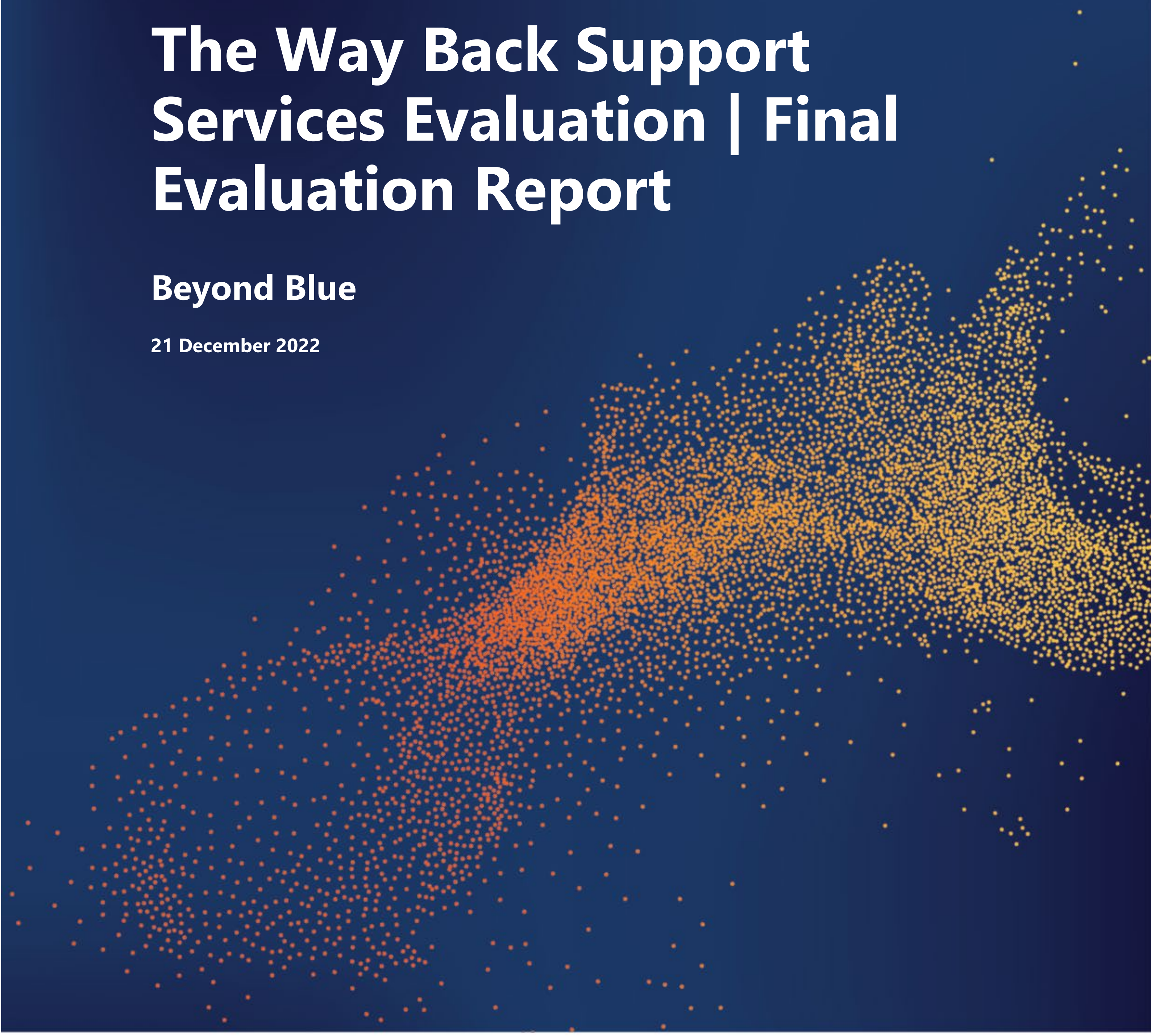


The Way Back Support Services Evaluation | Final Evaluation Report

Beyond Blue

21 December 2022

nous

Nous Group respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the traditional custodians of the land.

We pay respect to Elders past, present and future in maintaining the culture, country and their spiritual connection to the land.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

Acknowledgement of people with lived experience of mental illness:

We acknowledge those people with a lived experience of mental health issues, their families, friends and supporters who provided input into this report through direct consultation or other methods.

Disclaimer:

Nous Group (**Nous**) has prepared this report for the benefit of the Beyond Blue (the **Client**).

The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of Nous to the Client as to the matters within the scope of the report. Nous and its officers and employees expressly disclaim any liability to any person other than the Client who relies or purports to rely on the report for any other purpose. Nous has prepared the report with care and diligence. The conclusions and recommendations given by Nous in the report are given in good faith and in the reasonable belief that they are correct and not misleading. The report has been prepared by Nous based on information provided by the Client and by other persons. Nous has relied on that information and has not independently verified or audited that information.

Contents

Glossary

Glossary	Description
Aboriginal Community Controlled Health Organisations (ACCHOs)	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community.
Community mental health service	Services that treat mental illness in community-based settings or hospital-based outpatient care.
Core service model	The core service model is the key elements of The Way Back that make it work. They are described in Section 4, which draws from Beyond Blue's The Way Back service model documentation.
Cohorts of interest to The Way Back	Cohorts of people over-represented in suicide statistics and/or those who face greater barriers to accessing support identified by The Way Back Support Service Implementation and Procurement Guide.[1] These were people who: identified as Aboriginal and Torres Strait Islander, identified as LGBTQIA+, men, aged 80+ years old, middle-aged men, youth, and people with a mental health condition.
Cohorts of interest to the evaluation	Additional cohorts of people of interest to the evaluation identified through analysis of prevalence data of suicide attempts and deaths across specific cohorts or through identification of cohorts through the available data to the evaluation. These cohorts included but were not limed to people who: experienced a personality disorder, people with a culturally and linguistically diverse (CALD) background experience alcohol and/or other drug misuse, experienced homelessness, were unemployed.
Episode of care (referred to throughout this report as *service episode*)	For the purposes of the PMHC MDS, an Episode of Care is defined as a more or less continuous period of contact between a participant and a PHN-commissioned provider organisation/clinician that starts at the point of first contact and concludes at discharge.[2]
Completed service episode	Participants with service episodes that indicate that they exited from The Way Back via a planned service discharge at the end of their service episode.
Not completed service episode	Participants with a service episode that were closed for administrative reasons such as the being uncontactable or moving out of the area.
Follow-up support	Follow-up immediately after discharge to continue the provision of care and support to the individual, family and caregivers.
Friends, families and other support people	Friends, families, kinship groups and all other support people who play a vital role in supporting people experiencing suicidality by providing practical and emotional support to the person and assisting them with building capacity and the tasks of daily living. For simplicity of language, on occasion we refer to all as 'families' or 'family members', in line with the idea of 'chosen families' as people with who strong supportive ties are formed.
Key Evaluation Questions (KEQs)	High-level research questions that guide the evaluation. The KEQs for this evaluation were determined from the scope of enquiry, theory of change and program logic.

---

[1] Beyond Blue. 'The Way Back Support Service Implementation and Procurement Guide'. March 2020.

[2] Australian Department of Health. 2019. Key Concepts. Retrieved from: https://docs.pmhc-mds.com/projects/data-specification-wayback/en/v3/data-specification/key-concepts.html

Glossary	Description
Local Health Network (LHN) or Local Health District (LHD) or Hospital and Health Service (HHS) (referred to in this report as 'LHNs or equivalents')	These entities manage the delivery of public hospital services and other community-based health services as determined by their state or territory government.
Matched pair	Recorded scores of an outcome measure at both the beginning and at the completion of a participant service episode.
Mechanisms of change	In realist evaluation, the evaluator hypothesises in advance the likely mechanisms that cause change to occur and desired outcomes to be achieved. This also includes consideration of the context in which those changes occur.[3]
Primary eligibility criteria	The primary eligibility criteria applied to participants who have been hospitalised for a suicide attempt.
Primary Mental Health Care Minimum Data Set (PMHC MDS) or PMHC MDS and The Way Back extension	Primary Mental Health Care Minimum Data Set (PMHC MDS) is a data set that provides the basis for PHNs and the Australian Department of Health and Aged Care to monitor and report on the quantity and quality of service delivery and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Department of Health and Aged Care.[4] The Way Back extension is a supplementary dataset linked to the PMHC MDS that collects information specific to the aims and activities of The Way Back. Both the PMHC MDS and The Way Back extension were used for this evaluation.
Priority cohort	People who identified as Aboriginal/and or Torres Strait Islander, and identified as LGBTIQA+. These cohorts were prioritised through: Active data collection on service access, Service model adaptations in sites to include priority pathways for Aboriginal and Torres Strait Islander people. Active recruitment of those who identified as Aboriginal and Torres Strait Islander people, and/or identified as LGBTQIA+.5
Proactive aftercare	Proactive aftercare is proactive and rapid follow-up, case management and motivational support to remain engaged in a service. 'Proactive' means the care provider is responsible for maintaining contact with the participant.
Psychoeducation	Educative counselling tailored to people, carers, family members, or other treating professions to help them understand facts about mental illness and to access or learn strategies to deal with illness.[6]

---

[3] Gill Westhorp, 2014, 'Realist Impact evaluation: an introduction,' Retrieved from: cdn.odi.org/media/documents/9138.pdf

[4] Australian Department of Health. Primary Mental Health Care Minimum Data set', Retrieved from: https://pmhc-mds.com/index.html

[5] Beyond Blue. 'The Way Back Support Service Implementation and Procurement Guide'. March 2020.

[6] Australian Institute of Health and Welfare. 2013. 'Development of prototype Australian Mental Health Intervention Classification. Retrieved from: https://www.aihw.gov.au/getmedia/fa0ddf08-c8f1-4623-8217-b65ff1290826/15389.pdf.aspx?inline=true

Glossary	Description
Psychosocial supports/services	Psychosocial support services which aim to address the ongoing psychological and social needs of individuals and include (but are not limited to) individual or group based education, counselling, peer support, and other community services.[7]
Recovery	Recovery is used throughout this document to refer to a person's personal recovery following a suicide attempt. This recovery journey will be different for each person, but will often include emotional aspects, physical safety and other factors.
Secondary eligibility criteria	The secondary eligibility criteria applied to participants who have presented to a hospital, emergency department, or a community health service following a suicidal crisis, or whose risk of suicide is identified as imminent.
Service contact	For the purposes of the PMHC MDS, a service contact is defined the provision of a service by a PHN commissioned mental health service provider for a participant where the nature of the service would normally warrant a dated entry in the clinical record of the participant. A service contact must involve at least two persons, one of whom must be a mental health service provider. Service contacts can be either with the participant or with a third party, such as a carer or family member and/or other professional or mental health worker, or other service provider. Service contacts are not restricted to face-to-face communication but can include telephone, internet, video link or other forms of direct communication. Service provision is only regarded as a service contact if it is relevant to the clinical condition of the participant. This means that it does not include services of an administrative nature (for example, telephone contact to schedule an appointment).[8]
Service episode	See Episode of Care above; a continuous period of contact between a participant and a PHN-commissioned provider that starts at the point of first contact, has a series of one or more Service Contacts and concludes at discharge.
Service model variations	These are the site and context specific variations to the core service model, as articulated in section 4 of this report. They build on the core model to deliver a service that is suited to the needs of the local population and service provider.
Severe mental illness	Severe mental illness refers to mental illness characterised by a severe level of clinical symptoms and degree of impact of functioning to social, personal, family and occupational functioning.
State health service staff	The staff operating in state or territory operated health services (for example, hospitals) that collaborate to deliver The Way Back.
Suicidal crisis	When a person is experiencing distress, suicidal thoughts and articulating an intent to die. A suicidal crisis may or may not result in an ED attendance or a hospital admission.
Suicidal ideation	Suicidal ideation is thinking out, considering or planning suicide. It can range from fleeting thoughts to active plans for suicide.
Suicidality	The collective term for suicidal ideation, suicide plans and suicide attempts. [9]

---

[7] Australian Institute of Health and Welfare. 2022. 'Psychosocial services', Retrieved from: https://meteor.aihw.gov.au/content/522999

[8] PMHC MDS Working Group Division. 2019. 'Data model specifications'. Retrieved from: https://strategic-data-pty-ltd-docspmhc-mdscom.readthedocs-hosted.com/projects/data-specification/en/v2/data-model-and-specifications.html#service-contact

[9] Productivity Commission. 2020. Productivity Commission Inquiry Report: Volume 2. 30 June 2020

Glossary	Description
Suicide attempt	A non-fatal, self-directed, potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in physical injury and may or may not result in an ED attendance or a hospital admission.
Unique participant	A participant who accessed The Way Back service regardless of how many occasions they may have accessed the service. A unique participant may record multiple episodes of care.

1 Summary

Nous Group was engaged by Beyond Blue to conduct an evaluation of The Way Back Support Service (The Way Back). The Way Back is a non-clinical service providing proactive outreach and psychological support to people who have experienced a suicidal crisis.

THE EVALUATION WAS GUIDED BY 5 KEY EVALUATION QUESTIONS

1. What is being delivered under The Way Back, where, how, and why?	Between July 2018 and September 2022, The Way Back was established across 38 sites across seven states and territories, 27 of these sites were in-scope for this evaluation. Across the in-scope sites, 8,734 participants were reached. 79% of referrals to The Way Back were taken up. Of these participants, 65% had recorded safety plans, 55% had a recorded support plans, and there were 5,685 referrals made to other psychosocial or clinical services.
2. How well is The Way Back being delivered?	The Way Back was delivered in line with its intended design. Most participants who participated in the evaluation were satisfied with the service. There are opportunities to improve how well the service meets the needs of priority cohorts (i.e. Aboriginal and Torres Strait Islander people, and people who identify as LGBTIQA+). Governance, funding and data collection could also be improved.
3. What is changing, for whom, in The Way Back?	Participants of The Way Back experienced improved outcomes across wellbeing, suicidality and psychological distress during their service period. Outcomes were similar across sites.
4. Why and how does change occur in The Way Back, in which circumstances?	The therapeutic alliance (i.e. the trust and connection) between the support coordinator and the participant was a major contributor to participants' engagement with The Way Back and their subsequent recovery.

> *No red tape - I didn't have to prove myself, didn't need a VISA. With this service, I could just have it."*
>
> Participant of The Way Back

> *My coordinator made me feel like taking the easy way out wasn't so easy. She talked to me on a level that I couldn't even talk to my family about."*
>
> Participant of The Way Back

> *I wouldn't be here today talking to you if I didn't have the support from The Way Back."*
>
> Participant of The Way Back

> *I trusted [the support coordinator]. I let her know everything that was happening in my life, whether that is good or bad.*
>
> Participant of The Way Back

5. What can be done to improve the contribution of The Way Back and similar services to service outcomes and goals?

Given that current arrangements in place for The Way Back will cease from June 2023, the evaluation developed 16 recommendations to improve the delivery of The Way Back and future aftercare services, and two recommendations for the handover of The Way Back.

Service intake

1. Broaden inbound referral pathways.
2. Reduce the average length of time between initial contact and service delivery.
3. Funding is made available for a liaison officer role with sufficient FTE in all referring hospitals.

Service delivery

4. Increase the proportion of participants who have a completed safety and support plan.
5. Investigate variations to aftercare service models, co-design, that would lead to more significant improvements to service access, and outcomes for specific cohorts.
6. Continue to gather evidence to determine whether peer support should be included in the core service model for aftercare services.
7. Consider including the provision of support to participants in the core service model for aftercare services.

Governance & Funding

8. Provide greater certainty through longer duration of funding and earlier advice on commissioning intentions / service continuation.
9. Simplify and clarify funding arrangements.
10. Simplify and strengthen aftercare services' governance to ensure roles, responsibilities and accountabilities are clear and understood.

Workforce

11. Develop a capability framework for support coordinators.
12. Establish a community of practice to share best practice, problem solve, and upskill providers.
13. Improve support for aftercare services staff to better manage vicarious trauma and burnout.

Monitoring & continuous improvement

14. In the short term ensure measures are used appropriately, consistently and comprehensively with participants who agree to completing an assessment.
15. In the medium to longer term, review the appropriateness of mental health outcome measures for participants.
16. Reconcile and simplify data collection sharing, monitoring and reporting requirements to ensure better data consistency and quality across sites.

Recommendations for the handover of The Way Back

17. Beyond Blue to handover its existing role with The Way Back to the Australian Department of Health and Aged Care, and states and territories.
18. The Australian Department of Health and Aged Care should establish a Multistakeholder Transitional Steering Committee to oversee the transition.

CONCLUSIONS

The Way Back is an effective aftercare service that improves outcomes for people who have had a suicidal crisis or attempted suicide.

What makes The Way Back effective is relevant to other aftercare and mental health services across Australia. Key learnings include:

- **Aftercare as a non-clinical service has a significant impact on people's recovery** following a suicide attempt or suicidal crisis.
- There is a clear need to **address social, economic, and cultural determinants** (for example, housing and employment).
- The **therapeutic alliance** is an essential foundation for successful service engagement and outcomes.
- Effective mental health models of care are **participant led**, and flexibly respond to individual needs.
- Participants reported that **peer support** was an important contributor to their experience of The Way Back service.
- Strong partnerships supported by **formal arrangements with referring partners** are critical to a timely and seamless referral experience for participants.
- There are some good examples of **aftercare models that respond to (local) Aboriginal and Torres Strait Islander needs and preferences**. It should not be assumed that a universal aftercare model should attempt to replace or duplicate these.
- The success of aftercare services as a time-limited service that holds people between acute and ongoing supports is **limited by the effectiveness of the surrounding systems** (acute, mental health and community systems).
- There is **still a gap for people who want access to more intensive psychosocial suicide prevention** support prior to the point of crisis.

2 Introduction

This section provides an overview of The Way Back and outlines the evaluation purpose, methodology and limitations.

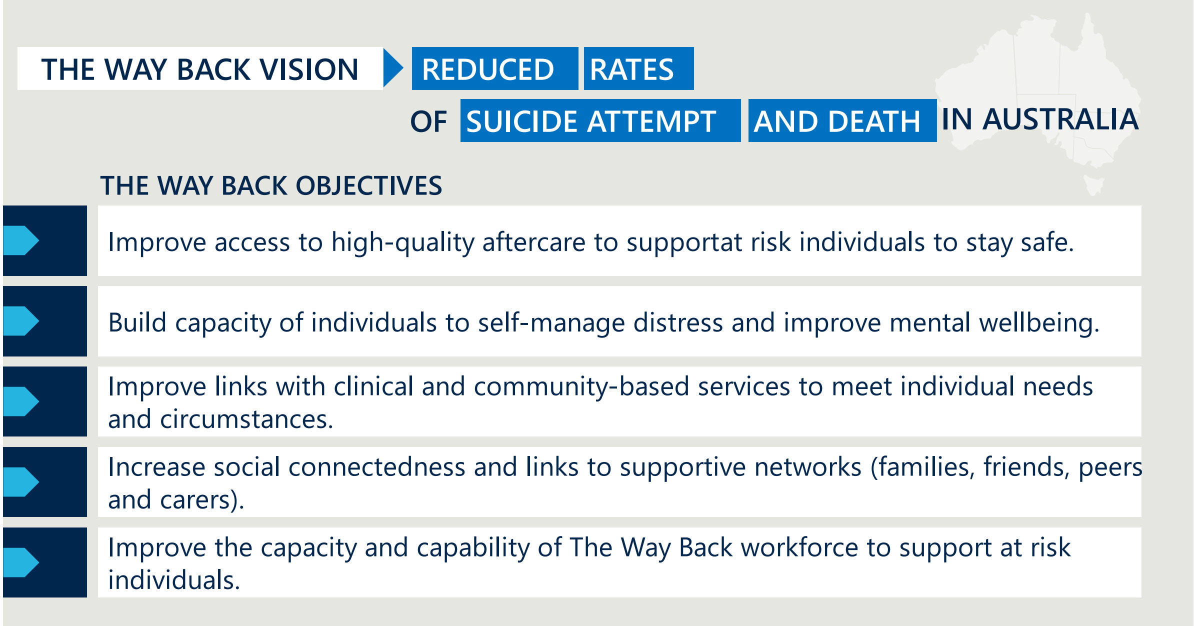
2.1 Overview of The Way Back

The Way Back is a non-clinical service providing proactive outreach and psychosocial support.

The Way Back Support Service (The Way Back) seeks to assist people to recover from a suicide attempt or crisis by supporting them to improve their emotional state, wellbeing resilience and protective factors. The service aims to contribute to a reduction in the rate, severity and duration of a person's suicidality and prevent death by suicide.[10] It operates in a complex mental health and suicide prevention system, and seeks to integrate services for participants between the public acute health and psychiatric hospital services (for example, emergency departments and non-specialised admitted units) and psychosocial services (for example, individual or group based counselling and education relating to psychological and social needs, domiciliary care) .

The Way Back's vision and objectives are shown in Figure 1. Appendix B provides detail on the rationale and existing evidence base for proactive suicide aftercare.

Figure 1 | Vision and objectives of The Way Back



THE WAY BACK VISION

REDUCED RATES OF SUICIDE ATTEMPT AND DEATH IN AUSTRALIA

THE WAY BACK OBJECTIVES

- Improve access to high-quality aftercare to supportat risk individuals to stay safe.
- Build capacity of individuals to self-manage distress and improve mental wellbeing.
- Improve links with clinical and community-based services to meet individual needs and circumstances.
- Increase social connectedness and links to supportive networks (families, friends, peers and carers).
- Improve the capacity and capability of The Way Back workforce to support at risk individuals.

Beyond Blue developed The Way Back as a pilot program in 2014 and in partnership with the Movember Foundation and provided $4 million in funding ($1.9 million from Beyond Blue and $2.1 million from the Movember Foundation) to trial the program in the Northern Territory (NT), Australian Capital Territory (ACT) and New South Wales (NSW).[11] The Australian Department of Health and Aged Care subsequently

---

[10] Beyond Blue, 'The Way Back Support Service - Service delivery Model', March 2020.

[11] Beyond Blue, 'The Way Back Support Service: aftercare following attempted suicide; 2018-19 Budget Proposal, January 2018.

funded the roll-out of The Way Back and at the release of this report, 38 sites were operating (see Appendix C).

2.2 Purpose of the evaluation and this report

Nous Group delivered a process and outcomes evaluation of The Way Back from 2020-2022.

Beyond Blue commissioned Nous Group (Nous) to independently evaluate The Way Back under the Australian Department of Health and Aged Care Agreement from June 2020 to November 2022. The objectives are to assist Beyond Blue and providers to:

- be accountable for implementation progress and quality
- understand the outcomes emerging for participants
- influence evidence-based policy and service design

This final report details how well The Way Back was being delivered, participant experiences and outcomes, and what contributes to recovery after a suicide attempt or crisis, for whom and how. The evaluation approach:

- **Was guided by a program theory:** The program theory outlined the ways in which The Way Back was expected to support recovery, considering personal and community circumstances and operational and policy contexts. The program theory enabled the evaluation to test *what happened compared to what was thought to happen for whom, and why*. The evaluation was not informed by experimental research (i.e., *what happened in a program compared to another program)*. Appendix B provides the theory of change and program theory for The Way Back.
- **Had a formative focus:** The evaluation examined The Way Back's implementation service model design, service quality and participant outcomes over time. Nous examined factors that shaped outcomes, to inform continuous improvement and provide recommendations to inform improvements to future aftercare service models in Australia. The evaluation did not have a summative focus; it did not closely examine the extent to which the program achieved its intended outcomes, or the impact of those outcomes.
- **Used a realist perspective:** The evaluation sought to understand what works, for which participants, in what circumstances and why. Key to this enquiry was the identification of specific mechanisms or aspects of The Way Back service model that create the changes in people that contribute to their recovery (see Section 8.11).
- **Had a developmental intent:** Nous iteratively shared findings with Beyond Blue and The Way Back service network to support learning and adaptation during service implementation. It should be noted that the evaluation was conducted during the COVID-19 pandemic. This impacted on sites' ability to enact changes to service delivery due to significant disruptions to normal operations.

2.3 Evaluation methodology

The evaluation intended to understand what works, for whom, why and how.

Reflecting the evaluation purpose, five Key Evaluation Questions (KEQs) guided data collection and analysis:

1. What is being delivered under The Way Back, where, how, and why?
2. How well is The Way Back being delivered?
3. What is changing, for whom, in The Way Back?
4. Why and how does change occur in The Way Back, in which circumstances?
5. What can be done to improve the contribution of The Way Back and similar services to service outcomes and goals?

Twenty-seven (of 38 sites) were in-scope for this evaluation. All HOPE sites (six) were excluded as they were covered by a different evaluation. The remaining four sites were excluded as they were not included in the ethics application due to either declining to participant in the evaluation or becoming operational after the ethics application was submitted and approved (see Appendix A for full list of sites included in this evaluation). Nous conducted primary research in eight of those sites (referred to as 'deep dive sites').

Nous received approval from Bellberry Human Research Ethics Committee (HREC) (in 2021 and 2022) and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) HREC (in 2022).

The Way Back was evaluated using a mixed-methods methodology.

Nous delivered the mixed-methods evaluation between June 2020 and November 2022. Figure 2 summarises data sources that informed the evaluation. Appendix B provides the detailed methodology.

Figure 2 | Data sources that inform the evaluation

CONSULTATIONS

57 **interviews with participants** between June 2021 and April 2022.

35 **interviews with provider staff** with 70 contributors between June 2021 and April 2022.

15 **interviews with referring health** service staff with **20 contributors between June 2021 and April 2022.**

4 **collective analysis workshops with providers and PHNs** between August 2021 and October 2022.

2 **PHN focus groups** with 10 people in August 2021 and 7 people in March 2022.

2 **interviews with Beyond Blue staff** in August 2021 and March 2022.

2 **interviews with Project Steering Committee members** in 2021 and 2022.

2 **interviews with the Beyond Blue CEO, Chief Strategy Officer and Chief Services Officer** in 2021 and 2022.

PHMC MDS AND THE WAY BACK EXTENSION DATA

National activity data and outcomes data analysed for

27 in scope sites between July 2018 and September 2022

DOCUMENT AND LITERATURE REVIEW

THE WAY BACK DOCUMENTS

09 licencing agreements (including variations)

36 documents describing program design and implementation

Analysis of The Way Back referral data dashboard

LITERATURE

14 gray literature articles

10 peer reviewed literature articles

04 supporting evaluations (e.g. HOPE evaluation documents and Hunter The Way Back evaluation)

QUARTERLY REPORT DATA AND SUPPLEMENTARY DATA

Quarterly report data was collected between Q4 2021 to Q4 2022. The number of sites with data available over this time period varied as additional sites were established and sites improved their data collection methods. **The number of sites with data collected across each time period is as follows:**

Q4 2021 = **21 sites**
Q1 2022 = **21 sites**
Q2 2022 = **26 sites**
Q3 2022 = **27 sites**
Q4 2022 = **27 sites**

The supplementary data supports input into quarterly reports. It provides site-level data on referrals into The Way Back, and the number of participants that consent to accessing The Way Back.

SURVEYS

79 **respondents to the participant survey**

Online survey distributed to participants between June 2021 and June 2022 who completed their engagement with the service between 1 to 4 months previously.

95 **respondents to the provider survey**

Online survey distributed to all operational The Way Back sites between June 2021 and June 2022.

59 **respondents to Blue Voices and Roses in the Ocean (BVRITO) members survey**

Online survey distributed to members of Blue Voices or Roses in the Ocean who had lived experience of suicidality over June 2021 and February 2022.

2.4 Evaluation limitations

There are limitations to the evaluation data that are important to understand when reviewing the information in this report.

Four limitations were important to understand when considering the findings in this report. These were:

- Variability in the completeness and quality of quantitative data from service sites
- Potential positive bias in the qualitative data on participant experiences and outcomes
- Low numbers of participants in the survey and interviews, and very low numbers of interviews/survey responses from carers and participants receiving peer support, and some specific population cohorts.

Each of these limitations are explained below. The overall impact was minimised by drawing on the most appropriate data source for each evaluation question being answered. This ensured that the limitations' impact on the robustness of findings was low. The methodology addressed limitations by triangulating data to validate findings where possible. The report identifies specific findings that should be interpreted with caution.

Variability in the completeness and quality of quantitative data.

