THE UNIVERSITY OF MELBOURNE

LIFEWAYS

TRANSLATING SUICIDE PREVENTION RESEARCH INTO POLICY AND PRACTICE

QCMHR

Queensland Centre for Mental Health Research

The Australian Suicide Prevention Planning Model (AuSPPM): service taxonomy and workforce descriptions

Version: DRAFT

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Contents

3 Glossary

General information	
Service description	Describes the service and lists key activities.
Intent of care	The intent of the service (e.g., 'to support long-term social and emotional wellbeing')
Intended length of support	The intended length of support to be provided whether that be in months or years; this may not be relevant for all items in the taxonomy.
Indicative unit size	For admitted services, this refers to the number of available beds.
Target population	
Presenting features	The expected social, emotional, or clinical status of persons likely to be receiving the service.
Age	The age group that is modelled as receiving the service within the model.
Population profile	The socio-demographic characteristics, beyond age, of the population for whom the service targets where a service is specifically tailored to the unique needs of a particular population.
Workforce	
Workforce type	The type of workforce designated to provide support.
Staffing duration	The designated work hours of the staff, demonstrating the availability of the service and the workforce requirements. For example, this may be general business hours of 9am – 5pm or 'extended hours'.
Example services	
	A list of 'real world' services that assists end-users in their understanding of each taxonomy item. Example services are not always evidence-based but rather reflect those currently operating in Australia or elsewhere that either have an evidence base or have anecdotally been recognised by the sector as demonstrating promise. Example services should therefore not be considered the gold standard approach. Example services have been provided in alphabetical order for each taxonomy item and are not exhaustive.
Levels of evidence	
Summary	A brief, narrative overview of the existing evidence base for the taxonomy item where this exists.
Citations	A list of citations that were consulted to develop the narrative overview.

4 Background

This document forms part of the Australian Suicide Prevention Planning Model (AuSPPM) documentation package. It provides detail on the service models in the model's taxonomy, including their key characteristics, designated workforce, example services, and brief summaries of their evidence base, where available.

Briefly, the service taxonomy was developed using literature reviews and with input from the project's Expert Advisory Group, a series of focus groups comprising academics, clinicians, and persons with lived experience, and the broader suicide prevention sector. A detailed overview of the methods used to develop the taxonomy is available here: https://doi.org/10.31234/osf.io/4vmw8_v1

Please note that the AuSPPM does not model resource estimates for all taxonomy items outlined in this document as per **Table 1**. Further information on why estimates have not been modelled for these taxonomy items is available in the linked publication.

TABLE 1. TAXONOMY ITEMS NOT RESOURCED IN THE MODEL

Service Stream	Service categories*
System development to enhance wellbeing	Policy and strategy development
	Workforce development
	Workplace-based training in mental health and suicide prevention
	Means restriction
	Data, research and evaluation
Reducing drivers of distress	Population level suicide prevention communication guidelines
	Psychoeducation – general, media-based
	Enhancing protective factors and promoting general wellbeing
	Stigma reduction and behaviour change initiatives
	Environmental controls
Early engagement	Identifying distress
	Socioeconomic and situational support services
	Supports for drug and alcohol use
	Supports for mental illness

*Includes service elements nested within these service categories not shown in this table

5 Workforce

Within the model, resource estimates such as number of required beds, workforce hours, and workforce full-time-equivalents are calculated using a range of parameters associated with each taxonomy item and workforce type. This includes the workforce mix for team-based services and modelled operational parameters such as occupancy and annual readmission rates for bed-based services, and workforce hours. Parameters for each modelled service are modelled at desirable, efficient operational rates and are based on the parameters of the National Mental Health Service Planning Framework (NMHSPF) or the parameters of existing suicide prevention service models.

Workforce categories and types designated to specific taxonomy items are not designed to be prescriptive but rather represent the lowest level training/education required to deliver a particular service. The exception to this relates to service models that are purposefully designed to be delivered by persons with lived experience (i.e., peer workers), The accompanying planning tool has been designed to allow for end-users to edit the workforce designated to each taxonomy item.

Table 2 describes the different types of workforce categories and types used in the model. In some instances, a service is provided by a multidisciplinary team as described in Table 3. The composition of workforce teams have been modelled based on real-world services or teams described in the NMHSPF. The distribution of workforce types within a team, and the annual full-time equivalent hours designated to each workforce type, can be found in the Excel tool.

Table 2. Model workforce categories and types

Workforce category		
System Development Coordinator	System development coordinators may have a tertiary qualification in a health-related field or equivalent experience in suicide prevention and mental health, and/or have a lived experience of suicide. They are responsible for assisting with the coordination and integration of early intervention and suicide prevention activities across regional stakeholders and service providers.	
Consultant	Consultants are persons with a relevant qualification in health, psychology, social work, social science or social welfare, health promotion, community development or similar, and/or equivalent experience in the promotion, planning, and implementation of suicide prevention initiatives within schools, workplaces, and/or the broader community where a suicide death has occurred.	
Training Facilitator	Training facilitators provide training and psychoeducation related to the identification of, and response to, suicidal distress in the community. They may also be involved in the marketing, implementation, upkeep, and trouble-shooting related to either face-to-face and/or digital, self-guided skills training. Training facilitators may have received formal education in health, psychology, social work, social sciences, social welfare, health promotion or similar, or have equivalent experience in the delivery of training and psychoeducational programs in mental health and/or suicide prevention.	
Peer Worker	Roles that must be performed by someone with a lived experience of suicide. This includes persons who have an experience of supporting or caring for someone who has experienced suicidal distress or attempt, or who has died by suicide. Some peer workers may hold dual roles. Peer workers are a credentialed workforce who have received appropriate training to deliver care.	
Workforce category		**Workforce type**
Vocationally Qualified	Primarily a non-clinical workforce (i.e. not a university-trained clinician) with a TAFE level qualification up to Advanced Diploma level in suicide prevention, mental health or a related area.	**Enrolled Nurse**
		VQMH Worker
		VQ Other
		Indigenous Mental Health Worker
		VQ Crisis Counsellor
Tertiary Qualified	University trained (or equivalent) with a minimum three-year Bachelor degree in a discipline related to mental health care. 'Other' includes other professionals such as physiotherapists, exercise physiologists, dieticians, speech therapists, pharmacists,	**Nurse Practitioner**
		Registered Nurse
		Psychologist
		Occupational Therapist
		Social Worker

Workforce category		
	and tertiary qualified program managers/supervisors.	Other TQ
		Indigenous Mental Health Clinician
		Social Worker
Medical	Medically trained professionals providing mental health care. Psychiatrists, registrars and junior medical officers are included only in teams. Most workforce types here are embedded in state-funded clinical care teams and do not appear separately in the model.	General Practitioner
		Psychiatrist
		Junior Medical Officer
		Registrar
		Other Medical Specialist

Table 3. Workforce teams

Team name	Team response	Team members*	Hours of operation	Example service†
Acute care team	Post-discharge follow-up for populations with crisis presentations (e.g., emergency department, short stay (multidisciplinary) unit or acute inpatient unit). May provide triage, crisis assessment and resolution, assist in identifying and addressing drivers of suicidality (including substance use), engage with families, safety planning, counselling on lethal means, and onward referral to other services including primary care.	Peer Worker Indigenous Mental Health Worker Tertiary Qualified Medical	Business hours	Parameters based on the NMHSPF
Acute inpatient services – Youth (12 – 24 years)	Specialist short term 24-hour hospital inpatient assessment and treatment for people experiencing acute suicidality in mental health acute inpatient units.	Peer Worker Enrolled Nurse Nurse Practitioner Registered Nurse Psychologist Occupational Therapist Social Worker Other TQ	24/7	Parameters based on the NMHSPF
Acute inpatient services – Adult (25 – 64 years)				
Acute inpatient services – Older adult (65+ years)				

Team name	Team response	Team members*	Hours of operation	Example service†
		Psychiatrist Junior Medical Officer Registrar		
Aftercare services	Multidisciplinary, non-clinical and/or peer-led short-term support services that focus on recovery, safety plans and coping skills, advocacy and linkages to services and support networks following suicidal crisis. Teams comprise peer workers, support coordinators, and team leaders, with varied requirements across services regarding minimum educational requirements. Some services also comprise mental health clinicians (e.g., social workers and psychologists).	Peer Workers Vocationally Qualified Tertiary Qualified	Business hours	The Way Back Support Service
Clinical community treatment team – Youth (12 – 24 years)	Assessment, on-going follow-up support, and/or referral to those who have experienced or are experiencing a suicidal crisis.	Peer Worker Vocationally Qualified Tertiary Qualified Medical	Extended hours	Parameters based on the NMHSPF
Clinical community treatment team – Adult (25 – 64 years)			Business hours	
Clinical community treatment team – Older adult (65+ years)			Business hours	

Team name	Team response	Team members*	Hours of operation	Example service†
Community-based support – safe spaces for crisis	Non-clinical peer support, assessment, and referral to persons experiencing distress or in crisis. Tertiary qualified members of the team generally provide service oversight, clinical supervision, and assist with crisis intervention.	Peer Worker Tertiary Qualified	After hours	Brisbane Safe Spaces Network
Consultation liaison – emergency department (hospital)	Assessment, support, and referral provided to persons presenting to hospital emergency departments in suicidal crisis.	Nurse Practitioner Registered Nurse Psychologist Psychiatrist Registrar	24/7	Parameters based on the NMHSPF
Consultation liaison – general (hospital)	Assessment, support, and referral provided to inpatients in the general hospital setting who are also experiencing suicidal distress or crisis.	Nurse Practitioner Registered Nurse Psychologist Psychiatrist Registrar	24/7	Parameters based on the NMHSPF
Co-response team	Assessment, support, and referral to persons experiencing suicidal crisis in the community. Co-response teams are initialised by a call from public emergency	Peer Worker Tertiary Qualified	After hours	Mental Health Co-Responder Service - WMHHS

Team name	Team response	Team members*	Hours of operation	Example service†
	services. Some co-response teams also include paramedics and/or police officers.			
Group carer peer support	Non-clinical peer support, provision of resources, skill development, education, and strategies for coping to empower and support family, friends, carers, and support people of persons with a lived experience of suicide.	Peer Worker	Extended hours	Parameters based on the NMHSPF
Group carer support	Non-clinical peer support, provision of resources, skill development, education, and strategies for coping to empower and support family, friends, carers, and support people of persons with a lived experience of suicide. Tertiary qualified professionals within the team focus on the delivery of general psychoeducation and strategies for coping.	Peer Worker Tertiary Qualified	Extended hours	Parameters based on the NMHSPF
Postvention crisis response team	Coordination of care between different service types and sectors of the health system via liaison with a range of providers, for persons bereaved by suicide and the provision of supports (e.g., practical and emotional support,	Peer Workers Vocationally Qualified Tertiary Qualified	Extended hours	Standby Support After Suicide

Team name	Team response	Team members*	Hours of operation	Example service†
	psychological first aid and information relating to self-care (e.g., sleep hygiene, nutrition, managing relationships)).			
Postvention group support	Structured group-based support co-led by a professional facilitator(s) and peer for persons bereaved by suicide. Focus of care is to assist persons in managing intense and complex feelings associated with losing a loved one to suicide.	Peer Worker Tertiary Qualified	Business hours	Jesuit Social Services: support after suicide
Psychoeducation and community-building – school-based	Oversee the planning and implementation of psychoeducation within the school-based setting and the delivery of psychoeducational materials.	Consultant Training Facilitator	Business hours	Be You by headspace
Psychoeducation and community-building – workplace	Oversee the planning and implementation of psychoeducation within the workplace setting and the delivery of psychoeducational materials.	Consultant Training Facilitator	Business hours	MATES in construction
Psychoeducation and community-building – communities impacted by suicide	Oversee the planning and implementation of psychoeducation within communities impacted by suicide and the delivery of psychoeducational materials.	Consultant Training Facilitator	Business hours	Postvention Coordination - Support After Suicide

Team name	Team response	Team members*	Hours of operation	Example service†
Short-stay residential (multidisciplinary led)	Provision of intensive, short-term clinical and non-clinical care to persons experiencing suicidal distress or in crisis.	Peer Worker Vocationally Qualified Tertiary Qualified	24/7	The Luminos Project
Short-stay residential (peer led)	Provision of intensive, short-term, non-clinical support to allow for individuals in suicidal crisis who do not require medical attention a space to manage and resolve the crisis, Tertiary qualified members of the team generally provide service oversight, clinical supervision, and may assist with crisis intervention.	Peer Workers Tertiary Qualified	24/7	Afiya Peer Respite

*More information on the distribution of the workforce within each team is available in the Excel tool in the 'Workforce distribution' spreadsheet

† Refers to the service from which workforce information was used to build the teams within the model

NMHSPF: National Mental Health Service Planning Framework

6 Funders

Within the care profiles, taxonomy items have been designated funder labels. The inclusion of funder labels is designed to assist planners in identifying the types of services in-scope for their planning. Funder labels attached to the taxonomy items therefore reflect the likely funder of the service models represented in the taxonomy, based on current practice. Given the preferred whole-of-government approach to suicide prevention in Australia, this means that many taxonomy items have been designated multiple funders.

Flexibility has been built into the model to allow end-users to adjust funder label designation based on funding arrangements within their planning region.

TABLE 4. FUNDER LABELS AND DESCRIPTIONS

Funder label*	Description
Regional	The service is funded and rolled out at the local level†
State/Territory	The service model is funded and rolled out at the state/territory level
National	The service model is funded and rolled out at the national level

* Local governments may also contribute funding to means restriction, disaster response services, and programs designed to improve community connection. This type of funder, however, has not been included as a separate funder label.

†For example, funding received via Primary Health Networks

- **System development to enhance wellbeing**
  - **Policy and strategy development**
  - **Service development and coordination**
    - Suicide prevention networks and coordinators
    - Development of cross-sector partnerships
    - Lived experience leadership
  - **Workforce development**
  - **Workplace-based Training in Mental Health and Suicide Awareness**
  - **Skills training**
    - Skills training – health professionals
    - Skills training – peers
    - Skills training – other non-health professionals
  - **Refresher training**
    - Refresher training – health professionals
    - Refresher training – peers
    - Refresher training – other non-health professionals
  - **Means restriction**
  - **Data, research, and evaluation**
- **Reducing drivers of distress**
  - **Population-level suicide prevention communication guidelines**
    - Responsible reporting guidelines
    - Public communication guidelines
  - **Psychoeducation – general, media-based**
  - **Psychoeducation and community-building – sub-population specific**
    - Psychoeducation and community-building – workplace based
    - Psychoeducation and community-building – school-based
    - Psychoeducation and community-building – selective populations
    - Psychoeducation and community-building – selective individuals
    - Psychoeducation and community-building – communities impacted by suicide
  - **Enhancing protective factors and promoting general wellbeing**
  - **Stigma reduction and behaviour change initiatives**
  - **Environmental controls**
  - **Recovery response suicide prevention outreach services**
- **Early engagement**
  - **Telephone and web-based support services**
    - Telephone and web based support services – peer warmlines
    - Telephone and web based support services – self-guided
    - Telephone and web based support services – self-guided (families/ carers)
    - Telephone and web based support services – self-guided (postvention)
  - **Identifying distress**
  - **Brief interventions**
  - **Brief support**
  - **Service navigation**
  - **Socioeconomic and situational support services**
  - **Supports for drug and alcohol use**
  - **Supports for mental illness**
- **Primary care**
  - **Assessment and planning**
    - **Review +/- ongoing management**
    - **Care coordination and liaison**
    - **Structured psychological therapies**
      - Structured psychological therapies - individual
      - Structured psychological therapies - family
- **Community based intensive interventions**
  - **Community based support and respite**
    - Short-stay residential (multidisciplinary teams)
    - Short-stay residential (peer led)
    - Community-based support – safe spaces for crisis
  - **Time limited interventions**
    - Discharge follow-up and support – outpatient based
    - Time limited interventions – telephone/digital helplines
  - **Co-response teams**
  - **Acute care services**
  - **Consultation liaison**
    - Consultation liaison – emergency department (hospital)
    - Consultation liaison – general (hospital)
  - **Clinical community treatment teams**
    - Clinical community treatment teams – youth (12 – 24 years)
    - Clinical community treatment teams – adult (25 – 64 years)
    - Clinical community treatment teams – older adult (65+years)
- **Bed-based services**
  - **Acute inpatient services**
    - Acute inpatient services – youth (12 – 24 years)
    - Acute inpatient services – adult (25 – 64 years)
    - Acute inpatient services – older adult (65+ years)
- **Supports for long-term wellbeing**
  - **Individual psychosocial support services**
  - **Suicide prevention support services**
    - Individual suicide prevention support services
    - Group suicide prevention support services
  - **Aftercare services**
  - **Postvention services**
    - Postvention individual support services
    - Postvention group support services
    - Postvention group peer support services
    - Postvention family support services
  - **Family and carer supports**
    - Individual carer peer support
    - Individual carer peer support – service navigation
    - Group carer peer support
    - Group carer support

