

Universal aftercare in Tasmania

Consultation summary report

May 2025

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We also sincerely thank all individuals and organisations who contributed their time, insights and lived and living experience to this important consultation process. Your input has been invaluable in shaping the future direction of aftercare services in Tasmania.

Primary Health Tasmania Limited
1300 653 169
info@primaryhealthtas.com.au
www.primaryhealthtas.com.au
ABN 47 082 572 629

Safety and supports

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- Lifeline Australia: 13 11 14
- 13YARN: 13 92 76
- MensLine Australia: 1300 789 978
- Suicide Call Back Service: 1300 659 467
- SANE Australia Helpline: 1800 18 SANE (7263)
- Veterans and Veterans Families Counselling Service: 1800 011 046
- QLife: 1800 184 527 (3pm-12am)
- A Tasmanian Lifeline: 1800 98 44 34 (8am-8pm)

Background

In Australia, approximately 65,000 people make a suicide attempt each year. A prior suicide attempt is a significant risk factor for future suicide attempts and suicide deaths. Evidence shows that the relative risk for suicide after an attempted suicide is between 20 to 40 times higher than in the general population, with the risk being greatest in the days and weeks following hospital discharge. The period following a suicide attempt is a critical time for proactive support for the person who attempted suicide and for their families, friends, carers and support people.

The term 'aftercare services' refers to services provided to people following a suicide attempt. This may include involvement of families, friends, carers and support people. The aim of aftercare is to enable access to and engagement with care and support, to ensure all people who have experienced a suicide attempt or suicidal crisis have access to, and are supported towards, compassionate, effective and appropriate support services. However, less than half of people admitted to hospital after a suicide attempt are connected with services or supports following discharge. Additionally, the current aftercare system does not capture people outside of hospital settings, meaning more needs to be done to increase referral pathways and access to aftercare services.

Under the National Mental Health and Suicide Prevention Agreement, the Australian and state and territory governments have committed to achieving what is referred to as 'universal aftercare'. The concept of universal aftercare expands the pathways to aftercare support beyond hospital settings. It involves connecting people with aftercare services across various settings where people may present with suicidal distress.

The Tasmanian Suicide Prevention Strategy (2023-2027) also prioritises delivering compassionate and connected services that meet people's needs (Priority 2), with aftercare explicitly mentioned as part of the service system in Tasmania. This strategy highlights the need to increase the availability, accessibility and quality of aftercare services in Tasmania for people following a suicide attempt or people who are experiencing a suicidal crisis.

This summary report

In 2024, Primary Health Tasmania commissioned Jane Austin Consulting in partnership with Everymind to undertake the Defining Universal Aftercare in Tasmania Project (the project). The project involved consultation with various service providers, key informants, community members with lived and living experience of suicide and families, friends, carers and support people of those with a lived and living experience. It aimed to comprehensively understand the most practical and beneficial approach to defining and delivering universal aftercare in Tasmania. A key output was a definition of universal aftercare in Tasmania.

Primary Health Tasmania values all feedback provided through the stakeholder consultation process and all feedback will inform the broader project. This report provides a summary of the main findings from the consultation and outlines the definition of universal aftercare.

Primary Health Tasmania is making this summary report available in order to share findings with those people who volunteered their time to participate in the consultation, and to help increase shared understanding across the sector of the challenges and opportunities associated with the provision of aftercare services in Tasmania, as identified through this consultation.

Survey consultation

Methodology

An online survey was conducted with service providers and community members. For the purposes of this report, the phrase *community members* encompasses the general Tasmanian public, those with lived and living experience, and families, friends, caregivers and support people of those with a lived or living experience. The same survey questions were asked of both service providers and community members,

however they were shared via separate links so responses could be compared. A total of 85 people responded to the survey (32 to the community survey and 53 to the service provider survey).

Outcomes

The survey was designed with all questions being multiple choice, often allowing participants to select more than one option in their responses (i.e. 'mark all that apply'). Each question also included an 'other' option, encouraging elaboration via open-ended responses.

Responses to the survey were similar between service providers and community members, indicating that service providers have a good understanding of the needs of clients. Responses also tended to align with existing literature on aftercare support.

A key theme that emerged across the survey was the need for an individualised response to aftercare, which can change depending on the needs and circumstances of the person accessing the service. This may mean different approaches to support modality, contact duration and frequency, the type of support provided, and the additional services the person is referred to.

The majority of participants (97% of community participants and 83% of service providers) agreed that aftercare services in Tasmania should include support for people experiencing suicidal thoughts or suicidal distress, as well as for people who have experienced a suicide attempt.