Variability in the completeness and quality of quantitative data sources were likely due to:

- Different commencement times of providers, and therefore staggered data collection and reporting of data by providers into the Primary Mental Health Care Minimum Data Set (PMHC MDS) over time. This variability in the volume of data from different sites limited the evaluations' ability to draw comparisons across sites.
- Different client management systems (CMSs) were used across sites to report into the PMHC MDS. This meant that sites had varied issues with how and what data was uploaded into the PMHC MDS. For example, one site indicated that their system had a mandatory requirement to complete fields on outcomes measures which meant they were unable to continue inputting any data until the field was filled. This resulted in a period of incorrect data within the PMHC MDS for this site. This data was identified and has been excluded from analysis. Another site reported issues with the upload process itself between the CMS and the PMHC MDS (i.e., the PMHC MDS did not accurately reflect what was captured into the CMS).
- Different approaches in how sites collected data for quarterly reports. Some sites inputted data manually into regular quarterly reports, while others uploaded data from the PMHC MDS data portal directly into the quarterly reports[12]. This impacted the consistency of data across sources and also introduced the potential for human error. The evaluation drew on the most appropriate data source for the evaluation question being answered. The data source used was based on the quality and consistency of data reported across sites. The data source with the least amount of variation across sites (i.e. the quality and completeness of the data was consistent across sites) was chosen for analysis. The report identifies where different datasets were used and the rationale for this.[13]

Potential positive bias in the data on participant experiences and outcomes.

Participants who engaged in interviews for this evaluation were self-selected which may have created a sample biased towards those who have had positive experiences and outcomes with the service. We are unable assess the extent to which this occurred, however there is evidence that those who did take part

---

[12] Data drawn directly from PMHC MDS was interpreted incorrectly in KPI calculations in some Quarterly Reports in some instances. This evaluation has used PMHC MDS directly to produce the correct KPI calculations to supplement the Quarterly Reports where required.

[13] It should be noted that it was expected that sites derive data for the quarterly reports from the PMHC MDS. However due to upload issues from sites' CMSs to the PMHC MDS, providers in interviews indicated that PMHC MDS was not the most accurate representation of site activity. As such, sites derived data directly from their CMSs (as an example) as this more accurately represented their site's activities.

felt able to provide open and honest feedback, as some participants discussed mixed or negative experiences.

Limited data on participants who did not take up a referral to The Way Back.

PMHC MDS does not record demographic data for participants who did not take up their referral to The Way Back. As such, there is very limited data on who does not take up the service, and why they decline to participate.

Lower than expected participant engagement in the evaluation may limit adequate representation of all participants' experiences of The Way Back.

The evaluation had lower than expected participation in participant interviews and in responses to the participant survey. The evaluation conducted 57 interviews with participants, though it was expected that the evaluation would conduct 80 interviews (ten per deep dive site). The evaluation also had lower than expected respondents to the participant survey (n =79). It was expected that the evaluation would receive a minimum of 580 responses. It is likely that many participants did not want to engage with the evaluation as it would require them to reflect on a very difficult time of their life. The findings may not adequately represent the views of all participants that accessed The Way Back.

Limited ability to report on the experiences of some cohorts and support persons in interviews.

The evaluation sought to recruit and engage in interviews with participant support persons, priority cohorts and priority cohorts of interest to The Way Back and the evaluation, including Aboriginal and Torres Strait Islander people, people who identify as LGBTIQA+, people from culturally and linguistically diverse backgrounds (CALD) backgrounds, veterans and older persons. It was difficult to recruit a sample size from which the evaluation could draw reliable conclusions about the effectiveness of The Way Back for these cohorts. There was also limited input from support persons (family, friends and/or carers who provide support to someone who is accessing The Way Back due to a suicidal crisis).[14]

Detailed limitations associated with each data source are at Appendix B.

---

[14] The Way Back did not collect the details of support people, nor did they collect the permissions to contact support persons as part of the evaluation. Nous sought to capture support person input via a survey and interviews, but there was limited input.

3 Policy and operating context

This section contributes to answering KEQ 1 | What is being delivered under The Way Back, where, how and why?

The delivery of The Way Back was influenced by the complex mental health system it sits within. The Way Back operated at the interface of Australian and state or territory governments' suicide prevention and mental health policy and service delivery, where there is shared responsibility for funding and delivering services. The varied ways in which state and territories delivered health and psychosocial services means that the local context of the delivery of The Way Back can vary substantially across sites.

KEQ 1 is further answered in section 4 and section 5.

3.1 Australian Government's commitment to improving suicide aftercare provides the setting for The Way Back, albeit the setting is a complex one.

There is a strong policy impetus for investment in suicide prevention. In January 2020, the Australian Government made suicide prevention and mental health a national priority, and appointed a National Suicide Prevention Adviser to rethink Australia's approach to suicide prevention.[15] In November 2020, the Productivity Commission released its Inquiry into Mental Health Final Report (the Inquiry), which recommended 'effective aftercare to anyone who presents to a hospital, general practitioner (GP) or community mental health service following a suicide attempt' (Action 9.1).[16] This culminated in the release of the National Suicide Prevention Adviser's Final Advice to the Prime Minister (Final Advice) in December 2020 which recommended that all governments 'work together to progress service reform for people experiencing suicidal distress, people who have attempted suicide as well as caregivers and people impacted by suicidal behaviour '.[17]

The Australian Government committed to passing all recommendations from the Inquiry and the Final Advice, either in part, in full, or in principle.[18] In 2021, the Australian Government announced a $158.6 million funding commitment for universal aftercare services for every Australian discharged from hospital following a suicide attempt.[19] As part of the National Agreement for Mental Health and Suicide Prevention, and associated bilateral agreements, most jurisdictions have now committed to universal aftercare, where every Australian discharged from hospital following a suicide attempt can receive follow-up care in the immediate months.[20] States and territories also have strategies and priorities for suicide prevention which are considered or incorporated together with bilateral agreements with the Australian Department of Health and Aged Care. The announcement of the roll-out of universal aftercare impacted on the developmental intent of the evaluation by making it difficult to adapt the service during the evaluation period knowing that the service will not continue in the same form under universal aftercare arrangements, and the associated ambiguity.

---

[15] Department of Health and Aged Care. 2020. *Suicide prevention and mental health package signals once in a generation reforms.* Retrieved from: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/suicide-prevention-and-mental-health-package-signals-once-in-a-generation-reforms

[16] Productivity Commission. 2020, Mental Health, Report no. 95, Canberra, p.432

[17] Department of Health and Aged Care. 2020. *National Suicide Prevention Adviser – final advice.* Retrieved from: https://www.health.gov.au/sites/default/files/documents/2021/05/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf

[18] Australian Government. 2021. National Mental Health and Suicide Prevention Plan. Retrieved from: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf

[19] Australian Government. 2021. National Mental Health and Suicide Prevention Plan. Retrieved from: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf

[20] Commonwealth of Australia (2021), Department of Health, National Mental Health and Suicide Prevention Plan https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf

The Way Back sits at the interface of Australian Government, and state or territory mental health policy and service delivery, with shared responsibility for funding and delivering services. Roles and responsibilities are not always clear.[21] The Australian Department of Health and Aged Care funds consultations with specialists, GPs and psychologists through the Medicare Benefits Scheme (MBS) and other primary mental health services through the Primary Health Networks (PHN). State and territory governments deliver mental health services through public hospitals, including emergency departments (EDs) and residential and community mental health services. Non-Governmental Organisations (NGOs) are also funded to deliver psychological support services, funded by both states and territory governments and the Australian Department of Health and Aged Care via PHNs. Mental health care is also provided in private hospitals. Both the Australian Department of Health and Aged Care, and state and territory governments assume responsibilities in suicide prevention and aftercare. The Way Back's governance arrangements and funding streams reflect this complexity (see Section 9.3).

3.2 Differences in health and community service delivery nationally affect how The Way Back operates in different sites.

Each jurisdiction has control over how acute, community health, mental health and psychosocial services are governed and delivered, with consequent variations in what is made available to people who need support. The Way Back sites must respond to variations in service availability and community context, resulting in differences in service model design (which the service model allows for). Disparity in health provision, capacity of services, referral pathways, and the ways in which these variations have affected The Way Back's site design and operations include:

- **Presence of other aftercare and suicide prevention services.** This enables consumers to choose which service best meets their needs, though this can impact The Way Back's referral numbers. For example, South Australia is also delivering an Aboriginal-led aftercare service delivered by Country SA PHN.[22]
- **Effectiveness and capacity of surrounding service systems.** The Way Back relies on acute health services being available and referring participants o The Way Back. It also relies on the ability to provide outbound referrals to relevant and accessible clinical and psychosocial services.
- **Existing level of integration at sites.** The Way Back's ability to coordinate with acute health and/or psychosocial services is more effective when a site already has some form of integration (for example, formalised referral pathway agreements, strong relationships and partnerships between sites and referring services).
- **Disparities between metropolitan and regional, and remote areas**. People have less access to health, mental health and psychosocial services in regional and remote areas. This affects the ability of The Way Back to refer regional, rural and remote participants to services to meet their needs and/or have short wait times. People from regional and remote communities engage with aftercare in different ways, which affects what adaptations are made in The Way Back sites to meet local community needs.
- **The social determinants affect how and whether people seek out and access aftercare**. Social determinants impact access, participant needs and outcomes. As such, the ability of providers to adapt The Way Back to local needs and contexts is important. Adaptations to The Way Back service model across sites are detailed further in section 4.
- **The COVID-19 pandemic.** These associated restrictions implemented across Australia due to COVID-19 had a significant impact on the way in which services were delivered across Australia.

---

[21] Parliament of Australia, 'Health in Australia: a quick guide', August 2018.

[22] Country SA PHN. 2020. *Evaluation of an Aftercare Service Model in a Aboriginal Community Controlled Health Organisation.* Retrieved from: https://www.countrysaphn.com.au/wp-content/uploads/2021/05/CSAPHN_Evaluation-Report_V4.pdf.

4 The Way Back service model and variations

This section contributes to answering KEQ 1 | What is being delivered under The Way Back, where, how, and why?

The Way Back was designed to deliver an immediate and proactive aftercare service for people who have experienced a suicide attempt or crisis. A key feature of The Way Back was the scope for service design to enable variations that respond to local needs and circumstances, most commonly through peer and family support.

There were two priority cohorts identified in The Way Back; those who identified as Aboriginal and/or Torres Strait Islander; and identified as LGBTIQA+.

Workforce, governance and funding arrangements, partnerships and engagements (particularly through the relationships between providers and referring health services), and monitoring and continuous improvement activities enabled the delivery of The Way back.

KEQ 1 is further answered in section 4 and section 5. 3

4.1 The Way Back was designed to provide immediate and proactive aftercare for people who are experiencing a suicide attempt or crisis.

The Way Back is available to people who have experienced a suicide attempt (primary eligibility criteria) or a suicidal crisis (secondary eligibility criteria). People are ineligible if they engaged with another proactive outreach service that includes mental health support.[23] Identified cohorts of interest to The Way Back were those who were overrepresented in suicide statistics and/or those who faced greater barriers to accessing support. These were people who: identified as Aboriginal and Torres Strait Islander, identified as LGBTQIA+, men, aged 80+ years old, middle-aged men, youth, and people with a mental health condition.[24] The Way Back also had two priority cohorts. These were people who identified as Aboriginal/and or Torres Strait Islander and identified as LGBTIQA+. These cohorts were prioritised through:

- Data collection on service access,
- Service model adaptations in sites to include priority pathways for Aboriginal and Torres Strait Islander people.
- Active recruitment of The Way Back staff who identified as Aboriginal and Torres Strait Islander people, and/or identified as LGBTQIA+.[25]

The evaluation also identified additional cohorts of interest that were important to investigate through analysis of prevalence data of suicide attempts and deaths across specific cohorts or through identification of cohorts through the available data to the evaluation. These cohorts included but were not limited to people who experienced a personality disorder, people from a culturally and linguistically diverse (CALD) background, people who use alcohol and/or other drugs, people who were experiencing homelessness, people who were unemployed.

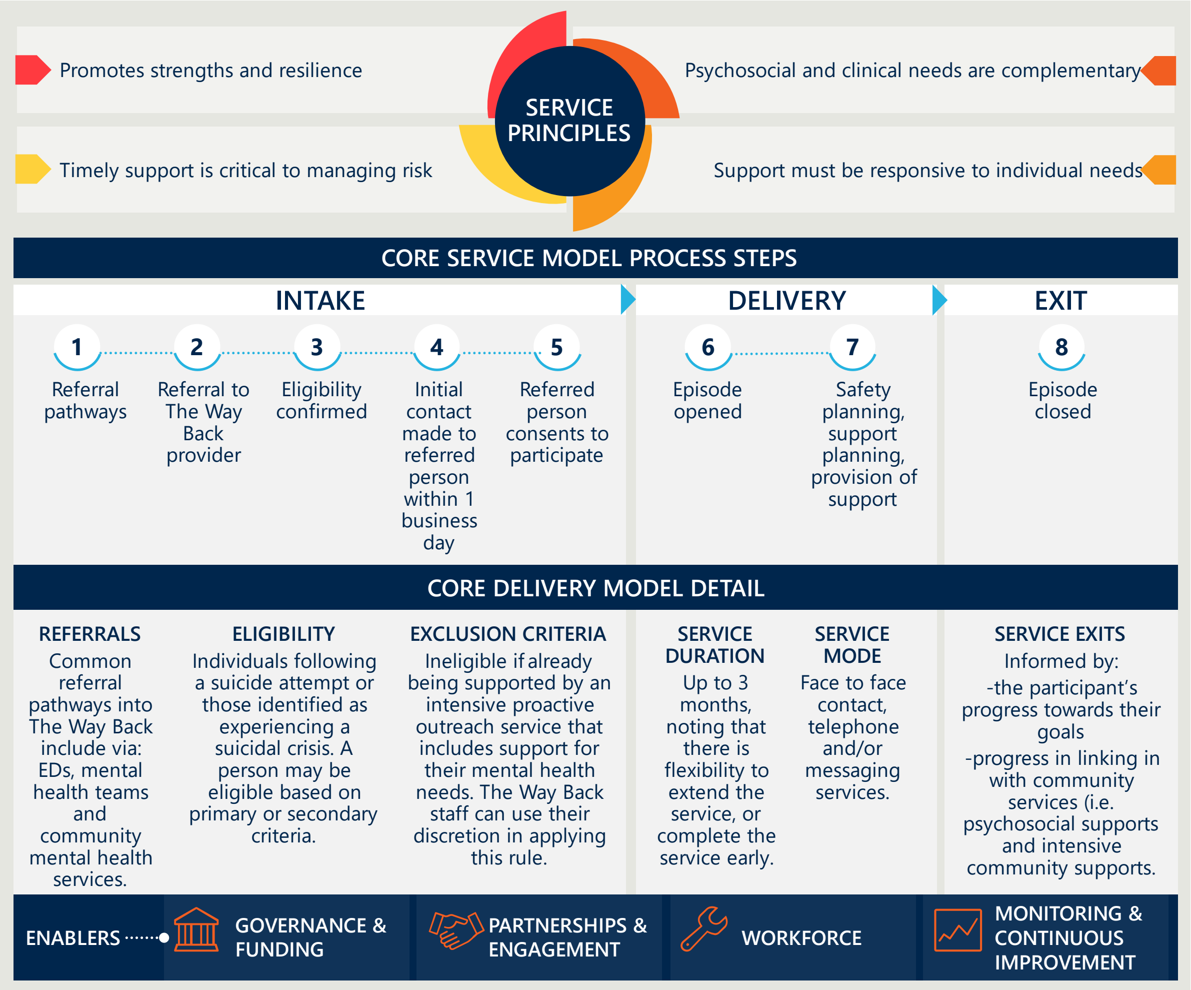
Core features of The Way Back service model include:

---

[23] Beyond Blue, 'The Way Back Support Service – Service Delivery Model', March 2020.
[24] Beyond Blue. 'The Way Back Support Service Implementation and Procurement Guide'. March 2020.
[25] Beyond Blue. 'The Way Back Support Service Implementation and Procurement Guide'. March 2020.

- The Way Back is free of charge for anyone living in Australia
- Participants are contacted within one business day of being referred to The Way Back
- The service provides proactive psychosocial follow-up and support for up to three months
- The participant is provided with a support coordinator who connects them with the tools, services and supports needed to support recovery
- The service aims to ensure continuity of care by supporting the participant to access further supports to address the issues contributing to their suicidality.[26]

Figure 3 | The Way Back service model[27]



SERVICE PRINCIPLES

Promotes strengths and resilience

Psychosocial and clinical needs are complementary

Timely support is critical to managing risk

Support must be responsive to individual needs

CORE SERVICE MODEL PROCESS STEPS

INTAKE

1 Referral pathways

2 Referral to The Way Back provider

3 Eligibility confirmed

4 Initial contact made to referred person within 1 business day

5 Referred person consents to participate

DELIVERY

6 Episode opened

7 Safety planning, support planning, provision of support

EXIT

8 Episode closed

CORE DELIVERY MODEL DETAIL

REFERRALS
Common referral pathways into The Way Back include via: EDs, mental health teams and community mental health services.

ELIGIBILITY
Individuals following a suicide attempt or those identified as experiencing a suicidal crisis. A person may be eligible based on primary or secondary criteria.

EXCLUSION CRITERIA
Ineligible if already being supported by an intensive proactive outreach service that includes support for their mental health needs. The Way Back staff can use their discretion in applying this rule.

SERVICE DURATION
Up to 3 months, noting that there is flexibility to extend the service, or complete the service early.

SERVICE MODE
Face to face contact, telephone and/or messaging services.

SERVICE EXITS
Informed by:
-the participant's progress towards their goals
-progress in linking in with community services (i.e. psychosocial supports and intensive community supports.

ENABLERS

GOVERNANCE & FUNDING

PARTNERSHIPS & ENGAGEMENT

WORKFORCE

MONITORING & CONTINUOUS IMPROVEMENT

The key service features were developed by Beyond Blue based on the available evidence on aftercare and suicide prevention. For example, evidence demonstrated that effective models of aftercare address the psychosocial needs of participants, provide continuity of care and involve a strong therapeutic alliance between the support coordinator and the participant.[28] The service model also aimed to engage participants at their highest period of risk, which is within three months of discharge from hospital following a suicide attempt.[29]

---

[26] Beyond Blue. 'The Way Back Support Service: aftercare following attempted suicide – 2018-19 Budget Proposal.' January 2018. pp. 15-16. Note that some sites only accept participants with primary criteria due to demand for the service.

[27] Depiction based on information captured in Beyond Blue, 'The Way Back Support Service – Service Delivery Model', March 2020.

[28] SAX Institute. 'Suicide aftercare services'. October 2019. pp. 7.

[29] Beyond Blue. 'The Way Back Support Service: aftercare following attempted suicide – 2018-19 Budget Proposal.' January 2018. pp.15.

4.2 PHNs determined the feasibility of implementing The Way Back in their local area.

Suggested site locations were outlined in the 2018 bilateral funding agreement (see section 9.3). Beyond Blue sought expressions of interest to determine which PHNs would be interested in establishing The Way Back. PHNs were requested to also consider how The Way Back would complement their existing mental health system. This included considerations such as:

- locations of hospitals.
- existing funding arrangements for other suicide prevention programs.
- the availability of other mental health programs and how these respond to suicidality.

4.3 Beyond Blue, states and territories, PHNs, and providers supported implementation of The Way Back.

If the Australian, and states and territory governments chose to establish a new site, the PHN in the local area received funding to commission a provider to deliver The Way Back. Beyond Blue, PHNs and providers all contributed to implementing The Way Back.

Beyond Blue provided The Way Back license to PHNs so they could commission a provider to deliver The Way Back. Beyond Blue also provided ongoing and support and guidance to PHNs regarding commissioning, collaboration with referring partners, governance, data compliance, reporting, training, and marketing.

States and territories also contributed to the safe and effective delivery of services through their attendance at site steering groups and ensuring local needs were considered at a national level through attendance on the National Advisory Committee and Data Management and Evaluation Sub Committee.

The PHNs provided expert local knowledge of sites, and established stakeholder relationships (for example, between Beyond Blue and providers) and reporting and governance processes for their site.

Some providers:

- Adapted the service model to suit the site’s local context, while maintaining the core elements of the model to ensure service model fidelity and quality.
- Used project management software to monitor progress made to implement the service model at a new site.
- Recruited and trained staff to deliver The Way Back (supported by the Beyond Blue training program).
- Reviewed the service from a clinical governance perspective to ensure appropriate clinical risk management processes were put in place.
- Worked with their commissioning PHNs to establish reporting and governance processes.

Appendix A provides a list of operational sites and commencement dates.

4.4 Four key enablers supported delivery of The Way Back.

As outlined in Figure 3 the evaluation identified four key enablers that supported delivery of The Way Back. These were:

- **Governance and funding.** These were the accountabilities of key stakeholders such as the Australian Department of Health and Aged Care, state and territory governments and Beyond Blue to oversee delivery of The Way Back, and the funding arrangements in place to deliver The Way Back across multiple sites in different jurisdictions.

- **Partnerships and engagement.** These were relationships established between key stakeholders, including governments, PHNs, LHD/HHS and service providers to deliver The Way Back.
- **Workforce.** These were the staffing arrangements and corresponding expertise required to deliver The Way Back service.
- **Monitoring and continuous improvement.** These were data collection initiatives in place to monitor delivery of The Way Back and to identify opportunities and initiatives to improve delivery of the service.

Further detail of these enablers and their effectiveness is outlined in section 9.3.

4.5 Service model variations allowed for flexibility to respond to local needs and contexts.

A key feature of The Way Back was the scope for service design and delivery variations that respond to local needs and circumstances.[30] Through interviews with providers and The Way Back documentation, evaluation identified two variation categories that existed across sites, these were:

- **Contracted variations.** These were service model variations stipulated in a site's contract and developed prior to implementation of The Way Back.
- **Service enhancement variations.** These were variations that were not stipulated in a site's contract and were implemented in response to needs identified during implementation.

Figure 4 shows the variations that were implemented across the eight deep dive sites. In summary:

- Most contracted variations in the service delivered to participants were implemented. There were two contracted variations that were not implemented. There is no information available for the evaluation on why these were not implemented.
- Model variations for peer and family support existed across three deep dive sites.
- Model variations for expanded referral pathways between The Way Back and under other organisations (for example, community mental health organisations) existed for one site. Stakeholders reported that this was due to infancy of partnerships with referral organisations (such as with Aboriginal Community Controlled Health Organisations (ACCHOs).
- Several providers indicated there were variations suitable for their site, particularly an Aboriginal and Torres Strait Islander referral pathway, that they had not yet implemented.
- Two variations for data enhancement emerged in consultations with providers at Gold Coast and Brisbane North sites to better integrate Queensland mental health and The Way Back datasets.
- Some providers in interviews noted the rigidity of contracts limited their ability to implement service enhancement variations upon delivery. Provider contracts often only provided scope to establish referral pathways within emergency departments or in-patient units. Additionally, one site indicated that there was little scope in their current contract to implement family and carer support.
- Other contracted variations implemented in some sites include:
    - **GP referral pathways.** A small number of sites established referral pathways with local GPs.
    - **Referrals from a toxicology unit** were accepted by one site.
    - **One team allocated over multiple locations.** This involves a site located in a regional/remote location allocating its team over multiple locations to cover a large geographical area.[31]

---

[30] Opportunities to vary The Way Back service model are considered locally according to the needs, priorities and complimentary funding opportunities available at the local PHN level. To ensure model fidelity is maintained, it is expected that local enhancements are developed in consultation with Beyond Blue and other local stakeholders and endorsed according to the requirements of the License Agreement. This is usually in the form of a contract variation.

[31] Beyond Blue. 'Site Context.' July 2020.

Figure 4 | Variations to The Way Back delivery model for the eight deep dive sites

VARIATIONS	DESCRIPTION OF VARIATION	RATIONALE	DEEP DIVE SITES							
Referral pathway	Sites may establish a specific referral pathway tailored to a specific group. Current examples include an Aboriginal and Torres Strait Islander pathway, veterans, toxicology -only pathways or a GP pathway.	Certain cohorts or locations have specific needs or ways they interact with health services that mean they would benefit from a tailored pathway outside of referrals from emergency departments and community mental health services. In addition, certain cohorts are more at-risk of suicide (re)attempts or experience specific risk factors.	🟠	🟢						
Peer support	Sites may establish a peer support enhancement, in which participants interact with a peer with lived experiences to provide support (e.g. peer care companion, informal coffee catch ups with previous participants).	There is some evidence that peer support improves participants experiences and progress towards recovery.	🔵	🔵	🔵	🟠				
Family support	Sites may establish a family support role (e.g. family peer care companion), in which a family member is involved in supporting recovery.	Families of people who (re)attempt suicide can be an important support through recovery (e.g. strong relationships can be a protective factor).	🔵	🟢						
Group sessions	Sites may offer past and present participants the opportunity participate in coffee or walking groups.	Group sessions provide participants with the opportunity to connect with people who have had lived experience of suicidality.	🔵	🔵						
After hours support	Sites may have support available outside of standard business hours (e.g. one business day response, weekend coverage).	Participants will sometimes require support outside of business hours.	🔵	🟢						
Coordinated care	A site may integrate The Way Back with other existing suicide prevention programs. They may also fund an intake role who is the central point of contact for all referrals.	Sites may have existing services that The Way Back should align to, to prevent duplication and improve participant experience of integrated care. The intake role ensure participants are contacted in a timely manner (i.e. within 1 business day) and are allocated to a support coordinator that can best meet their needs.	🔵	🔵						
Additional funding for clinical care	Some sites have secured additional funding for a clinical psychologist to service the clinical needs of The Way Back participants.	Participants are unable to access local psychological support services in a timely manner. Additional clinical support acts as an in-between measure whilst a participant is waiting for connection with a psychologist outside of The Way Back.	🔵	🔵						
Shared information systems	Sites may have a developed a system so that The Way Back staff can easily access participants' clinical information, and referring health services are able to see if participants have been escalated back into acute care.	Easy access to participant information enables The Way Back's support coordinators to quickly understand the participants needs, and minimises the need for participants to retell their story.	🔵							

LEGEND	IMPLEMENTED CONTRACT VARIATIONS	🔵	CONTRACT VARIATIONS NOT IMPLEMENTED	🟠	IMPLEMENTED SERVICE ENHANCEMENT VARIATIONS	🟢

5 Service reach

This section contributes to answering the following KEQs:

KEQ 1 | What is being delivered under The Way Back, where, how, and why

Between July 2018 and September 2022, The Way Back was established across 38 sites in seven states and territories, 27 of these sites were in-scope for this evaluation. Across the 27 in-scope sites, 8,734 participants were reached. 79 per cent of referrals to The Way Back were taken up, 65 per cent of participants had recorded safety plans, 55 percent of participants had recorded support plans, and there were 5,685 outward referrals made to other psychosocial or clinical services.

KEQ 1 is further answered in section 3, and section 4.

KEQ 2 | How well is The Way Back being delivered?

Across Australia, referrals to The Way Back exceeded projected targets. In line with the service model, sites engaged in strategies to better manage higher than expected demand by prioritising those at higher risk, including those with primary eligibility criteria, and priority cohorts for The Way Back (including Aboriginal and Torres Strait Islander people, people who identify as LGBTIQA+).

The characteristics of people accessing the service were broadly in line with who was expected to access the service in that most people had a reported mental health diagnosis (79 per cent), and/or had made a pervious suicide attempt (37 per cent). The other most common characteristics of The Way Back participants were born in Australia (85 per cent) and identified as a heterosexual female (58 per cent).

The Way Back appeared to be meeting the needs of Aboriginal and Torres Strait Islander people, though there was limited publicly available data for some other priority cohorts (for example, people who identify as LGBTQIA+, people with CALD backgrounds, and people who were experiencing a borderline personality disorder) to establish whether The Way Back was adequately meeting their needs. KEQ 2 is further answered in section 6 and section 9.

