resources

The below resources may be helpful sources of information for service providers

- R U Okay – Tips to help support neurodivergent people
- NSW Health – Responding to the needs of people with disability
- Suicide Response Project- La Trobe University
- Autism CRC
- Intellectual Disability Mental Health Connect
- Just Include Me eLearning
- Black Dog Institute - Healthy Mind
- Intellectual Disability – Mental Health Direct
- Intellectual Disability Health Education
- Privacy and persons with reduced decision-making capacity
- Autism adapted safety plan

Older People

Overview

For the purposes of service delivery, NSW Health defines older people as those aged 65 years and above. Aboriginal people aged 50 years and over are eligible to access specific services targeted at older people, e.g. Older People's Mental Health services.

Older people are identified as a population disproportionately impacted by suicide in Australia. Males aged 85 and older experience the highest age-specific rate of suicide[55] across all age groups. In 2022, females aged over 85 years had the highest suicide rate of all female age groups[56].

Risk Factors and Challenges

Older people can have an increased risk of suicide due to[57]:

- Grief and bereavement

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[55] **Australian Bureau of Statistics.** Causes Of Death, Australia: Intentional Self-Harm Deaths (Suicide) In Australia [Internet]. Canberra (AU): ABS; 2023 [cited 25 Sept 2024]. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-australia

[56] **Life in Mind Australia.** Older Adults: Priority Populations In Suicide Prevention [Internet]. Newcastle (AU): Life in Mind Australia; 2023 [cited 29 Sept 2024]. Available from: https://lifeinmind.org.au/suicide-prevention/priority-populations/older-adults

[57] Ibid.

- Unresolved trauma
- Ageism
- Financial distress, unemployment and poverty
- Social isolation and loneliness
- Loss of ability to live independently due to physical health, disability or age-related difficulties
- Living with chronic health issues or chronic pain
- Existing mental ill-health conditions
- Perceiving oneself to be a burden on others
- Retirement and losing a sense of purpose or role in life
- Losing sense of agency – ability to make your own decisions

Considerations

In 2021, the NSW Ministry of Health commissioned the development of an Older People's Aftercare Service Delivery Model which provides detailed consideration for supporting Older People in aftercare.

The guiding principles for older persons' aftercare are [58]:

- Anti-ageism
- Anti-stigma
- Empowerment and agency
- Conveying hope
- Patience and pace
- Accessible
- Finding purpose through connections and meaningful activity.

Some key considerations include:

- People of different ages may need different approaches.
- Consider home based, in-reach appointments.
- Be patient and don't make assumptions about a consumer's capabilities.
- Don't assume that older people cannot, or do not want to learn how to engage with technology. Consider measures to support the use of technology with skill-based learning or adapting technology/engagement to suit the consumer's needs.
- Recognise that crisis and self-harm may look different for older people, e.g. refusing to eat, refusal to address health issues and terminal conditions, misuse of medications.
- Avoid or challenge thoughts of therapeutic nihilism – the view that treatment is of a limited or no benefit to the consumer.

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[58] **Wand AP, Karageorge A, Browne R, et al.** A Qualitative Study Of Multiple Voices To Inform Aftercare Services For Older Persons Following Self-Harm. Int J Geriatr Psychiatry. 2023;e5876. doi: 10.1002/gps.5876

- Older people may have difficulty in communication and/or comprehension due to sensory and/or cognitive impairments. Consider communication strategies.

Helpful Resources

- Older People's Mental Health services
- Life in Mind – Older Adults
- Older People's Suicide Prevention Pathway Project evaluation report
- Anglicare Training - Suicide Prevention for Seniors Program

Rural and Remote Communities

Overview

About 25% of the NSW population live outside of major cities[59]. People living in rural and remote areas enjoy higher levels of life satisfaction, increased community interconnectedness and social cohesion and higher levels of community participation, compared to their urban counterparts[60]. However, Australians living in these areas face additional challenges due to their geographic isolation and often have poorer health and welfare outcomes compared to those living in major cities[61].

Recent data indicates that suicide rates increase as population density decreases[62], meaning the further away from a major city there is a higher rate of suicide and suicidal behaviours.

Risk Factors and Challenges

Risk factors for people in rural and remote communities often also pose as barriers to accessing the appropriate care. Common risk factors and challenges include[63]:

- Limited availability of resources and services – e.g. primary health care, tertiary care, housing, employment and education.
- A lower likelihood to seek help (particularly by rural men).
- Limited access to culturally appropriate services for Aboriginal people.
- Barriers posed by travelling to access services – including distance, time and cost.

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[59] **NSW Mental Health Commission.** Rural Communities [Internet]. Sydney (AU): NSW Mental Health Commission; 2023 [cited 25 Sept 2024]. Available from: https://www.nswmentalhealthcommission.com.au/content/rural-communities

[60] **Australian Institute of Health and Welfare.** Suicide By Remoteness Areas [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/suicide-by-remoteness-areas

[61] Ibid.

[62] Ibid.

[63] **Life in Mind Australia.** Rural and Remote Populations: Priority Populations In Suicide Prevention [Internet]. Newcastle (AU): Life in Mind Australia; 2023 [cited 29 Sept 2024]. Available from: https://lifeinmind.org.au/suicide-prevention/priority-populations/rural-and-remote-populations

- Increased isolation.
- Climate distress – including experiencing drought, floods or bushfire.
- Increased access to firearms, chemicals or other means that might increase risk.
- Increased socioeconomic disadvantage due to job availability or security
- Increased financial distress due to natural disasters, loss of livestock, loss of property, cost of living and job security.

Considerations

Suicide prevention strategies in rural and remote Australia must be unique to the area and require different approaches to those strategies used in metropolitan areas[64].

Key considerations include:

- Appropriate and safe modes of delivery, including face to face or virtual care and when to use these (see Service Delivery).
- Ensure that service mapping covers smaller towns if service providers have provision in large geographic areas.
- Link in with local knowledge groups if service mapping is limited.
- Familiarise yourself with the cultural, economic, and social factors of the consumer's region and/or town. Not one town is the same.
- Take the time to understand how the consumer's region may influence their care and recovery (e.g. employment availability and housing availability).
- Link consumers in with community supports and networks to promote a sense of community and connection. Particularly helpful when service access is limited.
- Adapt solutions to be appropriate based on the location of the consumer (e.g. recognising limited employment opportunities in smaller towns).
- Adapt safety plans and risk escalation processes to consider factors such as rurality, access to firearms and distance to emergency service access.
- Workforce safety – for more information, see Modes of Delivery.

Helpful Resources

- Rural Adversity Mental Health Program
- Life in Mind – Rural and Remote Populations
- Conversations Matter
- National Centre for Farmer Health
- NSW Health

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[64] **Life in Mind Australia.** Rural and Remote Populations: Priority Populations In Suicide Prevention [Internet]. Newcastle (AU): Life in Mind Australia; 2023 [cited 29 Sept 2024]. Available from: https://lifeinmind.org.au/suicide-prevention/priority-populations/rural-and-remote-populations

Younger People

Overview

Suicide is the leading cause of death for young people[65]. The Sax Institute reports[66], around 7.5% of all young people aged 12-17 experience suicidal ideation, with females reporting rates more than double those of young males and 26% of females aged 14-17 report having engaged in self-harm compared to 9% of young males. Rates also appear to have increased over time, with young females accounting for much of this growth. These statistics highlight the urgency and necessity for Aftercare services to be responsive to the needs of young people.

Whilst there are some youth specific models in Australia aimed at reducing suicide in children and young people, there is limited access to youth Aftercare services in NSW. Therefore, it is the responsibility of all mainstream providers to ensure they are considering the specific needs of young people accessing their services.

As highlighted in Governance, service providers are encouraged to build partnerships with schools/educational environments and other key youth organisations (e.g. headspace) to promote referral pathways, enable access to aftercare and consistency of support.