LEGEND

Service category

Service element

FIGURE 1. SERVICE TAXONOMY OVERVIEW

7 Service Stream - System development to enhance wellbeing

The *system development to enhance wellbeing* service stream comprises initiatives that aim to enhance general wellbeing by strengthening social, economic, structural, and environmental factors that foster healthy, safe, secure, and fulfilling lives. This stream comprises the following key service categories:

- Policy and strategy development
- Service development and coordination
- Workforce development
- Workplace-based training in mental health and suicide awareness
- Skills training
- Refresher skills training
- Means restriction
- Data, research, and evaluation

7.1 Service Category – Policy and strategy development

General information	
Service description	Encompasses policies, plans, and vision statements that aim to reduce suicide risk in the community at the local, state/territory, and national level. The focus may be explicit to suicide prevention, relate to improving the general wellbeing for specific sub-populations, and/or aim to address the social determinants (e.g., unemployment, housing and homelessness, loneliness) as a means of improving population health and wellbeing.
Intent of care	Develop policies and strategies that address suicide/risk factors for suicide.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Australia's National Mental Health and Suicide Prevention Plan	Sets out the Australian Government's commitment to supporting mental health and suicide prevention for all Australians over a five-year period from 2021 to 2026.
Ending Loneliness Together Initiative	The development of strategy to guide activity and investment on initiatives that build social connectedness and a sense of belonging in recognition of the impact of loneliness and social isolation on mental illness and suicide.
National Children's Mental Health and Wellbeing Strategy	Provides a framework for guiding investment in the mental health and wellbeing of children and families to ensure improved mental health outcomes for all Australians.
National Guidelines for inclusion of wellbeing in early childhood checks	National Guidelines to include mental health and wellbeing in Early Childhood Health Checks for children aged 0 – 5 years.

National Mental Health Stigma and Discrimination Reduction Strategy	A strategy to reduce stigma and discrimination toward persons with mental illness, recognising its impact on the wellbeing of persons with mental illness and their families.
National Housing and Homelessness Plan	A 10-year strategy that sets out a shared vision to inform future housing and homelessness policy in Australia jointly developed by the national and state/territory governments.
School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-suicidal Self-Injury	A guide for supporting school staff to identify and effectively respond to suicidal behaviour and/or non-suicidal self-injury in students in Western Australia.
Levels of evidence	
Summary	The World Health Organisation recognises that government-led, comprehensive national suicide prevention strategies are powerful tools that help ensure coordination and monitoring of efforts by the government and collaborating stakeholders, the provision of adequate resources for suicide prevention, and assurance that suicide prevention remains high on the political agenda [1]. The Australian National Suicide Prevention Strategy highlights the importance of policy and strategy development to address known drivers of distress in the community as a means of reducing suicide risk [2].
Citations	[1] World Health Organization. Advocating for national suicide prevention strategies Unknown [Available from: https://www.who.int/activities/advocating-for-national-suicide-prevention-strategies. [2] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

7.2 Service Category – Service development and coordination

7.2.1 Service Element – Suicide prevention networks and coordinators

General information	
Service description	Supports for communities to assist in the development of localised suicide prevention initiatives. Suicide Prevention Networks comprise a group of local community members and/or services brought together to develop a 'network' to address suicide prevention needs at the local level using grassroots prevention strategies and programs. Network activities are tailored to meet the needs of the local communities and may focus on: raising awareness; fostering help-seeking; reducing stigma; and/or skills training and capacity building.
Intent of care	Address the unique needs of communities at the local level to reduce suicide risk.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	System development coordinator
Staffing duration	Business hours
Example services	
Black Dog Institute Suicide Prevention Capacity Building and Implementation Support Program	This program aims to strengthen a region's capacity to develop and deliver suicide prevention initiatives that meet local needs. The program comprises six workshops delivered to local suicide prevention working groups. The focus of these workshops is guided by the participating working group region's needs, and current plans and approaches to suicide. They may focus on, for example, governance and collaboration of suicide prevention groups,

	interpreting and using suicide data, and understanding and incorporating lived experience.
Wesley LifeForce Suicide Prevention Networks	This is a nationally operating community-based suicide prevention network program comprising local community action groups across Australia. Wesley LifeForce Member Networks receive seed funding and guidance during the establishment phase and support in planning prevention projects in their local community. They also have access to a range of resources and tools. Community development coordinators assist newly developed networks to identify and engage with stakeholders in the community to ensure their Network's success.
Levels of evidence	
Summary	There is a paucity of research on the evaluation of suicide prevention networks. However, several studies demonstrate some support for their implementation. A scoping review found few (three) studies that evaluated the impact of suicide prevention networks [1]. The limited findings of the scoping review suggested that the implementation of suicide prevention networks has positive effects on suicide awareness, early detection, and linkage to relevant supports. One further Government funded youth program (i.e., Garret Lee Smith Youth Suicide Prevention Program) has demonstrated a reduction in suicide rates. However, this program was not community-led. More recently, across a cohort of 60 Wesley LifeForce Networks in Australia, there was evidence of a reduction in suicide rates following network establishment (1.04 fewer deaths per 100,000 per year) [2]. Although this effect was considered relatively small, given the scale of the Wesley Lifeforce Program (i.e., over 90 networks at the time the research was undertaken), and the far-reaching impact of suicide in the community, the effect may have important public health impact.
Citations	[1] Williamson M, Slichthorst M, Jordan H, Too T, Pirkis J, Reifels L. Community suicide prevention networks: a literature scoping review. The University of Melbourne; 2019. [2] Morgan AJ, Roberts R, Mackinnon AJ, Reifels L. The effectiveness of an Australian community suicide prevention networks program in preventing suicide: a controlled longitudinal study. BMC Public Health. 2022;22(1):1945.

7.2.2 Service Element – Development of cross-sector partnerships

General information	
Service description	The application of evidence-based frameworks to prioritise development and evaluation of cross-sector partnership models through co-funding arrangements between health and relevant non-health government portfolios, to promote collaboration, mutual capacity building and cross-sector service delivery.
Intent of care	To develop a whole-of-government approach to suicide prevention.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
	N/A
Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of cross-sector collaboration and a whole of government approach to suicide prevention [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

7.2.3 Service Element – Lived experience leadership

General information	
Service description	Support and activities to increase system and service readiness to integrate people with lived experience of suicide at all levels of the sector and support lived experience and community co-design of policies, plans, and services.
Intent of care	Embedding lived experience in policies, plans, and service design and evaluation.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Roses in the Ocean	Roses in the Ocean acts as a conduit for third party organisations to connect persons with lived experience with a range of projects related to, for example, service co-design and evaluation, policy/strategy development, and educational opportunities in suicide prevention.
Suicide Prevention Australia	Suicide Prevention Australia (SPA) has created a Lived Experience Panel who participate in SPA committees and collaborate on major projects.
Levels of evidence	
Summary	The importance of the active involvement of persons with lived experience of suicide, including those who have supported someone who has experienced suicidal distress or attempt and/or persons who have been bereaved by a suicide death, is well documented in the published literature [1,2,3]. Strategies, frameworks, and guidelines have been developed to ensure the safe and effective engagement of persons with lived experience across the suicide prevention sector [4,5,6,7].

	Australia's National Suicide Prevention Strategy also highlights the importance of lived experience involvement in all aspects of the sector, drawing on approaches outlined in Australia's *Compassion First* report [5,8].
Citations	[1] Brett J, Staniszewska S, Mockford C, Herron-Marx S, Hughes J, Tysall C, et al. Mapping the impact of patient and public involvement on health and social care research: a systematic review. Health Expectations: An International Journal of Public Participation in Health Care and Health Policy. 2012;17(5):637 - 50. [2] Byrne L. Promoting lived experience perspective: discussion paper prepared for the Queensland Mental Health Commission. Brisbane: Queensland Mental Health Commission; 2017. [3] Watling D, Preece M, Hawgood J, Bloomfield S, Kõlves K. Developing an Intervention for Suicide Prevention: A Rapid Review of Lived Experience Involvement. Archives of Suicide Research. 2022;26(2):465-80. [4] Roses in the Ocean. Lived experience of suicide informed and inclusive culture change suite of resources 2022 [Available from: https://rosesintheocean.com.au/lived-experience-of-suicide/lived-experience-of-suicide-informed-and-inclusive-culture-change-suite-of-resources/. [5] National Suicide Prevention Advisor. Compassion First: Designing our national approach from the lived experience of suicidal behaviour. Canberra; 2020. [6] Krysinska K, Ozols I, Ross A, Andriessen K, Banfield M, McGrath M, et al. Active involvement of people with lived experience of suicide in suicide research: a Delphi consensus study. BMC Psychiatry. 2023;23(1):496. [7] Suomi A, Freeman B, Banfield M. Framework for the engagement of people with a lived experience in prgoram implementation and research. Canberra, Australia: Australian National University; 2017. [8] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

7.3 Service Category – Workforce development

General information	
Service description	General development of the suicide prevention workforce to ensure capacity to meet population needs. This may include, for example, the credentialing of peer workers/the development of TAFE or university courses.
Intent of care	To increase workforce capacity to meet the needs of those experiencing suicidal distress and their family, friends, carers, and support persons.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
CheckUP's industry and workforce development programs	CheckUP's industry and workforce development programs lead a range of initiatives in sector capacity and capability building, innovative workforce planning, and education to employment programs. The aim is to build targeted solutions to attract and build a capable and sustainable workforce to support responsive health and community services in Queensland.
National Lived Experience (Peer) Workforce Development Guidelines	Principles developed to guide the development of the lived experience workforce in Australia.
Roses in the Ocean: Suicide Prevention Peer Worker Program	This program is designed to provide a supportive environment that encourages Suicide Prevention Peer Workers to explore how their lived experience, peer relationships, and communication skills can be used to support others experiencing suicidal distress and those bereaved/impacted by suicide. The program is designed for persons with a lived experience of suicide who are looking to work in non-clinical suicide prevention services roles.

Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of increasing the capacity of Australia's suicide prevention workforce in lieu of workforce shortages in clinical, non-clinical, and peer workforces across the health system [1]. It details the work to be undertaken to build and advance the suicide prevention workforce, including the development of a National Suicide Prevention Workforce Strategy.
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

7.4 Service category - Workplace-based training in mental health and suicide awareness

General information	
Service description	The inclusion of mental health and suicide awareness training as a key component of education/training for relevant professions and, more generally, mandatory workplace-based training or accreditation. Tailored training approaches are required across different professions where there are additional risks and associated needs to intervene differently. This is an evolving space with training programs yet to be developed and evaluated.
Intent of care	To ensure the public can appropriately identify and respond to persons experiencing suicidal distress, or persons who are bereaved or impacted by a suicide death, in the workplace.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	Persons in the workforce.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
	N/A
Levels of evidence	
Summary	N/A
Citations	N/A

7.5 Service Category – Skills training

7.5.1 Service Element – Skills training – Health professionals

7.5.2 Service Element – Skills training – Other non-health professionals

7.5.3 Service Element – Skills training – Peers (community)

General information	
Service description	Skills training encompasses evidence-based training and education for persons who have regular contact with the community to recognise and appropriately respond to persons experiencing suicidal distress and support persons bereaved by suicide. Training may be specific to identifying and responding to the unique needs of persons who belong to specific populations (e.g., Youth, First Nations people, LGBTIQA+ populations, older populations) and should be tailored to the trainee's profession, role, and/or setting in which they are employed. Training may be provided face-to-face or online (n.b. digital skills training is an evolving space – programs need to be designed and evaluated). Skills training encompasses a planning and implementation component to: (1) allow time for facilitators to meet with organisations and determine the approach to training delivery (face-to-face training); and/or (2) complete administrative tasks and troubleshooting (online training). This is modelled as 40% of a full-time equivalents' annual workforce hours. 'Skills training for health professionals refers to training for Australian Health Practitioner Regulation Agency (AHPRA) registered professionals and other non-registered health professionals (e.g., Social Workers, Counsellors, and First Responders) Skills training for other non-health professionals refers to training for persons who are employed in government agencies, financial institutions or schools who have regular contact with the public (e.g., employment services, housing services, prisons, Centrelink, financial counselling and insurance, teachers, university staff). Skills training for peers refers to training for persons in the community. Skills training may be specific to the peer group that the trainee belongs to (e.g., Aboriginal and Torres Strait Islander, LGBTQIA+ community).

Intent of care	To up-skill the community to appropriately identify and respond to persons experiencing suicidal distress/impacted or bereaved by suicide.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Training facilitator
Staffing duration	N/A
Example services	
LivingWorks ASSIST	A two-day workshop designed to teach participants how to identify and respond to persons experiencing suicidal distress. This includes how to provide a skilled intervention, develop a safety plan and connect to further supports. As of 2023, LivingWorks receives funding from governments, health networks, and other organisations.
MindOUT suicide prevention training	MindOUT develops and delivers national suicide prevention initiatives for mental health and suicide prevention to support the specific needs of LGBTQIA+ populations. Among their activities, MindOUT provides training and education for mental health professionals on LGBTQIA+ mental health. As of 2023, MindOUT is funded by the Australian Government Department of Health and Aged Care.
StandBy Support After Suicide	StandBy Support After Suicide offers several training workshops targeting different member of the public; two are outlined below: Pathways to Care Workshop Training for first responders, General Practitioners and other frontline responders, community organisations, and community suicide prevention action groups. What do I say? What do I do? Training for the public to increase understanding of suicide bereavement and learn basic support skills.

	As of 2023, StandBy Support After Suicide is jointly funded by the Australian Department of Health and Aged Care, and the New South Wales, Northern Territory, Queensland and Victorian Governments.
Levels of evidence	
Summary	There are multiple studies on the efficacy of skills training in the published literature. The findings of these studies suggest support for skills training. However, more studies of greater quality are required. One systematic review analysed the efficacy of skills training by analysing findings from 10 randomised controlled studies (RCTs) and six intervention studies, covering a range of types of skills training [1]. The findings were mixed regarding knowledge obtained and self-efficacy following training. Only one of the included studies demonstrated a positive impact of skills training on suicidal behaviour. Most studies included in the review were reported to have quality issues. A further systematic review analysed the long-term efficacy of skills training by analysing findings from 23 articles that evaluated a range of types of skills training [2]. To meet inclusion criteria, outcome assessments were required at baseline and at two follow-up timepoints post-training. Increases in knowledge and self-efficacy had the longest lasting training effects. However, knowledge appeared to wain with time. Trainee attitude (e.g., belief that asking about suicide is appropriate, thoughts on the inevitability of suicide) had returned to baseline levels at follow-up and behavioural intention and behaviour (e.g., implementation of skills) indicated a week training effect with poor translation of training into intervention behaviour.
Citations	[1] Yonemoto N, Kawashima Y, Endo K, Yamada M. Gatekeeper training for suicidal behaviors: A systematic review. Journal of Affective Disorders. 2019;246:506-14. [2] Holmes G, Clacy A, Hermens DF, Lagopoulos J. The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review. Archives of Suicide Research. 2021;25(2):177-207.