DATA QUALITY AND LIMITATIONS IN THIS SECTION

This section draws on three key data sources:

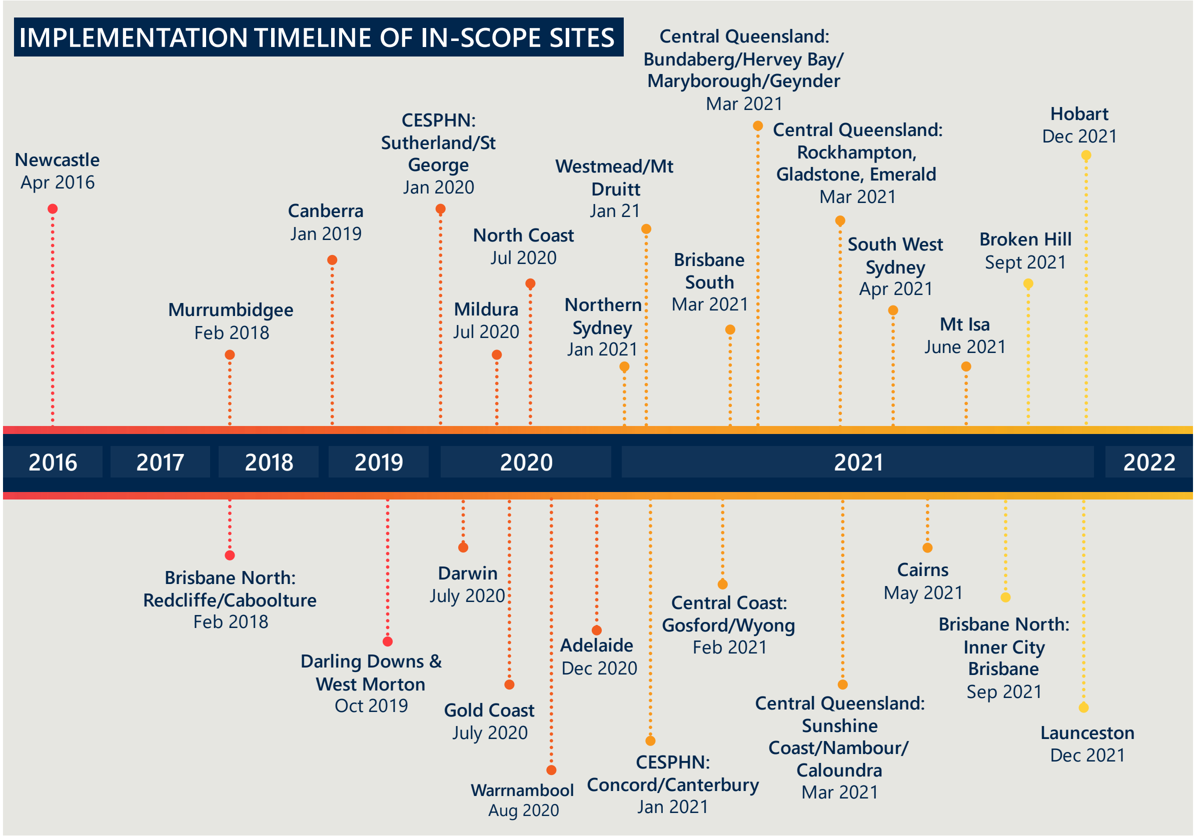
- PMHC MDS data for twenty-seven in-scope sites between July 2018 and September 2022,
- quarterly reports for twenty-seven sites between April 2021 and June 2022 and
- referral data for all operational sites since commencement of The Way Back
- interviews with provider staff between June 2021 and April 2022
- This section only reports on the twenty-seven in-scope sites of the 38 operational sites. Variability in the completeness and quality of quantitative data across sites has impacted the consistency of data across sources. Refer to section 2.4 and Appendix B for detailed limitations.

5.1 Key activities and outputs 2018-22

The Way Back was delivered in 38 sites, 27 of which were in-scope for this evaluation. Across those 27 sites, 8,734 participants were supported across seven states and territories between July 2018 and September 2022.

Figure 5 provides a timeline of when the 27 in-scope sites were implemented. It shows that all in-scope sites were implemented between April 2016 and December 2021, with majority of sites implemented throughout 2021. In its first year of operation in 2018 and 2019,[32] The Way Back supported 60 participants across two sites[33], this grew to 5,824 participants in 2021 and 2022 across the 27 sites[34]. To support the growth in the number of participants supported, the workforce has grown from approximately 107 FTE in Q4 2021 to approximately 150 FTE as of Q4 2022.[35]

Figure 5 | Implementation timeline of the 27 in-scope The Way Back sites[36]



An overview of key outputs delivered between July 2018 and September 2022 nationally and in each state or territory is provided in Figure 6.[37] A complete list of expected activities and outputs delivered by The Way Back are outlined in Appendix B.

---

[32] The evaluation notes that the Newcastle site was implemented as a trial site in 2016, before being funded as a fully operational site in 2018)

[33] Number of participants recorded in PMHC MDS data between 1 July 2018 and 1 July 2019. The evaluation notes that four sites were implemented during this time period though only two sites (Newcastle and Brisbane North) uploaded their data into the PMHC MDS during this time period.

[34] Number of participants recorded in PMHC MDS data between 1 September 2021 and 1 September 2022.

[35] Quarterly reports for in-scope sites between April 2021 and June 2022. Note, the number of FTE in the workforce when the service commenced in 2018 is not recorded in the data available for this evaluation.

[36] Based on dates from The Way Back Dashboard

[37] Note that the number of outputs vary in each site and state depending on sites' first date of operation, service maturity and local context. For example, states and territories with less mature sites will have received fewer referrals, and therefore will likely report fewer key outputs.

Figure 6 | Key evaluation outputs nationally and across state and territories for the 27 in-scope sites[38]

NATIONALLY

27 SITES

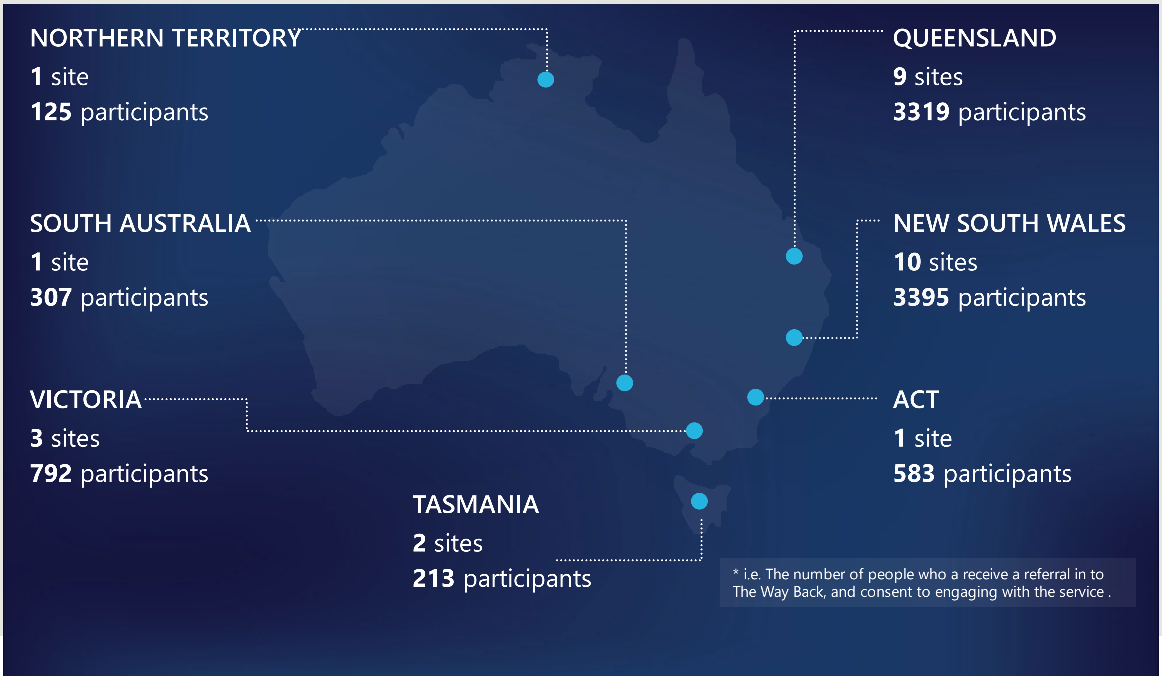
79% UPTAKE OF REFERRALS*

8734 PARTICIPANTS

65% RECORDED SAFETY PLANS

55% RECORDED SUPPORT PLANS

5685 REFERRALS OUT TO OTHER PSYCHOSOCIAL OR CLINICAL SERVICES



NORTHERN TERRITORY
1 site
125 participants

QUEENSLAND
9 sites
3319 participants

SOUTH AUSTRALIA
1 site
307 participants

NEW SOUTH WALES
10 sites
3395 participants

VICTORIA
3 sites
792 participants

ACT
1 site
583 participants

TASMANIA
2 sites
213 participants

* i.e. The number of people who a receive a referral in to The Way Back, and consent to engaging with the service .

5.2 Volume of referrals

Referrals to The Way Back exceeded the contracted referral target.

The Australian Department of Health and Aged Care Funding Agreement set out a *participant referral target* of 24,300 referrals by 30 June 2022.[39] This was subsequently revised to 19,000 referrals for all 38 sites by 30 June 2022 in a variation to the Funding Agreement[40] which took into a consideration the delays to execution of the Australian Department of Health and Aged Care and state/territory government bilateral agreements, associated delays in the commencement of new services, and to reflect a more realistic timeframe (see section 5.2).

For the purposes of this evaluation, the projected referral target of 19,000 for the 38 sites was revised down to 16,200 referrals to account for the 27 in-scope sites.[41] As of 30 June 2022, The Way Back received 17,477 referrals across 27 in-scope sites, thus exceeding the expected number of referrals for these sites by 8 per cent (1,277) based on The Way Back referral dashboard data.[42]

As of September 2022, The Way Back received 19,759 referrals (a growth of 13 per cent from June 2022). Referral targets and numbers differed across jurisdictions as each site's projected referral numbers were based on their geographical catchment, population health profile, and predicted rates of suicide. [43]

---

[38] Based on PMHC MDS data for 27 in-scope sites between July 2018 and September 2022, supplementary data for a sample of 27 in-scope sites and 6,016 referrals between July 2021 and June 2022, and quarterly reports for 27 in-scope sites between April 2021 and June 2022.

[39] Beyond Blue. July 2018. 'Commonwealth Standard Agreement – Version 3'.

[40] Beyond Blue. September 2019. 'Commonwealth Standard Grant Agreement – Version 5'.

[41] New participant referral targets are intended to reflect an estimation of the expected demand for the service at each site, rather than a measure of service performance or quality or contractual fulfilment.

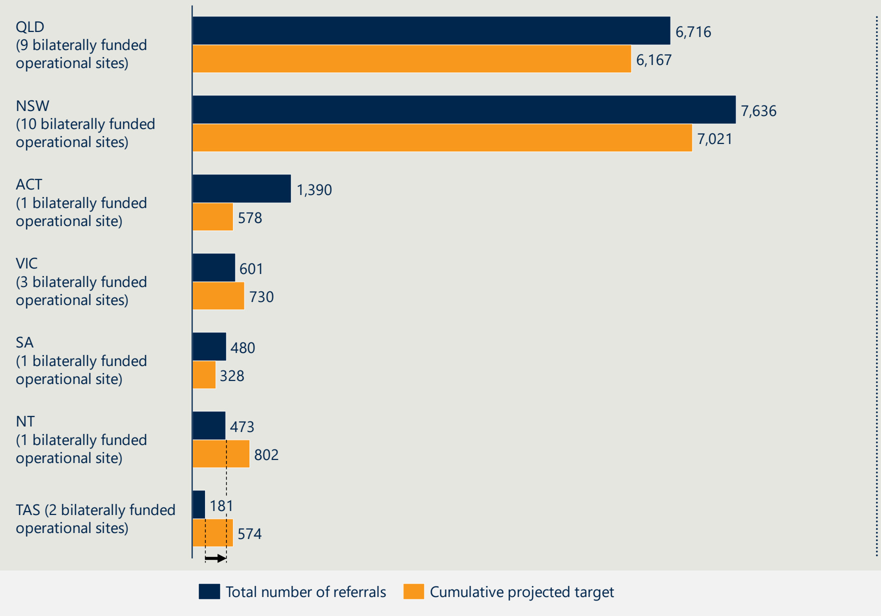
[42] Note that the cumulative projected target for each state and territory includes out of scope sites for Victoria. These sites contribute to approximately 10 per cent of total referrals.

[43] The Way Back Support Service Implementation and Procurement Guide, 2020.

Referrals to The Way Back suggest that the service was reaching those who required aftercare support.

There was variation in meeting referral targets across sites, though more than half of the states and territories delivering The Way Back exceeded their referral targets. Figure 7 highlights the number of actual referrals against referral targets for each jurisdiction from January 2019 to June 2022.[44] It should be noted that the referral targets have not been updated post 30 June 2022, as this was the end of the referral target period.

Figure 7 | Total referrals by jurisdiction, January 2019 to June 2022 (17,477 referrals for 27 sites)[45]



Included sites that were operational prior to June 2020 were more likely to report a higher level of referrals and greater service maturity.

The greater number of referrals than what was projected suggest that The Way Back was adequately reaching those who experienced an attempted suicide / a suicidal crisis and required aftercare support. In some sites, this also corresponded with higher than expected demand for the service (see p. 25 below). In interviews, providers and referring health services across states and territories identified several factors which influenced the increase in referrals compared to the targets. These factors are outlined below:

- **Operational maturity of sites**. Sites that were operational for more than 12 months were more likely to meet or exceed referral targets. Services that were operational for longer periods of time reported stronger partnerships and established referral pathways with health services.
- **Presence of a hospital liaison officer**. The presence of the funded hospital liaison officer was crucial for connecting The Way Back with health services, promoting the service with clinicians and establishing referral pathways.
- **Co-location with referring health services.** Co-location with referring health organisations supported strong relationships which meant health staff were more aware of The Way Back and more likely to refer participants to the service.
- **Collaboration agreements between The Way Back and health services.** Collaboration agreements provided structure and clearly defined the working relationship between The Way Back and health services.

Providers and referring health organisations in interviews also indicated that there were opportunities to improve the quality and timeliness of referrals received from referring health organisations. For example,

---

[44] For the 27 in-scope sites of the evaluation and based on The Way Back referral data dashboard for January 2019 to June 2022.

[45] Based on The Way Back referral data dashboard for January 2019 to June 2022. Targets for each state are calculated based on the proportion of cumulative projected targets by state and the 16,200 proportion of the total target for June 2022 of in-scope sites.

some providers noted that it was a challenge to contact participants in a timely manner when referrals were incomplete and/or did not provide correct details. Some referring health services noted that their organisation had onerous processes and practices in place, which meant that referrals could become 'bottle necked' with the hospital liaison role. This was despite referrers assessing potential risk for referrals as very low.

The number of referrals has accelerated over time as sites matured and additional sites were commissioned.

The number of referrals reported nationally increased by over four times from June 2020 (4,168) to June 2022 (17,477). Several factors contributed to this significant increase over the past 24 months including:

- The maturing of sites that became operational in early 2021 including Cairns, Mt Isa, Central Queensland and Southwest Sydney.
- The addition of four new sites since August 2021 (i.e., Broken Hill, Hobart, Launceston/Burnie and Inner-City Brisbane).
- The impact of contextual factors on mental health including the global pandemic and associated lockdowns, and psychosocial stressors including housing stress and increasing cost of living. [46]
- Newer sites may have used learnings from other sites to establish more effective referral pathways.

Some providers reported challenges managing demand.

In consultations, providers reported challenges in meeting the demand for The Way Back with current resources. Figure 7 reflects this challenge, with more than half of states and territories that delivered The Way Back recording referral numbers well above targets. There was insufficient quantitative data to further verify challenges to meeting demand. Sites anecdotally reported taking different approaches to manage challenges with meeting demand. These included:

- Prioritising referrals for primary criteria over secondary criteria where required. One site reported only having the capacity to accept referrals based on primary criteria since commencement of the service.
- Increasing emphasis on ensuring the appropriateness of referrals for The Way Back including where people were already linked in with other supports or required additional clinical care.
- Making initial contact following the referral but placing participants on a waitlist and ensuring the HHS provided support until there was a support coordinator available (for example, Gold Coast).[47]

In almost all consultations, providers, referring health organisations and participants consistently highlighted the importance of not having to wait too long to be allocated a support coordinator once accessing the service and having dedicated time with their support coordinator on a regular basis. The wait times for new participants to be allocated a support coordinator could not be verified using the quantitative data currently available[48]. It is recommended that this information is collected in the future (see section 10.1, recommendation 16).

---

[46] Australian Institute of Health and Welfare. 2022. *Suicide & self-harm monitoring.* Retrieved from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19

[47] There was no data available to the National Evaluation to inform how long people would wait on the waitlist before receiving the service. Beyond Blue note that the risks associated with this approach have been highlighted to the service provider as it does not adhere to the service model design.

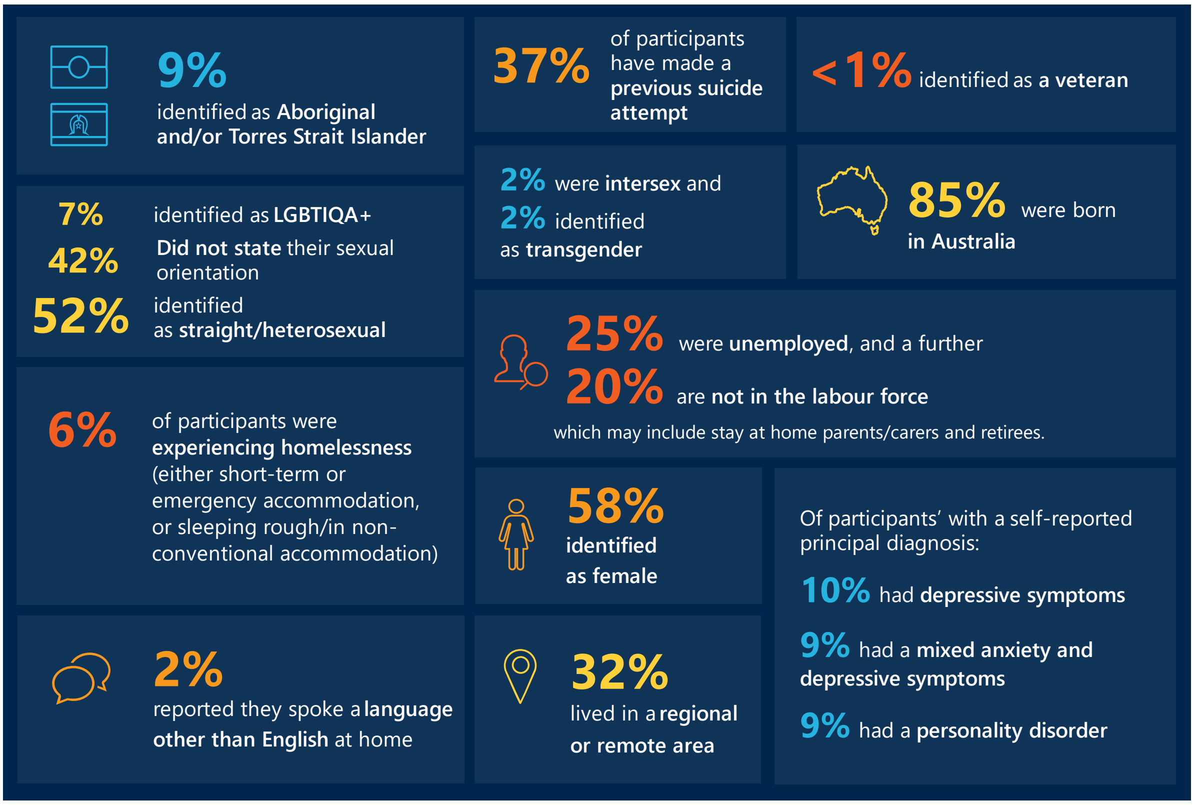
[48] It is not clear from the information available to this evaluation if the days to contact or days to service start recorded in the PMHC MDS data set accurately correspond to wait times for allocation to a support coordinator

5.3 Participants who access The Way Back

A third of participants had made a previous suicide attempt, 58 per cent were female and 85 per cent were born in Australia.

Figure 8 shows a sample of demographic and other characteristics for the 8,734 participants for which there was data in the PMHC MDS. [49]

Figure 8 | Proportions of The Way Back participants by key characteristics (based on a sample of 8,734 participants) [50]



The characteristics of participants in the PMHC MDS largely reflected the characteristics of those represented in suicide attempt statistics.[51] For example, the slightly higher proportion of participants who identified as female was to be expected (women are more likely than men to be hospitalised for self-harm, and suicide attempts although men are more likely to die as a result of a suicide attempt). Similarly, the higher proportion of participants with a prior suicide attempt was expected, given it is the most significant predictor of death by suicide and suicidal behaviour, and is the primary criteria for referral to The Way Back.

It should be noted that the PMHC MDS dataset may under-represent the characteristics of participants who access The Way Back. Analysis of PMHC MDS showed that across some demographic data, there was a greater count of participants that had missing data, or their status was not stated. These included Aboriginal and/or Torres Strait Islander status (17 per cent); sexual orientation (42 per cent); transgender status (31 per cent), intersex status (34 per cent); veteran (27 per cent); homelessness status (15 per cent). In consultations with providers and Beyond Blue, it was highlighted that missing demographic data may

---

[49] Based on analysis of PMHC MDS data for 27 in-scope sites between July 2018 and September 2022. The PMHC-MDS data may be under representative of true service use. Four of the 27 sites commenced operations from June 2021 and therefore have limited episodes recorded (≤ 50 episodes between 2018-2021). Six sites that were operational prior to June 2021 have ≤ 100 episodes between 2018-2021.

[50] Based on analysis of PMHC MDS data for 27 in-scope sites between July 2018 and September 2022. The percentage of participants that have made a previous suicide attempt refers to participants with suicide attempt prior to and in addition to the suicide attempt or suicide crisis that made them eligible for referral to The Way Back.

[51] AIHW, 2021, 'Intentional self-harm hospitalisations by states & territories', Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/intentional-self-harm-hospitalisations-by-states.

be the result of participants not feeling comfortable sharing specific details about themselves and/or data not being captured within the PMHC MDS when participants disclose this information at a later date.

Most participants referred to The Way Back self-reported a diagnosed mental health condition, and many were experiencing a situational crisis.

Analysis of the PMHC MDS data between September 2019 and September 2022 found that 79 per cent of participants referred to The Way Back self-reported a mental illness diagnosis. Of participants who had a diagnosis listed, the top 3 principal diagnoses included:

1. depressive symptoms (10 per cent or 843 participants).[52]
2. mixed anxiety and depressive symptoms (9 per cent or 778 participants)[53]
3. personality disorder (9 per cent or 782 participants)[54]

Some providers in interviews indicated that The Way Back can be beneficial for participants with complex needs – who may 'fall through the cracks' due to exclusionary eligibility criteria across other services. Other providers indicated that participants with greater complexity may be better supported by clinical services (though noted that these services often have long waitlists or high costs to access).

Twenty-one per cent (1,877) of participants had no recorded diagnosed mental health condition.[55] Some providers in interviews also emphasised that not all participants who experienced a suicidal crisis or attempt had a diagnosed mental illness. The evaluation found these participants were more likely to be experiencing situational/psychosocial crisis and/or distress due to unemployment, homelessness, workplace injury (physical or psychological) and/or relationship breakdowns than the general Australian population at the time of first engaging with The Way Back. Research on the top risk factors for suicide in Australia also highlight the impact of situational crises on suicidality. Spousal relationship problems, legal problems, relationship problems with friends and family, and employment problems were common risk factors for suicide.[56] Providers and participants also indicated that many participants were likely to have experienced trauma including but not limited to sexual abuse, domestic and family violence (DFV), loss of a loved one and trauma resulting from the suicide attempt or crisis itself.

The Way Back appeared to be meeting the needs of Aboriginal and Torres Strait Islander people, though there was limited publicly available data for some other priority cohorts to establish whether The Way Back was adequately meeting their needs.

The PMHC MDS data indicated that 9 per cent of The Way Back participants identified as being Aboriginal and/or Torres Strait Islander, relative to them representing approximately four per cent of the Australian population.[57] This higher representation in The Way Back is consistent with the higher rates of death by suicide in Aboriginal and Torres Strait Islander people compared to the broader Australian population.[58] The Aboriginal Advisory Group also suggested that the proportion of identified Aboriginal and Torres Strait Islander people accessing The Way Back (9 per cent) was a good indication that The Way Back was meeting the needs of this cohort.

---

[52] Based of PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and February 2022 It should be noted that it was not clear to the evaluation in the PMHC-MDS data whether the language of 'symptoms' represents an actual reported diagnosis, or whether reported symptoms of mental illness disorders were also captured (i.e. the participant did not have a reported diagnosis, and therefore this data-overrepresents the diagnoses that may exist amongst participants.

[53] Note that PMHC MDS data reports separately on symptoms of depression only, and symptoms of anxiety only. a

[54] Personality disorders includes the three types of personality disorders: eccentric personality disorders (Cluster A), dramatic personality disorders (Cluster B) and anxious personality disorders (Cluster C).

[55] Based on PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and February 2022.

[56] AIHW. (2021). *Risk factors for intentional self-harm deaths (Suicide) in Australia.* Retrieved from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#risk-factors-for-intentional-self-harm-deaths-suicide-in-australia

[57] Australian Bureau of Statistics. (2021). *Aboriginal and Torres Strait Islander Peoples.* Retrieved from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples#:~:text=As%20at%2030%20June%202021,of%20the%20total%20Australian%20population.

[58] Australian Institute of Health and Welfare. (2021). *Deaths by suicide amongst Indigenous Australians.* Based on 2020 data. Retrieved from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians

There was limited publicly available prevalence data available to the evaluation to establish whether The Way Back was adequately meeting the needs of priority cohorts (i.e. people who identified as LGBTIQA+) and cohorts of interest to The Way Back and evaluation (particularly, people from CALD backgrounds, and people who were experiencing personality disorders). The analysis undertaken in this evaluation was limited by the extent to which comprehensive demographic and prevalence on suicide rates, suicidal ideation, and suicidal crises was available for some of the priority cohorts.

In consultations, providers and Beyond Blue staff suggested that some cohorts of interest were underrepresented in The Way Back because they were more likely to face barriers to accessing mental health services Figure 9 details the reasons commonly cited by Beyond Blue, providers and referring health services as to why these cohorts may face greater barriers to accessing The Way Back. Further investigation is required to understand how well The Way Back is adequately supporting priority cohorts and barriers to accessing it.

Figure 9 | Barriers to cohorts of interest engagement with The Way Back

	BARRIERS TO COHORTS OF INTEREST ENGAGEMENT WITH THE WAY BACK[59]
People who identify as Aboriginal and/or Torres Strait Islander	• The availability of other more culturally appropriate and targeted services within the same area with a more diverse workforce. • Lack of co-design and partnerships with local Aboriginal and Torres Strait Islander communities, ACCHOs and AMSs and consideration of the Social and Emotional Wellbeing Model[60] in the design of the service. • Historical trauma experienced by Aboriginal and Torres Strait Islander people related to the health system. This meant that ED referral pathways did not meet the needs of some Aboriginal and Torres Strait Islander people. • The stigma associated with mental illness within Aboriginal and Torres Strait Islander communities. Some providers shared that in their experience Aboriginal and Torres Strait Islander people were reluctant to engage with The Way Back as they were worried about what other people and their community would think of them. Providers also mentioned this was particularly true in smaller regional and remote areas.
People who are from CALD backgrounds	• Language barriers or stigma within their communities due to religious and cultural beliefs about mental health. Some participants who were not Australian residents reported challenges accessing the mental health system and other services such as Medicare.
People living in regional and / or remote areas	• The stigma associated with mental illness and privacy and confidentiality concerns. Some participants and providers alluded to the ongoing challenge of accessing and providing services in smaller communities whilst maintaining privacy and confidentiality of participants. Providers noted that this can be a significant barrier which prevents participants engaging with the service particularly in a public context (for example, meeting in a library, park, café).

---

[59] Informed by interviews with Beyond Blue, provider and referring health services staff.

[60] Gee, G., Dudgeon, P., Shultz, C., Hart, A. & Kelly, K. (2014). Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. Available from: https://research.bond.edu.au/en/publications/aboriginal-and-torres-strait-islander-social-and-emotional-wellbe

	BARRIERS TO COHORTS OF INTEREST ENGAGEMENT WITH THE WAY BACK[59]
People who experience personality disorders and/or chronic suicidality	• People with personality disorders are at risk of suicidality. People with personality disorders are estimated to represent 7 per cent of the population, [61] though represent 9 per cent of participants accessing The Way Back. Interviews with participants experiencing a personality disorder highlighted that therapeutic treatment alongside psycho-social support through The Way Back is needed as part of their recovery (see section 8.1).
LGBTIQA+	• Some participants and providers hypothesised that individual’s may not feel it is relevant to identify their gender or sexuality to their support coordinator explicitly, and therefore the proportion of participants who identify as LGBTIQA+ is not well understood (i.e., 42 per cent of participants in the PMHC MDS did not state their sexual orientation). • The availability of other more appropriate and targeted services within the same area with a more diverse workforce.