Risk Factors and Challenges

Young people may face challenges that can put them at increased risk of suicide, including the following[67]:

- Bullying and interpersonal conflict.
- Stigma associated with mental health concerns, distress and thoughts of self-harm/suicide.
- Exploration of independence, self-identity, gender identity and/or sexuality.
- Experience of childhood trauma and/or family domestic violence.
- Increased feelings of isolation.
- Lack of control about life decisions due to age.
- Emotion dysregulation and high levels of distress, without a well-developed skill set to manage this.
- Misuse of alcohol and/or drugs

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[65] **Australian Institute of Health and Welfare.** Deaths In Children and Young People [Internet]. Canberra (AU): AIHW; 2023 [cited 25 Sept 2024]. Available from: https://www.aihw.gov.au/reports/children-youth/deaths#key-findings

[66] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

[67] **headspace.** Identifying Risk Factors And Warning Signs For Suicide [Internet]. Melbourne (AU): Headspace; 2023 [cited 25 Sept 2024]. Available from: https://headspace.org.au/assets/School-Support/Identifying-risk-factors-and-warning-signs-for-suicide-web.pdf

The following also act as barriers to accessing support (including Aftercare services):

- Communication methods not being specifically tailored with and for young people.
- Clinic or office-based settings where young people are required to wait or inflexible appointment availability.
- Limited availability of services outside of school hours.
- Having to be on waitlists to access a service whilst feeling distressed.
- Family conflict where the young person may not have the family support or resources to seek help, attend appointments or deal with changing circumstances in the availability of appointments.
- Poor intergenerational mental health literacy, affecting carer or guardian's responses to the young person's distress, or refusal to provide consent for mental health care.

Considerations

Young people want to be active participants in their care, rather than "fitting in" to existing programs that may not be responsive to their individual needs and circumstances. Below are some key considerations for adapting service delivery to support individualised needs:

- Have a flexible approach. Take the time to get to know the young person and build a trusting relationship.
- Employ a strength-based approach reflecting each young person's passions and interests. Focus on capacity building and resilience rather than difficulties and clinical labels.
- Find times and places to meet that best suit the young person and strengthen engagement.
- Tailor communication methods to suit the consumer, e.g. messaging apps etc.
- Use peer workers that young people can relate to and provide positive role models. Stories can be very powerful, hopeful and inspiring.
- Recognise the importance of positive role models.
- Have structured processes for using "co-production" methods where young people are partners at each level – from their own individual care and support right through to Youth Advisory Groups or similar governance structures (where applicable).
- Have a proactive approach to the involvement of family, carers, friends and kin and recognise their importance in young people's lives.
- Provide information and skills to family, carers, friends and kin on how to support the young person.
- Understand the intersectionality in the experiences of young people, particularly Aboriginal, LGBTIQ+, Culturally and Linguistically Diverse and neurodiverse people. These populations are at an even higher risk of suicide.
- Prioritise inclusivity in both practice and language e.g. signs and signals indicating that services are a safe space, including indigenous LGBTIQA+ flags, inclusive language, access to interpreters and other considerations for adjustments.
- Get comfortable with discomfort. It's a normal primary response to want to minimise or eliminate a young person's suffering but being able to sit in discomfort with them rather than defaulting to problem-solving mode is an important way to validate young people and treat them equally.
- Young people are experts in their own experience – listen to and treat them as such.

Helpful Resources

- headspace – particularly Understanding and Dealing with Suicide and Myth Buster: Suicide Ideation
- The Youth Self Harm Atlas
- Youth Peer Support and Youth Mental Health
- Reach Out – particularly resources on Self Harm and Suicide
- Project Air fact sheets
- Myth Buster: Self Harm

Other Vulnerable Populations

People experiencing significant transition or instability in their lives can be at a higher risk of suicide. These circumstances may include:

- Leaving closed settings (including inpatient or custodial settings).
- Transitioning from youth to adult health and care services.
- Key stages in education, e.g. starting high school, university or TAFE.
- Housing arrangements or intermittent homelessness.
- Changes to, or instability of employment.
- Financial instability or hardship.
- Receiving palliative care.
- Ineligibility for voluntary assisted dying.
- Recent diagnosis of a condition or illness.
- Experiencing chronic ill health or pain.
- Alcohol and/or other drug use.
- Loss of a significant relationship.
- Carers, family, friends or kin providing care to a loved one.
- Returned veterans or defense personnel.
- Experiences of:
    - Family and domestic violence
    - Social isolation and loneliness

Periods of significant change can increase vulnerability to suicide due to increased anxiety or stress, disruption to support networks or uncertainty of the future. Alongside the outlined priority populations, providers should be aware of the heightened risk of suicide amongst these consumers.

Workforce

This section addresses the key components of Universal Aftercare service workforce including:

1. A diverse workforce that reflects the local community it will support.
2. Lived and Living Experience roles.
3. Onboarding, training and education programs that focus on community connections, safe and inclusive practice, and consumer and worker safety.
4. Face-to-face cultural capability training that develops an understanding of the local Aboriginal community.
5. Access to wellbeing support and resources, including reflective practice.

A note on diversity of workforce

Employing a workforce that is reflective of the community they support is integral to supporting Universal Aftercare access. It has been noted[68] that a diverse workforce who represent groups less likely to access Aftercare services, helps to connect these priority populations with Aftercare services.

Employing a diverse Aftercare workforce is strongly encouraged. There is a recognised shortage of Lived and Living Experience and Aboriginal peer workers[69]. It is acknowledged that workforce shortages, particularly in smaller rural areas, may limit the ability to recruit a diverse workforce and in this case, Aftercare providers should connect with local partners to ensure staff are informed on the most appropriate ways to engage different priority populations (see Onboarding and Training and Education).

Workforce Structure

Note: The roles of peer workers and care coordinators will vary depending on the team structure. Peer workers can generally undertake all care coordinator responsibilities. The

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[68] **Suicide Prevention Australia.** Right From The Start: Report On The Design Of Australia's Universal Aftercare System. Sydney (AU): Suicide Prevention Australia; Dec 2022 [cited 25 Sept 2024]. Available from: https://www.suicidepreventionaust.org

[69] **Henderson C, Sam K, Tadros E, et al.** Mental Health Workforce Solutions: Towards A Strategy For Community-Managed Mental Health In NSW. Sydney (AU): Mental Health Coordinating Council; 2024 [cited 25 Sept 2024]. Available from: https://mhcc.org.au

below role overview and table is intended as a guide to how duties may be assigned to maximise peer workers capacity for consumer engagement.

Peer Workers

Peer workers draw upon their personal lived and living experience of suicide to provide authentic engagement and support for people accessing Aftercare services. There is experiential evidence that testifies to the importance of peer worker inclusion in the Aftercare workforce[170]. In the context of Aftercare services, a peer worker is someone with lived or living experience of suicide. This person may have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis or been bereaved by suicide.

A peer worker provides emotional and social support to consumers through shared experience and can build a mutual relationship that fosters hope and optimism[71]. Peer work aims to support recovery of a person's whole life, inclusive of personal passions, social interactions, study and work[72]. Peer workers can bridge the gap between services and the consumer, through their understanding of isolation, shame and stigma following a suicide attempt or crisis. Evidence demonstrates that peer workers can improve engagement between consumers and non-acute care and outpatient providers[73].

Aftercare services should prioritise employment of peer workers and design entry to care so that consumers entering the service have their first contact with a peer worker[74]. If it is not feasible to employ peer workers due to local workforce availability, the Aftercare provider can draw on local partnerships (such as local Safe Havens or SPOT) with a peer workforce to seek advice on appropriate means to engage and support consumers.