When asked about the types of services that people may present to following a suicide attempt or when experiencing suicidal distress, hospitals and emergency departments, telephone support services and psychologists/psychiatrists were the most commonly selected options. First responders, GPs and community and other supports (such as Safe Haven, Access Mental Health and general counselling and mental health services) were also selected by a high proportion of participants. 'Other' responses noted places where people have daily/regular contact, such as education, workplace and aged care facilities, as well as family, friends and peers. Community members were much more likely to cite family, friends and peers in their responses (67%) than service providers (10%).

When asked about services that should be able to provide referrals to the aftercare service, there was no clear prioritisation. However, services that were most commonly selected included GPs, psychologists/psychiatrists, hospitals and emergency departments, and informal referrals (e.g. self-referring or having a family member or friend refer). 'Other' responses showed a similar pattern, with various service types mentioned - such as mental health and counselling services, peer workers, and other services such as schools and the National Disability Insurance Scheme (NDIS).

Most community members and service providers (71%) indicated that referrals to the aftercare service should be made on the same day as presenting for support, with some support for referrals within 1-2 days. There was variability in responses around the preferred time taken for the aftercare service to contact the person following the referral, although overall, respondents still preferred same-day contact. This preference was much stronger for community members, who were almost twice as likely to choose same-day contact (59%) over 1-2 days (31%). Service providers showed similar support for same-day contact (46%) and contact within 1-2 days (44%).

Barriers to accessing aftercare services were explored, with both community members and service providers identifying system-level barriers, such as lack of awareness of available services and limitations in referral pathways among the top barriers. Trust in services, time limits on services, quality of services and stigma were also commonly cited as perceived barriers to access.

Preferred aftercare staff characteristics selected by around 90% of participants included compassion, appropriate skills and knowledge, and respect for individual preferences.

There was no strong preference for the best way to promote, share and receive information about aftercare services in Tasmania, however a website or electronic brochure was most commonly selected by both groups. 'Other' options provided by service providers included a range of advertising techniques such as radio, television, social media and billboards, as well as networking within the sector and informing local services on how to make a referral.

A phone call was strongly preferred by both groups as the primary method for the aftercare service to contact people. Some support for text messages indicated that this may be a good secondary or backup

contact method. 'Other' comments relating to this question noted the importance of considering individual preferences to ensure the service is accessible to everyone, particularly those who may have challenges with technology, vision or hearing.

Both community members and service providers preferred delivery of aftercare services in person, with around 95% of participants selecting this option. Online/video chat and telephone options were also selected by at least 50% of all participants.

When asked about the type of support an aftercare service should provide, both community members and service providers noted strategies to support wellbeing (91%) and regular and brief wellbeing check-ins (90%) as important. Services providers tended to see actions such as helping to identify and link with other support services or health assessments and support, and developing a safety plan, as more important than community members. A key theme that again emerged through open-ended responses was the need to meet the persons unique situation and preferences.

Both service providers and community members saw connection with mental health support and GPs as important to support recovery. The majority of 'other' responses (66%) stated that the appropriate services to be connected with would depend on individual needs and should be assessed on a case-by-case basis. A broad range of service types to connect into were mentioned in the open-ended feedback, including legal, parenting, family and domestic violence, loneliness, alcohol and other drug support, and employment.

Both service providers and community members selected 9-12 weeks as the preferred support duration. More than 20% of community members also selected the option of 17 weeks or more. More than 25% of participants in both groups provided a response under the 'other' option, with almost all of these responses noting that support should be provided for as long as needed, based on individual circumstances. These responses suggest the duration should be flexible, and that advising of an end date before people access the service can prevent engagement. Indefinite access to the aftercare service could create strain on the service and issues with accessibility, however it is a highly desired feature.

Once connected to the aftercare service, there was a preference for contact between one and three times a week, rather than more regular (daily) or less regular (fortnightly) contact. This preference was similar between community members and service providers. Providing an 'other' response was a popular option amongst both groups, with 93% of responses indicating contact frequency should be based on individual needs and preferences.

When it came to the most important support to receive when exiting an aftercare service, community members and service providers tended to have similar responses. Service providers slightly preferred referrals to another agency (96%), whereas community members slightly preferred follow-up contact (84%). Open-ended responses were mixed, with some touching on ensuring the individual is ready to exit the service, that others support them, and that their next steps are clearly set out. Almost all participants agreed that people should be able to access the aftercare service again without a new referral within three to six months.

Families, friends, and caregivers were not perceived to need support as promptly as those referred to the aftercare service. Service providers showed a clear preference for support to be provided within one week (69%). In contrast, community members showed a fairly even split between the same day (41%) and within one week (34%) options, with some indication (25%) that within two weeks would also be acceptable. Open-ended responses reflected individual preferences, with some noting that family, friends and caregivers should only be involved if and when the person wants them to be. Service providers and community members agreed that resources such as online information on how to support themselves and others and access to support groups would be helpful for the families, friends and caregivers of someone accessing the aftercare support service. However, community members (69%) were less likely than service providers (92%) to see support groups as helpful.