---

[61] Productivity Commission. 2020. Productivity Commission Inquiry Report: Volume 1. No 95, 30 June 2020

6 Participant journeys

This section aims to answer the following KEQs:

KEQ 2 | How well is The Way Back being delivered?

Overall, The Way Back was delivered in line with its intended design. The delivery of The Way Back was understood across the participant journey from entry to exit of The Way Back. This occurred across three stages:

Inbound referrals. Participants and providers highlighted that there is an opportunity for The Way Back to expand referral pathways to improve access to priority cohorts that are less likely to present at hospital or emergency departments (for example, Aboriginal and Torres Strait Islander people).

Referral uptake. Uptake rates for The Way Back (i.e., 79 per cent of those referred into The Way Back engaged with the service) were as expected for an aftercare service, suggesting the mechanisms in place to support an effective and timely referral were working well.

Service delivery. Service delivery was understood across the following components:

Service completion. On average, participants stayed in the service for 12 to 13 weeks, in line with the intended service model. However, completion rates of The Way Back could be improved. While most participants (59 per cent) completed their service episode, 41 per cent of participants did not complete their service episode (this was above the completion rates outlined in the literature which references approximately a 30 per cent non completion rate). Further, there is an opportunity to better understand why non-completion rates were higher across certain cohorts (i.e. males, people with alcohol and other drugs support needs, and people under 25 years of age). In contrast, participants were more likely to complete their service episode and engage with the service longer for 12 weeks if they had peer support and/or safety/support plans in place. This indicates that access to peer support as part of the core model is an important component to effectively engaging with participants in The Way Back.

Referrals out to services and supports. Importantly, the effectiveness of The Way Back to connect participants with services that met their needs was constrained by the quality and capacity of the service system in which it operated in some areas (more so in regional than metropolitan areas). The variety of outbound referrals from The Way Back reflected the service objective to connect participants to relevant services based on their assessed needs.

Participant satisfaction. The Way Back is positive experience for participants with almost all respondents (93 per cent) from a participant survey indicating that they were either satisfied or very satisfied with the service. Suggested improvements to The Way Back were often related to expanding the scope of the service’s original purpose significantly beyond that of an aftercare service - namely providing some participants with the option to stay in the service longer than 12 weeks.

KEQ 2 is further answered in section 5 and section 9.

DATA SOURCES, QUALITY AND LIMITATIONS This section draws on PMHC MDS data, referral dashboard data, quarterly report data and supplementary referral data.

Analysis of inbound referrals, service uptake and service delivery cannot be directly compared against one another as they relate to different time periods and data collection methods as outlined below:

- **Inbound referrals.** Quarterly report data was used and covers the period from March 2021 to June 2022.
- **Service uptake.** Supplementary data was used and covers dates between July 2021 and June 2022. It did not cover each in-scope site in each quarter.
- **Service delivery.** PMHC MDS data was used to understand outbound referrals from The Way Back, episode length, and episode completion rates. This section also refers to responses (n=59) of a survey of members of Blue Voices and/or Roses Ocean (BVRITO) who have lived experience of suicide. 88 per cent of respondents had no previous engagement with The Way Back. The survey respondents may not be representative of The Way Back participants. Responses from a participant survey (n=79) was also used to understand participant experiences of The Way Back. This may not be representative of all experiences of participants who accessed The Way Back.

The quantitative data was supplemented with qualitative data from interviews with participants, referring health providers and service provider staff.

Refer to Appendix B for detailed limitations.

The participant journey from entry to exit of The Way Back was understood across referral, uptake, and service delivery.

For the purpose of this report, the evaluation has defined the participant journey across three stages at which referred persons engaged (or not) with The Way Back:

- Inbound referrals - receiving a referral into the service
- Referral uptake - accepting a referral (or not)
- Service delivery – engaging with the service (if they accept the referral).

Figure 10 overleaf provides insights on service use across these three stages. Each is then explored in more detail in following sections.

Figure 10 | Snapshot of service use from referral to exit

INBOUND REFERRAL

42%
Public hospital

36%
Public mental health service

13%
Emergency Department

4%
Self-referral

1.5%
Community organisation/ health centre

0.8%
GP

3%
Other/not stated

Based on PMHC MDS data between July 2018 and September 2022

1

17,477
referrals into The Way Back between January 2019 and March 2022

52% primary criteria

41% secondary criteria

7% of inbound referral data do not state or inadequately describe eligibility criteria.

Based on The Way Back Dashboards Data and PMHC MDS data between July 2018 and September 2022

SERVICE UPTAKE

2

79%
of referrals consent to **engage with The Way Back**

16% of referrals **do not consent** (despite being eligible)

5% are **ineligible**

Of those who do not consent, 13% are supported by family, friends or other services and 7% do not want support or think the service is 'not for right now'. Most people who decline The Way Back do not provide a reason or cannot be contacted (78%).

Based on supplementary data between July 2021 and June 2022

SERVICE DELIVERY

3

Most common referrals were to
Physical health services - 26%
Psychiatric or mental health services (19%)
Community or peer support groups (18%)[1]

40%
of participants **exit** The Way Back by 12 weeks[1]

Participants who are from regional or remote areas, or are under 25, or are male are **more likely to leave prior to 12 weeks**

5

59%
of participants **complete** their service episode[1]

Participants who receive peer support, or complete a safety/support plan **are more likely to complete their service episode.**

6

94%
of surveyed participants were either satisfied or very satisfied with the service[2]

1. Based on PMHC MDS data between July 2018 and September 2022
2. Based on responses from a participant survey between June 2021 and June 2022.

6.1 Inbound referrals

Most participants (91 per cent) were referred via a public hospital or mental health service – this aligns with the service model.

Most participants who consented to a referral were referred by a public hospital or public mental health service (77 per cent or 6,793 participants).[62] A further 13 per cent were referred through the emergency department.[63] This aligns with The Way Back's service model to connect with those at most risk of suicide and require timely support (i.e. typically those presenting at a hospital, or emergency department). The remaining 9 per cent of participants were referred from other sources, including self-referred, (4 per cent) referred through a GP, (less than 1 per cent) or by a community organisation (1.5 per cent).[64] It should be noted that the core service model did not allow for participants to self-refer into The Way Back.[65] There was no information available to the evaluation to understand under what circumstances or how self-referrals occurred. It is hypothesised that providers accepted participants who requested support directly as it would be inappropriate to turn away someone who was experiencing a suicidal crisis and was seeking support.

Overall, 51 per cent of participants who accepted a referral (4,725 participants) were referred based on the primary eligibility criteria and 49 per cent were referred based on the secondary criteria (4,503 participants).[66] This varies significantly across sites; for example, 97 per cent of people were referred based on the primary eligibility criteria in Cairns, compared to 29 per cent in Western Sydney. Consultations with providers highlighted that this likely reflects the prioritisation of referrals based on eligibility criteria to manage demand (as outlined in section 5.2) though most sites did not identify a defined approach to prioritisation of entry criteria.

There is an opportunity to expand referral pathways to improve people's access to The Way Back.

While the distribution of referral sources was reasonably consistent across most sites, many participants, providers and referring health organisations in consultations noted there may be value in having other referral pathways, such as crisis hotlines, to enable better access and reach to The Way Back. Providers and participants highlighted that this would improve accessibility of The Way Back for specific cohorts (for example Aboriginal and Torres Strait Islander people) who would not typically access public hospitals or emergency departments during a suicidal crisis. The evaluation recommends that The Way Back expand inbound referral pathways (see section 10.1, recommendation 1).

---

[62] Quarterly report data from March 2021 to June 2022
[63] Quarterly report data from March 2021 to June 2022
[64] Quarterly report data from March 2021 to June 2022
[65] Or for family, friends or carers to make referrals to The Way Back.
[66] Quarterly report data from March 2021 to June 2022

6.2 Service uptake

Uptake of referrals to The Way Back exceeded the uptake of aftercare rates identified by the Productivity Commission but were less than those reported in the Hunter Evaluation.

Seventy-nine per cent of those referred to The Way Back consented to participate in the service (based on a sample of supplementary data between June 2021 and July 2022.[67] This was similar to the uptake rates reported for suicide aftercare services in the Hunter Evaluation (81 per cent)[68] and higher than those stated by the *Productivity Commission Inquiry*, which reported that half of the people offered aftercare take it up.[69]

Most people who declined the service did not provide a reason why or could not be contacted.

Sixteen per cent of people who were referred did not consent to participate in The Way Back despite being eligible.[70] Of those who declined to participate in The Way Back:

- 78 per cent did not provide a reason for declining the referral or could not be contacted (n=1,961).
- 13 per cent reported that they had sufficient support from family, friends or other services (n=316).
- 7 per cent did not want support or thought the service was 'not for right now' (n=178).[71]

Providers and referring health organisations provided further hypotheses as to why some people may decline a referral. These included because:

- They already had trusted or sufficient supports within the community.
- They were distressed at the time of assessment by the acute care team or became 'embarrassed' and withdrew from engaging with their referral to The Way Back (for example, if an attempt was made while under the influence of drugs or alcohol).
- They identified specific characteristics or needs that were better addressed through other services (such as targeted programs for young people experiencing gender dysphoria).
- They experienced lengthy or stigmatising referral and consent processes/forms/safety planning at the hospital, or stigma associated with referral through an involuntary treatment setting.

Inbound referrals were reportedly more successful (i.e., result in uptake) if participants understood how The Way Back could benefit them, in consideration of their personal circumstances (based on provider and referral health service consultations).

---

[67] For additional detail on data limitations and quantitative methodology see Appendix B. Note that Quarterly report data for Q4 2021 indicates a higher uptake rate of eighty-two percent.

[68] University of Newcastle, 'The NSW Way Back Support Service (Hunter): Process & Effectiveness Outcomes Evaluation Report', October 2019, p.53.

[69] Productivity Commission. 2020. Productivity Commission Inquiry Report: Volume 2. No 95, 30 June 2020.

[70] Based on a sample of supplementary data between July 2021 and June 2022

[71] Based on analysis of supplementary data July 2021 to June 2022

6.3 Service delivery

Most participants (59 per cent) completed their service episode (that is, they exited from The Way Back via a planned service discharge on completion), though these rates were lower than non-completion rates identified in the literature (70 per cent).

PMHC MDS data on the 27 in-scope sites indicated that most participants (4,524 or 59 per cent of closed episodes) completed their service episode as planned.

Analysis of PMHC MDS data between January 2019 and September 2022 found that 41 per cent (3,215) of participants did not complete their service episode. 'Did not complete' refers to participants whose service episodes were closed for administrative reasons such as the participant being uncontactable or moving out of the area. This non-completion rate aligned with providers in consultations experience when working with participants. This non-completion rate is slightly higher than the non-completion rates identified in the literature on suicide follow up services (which referenced approximately a 30 per cent non-completion rate).[72]

PMHC MDS data showed that there was no clear 'exit point' for participants who did not complete their service episode. Providers and participants in interviews reported participants that exited early from the service typically may:

- not have fully understood the purpose of the service until they have met with their support coordinator
- felt like they did not need this service
- felt like they had not connected well and built trust with their support coordinator.

For those who did complete their service episode, the average time in the service was between 12 to 13 weeks, in accordance with the specifics of the model of service.

For participants who completed a service episode, most were engaged with The Way Back for between 12 to13 weeks.[73] This aligns to the intended service model of a 12-week service period. Participants were more likely to stay in the service for longer if a safety and support plan was completed, or where they had access to peer support[74] (based on a representative sample of PMHC MDS data).[75]

The proportion of participants who exited the service prior to twelve weeks was 40 per cent, though this varied substantially across sites ranging from 11 per cent to 63 per cent.[76] Consultations with providers indicated that participants who exit the service prior to 12 weeks may not exit for 'negative' reasons. Reported reasons from consultations with participants included:

---

[72] The SAX Institute for the Minister of Health NSW, 'Evidence Check - Suicide aftercare services', October 2019, p29.

[73] Based on analysis (generalised linear mixed-effects model) of PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and February 2022

[74] For this evaluation, a participant is deemed to have access to peer support when their service episode includes a contact with a peer support worker contained within the Murrumbidgee site that is recorded in PMHC MDS data.

[75] Based on analysis of PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and February 2022

[76] Based on analysis of PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and February 2022

- they were on track with their recovery and/or were well connected into supports and no longer required The Way Back.
- they did not have time to continue accessing The Way Back due re-commencing full-time work, family and/or carer commitments or the travel time required, especially for participants in regional/remote areas.
- the service was not right for them at that time (for example they needed to be in a 'recovery mindset', other social factors impacting their ability to participate).
- they did not establish a therapeutic relationship with their support coordinator.[77]

> *"I was involved for about 8 – 9 weeks. I exited the service early because I thought I was alright." - The Way Back participant*

The proportion of participants who were engaged for longer than 12 weeks was 60 per cent (n=2,702). Participants and providers in consultations reported that this may be because they were:

- Not connected with long term community support, so The Way Back 'held' them for longer.
- At risk of re-attempting suicide at twelve weeks. Staying longer in the service minimised this risk.

There was limited quantitative data to identify the average number of sessions per participant episode. Anecdotally, participants and providers reported that participants were on average provided with one session per week across 12 weeks. The number and length of sessions were adjusted depending on the participant's needs.

Participants who received peer support, and participants with a safety/support plan were more likely to complete their service episode and stay in the service for longer than 12 weeks.

Based on analysis of PMHC MDS data,[78] participants were more likely to engage with The Way Back for longer than 12 weeks if:

- They received peer support.
- They completed a safety and support plan.

This aligns to findings from The Way Back Support Service Peer Support Trial.[79] Further detail in this trial is outlined below.

KEY FINDINGS FROM THE WAY BACK SUPPORT SERVICE PEER SUPPORT TRIAL EVALUATION

Nous Group was engaged by Beyond Blue to evaluate the Peer Support trial at the Murrumbidgee site between September 2020 and October 2021. There was limited qualitative and quantitative data available for this to draw broad conclusions about the effectiveness of the peer support model. However, analysis of the PMHC MDS data from July 2018 to September 2022 found that participants with peer support:

- complete their service episodes than those who did not have peer support.
- stayed in the service for longer than participants who do not have peer support.

Limited qualitative data from interviews highlighted that participant appeared to be satisfied with their peer support as an additional service to the core service model.

One possible reason for why peer support influenced participants' experience with The Way Back was that it enabled them to establish a strong therapeutic alliance with the support coordinator which supported

---

[77] Based on interviews with providers and participants, free text survey responses and quarterly reports.
[78] Based on analysis of PMHC MDS data for 27 in-scope sites between July 2018 to September 2022
[79] Nous Group (2021). The Way Back Support Service Peer Support Trial Evaluation, Final Report.

their recovery (see further detail the role of therapeutic alliance in The Way Back in section 8.1). Respondents to a participant survey highlighted the importance of connecting with someone with lived experience. They indicated that having a support coordinator with lived experience of suicidality was an important contributor to their recovery as they felt the support coordinator was able to better understand them.

There was no information available to the evaluation to understand other reasons why participants with safety plans, support plans or both were more likely to complete their service episode or stayed longer in the service. Overall, there is an opportunity to further collect evidence to determine whether peer support should be included as part of the core The Way Back service model (see section 10.1, recommendation 6).

Males, participants aged under twenty-five, and people with alcohol and other drug support needs were less likely to complete their service episode than others.

Cohorts who were **less likely** to complete their service episode based on analysis of the PMHC MDS included:

- Participants under 25 years of age compared to participants aged between 25 and 65 years of age.
- Participants who have alcohol and other drug support needs.
- Participants who identified as male compared to participants who identified as female.[80]

There was no information available to the evaluation about why these cohorts were less likely to complete their service episode. It is hypothesised that The Way Back did not adequately cater to the needs of younger and older people and did not identify or address the supports of people with alcohol and other drug support needs. Further investigation is required to understand why certain cohorts were less likely to complete their service episode (see section 10.1, recommendation 5).

The variety of services participants were referred out to from The Way Back reflected the service objective to connect participants to relevant services based on their assessed needs.

Figure 11 shows the proportion of service episodes that involved a referral out to an external service and support (based on PMHC MDS data from July 2018 to September 2022). It shows that:

- 26 per cent of episodes involved a referral to a GP, community health provider or private practice.
- 19 per cent of episodes involved a referral to a psychiatric or mental health service.
- Participants were less likely to be referred to Centrelink or employment services, financial or legal supports, family support services and housing or homelessness services.

The proportion of referrals out to housing and homelessness services (4 per cent) aligns to the demographic data that indicates about 5 per cent of participants were experiencing housing issues. This reflects the experiences of participants who engaged in interviews. While some participants were able to access longer-term housing support through The Way Back, other participants noted ongoing difficulties with accessing housing support, even with the assistance from the support coordinator. The proportion of episodes involving a referral to a particular provider type roughly matches the proportion of participants with needs indicated on their initial assessment:[81]

- 21 per cent of episodes had a physical health condition (26 per cent referred to physical health services).

---

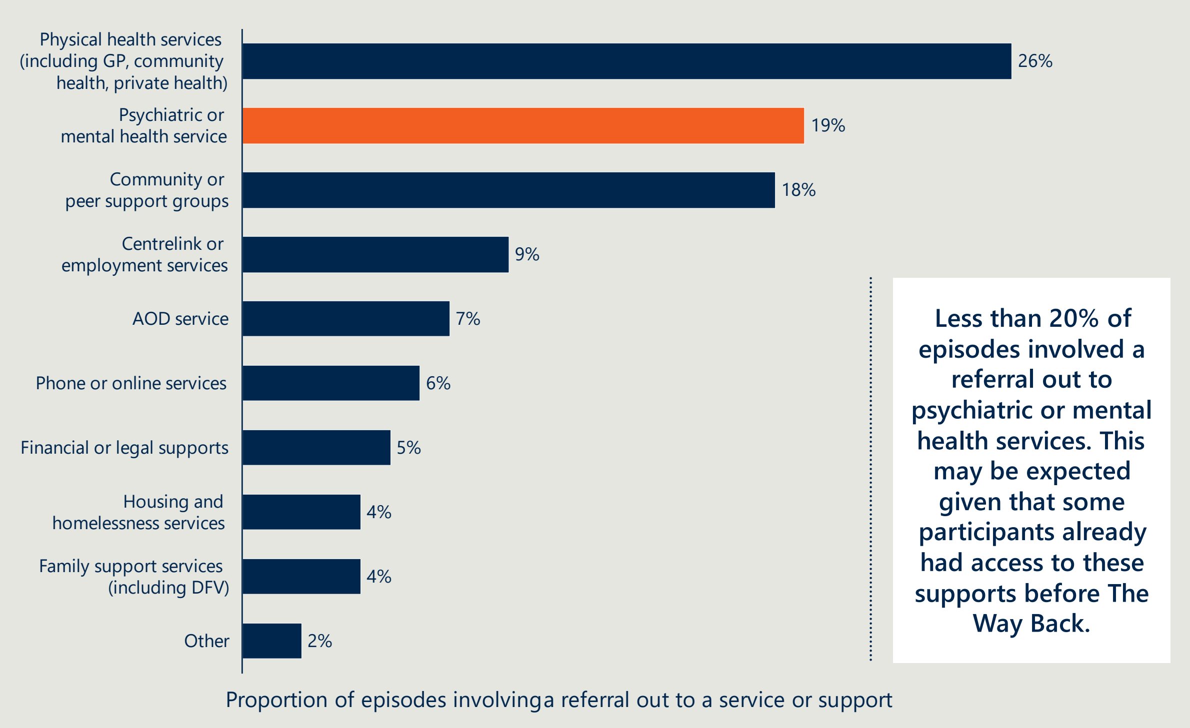
[80] Based on analysis (generalised linear mixed-effects model) of PMHC MDS data for 27 in-scope sites between July 2018 to September 2022.

[81] Based on analysis of PMHC MDS for 27 in-scope sites between July 2018 and September 2022.

- 19 per cent of episodes needed social support/sense of belonging (18 per cent referred to community or peer support services).
- 15 per cent had financial problems (9 per cent referred to Centrelink, employment, financial or legal services).
- 10 per cent had drug/alcohol issues (7 per cent referred to AOD services).

The proportion of episodes where the initial assessment included a self-reported diagnosed mental health condition (35 per cent), was higher than the proportion of episodes where participants were referred to a psychiatric or mental health service (18 per cent). Consultations with providers indicated that the limited number of services available in the local area created difficulties at times to connect participants with services that meet their needs. Alternatively, a lower proportion of referrals may exist as participants were already connected with these types of supports before accessing The Way Back.

Figure 11 | Proportion of episodes involving a referral to a particular provider type[82]



Less than 20% of episodes involved a referral out to psychiatric or mental health services. This may be expected given that some participants already had access to these supports before The Way Back.

The evaluation conducted a survey of members of Blue Voices and Roses in the Ocean (BV/RITO) to gain insights from lived experience and what matters for long-term recovery and resilience for people who have made who experienced suicidality.[83] Of the 59 members who responded to the survey, 88 per cent of respondents had no previous engagement of with The Way Back. As such, insights from this survey cannot be directly attributed to the experiences of The Way Back participants. Further detail on the survey methodology is provided in Appendix B. Respondents to the online survey selected similar services to those accessed by participants of The Way Back after a suicidal crisis or attempt. Of the services accessed (noting that participants could select more than one option):

- 83 per cent (n=49) of respondents accessed mental health services (for example, a psychologist or counsellor).

---

[82] Based on analysis of PMHC MDS for 27 in-scope sites between July 2018 and September 2022. It should be noted that there was very limited data recorded in the PMHC MDS on the number of referrals out to services and supported for some sites.

[83] Most survey respondents (95 per cent) had lived experience of suicidality. Survey respondents (n= 59) reported that their motivation for becoming a BVRITO member (noting they could select more than one option) was that they were bereaved from suicide (16 selections 27 per cent); experienced suicidal thoughts, crisis and/or attempted suicide (56 selections or 95 per cent), and/or supported someone who has experienced suicidal thoughts, crisis and/or attempt (26 selections or 44 per cent).

- 59 per cent (n=35) of respondents accessed physical health services (for example a GP).
- 53 per cent (n=31) of respondents accessed support from family, friends, or community.

This may explain the higher proportion of BVRITO respondents who accessed mental health services compared to the proportion of participants in The Way Back.

The effectiveness of The Way Back to refer and connect participants with clinical and psychosocial support services was constrained by the quality and capacity of the service system in which it operated in some areas (more so in regional than metropolitan areas).

Referrals from The Way Back to other service providers varied across jurisdictions. For example, 61 per cent of episodes in New South Wales involved a referral out to other services and supports compared to only 21 per cent in the Australian Capital Territory.[84] This may reflect the needs and demographics of participants in different geographical areas (for example, due to social determinants), the availability of services in the different geographical areas, and/or differences in data collection across sites. The effectiveness of outward referrals from The Way Back were further highlighted in consultations with participants:

- Most participants reported that they felt they had input and control over the referrals to other services they received and that their support coordinators were responsive to their needs and preferences.
- Some participants emphasised the importance of the support coordinator clearly communicating the role of the service they were being referred to. They also expressed appreciation for information from the support coordinator regarding the status of referrals and updates on when they could expect to hear back from the referrals (for example, if there were waitlists and how long they could expect to wait).
- Participants, providers and referring health services noted that The Way Back was limited in its ability to provide effective outward referrals by the availability, quality and capacity of the service system in which it operates. For example, participants in Darwin reported access to housing was a key area of their recovery but noted that The Way Back was not always able to effectively address these needs due to the high demand for housing services in the area and lack of available services.

The vast majority of participants surveyed were satisfied with The Way Back, mostly driven by their relationship with their support coordinator.

> *"I was one-hundred per cent satisfied. I'm inspired to help other people. I've considered taking up other courses so that I can help others. I imagine it would be very fulfilling to help someone else in this role." - The Way Back participant*

Ninety-three per cent of respondents to a survey of The Way Back participants reported that they were either very satisfied (74 per cent or 59 respondents) or satisfied (19 per cent or 15 respondents) with the service.[85]

Figure 12Figure 12 shows the factors that contributed to participants' satisfaction with The Way Back. Most survey respondents (83 per cent or 66 respondents) indicated that their relationship with the support coordinator was most likely to contribute to their satisfaction with the service. Conversely, a small proportion of respondents (39 per cent or 30 respondents) reported that their satisfaction with The Way Back was because it connected them with family or community. The free text responses from the participant survey

---

[84] Based on analysis of PMHC MDS for 27 in-scope sites between July 2018 and September 2022

[85] Based on responses to an online survey of The Way Back participants that was open from June 2021 to June 2022 (n= 79).

reinforced the importance of the relationship between participants and their support coordinator. Many respondents highlighted that the following elements of the relationship were particularly important:

- Participants felt safe and comfortable to talk about their experiences of suicidality.
- Support coordinators genuinely cared, were empathetic and non-judgemental.
- Support coordinators were truly able to understand the participants' experiences due to their own lived experience of suicidality.
- Participants felt listened to and heard by their support coordinators.

Figure 12 | Factors influencing participant satisfaction with The Way Back[86]

FACTORS INFLUENCING PARTICIPATION SATISFACTION*

*Note, respondents could select multiple response options

Relationship with support coordinator	83%
Information and advice support coordinator provided	73%
Amount of time spent with support coordinator	67%
Way that The Way Back helped participant understand mental health and personal situation	52%
Ability to connect with other services easily through The Way Back	38%
Way that The Way Back connected participant with family and community	23%

Participants were most likely dissatisfied with The Way Back if the relationship with their support coordinator was compromised or lost.

Based on qualitative responses to a survey of The Way Back participants,[87] and consultations with The Way Back participants, there were several reasons for why they were dissatisfied with service. Common reasons were:

- Not being able to contact their support coordinator when they needed.
- Not having a choice about where or how to meet (for example, having to meet virtually or the support coordinator insisting on meeting at their home or whilst they were still in an inpatient unit at hospital).
- Not having their requests for outbound referrals followed-up.

---

[86] Based on responses to a survey of The Way Back participants conducted between June 2021 and June 2022 (n= 79). Further detail on the survey methodology is provided in Appendix B.

[87] Responses based on an online survey of The Way Back Participants conducted between June 2021 and June 2022 (n=79). Seven per cent or five respondents were not satisfied or very satisfied with the service.

- Limited discussion prior to exiting the service. A small number of participants indicated there was no or limited discussion about their engagement with The Way Back ending prior to the service ceasing.
- Cultural and/or language barriers with their support coordinator. A small number of participants indicated they found it difficult to engage due to cultural and language differences.

These reasons highlight that the relationship between the participant and the support coordinator as foundational to participants remaining engagement and experience with the service. This is explored in further detail in section 8.1.

Participants identified opportunities to improve The Way Back service model, though these would expand the scope of the service's original purpose significantly beyond that of an aftercare service.

The evaluation identified three common opportunities to improve The Way Back's current service delivery model, informed by responses to the participant survey,[88] and interviews with The Way Back participants.

- **Providing some participants with the option to access the service for longer than 12 weeks.** Some participants reported that they would have benefited from being able to access continued emotional support, and service navigation (for example, for up to six months). Analysis of PMHC MDS found that improvements to participant outcomes that engaged with the service for longer than 12 weeks did not significantly differ to the average participant (see section 7.2).
- **Accessing The Way Back after a suicidal crisis or attempt via alternative means than a hospital**. Some participants indicated that more people who have a suicidal crisis or attempt could benefit from what is offered in aftercare if they could be referred via other services (other than EDs or community mental health teams).
- **Having access to the supports The Way Back offered before they reached a suicidal crisis**. It was frustrating that they had to reach a crisis point before they could access a service like The Way Back.

It is worth noting that expanding inbound referral pathways or broadening eligibility criteria to make the service available to people before the point of crisis would be a fundamental change to the purpose and intent of the service (as a dedicated aftercare service) and indeed constitute a new model of mental health or crisis support service. This suggests a broader service system issue as a gap in mental health and/or crisis support services relative to needs.

---

[88] Responses based on an online survey of The Way Back Participants conducted between June 2021 and June 2022 (n=79)

7 Participant outcomes

This section contributes to answering KEQ 3 | What is changing for whom, in The Way Back?