Example: The Aftercare service in Murrumbidgee delivers their Peer Support Program; a trauma informed, non-clinical, program delivered by trained Peer Workers with a lived and living experience of suicidality, a suicide attempt, and/or suicide bereavement. The

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[70] **Folk, Roses in the Ocean.** Lived Experience Of Suicide Service Guidelines: Aftercare. Sydney (AU): Roses in the Ocean; 2024 [cited 25 Sept 2024]. Available from: https://rosesintheocean.com.au

[71] Orygen. Peer Work. Melbourne: Orygen; [cited 29 Nov 2024]. Available from: https://www.orygen.org.au/Training/Resources/Peer-work

[72] Ibid,

[73] **Lopresti AL, Drummond PD, Sibbritt D, et al.** Effects Of Psychological Interventions On Suicidal Ideation In Adults: A Systematic Review And Meta-Analysis. BMC Psychiatry. 2020;20:305. doi: 10.1186/s12888-020-02688-9. Available from: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-020-02688-9

[74] **Folk, Roses in the Ocean.** Lived Experience Of Suicide Service Guidelines: Aftercare. Sydney (AU): Roses in the Ocean; 2024 [cited 25 Sept 2024]. Available from: https://rosesintheocean.com.au

program focuses on empowering consumers by providing compassion, guidance, encouragement, motivation, and follow-up. Peer Workers will support consumers to develop skills, confidence, and knowledge to improve their wellbeing and community connections, whilst encouraging them to engage actively with their care team, to maximise the benefit they can receive from these services.

Peer workers will have a lived or living experience of suicide and received training in safe storytelling, to facilitate meaningful use of their lived and living experience in supporting consumers in their own recovery. Formal credentials for a peer worker, such as a Certificate IV in Mental Health Peer Work and Intentional Peer Support (IPS), are desirable. Requiring qualifications may create barriers for peer workers trying to enter the workforce who may not be able to access further education. However, the core skills of peer work as a practice are learned through lived and living experience. It is important to foster an environment for the peer workforce to grow and imposing requirements for certification may gatekeep access to this important workforce. Peer workers will have strong interpersonal skills, communication and listening skills, are able to provide hope and validation, draw upon problem-solving skills and have a compassionate and warm approach to consumers.

It is important to provide appropriate supports to the Peer Workforce; this is detailed further in Governance.

Useful Resources:

The below resources may be useful for understanding the roles, scope of practice, required supports and leadership for employing people in designated Lived and Living Experience roles.

- The National Mental Health Commission's 'National Lived Experience (Peer) Workforce Development Guidelines'
- The Lived Experience Framework for NSW
- Primary Health Networks (PHN) mental health care guidance – peer workforce role in mental health and suicide prevention
- Roses in the Ocean – 'Readiness to be involved in suicide prevention'

Care Coordinators

Care Coordinators provide comprehensive non-clinical psychosocial support to consumers and work collaboratively with peer workers to provide tailored, holistic and comprehensive support to consumers throughout service delivery. Care coordinators need to build a high level of trust and rapport with consumers and maintain collaborative communication with the consumer's other care providers (with consent).

Care coordinators need to have a detailed knowledge of the local community demographics and service networks and expertise in working with vulnerable and at-risk populations.

Team Leaders

Team Leaders oversee and coordinate Aftercare services and ensure the service provides evidence-informed care that is innovative and tailored to the community they support. Team leaders guide and support staff, while managing consumer reviews, service demand and risk and escalation processes. As further detailed in Clinical Governance, team leaders can also support reflective practice and consumer care review, if they have the appropriate qualifications.

Team leaders should have leadership experience, an understanding of local services, community demographics, use a trauma informed approach and have the ability to build key working relationships with stakeholders – clinical and non-clinical – to support integrated care and referral pathways for consumers. Team leaders may also have experience coordinating a multi-disciplinary team.

It is important to foster career pathways for peer workers and care coordinators – who may not have clinical experience or qualifications - to become team leaders. This is an opportunity to promote career progression, highlight the importance of peer work and care coordinator experience in a team leader role, and most importantly centralise lived and living experience in leadership positions.

Mental Health Clinicians

Whilst Aftercare is designed as a non-clinical service, some models of care across the state may choose to incorporate a clinical component to their service. This is not a requirement of Aftercare services, but for some regions, this may best meet their communities' need.

Example: The ‘Next Steps’ Aftercare program in Southern NSW and Illawarra Shoalhaven LHDs. In this Model of Care, mental health clinicians (e.g. social workers or psychologists) work alongside consumers – together with their peer worker – to develop an Aftercare plan, conduct 4 weekly check-ins and develop a transition plan. The mental health clinicians also work collaboratively with peer workers to support consumer reviews.

Working Together

It is important that peer workers, care coordinators, team leaders and – depending on the Model of Care – clinicians, work effectively together to coordinate care and support for the consumer, whilst acknowledging the different skillsets of each role. Regular team meetings and modes of communication are encouraged to promote collaboration.

Table 3 provides an overview of the key role, responsibilities and skillsets of these different team members.

Table 3: Aftercare workforce key responsibilities and roles

	Peer Worker	**Care Coordinator**	**Team Leader/Manager**	**Mental Health Clinician**
Role Purpose	Draw on their lived and living experience to connect with and support consumers in their recovery. Peer workers are the conduit between consumer, Aftercare service, psycho-social services and support networks.	Coordinate and oversee the care and recovery for consumers in collaboration with peer workers.	Support peer workers and care coordinators in both the delivery of services and overall workforce wellbeing, through a trauma-informed lens. Ensure compliance with clinical governance and risk escalation procedures.	Work collaboratively with Aftercare workforce to offer clinical support and perspective to the consumer or, may work solely with the Aftercare workforce to provide guidance and consumer review.
Shared responsibilities	• Ensure person-centred and person-led care. • Advocate for the consumer and support them in their recovery. • Support care navigation and connections. • Work collaboratively across the team to ensure consistent care. • Listen, validate and encourage consumers.			
Example Responsibilities	▪ Advocate for the consumer from a lived and living experience lens. ▪ Support consumers in their recovery journey, from a lived and living experience perspective.	▪ Action inbound referrals. ▪ Complete intake and service delivery tools. ▪ Refer to relevant community-based supports.	▪ Assign and screen inbound referrals for eligibility and suitability. ▪ Manage and support Peer workers and Care Coordinators ▪ Ensure service is delivered in line with clinical	▪ Work collaboratively with peer workers and care coordinators in the provision of Aftercare services. ▪ Participate in consumer reviews, safety planning,

	▪ Develop and review both support and safety plans. ▪ Facilitate peer-led group sessions for consumers (if appropriate and trained in group facilitation). ▪ Promote family, carers, friends and kin involvement. ▪ Link consumers to support services. ▪ Contribute to support and safety planning. ▪ Provide in person support in an environment where consumers feel safe.	▪ Develop and review both support and safety plans. ▪ Provide in person support in an environment where consumers feel safe. ▪ Promote family, carers, friends and kin involvement, in collaboration with peer worker.	governance and contractual requirements. ▪ Provide oversight of risk and incident management and clinical escalation processes. ▪ Develop and maintain strong relationships with referral pathways (clinical and non-clinical). ▪ Engage with local governance groups and promote Aftercare service. ▪ Provide professional and personal development opportunities for peer workers and care coordinators.	support planning, Aftercare plans or transition plans, alongside the peer worker/care coordinator and consumer. ▪ Participate in co-reviews with Aftercare workforce. ▪ Support other clinical governance processes.

Workforce Development

Workforce development is a key enabler of a Universal Aftercare system[75]. There needs to be a focus on developing both the skills and career pathways of the workforce[76] [77]. Implementing this will simultaneously improve quality of care and minimise staff turnover. The below sections outline key elements of workforce development that will improve overall retention and service quality.