7.6 Service Category – Refresher training

7.6.1 Service Element – Refresher training – Health professionals

7.6.2 Service Element – Refresher training – Peers

7.6.3 Service Element – Refresher training – Other non-health professionals

General information	
Service description	Refresher training refers to training for those who have previously completed skills training on how to respond and support persons experiencing suicidal distress, and/or persons bereaved or impacted by a suicide death, to maintain currency of skills and knowledge retention. Refresher training courses may be delivered face-to-face or online and are usually half the duration of the initial skills training.
Intent of care	Up-skill the community to appropriately identify and respond to persons experiencing suicidal distress or bereaved by suicide.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Training facilitator
Staffing duration	N/A
Example services	
	As per 'Service Category – Skills training'
Levels of evidence	
Summary	As per 'Service Category – Skills training'
Citations	As per 'Service Category – Skills training'

7.7 Service Category – Means restriction

General information	
Service description	Reducing or restricting access to means or methods of suicide with the aim to reduce or prevent the lethality of a suicide attempt. This is usually via the development of government policy (e.g., introduction of medication dispensary or firearms laws) or the building of infrastructure (e.g., fencing along bridges).
Intent of care	To reduce or prevent the lethality of a suicide attempt.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Limiting access to jumping sites: safety fencing	Brisbane City has two bridges that were identified as suicide hotspots during the 1990s (i.e., the Gateway Bridge and Story Bridge). Safety fencing was installed on the Gateway Bridge seven years after the bridge's opening in response to an emerging number of suicides. Higher safety fencing was then installed in 2010 following renovation of the bridge. Safety fencing resulted in a reduction in suicide deaths without a realised substitution effect.
Medication legislation	Legislation in the United Kingdom to restrict pack sizes of paracetamol to reduce incidences of poisoning and deaths by suicide.
Levels of evidence	
Summary	Means restriction is regarded as a proven strategy for reducing suicide in the community. An umbrella review analysed findings from 12 systematic reviews evaluating means restriction initiatives [1]. Types of means restriction analysed included the prevention of suicide by firearms, jumping from heights and in front of moving objects, and suicide by hazardous agents. Results suggested support for the use of means restriction to reduce suicide in the community, noting that priority should be given

	to the most prevalent of methods for suicide, with minimisation of any substitution effect also considered. A second review analysed literature related to physical means restriction, and restriction of cognitive availability of means through media and other representations of suicide methods, to provide comment on the effectiveness of, and challenges associated with implementing, means restriction initiatives [2]. Findings were similar, with challenges to the successful implementation noted as potential substitution effects and community resistance to measures required to reduce access to means. Nonetheless, the authors highlighted that means restriction is effective in reducing suicide in the community.
Citations	[1] Nevarez-Flores AG, Pandey V, Angelucci AP, Neil AL, McDermott B, Castle D. (2024) Means Restriction for Suicide Prevention: An Umbrella Review. Acta Psychiatrica Scandinavica.n/a(n/a). [2] Hawton K, Knipe D, Pirkis J. Restriction of access to means used for suicide. The Lancet Public Health. 2024;9(10):e796-e801.

7.8 Service Category – Data, research, and evaluation

General information	
Service description	The development and continued refinement of suicide monitoring systems, and the research and evaluation of suicide prevention policies, programs, and services to promote continuous service and sector improvement.
Intent of care	Monitor the prevalence of suicide/risk in the community and determine the efficacy of potential policies, programs and services on reducing suicide risk/attempt.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
The National Suicide and Self-harm Monitoring System	The National Suicide and Self-harm Monitoring System (the system) was established to improve the quality, accessibility, and timeliness of data on deaths by suicide and on self-harming and suicidal behaviours. As of 2024, the system is managed by the Australian Institute of Health and Welfare, funded by the Australian Department of Health and Aged Care.
Levels of evidence	
Summary	The National Suicide Prevention Strategy highlights the importance of data, research, and program/service evaluation to ensure implementation of strategies that effectively address the drivers of suicide in the community [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra; 2025

8 Service Stream – Reducing drivers of distress

The *reducing drivers of distress* service stream involves upstream strategies that aim to address the drivers and circumstances known to cause distress, to reduce the likelihood of a person experiencing suicide.

8.1 Service Category – Population-level suicide prevention communication guidelines

8.1.1 Service Element – Responsible reporting guidelines

General information	
Service description	The implementation of comprehensive communication guidelines for safe, effective, and responsible reporting, portrayal, and communication of suicide in the media. Guidelines should be evidence-based and developed in consultation with media professionals or peak media bodies, suicide prevention organisations, and persons with lived experience.
Intent of care	Reduce the risk of suicide by means of appropriate reporting of suicidality in the media.
Intended length of care	N/A
Indicative unit size	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Life in Mind: National Communications Charter	The National communications charter (the Charter) is an evidence-informed document to help guide the way mental health and suicide prevention sectors, governments, businesses, communities and individuals communicate about mental health and wellbeing, mental health concerns, and suicide. By signing the Charter, governments, organisations, and individuals make a formal commitment to use safe

	and consistent communication about mental health and suicide that reduces stigma, minimises harm, and encourages help-seeking.
Mindframe: Guidelines	Mindframe have developed guidelines to support safe and accurate media reporting, portrayal and communication about suicide, to reduce stigma and encourage help-seeking. These guidelines are designed for media professionals but are publicly available online. As of 2024, Mindframe is managed by Everymind and funded by the Australian Government Department of Health and Aged Care under the National Suicide Prevention Leadership and Support Program.
Levels of evidence	
Summary	Evidence suggests that responsible reporting guidelines contribute to reductions in the number of suicides in the community. One study estimated that Australia's responsible reporting guidelines avert an average of 139 suicides over a five-year period [1]. A more recent umbrella review of six systematic reviews/meta-analyses also found that educating the media in the appropriate approach for disseminating information around suicidal behaviours and suicide helps to reduce suicidal behaviours in the community [2].
Citations	[1] Flego A, Reifels L, Mihalopoulos C, Bandara P, Page A, Fox T, et al. Cost-effectiveness of media reporting guidelines for the prevention of suicide. Suicide Life Threat Behav. 2022;52(5):1048-57. [2] Sufrate-Sorzano T, Di Nitto M, Garrote-Cámara ME, Molina-Luque F, Recio-Rodríguez JI, Asión-Polo P, et al. Media Exposure of Suicidal Behaviour: An Umbrella Review. Nurs Rep. 2023;13(4):1486-99.

8.1.2 Service Element – Public communication guidelines

General information	
Service description	The creation and implementation of guidelines on how to communicate safely about self-harm and suicide. Guidelines may be developed for the general population or may be specific to populations disproportionately affected by suicide.
Intent of care	Reduce the risk of suicide in the community by engaging in safe communication about self-harm and suicide.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
#chatsafe	#chatsafe is a set of guidelines for young people on how to safely chat about self-harm and suicide on social media and other digital platforms. The guidelines are designed for anyone who is responding to suicide-related content posted online or for young people who may want to share their experience of suicide online. The development of #chatsafe was supported by funding from the Australian Government Department of Health and Aged Care.
Conversations Matter	Conversations Matter is a suite of practical online resources by Everymind that is designed to support safe and effective community discussions about suicide. The resources assist people and communities to talk about suicide in ways that breaks down stigma and increase understanding and support for those impacted by suicide. Conversations Matter was developed with funding from the NSW Ministry of Health, NSW Mental Health Commission, and Everymind.
Levels of evidence	

Summary	There are currently few studies specifically evaluating the effectiveness of public communication guidelines. A pilot study on the feasibility and acceptability of #chatsafe found that the intervention was considered acceptable by young people aged 16 to 25 years [1]. Willingness to intervene against suicide online was higher post intervention and improvements in perceived confidence, self-efficacy and safety when communicating online about suicide were also noted. The involvement of young people in the co-design was highlighted as a likely contributor to the intervention's success. Further evaluation of #chatsafe via RCT was recommended and a study protocol was registered with data collection expected to be completed by June 2024 [2], however the results were not published as of the writing of this document.
Citations	[1] La Sala L, Teh Z, Lamblin M, Rajaram G, Rice S, Hill NTM, et al. Can a social media intervention improve online communication about suicide? A feasibility study examining the acceptability potential impact on the #chatsafe campaign. PLoS ONE. 2021;16(6): e0253278. [2] Robinson J, La Sala L, Cooper C, Spittal M, Rice S, Lamblin M, et al. Testing the Impact of the #chatsafe Intervention on Young People's Ability to Communicate Safely About Suicide on Social Media: Protocol for a Randomized Controlled Trial. JMIR Research Protocols. 2023;12.

8.2 Service Category – Psychoeducation – General, media-based

General information	
Service description	Dissemination of suicide prevention messaging over a range of media platforms (i.e., radio, television, the internet, social media, and other public communication platforms), and via hard-copy resources available in community clinics/non-government organisations, with the aim to improve the public's understanding of suicide, identify risk and protective factors, and promote help-seeking and help-offering behaviours.
Intent of care	Upskill the public to better understand suicide, identify risk factors and protective factors, and promote help-seeking and help-offering behaviours.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
The Community Broadcasting Suicide Prevention Project	A series of segments designed to promote help seeking behaviour and positive lifestyle choices, using interviews with service providers, as well as profiles of people who have successfully navigated stressful times in their lives. This content is broadcasted across community radio. The series was developed by the Community Broadcasting Association of Australia alongside the Australian Government Department of Health and Aged Care.
R U OK? Day	A national campaign designed to build the confidence and capacity of Australians to connect and converse about issues of mental health and build capacity to support others in distress or who may be struggling. As of 2023, R U OK? Day is predominately funded by corporate sponsorships, community donations, merchandise, with a small percentage from the Australian Government Department of Health and Aged Care.

Levels of evidence	
Summary	There is general support for media-based psychoeducation to prevent suicidality in the community. However, more robust studies are required to accurately evaluate the outcomes of these initiatives. A systematic review on suicide prevention media campaigns determined that from 20 evaluation studies of varying quality, there is general support for the role of media campaigns in preventing suicide [1]. Around half of the studies demonstrated that campaign exposure leads to improved knowledge and awareness of suicide. However, there were mixed results as to whether media campaigns can boost help-seeking and help-offering behaviours and few studies had sufficient statistical power to examine impact on number of suicides in the community with just two adequately powered studies demonstrating significant reductions. In a recent Australian workshop, there was general agreement that safe and effective suicide prevention media messages, should: (1) validate or reflect the target audience's difficulties; and (2) promote help-seeking behaviours and services such as calling a helpline or other service [2]. It was also regarded as essential that media messaging be pre-tested in both target and non-target audiences before being released at a population level to determine its interpretation and impacts on various at-risk groups.
Citations	[1] Pirkis J, Rossetto A, Nicholas A, Ftanou M, Robinson J, Reavley N. Suicide prevention media campaigns: a systematic literature review. Health Communication. 2019;34(4):402-14. [2] Ftanou M, Skehan J, Krysinska K, Bryant M, Spittal MJ, Pirkis J. Crafting safe and effective suicide prevention media messages: outcomes from a workshop in Australia. International Journal of Mental Health Systems. 2018;12(1):23.

8.3 Service Category – Psychoeducation and community-building – Sub-population specific

8.3.1 Service Element – Psychoeducation and community-building – Workplace-based

8.3.2 Service Element – Psychoeducation and community-building – School-based

8.3.3 Service Element – Psychoeducation and community-building – Selective populations

8.3.4 Service Element – Psychoeducation and community-building – Selective individuals

8.3.5 Service Element – Psychoeducation and community-building – Communities impacted by suicide

General information	
Service description	Population-level delivery of evidence-based suicide prevention messaging and the dissemination of psychoeducational resources that are tailored to meet the needs of specific populations in the community. Psychoeducation is delivered in a community setting and targeted at specific groups (e.g., males, Aboriginal and Torres Strait, culturally and linguistically diverse, youth, LGBTQI+, sporting groups, TAFE students). The aim is two-fold: (1) help the public to better understand suicide, identify risk and protective factors, and promote help-seeking and help offering behaviours, recognising the different risk factors and structural and social barriers that uniquely impact certain high priority populations, and (2) build a sense of culture and community. *Psychoeducation and community-building – workplace-based* includes the provision of general mental health and awareness training tailored and delivered to employees of certain workplaces or industries within the workplace setting. *Psychoeducation and community-building – school-based* includes the provision of psychoeducational programs as part of the school curriculum, delivered to upper primary and high-school students. Programs should be developmentally appropriate and offered on multiple occasions across a student's schooling years. They may also include a universal distress identification component and follow-up care may be offered to young people who are identified as requiring further support. Follow-up support may be delivered by a school-counsellor or young people may be directed to web-based self-guided supports.

	Psychoeducation and community building – selective populations includes the provision of psychoeducational resources for populations disproportionately impacted by suicide (e.g., males, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations (CALD), LGBTQIA+ populations). Programs are tailored in recognition of the structural and social barriers that uniquely impact populations disproportionately affected by suicide. *Psychoeducation and community building – selective individuals* includes the provision of psychoeducational resources within existing services (e.g., housing services, financial services, Centrelink) where as individual has been identified as at-risk. *Psychoeducation and community building – communities impacted by suicide* includes the provision of community and/or school-level postvention programs aimed at helping individuals process a suicide death and reduce the risk of further suicides. These programs may also include communication guidelines, education for a range of community members (e.g., in a school setting this might be staff, students, and parents), and liaison with key community members.
Intent of care	To educate and develop a sense of community to encourage help-seeking and help-offering behaviours in the community.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	Persons employed in labour workforce, particularly those employed in high-risk industries Young people attending upper primary and high school Populations disproportionately affected by suicide Persons identified at risk during routine care/service delivery Persons impacted by suicide
Workforce	
Workforce type	The designated workforce type is dependent upon the setting/context in which the service is delivered and may include any of the following:

	Psychoeducation and community-building – general Psychoeducation and community-building – communities impacted by suicide
Staffing duration	Business hours
Example services	
headspace Be You	The Be You program is a national mental health and wellbeing initiative for learning communities, delivered by Beyond Blue, alongside Early Childhood Australia and headspace. The program is for Australian educators and provides a range of online, evidence-based tools, resources and professional learning to improve their skills and knowledge on mental health and wellbeing. Be you is funded by the Australian Department of Health and Aged Care.
MATES in construction	MATES in Construction is a multi-component suicide prevention and early intervention program aimed at populations in the construction industry, and fly-in, fly-out (FIFO)/drive-in, drive out (DIDO) workers. The psychoeducation component of the program focuses on general awareness of mental health problems and suicide risk factors. It aims is to reduce stigma and encourage help-seeking. MATES in construction is funded by Government entities, industry partners, and through donation.
NACCHO Suicide Story program	Suicide Story is a suicide prevention and community capacity building program for Aboriginal and Torres Strait Islander remote communities. The program has been funded by the National Suicide Prevention Leadership & Support Program grant funding from the Australian Department of Health and Aged Care
Seasons for Life	Seasons for Life trains school-staff on how to deliver the 'Seasons for Growth' program to secondary school students (a loss and grief education program for young people following a suicide or loss). As part of the Seasons for Life program, staff are also trained on how to deliver an accompanying parent session and have access to a range of resources. As of 2023, Seasons for Life is funded by the Australian Department of Health and Aged Care (2022 – 2025).
Levels of evidence	
	Psychoeducation campaigns are widespread but there is a lack of good quality research regarding their effectiveness in reducing suicide. Nonetheless, they show promise in increasing public knowledge of suicide. One systematic review found that such programs appear to be successful in changing attitudes and improving the knowledge of the

	public concerning suicide but that this does not necessarily translate to changes in behaviour (e.g., help-seeking) [1]. The authors noted problems with study quality, reporting that 'findings often constitute opinion rather than 'review''. A more recent systematic reviewed echoed these findings, noting an increase in the evaluation of 'public awareness campaigns' but a lack of Randomised Controlled Trials' thereby limiting our understanding of the effectiveness of these campaigns in reducing suicide [2].
Citations	[1] Fountoulakis KN, Gonda X, Rihmer Z. Suicide prevention programs through community intervention. Journal of Affective Disorders. 2011;130(1):10-6. [2] Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M, et al. Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry. 2016;3(7):646 - 59.