Participants' suicidal ideation, psychological distress and mental wellbeing significantly improved during their engagement with The Way Back. Analysis of changes to participant scores relating to these outcomes (SIDAS, K10 and WHO-5 respectively) between the start and the end of their engagement showed that participants of The Way Back experienced a:

- 63 per cent reduction in suicidal ideation
- 28 per cent reduction in psychological distress
- 86 per cent improvement in wellbeing.

Participants in interviews also reported improved outcomes during their time with The Way Back and this improvement was sustained four-months post-service exit. Participants also highlighted that support coordinators enabled them to engage with supports through outbound referrals.

Length of engagement (i.e. participants who engaged with the service for longer than 12 weeks) and local site contexts did not appear to impact on changes to participant outcomes.

The Way Back's contribution to participant outcomes differs across cohorts of interest to The Way Back and the evaluation. Participants who identified as Aboriginal and Torres Strait Islander (for suicidality), and from regional and remote locations (for suicidality and psychological distress) experience a significantly greater improvement in outcomes than the average. In contrast, outcomes for psychological distress, and wellbeing for participants diagnosed with a personality disorder improved, however their improvements were significantly less than experienced by the average participant.

There are opportunities to improve how outcomes data is collected and measured in The Way Back. Issues identified included:

- Participants and providers noted that K10, SIDAS, and WHO5 outcome measures were often perceived as clinical in nature, and not appropriate for a psychosocial service like The Way Back.
- Outcomes measures were not consistently and comprehensively collected across sites.

There was very limited data available to the evaluation to discern whether outcomes were changing for family, friends or carers of people who were participants of The Way Back.

DATA QUALITY AND LIMITATIONS IN THIS SECTION

This section outlines the extent to which participants are achieving these outcomes and goals, based on analysis of PMHC MDS data for the 27 in-scope sites, responses to the participant survey and interviews with participants at the eight deep dive sites.

Participant outcomes were measured using three validated outcome measurement tools that examine the severity of suicidal ideation(SIDAS), psychological distress (K10) and wellbeing (WHO-5). The evaluation also drew from interviews with participants to understand the change in outcomes during their time with The Way Back. It is important to consider the following limitations to the data:

- **Positive bias**. The eligibility criteria for interview participants required participants to have *completed* the service within the last four months and to be in a safe mental disposition to participate. As such, the sample of participants who were eligible and self-selected to participate in the interviews may have been biased toward those who had positive or relatively more positive experiences with The Way Back. This is likely exacerbated by the necessary requirement that interview participants had to be in a safe mental disposition.
- **Limited sample size.** Only a small proportion of episodes recorded in the PMHC MDS have completed outcome measures recorded at beginning and end of episode to measure change in outcomes over time. Twenty-two per cent of episodes have a matched pair recorded for the K10 (n=1,933), 17 per cent for the WHO-5 (n=1,514) and 19 per cent for the SIDAS (n=1,675). However, descriptive analysis of the cohort of participants with matched pairs indicates the sample is representative of the broader PMHC MDS sample and therefore a valid representation of The Way Back participants.
- **Incomplete outcomes data.** There was very limited data available for participants who did not complete their service period (and therefore complete outcomes assessments). There is an opportunity to improve how the consistency and completeness of information is captured in the future for those who do not complete their service period (see section 10.1, recommendation 14).
- **Suitability of outcome measures across participant cohorts.** Evidence suggests that the empirical outcome measures adopted by The Way Back (particularly SIDAS and WHO-5, as the K5 is offered to Aboriginal and Torres Strait Islander participants, as an alternative to the K10) may not be the most appropriate and sensitive measures for all population cohorts such as Aboriginal and Torres Strait Islander people[89]. The evaluation also heard from providers anecdotally that Aboriginal and Torres Strait Islander people are more likely to experience gratuitous concurrence[90] and the outcome measures reported may not be a true reflection of outcomes for some participants. There is an opportunity to improve the appropriateness of outcomes data captured for participants of The Way Back (see section 10.1, recommendation 15).

---

[89] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. (2022). Best practice screening and assessment: Mental health assessment. Retrieved from: https://cbpatsisp.com.au/clearing-house/best-practice-screening-assessment/mental-health-assessment; note that The Way Back also adopted the K5 as an alternative measure used to measure outcomes for Aboriginal and Torres Strait Islander people.

[90] A Lowell. (1998). 'Communication in Aboriginal health care; an overview,' Cooperative Research Centre for Aboriginal and Tropical Health.

7.1 Overall participant outcomes

Three outcome measures were used to understand changes in participant outcomes at the beginning and end of their service episodes.

The three outcome measures used by The Way Back were:

- **Severity of suicidal ideation**. The Suicidal Ideation Attribution Scale (SIDAS)[91] was used to measure participants' suicidal ideation at entry, review and exit. The SIDAS has a maximum score of 50, with those scoring ≥21 considered at high risk of suicidal behaviour.
- **Psychological distress**. Kessler Psychological Distress Scale (K10)[92] was used to measure participants' psychological distress based on self-reported levels of nervousness, agitation, psychological fatigue and depression over the previous month. The K10 has a maximum score of 50, with scores ≥ 30 indicating a high likelihood of experiencing a mood disorder (for example, anxiety and/or depression).
- **Wellbeing.** World Health Organisation – Five Wellbeing Index (WHO-5)[93] was used to measure participants' current mental wellbeing. The scale has a maximum raw score of 25 with higher scores representing better wellbeing.

The evaluation analysed the average change in outcomes for participants with a recorded 'matched pair' in the PMHC MDS. A 'matched pair' is when a participant has scores recorded for an outcome measure at both the beginning and at the completion of a service episode. Interviews with participants also provided insights on the extent to which The Way Back improved their circumstances and contributed to their recovery.

Cohen's *d* was used to understand the average magnitude of changes (i.e. effect size) experienced by participants across the outcome measures. A Cohen's *d* score greater than 0.8 is generally considered to indicate a program had a large contribution to changes in outcomes.[94]

Overall, participants' suicidal ideation, psychological distress, and mental wellbeing significantly improved during their engagement with The Way Back.

Figure 13 shows that between the start and the end of their service episode, participants experienced a significant improvement in their outcomes scores for SIDAS (suicidal ideation), K10 (psychological distress) and WHO-5 (mental wellbeing).

---

[91] The SIDAS is designed to screen individuals in the community for presence of suicidal thoughts and assess the severity of these thoughts. It consists of five items, each targeting an attribute of suicidal thoughts: frequency, controllability, closeness to attempt, level of distress associated with the thoughts and impact on daily functioning. Responses are measured on a 10-point scale. Items are coded so that a higher total score reflects more severe suicidal thoughts.

[92] The K10 is widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. The K10 uses a five value response option for each question – all of the time, most of the time, some of the time, a little of the time and none of the time which can be scored from five through to one. The maximum score is 50 indicating severe distress, the minimum score is 10 indicating no distress.

[93] The WHO-5 is a short self-reported measure of current mental wellbeing. The WHO-5 has been found to have adequate validity in screening for depression and in measuring outcomes in clinical trials.

[94] J Cohen, 'Statistical power analysis for the behavioural sciences,' Lawrence Erlbaum Associates. 1988.

Figure 13 | Average percentage change in outcomes scores for participants[95]

On average, participants of The Way Back experienced a significant (63 per cent) reduction in the severity of suicidal ideation at the end of their service period.

Participants of The Way Back experienced a 63 per cent reduction in the severity of suicidal ideation, as measured by SIDAS, by the end of their service period, as shown in Figure 14.[96] Analysis of the PMHC MDS data showed that participants had a mean score of 29.3 out of 50 at the start of their service period and 10.8 out of 50 at the end of the service period, reflecting an average decrease of 18.5 points across the 1,689 episodes where there was a matched pair of scores on the SIDAS. This represents a substantial reduction in participants' suicidal ideation during their service period, with a large effect size (Cohen's d = -1.275).[97]

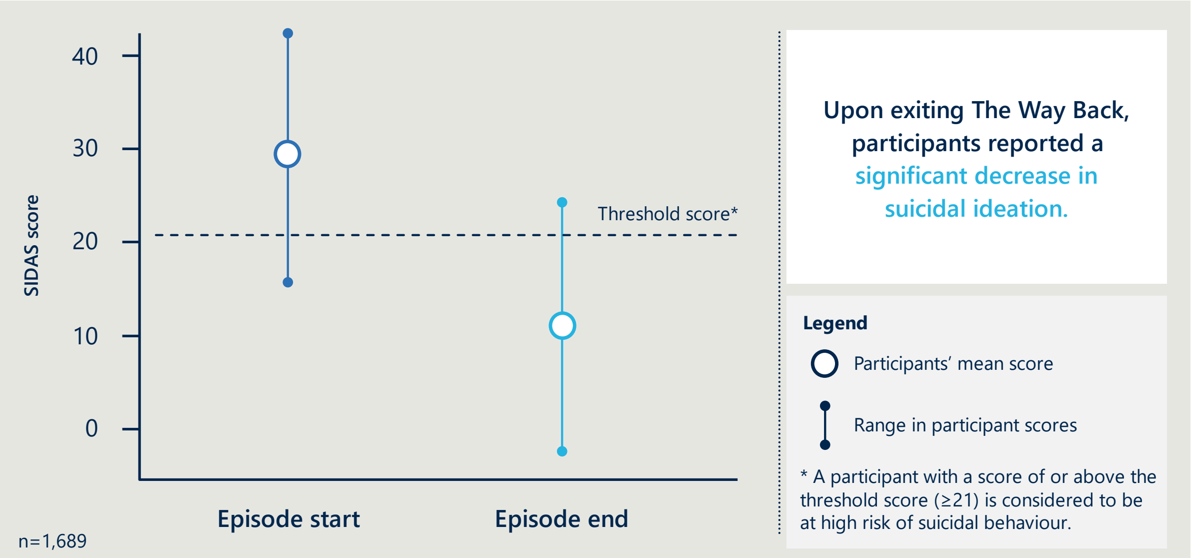
Twenty-two per cent of participants received a score of more than or equal to 21 (i.e. at high risk of suicidal behaviour) at the end of their service episode. Two per cent (n = 184) of active participants with a recorded service episode attempted suicide during their service period and 9 participants died by suicide during their service period. In contrast, the literature indicates that this can be compared to a non-fatal reattempt rate of 12 to 15 per cent in the first year after a suicide attempt with 75 per cent of these occurring in the first six months.[98]

The complex presentations and inconsistencies in definitions and reporting practices across different sites makes it challenging to robustly measure the prevalence of suicidality amongst participants, beyond the recorded SIDAS assessments. Much of the existing evidence base measures deaths by suicide and hospitalisations due to suicide attempt, with suicidal ideation outside of crisis incidents being challenging to measure.

---

[95] Based on analysis of PMHC MDS data between July 2018 and September 2022.
[96] Based on analysis PMHC MDS data between July 2018 and September 2022
[97] The change is considered statistically significant where $p<0.05$. Effect sizes are considered small at 0.2, medium at 0.5 and large at 0.8 as per standard definitions.
[98] Demesmaeker et al., 'Risk factors for reattempt and suicide within 6 months after an attempt in the French ALGOS Cohort,' Focus on Suicide. 2021.

Figure 14 | SIDAS scores at participants' first and last service contact, (i.e. matched pair scores) July 2018 to September 2022[99]



Upon exiting The Way Back, participants reported a significant decrease in suicidal ideation.

* A participant with a score of or above the threshold score (≥21) is considered to be at high risk of suicidal behaviour.

On average, participants experienced a significant reduction (28 per cent) in psychological distress at the end of their service period.

Participants of The Way Back experienced a 28 per cent reduction in psychological distress by the end of their service period, as shown in Figure 15, participants reported a mean score of 35.9 out of 50 at the start of their service period and 26.0 out of 50 at the end of the service period. Analysis of the PMHC MDS indicated participants reported an average decrease of 9.9 points across the 1,948 episodes where there was a matched pair of scores on the K10. This represents a substantial reduction in participants' psychological distress during their service period with a large effect size (Cohen's *d* = -1.11).[100]

> *"I was blaming myself for everything that was going wrong in my world, in my life. She led me to understand that I'm worth something." – The Way Back participant*

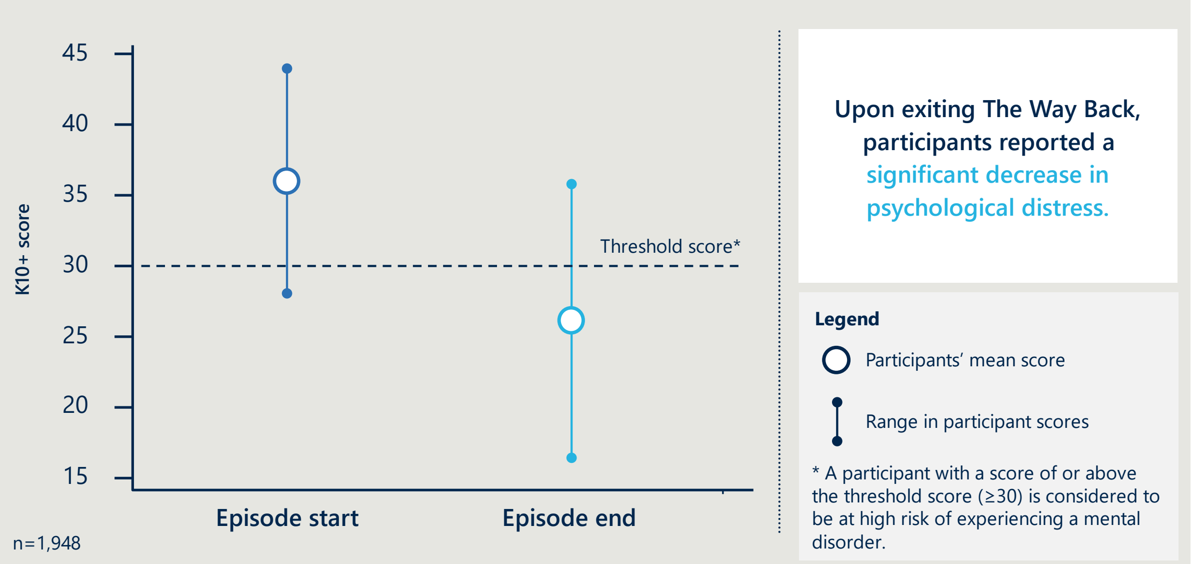
Aboriginal and Torres Strait Islander participants were offered K5 assessment as an alternative to the K10 score. The sample size of K5 matched pairs was smaller (n=48), but a statistically significant decrease was observed in mean score of 5.4, from 18.2 out of 25 at the start of participant's episodes to 12.8 out of 25 at the end of their episodes as shown in Figure 16. The effect size observed was large (Cohen's *d* = -0.958) but smaller than that observed for all participants with a matched pair of K10 scores (Cohen's *d* = -1.11).

---

[99] Data is based on PMHC MDS and The Way Back Extension data for 27 sites between September 2019 and February 2022.

[100] The change is considered statistically significant where p<0.05. Effect sizes are considered small at 0.2, medium at 0.5 and large at 0.8 as per standard definitions.

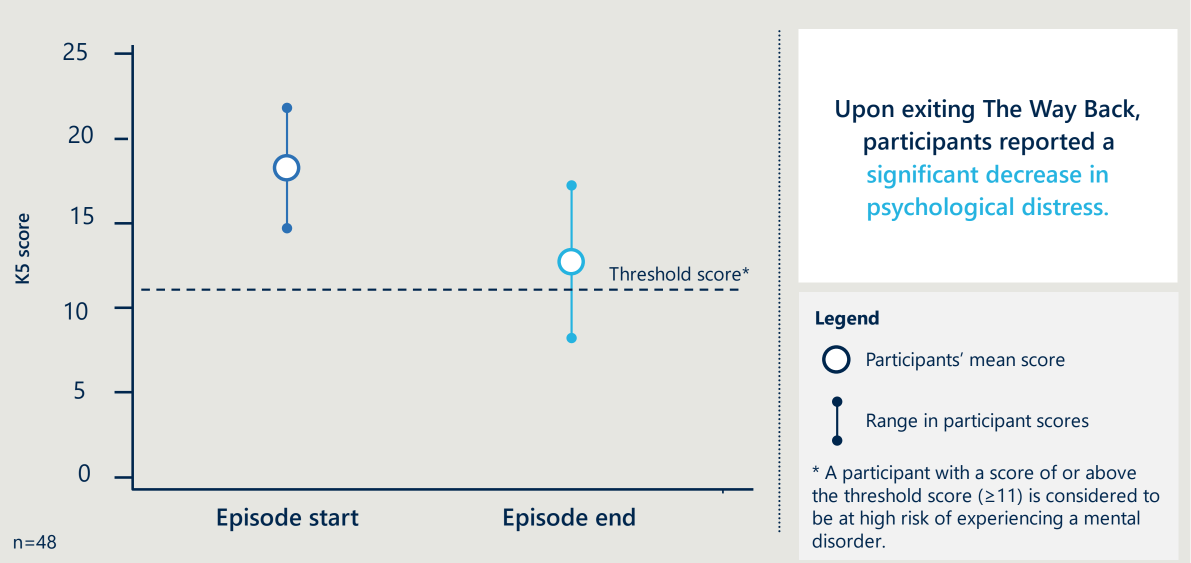
Figure 15 | K10 scores at first and last service contact, July 2018 to September 2022[101]



Upon exiting The Way Back, participants reported a significant decrease in psychological distress.

* A participant with a score of or above the threshold score (≥30) is considered to be at high risk of experiencing a mental disorder.

Figure 16 | K5 scores at first and last service contact, July 2018 to September 2022[102]



Upon exiting The Way Back, participants reported a significant decrease in psychological distress.

* A participant with a score of or above the threshold score (≥11) is considered to be at high risk of experiencing a mental disorder.

In interviews, many participants reported increased feelings of hope, purpose and belonging, including the realisation that they deserve and can access the support they need. Some participants also reported that The Way Back helped them to normalise their experience of suicidality and feel less shame around seeking help.

At the end of their service episode, 36 per cent of participants scored more than or equal to 30 for the K10 at the end of the service episode, indicating a high risk of experiencing a mental health disorder, and 61 per cent of participants scored more than or equal to 11[103] for the K5 at the end of the service

> *"I'm still getting 'me' back but with The Way Back I can be a better person. She said she was always there if I ever need to go back – I haven't yet, which is good, but good to know that the support is there." – The Way Back participant*

---

[101] Data is based on PMHC MDS and The Way Back Extension data for 27 sites between September 2019 and February 2022.

[102] Data is based on PMHC MDS and The Way Back Extension data for 27 sites between September 2019 and February 2022.

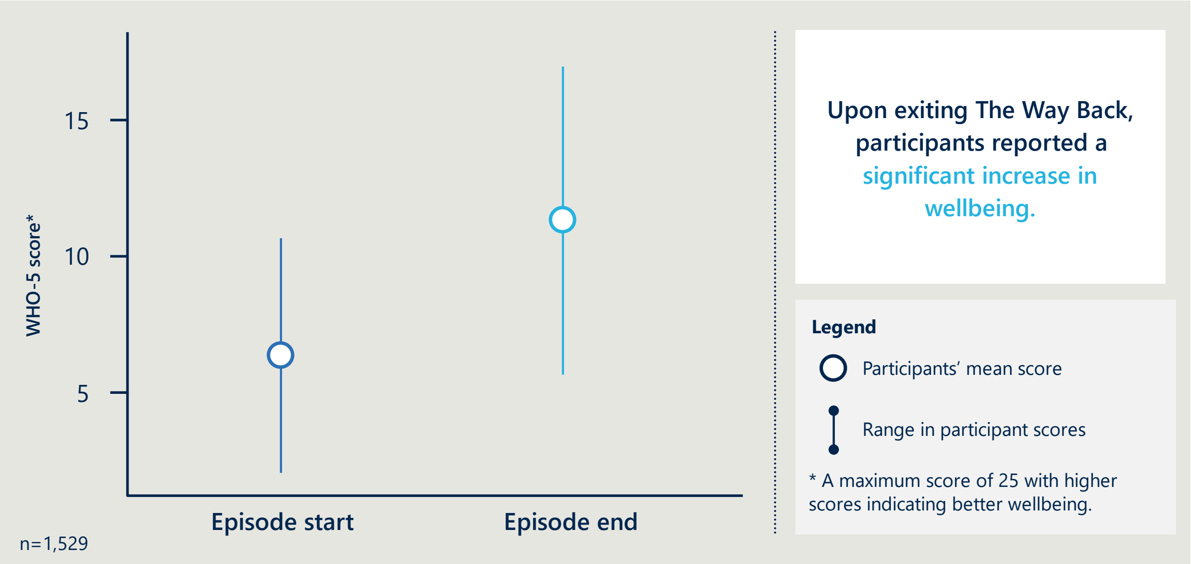
[103] Brinckley, MM., Calabria, B., Walker, J. et al. Reliability, validity, and clinical utility of a culturally modified Kessler scale (MK-K5) in the Aboriginal and Torres Strait Islander population. BMC Public Health 21, 1111 (2021). https://doi.org/10.1186/s12889-021-11138-4.

episode, indicating a high risk of experiencing a mental health disorder. This suggests that while on average, participants experienced significant improvements to their psychological distress, recovery from a suicidal crisis attempt continues beyond completing engagement with The Way Back. Many participants in interviews emphasised the non-linear nature of recovery from suicidal crisis or attempt. They acknowledged that while the significant distress they experienced at the time of their referral reduced during their service period, they would like to see longer term improvements in their emotional state. This highlights the important role of The Way Back in facilitating longer term improvements by referring participants to ongoing supports that continue after they finish their time with The Way Back.

On average, participants reported a substantial increase (86 per cent) in wellbeing at the end of their service period.

On average, participants of The Way Back experienced an 86 per cent increase in their wellbeing score by the end of their service period, as shown in Figure 17. Participants reported a mean score of 6.1 at the start of their service period and 11.4 at the end of the service period.[104] Analysis of the PMHC MDS indicated participants reported an average increase of 5.3 points across the 1,529 episodes where there was a matched pair of scores on the WHO-5. This represents a substantial improvement in participants' wellbeing during their service period with a large effect size (Cohen's d = 0.800).[105]

Figure 17 | WHO-5 scores at first and last service contact, July 2018 to September 2022[106]



Upon exiting The Way Back, participants reported a significant increase in wellbeing.

* A maximum score of 25 with higher scores indicating better wellbeing.

A number of participants reported in interviews that, while they still had 'bad days', they felt more equipped to manage these feelings of distress through a better understanding of the triggers for their mental health and/or their suicidality and the coping mechanisms that work for them.

Some participants reported in interviews that at the beginning of the service period, they felt reliant on their support coordinator to help them access other supports and manage their mental health. Many of these participants said that by the end of the service period they felt confident to reach out for help and coordinate many of their supports themselves. However, several participants reported that they continued to experience difficulty navigating the service system independently following their service period. They suggested that a longer service period with The Way Back or a transition to a lower intensity support service may have been helpful to further improve help-seeking behaviours. This highlights a broader

---

[104] Psychiatric Research Unit, WHO Collaborating Centre for Mental Health, Frederiksborg General Hospital, DK-3400 Hillerød; A ten per cent difference in score indicates a significant change in wellbeing however a raw score 13 indicates poor wellbeing and is an indication to test for depression under ICD-10.
[105] The change is considered statistically significant where $p<0.05$. Effect sizes are considered small at 0.2, medium at 0.5 and large at 0.8 as per standard definitions.
[106] Data is based on PMHC MDS and The Way Back Extension data for 27 sites between July 2018 and September 2022.

service system gap within the mental health in the availability of service navigation supports (as this is outside the scope of The Way Back; see section 7.3.

Participants who reported feeling empowered to engage with supports were more likely to report larger improvements in their wellbeing.

In interviews, most participants reported that referrals to other services were very helpful. This was particularly evident, where referrals made by support coordinators aligned with the participants' goals (for example to secure safe housing, to engage with clinical supports). Participants in interviews indicated that where clinical referrals were made and endorsed by their support coordinator, they felt more trusting of the service. Participants also highlighted that these referrals were an important contributor to their recovery and overall outcomes. Participants reported improved outcomes up to four-months post-service exit, which was the time limit to post-service engagements.

> *"She helped me realise that I am at risk. And when I am at risk, what the tools are to help me find my way back. It's given me a better chance to find my own direction nowadays even after the program end. We have tough days, but there are skills you can learn and things you can do that help you get through the day without being so severe." - The Way Back participant*

Interviews with participants indicated that many participants are still experiencing reduced suicidality up to four months post-service exit.[107] Participants also reported improvements in emotional state, wellbeing and resilience and strengthened protective factors including improved help seeking behaviours and awareness of suitable supports. In line with the program logic, these intermediate outcomes are linked to reduced suicidality as outlined in Appendix B. Data on longer-term outcomes for participants and prevalence of suicide re-attempts was not available.

Data on outcomes achieved for families and communities was extremely limited.

Support persons (n =2) and providers in interviews identified the importance of education around suicide and suicidal ideation for families and friends of people with lived experience of suicide and suicidal crisis.[108] Support persons also highlighted that The Way Back did not have a structured and consistent approach to offering support to support persons, but that this was an important element of a participant's recovery and should be considered further in the core service delivery model (see section 10.1, recommendation 7).

Participants of The Way Back in interviews reported variable outcomes in terms of improvements in their family members' understanding of their suicidality and how to respond. Some reported a greater capacity as individuals to communicate with family, peers and the broader community about their mental health triggers and needs. Others spoke about reduced stigma surrounding their mental health and suicidality in family and community contexts. Many participants in interviews reported that outcomes related to family and community were not relevant to their experience with The Way Back. This varied for participants who identified with a CALD background who recognised the instrumental role of The Way Back in helping them to reconnect with family and friends.

Some sites placed a greater focus on family and / or community involvement in The Way Back than others. For example, Murrumbidgee employed peer care companions and peer family companions to provide support to family members of those referred to The Way Back. Whilst this model did not demonstrate

---

[107] Only participants who had completed The Way Back within one to four months were eligible for an evaluation interview.

[108] It should be noted that given the very small sample of support persons interviewed for the evaluation, the themes identified may not be representative of all support persons who accessed The Way Back.

significantly different changes in outcomes for participants, [109] providers in interviews indicated that it was greatly valued as an important model element which acknowledges and offers support to participants and their families.

Participants who were engaged with The Way Back for longer than 12 weeks had similar improvements in suicidality and psychological distress, and slightly better improvements in wellbeing.

The evaluation analysed the PMHC MDS data to determine whether the average change in outcomes (measured by change in SIDAS, K10 and WHO scores at the start and at the end of service episodes) for participants that engaged with the service for longer than 12 weeks was different to the average change in outcomes for all participants.[110] The evaluation found for participants who engaged with The Way Back for more than 12 weeks:

- the average change in SIDAS and K10 score improvement was not significantly[111] different from the average change in outcomes across all participants.
- the average change in WHO score improvement was significantly different from the average change in outcomes across all participants. However, the observed difference in average change in WHO score is only 5 per cent smaller (from 5.3 for all participants with matched pairs, down to 5.1 for participants with matched pairs who had a service episode lasting longer than 12 weeks).

7.2 Participant outcomes by cohort

All cohorts experienced significant improvements in outcomes. Some cohorts of participants experienced a more significant improvement in some outcome measures than others.

On average, participants of The Way Back experienced significantly improved outcomes, indicating the service model is effective across different cohorts.

Analysis of the PMHC MDS data indicated that while all cohorts experienced improved outcomes, there were some variations in the size of change in outcomes across different cohorts of participants.[112] Figure 18 outlines the change in outcomes for specific cohorts, and highlights whether they reported a significantly greater or lower improvement in outcome scores compared to the average of all The Way Back participants with matching pairs of scores from the start and end of their service period.[113] It also provides observations on why there was or was not significant differences in outcomes scores compared to the average. In summary:

- Not all cohorts' average improvement in SIDAS, K10 and WHO scores were significantly different from the average participant's improvement in outcome scores. The differences to changes in outcomes scores for specific cohorts highlight important learnings about the effectiveness of The Way Back for priority cohorts identified in the service model and cohorts of interest the evaluation. In particular, compared to the average participant of The Way Back it appears that:
    - Improvements to outcomes were significantly larger for Aboriginal and Torres Strait Islander people, and people living in regional and remote areas.

---

[109] Compared to changes in outcomes for all participants.

[110] Analysis is based on PMHC MDS and The Way Back Extension data for 27 sites between September 2019 and February 2022.