Recruitment

Recruitment efforts should be targeted to people with lived and living experience of suicide and who are members of the local priority populations. Whilst recruitment needs to be balanced with merit and skillsets, where appropriate, priority should be given to people with lived and living experience who represent priority populations in your community.

In the interests of employing a diverse workforce, vacancies should be advertised and targeted to the communities and priority populations that you wish to support. For example, consider marketing vacancies though community forums and organisations, education providers (e.g. TAFE), interagency networks and social media.

Potential candidates should demonstrate:

- Knowledge or experience working with people in suicidal crisis
- Knowledge or experience supporting consumers through complex systems
- Strong interpersonal skills, with an ability to connect, listen and support recovery.

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[75] **Suicide Prevention Australia.** Right From The Start: Report On The Design Of Australia's Universal Aftercare System. Sydney (AU): Suicide Prevention Australia; Dec 2022 [cited 25 Sept 2024]. Available from: https://www.suicidepreventionaust.org

[76] **Henderson C, Sam K, Tadros E, et al.** Mental Health Workforce Solutions: Towards A Strategy For Community-Managed Mental Health In NSW. Sydney (AU): Mental Health Coordinating Council; 2024 [cited 25 Sept 2024]. Available from: https://mhcc.org.au

[77] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care [Internet]. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024]. Available from: https://www.health.gov.au/resources/publications/evidence-check-suicide-aftercare-services?language=en

Onboarding

The onboarding of new staff is an opportunity to introduce and orient them to broader local governance and draw on the knowledge and skills of key partners. Frequent staff turnover risks loss of knowledge and can be disruptive to services and referral pathways.

In addition to standard organisational onboarding processes, Aftercare providers are encouraged to establish an onboarding checklist that includes:

- Introduction to local services, interagency networks and referral pathways.
- A face-to-face meeting with local Aboriginal Community Controlled Health Services and Aboriginal Community Controlled Organisation (e.g. Land Council).
- Education on the local priority populations and their needs.
- An outline of staff supports and wellbeing resources (see Clinical Governance).

Training and Education

Requirements

Promoting training and education amongst the Aftercare workforce is an opportunity to improve the quality of Aftercare services and workforce satisfaction, thus improving retention. Better retention of staff will also improve the quality of services through provision of more consistent care, minimised disruptions to staff and partnerships, and sustaining local knowledge.

Appropriate training and upskilling should be identified for the workforce, and routinely offered to staff. This may include formal training (workshops, online training), or informal training and education opportunities through local partnerships. We encourage service providers to collaborate with their workforce on what their training or upskilling goals may be.

The following training is the minimum to be undertaken by all Aftercare workforce:

- Applied suicide intervention skills training (ASIST)
- Safety and recovery planning
- Cultural capability training tailored to your local Aboriginal community
- Managing wellbeing and recognising vicarious trauma
- Trauma informed care (particularly through a cultural lens)
- Family, carers, friends and kin training
- Training targeted to understanding and supporting priority populations, as determined by your local community.

Additional training specific to role includes:

- Team leaders/managers: Managing and supporting workers with lived and living experience.
- Peer Workers: Safe story telling in the context of suicide prevention (e.g. Voices of Insight - Roses in the Ocean), Intentional Peer Support.

Training Resources

There are numerous resources and platforms established to support the training and education of staff supporting consumers in their recovery. Below is a list of some suggested online resources:

- PEERnet - Roses in the Ocean
- LearnLinc - Suicide Prevention Australia
- Peer Work Hub – NSW Mental Health Commission
- Health Education Training Institute – NSW Health (NB: available to health staff only)
- Black Dog Institute
- Zero Suicide Healthcare Training - Life in Mind

In fiscally constrained environments, drawing on the knowledge and skills of local partners is encouraged. For example, facilitating a local education or upskilling session with:

- Local health district staff
- Local ACCHO/ACCO
- Governance groups

Cultural Capability

It is encouraged that staff receive face to face cultural capability training from either the local ACCHO or ACCO, or a provider that these organisations recommend, to ensure an understanding of the local Aboriginal community. This may be in addition to other online cultural training offered. Any cultural capability training must be sourced from an Aboriginal provider.

Understanding the local Aboriginal community in which they will be working is invaluable and should be encouraged. Facilitating this training will also further strengthen local partnerships with ACCHOs/ACCOs. At a minimum, cultural safety training should be undertaken on commencement of employment and on an ongoing annual basis.

Cultural capability training and education is an ongoing learning process and opportunities to deepen one’s understanding of the local community and needs should be encouraged.

Informal opportunities should also be encouraged amongst Aftercare workforce to enrich connections to, and deepen understanding of, the local Aboriginal community. For example, attending local cultural days or events, where appropriate. Fostering a connection to the local Aboriginal community can be effective in furthering cultural capability and strengthening allyship, whilst also improving the safety of services for Aboriginal people accessing Aftercare services.

Career Pathways

Thorough onboarding and comprehensive and ongoing training and education are vital to developing the workforce. These are core components of supporting the development of career pathways.

The promotion of career pathways and progression will support staff retention and satisfaction. It is important to understand staff's career and performance goals and, where possible, align this with training and upskilling opportunities. Existing internal processes such as performance reviews, goal setting, and managerial support and mentorship can support the development of career pathways.

Workforce Wellbeing

It is imperative that the Aftercare workforce have access to support and resources to maintain their wellbeing. Fostering a supportive and positive work environment will contribute to worker wellbeing, overall satisfaction and retention[78]

A well supported workforce will be better equipped to support Aftercare consumers in their recovery. Aftercare providers are encouraged to have a comprehensive mental health and wellbeing strategy for their Aftercare workforce; including strategies for addressing vicarious trauma, burnout and the unique demands placed on Aftercare workforce in supporting consumers in their recovery.

In addition to standard employee supports, such as managerial structures and the Employee Assistance Program, the following should be considered:

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[78] **Scanlan JN, Still M, Radican J, et al.** Workplace Experiences Of Mental Health Consumer Peer Workers In New South Wales, Australia: A Survey Study Exploring Job Satisfaction, Burnout And Turnover Intention. BMC Psychiatry. 2020;20:270. https://doi.org/10.1186/s12888-020-02688-9

Understanding Lived and Living Experience

It is important to acknowledge that any employee – even if not employed as a peer worker – may themselves have lived experience of suicide. Managers at all levels should be trauma-informed and undertake training to understand how to provide effective managerial support for people with lived experience of suicide, and for those working closely with people who are experiencing suicidality.

Staying Connected

The Aftercare workforce should be encouraged and supported to network with colleagues and peers who understand the experience of supporting consumers in recovery. This is particularly important for peer workers and people with lived and living experience, who should be connected to wider peer workforce networks. The Aftercare workforce is also encouraged to link in with relevant communities of practice. Facilitating group debriefing is an effective way to do this and is detailed further in Governance.

Reflective Practice

Reflective practice focuses on the needs and wellbeing of the employee and is an opportunity to reflect and debrief on challenges, successes and ways to work effectively with consumers. Reflective practice should be undertaken monthly.

Reflective practice activities can be offered by appropriately trained and experienced internal staff or externally sourced. If due to budgetary constraints it is not possible to engage someone externally, Aftercare providers are encouraged to draw on local partnerships, e.g. the LHD and SHN workforce.

Example: An Aftercare service provider in Far West NSW engages an external clinical provider who offers reflective practice support sessions to staff. This is an opportunity for staff to debrief on their own mental health and wellbeing or discuss approaches to individual consumer care. Staff have access to the provider as often as fortnightly and at a minimum of monthly. This may be a solution when recruitment and retention of clinically skilled staff is difficult, particularly in rural areas.

For more information on reflective practice, the types available for different workforce, and who should be providing this service, see Governance.