8.4 Service Category – Enhancing protective factors and promoting well-being

General information	
Service description	General campaigns and programs designed to enhance protective factors and promote wellbeing. This may include, for example: school-based programs focusing on the development of prosocial behaviours and resilience; population level physical and mental health literacy campaigns; and programs and services to increase parents' and cares' mental health literacy. Campaigns and programs may be delivered in school-settings, workplaces, or may be population-wide.
Intent of care	Enhance protective factors and promote wellbeing to reduce suicidality in the community.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Good Behaviour Game	A prevention intervention implemented by trained teachers in classrooms. It consists of evidence-based behavioural strategies that aim to build children's ability to self-regulate, strengthen their relationships with their peers, reduce impulsivity, and teach prosocial decision-making. As of 2024, the implementation of the GBG is supported in some Australian states by the Department of Education.
Triple P – Positive Parenting Program	A free, evidence-based program designed to assist parents in managing everyday parenting challenges and raise happy and resilient children. As of 2024, delivery of the Triple P program is supported by funding from the Australian Government Department of

	Health and Aged Care under the Parenting and Education Support Program.
Levels of evidence	
Summary	Australia's National Suicide Prevention strategy highlights the importance of improving and maintaining general health and wellbeing as a means of reducing distress and suicide risk in the community [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 – 2035. Canberra; 2025

8.5 Service Category – Stigma reduction and behaviour change initiatives

General information	
Service description	Campaigns and programs designed to reduce risk and incidence of suicide and increase help-seeking for, for example: school-based bullying; domestic violence; sexual assault; child abuse; drug and alcohol problems; gambling; financial problems; and any other potential risk factors for suicide.
Intent of care	Reduce associated stigma, increase community education, and elicit positive behaviour change.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
The GambleAware campaign	The GambleAware campaign is designed to encourage people to think about how gambling might be impacting their lives and for those at risk of gambling harm, to familiarise themselves with support and treatment options available. It comprises a suite of resources (e.g., videos, images, text, and links) that can be shared by the public to raise awareness. As of 2024, the campaign is funded by the New South Wales State Government.
That is Violence Campaign	That is Violence is a campaign designed to increase awareness of domestic violence for women with disability. The campaign comprises

	a suite of resources (e.g., videos, images, text, and links) that can be shared by the public to raise awareness. It also provides links to online, phone, and video call supports for persons experiencing abuse or violence. As of 2024, the campaign is funded by the Australian Government Department of Social Services.
Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of addressing stigma and harmful behaviours that may lead to distress to reduce suicide risk in the community [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 – 2035. Canberra, 2025

8.6 Service Category – Environmental controls

General information	
Service description	Environmental controls refer to controls in place to reduce high-risk behaviours that may have a negative impact on wellbeing.
Intent of care	Reduce high-risk behaviours that may negatively impact on general wellbeing and distress.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
BetStop – the National Self-Exclusion Register	A national register that lets the public exclude themselves from all Australian licensed online and phone wagering services.
Northern Territory's Living with Alcohol Program	The Northern Territory's Living with Alcohol Program (1992 – 2002) was designed to increase alcohol taxation to reduce excessive alcohol consumption and related harms. The program demonstrated significantly reduce alcohol-attributable deaths and financial cost savings to the Northern Territory.
Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of addressing harmful behaviours that may lead to distress to reduce suicide risk in the community [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 – 2035. Canberra, 2025

8.7 Service Category – Recovery response suicide prevention outreach service

General information	
Service description	Suicide prevention outreach services as part of recovery responses to disasters or economic crises. May provide psychoeducation, resilience building, therapeutic interventions, practical supports and/or referral to other services.
Intent of care	Reduce distress among populations impacted by disasters or economic crises.
Indicative unit size	N/A
Intended length of support	Usually time-limited and available during/in the months following a disaster.
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	Persons impacted by epidemics, pandemics, natural disasters, and/or economic crises.
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Be You Bushfire Response Program	This program was developed following the Black Summer bushfires in Australia during 2019–2020. The program aimed to provide support for schools and early learning services affected by bushfires to help them understand the impacts of disaster, and how to support recovery and resilience.
COVID-19 Temporary MBS Telehealth Services	This scheme was rolled out during the COVID-19 pandemic to ensure access to Medicare subsidised care without risking the transmission of COVID-19,
Levels of evidence	
Summary	Australia's National Suicide Prevention strategy highlights the importance of improving and maintaining general health and wellbeing as a means to reduce distress and suicide risk in the community [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 – 2035. Canberra, 2025

9 Service Stream – Early engagement

The *early engagement* service stream aims to identify, engage, and support individuals who are at a heightened vulnerability for suicidal distress. The services described below aim to enable and empower communities to recognise and respond to persons who are, or may be at-risk of, suicidal distress.

9.1 Service Category – Telephone and web-based support services

9.1.1 Service Element – Telephone and web-based support services – peer warmlines

General information	
Service description	Suicide prevention telephone-based call-back services for persons experiencing suicidal distress, or who are bereaved by a suicide death, to connect with others with a lived experience of suicide.
Intent of care	Provide relief from emotional distress, explore coping strategies, and assist with navigation to resources and other service types.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons experiencing suicidal distress (excluding those in crisis) and/or persons supporting someone experiencing suicidal distress and/or persons who are bereaved or impacted by a suicide death.
Age	18+ years
Population sub-group	N/A
Workforce	
Workforce type	Peer Worker
Staffing duration	24/7
Example services	
Roses in the Ocean: Peer CARE Companion Warmline	The Peer CARE Companion Warmline is a call-back service provided by Roses in the Ocean to provide a safe place for people with a lived experience of suicide to connect with peers. The Peer CARE Companion is not a crisis support line and is only available to persons aged 18+ years. As of 2023, Roses in the Ocean is funded by the Australian Department of Health and Aged Care and philanthropic support.
The Brook RED Warm Line	The Brooke RED Warm Line is a peer-staffed phone service delivered by Brook RED offering people experience suicide-related distress

	connection with a peer worker after hours (5pm – 9pm Mon-Friday and 3pm – 9pm on weekends). As of 2023, this service was operating in Queensland funded and funded by the Queensland Department of Health.
Levels of evidence	
Summary	There are few studies specifically evaluating the effectiveness of peer warmlines. A longitudinal analysis of the effects of peer warmline service for psychiatry recovery ('Intentional Warm Line') in the United States did not demonstrate statistically significant differences in Recovery Assessment Scores among callers [1]. However, findings suggested that callers showed increases in visits to primary care, leisure activities, and socialisation with others. There were several limitations to study, two being that the study was not a randomised controlled trial, and the study sample only comprised 48 callers. An older exploratory study described the impact of a peer warmline in the United States on the lives of persons with psychiatric disability [2]. Warmline users (n = 480) repeated phone surveys over a course of four years. Findings revealed self-reported reductions in the use of crisis services and feelings of isolation. Despite the lack of good quality evidence of the effectiveness of peer warmlines, both academic and grey literature has consistently highlighted the importance of peer involvement in health and support services in reducing distress [3,4,5].
Citations	[1] Dalgin RS, Dalgin MH, Metzger SJ. A Longitudinal Analysis of the Influence of a Peer Run Warm Line Phone Service on Psychiatric Recovery. Community Mental Health Journal. 2018;54(4):376-82. [2] Dalgin RS, Maline S, Driscoll P. Sustaining recovery through the night: impact of a peer-run warm line. Psychiatric Rehabilitation Journal. 2011;35:65 - 8. [3] Brett J, Staniszewska S, Mockford C, Herron-Marx S, Hughes J, Tysall C, et al. Mapping the impact of patient and public involvement on health and social care research: a systematic review. Health Expectations: An International Journal of Public Participation in Health Care and Health Policy. 2012;17(5):637 - 50. [4] Byrne L. Promoting lived experience perspective: discussion paper prepared for the Queensland Mental Health Commission. Brisbane: Queensland Mental Health Commission; 2017.

	[5] National Suicide Prevention Advisor. Compassion First: Designing our national approach from the lived experience of suicidal behaviour. Canberra; 2020.

9.1.2 Service Element – Telephone and web-based support services – self-guided

9.1.3 Service Element – Telephone and web-based support services – self-guided (families/carers)

9.1.4 Service Element – Telephone and Web Based Support Services – self-guided (postvention)

General information	
Service description	Self-guided digital supports are web-based supports designed to limit both structural and social (i.e., fear of stigma) barriers to accessing supports for emotional distress and to allow users to navigate support in their own time, at their own pace. Dependent upon their target group, these types of supports may include the following components: general psychoeducation; exploration of coping strategies and safety planning; information on how to support someone experiencing suicidal distress; and the provision of additional resources and information. Some self-guided digital supports may include aspects of structured psychological interventions. For example, cognitive behavioural therapy or dialectical behavioural therapy. Self-guided digital supports may be designed for the general population or may be specific to a particular sub-population
Intent of care	Educate, alleviate emotional distress, encourage users to identify coping strategies to manage difficult emotions, and provide access to resources and other services information.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons experiencing suicidal distress (excluding those in crisis) and/or persons supporting someone experiencing suicidal distress and/or persons who are bereaved or impacted by a suicide death.
Age	12+ years
Population sub-group	N/A

Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Beyond NOW	Beyond NOW is a safety planning application designed to support people experiencing suicide-related distress by stepping them through the process of generating a personalised safety plan. Users are encouraged to develop and/or share their safety plan with their General Practitioner, other mental health professional, and/or 'trusted supports'. Beyond NOW is a Lifeline initiative.
LifeBuoy	LifeBuoy is a brief, self-guided application for young people aged 15 – 24 years. It comprises a series of activities designed to help users improve their emotion regulation and resilience to distress. The content of the application is based on the principles of dialectical behavioural therapy. LifeBuoy's development and evaluation has received funding from a range of individuals and organisations.
Levels of evidence	
Summary	There is support for self-guided digital interventions in reducing the risk of suicide. A systematic review and meta-analysis of randomised controlled trials (RCTs) evaluating self-guided digital interventions found that direct interventions (e.g., interventions that specifically address suicidal thoughts and behaviours) demonstrated small significant effects on suicidal ideation immediately following intervention [1]. Indirect interventions (e.g., interventions that target, for example, depression) were not found to significantly reduce suicidal ideation. A more recent scoping review of studies utilising RCT or quasi-experimental designs also found that digital-based interventions such as smartphone apps, online learning modules and game-based interventions have the potential to be effective in reducing the risk of suicidal behaviours among those who use them [2].
Citations	[1] Torok M, Han J, Baker S, Werner-Seidler A, Wong I, Larsen ME, et al. Suicide prevention using self-guided digital interventions: a systematic review and meta-analysis of randomised controlled trials. The Lancet Digital Health. 2020;2(1):e25-e36. [2] Yosep I, Hikmat R, Mardhiyah A, Hernawaty T. A Scoping Review of Digital-Based Intervention for Reducing Risk of Suicide Among Adults. Journal of Multidisciplinary Healthcare. 2024;17(null):3545-56.

9.2 Service Category – Identifying distress

General information	
Service description	The identification of persons experiencing suicidal distress via targeted and opportunistic conversations. These conversations should be initiated by persons trained to identify and respond to potential suicidal distress across a range of settings, for example: in schools; in health care settings (e.g., alcohol and other drug services, chronic disease, and disability services) and non-health care settings (e.g., housing, employment, and social services) during normal service delivery; and in primary care and mental health care services.
Intent of care	Identification of persons experiencing distress and referral and service linkage.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Workforce type is dependent on the setting/context in which care is delivered and may include any of the following: General Practitioner; Tertiary Qualified; and/or Clinical Community Treatment Team.
Staffing duration	Business hours
Example services	
	A range of skills training options are designed to teach persons how to accurately identify someone in distress and provide a brief intervention, as well as linkage to further supports. You can read more about these under 'Service Category – Skills training' in this document.
Levels of evidence	

Summary	The National Suicide Prevention Strategy highlights that the provision of support to persons experiencing suicidality should not be dependent on them reaching out for support [1]. Rather, proactive approaches are required to identify and response to the community's needs. This includes early identification and brief intervention delivered by trained members of the community.
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

9.3 Service Category – Brief intervention

General information	
Service description	Generally one-off brief, supportive, therapeutic interventions, including the provision of information, referral to other support services, and social prescribing to navigate persons to social and economic supports. Persons receiving brief interventions may have been identified as experiencing distress and requiring further support via contact with: trained members of staff in the school-setting; trained members of staff/peers in the workplace; contact with general health services (e.g., disability, chronic disease) and/or non-health services (e.g., housing services, financial services); and/or contact with primary care or mental health services. Key attributes of the intervention will vary dependent on the person receiving the brief intervention and the context in which it is delivered.
Intent of care	Brief therapeutic support, provision of information, and service linkage/referral
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons experiencing distress (excluding those in crisis)
Age	12+ years
Population sub-group	N/A
Workforce	
Workforce type	The designated workforce type is dependent on the setting/context in which the person has been identified as distressed and may include any of the following: General Practitioner; Tertiary Qualified; and/or Clinical Community Treatment Team.
Staffing duration	Business hours
Example services	

	A range of skills training options are designed to educate the public on how to accurately identify someone in distress and provide a brief intervention, as well as linkage to further supports. You can read more about these under 'Service Category – Skills training' in this document.
Levels of evidence	
Summary	The National Suicide Prevention Strategy highlights that the provision of support to persons experiencing suicidality should not be dependent on them reaching out for support [1]. Rather, proactive approaches are required to identify and response to the community's needs. This includes early identification and brief intervention delivered by trained members of the community.
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

9.4 Service Category – Brief support

General information	
Service description	Brief, non-clinical community-based supports for persons experiencing psychological distress who may be at heightened risk of suicide. The service focuses on the provision of practical solutions to manage distress and the identification of additional, local services to aid long term management of distress. Users of this service may have been identified as requiring brief supports by trained persons in the community who act as community engagement touchpoints for the service.
Intent of care	Reduce distress as a means of reducing suicide risk.
Indicative unit size	NA
Intended length of support	Two weeks
Target population	
Presenting features	Persons in distress or at heightened risk of suicide, excluding those in crisis.
Age	18+ years
Population sub-group	NA
Workforce	
Workforce type	Vocationally Qualified
Staffing duration	Business hours
Example services	
Distress Brief Support	Distress Brief Support (DBS) is a short-term, community-based approach that offers a non-clinical response to adults in distress but who are not in crisis and do not require emergency care. The program aims to equip persons with skills and tools to manage their distress. As of 2024, DBS programs are jointly funded by the Australian Department of Health and Aged Care and State and Territory health Departments as part of the National Bilateral Agreements.
Levels of evidence	
Summary	There is some support for brief support in reducing distress. A review of the Scottish Distress Brief Intervention (DBI) revealed that most individuals who accessed the program reported receiving a compassionate and practical response that contributed to their ability

	to manage and reduce their distress in the short, and for some, in the longer term [1]. Australia's DBS program is an adaption of DBI.
Citations	[1] Duncan E, Harris F, Calveley E, Maxwell M, Mclean J, Shields J, et al. Evaluation of the Distress Brief Intervention Pilot Programme: health and social care. 2022.

9.5 Service Category – Service navigation

9.6 Service Category – Service navigation – designated phone lines

General information	
Service description	Service navigation refers to linking at-risk persons to appropriate support services. Service navigation may be: provided by social workers in the context of discharge from an hospital emergency department or inpatient unit following a suicide attempt, or from a short-stay multidisciplinary unit; accessed via clinically staffed phone lines (e.g., MHCALL or Primary Health Network phones lines (i.e., Initial Assessment and Referral (IAR) tool), the Suicide Call Back Service, and/or Head to Health phone services); and/or part of a broader Employee Assistance Program (EAP) or dedicated suicide prevention workplace program.
Intent of care	Service linkage to ensure continuity of care for at-risk individuals.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons in distress or at heightened risk of suicide, excluding those experiencing a suicidal crisis.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	The designated workforce type is dependent on the setting/context in which care is delivered and may include any of the following: Tertiary Qualified Vocationally Qualified Peer Worker
Staffing duration	Business Hours
Example services	
Head to Health service navigation support	Head to Health service navigation is a national call line that connects callers to local Head to Health teams that link them, or the person they are supporting, with the most appropriate services to meet their needs.

Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of access to timely and appropriate suicide prevention services, including up-to-date platforms that encourage the use of service navigation to help connect people with relevant services [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

9.7 Service Category – Socioeconomic and situational support services

General information	
Service description	Services that support and build resilience of people who are negatively impacted by socioeconomic or situational factors that may increase the risk of suicide. This may include, for example: domestic violence family support services; relationship counselling services; employment services; housing services; financial counselling services; legal support services; loneliness and social isolation interventions; and transition services (e.g., transition from out-of-home care back into the community). The types of services accessed would vary based on a persons age. For example, older persons may require aged care supports while young adults may require more assistance from employment and financial counselling services.
Intent of care	To address negative socioeconomic and situational factors to reduce the risk of suicide.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Domestic Violence Crisis Service	The Domestic Violence Crisis Servies offers telephone support, legal support and advocacy, peer support programs, and advice and information for persons impacted by domestic violence.

Micah Projects: housing and homelessness services	Michah Projects' housing and homelessness services offers 24/7 support for persons requiring practical assistance with accessing and maintaining housing.
Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of addressing socioeconomic and situational factors that may lead to suicide in the community [1]. Evidence suggests an increase in resilience, and reduction in distress and suicide rates, among populations where persons feel safe, healthy, connected, and satisfied with their lives.
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025 Selection of academic and grey literature cited in the National Suicide Prevention Strategy Case A, Deaton A. Suicide, age, and well-being: an empirical investigation. Insights in the Economics of Aging: University of Chicago Press; 2015. p. 307 - 34. Dev S, Kim D. State- and County-Level Social Capital as Predictors of County-Level Suicide Rates in the United States: A Lagged Multilevel Study. Public Health Rep. 2021;136(5):538-42. Helliwell JF. Well-Being and Social Capital: Does Suicide Pose a Puzzle? Social Indicators Research. 2007;81(3):455-96. Kelly BD, Davoren M, Mhaoláin AN, Breen EG, Casey P. Social capital and suicide in 11 European countries: an ecological analysis. Social Psychiatry Psychiatric Epidemiology. 2009;44(11):971-7. Kunst AE, van Hooijdonk C, Droomers M, Mackenbach JP. Community social capital and suicide mortality in the Netherlands: a cross-sectional registry-based study. BMC Public Health. 2013;13(1):969.

9.8 Service Category – Supports for drug and alcohol use

General information	
Service description	Services for persons experiencing problems with their drug and alcohol use to reduce potential further harmful behaviours and distress. Services may include: inpatient services; peer-based community support services; withdrawal management and rehabilitation; and/or family support services.
Intent of care	Address drug and alcohol use as a means of increasing general wellbeing and reducing suicide risk.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons experiencing problematic drug and alcohol use.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Brisbane North PHN	Alcohol and other drug services are funded by all levels of government and some Primary Health Networks (PHNs). A range of service options are available dependent on an individual's level of acuity and circumstance.
Brisbane Metro North Health alcohol and other drugs services	
Levels of evidence	
Summary	The National Suicide Prevention Strategy highlights that alcohol and drug-related issues have been consistently linked to suicide, noting the need to reduce the prevalence and harm of unsafe and addictive behaviours as a means to reduce distress and suicide risk [1]
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra; 2025

9.9 Service Category – Supports for mental illness

General information	
Service description	Services for persons experiencing mental illness to reduce potential further distress. This may include: inpatient and community clinical care; community and peer-based support services; and family/carer support services.
Intent of care	Treat and manage the symptoms of mental illness to reduce potential further distress and suicide risk.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons with mental illness
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	N/A
Staffing duration	N/A
Example services	
Medicare Benefits Schedule: Better Access	Supports for mental illness are funded by all levels of government and Primary Health Networks (PHNs). A range of service options are available dependent on an individual's level of acuity and circumstance.
Brisbane South PHN	
Brisbane Metro South	
Levels of evidence	
Summary	The Australian National Suicide Prevention Strategy (the Strategy) acknowledges that not all people who die by suicide have a mental illness [1]. Nonetheless, mental illness is among the risk factors known to be closely related to suicide. The Strategy therefore highlights the importance of a cohesive, accessible and effective mental health system.
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra; 2025

10 Service Stream – Primary care

The *primary care* service stream aims to represent the primary and ambulatory care delivered by specialist clinical professionals to an individual experiencing suicidal distress or engaging in self-harm when presenting to a primary care facility. The services below aim to provide accessible, comprehensive, and compassionate care that offers coordinated, timely and tailored interventions to these individuals.

10.1 Service Category – Assessment and planning*

General information	
Service description	Assessment of suicidality risk and need for care via the collection and evaluation of information and data relating to the person's history, presenting signs of distress, and situational and supporting factors. Where needed, this includes the development of care plans and safety plans to support the individual. Includes brief intervention and social prescribing to navigate people to social and economic support options.
Intent of care	Assess and direct persons toward appropriate care.
Target population	
Presenting features	Persons experiencing suicidal distress or who have attempted suicide.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	The designated workforce type is dependent on the setting/context in which care is delivered: General Practitioner Vocationally Qualified Peer Worker
Staffing duration	N/A
Example services	
Collaborative Assessment and Management of Suicidality (CAMS)	The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based approach to treating people suffering from suicide-related distress. Together, the provider and person identify drivers of distress to develop treatment and stabilisation plans. CAMS

	is supported by 11 clinical trials, 7 randomised control trails and 2 meta-analyses.
Levels of evidence	
Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

10.2 Service Category – Review +/- ongoing management*

General information	
Service description	Review and ongoing management of a person's experience of suicide distress and/or need for suicide prevention services. Involves the collection, analysis, interpretation of information and may include: mental health status monitoring; risk assessment; physical health review; family, friends, support people and carers needs assessment; social and environment assessment; and review and update of care/safety plans.
Intent of care	Monitor a person's experience of suicide-related distress and review and update care/safety plans accordingly.
Target population	
Presenting features	Persons experiencing suicidal distress or who have attempted suicide.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	The designated workforce type is dependent on the setting/context in which care is delivered and may include any of the following: General Practitioner Tertiary Qualified Clinical Community Treatment Team
Staffing duration	N/A
Example services	
	N/A
Levels of evidence	
Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

10.3 Service Category – Care coordination and liaison*

General information	
Service description	Aims to provide coordination of care via liaison with other health professionals and persons in caring positions (e.g., family and friends, teachers). Includes working in partnership with primary care providers, acute health and emergency services, rehabilitation and support services, family, friends, support people and carers and other agencies that occur outside of the clinical encounter. Care coordination and liaison may include: person centred interagency planning meetings (case conferences); liaison and/or consultation with family, friends, support people and carers; referral to relevant health professionals (e.g., psychologists, social workers, general practitioners), social supports (e.g., support groups), or other local relevant support services; liaison with other services/agencies including schools (may be verbal or written); and multidisciplinary Team Reviews.
Intent of care	To ensure continuity of care via referral to appropriate services and supports.
Target population	
Presenting features	Persons experiencing suicidal distress, who have attempted suicide, or are bereaved by a suicide death.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	The designated workforce is dependent upon the context in which the service is being delivered and may be any of the following: Vocationally Qualified professionals Tertiary Qualified professionals Peer Workers General Practitioners

	Crisis Response Teams
Staffing duration	N/A
Example services	
	N/A
Levels of evidence	
Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

10.4 Service Category – Structured psychological therapies*

10.4.1 Service Category – Structured psychological therapies – Individual*

10.4.2 Service Category – Structured psychological therapies – Family*

General information	
General service description	Structured Psychological Therapies are interventions that include a structured interaction between a person or group of persons and a qualified mental health professional(s) using a recognised, psychological method, for example, dialectical behavioural therapy, family therapy or psycho education counselling. Structured psychological therapies are typically delivered in an office or community setting to an individual or family. Family interventions may focus on building personal capacity, resilience, coping skills and mutual support for family, friends, support people and carers, as well as grief counselling. They may also include the provision of education and information, individual advocacy and support to navigate community care systems. Where long-term, ongoing therapy is required, input from a psychiatrist may be necessary
Intent of care	Alleviate psychological distress, change maladaptive behaviour, and foster mental health.
Target population	
Presenting features	Persons experiencing suicidal distress, who have attempted suicide, are bereaved by a suicide death, and their family, friends, carers, and support persons.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Tertiary Qualified
Staffing duration	N/A
Example services	
	Structured psychological therapies are delivered by a range of tertiary and medically qualified professionals across varied settings within the community.
Levels of evidence	

Summary	There is some support for the use of certain types of structured psychological therapies for suicide prevention across different age cohorts, but there are methodological limitations to the available research. One Cochrane review found positive effects for cognitive behavioural therapy (CBT) based approaches at long-term follow-up, and metallisation-based therapy (MBT) and emotion-regulation psychotherapy post-intervention, on repetition of self-harm (encompassing self-harm with and without intent) among adults. There was also some evidence of the effects of dialectical behavioural therapy (DBT) on frequency of self-harm repetition. The authors noted, however, that there are important methodological limitations to the studies that comprised the review [1]. A second Cochrane review highlighted the moderate or very low quality of available evidence for therapies for suicide prevention among children and adolescents [2]. DBT for adolescents demonstrated some promise on repetition of self-harm but the authors noted that further research is required to be sure of its effects. There was no evidence for CBT-based psychotherapy for adolescents, MBT for adolescents, group-based psychotherapy, enhanced assessment approaches, compliance enhancement approaches, family interventions, or remote contact interventions in preventing repetition of self-harm in this age group. Nonetheless, given the benefit of CBT approaches among adults, it was argued that these approaches should be further developed and evaluated among children and adolescents.
Citations	[1] Witt KG, Hetrick SE, Rajaram G, Hazell P, Taylor Salisbury TL, Townsend E, et al. Psychosocial interventions for self-harm in adults. Cochrane Database of Systematic Reviews. 2021(4). [2] Witt KG, Hetrick SE, Rajaram G, Hazell P, Taylor Salisbury TL, Townsend E, et al. Interventions for self-harm in children and adolescents. Cochrane Database Syst Rev. 2021;3(3):Cd013667.

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

11 Service Stream – Community-based intensive interventions

The *community-based intensive Interventions* service stream aims to provide more intensive suicide prevention services for individuals experiencing a suicidal crisis within the community setting. This ensures provision of compassionate, person-centred care through accessible, timely and appropriate suicide prevention services that are coordinated and integrated.

11.1 Service Category – Community-based support and respite

11.1.1 Service Element – Short-stay residential (multidisciplinary team)

General information	
Service description	Home-like, short-stay residential units located on hospital campuses offering an alternative to hospital emergency department presentation and psychiatric hospitalisation. Services may consist of: assessment; diagnosis; treatment planning; observation; case management; individual and group counselling; skills training; prescription and monitoring of psychotropic medication; referral; and service linkage. Service delivery is offered on a 24-hour basis, delivering 'sub-acute' care. Units are staffed by both clinical and non-clinical professionals, including peer workers.
Intent of care	Assessment, triage, treatment planning, counselling, de-escalation of distress/risk, and service linkage
Indicative unit size	Five-bed unit
Intended length of support	Up to 4 nights, 5 days
Target population	

Presenting features	Persons experiencing suicidal distress, including those in crisis.
Age	16 – 24 years
Population sub-group	N/A
Workforce	
Workforce type	Short-stay residential (multidisciplinary team)
Staffing duration	24/7
Example services	
The Luminos Project	The Luminos Project is a non-medical, short-stay residential service for young people aged 16 – 24 years experiencing thoughts of suicide. It is designed to have a home-like environment with the opportunity for young people to engage in skills groups, relaxation activities, and one-on-one conversations with staff and volunteers. The service is staffed by clinical supports, peers, support coordinators, and volunteer support counsellors. The service is offered as a four night/five day residential stay. The service was developed by RUAH in partnership with Samaritans WA and the Telethon Kids Institute and is situated in Western Australia.
Levels of evidence	
Summary	A systematic review and meta-analysis revealed that short-stay mental health crisis units are effective for reducing emergency department wait times and inpatient admissions. [1]. However, further research is required to provide comment on their effectiveness in reducing suicide/risk in the community.
Citations	[1] Anderson K, Goldsmith LP, Lomani J, Ali Z, Clarke G, Crowe C, et al. Short-stay crisis units for mental health patients on crisis care pathways: systematic review and meta-analysis. BJPsych Open. 2022;8(4):e144.

11.1.2 Service Element – Short-stay residential (peer-led)

General information	
Service description	Home-like short-stay residential units located in the community offering an alternative to hospital emergency department presentation and psychiatric hospitalisation. Service delivery is offered on a 24-hour basis and includes the provision of intensive, short-term, non-clinical supports to allow individuals in suicidal crisis who do not require medical attention, a space to manage and resolve the crisis. Units are staffed by trained peer workers
Intent of care	De-escalation of distress/risk, peer support, and service linkage
Indicative unit size	Three private rooms
Intended length of support	Seven nights
Target population	
Presenting features	Persons experiencing suicidal distress, including those in crisis.
Age	18+ years
Population sub-group	N/A
Workforce	
Workforce type	Short-stay residential (peer led)
Staffing duration	24/7
Example services	
Afiya Peer Respite	Afiya is a 24/7 peer-run support service for persons aged 18+ years. The service provides stays up to seven nights as an alternative to psychiatric hospitalisation and other higher-intensity services. The service offers individual and group peer support options, and support to act and establish next steps upon leaving the service. Persons also have access to a 'community bridger' who may assist with organisation appointments, accessing resources, benefits, and additional peer support, and organising social activities.
Levels of evidence	
Summary	A range of similar services have demonstrated effectiveness in supporting persons in crisis and diverting them away from emergency department care [1]. However, further research is required to provide comment on their effectiveness in reducing suicide/risk in the community.

Citations	[1] Saxon V, Mukherjee D, Thomas D. Behavioral health crisis stabilization centres: a new normal. Journal of Mental Health and Clinical Psychology. 2018;2(3).