[111] Statistical significance based on threshold probability of the observed difference being due to natural, random variability in sampling of 5 per cent.

[112] Analysis is based on PMHC MDS and The Way Back extension data for 27 sites between September 2019 and February 2022.

[113] The change is considered statistically significant where $p<0.05$

- Improvements to outcomes were similar for people with alcohol and other drug needs, and participants aged over 65.
- Improvements to outcomes were significantly smaller for participants diagnosed with a personality disorder, aged under 25, identified as male, unemployed, and those referred on the basis of secondary criteria.

It is important to note that there were limitations to drawing conclusions about the effectiveness of The Way Back for specific cohorts. Specifically, given the limited sample size and lack of demographic data across some cohorts, in particular those receiving peer support as part of their engagement with The Way Back and those with alcohol and/or other drug needs, and the details collected, the evaluation cannot draw conclusions about the reasons why The Way Back improved outcomes by more/less for specific cohorts. However, consultations with provider staff and participants provided some reasons on what mechanisms contributed to a greater or lower change in outcomes for specific cohorts (8.1.2). In addition, while some cohorts' average improvement in outcome measures had statistically significant differences from the average participant's improvements, the differences in outcome scores were relatively minor in scale. Overall, participants experienced statistically significant improvements on average.

Figure 18 | Variations in outcomes across cohorts

COHORT	AVERAGE CHANGE IN SCORE FOR EACH OUTCOME MEASURE (* indicates statistical significance, p -value < 0.05)			OBSERVATIONS
	SIDAS	K10+	WHO-5	
🟦 Average of all participants with matched pairs	18.5 (n=1,689)	9.9 (n=1,948)	5.3 (n=1,529)	On average, all participants with a matched pair experienced a significant improvement in outcomes.
🟧 Participants who identify as male	17.53* (n = 647)	9.65 (n = 754)	5.49 (n = 592)	The Way Back appeared to be less effective in addressing the suicidal ideation of participants who identified as male. Improvements to psychological distress and wellbeing were similar to the average participant. This cohort was less likely to complete their service episode than others (see section 6.3).
🟩 Participants who identify as Aboriginal and Torres Strait Islander	21.01* (n = 166)	11.33 (n = 117)	5.21 (n = 136)	The Way Back appeared to be more effective in addressing the suicidal ideation of this cohort. Improvements to psychological distress and wellbeing were similar to the average participant. However, the evaluation heard from providers anecdotally that Aboriginal and Torres Strait Islander people were more likely to experience gratuitous concurrence and the outcome measures reported may not be a true reflection of outcomes for some participants. It should be noted that Aboriginal and Torres Strait Islander participants also have the option to complete the K5, which may have influenced the average.
🟧 Participants who identify as LGBTIQA+	17.00 (n = 177)	8.03* (n = 187)	4.19* (n = 143)	The Way Back appeared to be less effective in improving psychological distress and wellbeing for participants who identified as LGBTIQA+. Improvements in suicidal ideation for this cohort were similar to the average participant. It is important to note that given that 42 per cent of participants did not state their sexual orientation, this finding may not be representative of all participants who identified as LGBTIQA+.
🟦 Participants with AOD needs	19.23 (n = 39)	10.89 (n = 45)	6.59 (n = 37)	Outcomes for this cohort were similar to the average participant. Some providers indicated that successfully linking these participants with alcohol and other drugs supports was a key contributor to their recovery.
🟩 Participants living in regional and remote areas	20.26* (n = 734)	10.76* (n = 765)	5.41 (n = 698)	The Way Back appeared to be more effective in improving suicidal ideation and psychological distress for this cohort. Improvements to wellbeing were similar to the average.
🟦 Participants receiving peer support	20.88 (n = 32)	11.31 (n = 32)	5.69 (n = 32)	Outcomes for participants receiving peer support were similar to the average participant.
🟧 Participants with a reported personality disorder diagnosis	16.86 (n = 160)	8.50* (n = 175)	3.95* (n = 144)	The Way Back appeared to be less effective in improving psychological distress and wellbeing for participants with a reported personality disorder diagnosis. Improvements in suicidal ideation for this cohort were similar to the average participant. Some participants in consultations indicated that it was important to have therapeutic supports alongside The Way Back in order for the service to be effective.
🟧 Participants aged under 25	18.09 (n = 511)	9.00* (n = 562)	4.73* (n = 430)	The Way Back appeared to be less effective in improving psychological distress and wellbeing for participants aged under 25. Improvements to suicidal ideation for this cohort was similar to the average participant. Providers in consultations highlighted that it was difficult to engage with young people in the service, which may explain the smaller improvement in some outcomes. This cohort was less likely to complete their service episode than others (see section 6.3).
🟦 Participants aged over 65	16.96 (n = 51)	7.85 (n = 71)	6.02 (n = 54)	Improvements to suicidal ideation, psychological distress, and wellbeing were similar to the average participant.
🟧 Participants referred for secondary criteria	16.58* (n = 667)	9.72 (n = 833)	5.11 (n = 655)	The Way Back may be less effective in improving suicidal ideation for participants referred for secondary criteria. Participants referred for secondary criteria appeared to have a similar improvement in psychological distress and wellbeing to the average participant.
🟧 Participants unemployed at the time of engagement	17.57 (n = 534)	9.25* (n = 595)	4.72* (n = 478)	The Way Back appeared to be less effective in improving psychological distress and wellbeing outcomes for this cohort. Improvements to suicidal ideation were similar to the average participant. Unresolved social issues (such as homelessness) may have affected the change in outcome measures.

LEGEND			
	SIGNIFICANTLY GREATER DIFFERENCE IN AT LEAST ONE OUTCOME MEASURE 🟩	NO SIGNIFICANT DIFFERENCE IN ANY OUTCOME MEASURE 🟦	SIGNIFICANTLY LESSER DIFFERENCE IN AT LEAST ONE OUTCOME MEASURE 🟧

7.3 Participant outcomes by site

There were no significant differences in participant outcomes between sites.

The evaluation investigated the effect of site-specific conditions on outcomes (by including all cohorts in the set of participants with matched pairs). The results indicated that there was no significant effect of any individual site on outcomes. The greater improvement in outcomes for participants living in regional and remote areas identified in the previous section is outweighed by the effects of other site variables which resulted in no statistically significant effect on outcomes between sites overall.[114]

The lack of significant effect of site on participant outcomes includes no significant difference in outcomes achieved at the Murrumbidgee peer support site compared to other sites (see section 6.3).[115] This is consistent with the finding that participants who received peer support as part of their engagement with The Way Back achieved improvements in outcome measures that were not statistically significantly different from the average improvement across all participants.

Across all sites, staff in focus groups and a few participants in interviews reported that the improvement in outcomes was increased for participants as a result of enhancements in their site and greater integration between clinical and psychosocial services. See section 4 for a complete list of site enhancements and section 9.2 for further information on the role of integration.

7.4 Contribution of The Way Back to participant outcomes

Most participants indicated The Way Back played an important role in their recovery and wellbeing.

As outlined in section 7.1 most participants who completed the interview and survey reported The Way Back had a significant impact on their life across all the intended service outcomes and goals. In interviews, participants were asked to what extent The Way Back contributed to their recovery, this included rating to what extent The Way Back supported their recovery and wellbeing on a scale of one (did not support me at all) to ten (greatly supported me). The findings from these interviews are summarised below in Figure 19.

---

[114] Analysis is based on PMHC MDS and The Way Back Extension data for 27 sites between September 2019 and February 2022. The comparison of

[115] The PMHC MDS data is not able to identify which individual participants accessed peer support services at the Murrumbidgee site. The regression modelling uses a flag for Murrumbidgee as a 'peer support site' and compares differences in outcomes between all people who accessed The Way Back at Murrumbidgee and those at other sites.

Figure 19 | Summary of the contribution of The Way Back to participant outcomes

> **The Way Back, these guys here saved my life.** They are real people, who have had real experiences and that is the key. They really understand what you are thinking, what your body is feeling.

> **I wouldn't be here today talking to you** if I didn't have the support from The Way Back

> **I would have ended up dead if it wasn't for Beyond Blue** because of the lack of services and access to services.

OF **57** PARTICIPANTS INTERVIEWED

MOST REPORTED that The Way Back helped them to feel MORE HOPEFUL

Approximately **75%**

- felt a **greater sense of purpose** and **belonging**
- felt **better connected** with other services
- felt **more confident to reach out for help** when needed

More than three quarters reported that they felt **better able to manage their distress** and to engage in interests and hobbies.

A lower proportion of participants reported that they **felt better connected with friends, family** and **community.**

Two thirds felt they **better understand their triggers** and mental health.

The Way Back had a similar effect on participant outcomes as other mental health services.

The evaluation used Cohen's d analysis to determine whether the effect size of The Way Back on intended outcomes is similar to other mental health services.

There was no control group to compare The Way Back effect sizes against, so comparison was done against similar programs (see Appendix B).[116] Preliminary analysis of the effect size of The Way Back on the three standardised outcome measures – K10, WHO-5 and SIDAS – compared to other mental health services demonstrated that:

- The Way Back effect size for the K10 measure (Cohen's d = -1.11, $p<0.005$) was and had a greater or similar to most effect sizes of other mental health services, See Appendix B for more detail.

---

[116] J Cohen, 'Statistical power analysis for the behavioural sciences,' Lawrence Erlbaum Associates. 1988.

- There was limited data available on the use of the WHO-5 and SIDAS measures in other mental health services and we were therefore unable to conduct analysis on these measures.

It should be noted that the evaluation did not have an experimental design so cannot attribute outcomes specifically to The Way Back (see section 2.2 for more detail on the evaluation design). However, The Way Back assisted people by connecting participants to broader supports – inherent in this is other supports have a critical role to play in peoples’ recovery.

8 Mechanisms that help contribute to outcomes

This section answers KEQ4 | Why and how does change occur in The Way Back, in which circumstances?

The mechanisms of change articulate the critical elements of a participant's experience in an aftercare service that contributes to their recovery. Overall:

- People's circumstances influence how 'ready' they were to engage in aftercare supports.
- The therapeutic alliance (the trust and connection developed between the support coordinator and the participant) was the foundational mechanism and improved the participant's remaining experience and engagement with The Way Back. The establishment of the therapeutic alliance should continue to be an important focus for future aftercare services.
- Providing flexibility and choice in the way that support coordinators offered supports to meet participants needs was the secondary context which enabled recovery. The key supports to participants included:
  - Providing hope and motivation
  - Offering clinical, therapeutic, or psychosocial supports
  - Building skills to manage emotional distress
  - Identifying protective factors to manage recovery.
- The mechanisms of change for The Way Back participants in interviews appeared to remain consistent regardless of their background or circumstances. However, the evaluation did find that some participant cohorts emphasised certain mechanisms that were important to their recovery. This is detailed further below.

DATA QUALITY AND LIMITATIONS IN THIS SECTION

This data is based on insights from over 57 interviews with participants and supported by a number of consultations with The Way Back provider staff, PMHC and MDS data, and other stakeholders.

The findings in this section were limited by the lack of survey data. Findings were based on qualitative observations made from participant interviews and stakeholder consultations. As such, it is not known the extent to which these findings can be attributable to all The Way Back participants, or all people who access an aftercare service.

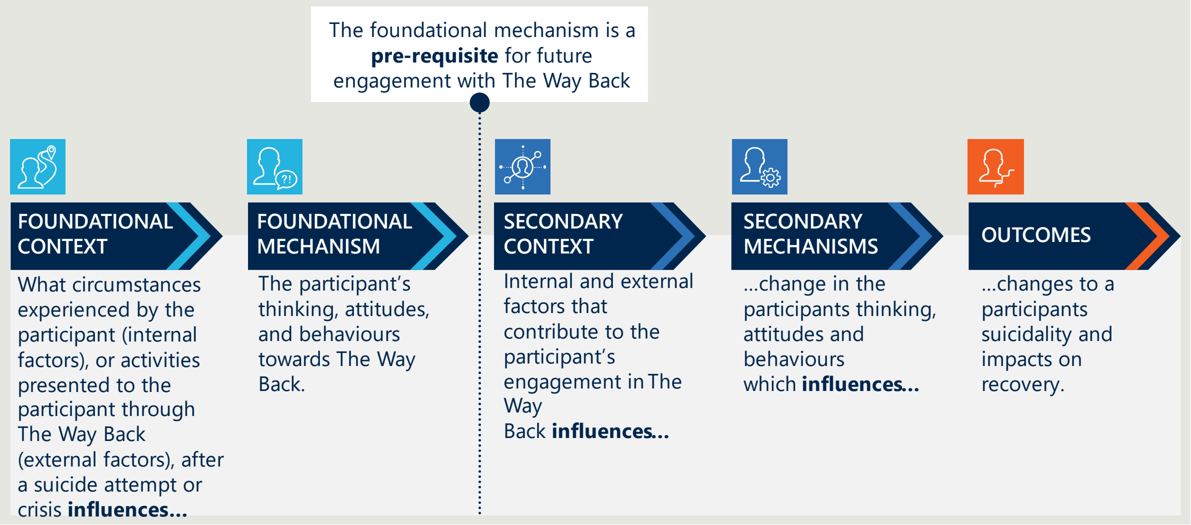
Refer to Appendix B for detailed limitations.

8.1 Common mechanisms that contribute to recovery

The mechanisms of change articulate the critical elements of a participant's experience in an aftercare service that contributes to their recovery.

The mechanisms of change explain what elements of The Way Back contribute to change for participants. They comprise of five key elements: the '**foundational context**', '**foundational mechanism**', '**secondary context**', '**secondary mechanism**' and '**outcome**'. Figure 20 describes each of these elements below. It shows there are a number of circumstances and changes to thinking and behaviours that connects the foundational context with outcomes.

Figure 20 | Defining the terms used to describe the mechanisms of change



The foundational mechanism is a **pre-requisite** for future engagement with The Way Back

FOUNDATIONAL CONTEXT

What circumstances experienced by the participant (internal factors), or activities presented to the participant through The Way Back (external factors), after a suicide attempt or crisis **influences…**

FOUNDATIONAL MECHANISM

The participant's thinking, attitudes, and behaviours towards The Way Back.

SECONDARY CONTEXT

Internal and external factors that contribute to the participant's engagement in The Way Back **influences…**

SECONDARY MECHANISMS

…change in the participants thinking, attitudes and behaviours which **influences…**

OUTCOMES

…changes to a participants suicidality and impacts on recovery.

The mechanisms of change have implications for how The Way Back is delivered to participants in practice. They highlight *what* elements of an aftercare service are most important to the participant's recovery, and *how* the delivery of these elements change depending on the circumstances of the participant.

Figure 20Figure 21 summarises the mechanisms of change for The Way Back.[117] It shows that there were key features of The Way Back that helped to enact the changes in participants' thinking and behaviour that started their journey recovery.

The mechanisms of change identified in this evaluation did not include culturally safe service provision. This may be due to the low number of Aboriginal and Torres Strait Islander people who participated in interviews and responded to the participant survey for this evaluation.[118]

Further explanation of the mechanisms of change is provided below.

---

[117] Figure 21 was informed originally by hypotheses evaluators developed about why and how change occurred for participants, in consultation with service providers, and based on existing evidence about how aftercare works for people. Evaluators tested and re-refined these hypotheses during the evaluation, including with input from The Way Back, Beyond Blue, the Aboriginal Advisory Group and participants of The Way Back.

[118] One person reported identified as Aboriginal and/or Torres Strait Islander in interviews and 4 respondents identified as Aboriginal in the participant survey administered between June 2021 and June 2022 (n =79).

Figure 21 | Mechanisms of change for The Way Back participants[119]

FOUNDATIONAL CONTEXT

INTERNAL FACTORS

- The participant's self-stigma around suicide, suicidality and mental health doesn't prevent engagement
- The participant is emotionally ready and willing to begin their recovery journey when they enter The Way Back
- The participants mental health is stable enough to engage in psychosocial support

EXTERNAL FACTORS

The support coordinator:

- Delivers flexible and person-centred care (e.g. ability to text and call; do outreach; change timing to suit the participant)
- Actively listens to participants which makes them feel 'heard'
- Has a non-judgemental attitude and creates a safe space for the participant to share things about themselves
- Draws on their own lived experience helps to build rapport with the participant
- Maintains the balance between being personable and professional boundaries
- Has experience in delivering supports to other participants

FOUNDATIONAL MECHANISM

Participant likes, trusts and connects to the worker

PREREQUISITE/THRESHOLD

As an immediate result of relationship, participant feels:

- 'like a human'
- less alone or lonely
- there is a path forward / hope
- empowered (due to flexibility of and 'participant-led' element)
- like someone cares
- their needs are also important (including carers)
- 'safe' in the caring and expert hands of the worker

SECONDARY CONTEXT

HOPE AND MOTIVATION

- The participant leads and sets the pace
- The support coordinator helps participants address immediate psychosocial needs
- The support coordinator draws on strong rapport with participants to support and empower the participant to problem solve
- The support coordinator helps the participant to understand their goals through their support plan

ENGAGING WITH SUPPORTS

- The participant's basic needs have been addressed (e.g., safe and stable housing, access to employment and/or education)
- The participant's prior experience of support services, particularly clinical mental health services
- The support coordinator helps the participant to understand their triggers and identify appropriate supports through the completion of safety and support plans
- The support coordinator recommends services and supports which they know and trust
- The availability, quality and affordability of services

EMOTIONAL DISTRESS

The support coordinator:

- delivers a service that is participant led, so they decide what is done
- provides encouragement and reassurance of self-efficacy for the participant
- looks for opportunities to empower rather than 'do' on behalf of participant
- creates a safety plan with the participant to provide tools for participants to 'self help'
- helps develop emotional literacy and self-regulation for participants emotions

PROTECTIVE FACTORS

- The availability and readiness of the participants' family and friends to act as supports for the participant
- The participant's relationship with their family and friends
- The ability of the support coordinator to identify gaps in the participant's protective factors and work with them to address it
- The support coordinator's ability to identify a participant's activities of interest, passions or hobbies

SECONDARY MECHANISMS

1. The participant gains the hope and motivation required for recovery
2. The participant engages with appropriate supports
3. The participant builds their own capacity to manage emotional distress
4. The participant develops protective factors that enable them to manage their own recovery

OUTCOMES

- Increased feelings of hope, purpose and belonging
- Increased ability to resolve immediate needs
- Increased engagement with interests/hobbies

- Greater knowledge of where and how to access support
- Engagement with clinical mental health services
- Engagement with peer services
- Engagement with other services as needed
- Understanding of suicide and / or mental health triggers
- Reduced self-stigma around suicidality

- Has an improved understanding of and management of mental health needs ('mental health literacy')
- Experiences a reduction in stress and greater quality of life
- Experiences a reduction in isolation
- Increased engagement with interests / hobbies
- Ability to comprehend the drivers of their suicidality

- Feeling empowered as a partner in recovery
- Increased levels of (perceived) social and familial connectedness
- Greater knowledge of where and how to access support (e.g. activate their safety plans)
- Increased willingness and capacity to communicate when experiencing suicidality
- Engagement in hobbies, activities and passions

---

[119] Please note, the inputs into the development of the mechanisms of change are based on input from stakeholders.

People's circumstances influenced how and when they were ready to engage in aftercare support.

People's circumstances can impact their experience when accessing a service immediately following a suicide attempt or crisis ('**context**'). These can be internal circumstances – such as their readiness to engage in recovery, or external factors – such as the ease of referral into an aftercare service.

These factors can influence how and when people are ready to engage in support, their experience of accessing services and subsequently *how* change will occur through their recovery journey.[120] Participants commonly reported that they felt they were only able to engage in the service when the circumstance that led to their suicide attempt or crisis had either been resolved or stabilised, for example:

- Participants who reported experiencing homelessness at the time they were referred to The Way Back. These participants often reported their ongoing situational crisis of homelessness made it difficult to engage with other psychosocial supports and focus on recovery.
- Participants who reported that they were still seeking to stabilise their mental health using medication but needed more time to refine type/dosage of medication. These participants often felt they needed to achieve medication stability before they had the capacity to engage in additional supports to progress their recovery.

The analysis of PMHC-MDS data found that of the participants who did not consent to participate in The Way Back (21 per cent), just over a third of those who provided a reason for declining the service did so because they did not want support or thought the service was 'not for right now' (noting that 79 per cent of people did not provide a reason for declining the referral). See section 6.2 for further details on service uptake.

Participant trust and connection with support coordinators were foundational mechanisms that influenced the participant's remaining experience with The Way Back.

Consultations with The Way Back participants revealed there was one foundational mechanism that helped to create change for participants in their recovery which was the trust and connection to their support coordinator – the 'therapeutic relationship or alliance'. Based on participant interviews and survey responses, appeared to be a prerequisite to participants continuing engagement with the service and being open and ready to discuss supports and recovery. The importance of the participant's relationship with the support coordinator aligns with the literature on suicide aftercare which demonstrates that a strong therapeutic alliance between the participant and their support person is associated with better outcomes for the participant.[121]

> *"I trusted [the support coordinator]. I let her know everything that was happening in my life, whether that is good or bad. When I shared positive things with her, she was happy for me. It felt good seeing someone happy for me."- The Way Back participant*

The importance of the support coordinator is also highlighted in responses in the Participant survey.[122] As outlined in section 6.3, 83 per cent of respondents indicated that their relationship with their support coordinator influenced their level of satisfaction with The Way Back. Peer workers may also contribute to the strength of the therapeutic alliance. Two participants who were interviewed and received peer support in The Way Back reported that they also liked, trusted and connected with their peer worker, which contributed to their experience with The Way Back.[123]

---

[120] Based on 2021 and 2022 interviews with participants who accessed The Way Back, and focus groups with The Way Back staff.

[121] SAX Institute. (2019). *Suicide aftercare services.* pp. 8. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

[122] Administered between June 2021 and June 2022 n = 79

[123] Nous Group (2021). The Way Back Support Service Peer Support Trial Evaluation, Final Report.

Receiving a range of supports relative to needs was the secondary mechanism which enabled recovery.

The support the participant was offered through The Way Back depended on the participant's individual needs (i.e. what issues that led to a suicide attempt or suicidal crisis need to be addressed through The Way Back) and what was offered by the support coordinator. Respondents to the participant survey also highlighted similar elements of The Way Back that were important to their recovery. The top five responses in the participant survey that respondents to the participant survey reported as being most helpful to their recovery included:[124]

> *"I came here with the intentions of not knowing anyone or getting to know anyone – he was really one of the first people I could open up to, to feel okay interacting with. I guess it kind of made me rethink what I wanted to do" - The Way Back participant*

1. Person to speak to (88 per cent or 69 responses)
2. Phone calls (53 per cent or 41 respondents)
3. Setting goals (49 per cent or 38 respondents)
4. Finding out where, when and how to access support in the future (43 per cent or 34 respondents
5. Specific services to help with other things (42 per cent or 33 respondents)

Similarly, respondents to the provider survey highlighted similar elements that were most helpful to participants' recovery. These included: [125]

1. Someone to speak to (91 per cent or 86 responses)
2. Safety planning (47 per cent or 45 responses)
3. Help accessing support (47 per cent or 45 responses)
4. Setting goals (27 per cent or 25 responses)
5. Recommendations to other services (23 per cent or 22 responses).

> *"My coordinator ...... talked to me on a level that I couldn't even talk to my family about."*

Notably, while providers highlighted safety planning as most helpful to recovery, participants did not.

The supports helped to facilitate and shape a participants' reasoning and behaviour in recovery (based on participant interviews). Participants did not need to be provided with all elements outlined in the secondary mechanisms to support recovery. Outcomes for the participant depended on the issues addressed and the support offered through The Way Back. For example, some participants needed strong encouragement and reassurance from their support coordinators and help to develop their emotional literacy and self-regulation (secondary context). This in turn resulted in changes in the participant's capacity to better manage their own emotional distress (secondary mechanism). The participant's ability to better manage their own emotional distress caused the participant to better comprehend the drivers of their suicidality and to experience a better quality of life (outcome).

The following vignettes or archetypes of The Way Back have been developed based on interviews across from multiple participants. Their stories represent how the mechanisms of change can be understood in practice. For both archetypes, the relationship with their support coordinator was a prerequisite to their remaining engagement of The Way Back. The differences in how each participant engaged in The Way Back highlights the flexibility of The Way Back to meet the participants' needs. Note that participants have been de-identified.

> *"Being able to vent it out [was important to my recovery]. The Way Back stopped me from letting things to explode, this was closely related to reaching out for help when I need it" - The Way Back participant*

---

[124] Based on responses from the Participant survey administered between June 2021 and June 2022 n = 79.

[125] The provider survey was administered to support coordinators or team leaders of The Way Back between June 2021 and June 2022, n = 95

HELENA, 24 YEARS OLD

Helena can't believe how well she feels compared to her engagement with services following her first suicide attempt. Helena was referred to The Way Back the second time she attempted suicide. The first time she attempted, she was supported through a state-based crisis team but said she 'dropped off their radar' after a few weeks.

Helena really liked that The Way Back support coordinator reached out to her proactively while she was still at the in-patient unit in the local hospital. Helena appreciated that her support coordinator was flexible with where, when and how often they met. This helped make it as easy as possible for Helena, who was busy juggling full time work and looking after her two young children. She also liked that her support coordinator responded to her specific needs to make her feel relaxed in talking about what was going on– they often had their sessions over a cup of coffee in a park nearby where she works.

Her support coordinator connected Helena to a psychologist who worked with her to work through her mental health issues, and a local support group for young mothers. While she misses her support coordinator occasionally, Helena doesn't feel like she needs them anymore and says she has made lifelong friendships with other young mums who have gone through similar experiences themselves.

ANDREW, 46 YEARS OLD Andrew was so glad he could finally talk to someone who could provide a third-person, non-judgemental perspective on some of the issues he could not always talk about with his friends or family.

Andrew was referred to The Way Back by a psychiatrist from hospital. Due to COVID-19, Andrew could only talk to his support coordinator over the phone. While this was not ideal for Andrew, he still found it comforting to have a support coordinator as someone who could help him in the three months after his suicidal crisis.

Andrew migrated to Australia 5 years ago He was struggling to talk about his mental health with friends and family, as there is often a negative stigma within his cultural group. He really appreciated how his support coordinator connected him with several supports, including a 24/7 helpline. He used this number to reach out for help when he needed it. Andrew found the most valuable aspect of The Way Back was how his support coordinator was able to act as a sounding board to the issues he was experiencing and helped him to become more comfortable to reach out to his family and friends about his mental health.

Andrew now feels he has the skills to better regulate his emotions and confidence to reach out for help when he needs it.

Cohort-specific mechanisms of change

The foundational context differed across some participant cohorts which influenced the type and importance of mechanisms that existed for some participants.

The Way Back identified priority cohorts (i.e. Aboriginal and Torres Strait Islander people, and LGBTQIA+). The Way Back, and the evaluation also identified cohorts of interest that were at higher risk of suicide than average suicide rates across Australia or happened to be identified in the data available to the evaluation (see section 5.3 for more detail on these cohorts). It is important to understand whether the supports they need to recover from a suicide attempt or crisis differ from the ''average' person who access aftercare services. This has implications for how The Way Back can be adapted in sites where the local area has a high proportion of participants from specific cohorts that experience a higher prevalence of suicidality.

Figure 22 summarises these cohorts' contexts and additional or alternative mechanisms of change that helped to enact changes in behaviour and thinking that enable recovery based off interviews with participants, and The Way Back providers. It highlights that:

- Some cohorts placed greater value on certain elements of the mechanisms of change. For example, in interviews, participants who were experiencing bipolar disorder highly valued having a support coordinator who also had lived experience.
- Other cohorts valued the availability of alternative approaches to receiving support. For example, young people felt more comfortable to engage with their support coordinator via text message.

It is important to note that there was limited primary data (through participation in interviews, and responses to the participant survey) available to the evaluation to understand whether mechanisms differed for certain cohorts (in particular, Aboriginal and Torres Strait Islander people, and people who identified as LGBTIQA.). Further investigation is needed to determine the extent to which these mechanisms are important to enact as part of these cohorts' recovery (see Section 10.1 recommendation 5). Further, the mechanisms of change outlined in Figure 21 above still apply to these cohorts.