Governance

This section addresses the key components of Universal Aftercare governance including:

1. Collaborative and thorough service and stakeholder mapping, to identify key stakeholders, service partners and referral pathways.
2. Formalised partnerships between Aftercare providers, PHNs, LHDs/ SHNs and key stakeholders, promoting strong collaboration, ways of working and operational governance within regions.
3. Clear policies and procedures for risk monitoring and escalation, including identified escalation pathways.
4. Supportive clinical governance processes to support consumers and the workforce in the delivery of safe and effective Aftercare services, including reflective practice, group debriefing, consumer care reviews and additional supports for the Peer and Aboriginal workforce.
5. Co-production principles inform the planning, design, delivery and evaluation of Aftercare services.
6. Performance indicators reflect outcomes that are important and meaningful to both the consumer and community.
7. Data and performance indicators are collected and used in a safe, meaningful way that informs best practice, including the collection of qualitative consumer stories and experiences.

Operational Governance

Robust operational governance is needed to support the sustained integration of service partners and Aftercare service quality. Operational governance supports communication between services, facilitates cross-service promotion, ensures streamlined service delivery and protects services against loss of regional knowledge due to staff turnover. Strong operational governance will support improved Aftercare service quality and is an important foundation of Universal Aftercare. This section outlines ways to establish and maintain operational governance by identifying key partners, formalising these partnerships and establishing effective ways to work together.

Governance is a shared responsibility of both the Aftercare providers and the PHNs.

Section 9 'Roles and responsibilities of the Commissioning Partners' of the Mental Health and Suicide Prevention Bilateral Schedule Head Agreement for Aftercare Services in NSW and relevant Schedules, states that PHNs are responsible to "participate in agreed governance arrangements…".

Local Partnerships

Strong integration between key partners is key to delivering effective aftercare[79]. Drawing on the expertise and knowledge of local partners is beneficial for the workforce, and ultimately beneficial to the consumer. Resource and knowledge sharing can also be advantageous, particularly when operating in rural areas or other resource limited environments.

Cross-border considerations

Local partnerships should also involve cross-border and jurisdiction partners in governance, planning and service delivery to ensure that any service and state borders do not negatively impact consumers.

Service Mapping

Service mapping focuses on the availability of, and linkages with, local services. It aims to:

- Identify key services and providers in your region.
- Increase knowledge of referral and treatment/care options.
- Highlight gaps in service delivery and/or barriers to accessing these services.
- Identify opportunities to work together with local partners to improve access.

All Aftercare providers should undertake service mapping of their local area, in collaboration with their LHD/ SHN and PHN. Service mapping should be kept current and reviewed frequently. Completing service mapping together with all involved services will ensure accuracy and consistency across the region.

Focus on identifying the following services within your region:

- LHDs and SHNs:
    - Hospital and community services

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[79] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024].

    - Drug and alcohol services
    - Mental health services (including Towards Zero Suicides initiatives e.g. Safe Havens, SPOTs)
    - Aboriginal Mental Health Clinical Leader and/or District Coordinator
    - LHD/SHN Aboriginal Health Unit.
  - ACCHOs
  - Mental Health CMOs
  - Recovery Colleges
  - Private mental health providers
  - General Practitioners
  - NDIS services
  - Social services (e.g. family violence, financial counselling, drug and alcohol, housing, and employment)
  - Cultural services (e.g. settlement services, ACCOS and other Aboriginal support services).
  - Other priority population support services (e.g. disability, LGBTIQ+, children, youth, men).
  - Services that support family, carers, friends and kin (e.g. Everyminds' Minds Together program, NSW Family and Carer Mental Health Program and Mental Health Carers NSW).
  - Services or facilities that support older people (e.g. residential aged care facilities, aged care assessment services and aged health services).

Including service mapping information in onboarding for new workforce will support service promotion and the maintenance of workforce knowledge. Service mapping can also be a useful tool for managing incoming referrals when the service is at capacity. For more information on this, see Service Delivery.

Stakeholder Mapping

Stakeholder mapping focuses on identifying key organisations or individuals that should be considered for local partnerships and engagement. Stakeholder mapping may identify contacts that are not included in service mapping (i.e. entities not involved in service delivery, such as peak bodies). It is important to undertake both service and stakeholder mapping to ensure all key partners are identified and, where appropriate, can be included in local governance groups.

All Aftercare providers should undertake stakeholder mapping of their local area. Stakeholder mapping should be kept current and reviewed frequently. Ideally, this is completed with local governance groups to ensure membership is current.

- In addition to the key stakeholders identified from service mapping, focus on identifying the following stakeholders within your region: Lived Experience peak bodies, organisations or representatives.
- Family, carers, friends and kin peak bodies, organisations or representatives.
- Other peak bodies (e.g. suicide prevention, mental health professionals, AH&MRC).
- Suicide prevention networks and local response groups.
- Social and community groups (e.g. sporting clubs, faith groups).
- LHD and SHN Aftercare and Zero Suicides in Care Coordinators.
- PHNs
- Schools

Key Partners and Roles

Table 4 below outlines the main purpose and responsibilities of key partners in the delivery of Universal Aftercare services. This table is intended as a visual guide to demonstrate how different service partners may work together in a local area and is not an exhaustive list of stakeholders nor their responsibilities. Thorough service and stakeholder mapping is essential.

Table4: Key Partners and Roles

	PHNs	**Aftercare Provider**	**Local Health Districts and Specialty Health Networks**	**CMOs (including ACCHOs)**
Purpose	Funded by the state and commonwealth to commission Aftercare services in a local region.	Funded by the PHNs to deliver the Aftercare service.	Deliver clinical and acute mental health, emergency and general health care.	Deliver complementary psychosocial and other supports.
Key roles	▪ Participate in relevant operational and clinical governance activities as per the Mental Health and Suicide Prevention Bilateral Schedule Head Agreement for Aftercare Services in NSW and relevant Schedules. ▪ Establish and manage the aftercare tender process.	▪ Design service and referral pathways. ▪ Deliver recovery-focused care coordination and support activities to the consumer. ▪ Connect consumers to peer workers. ▪ Monitor suicide risk and support consumer engagement with other required services. ▪ Establish, support and develop Aftercare workforce.	▪ Support aftercare commissioning process as required. ▪ Establish and support referral pathways to Aftercare services, including how aftercare fits into suicide prevention care pathways. ▪ Confirm and enact consumer escalation or reconnect pathways. ▪ Contribute to and/or participate in relevant	▪ Contribute to coordinated care and support based on consumers' needs. ▪ If local pathways allow, refer relevant consumers to aftercare. ▪ Participate in aftercare communities of practice and

	- Oversee aftercare contractual obligations. - Communicate Commonwealth & State expectations. - Support integration and linkages across providers in a local region. - Facilitate the establishment of aftercare-specific communities of practice.	- Engage with and promote service across community. - Embed and enact operational and clinical governance processes and structures. - Establish and participate in aftercare community of practice. - Service promotion amongst referral pathways and key stakeholders.	governance or shared care activities. - If negotiated, support Aftercare workforce with clinical governance. - Participate or contribute to aftercare community of practice. - Share relevant data to inform service and care planning. - Oversee Suicide Care Pathways (noting potential to link in with 'Transition of Care')	governance groups where relevant.
Key contacts	- Suicide Prevention Commissioning Manager - Mental Health and/or Suicide Prevention Managers - Suicide Prevention Regional Response Coordinator/Leads	- Team Leaders - Service Managers	- Aftercare Coordinator - Towards Zero Suicide staff (including Zero Suicides in Care coordinators, Safe Havens and SPOTs staff) - Acute Care Team Leaders - Psychiatric inpatient Nurse Unit Managers - Emergency Department-mental health practitioners - Aboriginal Mental Health Clinical Leader/District Coordinator	- Team Leaders - Service Managers

Formalising Partnerships

There has been a call from Aftercare providers[80] to formalise local partnerships, particularly between LHDs and Aftercare providers. Formalised partnerships allow services to clarify roles and responsibilities, establish referral pathways, promote collaboration, and improve knowledge about the service system. It also supports the integration of care across services to ensure the highest quality of care is delivered.