11.1.3 Service Element –Community-based support – safe spaces for crisis

General information	
Service description	Home-like, community-based service offering an alternative to emergency department and psychiatric hospitalisation and providing ambulatory care and support with a focus on suicide prevention. The aim of the service is to: provide a safe environment; relieve crisis symptoms immediately; provide observation; determine level of care; and deflect from unnecessary higher levels of care. Services may be led by a multidisciplinary team or peer run*
Intent of care	Assessment, support, and service linkage.
Indicative unit size	N/A
Intended length of support	Average presentation duration is 2 to 4 hours.
Target population	
Presenting features	Persons in distress or experiencing a suicidal crisis who do not require medical input
Age	16+ years
Population sub-group	N/A
Workforce	
Workforce type	Community-based support – safe spaces for crisis
Staffing duration	5pm – 9pm on weekdays, 3pm – 7pm on weekends
Example services	
Robina Hospital Crisis Stabilisation Unit	The Crisis Stabilisation Unit in Robina on the Gold Coast is a 12 chair, eight bed unit established to divert people experiencing an acute mental health crisis from emergency departments into a comfortable, therapeutic, and home-like environment. The maximum length of stay for persons using the service is 23 hours. Persons are provided an acute mental health assessment, treatment, and management. They may include a range of short-term options tailored to an individual's needs with a focus on supporting safe discharge. The service is available for persons aged 18+ years who are experiencing a mental health crisis and would alternatively have need for care requiring

	them to present to an emergency department. As of 2024, this service is funded by the Queensland Department of Health.
Safe Haven Cafes	Safe Haven Cafes are operate as a drop-in service for persons experiencing emotional distress, including suicidal distress who are seeking support and social connection. Services are peer led and persons are welcomed to talk to Peer Workers or join in on available activities. Safe Havens peer workers offer trauma informed support and persons have access to both individuals and group work/support, sensory modulation activities, health education and wellbeing planning, and assistance with accessing a range of other services. These services generally operate after hours (e.g., 5pm – 8:30pm weekdays and for select daytime hours on weekends).
Safe Spaces	Safe spaces refer to non-clinical, peer-led supports for persons experiencing suicidal distress. They are an alternative to conventional mental health and hospital services. As an example, the Brisbane North Safe Space operates from 5am – 9pm weekdays and 8am – 1pm on weekends. Peer workers are onsite to listen to concerns, support de-escalation, safety plan, initiate warm connections with the individual and other services and supports, and offer follow-up contact.
Levels of evidence	
Summary	There is some support for the use of community based safe spaces for crisis, however further robust evaluation required. An evaluation of Brisbane North Primary Health Network's (PHN) Safe Spaces program, comprising four Safe Spaces throughout the PHN, revealed a strong demand for this service model, with over 85% of persons using the service reporting improvements in levels of distress between the start and end of their visit [1]. Most persons using the service were repeat visitors, with recommendations made to adapt the service to better accommodate repeated visitors and different presentations of distress. An evaluation of a Safe Haven Café in Melbourne found that three main benefits of the café were a reduction in mental health related emergency department presentations, improved patient experiences, and improved social connections within the local community [2]. In 2022, a study protocol was published for research that aims to investigate the implementation, effectiveness, and sustainability of Safe Space models as alternatives for people who might usually present to the emergency department or choose not to access help

	due to past negative experiences [3]. As of February 2025, this project is still in progress [3].
Citations	[1] Nous Group. Safe Spaces evaluation - progress report. 2023. [2] PWC. Economic impact of the Safe Haven Cafe Melbourne. 2019. [3] Banfield M, Fitzpatrick SJ, Lamb H, Giugni M, Calear AL, Stewart E, et al. Co-creating safe spaces: Study protocol for translational research on innovative alternatives to the emergency department for people experiencing emotional distress and/or suicidal crisis. PLOS ONE. 2022;17(10):e0272483.

*This service taxonomy has been built to represent Safe Spaces/Havens operating in the community. Adjustments can be made in the model to adapt the workforce designated to this service to reflect ambulatory care provided in Crisis Stabilisation units that are led by multidisciplinary teams providing clinical and non-clinical care.

11.2 Service Category – Time-limited interventions

11.2.1 Service Element – Discharge follow-up and support – outpatient-based

General information	
Service description	Next day follow-up support provided by a mental health clinician in a hospital outpatient setting following presentation to a hospital emergency department for intentional self-harm or suicide attempt not requiring a hospital inpatient stay. Support may be provided over three sessions with a focus on: goal setting; practising targeted interventions (e.g., mindfulness, relaxation, problem solving); connection to appropriate services; and warm handover back to a person's usual care team. Referrals to the service are received from the hospital emergency department following assessment by a psychiatry registrar.
Intent of care	Follow-up support and service linkages following self-harm or suicide attempt.
Indicative unit size	N/A
Intended length of support	Three sessions
Target population	
Presenting features	Persons who have attempted suicide and require emergency department care but not a hospital admission.
Age	18+ years
Population sub-group	N/A
Workforce	
Workforce type	Clinical community treatment team – Adult (25 – 64 years) Clinical community treatment team – Older adult (65+ years)
Staffing duration	Business hours
Example services	
Green Card Clinic	The Green Card Clinic operates at St Vincent's Hospital Sydney is for individuals over 15 years old presenting to the emergency department with suicidality. These individuals are provided with a 'green card' that includes the details of their next appointment time and telephone numbers to contact when in crisis. Individuals receive

	three sessions of support after which they may be referred on to further appropriate services.
Gold Card Clinic	The Gold Card Clinics provides clinical services to adults aged 18-65 years who frequently present to emergency departments or acute inpatient services with emotion dysregulation, suicidal ideation or self-harming behaviour. The program provides three sessions of support focusing on identifying and addressing psychological and behavioural factors that contributed to the crisis, with an additional session for carers, partners and family members if needed. As of July 2018, this has been funded by New South Wales Ministry of Health and in collaboration with the University of Wollongong.
Levels of evidence	
Summary	There is some support for time-limited interventions for persons presenting in crisis to hospital emergency departments, but further research is required to comment on their effectiveness. A systematic review has examined the effectiveness of brief psychological interventions in addressing suicidal thoughts and behaviours [1]. The review included four controlled studies that were deemed 'low risk of bias'. Although the evidence base is small, it was found that brief psychological interventions appear effective in reducing suicide and suicide attempts among persons who had received emergency department care for a suicide attempt.
Citations	[1] McCabe R, Garside R, Backhouse A, Xanthopoulou P. Effectiveness of brief psychological interventions for suicidal presentations: a systematic review. BMC Psychiatry. 2018;18(1):120.

11.2.2 Service Element – Time-Limited Interventions – telephone/digital helplines

General information	
Service description	Telephone/digital helplines are 24-hour free crisis helplines. The focus of the service is establishing rapport, exploring suicidal risk, triage, and identifying coping strategies. In the context of acute, imminent suicidal risk, the provider may obtain caller location and dispatch emergency personnel Services may be delivered via a range of modalities including via telephone, web-based platforms, instant messaging, and SMS.
Intent of care	Reduce distress, identify coping strategies, and refer to services as needed.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons experiencing distress, suicidal distress, or in suicidal crisis.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	VQ Crisis Counsellor
Staffing duration	24/7
Example services	
Lifeline	Lifeline is a free nationwide service providing 24/7 crisis support and suicide prevention services. Services are available via telephone, online, or via SMS. Lifeline is funded by federal and state and territory governments, and several Primary Health Networks. Lifeline also receives funding via donations.
Kids Helpline	Kids Helpline is a free nationwide service providing 24/7 online and phone counselling for young people aged 5 – 25 years. Services are delivered by qualified counsellors. Kids Helpline is funded by the federal government, state governments, and other organisations.
Suicide Call Back Service	The Suicide Call Back Services is a free nationwide service providing 24/7 phone and online counselling to persons affected by suicide. The service is available via telephone or online. As of 2024, the

	Suicide Call Back Service is funded by the Australian Government Department of Health and Aged Care and Delivered by Lifeline.
Levels of evidence	
Summary	There is some evidence for the effectiveness of telephone/digital helplines in reducing suicidal distress. However, good quality research is lacking. One systematic review examined the effectiveness of crisis line services across 33 studies [1]. The review found support for the effectiveness of telephone/digital helplines on 'proximal' outcomes (i.e., outcomes measured during or at the end of the call), including client mood/satisfaction at the end of the call, the provision of referrals, and 'suicidal self-directed violence'. There was less support for the effectiveness of telephone/digital helplines on 'distal' outcomes, and specifically future engagement with services and 'suicidal self-directed violence'. Most studies included in the review were rated at Oxford level four evidence (i.e., poor quality) and 80% were assessed at high risk of bias.
Citations	[1] Hoffberg AS, Stearns-Yoder KA, Brenner LA. The effectiveness of crisis line services: a systematic review. Frontiers in Public Health. 2020;7.

11.3 Service Category – Co-response teams

General information	
Service description	Co-response to persons in suicidal crisis by mental health clinicians, the peer workforce, and +/- police officers and paramedics. Co-response teams are initialised via a call from public emergency services The role of co-response teams is to provide advice, conduct mobile assessments, and connect the person to further relevant supports, as required.
Intent of care	Assessment, de-escalation of distress, triage and referral.
Indicative unit size	N/A
Intended length of support	N/A
Target population	
Presenting features	Persons who are experiencing a suicidal crisis.
Age	18+ years
Population sub-group	N/A
Workforce	
Workforce type	Co-response team
Staffing duration	Thursday – Monday, 2.00pm – 10.00pm
Example services	
Police, Ambulance, and Clinician Early Response (PACER)	PACER teams are funded across Australia by state and/or territory governments. They are multi-agency teams comprising police officers, paramedics, and mental health clinicians. PACER teams are initialised by a call to emergency services and provide assessment, brief support, and service referral to those experiencing a mental health or suicidal crisis.
Mental Health Co-Responder Project (MH-CORE)	MH-CORE is a co-responder model in Queensland. The initiative involves the employment of mental health staff to work alongside police during the assessment and referral for individuals in the community experiencing a mental health or suicidal crisis.
Levels of evidence	
Summary	Co-response models appear promising but there is a lack of good quality studies evaluating their effectiveness. One rapid review found that co-response models (e.g., Crisis Intervention Teams (trained police) and mental health co-responder models) may increase

	referrals for mental health services, reduce time spent responding to mental health incidents, improve practitioner's knowledge, perceptions, and attitudes toward mental illness, and change perceptions of police in the community [1]. However, the authors noted that due the small number of high-quality evaluation studies, these findings should be interpreted with caution. A second review of police, co-responder, and non-police models also highlighted the lack of good quality evaluation research [2]. The review found that co-responder models demonstrated improved outcomes compared to police only models (e.g., reduction in emergency department visits), however, evidence was often mixed. Non-police models varied significantly, and studies tended to be too low quality to make comparisons or draw conclusions.
Citations	[1] Eggins E, Hine L, Mazerolle L, McEwan J, Hassall G, Roetman S, et al. Mental health co-response models: a rapid review of the evaluation literature: final report. 2020. [2] Marcus N, Stergiopoulos V. Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. Health & Social Care in the Community. 2022;30(5):1665-79.

11.4Service Category – Acute care services

General information*			
Service description	Acute care services provide suicide prevention services to all persons with acute care needs in a community setting (e.g., a person's home). These services facilitate 24/7 community access and timely care by a multidisciplinary team. Acute care services are integrated with local suicide prevention services, emergency departments, as well as primary care supports.		
Intent of care	Triage, crisis assessment, and onward referral.		
Target population			
Presenting features	Persons experiencing suicidal distress, including those in crisis.		
Age	All ages		
Population sub-group	N/A		
Workforce			
Workforce type	Acute Care Team		
Staffing duration	12 – 17 years	18 – 64 years	65+ years
	Business hours	24 hours/7 days	Business hours
Example services			
Acute Care Teams (ACTs)	Multidisciplinary teams located at major hospitals that provide mental health assessment, treatment, and support in managing short-term distress. ACTs provide care in the community, usually in a person's home. This service is available 24/7 and is accessible via the MH Call hotline or referral from another government or non-government service, family member, or friend.		
Crisis Assessment and Treatment Team (CATT)	Multidisciplinary teams located at major hospitals that provide support during crisis. CATTs are available 24/7 and work with other services where required including the police, ambulance, alcohol and other drug services, child protection, and community services. CATTs provide assessment and support in the community, usually in a person's home.		
Levels of evidence			
Summary	N/A		
Citations	N/A		

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

11.5 Service Category – Consultation Liaison

11.5.1 Consultation liaison – Emergency department (hospital)

11.5.2 Consultation liaison – General (hospital)

General information*	
Service description	Consultation liaison provides specialist suicide prevention services to patients in the general hospital inpatient setting or in a hospital's emergency department. The service involves an assessment for suicidality and the provision of advice on clinical management to the general health treating team. Consultation liaison teams also provide linkages between the general hospital, primary care and other health services for patients whose physical care is complicated by their suicidal distress/suicidality. They may also provide teaching, training and suicide prevention promotion support for general hospital staff.
Intent of care	To assess and provide referral to on-going supports as required, ensuring continuity of care between hospital and community services.
Target population	
Presenting features	Persons experiencing suicidal distress in the hospital setting
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Consultation liaison – Emergency department (hospital) Consultation liaison – General (hospital)
Staffing duration	24/7
Example services	
Consultation Liaison Psychiatry Services (CLPS)	A specialised team that primarily provide consultation and support to persons within the general hospital setting. The team supports persons who have presented with either a primary medical condition or suicidal distress and require assessment, support, and referral. CLPS's operate in most Hospital and Health Services throughout Australia.
Levels of evidence	
Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

11.6 Service Category – Clinical community treatment team*

11.6.1 Service Element – Clinical community treatment team – youth – 12 – 24 years

11.6.2 Service Element – Clinical community treatment team – adult – 25 – 64 years

11.6.3 Service Element – Clinical community treatment team – older adult – 65+ years

General information	
Service description	Clinical community treatment teams provide intensive, developmentally appropriate, specialist ongoing assessment and care for those persons who require higher intensity (e.g., level of contact, range of interventions/services) treatment, rehabilitation and support. These teams work with the person and their network to develop their sense of self-efficacy, personal support systems, and ability to live independently and participate fully in their community. There is a strong emphasis on psychoeducation, vocational rehabilitation, and consultation, collaboration and co-ordination with other key services and health care providers. The service is provided in a manner than promotes flexibility of service offerings to meet consumer preferences.
Intent of care	To provide ongoing assessment, support, and referral to relevant services.
Indicative unit size	N/A
Target population	
Presenting features	Persons experiencing on-going, severe suicidal distress that has a significant impact on their functioning.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Clinical community treatment team – youth (12 – 24 years) Clinical community treatment team – adult (25 – 64 years) Clinical community treatment team – older adult (65+ years)
Staffing duration	Business hours
Example services	
	N/A
Levels of evidence	

Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

12 Service Stream – Bed-based services

The *bed-based services* stream includes specialist suicide prevention services that require overnight, acute care in a hospital. These services are usually used by individuals with significant thoughts of suicide and high risk of self-harm, and various levels of associated functioning.

12.1 Service Category – Acute inpatient services

12.1.1 Service Element – Acute inpatient services – youth (12 – 24 years)

12.1.2 Service Element – Acute inpatient services – adult (25 – 64 years)

12.1.3 Service Element – Acute inpatient services – older adult (65+ years)

General information*			
Service description	Acute inpatient services provide specialist care for people with acute episodes of suicidal distress/who are in crisis. These services are short-to medium-term 24-hour inpatient assessment and treatment services for those who cannot be adequately supported in a less restrictive environment. The core business is to provide multidisciplinary specialised assessment, best practice, evidence-based and collaborative planning, interventions and preparation for discharge delivered through recovery-oriented practices and procedures, in a safe, therapeutic, and person-friendly environment. Support focuses on decreasing acuity to a level that can be treated in less intensive environments.		
Intent of care	Specialist supports for persons experiencing acute suicidal distress/in crisis.		
Indicative unit size	12 – 24 years	25 – 64 years	65+ years
	12 beds	24 beds	16 beds
Intended length of support	12 – 17 years	25 – 64 years	65+ years
	14 days	14 days	42 days
Target population			
Presenting features	Persons that have thoughts of suicide and risk of self-harm that cannot be supported in a less restrictive service.		
Age	All ages		
Population sub-group	N/A		

Workforce	
Workforce type	Acute inpatient services – youth (12 – 24 years) Acute inpatient services – adult (25 – 64 years) Acute inpatient services – older adult (65+ years)
Staffing duration	24/7
Example services	
Adult Acute Mental Health Inpatient Service	Inpatient care delivered by a multidisciplinary team offering clinical treatment programs, psychological interventions, functional and vocational support, and access to group programs. This service is for persons who are experiencing acute suicidal distress/are in crisis.
Levels of evidence	
Summary	N/A
Citations	N/A

*Service category has been adapted from the NMHSPF: Service Element and Activity Descriptions. For more information about the descriptions in the NMHSPF, please visit: https://www.aihw.gov.au/nmhspf/overview/documentation.

13 Service Stream – Supports for long-term wellbeing

The *supports for long-term wellbeing* service stream aims to provide support for persons who have experienced suicidality, and their family and carers. The risk of suicide is particularly elevated in the first three to six months following a previous attempt. The supports below aim to alleviate the immediate distress, ensure continuity of care and provide a path to restoring wellbeing in the long-term.