Figure 22 | Mechanisms of change for populations of interest

COHORT	CONTEXT	HOW THE MECHANISMS OF CHANGE MAY DIFFER
People who identify as Aboriginal and/or Torres Strait Islander	The evaluation was unable to comment on the differences from the perspective of Aboriginal and Torres Strait Islander participants as there were a limited number of Aboriginal and Torres Strait Islander participants who participated in interviews.	Anecdotally, stakeholders from the Beyond Blue Aboriginal Governance Group and The Way Back staff suggested that it was important The Way Back should be culturally safe and appropriate for Aboriginal and Torres Strait Islander participants. It was also important that participants maintained their connection to their community throughout their journey to recovery. Recommendations for identifying how aftercare services could be better delivered to Aboriginal and Torres Strait participants is outlined section 10.1, recommendation 5. In section 10.1.
People who are from CALD backgrounds	Participants from CALD backgrounds often reported that it was difficult to talk about their mental health with their friends and family because of the negative	Not having people in their life they could talk to meant that they especially valued having a support coordinator who was non-judgemental and open to the issues they

COHORT	CONTEXT	HOW THE MECHANISMS OF CHANGE MAY DIFFER
	stigma associated with suicide and mental health in their culture. Participants of CALD backgrounds were also more likely to report that part of their suicidality stemmed from being isolated from their friends and family (either because their mental health issues affected their ability to connect with their loved ones, it was difficult to talk about the issues they were facing due to stigma, or because they were physically unable to see their friends and family, often due to the COVID-19 pandemic).	were facing and was someone they could relate to (i.e. share mutual experiences). Participants highlighted the importance of reconnecting with friends and family as an important part of their recovery.
People who experience alcohol and/or other drug (AOD) issues	Participants reported that their readiness to engage in AOD services before or during their support from The Way Back was often important to their recovery journey.	Participants shared that while they were offered AOD services, they weren't always ready to engage. Analysis of the PMHC MDS between July 2018 and September 2022 also suggested this; of the 354 episodes where the participant was referred to AOD services, only 30 per cent engaged with the support.
People living in regional and / or remote areas	The Way Back staff anecdotally reported that social isolation was a driver of suicidality for participants living in regional and /or remote areas. These areas often comprised of small communities where 'everybody knows everybody', making it difficult for participants to talk about their issues, due to concerns with privacy and confidentiality. It was also challenging for participants to access support due to the low availability of services in their area.	Participants reported that support coordinators used technology to improve access to The Way Back. Some participants indicated that phone support was less impactful than face to face support. Participants in regional and/or remote areas typically placed more importance on the companionship provided by the support coordinator, rather than as service navigators and accountability mechanisms. Participants also benefited from having someone who is outside of their family and friend circles, with whom they can be more open about their suicidality.
Young people and older people	People experienced the support offered by The Way Back differently and valued different aspects of it based on their age. For example: Younger people (typically under 25): The Way Back site in Brisbane indicated that young people are more difficult to build a strong therapeutic relationship with, they	Young people often preferred contact via text message and used different language to adult participants. Providers in interviews indicated that often psychoeducation and linkages into groups with people of similar ages was most helpful to the young person. Older people: Some participants reflected that they valued having a support coordinator with 'life experience', as it enabled them to better connect. Many older

COHORT	CONTEXT	HOW THE MECHANISMS OF CHANGE MAY DIFFER
	might be between services and supports – they are neither children nor adults. In these cases, providers in interviews indicated that parent engagement was critical and not always there. Older people (typically over 50): Some providers in interviews noted that older people found it more challenging to be inspired by the future and to engage with the service, due the participants' own personal assessment of how much time they believe they have to live. Often, older people were more likely to have navigated the mental health system for a longer period of time and had likely previously been let down by what was promised to them in the system.	participants shared that it was important for support coordinators to be honest and transparent about what can be achieved through The Way Back – 'if you say you're going to do something, you should do it.'
People who experience personality disorders and/or chronic suicidality	Across several sites, The Way Back staff anecdotally reported in interviews that many participants (particularly repeat participants; anecdotally approximately 50 per cent) have a diagnosis or visible traits of borderline personality disorder (BPD) or other personality disorders.	Some participants with BPD outlined that when support coordinators disclosed their own lived experience of BPD it helped to 'normalise' their condition and that they learned practical strategies for managing their condition and suicidality. It was important for participants to have access to dialectical behaviour therapy as primary tool to support people with BPD, alongside The Way Back.
People who engaged after their first suicide attempt, had low engagement with similar services previously	Providers and participants in interviews indicated that people who had experienced their first suicide attempt or had not engaged with similar services previously found The Way Back to be effective. The available evidence has found that participants have better outcomes if they accessed aftercare support after their first suicide attempt, than those who have access aftercare support after multiple suicide attempts.[126]	There was limited data available to the evaluation to highlight whether mechanisms of change differ for these cohorts.

---

[126] SAX Institute. (2019). *Suicide aftercare services*. pp. 8. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

COHORT	CONTEXT	HOW THE MECHANISMS OF CHANGE MAY DIFFER
People who are carers	Participants who were carers outlined that they often did not take time out to care for themselves and did not see their own needs as important. Providers observed that participants who were carers seemed to feel very alone in their experience.	Providers in interviews outlined that support, encouragement, and Socratic questioning[127] helped participants to understand that their needs were also important (or that they needed to be in a good place to be able to continue caring). They suggested normalising this behaviour of self-care was important and could be achieved via connecting participants to groups where they could meet others who were experiencing similar thoughts, build supportive relationships and learn from one another.
People who require higher-intensity support to manage with their day-to-day responsibilities	Participants who needed higher-intensity support in their day-to-day responsibilities. Some participants in interviews who were identified in this group shared that there were other services that could deliver a much higher intensity of support and were happier with this support compared to The Way Back.	Participants indicated that at the beginning of their engagement with The Way Back, they required higher-intensity support. As they gained stability and independence, they required less support through The Way Back.
People with high clinical needs (for example, severe psychosis)	Providers in interviews indicated that the service appeared to be less effective for participants who were experiencing mental health crisis,[128] as they typically needed very intense clinical support before they were ready to engage with The Way Back.	In interviews, participants with high clinical needs reported that the availability of high quality and affordable mental health supports that met their needs was crucial for their capacity to engage with The Way Back, and their subsequently, their journey to recovery.
The 'missing middle'[129] in mental health needs / support	It was common for participants who were observed to be part of the 'missing middle' to access The Way Back, as they often had to get to the crisis point of suicidality before they could finally access care through The Way Back. Before The Way Back, participants in interviews reported that they	These participants valued how their support coordinators were able facilitate access to the mental health supports they needed where they felt they would not have had access to without having been referred to The Way Back.

---

[127] Socratic questioning is a form of disciplined questioning that can be used to pursue thought in many directions and for many purposes, including: to explore complex ideas, to get to the truth of things, to open up issues and problems, to uncover assumptions, to analyse concepts, to distinguish what we know from what we do not know, to follow out logical consequences of thought or to control discussions.

[128] **A mental health crisis** is any situation in which a person's actions, feelings and behaviours can lead to them hurting themselves or others and/or put them at risk of being unable to care for themselves or function in the community in a healthy manner.

[129] The 'missing middle' is a term used to describe "people whose needs are not met by current mental health services". They are often too unwell for primary care, but not unwell enough for state-based services. They may have accessed services in the past year, however, these services were not able to deliver either the duration of care, or level of specialist care appropriate for more complex and serious mental ill-health." See Orygen, 'Defining the missing middle.' Retrieved from: www.orygen.org.au/Policy/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle/orygen-defining-the-missing-middle-pdf.aspx?ext=.

COHORT	CONTEXT	HOW THE MECHANISMS OF CHANGE MAY DIFFER
	struggled to access the affordable support, close to home and in a timely manner.	
$ People from lower socio-economic backgrounds	Participants who were participants who were experiencing (or reported) financial stress often were experiencing homelessness and/or unemployment. Homelessness was a key driver towards suicidality for this cohort.	Participants outlined that establishing a stable living situation was vital to their recovery. Participants who had access to safe and affordable housing were then able to focus on addressing other issues that led to their suicidality, such as their mental health.
♂ Men	Providers in interviews indicated that young men who previously had negative experiences with the mental health system typically did not engage with The Way Back or were very reluctant to engage with the service, if they did decide to accept a referral. More generally, men who accessed the service commonly reported in interviews they were facing situational crisis such as relationship breakdowns or the loss of a partner through death.	Participants who identified as male often described the same mechanisms of change as other cohorts.
⚧ LGBTIQA+	There was a limited number of participants who were interviewed and identified as LGBTIQA+ or discussed their sexuality and / or gender.	Participants who did identify as LGBTIQA+ predominantly described the same mechanisms of change as other cohorts. However, the ability of the support coordinator to be non-judgemental and use appropriate language around gender, sexuality and identity was especially important to their engagement with The Way Back.

9 Service performance

This section contributes to answering KEQ 2 | How well is The Way Back being delivered?

On average, most sites were meeting three of the six KPIs on average over time, suggesting that most sites were delivering the service in line with its intended design. The evaluation found that the appropriateness and clarity of some KPIs (particularly the KPIs related to completion of safety and support plans) created difficulties in reporting against them and therefore the assessment of whether or not they were met. Actual performance against KPIs was also impacted by external factors beyond the control of services (for example, the impact of COVID-19).

The evaluation identified that the following enablers and initiatives of The Way Back appeared to improve the effectiveness of service delivery for providers and participants:

- Established mechanisms to improve integration between The Way Back and referring health services improved the delivery of the service and experience of participants between referral and uptake of the service. These mechanisms included funded hospital liaison officer positions and formal coordination agreements.
- Strong networks with clinical and psychosocial services to support inbound and outbound referrals.
- The non-clinical relationships between participants and support coordinators (i.e. therapeutic alliances) were critical to participants' positive experience of the service.

In contrast, there were some service delivery elements of The Way Back that could be improved. These were:

- Significant confusion around lines of accountability, and funding uncertainty for The Way Back.
- Staff recruitment and retention issues, due to significant caseloads, limited professional development opportunities for staff, and uncertainty of funding for The Way Back.
- Limited use of data to inform effective management of service delivery or to identify and realise opportunities for improvements.

KEQ 2 is further answered in section 5 and section 6.

DATA QUALITY AND LIMITATIONS IN THIS SECTION

Data quality and limitations in this section: The key data sources used in this section were drawn from consultations, the quarterly reports for 27 in-scope sites between April 2021 and June 2022 and PMHC MDS data for 27 in-scope sites between April 2021 and June 2022. It is important to understand the following limitations for this section:

- **Inconsistent data collection approaches across sites |** Different approaches in how sites collected data for quarterly reports affected the quality of data used in this analysis. Some sites inputted data manually into the quarterly reports, others uploaded data from the PMHC MDS data portal directly into the quarterly reports. This impacted the consistency of data and introduced the potential for human error and variation in data interpretation/input.
- **Limitations to comparisons across sites |** Analysis of trends and comparisons between sites was limited as new sites joined and matured at different times and KPIs were captured differently across sites.
- **Inability to extract data |** Some sites indicated that the introduction of new (CMSs) did not allow extraction of or input into The Way Back extension data. As such, sites were unable to reflect their data in the system.
- **Limited data on cohorts** | Also, the referral data collected in the quarterly reporting did not collect demographic information of referrals. Therefore, the evaluation is unable to discern key populations that were referred to The Way Back but do not access it.
- Refer to section 2.4 and Appendix B for detailed limitations.

9.1 Alignment of service delivery with service model

Six KPIs were used to monitor The Way Back service delivery.

Providers were required to report six KPIs related to time for initial contact with a referred person, safety and support planning, and communication with other health professionals. The six KPIs are below. It should be noted that as of July 2022, Beyond Blue implemented changes to KPIs to improve their appropriateness and clarity, this included removal of KPI 2 and KPI 3 (see Appendix C for further detail on these changes).[130]

1. **KPI 1: Initial contact with referred person:** For referred persons who are confirmed as eligible for The Way Back, contact must be attempted with the referred Person within one business day of receipt of the referral by the service provider.
2. **KPI 2: Correspondence with primary nominated professional on entry to the service:** For all participants who have provided consent for their primary nominated professional to be notified, correspondence must be sent advising their primary nominated professional of participation in The Way Back within three business days of consent being obtained.
3. **KPI 3: Correspondence with primary nominated professional on exit from the service:** For all participants exited from the service (unplanned or planned) and who have nominated a primary nominated professional, correspondence must be sent by the service provider to their identified primary nominated professional within three business days of the exit date.
4. **KPI 4: Safety plan update / development:** Safety plans must be updated or developed preferably at the initial contact with the participant and no later than the second contact.
5. **KPI 5: Support plan development:** Support plan is to be developed within two weeks of consent to participate in the service.

---

[130] It should be noted that as of July 2022, Beyond Blue implemented changes to KPIs to improve the appropriateness and clarity of KPIs, including the removal of the need to report against KPIs 2 and 3

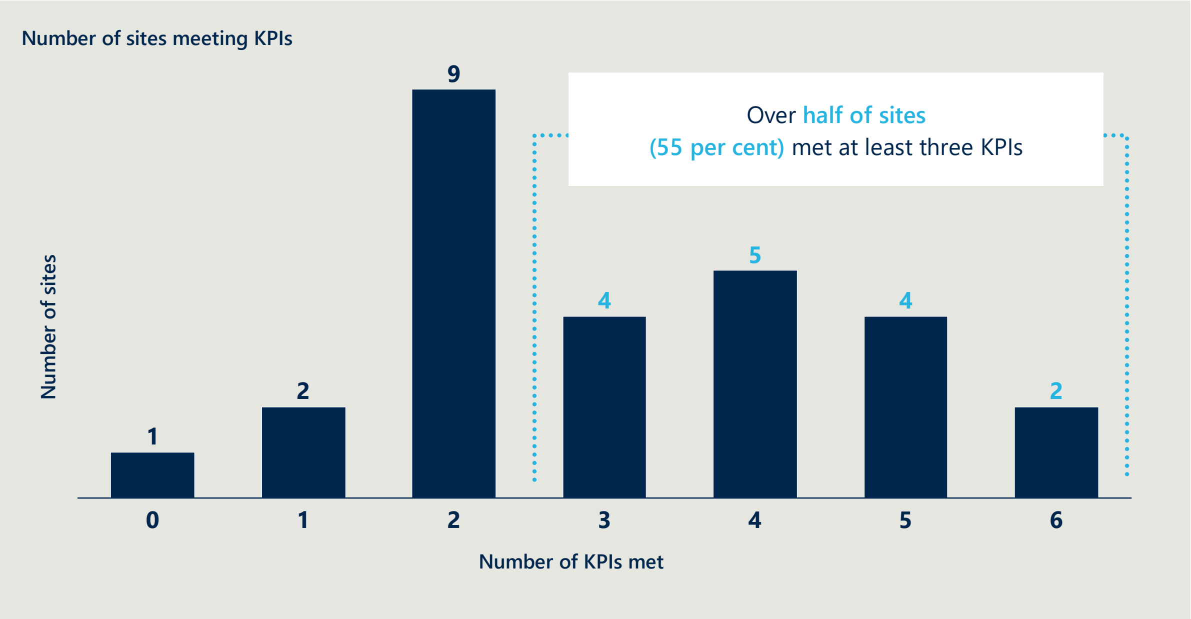
6. **KPI 6: Quarterly new participant episode target:** Achieve 100 per cent of the relevant quarter new participant episode target per quarter.

Two sites met all six KPIs; over half of all sites met at least three KPIs.

Figure 23 shows the proportion of in-scope sites that met each KPI (based on Quarterly Report data from Q4 2022 and PMHC MDS data from Q4 2022). It shows that:

- Two sites met all the KPIs.
- 41 per cent (11 sites) met four or more KPIs in Q4 2022[131]
- 11 sites only met one or two KPIs in Q4 2022
- One site did not meet any KPIs in Q4 2022

Figure 23| Number of KPIs met according to 27 in-scope sites' Q4 2022 quarterly reports and PMHC MDS[132]



Most sites consistently met three or more KPIs (between June 2021 and June 2022).

Figure 24 provides an overview of the total number of sites meeting KPIs over time. It shows that sites consistently met most of their KPIs.

Providers in consultations and quarterly reports indicated KPIs may not be met for the following reasons:

- Some sites which were operational for less than four months (i.e. less mature) and as a result were still implementing the service or may not have had much data to be able to report.
- Some sites experienced delays due to COVID-19 and were waiting to return to face to face before recommencing service delivery.
- Most sites noted difficulties engaging participants to develop safety and support plans attributing this to participants feeling the plans do not work, were reluctant to develop plans, felt the plans were too clinical, or agreed but then later disengaged from The Way Back.

---

[131] Based on quarterly report data for the 27 reports received from in-scope sites in Q4 2022, supplemented with PMHC MDS data for the same sites in the same period.

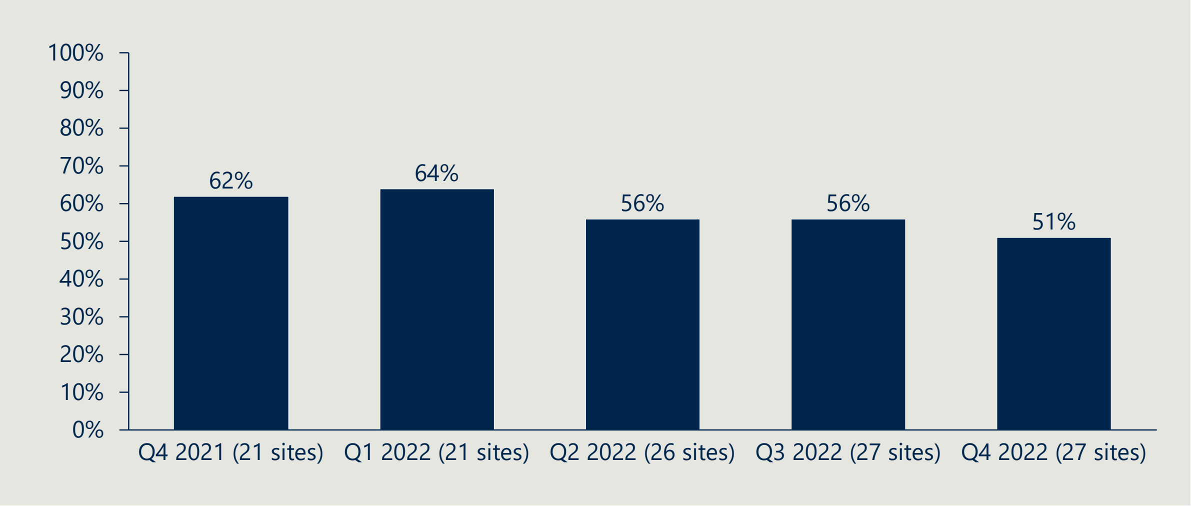
[132] With supplementary PMHC MDS data for the in-scope sites in the same period.

- Some sites indicated that the introduction of new CMSs resulted in issues with how and what data was uploaded in to the PMHC MDS and The Way Back extension data. . As such, sites were unable to reflect their data in the system.
- The evaluation also identified that the amendment to KPIs (that aimed to improve the appropriateness and clarity of KPIs) recently may have impacted sites' ability to meet KPIs.

Where there were improvements to meeting KPIs over time, providers in consultations highlighted the following reasons for improvement:

- Staff having more clarity on KPI definitions (and therefore improved data collection).
- More established relationships with the referring providers (which reportedly impacted achievement of KPI 1 on the initial contact with referred persons).

Figure 24 | Percentage of KPIs met by sites by quarter, Q4 2021 to Q4 2022[133]



Sites most often met the KPI related to having a safety plan updated or developed and least often met the KPI related to the quarterly new episode target.

Sites met some KPIs more than others (as shown in Figure 25). In summary:

- Sites met the KPI related to having a safety plan updated or developed at the initial contact or the second contact most often (85 per cent of the time).
- Sites often met the KPI related to correspondence between participants and the Primary Nominated Professional on entry to The Way Back most often (69 per cent of the time) and the KPI related to notification of participant's identified primary nominated professional within three business days of the exit date (65 per cent of the time).
- Sites met the KPI related to the number of new participants referred each quarter least often (27 per cent of the time).[134]

Where a site was not meeting a KPI, it was typically less than 20 per cent from meeting the target (i.e., 75 per cent of the time sites were within 20 per cent of the target[135]).

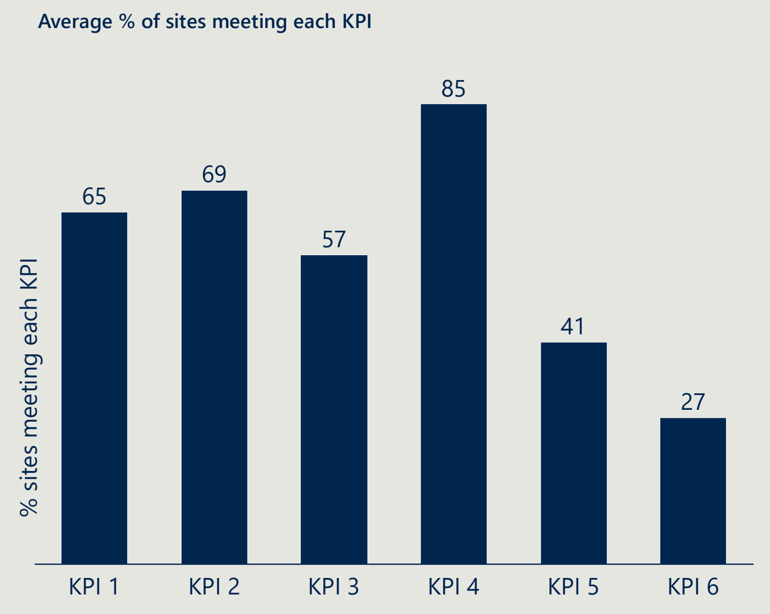
---

[133] Quarterly report data Q4 2021 to Q4 2022Note

[134] Based on quarterly report data for 27 in-scope sites between Q4 2021 and Q4 2022, supplemented with PMHC MDS data for the same sites in the same period.

[135] Based on quarterly report data for 27 in-scope sites between Q4 2021 and Q4 2022 supplemented with PMHC MDS data for the same sites in the same period.

Figure 25 | Average proportion of the 27 in-scope sites meeting each KPI between Q4 2021 and Q4 2022[136]



KPI 1	Initial contact with referred person
KPI 2	Primary Nominated Professional are notified of participant's entry to the service
KPI 3	Primary Nominated Professional are notified of participant's exit from the service
KPI 4	Safety plans updated/developed
KPI 5	Support plans completed
KPI 6	Quarterly new participant episode target

Providers in consultations indicated the following reasons for variability in progress toward KPI targets:

- **KPI 4 and KPI 5**: Sites reported several reasons associated with the difficulties with meeting these targets including:
    - Variability in the interpretation of these KPIs. Some sites reported that the time limit for completing the safety and support plan was unclear.
    - Participants had already developed a safety plan in hospital and so did not feel the need to complete another one with The Way Back.
    - Participants chose not to complete and safety and support plan as they did not feel they needed it to support their recovery.
- **KPI 6**: Meeting quarterly participant episodes was dependent on the maturity of the referral pathway and referrers' understanding of The Way Back. Referring providers (LHNs/LHDs/HHSs)who were not familiar with the role of The Way Back or did not have the time and ability to identify a person who was experiencing suicidality impacted referral numbers and subsequently episode targets.

Providers and PHNs questioned the appropriateness and clarity of some KPIs.

Many providers and PHNs in consultations reported a view that some KPIs did not accurately reflect the performance of The Way Back, as some were dependent on uncontrollable external factors. Examples included:

- **KPI 1 (related to new participant episodes target)** Providers in interviews also reported that the definitions of KPI 1 (initial contact on service) were unclear and this impacted how numbers were recorded in the data.
- **KPI 2 and KPI 3 (both related to contacting a Primary Nominated Professional at entry and exit to the service).** Providers in interviews questioned the appropriateness of these KPIs as many participants who access The Way Back did not have a primary nominated professional.

---

[136] Quarterly report data Q4 2021 to Q4 2022

- **KPI 4 (related to safety plans) and KPI 5 (related to support plans).** Providers in interviews indicated that rigidly aiming to meet these KPIs did not reflect the intent of The Way Back to be a participant-led service, flexible to participant needs and preferences. For example, some participants did not want to complete a support plan and/or may have already recently completed a safety plan. Therefore, providers would not 'force' participants to, meaning they would then not meet this KPI.

It should be noted that the interim report for this evaluation recommended improving the appropriateness and clarity of The Way Back KPIs. In response to the interim report recommendations from this evaluation, Beyond Blue addressed these challenges of KPIs as of July 2022. As such, KPI 2 and KPI 3 were removed as KPIs, and the definitions of KPI 4 and KPI 5 were clarified. Detailed changes to KPIs are provided in Appendix C.

9.2 Effectiveness of service delivery

Research shows that integrated aftercare reduces the likelihood of suicide attempts and improves participants' quality of life and motivation.

The Sax Institute Review found that aftercare models that integrate post-hospital clinical services with psychosocial supports and follow-up services were more effective compared to those that do not.[137] Benefits included:

- a reduced likelihood of suicide attempts (by up to 19.8 per cent) [138] [139]
- observable changes in suicidal behaviour
- benefits to an individual's quality of life and motivation.[140]

. The Way Back's service principle '*psychosocial and clinical needs are complementary*' stipulates that the services' psychosocial support should be integrated with clinical supports. The type of integration The Way Back focused on was 'clinical integration' – which is the integration of care delivered by professionals and providers to patients into a single or coherent process within/across professions (such as the use of shared guidelines/protocols). This is opposed to full organisational integration, functional integration (for example, integration of non-clinical/back-office functions) or service integration (for example, use of multi-disciplinary teams (MDTs)).[141]

The Way Back sites used different combinations of mechanisms to support clinical integration.

Consultations with sites' The Way Back providers and referring health provider staff, highlighted multiple mechanisms that enabled integration with clinical and psychosocial services, a variety of which were used across The Way Back sites (and often more than one per site), as shown in Figure 26.

---

[137] SAX Institute. (2019). Suicide aftercare services. pp. 28-30. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

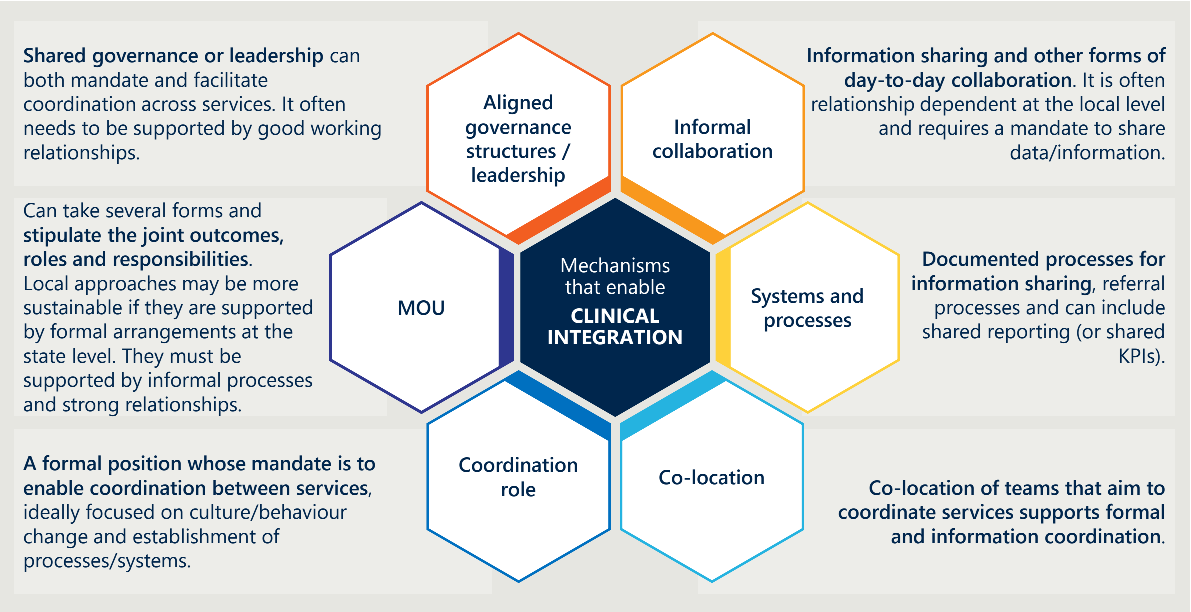
[138] Krysinska K, Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N and Christensen H, '*Best strategies for reducing the suicide rate in Australia*', Australian and New Zealand Journal of Psychiatry. 2016;50(2):115-118.