At a minimum, there should be formalised partnerships between the PHN, LHD/SHN and local Aftercare service providers. While there may be formal contractual agreements between PHNs, LHDs/SHNs and Aftercare providers, there is a need to formalise partnerships between Aftercare providers and LHDs/SHNs to clarify roles and responsibilities and referral pathways. This partnership should encompass emergency departments, Safe Havens, SPOT, alcohol and other drugs, Aboriginal Mental Health Clinical Leader/District Coordinator, community mental health etc.

Formalising partnerships between Aftercare providers and the services and stakeholders identified in mapping activities, where appropriate, is strongly encouraged.

Building Networks

To achieve effective governance partners should establish networks and shared ways of working. Below are suggestions as to how to achieve this.

Local Governance Groups

A governance group is focused on operational matters and broader issues relating to the effective delivery of a program. An aftercare governance group would typically have smaller membership than the Community of Practice (CoP) and higher representation of those in managerial positions to inform operational discussions. A more targeted membership allows for more specific and sensitive discussion in relation to local governance issues.

PHNs are responsible for establishing and leading the local governance group. Aftercare providers should be involved in the design of governance structures they need to support the delivery of effective Universal Aftercare. This ensures the governance group meets the needs of the Aftercare provider and aligns with the governance responsibilities as outlined

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[80] **NSW Agency for Clinical Innovation.** NSW Universal Aftercare Project: Consultation Findings. Sydney (AU): NSW Agency for Clinical Innovation; 2024 [cited 25 Sept 2024].

in the Mental Health and Suicide Prevention Bilateral Schedule Head Agreement for Aftercare Services in NSW and relevant Schedules.

The group role and scope should be defined in a Terms of Reference, with regular meetings set (e.g. quarterly). Discussions may focus on:

- Performance indicators and data sharing
- Operational issues (e.g. referrals)
- Clinical governance issues and risk escalation protocols
- Integration of and support for Lived and Living Experience
- Strategies for service promotion amongst referrers, stakeholders and community.

Membership should have representation from:

- Aftercare provider
- PHN
- LHD/SHN
- ACCHOs and/or ACCOs
- Primary care (e.g. General Practitioner)
- Lived and Living Experience
- Family, carers, friends and kin
- Local priority populations
- Key referring organisations

Local Community of Practice

A Community of Practice (CoP) gathers to share information, promote best practice, improve processes and identify local solutions to challenges facing the sector.

PHNs are encouraged to establish a local CoP to share best practice and improve support for the Aftercare service workforce, in close collaboration with the Aftercare provider and local partners. There may already be an existing CoP in your area that Aftercare providers can link with.

Membership is likely to have strong representation from frontline workers who are closely involved in the delivery of services and engagement with consumers. Membership should also be open to key service partners and stakeholders identified in mapping exercises.

Other Opportunities

In addition to establishing a CoP and local governance group, stakeholders are encouraged to consider other opportunities to strengthen local partnerships and promote service integration. Some examples may include:

Local Response Groups

The Murrumbidgee local response group (LRG) is a group of government and non-government agencies working collaboratively to respond to deaths by suicide in the local area. The aim of the group is to ensure the right supports are implemented in a timely manner, and to streamline responses and maximise resources.

The inclusion of Aftercare services in the local response group (LRG) ensures the provision of holistic and collaborative support to communities and families. The LRG is a collective of the LHD/SHN, NSW Police, NSW Ambulance, the PHN and the service provider (delivering both aftercare and postvention support) who responds to deaths by suicide in the area.

Other LRGs are being established across NSW and we encourage stakeholders to explore opportunities to join, or establish, these groups.

Co-location of Services or Staff

The co-location of Aftercare services or staff (e.g. within a Safe Havens or other Mental Health CMO) is an opportunity for service promotion, collaboration, and workforce development and support.

For example, in Western NSW, the local Aftercare provider is co-located with another Mental Health CMO once a week. This has supported referral pathways and collaboration.

Standardisation of Forms

Where there is more than one Aftercare provider delivering support within an LHD region, a standardised referral form and/or process should be established across providers to reduce the likelihood that referrals are not progressed due to lack of knowledge about when/who/how to engage Aftercare services. Similarly, when safety plans are developed, these should be shared (with permission) across providers to allow for consistency of care and to reduce burden on the consumer to develop duplicate plans.

Clinical Governance

Aftercare programs provide non-clinical services with a focus on psycho-social supports and empowering consumers to establish ongoing community supports, in a non-acute setting[81]. The benefit of non-clinical service provision is it allows for delivery of a peer-led service, that centralises lived and living experience and the voice of the consumer. It is important to maintain the integrity of this service design, whilst also ensuring the safety of both the workforce and consumers.

Whilst Aftercare programs are a non-clinical service, there is still a need for clinical governance in these programs. Strong clinical governance allows for the delivery of safe and high-quality care to consumers[82]. The key elements of clinical governance in aftercare should include:

- Responding to escalated suicide risk
- Consumer care review
- Reflective practice
- Group Debriefing
- Internal team meetings, reviews and processes

Section 9 ‘Roles and responsibilities of the Commissioning Partners’ of the Mental Health and Suicide Prevention Bilateral Schedule Head Agreement for Aftercare Services in NSW and relevant Schedules, states that PHNs are responsible to “maintain appropriate clinical governance and quality assurance arrangements for all components of the Aftercare Program, with a particular focus on the Aftercare services commissioned.”

Helpful Resources:

- National Safety and Quality Health Service Standards
- Australian Safety and Quality Framework for Health Care

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[81] **Martin A, Chakouch C, Josifovski N, et al.** Suicide Aftercare Services: An Evidence Check Rapid Review Brokered By The Sax Institute For The Commonwealth Department Of Health And Aged Care. Sydney (AU): Sax Institute; 2023 [cited 25 Sept 2024]

[82] **Australian Commission on Safety and Quality in Health Care.** Clinical Governance Standard [Internet]. Sydney (AU): ACSQHC; 2023 [cited 25 Sept 2024]. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance/clinical-governance-standard

Responding to Escalated Suicide Risk

It is essential that clear policies and procedures are in place for how to respond to acute or escalating consumer suicide risk.

This includes clear service guidelines about:

- Under what circumstances emergency services should be contacted (including against consumer's wishes)
- Agreed escalation pathways with local stakeholders
- How different workforce roles should respond when a person indicates they are currently suicidal.
- Which roles have responsibility for conducting suicide risk assessments and making decisions about the need for additional immediate support.
- When, where and how discussions about current suicidality are documented.
- Engaging with other supports if a consumer indicates they are actively considering suicide.
- Under what circumstances family, carers, friends and kin should be contacted.
- Follow-up and monitoring processes.
- Short-term workforce debriefing mechanisms.

Postvention Processes and Support

It is important that services develop clear processes and guidelines about how to respond in the event of a consumer death by suicide, and how to support staff. This should include:

- Notifications protocols for deaths and Adverse events
- Identifying local postvention supports available to the workforce and community (e.g. StandBy), with consideration for culturally appropriate supports (e.g. Thirrili)
- Linkages to Local Response Groups, as outlined in Building Networks.
- If local linkages cannot be identified, Aftercare providers should escalate to PHN Suicide Prevention lead.
- Guidance about how to support workforce in the short (e.g. <24 hours, <1 week) and longer (e.g. 6+ weeks, anniversaries) term.
- Respectful and sensitive acknowledgement of the death (articulating when it is and is not appropriate to share information in the workplace and the how to maintain a person and their family's privacy and confidentiality).