13.1Service Category - Individual psychosocial support services

General information	
Service description	Supports to improve quality of life and psychosocial functioning. Support may take the form of recovery planning/goal setting, skill development, and the provision of information and resources, as well as service linkage and referral. Key focus areas may vary dependent on a person's age. For young people aged 12 – 24 years, a key focus of care may be supporting the young person to maintain engagement with school and/or employment and the meeting of developmental milestones (e.g., obtaining a driver's license). The development of return to school plans are particularly important for persons aged 12 – 17 years. For adults and older persons, the key focus may be supporting persons with the management of everyday activities/engagement in employment. Supports may be provided in the persons home or wherever they are residing.
Intent of care	Improve quality of life and psychosocial functioning as a means of reducing suicidal distress.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons who have thoughts of suicide, have attempted suicide, or who are bereaved by a suicide death.
Age	12+ years
Population sub-group	N/A
Workforce	
Workforce type	Peer Worker

	Vocationally Qualified
Staffing duration	Business hours
Example services	
Commonwealth Psychosocial Support Program	The Commonwealth funds this program for persons with severe mental illness who may need extra support with day-to-day living. The program helps to connect these persons to community services, and strengthen their social, educational, and vocational skills.
Levels of evidence	
Summary	There is some support for the efficacy of psychosocial support services for persons with severe mental illness. A recent systematic review of the effects of non-clinical services on functional outcomes of young people with severe mental illness revealed consistent evidence of the impact of vocational support services in helping young people obtain employment [1]. There were mixed results regarding lifestyle interventions (e.g., multidisciplinary interventions that may include education regarding diet and nutrition, health coaching and exercise or physical activity interventions). There were only two studies on social supports, and no studies on peer support or youth development services (e.g., aim to support normative development among young adults during an episode of mental illness. Their key purpose is to teach new skills during the transition to adulthood, such as cooking, cleaning, developing and managing a budget and accessing public transport). The study concluded that further research is required to better understand whether these types of services help to improve functional outcomes and hence, quality of life, for this specific population. The recent National Suicide Prevention Strategy highlights an increase in resilience, and reduction in distress and suicide rates, among populations where persons feel safe, healthy, connected, and satisfied with their lives [2].
Citations	[1] Gossip, K., John, J., Comben, C., Erskine, H.E., Scott, J.G. and Diminic, S. (2024), Do Non-Clinical Services Help to Improve Functional Outcomes Among Young Adults With Mental Disorders? A Systematic Review. Early Intervention in Psychiatry, 18: 773-788. https://doi.org/10.1111/eip.13606 [2] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

13.2 Service Category – Suicide prevention support services

13.2.1 Service Element – Individual suicide prevention support services

General information	
Service description	Individualised, non-clinical community support services with a focus on general counselling, psychoeducation, and service linkage. Services may be delivered online or face-to-face.
Intent of care	Reduce suicidal distress/risk through the development of coping strategies and improving social connectedness and general wellbeing.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons experiencing suicidal distress
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Peer Worker Vocationally Qualified
Staffing duration	N/A
Example services	
Peer CARE companion in the community	Trained and supported community members with lived experience of suicide known as Peer CARE Companions provide 'light touch' peer support and connection in the community for persons experiencing distress, isolation, and/or suicidality.
Gold Coast Community Support Program	An 8-week flexible program supporting individuals living on the Gold Coast who may experiencing situational distress. This service provides non-clinical support to individuals and their families either over the phone, face-to-face or online. This service is funded by the Gold Coast Primary Health Network.
Levels of evidence	
Summary	N/A
Citations	N/A

13.2.2 Service Element – Group suicide prevention support services

General information	
Service description	Group-based community support services generally targeting populations disproportionately affected by suicide. The focus of these support services is to reduce social isolation and enhance wellbeing through the sharing of experiences and peer support. These services may also include any of the following components: psychoeducation; early identification of suicide warning signs/risk; skill development; and service linkage to other supports as required. Groups may be specific to certain populations (e.g., LGBTQIA+ persons, Aboriginal and Torres Strait Islander people, veterans) Services may be delivered face-to-face or online and are generally delivered by trained peer workers.
Intent of care	Reduce suicide risk through the development of coping strategies and by improving social connectedness and general wellbeing.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Peer Worker Vocationally Qualified
Staffing duration	N/A
Example services	
Parents Beyond Breakup	Parents Beyond Breakup (PBB) is a suicide prevention charity supporting mothers, fathers, and grandparents impacted by family separation and breakdown. PBB runs a series of peer-based group support services. For example, Dads in Distress is a national suicide prevention program, offering community peer support groups for men

	experiencing relationship breakdown. The group provides an opportunity for dads to share their experiences and coping strategies and to develop a support network. These meetings are available face-to-face and online.
Buddy Up Australia	Buddy Up Australia connects current and former serving military and first responders, and their immediate families to their communities through physical fitness, social activities and volunteering.
Alt2Su groups	Alt2Su groups are peer-based groups supporting persons who have made suicide attempts or who have experienced suicidal thoughts. The focus is providing a space for voicing, sitting with, understanding and moving through suicidal thoughts. Alt2Su groups are funded through various levels of government and organisations throughout Australia.
Levels of evidence	
Summary	A recent systematic review aimed to analyse whether peer support programs are effective at reducing suicidality among persons experiencing suicidal distress [1]. The review included eight studies of seven peer-led support programs for suicide prevention; only three studies included data on effectiveness. One of the three studies demonstrated that attendees of an Alternatives to Suicide program perceived the support groups as helpful, felt an increased sense of community, and developed a better understanding of why they might experience suicidal thoughts. The second of the three studies evaluated the effectiveness of an online peer support program, with results indicating that around 30% of users reported a decrease in the intensity of their suicidal thoughts and 22% reported that they were more motivated to seek outside professional help. Similarly, the last study examined the effectiveness of an online forum and found that several types of communicative strategies (i.e., receiving constructive advice, being actively listened to, receiving empathy, and provision of alternatives to suicide by other members of the forum) were associated with psychological improvements. The authors of the review acknowledged that the lack of research on the evaluation of group peer support programs ultimately may undermine and broad conclusions about the effectiveness of these interventions.
Citations	[1] Schlichthorst M, Ozols I, Reifels L, Morgan A. Lived experience peer support programs for suicide prevention: a systematic scoping review. International Journal of Mental Health Systems. 2020;14(1):65.

13.3 Service Category – Aftercare services

General information	
Service description	Provision of follow-up and coordinated clinical and non-clinical services for persons after a self-harm or suicide attempt. Aftercare services can consist of any of the following components: Brief contact interventions – automated text messages, or postcards/letters sent to persons post-discharge from hospital emergency departments, medical wards or inpatient units for a self-harm or suicide attempt. Non-clinical supports – non-clinical, short-term support service providing linkages to support networks post-discharge following self-harm or suicide attempt. Peer-led supports – non-clinical, peer-led support programs focusing on recovery, advocacy and service linkages post-discharge following self-harm or suicide attempt. Proactive and responsive outreach and case management (commonly referred to as 'Assertive Outreach') – provision of assertive and coordinated care using clinic-based interventions and outreach support post-discharge to reduce suicide re-attempts post-discharge.
Intent of care	Provision of individualised support and recovery services for people who have self-harmed or attempted suicide.
Indicative unit size	N/A
Intended length of care	At least 12 weeks with access to ongoing, less intensive support available longer-term
Target population	
Presenting features	Persons who have self-harmed or attempted suicide and have been referred from either ambulatory care, a hospital emergency department, or following discharge from a hospital inpatient stay.
Age	16+ years
Population sub-group	N/A
Workforce	
Workforce type	Aftercare services
Staffing duration	Business hours
Example services	

The Way Back Support Service (TWBSS)	A non-clinical, short-term support service to assist people to recover from a suicide attempt or crisis. As of 2023, TWBSS was under a federal and state bi-lateral agreement to provide funding to PHNs and Beyond Blue. Then on July 1, 2023, The Way Back Support Service governance was transferred from Beyond Blue to the Australian Government.
Hospital Outreach Post-Suicidal Engagement (HOPE) Program	Hospital Outreach Post-Suicidal Engagement (HOPE) programs aim to provide proactive and responsive case management and coordinate care post-discharge, using outreach and clinic-based therapeutic interventions to reduce the risk of re-attempts, for up to 90 days. As of 2023, funding has been provided by the state/territories.
Reconnecting AFTer self-harm (RAFT)	Digital brief contact intervention post-discharge sending a series of automated text messages for people post-discharge. As of 2023, this program is in a clinical trial phase to assess reduction in suicidal ideation, self-harm, and repeat hospital presentations.
Levels of evidence	
Summary	The evidence for aftercare models is growing and shows encouraging signs of effectiveness, yet more studies and evaluations need to be conducted and added to the evidence base. A rapid review found that aftercare services and support following a suicide attempt are effective in reducing subsequent suicide attempts [1]. Furthermore, they are likely to have the strongest reduction in suicide attempts by approximately 20% when implemented as part of a systems approach to suicide in Australia [1, 2]. They also appear to be scalable [3], and highly likely to be cost-effective [4]. Dedicated older-adult aftercare interventions with a multifaced, assertive follow-up has also shown promise in a systematic review [5]. However, limited studies have published tailored aftercare models for high-priority populations (e.g., LGBTQIA+ people, Aboriginal and Torres Islander peoples) [1]. Aftercare services can be categorised into brief interventions, brief contact interventions, and assertive aftercare and case management. Brief interventions as well as assertive aftercare and case management models demonstrate effectiveness in reducing repeated suicide attempts with a control group (mostly treatment as usual) [1]. Brief contact interventions have also found to reduce the incident rate of repeat suicide attempts or self-harm, but not the proportion of people who initially have a suicide attempt [1].

	Evaluation of TWBSS found to improve service user outcomes in wellbeing, with significant reductions to suicidality and distress [6]. Likewise, a HOPE evaluation determined the program was feasible to deliver, highly valued, and contributed to improved outcomes for suicidal ideation, distress, and wellbeing over a three-month program, at three-months [7] and 6-months post-discharge [8]. Common features across effective aftercare models include: Rapid follow-up with greater frequency in the first month post-discharge A strong focus on therapeutic alliance, engagement and continuity of care Provision of the first session face-to-face if the follow-up service is mainly delivered by telephone; and Addresses a wide range of psychosocial needs, involvement of a support person and integration with clinical care [1]
Citations	[1] Shand F, Woodward A, McGill K, Larsen M, Torok M, Petheridhe A, et al. Suicide aftercare services: an evidence check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Minsitry of Health, 2019. [2] Krysinska K, Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N, et al. Best strategies for reducing the suicide rate in Australia. Aust N Z J Psychiatry. 2016;50(2):115-8. [3] Mann JJ, Michel CA, Auerbach RP. Improving suicide prevention through evidence-based strategies: a systematic review. The American Journal of Psychiatry. 2021;178(7):611-24. [4] Le LK-D, Flego A, Krysinska K, Andriessen K, Bandara P, Page A, et al. Modelling the cost-effectiveness of brief aftercare interventions following hospital-treated self-harm. British Journal of Psychiatry Open. 2023;9(5):139-139. [5] Wand APF, Browne R, Jessop T, Peisah C. A systematic review of evidence-based aftercare for older adults following self-harm. Australian & New Zealand Journal of Psychiatry. 2022;56(11):1398-420. [6] Nous Group. The Way Back Support services evaluation | final evaluation report. 2022. [7] Wright AM, Lee SJ, Rylatt D, Henderson K, Cronje H-M, Kehoe M, et al. Coordinated assertive aftercare: Measuring the experience and impact of a hybrid clinical/non-clinical post-suicidal assertive

	outreach team. Journal of Affective Disorders Reports. 2021;4:100133. [8] Kehoe M, Wright AM, Lee SJ, Rylatt D, Fitzgibbon BM, Meyer D, et al. Provision of a multidisciplinary post-suicidal, community-based aftercare program: a longitudinal study. Community Mental Health Journal. 2023;59(4):680-91.

13.4 Service Category – Postvention

13.4.1 Service Element – Postvention individual support services

General information	
Service description	Individualised supports for persons who are bereaved or impacted by a suicide death. This typically includes a crisis intervention shortly after a death by suicide (e.g., within 1 – 5 days). Supports may involve any of the following: immediate crisis counselling; psychological first aid; practical and emotional support (e.g., navigating coroners, organising funerals, police liaison); information related to self-care (e.g., sleep hygiene, nutrition, managing relationships); and linkage to local services and/or support groups for persons bereaved by suicide. Supports may be provided as a one-off service or on an on-going basis dependent on the needs of the individual. Following initial contact, follow-up and coordination support is available at one week, one month, three months, six months, and 12 months. Beyond 12-months, follow-up coordination and support may be provided at key time points (e.g., birthdays, anniversaries) to check-in and provide referral as needed. Supports may be provided face-to-face or via telephone or the web.
Intent of care	To support the social and emotional wellbeing of those bereaved by a suicide death.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons bereaved by suicide
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Crisis response team
Staffing duration	Extended hours

Example services	
Active Response Bereavement Outreach Program (ARBOR)	The Active Response Bereavement Outreach Program (ARBOR) offers a range of supports for those bereaved by suicide. This includes individualised short-to-medium term grief counselling with professional grief counsellors. ABOR is a free service run by Anglicare Western Australia and funded by government entities, and a range of individuals and organisations via donation.
Jesuit Social Services - Support after Suicide	The Jesuit Social Services Support after Suicide program provides counselling services, support groups, and online resources to persons of all ages who are bereaved by suicide. Individual counselling is delivered by persons with expertise and knowledge in the areas of suicide, trauma and grief. Counselling is available face-to-face (in the state of Victoria), or via the phone or web and is free of charge.
StandBy Support After Suicide: Peer Support and Suicide Bereavement Counselling Service	StandBy Support After Suicide offers individualised Peer Support and Suicide Bereavement Counselling (SBC) to persons bereaved by suicide; these services are delivered by peer workers and experienced counsellors, respectively. The SBC service is offered via telephone or online between 8am – 8pm, Monday to Friday. General phone support delivered as part of the Standby Support After Suicide program is available from 6am – 10pm, 7-days a week and provides two years of follow-up support to those who enter the program. As of 2024, the StandBy Support After Suicide is funded annually by the Australian Government Department of Health and Aged Care.
Levels of evidence	
Summary	There is some evidence of the effectiveness of general postvention services, but good quality studies are lacking. A systematic review of studies (n = 8) and guidelines (n = 12) for general postvention services, published from 2014 – 2019, highlighted the lack of good quality evidence for these service types but noted some evidence of positive outcomes regarding grief, mental health, and suicidality [1]. Findings were similar to those highlighted in a previous systematic review that focused on literature published between 1982 – 2018 (n = 11 studies) [2]. Potentially effective components of postvention services identified in the literature included the involvement of trained volunteers/peers and focusing the intervention on grief [1]. Two studies on the effects of Australia's Standby Support After Suicide suggests that within 12 months after a loss, people who received StandBy's support reported significantly lower levels of suicidality and loneliness than people who had not received their

	support (n.b. supports were not necessarily *individualised* postvention supports but may be any type of support offered as part of the Standby program to family, friends, support persons, and carers of a person who had died by suicide) [3,4]. The evaluation employed a longitudinal observational study design whereby an online survey was selected as an appropriate data collection method to compare outcomes between the StandBy group and the comparison group and to observe changes over time; an experimental design with randomisation was considered potentially unethical with the target population.
Citations	[1] Andriessen K, Krysinska K, Kolves K, Reavley N. Suicide Postvention Service Models and Guidelines 2014 - 2019: A Systematic Review. Frontiers in Psychology. 2019;10:2677. [2] Andriessen K, Krysinska K, Hill NTM, Reifels L, Robinson J, Reavley N, et al. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry. 2019;19(1):49. [3] Visser V, Tretheway R. A Longitudinal Study of the Impact of a Suicide Bereavement Service on People Bereaved by Suicide. OMEGA - Journal of Death and Dying. 2023:00302228231188751. [4] Gehrmann M, Dixon SD, Visser VS, Griffin M. Evaluating the Outcomes for Bereaved People Supported by a Community-Based Suicide Bereavement Service. Crisis. 2020;41(6):437-44.