Participants who provided further information in the additional feedback section covered issues including challenges on services not meeting clients' needs, the need for aftercare services and mental health and suicide support services more broadly to encompass individual needs and preferences, and address eligibility and access challenges.

Qualitative consultation

Methodology

Qualitative consultations were also conducted with 103 participants via various formats, including individual online interviews, online consultations with small groups, and in-person roundtables. Consultations employed semi-structured interviews and explored five key domains:

- 1) unique needs
- 2) current aftercare response
- 3) governance and context
- 4) workforce
- 5) the role of families, friends and caregivers.

Thematic analysis was used to understand the key themes emerging from the data collected.

Outcomes

The figure below provides a summary of the most prevalent themes that were coded for each domain.

Unique needs	Current aftercare response	Governance and context	Workforce	Families, friends and caregivers
<ul style="list-style-type: none">•Pathways•Barriers•Communication•Design considerations•Complex needs	<ul style="list-style-type: none">•Appropriateness of existing services•Service adaptability•Access/outreach•Personal connection/trust•Stigma	<ul style="list-style-type: none">•Knowledge of services•Integration and connection between services•Current response•Governance•Commissioning	<ul style="list-style-type: none">•Formal qualifications and training•Understand unique needs•Resourcing•Skills and experience•Peer workers	<ul style="list-style-type: none">•Support needed•Active involvement•Education/capacity building•Role of family•Tailored support

In terms of unique needs, it was noted that everyone presenting to an aftercare service will likely be experiencing a unique set of circumstances and that aftercare services need to be equipped to provide holistic support that addresses multiple drivers of distress for the person accessing support. Specific needs and challenges were identified by some groups involved in consultations, such as young people, veterans, Aboriginal and Torres Strait Islander people, the LGBTIQA+ community and people from different cultural backgrounds.

Strong relationships and trust were frequently noted as essential. Service providers prefer to make referrals to services they know and trust, whereas service users want service providers they feel they can trust and confide in.

Confusing or complex referral processes and limited eligibility criteria were among the more frequently noted barriers to accessing services. Another common barrier cited was stigma. Discussing the current aftercare response in Tasmania revealed a general lack of awareness of the current service. Of those who were aware of the service, challenges with the referral process and a lack of clarity on the scope of the service were noted. Some enablers that were suggested to improve the service included peer workers and outreach.

The hospital emergency department environment being distressing and unhelpful to those experiencing suicidal distress was regularly discussed. The need for triage out of the emergency department into more supportive services was seen as essential by many participants, with suggestions that aftercare could somehow be integrated into emergency settings.

The broader Tasmanian service context and governance were explored, revealing that knowledge of other available services and the ability to integrate, connect and communicate between services is important to service providers across Tasmania. This connection was seen to facilitate clearer pathways to support and more effective service delivery. It was seen as important that the aftercare service has formalised key performance indicators in place to ensure the aftercare service providers establish relationships and connect with other services.

The need for a diverse, experienced and well-trained workforce was expressed throughout consultations. Given their important role in supporting people experiencing suicidal crisis, it was expressed that a mixture of qualifications and experience is valuable, and regular training to develop important skills is important. Compassion was often seen as the most desirable characteristic of the workforce. Integrating a peer workforce into the service was also discussed as a useful way to engage with, gain the trust of, and represent diverse client groups.

Families, friends and caregivers were seen to play an important role in providing support to those accessing aftercare. It was widely acknowledged that families would likely require support while their loved one was accessing aftercare services. Several suggestions relating to access to resources, education, training and other helpful information for families were discussed.

Defining universal aftercare in Tasmania

The consultation process supported the following definition, aligned to the best-practice literature on aftercare.

“Universal aftercare in Tasmania is defined as proactive and coordinated services and supports provided to people following a suicidal crisis or suicide attempt, with broad referral pathways within and outside of the health and hospital system and integrated support for family, friends and caregivers.”

It is acknowledged that this is an aspirational definition that will guide future efforts with respect to universal aftercare services in Tasmania.

Next steps

The findings from this consultation process, alongside other related work Primary Health Tasmania is undertaking, will be important in shaping best-practice universal aftercare in Tasmania into the future. Primary Health Tasmania recognises that strengthening aftercare services will require coordinated action across the system. We will continue working with stakeholders including government, service providers, people with a lived and living experience, and families, friends and caregivers, to improve referral pathways to aftercare and support better integration across services.

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