Consumer Care Review

Consumer care review focuses on reviewing the nature of support provided by a service with respect to a consumer's needs and safety. While this should occur for all consumers of the service, it is particularly important for ensuring consumers with acute and/or complex or long-term mental health needs are being provided effective and relevant care.

Consumer care review should be undertaken by the peer worker and/or care coordinator in collaboration with an appropriately qualified mental health clinician. This can be done by the team leader or other staff if they meet the above requirements. If this is not available internally, Aftercare providers should identify an external resource to provide consumer care review. If due to budgetary constraints it is not possible to engage someone externally, Aftercare providers are encouraged to draw on local partnerships, e.g. the LHD and SHN workforce.

Consumer care review should be undertaken monthly, at a minimum. This would equate to three sessions per consumer throughout the typical 12 week duration of aftercare. If more frequent review is required, this should be available and supported. Any member of the team can request a review. Consideration for when additional review is required should be included in responding escalating consumer suicide risk policies and procedures.

Reflective Practice

Reflective practice is focused on providing a space to discuss and explore the professional practices, needs and wellbeing of the Aftercare worker, including staff who have their own lived and living experience of suicide (disclosed or not).

Reflective practice activities should be undertaken by staff in collaboration with an appropriately qualified practitioner (either internal or external staff). It is generally undertaken monthly at a minimum but if staff require more frequent support, this should be available. Reflective practice activities can be offered by appropriately trained and experienced internal staff or externally sourced. If due to budgetary constraints and it is not possible to engage someone externally, Aftercare providers are encouraged to draw on local partnerships, e.g. the LHD and SHN workforce.

Lived and Living Experience Supervision

Peer workers may choose to undertake additional reflective practice activities that focus on how their work impacts on their lived and living experience, and how they draw on this experience in consumer engagement. Lived and living experience supervision can be provided by an appropriately trained person with lived or living experience.

The requirement for lived and living experience supervision should be determined by the peer worker's needs. Aftercare providers should support staff to receive this additional reflective practice if they chose to.

Cultural Supervision

Aboriginal staff may choose to receive cultural supervision. Cultural supervision offers a space to reflect on a worker's practice and provides cultural context which is often a critical component that is not available in mainstream supervision. Cultural supervision can be provided by an appropriately trained Aboriginal person.

The requirement for cultural supervision should be determined by the worker's needs. Aftercare providers should support staff to receive this additional reflective practice if they chose to.

Group Debriefing

Aftercare workforce should have the opportunity to participate in trauma-informed group debriefing. In this context, group debriefing is a structured group discussion and is an opportunity to talk about challenges, successes and stressors in relation to supporting consumers in their recovery.

Group debriefing should be available to all Aftercare workforce, but it is not mandatory to participate if the person does not wish to or have the need to. The frequency of group debriefing will be determined by the teams' needs.

Group debriefing must be led by someone trained in facilitating group debriefing. This may be an internal staff member or may be sourced externally.

Summary Table

Table 5 below summarises the core aspects of consumer care review, reflective practice and group debriefing including its purpose, those involved in delivery and participation, and suggested frequency.

Table 5: Clinical Governance Activities

	Consumer Care Review	**Reflective Practice**	**Lived and Living Experience Supervision**	**Cultural Supervision**	**Group Debriefing**
What is the purpose?	Focused on the needs and safety of the consumer.	Focused on the needs and wellbeing of the employee.	To reflect on how peer work impacts on the lived and living experience of peer workers, and how they draw on this experience in consumer engagement.	To reflect on a worker's practice and provide cultural context and support.	An opportunity for workforce to talk about challenges, successes and stressors in relation to supporting consumers in their recovery.
Who can deliver it?	Any appropriately qualified mental health clinician	Any appropriately qualified practitioner	An appropriately trained person with lived or living experience.	An appropriately trained Aboriginal person.	Anyone trained in facilitating group debriefing
Who can participate?	Peer Workers and Care Coordinators	Peer Workers and Care Coordinators	Peer Workers	Aboriginal Workforce	Peer Workers, Care Coordinators and Team Leaders
How often must it be undertaken?	Monthly, more frequent if needed.	Monthly, more frequent if needed.	As determined by the needs of the peer worker.	As determined by the needs of the worker.	As determined by teams' needs. Must be offered but not mandatory to participate.

Best Practice and Quality Improvement

The aim of Universal Aftercare is to improve outcomes for all people experiencing suicidal crisis by ensuring services are universally accessible and responsive to the needs of service users. Continued quality improvement has a key role in supporting this.

The adoption of co-production practices, promotion of best practice, meaningful data collection and effective use of performance indicators can support continued quality improvement of Aftercare services.

The National Safety and Quality Health Service Standards and Australian Safety and Quality Framework for Health Care are useful resources designed for health service organisations to guide them in delivering safe and high-quality care. Whilst these frameworks have been developed for clinical services, the core principles are still relevant for Aftercare services and could inform the design of quality improvement activities.

Accreditation

All aftercare services should be safe, of high quality and effective in their care. Universal Aftercare services should be accredited or working towards accreditation. Accreditation is available from the Suicide Prevention Australia Standards for Quality Improvement.

Co-Production in Universal Aftercare

The transition to a Universal Aftercare system in NSW will expand existing Aftercare services, establish new services, and trial new and expanded aftercare referral pathways across the state. Stakeholders should consider the role of co-production in the design and expansion of Aftercare services and processes.

Co-production is a way of working where consumers, service providers, key partners, policy makers and family, carers, friends and kin work collaboratively to design and implement a service that meets the needs of the community[83]. This is a value-driven approach and centralises the notion that people who use a service are best placed to contribute to service design.

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[83] **Social Care Institute for Excellence.** Co-Production: What And How [Internet]. London (UK): SCIE; 2023 [cited 25 Sept 2024]. Available from: https://www.scie.org.uk/co-production/what-how/

Community participation in this process is essential to ensure Aftercare services are appropriately designed and implemented[84]. Co-production occurs at every level of a program including planning, design, delivery and evaluation. Figure 2, developed for the New Horizons' i.am child and youth aftercare service, shows the practice of co-production at different stages and how this process can be embedded between the young person (consumer), site and program. The figure also demonstrates how co-production interacts with, and informs, organisational transformation funding cycles and policy development.