13.4.2 Service Element – Postvention group support services

General information	
Service description	Structured, group-based support services that focus on supporting persons who are bereaved or impacted by a suicide death. Supports may include any of the following: counselling to assist persons to address and manage complex emotions and grief; general psychoeducation; the provision of resources; and referral to appropriate higher-intensity services as needed. Groups may be peer matched (i.e., specific to certain population) or experience matched (i.e., carers, domestic and family violence) Supports may be face-to-face or via telephone or the web.
Intent of care	To support the long-term social and emotional wellbeing of those bereaved or impacted by suicide.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	NA
Age	All ages
Population sub-group	Persons bereaved or impacted by suicide
Workforce	
Workforce type	Postvention group support services
Staffing duration	Extended hours
Example services	
Jesuit Social Services - Support after Suicide	The Jesuit Social Services Support after Suicide offers a range of support groups tailored to specific populations as outlined below: Monthly Groups Facilitated by a bereavement counsellor and trained lived experience volunteer monthly support groups offer participants an opportunity to share and process their grief and trauma and explore coping strategies. Groups are offered for those who have lost a child, parent,

	partner or sibling to suicide, as well as an online open bereavement group and coffee morning. Early Bereavement Program An eight-week program for persons bereaved by suicide in the last three months to two years. The program follows a weekly outline, is limited to eight participants, and may be held online or in person.
Levels of evidence	
Summary	There is some evidence of the effectiveness of postvention group support services, but good quality evidence is lacking. A systematic review of 11 controlled studies from 1984 – 2018 [1] of interventions for persons bereaved by suicide identified some evidence of the effectiveness on grief outcomes of an 8-week support group program facilitated by a health professional and trained volunteer [2] A more recent iteration of the review, focusing on studies and guidelines published from 2014 - 2019, again highlighted the lack of good quality evidence for postvention services more generally but noted some evidence of positive outcomes regarding grief, mental health, and suicidality [3]. A report on the effects of Standby Support After Suicide suggests that within 12 months after a loss, people who received StandBy's support reported significantly lower levels of suicidality and loneliness than people who had not received their support (n.b. supports were not necessarily postvention *group* supports) [4]. The evaluation employed a longitudinal observational study design whereby an online survey was selected as an appropriate data collection method to compare outcomes between the StandBy group and the comparison group and to observe changes over time; an experimental design with randomisation was considered potentially unethical with the target population (people bereaved by suicide).
Citations	[1] Andriessen K, Krysinska K, Hill NTM, Reifels L, Robinson J, Reavley N, et al. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry. 2019;19(1):49. [2] Farberow NL. The Los Angeles Survivors-After-Suicide program. An evaluation. Crisis. 1992;13(1):23-34.

	[3] Andriessen K, Krysinska K, Kolves K, Reavley N. Suicide Postvention Service Models and Guidelines 2014 - 2019: A Systematic Review. Frontiers in Psychology. 2019;10:2677. [4] Visser V, Tretheway R. A Longitudinal Study of the Impact of a Suicide Bereavement Service on People Bereaved by Suicide. OMEGA - Journal of Death and Dying. 2023:00302228231188751.

13.4.3 Service Element – Postvention peer group support services

General information	
Service description	Open, monthly drop-in group-based peer support services for persons who are bereaved or impacted by a suicide death. The focus of the group is sharing experiences and information with peers, and normalising feelings and reactions of those bereaved or impacted by suicide. Groups may be peer matched (i.e., specific to certain population) or experience matched (i.e., carers, domestic and family violence) For persons younger than 18 years of age, group-based supports are more likely to be activity-based (e.g., art sessions)
Intent of care	To support the long-term social and emotional wellbeing of those bereaved by suicide.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	N/A
Age	All ages
Population sub-group	Persons bereaved or impacted by suicide
Workforce	
Workforce type	Peer Worker
Staffing duration	After hours
Example services	
Active Response Bereavement Outreach Program (ARBOR)	The Active Response Bereavement Outreach Program (ARBOR) offers a range of supports for those bereaved by suicide. This includes a lived experience suicide bereavement support group which provides informal social support to persons bereaved by suicide, guided by an ARBOR lived experience Peer Volunteer and a Project Officer. The group provides a safe environment for people to share their grief-journey. Currently the ARBOR support group meets monthly, face-to-face. As of 2024, ARBOR is a free service run by Anglicare Western Australia and is funded by government entities, and a range of individuals and organisations.
Jesuit Social Services - Support after Suicide	The Jesuit Social Services Support after Suicide offers a range of support groups tailored to specific populations as outlined below:

	Peer Support Groups The *Men's Program* is a monthly peer group for bereaved men to connect with other men who have lost a loved one to suicide. At each meeting a guest speaker shares their thoughts and experiences that provide points for discussion. The *Older Adolescent Young Adult group* is for young people aged 18 – 25 years. The group meets once a quarter for dinner with members of the Support After Suicide counselling team and is a chance for young people to share their experiences in a supportive environment. The *Serious Fun* program is for primary school aged children and is held during school holidays. Sessions are facilitated by members of the Support After Suicide counselling team and trained volunteers. Themes of the session relate to loss and grief but incorporate time for play.
Levels of evidence	
Summary	There is some evidence for the use of peer-support group programs for persons bereaved by suicide. However, good quality evidence is lacking. A recent systematic review of 14 studies found that postvention peer support groups provided a safe place, social support, helped participants learn different coping strategies for managing their grief, and decreased feelings of guilt, anger, isolation, and shame among [1]. No studies assessed levels or changes in suicidal ideation, attempt or completed suicide among participants. Most included studies were qualitative studies that followed an interpretative approach (e.g., used semi-structured interviews, researcher observations, and field diaries and/or a participatory action approach); only two studies used quantitative methods (e.g., surveys or self-reported rating scales). A study on the effects of Standby Support After Suicide suggests that within 12 months after a loss, people who received StandBy's support reported significantly lower levels of suicidality and loneliness than people who had not received their support (n.b. supports were not necessarily postvention *individual* supports) [2,3]. The evaluation employed a longitudinal observational study design whereby an online survey was selected as an appropriate data collection method to compare outcomes between the StandBy group and the comparison group and to observe changes over time; an experimental design with randomisation was considered potentially unethical with the target population (people bereaved by suicide).

Citations	{1] Inoxtroza C, Rubio-Ramirez F, Bustos C, Quijada Y, Fernandez D, Buhring V, et al. Peer-support groups for suicide loss survivors: a systematic review. Social Work With Groups. 2024;47(3):234 - 50. [2] Visser V, Tretheway R. A Longitudinal Study of the Impact of a Suicide Bereavement Service on People Bereaved by Suicide. OMEGA - Journal of Death and Dying. 2023:00302228231188751. [3] Gehrmann M, Dixon SD, Visser VS, Griffin M. Evaluating the Outcomes for Bereaved People Supported by a Community-Based Suicide Bereavement Service. Crisis. 2020;41(6):437-44.

13.4.1 Service Element – Postvention family support services

General information	
Service description	Whole-of-family approach to delivering immediate, counselling-oriented support for young people who have lost a friend, peer, family member or other loved one to suicide. Typically includes a crisis intervention shortly after death by suicide (e.g., 1-5 days). Supports may involve any of the following: immediate crisis counselling; psychological first aid; practical and emotional support (e.g., navigating coroners, organising funerals, police liaison); information related to self-care (e.g., sleep hygiene, nutrition, managing relationships); and linkage to local services and/or support groups for persons bereaved by suicide. Supports may be provided as a one-off service or on an on-going basis dependent on the needs of the individual. Following initial contact, follow-up and coordination support is available at one week, one month, three months, six months, and 12 months. Beyond 12-months, follow-up coordination and support may be provided at key time points (e.g., birthdays, anniversaries) to check-in and provide referral as needed. Supports may be provided face-to-face or via telephone or the web.
Intent of care	To support the long-term social and emotional wellbeing of young people bereaved by suicide.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Young people bereaved by suicide.
Age	12 – 17 years
Population sub-group	N/A
Workforce	
Workforce type	Postvention crisis response team
Staffing duration	Extended hours

Example services	
	N/A
Levels of evidence	
Summary	There is a lack of research on family-based postvention supports for young people. However, there is some support for family-based supports for young people for suicide prevention more broadly. According to one systematic review, randomised controlled trials (RCTs) evaluating family-based interventions in suicidal adolescents have consistently shown a decrease in suicidal ideation and suicide risk factors, as well as enhanced protective factors, compared with routine care [1,2,3]. Additionally, a brief family-based crisis intervention with suicidal adolescents in hospital emergency departments demonstrated reduced psychiatric hospitalisations and suicide attempts at three-month follow-up [4].
Citations	{1] Diamond GS, Wintersteen MB, Brown GK, Diamond GM, Gallop R, Shelef K, et al. Attachment-based family therapy for adolescents with suicidal ideation: a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry. 2010;49(2):122-31 [2] Hooven C, Walsh E, Pike KC, Herting JR. Promoting CARE: including parents in youth suicide prevention. Fam Community Health. 2012;35(3):225-35. [3] Pineda J, Dadds MR. Family intervention for adolescents with suicidal behavior: a randomized controlled trial and mediation analysis. Journal of the American Academy of Child and Adolescent Psychiatry. 2013;52(8):851-62. [4] Wharff, E. A., Ginnis, K. M., & Ross, A. M. (2012). Family-based crisis intervention with suicidal adolescents in the emergency room: a pilot study. *Social work*, *57*(2), 133–143. https://doi.org/10.1093/sw/sws017

13.5 Service Category – Family and carer support

13.5.1 Service Element – Individual carer peer support

General information	
Service description	Individualised peer support and the provision of resources, skill development, education, and strategies for coping.
Intent of care	To empower and support families, friends, support people and carers of people experiencing suicidal distress or crisis through the sharing of experiencing and the development of social networks.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons who are supporting others who are experiencing suicidal distress.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Peer Worker
Staffing duration	N/A
Example services	
Crossing Paths Carer Support	Provision of practical one-on-one carer peer support, as well as access to a peer-led connection group. This includes education for safety planning, coping strategies, and self-care, as well as advocacy, service navigation and referral.
Peer CARE companion in the community	Trained and supported community members with lived experience of suicide known as Peer CARE Companions provide 'light touch' peer support and connection.
Levels of evidence	
Summary	There is some evidence for the effectiveness of interventions for persons who are supporting someone through suicidal distress, including attempt, but good quality studies are lacking. A recent systematic review (n = 7 studies) found that psychosocial interventions for family members and other informal support persons of individuals experiencing suicidal distress/attempt can lower the burden of care for informal carers and improve their ability and willingness to care for a suicidal family member. There were mixed

	results in terms of family functioning; only one study reported on the effects of a support program on psychosocial well-being and satisfaction with life. Nonetheless, engagement and satisfaction with these types of services was high, with one study reporting that psychoeducation, community skills training, and the opportunity to meet and work with other families were intervention components that best met the needs of informal carers. Overall, however, good quality evidence for the effectiveness of supports for 'informal carers' is lacking.
Citations	[1] Krysinska K, Andriessen K, Ozols I, Reifels L, Robinson J, Pirkis J. Effectiveness of psychosocial interventions for family members and other informal support persons of individuals who have made a suicide attempt. Crisis. 2022;43(3):245 - 60.

13.5.2 Service Element – Individual carer peer support – service navigation

General information	
Service description	The provision of support, and linkage to relevant services/supports, to persons identified as family, friends, carers, or support persons of persons experiencing suicidal distress.
Intent of care	Empower and support families, friends, support persons, and carers of people experiencing suicidal distress
Indicative unit size	NA
Intended length of care	Supports may be provided as a one-off service or on an on-going basis dependent on the needs of the individual.
Target population	
Presenting features	Persons who are supporting others with suicidal distress/who have made a suicide attempt.
Age	12+ years
Population sub-group	N/A
Workforce	
Workforce type	Workforce type is dependent on the setting in which the service is being delivered and may be either of the following: Peer Worker Social Worker
Staffing duration	N/A
Example services	
Head to Health service navigation support	Head to Health service navigation is a national call line that connects callers to local Health to Health teams that link them, or the person they are supporting, with the most appropriate services to meet their needs.
Levels of evidence	
Summary	Australia's National Suicide Prevention Strategy highlights the importance of access to timely and appropriate suicide prevention services, including up-to-date platforms that encourage the use of service navigation to help connect people with relevant services [1].
Citations	[1] National Suicide Prevention Office. The National Suicide Prevention Strategy 2025 - 2035. Canberra: 2025

13.5.3 Service Element – Group carer peer support

General information	
Service description	Group-based peer support and the provision of resources and education for family, friends, support persons, and carers of persons experiencing suicidal distress, Groups may be specific to certain populations (e.g., parents, LGBTQIA+ persons, Aboriginal and Torres Strait Islander persons, family members of Veterans) This type of service is facilitated by a peer worker, with input or supervision provided by a tertiary qualified professional.
Intent of care	Empower and support families, friends, support persons, and carers of people experiencing suicidal distress
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons supporting others experiencing suicidal distress.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Group carer peer support
Staffing duration	N/A
Example services	
Carer gateways – in-person peer support	An opportunity to connect with other carers with the support of a facilitator who has their own caring experience. These peer support groups explore common issues and concerns and share ideas for managing challenges in their caring role (n.b. this service is not exclusive to persons supporting others suicidal distress but rather anyone in a caring role).
Levels of evidence	
Summary	There is some evidence for the effectiveness of interventions for persons who are supporting someone through suicidal distress, including attempt, but good quality studies are lacking. A recent systematic review (n = 7 studies) found that that these types of interventions can lower the burden of care for informal carers and improve their ability and willingness to care for a suicidal family

	member [1]. There were mixed results in terms of family functioning; only one study reported on the effects of a support program on psychosocial well-being and satisfaction with life. Nonetheless, engagement and satisfaction with these types of services was high, with one study reporting that psychoeducation, community skills training, and the opportunity to meet and work with other families were intervention components that best met the needs of informal carers. Overall, good quality evidence for the effectiveness of supports for 'informal carers' in lacking.
Citations	[1] Krysinska K, Andriessen K, Ozols I, Reifels L, Robinson J, Pirkis J. Effectiveness of psychosocial interventions for family members and other informal support persons of individuals who have made a suicide attempt. Crisis. 2022;43(3):245 - 60.

13.5.4 Service Element – Group carer support

General information	
Service description	Group-based support, psychoeducation, and the provision of resources for family, friends, carers, and/or support people of persons experiencing suicidal distress or crisis. Groups may be specific to certain populations (e.g., parents, LGBTQIA+ persons, Aboriginal and Torres Strait Islander persons, family members of Veterans) This type of service is structured and co-facilitated by a peer worker and tertiary qualified professional.
Intent of care	Education, and the development of coping strategies and support networks for crisis situations.
Indicative unit size	N/A
Intended length of care	N/A
Target population	
Presenting features	Persons supporting others experiencing suicidal distress.
Age	All ages
Population sub-group	N/A
Workforce	
Workforce type	Group Carer Support
Staffing duration	N/A
Example services	
The Carer Support Program – suicide prevention	Provides connection, support, and information for family members and friends of a person at risk of suicide or experiencing self-harm. The program comprises three, two-hour sessions over a five-week period co-facilitated by peer worker and 'family clinician'. Specialised groups are available under the program (i.e., carers supporting young people, carers supporting men, carers of people from the LGBTQIA+ community).
Levels of evidence	
Summary	There is some evidence for the effectiveness of interventions for persons who are supporting someone through suicidal distress, including attempt, but good quality studies are lacking. A recent systematic review (n = 7 studies) found that that these types of interventions can lower the burden of care for informal carers and

	improve their ability and willingness to care for a suicidal family member [1]. There were mixed results in terms of family functioning; only one study reported on the effects of a support program on psychosocial well-being and satisfaction with life. Nonetheless, engagement and satisfaction with these types of services was high, with one study reporting that psychoeducation, community skills training, and the opportunity to meet and work with other families were intervention components that best met the needs of informal carers. Overall, good quality evidence for the effectiveness of supports for 'informal carers' in lacking.
Citations	[1] Krysinska K, Andriessen K, Ozols I, Reifels L, Robinson J, Pirkis J. Effectiveness of psychosocial interventions for family members and other informal support persons of individuals who have made a suicide attempt. Crisis. 2022;43(3):245 - 60.