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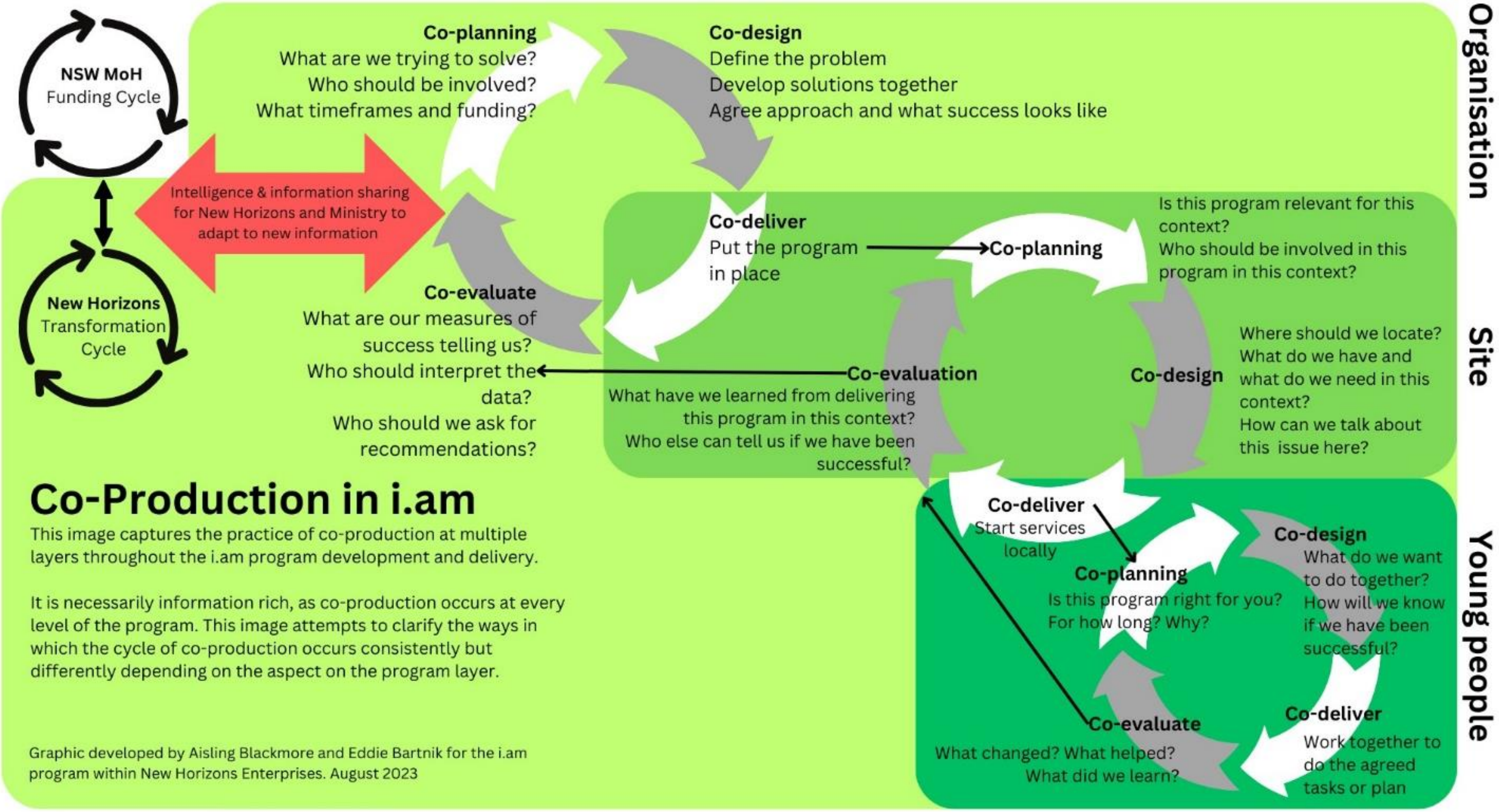
[84] **Vargas C, Whelan J, Brimblecombe J, et al.** Co-Creation, Co-Design, Co-Production For Public Health - A Perspective On Definition And Distinctions. Public Health Res Pract. 2022 Jun 15;32(2):3222211. doi: 10.17061/phrp3222211. PMID: 35702744

Figure 2: Co-production throughout development and delivery of i.am program



Co-Production in i.am

This image captures the practice of co-production at multiple layers throughout the i.am program development and delivery.

It is necessarily information rich, as co-production occurs at every level of the program. This image attempts to clarify the ways in which the cycle of co-production occurs consistently but differently depending on the aspect on the program layer.

Graphic developed by Aisling Blackmore and Eddie Bartnik for the i.am program within New Horizons Enterprises. August 2023

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[85] Graphic developed by Aisling Blackmore and Eddie Bartnik for the i.am program within New Horizons Enterprises. August 2023

Minimum Data Set

The aftercare Minimum Data Set (MDS) has been defined by the Commonwealth Department of Health (the Primary Mental Health Care MDS) and all Aftercare providers are expected to report the MDS to the PHN, as part of their funding agreement. PHNs may choose to tailor the MDS which is used to track program performance.

It is important to ensure that collection of MDS items is built into routine business processes and can be extracted from client management systems easily.

Where possible, Aftercare services should establish ways of providing snapshots of relevant MDS indicators back to the workforce to support quality improvement e.g. internal data dashboards. The MDS can also be used to understand service uptake, consumer and service engagement patterns, consumer needs and to inform service planning.

Performance Indicators

Performance indicators are negotiated at the local PHN level and will reflect local priorities and needs. Ideally, performance indicators reflect outcomes that are important and meaningful to both the consumer and community. Performance indicators typically draw from the MDS; however, they may require data that is not captured through the MDS.

The RE-AIM framework[86] can provide a useful guide to identifying and developing metrics that reflect important outcomes.

Potential aftercare-relevant metrics are provided in table 6 below.

Table 6: Example Performance Indicators

Domain	Description	Example Indicators
Reach	The degree to which the program reaches the intended target group	▪ Number of referrals ▪ Number of referrals that translate into service engagement ▪ Characteristics of consumers who are referred or engage with the program (e.g. sex, gender, sexual orientation, age, priority populations, social determinants of health).
Effectiveness	The meaningful outcomes consumers	▪ Progress towards consumer goals e.g. Quality of Life Scale (QOLS)

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[86] **RE-AIM.** RE-AIM: Reach Effectiveness Adoption Implementation Maintenance Framework [Internet]. Fort Collins (CO): RE-AIM; 2023 [cited 25 Sept 2024]. Available from: https://re-aim.org/

	experience through participation in the program	▪ Change in outcomes measures e.g. K-10, Suicidal Ideation Attributes Scale (SIDAS) ▪ Consumer satisfaction (PREMs) or Your Experience of Service (YES) Questionnaire ▪ Adverse outcomes: number and type ▪ Consumer re-presentations to hospital for suicidal related reasons. ▪ Family, Carer, Friend and Kin involvement and support (if applicable).
Adoption	The representativeness of recipients and intervention agents and why	▪ Proportion of consumers who present to ED in suicidal crisis who are referred to aftercare ▪ Referrals by service/organisation type ▪ Aftercare-employed workforce
Implementation	The nature of service delivery and core components of a program	▪ Proportion of consumers who are contacted within two business days from receipt of referral ▪ Proportion of consumers who engage with the service who complete a safety plan ▪ Proportion of direct client contacts that are face to face or virtual/remote/phone
Maintenance	The degree to which a program has become routine practice	▪ Service phase e.g. design, implementation, business as usual ▪ Maturity of policies and procedures

Informing Best Practice

Performance indicators should not just be about meeting contractual obligations but about collecting meaningful data to inform local practice and improve care.

Where possible, performance indicator tracking should be fed back to teams and discussed in relevant governance forums to troubleshoot areas of weakness and ensure that the service is being delivered in the intended way.

Real-time tracking of consumer outcomes can be useful to review and discuss with the consumer. Changes in scores on outcome measures can inform engagement with the consumer to identify what has contributed to positive outcomes and/or what needs to be addressed to see a change in areas where there is no change.

Where possible, performance indicators should be supplemented with consumer stories and experiences that speak to the impact the service has had (with consent). Experiential evidence helps to centralise lived and living experience and demonstrate the benefits of Aftercare services from a human perspective.

The Most Significant Change (MSC) approach is a useful evaluation method for collecting and reporting personal stories of change[87]. Aftercare providers may find this methodology beneficial. New Horizons successfully used a condensed MSC methodology to capture qualitative stories of the impact of the i.am child and youth aftercare service in 2023.

Principles for Data Collection

When collecting or requesting data, stakeholders are encouraged to consider the following principles to ensure safe and meaningful data collection

- Provide clear information about what data is being collected, data and privacy protection policies, how the data will be used and why it is important.
- Only collect required data to reduce the burden on the consumer
- Make the process for data collection easy for the consumer
- Provide opt in and opt out options for consumers
- Collect feedback data at consistent intervals after contact with a service (e.g. 1 month post last contact instead of once a year).
- Share results with consumers, in a comprehensive and accessible format.
- Data collection processes align with privacy and confidentiality requirements, as outlined in Consent and Confidentiality.

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[87] **BetterEvaluation.** Most Significant Change [Internet]. Melbourne (AU): BetterEvaluation; 2023 [cited 25 Sept 2024]. Available from: https://www.betterevaluation.org/methods-approaches/approaches/most-significant-change