[139] Hazell, T., Kay-Lambkin, K., Warren, B., Skehan, J., Maxwell, K., Moore, C., & Kemp, E. (2006), '*Safety after leaving hospital: The* reduction in risk of suicide in people who are discharged from inpatient mental health care', Hunter Institute of Mental Health

[140] SAX Institute. (2019). Suicide aftercare services. pp. 28-30. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

[141] Lewis R, Rosen R, Goodwin N, Dixon J. Where next for integrated care organizations in the English NHS? London: The King's Fund; 2010.

Figure 26 | Mechanisms which supported integration of The Way Back with clinical and psychosocial services



Shared governance or leadership can both mandate and facilitate coordination across services. It often needs to be supported by good working relationships.

Information sharing and other forms of day-to-day collaboration. It is often relationship dependent at the local level and requires a mandate to share data/information.

Can take several forms and **stipulate the joint outcomes, roles and responsibilities**. Local approaches may be more sustainable if they are supported by formal arrangements at the state level. They must be supported by informal processes and strong relationships.

Documented processes for information sharing, referral processes and can include shared reporting (or shared KPIs).

A formal position whose mandate is to enable coordination between services, ideally focused on culture/behaviour change and establishment of processes/systems.

Co-location of teams that aim to coordinate services supports formal and information coordination.

Funded hospital liaison officers and the use of both informal and at least one formal mechanism at a site enabled better clinical integration.

Sites that had a funded hospital liaison officer and/or sites that established both informal and at least one formal clinical integration mechanism were more likely to report effective integration.[142] More specifically:

- **Sites that had a funded hospital liaison officer in referring service/s were more likely to report effective referral pathways.** This included a higher likelihood of The Way Back receiving appropriate referrals and better understood referral processes. In consultations, these sites also indicated this dedicated capacity for integration allowed more time for better matching support coordinators to participants. It is recommended that hospital liaison officers continue to be funded in the future (see recommendation 3).
- **Sites without a funded hospital liaison officer in referring health service/s were more likely to report ineffective referral pathways.** In consultations, these sites were more likely to report issues with referral pathways, such as confusing processes, lack of clarity about eligibility criteria (resulting in inappropriate referrals, sometimes not known until after a participant consents), and longer times to contact participants (as referrals take longer to be passed on to The Way Back).
- **Sites that reported both an informal working relationship with their referring health service/s and at least one formal coordination mechanism were more likely to report benefits of integration**. For example, in interviews, some sites indicated that informal relationships, plus co-location and a funded role reported greater dedicated capacity for coordination and agreements to share case notes (reducing the likelihood of participant's need to 'repeat their story'). Likewise, other sites with an informal relationship and formal monthly meetings between The Way Back and the Health Network reported strong working relationships and effective referral processes.
- **Sites that reported only an informal relationship between The Way Back and the referring health service/s were more likely to report issues with referrals.** In consultations, these sites indicated referral processes were confusing and referrals were often delayed from the hospital to The Way Back. Evidence demonstrates this; without formal coordination processes, coordination and

---

[142] Based on insights reported by The Way Back staff, referring health services and participants at eight The Way Back sites (deep dive sites).

collaboration was often depending on proactive individuals with a commitment to integration or individual relationships.[143]

Commonly cited benefits of greater clinical integration included stronger relationships between The Way Back and clinicians, more effective referral pathways, greater capacity to dedicate to collaboration, faster referral times and better matching of support coordinators to participants.

Regardless of the mechanism employed, a fundamental enabler of clinical integration is a dedicated liaison officer.[144] The positive benefits seen at sites that employ a dedicated hospital liaison officer reflect this evidence.

There was limited data available to understand whether outcome measures and uptake rates differed across sites that were more integrated.

There was limited outcomes data available in the PMHC MDS to compare differences in outcomes across sites that were more or less integrated. However, given that there was no significant difference in outcomes between sites overall (See section 7.3), it would appear that variability in degrees of integration across sites was not associated with variation in outcomes across sites.

There was also insufficient data to draw a robust conclusion on whether integration was associated with uptake rates across sites. Assessment of deep dive sites using a service maturity matrix[145] was used to determine whether there was relationship between integration and uptake rates.[146] The analysis found that confounding variables created difficulties in drawing any conclusions as:

- Sites with higher uptake rates also had a higher number of referrals (i.e. uptake rates may be associated with service volumes). Section 5.2 outlines some elements of integration that were associated with greater referral volumes including presence of a hospital liaison officer, co-location, and collaboration agreements. However, this cannot be directly attributed to uptake rates, as there was limited data available to the evaluation to understand which sites were more integrated and how this influenced uptake rates in their region.
- Site maturity is measured across multiple domains that are broader than measures of integration such as operational status, data collection, and service outputs (i.e. development of a safety and support plan).

9.3 Effectiveness of service enablers

As outlined in Section 4 the evaluation identified four key enablers to deliver The Way Back. These were: governance funding; partnerships and engagement; workforce; and monitoring and continuous improvement. This section provides a detailed overview of these enablers and their effectiveness in delivering The Way Back.

Governance and funding

The Australian, state and territory governments and Beyond Blue governed and funded The Way Back.

The Way Back governance reflected the complex funding arrangements, and complex policy and operational arrangements for the establishment and operation of The Way Back (see section 4). The governance arrangements aimed to ensure that stakeholders were accountable for commissioning and delivering The Way Back in line with the service model and the implementation and procurement guide. Figure 27 summarises the governance arrangements and accountabilities.

---

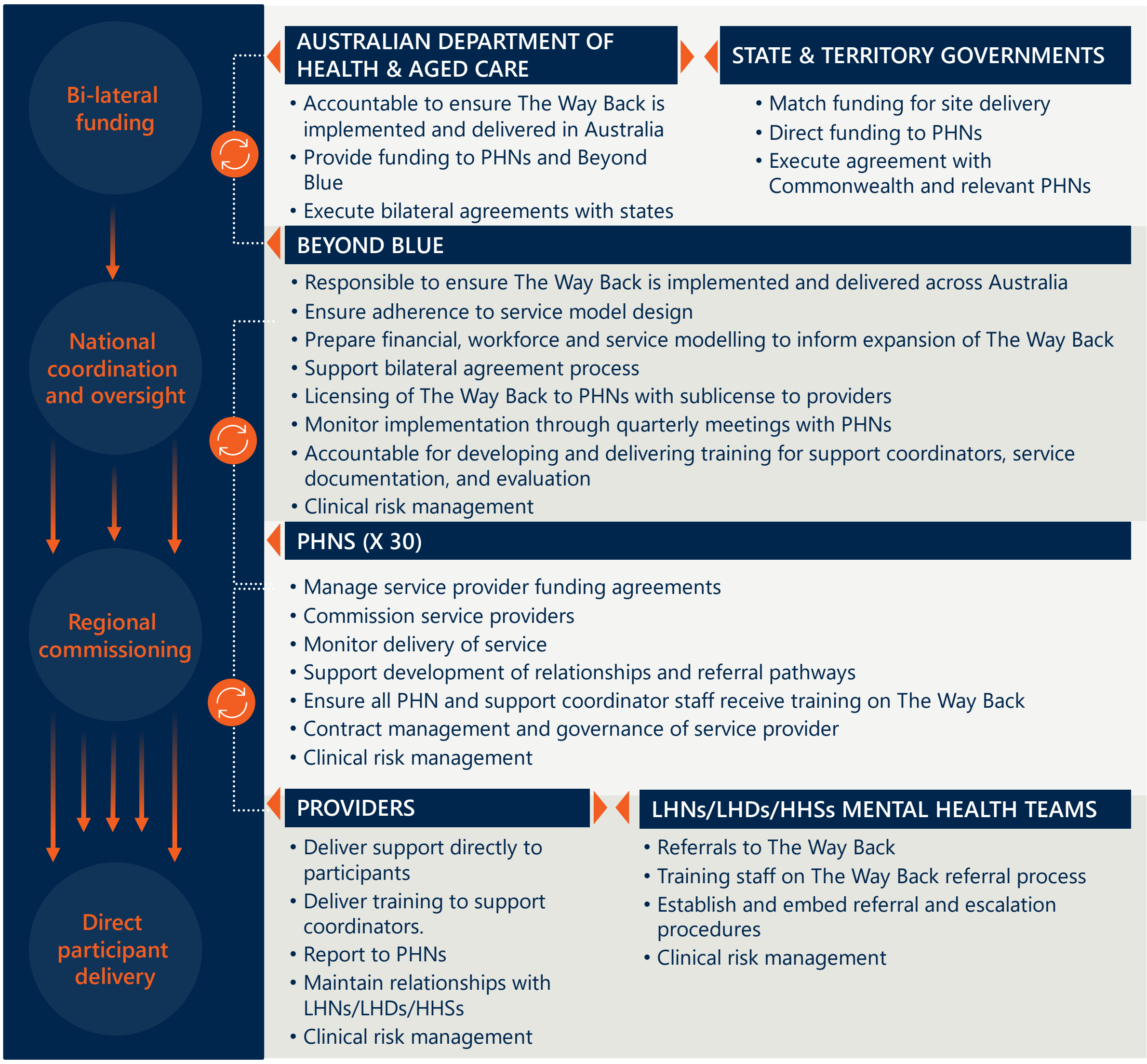
[143] Isaacs, A. N. (2021). Care coordination as a collaborative element of recovery-oriented services for persons with severe mental illness.

[144] Ibid.

[145] The service maturity matrix measured site maturity across three domains: design, implementation, and service delivery.

[146] Based on supplementary data between June 2021 and June 2022.

Figure 27 | The Way Back governance arrangements and accountabilities[147]



Bi-lateral funding

National coordination and oversight

Regional commissioning

Direct participant delivery

AUSTRALIAN DEPARTMENT OF HEALTH & AGED CARE

- Accountable to ensure The Way Back is implemented and delivered in Australia
- Provide funding to PHNs and Beyond Blue
- Execute bilateral agreements with states

STATE & TERRITORY GOVERNMENTS

- Match funding for site delivery
- Direct funding to PHNs
- Execute agreement with Commonwealth and relevant PHNs

BEYOND BLUE

- Responsible to ensure The Way Back is implemented and delivered across Australia
- Ensure adherence to service model design
- Prepare financial, workforce and service modelling to inform expansion of The Way Back
- Support bilateral agreement process
- Licensing of The Way Back to PHNs with sublicense to providers
- Monitor implementation through quarterly meetings with PHNs
- Accountable for developing and delivering training for support coordinators, service documentation, and evaluation
- Clinical risk management

PHNS (X 30)

- Manage service provider funding agreements
- Commission service providers
- Monitor delivery of service
- Support development of relationships and referral pathways
- Ensure all PHN and support coordinator staff receive training on The Way Back
- Contract management and governance of service provider
- Clinical risk management

PROVIDERS

- Deliver support directly to participants
- Deliver training to support coordinators.
- Report to PHNs
- Maintain relationships with LHNs/LHDs/HHSs
- Clinical risk management

LHNs/LHDs/HHSs MENTAL HEALTH TEAMS

- Referrals to The Way Back
- Training staff on The Way Back referral process
- Establish and embed referral and escalation procedures
- Clinical risk management

The Way Back was jointly funded by the Australian Department of Health and Aged Care, state and territory governments, and Beyond Blue, with Beyond Blue also receiving $11.89m of funding from the Australian Department of Health and Aged Care. PHNs were the commissioner of The Way Back in their regions and hold service agreements with service providers (and in few cases, hospitals) to deliver the service. As of September 2021, approximately $82.3 million of funding was budgeted for the delivery of The Way Back from 2018 to 2022. The funding arrangements are detailed in Figure 28.[148]

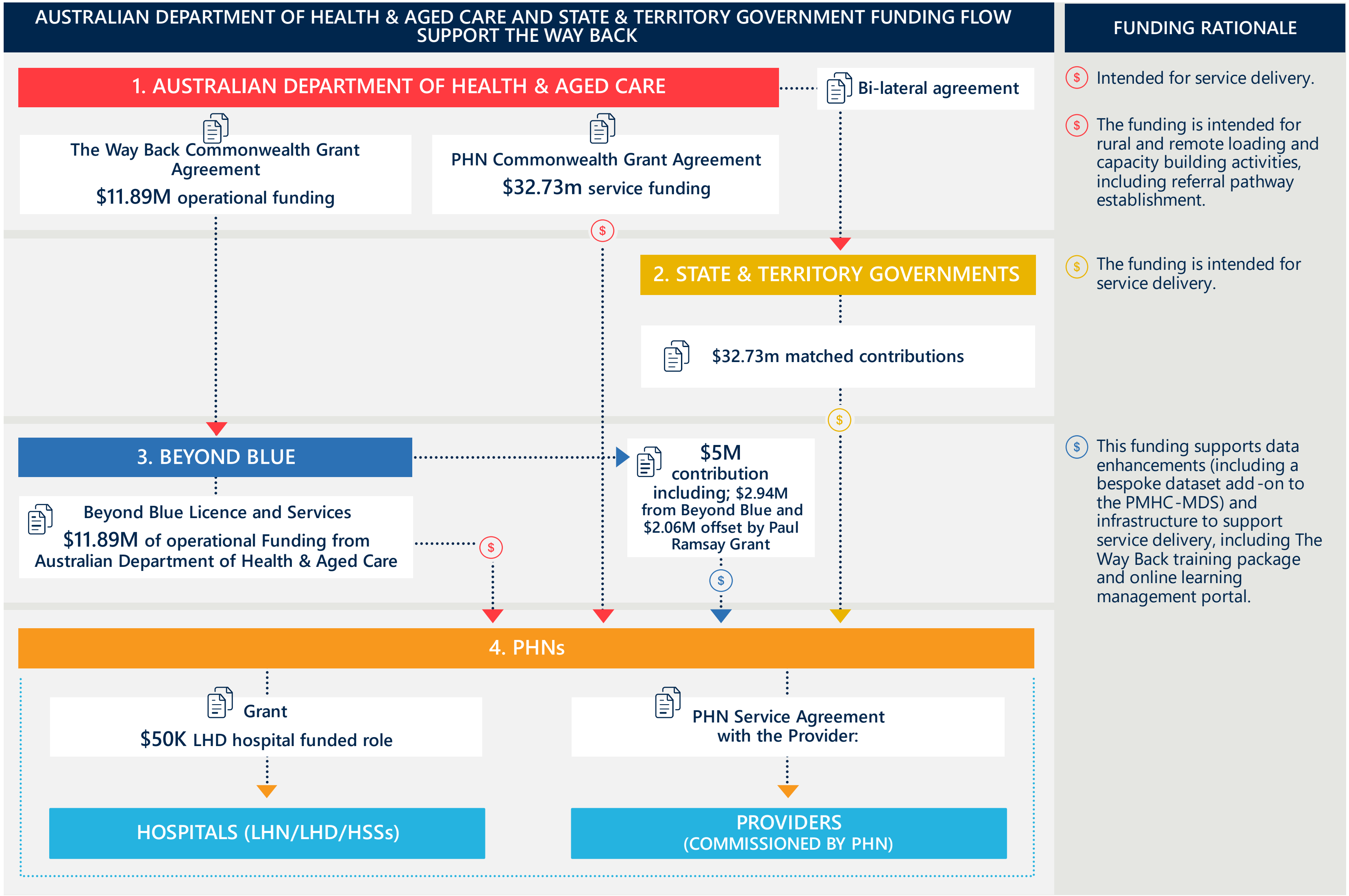
From July 2022, Beyond Blue commenced the transition of The Way Back sites and infrastructure to the Australian Department of Health and Aged Care and states and territories. The Australian Department of Health and Aged Care has allocated an additional $14 million to Beyond Blue to support the transition from July 2022 to December 2023.

---

[147] Depiction based on information captured in Beyond Blue, 'The Way Back Support Service – Service Delivery Model', March 2020. Number of PHNs is representative of all 31 operational sites, noting some PHNs have more than 1 site in their region.

[148] Note that a further $7 million was provided by the Australian Government and the Victorian Government to support the expansion of The Way Back and Hospital Outreach Post-suicide Engagement (HOPE) sites.

Figure 28 | The Way Back funding model



Intended for service delivery.

The funding is intended for rural and remote loading and capacity building activities, including referral pathway establishment.

The funding is intended for service delivery.

This funding supports data enhancements (including a bespoke dataset add-on to the PMHC-MDS) and infrastructure to support service delivery, including The Way Back training package and online learning management portal.

Bilateral agreements intended to set out clear expectations; in practice there was significant confusion around lines of accountability and funding uncertainty.

Stakeholders including PHNs and providers in consultations reported that governance and funding arrangements, particularly for PHNs, were complex and could be simplified. The Productivity Commission's Inquiry into Mental Health identified complex governance mechanisms across mental health services inhibit clarity of roles and accountability to deliver outcomes.[149] Complicated or unclear governance arrangements have meant there were significant delays in the implementation of The Way Back in some states and/or at some sites.

Further, funding levels and uncertainty impacted providers' ability to deliver the service, recruit and retain their workforce. Providers consistently reported that they would benefit from additional funding to expand their service in various ways (for example, recruit additional support coordinators or administrative staff, extend service delivery hours) to better meet the demand and maximise value of support coordinator time (for example, less time on administrative tasks). Further, the uncertainty of funding beyond July 2022 for the service created a significant challenge for services when accepting new participants where the period until July 2022 was less than the 12-week service model. This meant services were unable to guarantee participants would have access to the full 12-week service.

The evaluation identified that there is a need for The Australian Department of Health and Aged Care, and states and territories to simplify, clarify and provide certainty on funding for The Way Back. Further, there is an opportunity to ensure accountabilities and responsibilities to deliver this service are clear. Section 10.1 provides recommendations on this for future aftercare services (recommendation 8, recommendation 9, and recommendation 10),

Partnerships and engagement

The Way Back was delivered through partnerships between governments, PHNs, and providers.

Established partnerships between key stakeholders supported the governance arrangements and service delivery. As of December 2022, Beyond Blue partnered with 30 PHNs and seven and territory governments, together with hospitals and the Australian Department of Health and Aged Care. These partnerships were central to the implementation and delivery of The Way Back. They enabled the service to deliver on its intended purpose by ensuring people who experienced suicide and/or suicidal crisis were connected and had access to timely and appropriate services.

Further, partnerships between The Way Back, a psychosocial service, and clinical services were critical to ensure participants received continuity of care and longer-term support to address the whole person (including their psychosocial needs as well as clinical needs).

Strong networks and partnerships with clinical and psychosocial services helped to deliver The Way Back.

Providers in interviews reported having strong relationships with referring providers, clinical and psychosocial services, all of which were critical to service delivery. Providers with stronger relationships felt their better understood local need, however many providers noted they have limited partnerships with Aboriginal and Torres Strait Islander organisations, such as local ACCHOs or AMSs.
The development and maintenance of strong referring outbound relationships is an important lesson that can be applied to aftercare and mental health services more broadly across Australia. The development of

---

[149] Productivity Commission. Mental Health Productivity Commission Inquiry Report Volume. (2020). Retrieved from: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf.

these partnerships and relationships are critical to ensure participants have access to timely, continuous and integrated support that meets their individual needs.

Workforce

Sites’ local context informed The Way Back’s workforce requirements.

The funded staff profiles at sites were determined through analysis and modelling of local contexts to identify the appropriate ‘funding category’. The funding category was determined by the location’s population catchment and five-year average death by intentional self-harm data. Higher population levels and higher average death by intentional self-harm represented a higher case load, and in turn, higher staff full time equivalent (FTE) funding allocation, compared to lower levels of these two indicators. Appendix C provides further detail on the three funding categories.

Regardless of the funding category, all sites received funding for three core roles: team leader, administration and/or data entry assistant, and support coordinators. All LHD/LHN/HHSs also received FTE funding for a hospital liaison role to link the LHD/LHN/HHSs with the provider and provide clinical risk management over referrals into the service. Some providers may also have additional roles in the service such as referral coordinator. The therapeutic alliance between support coordinators and participants was fundamental to effective delivery of The Way Back.

Building the therapeutic alliance should continue to be a focus for support coordinators for future delivery of The Way Back and other aftercare services. The therapeutic alliance (i.e. the trust and connection between the participant and support coordinator) was identified as the primary mechanism of change which was fundamental for the service (see section 8.1). Participants consistently reported the importance of this non-clinical relationship on outcomes. This evaluation finding was consistent with the findings of other non-clinical proactive aftercare programs which referenced the support of a non-clinical support for persons experiencing suicidality and crisis.[150]

There are opportunities to improve The Way Back staff experience.

Providers in consultations noted ongoing recruitment and retention challenges for a mental health and suicide prevention workforce. An inability to recruit and retain staff has meant some sites have less staff than required under the staffing model (outlined in Appendix C) and as a result staff at those sites managed higher than anticipated caseloads. This challenge aligns with the broader workforce challenges that exist across the Australia’s mental health system. Key drivers of workforce shortages relate to staff being over-worked, under-supported, burnout, and lack of professional development opportunities and career pathways.[151]

Respondents to the provider survey (47 per cent or 44 responses) highlighted that additional support to manage a reasonable workload would help them better deliver The Way Back. Additionally, respondents to the provider survey highlighted that the following supports would be most helpful to enable them to deliver improved service to The Way Back participants:

- Support from The Way Back manager or team leader (61 per cent or 58 responses)
- A manageable caseload (57 per cent or 54 responses)
- Specific training provided by The Way Back (56 per cent or 53 responses).[152]

The evaluation identified several opportunities to improve staff experience of delivering The Way Back. This includes through the introduction of a capability framework, improving supports to better manage

---

[150] SAX Institute. (2019). Suicide aftercare services. pp. 28-30. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

[151] Institute for Social Science Research. 2020. *National Mental Health Workforce Strategy – A literature review.* Retrieved from: https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.docx

[152] Survey administered between June 2021 and June 2022, n = 95.

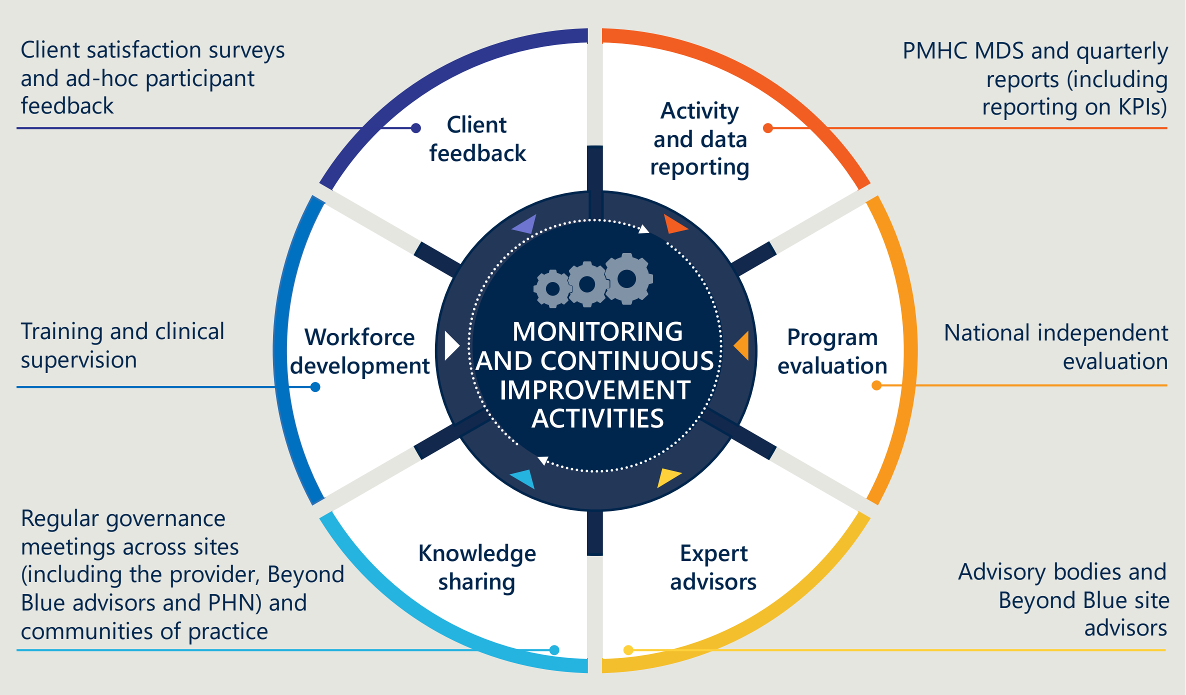
vicarious trauma, and improving The Way Back's current community of practice. These improvements are outlined in detail in section 10.1 (recommendation 11, recommendation 12, recommendation 13).

Monitoring and continuous improvement

Monitoring and continuous improvement activities occurred at the national, state and territory, PHN and provider level.

There were several activities that contributed to the monitoring and continuous improvement of The Way Back, outlined in Figure 29.

Figure 29 | The Way Back continuous improvement activities



Service delivery and performance was measured against six Key Performance Indicators (KPIs).[153] These were informed by evidence of best practice in aftercare and were:

1. **Initial contact with referred person.** For referred persons who were confirmed as eligible for The Way Back Support Service, contact[154] must be attempted with the referred person within one Business Day of receipt of the referral by the provider.
2. **Correspondence with Primary Nominated Professional on entry to the service.** For all participants who provided consent for their Primary Nominated Professional to be notified, correspondence must be sent advising them of their participant's engagement with The Way Back within three business days of consent being obtained.
3. **Correspondence with Primary Nominated Professional on exit from the service.** For all participants who exited from the service (unplanned or planned) and who have nominated a Primary Nominated Professional, correspondence must be sent by the provider to their identified Primary Nominated Professional within three business days of the exit date.
4. **Safety plan update/development.** Safety plans must be updated or developed preferably at the initial contact with the participant and no later than the second contact.

---

[153] Note that from 1 July 2022, KPIs have been amended to better reflect service model intent. These changes are outlined in Appendix C.

[154] In some cases, more than one attempt at contact may be required before The Way Back Support Service is able to reach the Participant. The requirement of contact to be made within one business day relates to the first attempt at contact and not necessarily when contact is made.

5. **Support plan development.** A support plan is to be developed within two weeks of consent to participate in the service.
6. **Quarterly new participant episode target.** Achieve 100 per cent of the relevant quarterly new participant episode target per quarter.[155]

See Appendix C for detail on KPI reporting and monitoring and continuous improvement.

The Way Back provided new aftercare data but monitoring and reporting processes are burdensome, and data insights are not being used effectively to inform service delivery or improvement within sites.

The data collection and reporting processes have been burdensome on staff and have inhibited the ability of the evaluation to understand the implementation progress of The Way Back across sites and the delivery of outcomes for participants (due to data quality or incompleteness). There is a need to improve data collection processes.

The PMHC MDS has enabled providers, PHNs and Beyond Blue to collect new aftercare data. However, providers, Beyond Blue and PHNs have encountered significant challenges setting up data collection and reporting processes due to capability issues and data input variations across sites. Further, providers reported that insights from the data are not regularly shared across sites and therefore providers did not have an understanding of how The Way Back operates at other sites and opportunities to continuously improve their service. Improvements to data collection, monitoring, and continuous improvement of The Way Back is outlined in section 10.1, (recommendation 14 and recommendation 16).

> *"I've never worked in a service with such a burdensome data collection process." - The Way Back service provider, 2022*

---

[155] A grace period of 120 days shall be provided on achievement of the Total Annual Cases KPI. This is recognising that there will be a period of time before the Service Provider builds to full capacity and the referral pathways are efficiently established.

10 Recommendations

This section answers KEQ 5; What can be done to improve the contribution of The Way Back and similar services.

Given that the current governance and management arrangements in place for The Way Back will cease from June 2023, this section provides recommendations for improvements to The Way Back and future aftercare services more broadly (16 recommendations), the handover of The Way Back (two recommendations) and emerging lessons for mental health services in understanding participant recovery.

10.1 Recommendations for future aftercare services in Australia

The evaluation provides 16 recommendations for future aftercare services

16 Recommendations to improve future aftercare services are outlined below. These recommendations were drawn from the interim and final evaluation findings. The recommendations address gaps, opportunities and challenges across five domains:

1. Service intake
2. Service delivery
3. Governance and funding
4. Workforce
5. Monitoring and continuous improvement

Recommendations for future aftercare services are summarised in Figure 30Figure 30 and detailed overleaf in Figure 31.

A note on the recommendations: In early 2022, Beyond Blue reviewed the six KPIs mandated under the existing Australian Department of Health and Aged Care Funding Agreement. Beyond Blue has commenced work to refine three and remove two of the six KPIs to better clarify definitions and language and better align what should and is being measured to what evidence suggests is important for participant outcomes. The findings of the evaluation supported the proposed changes to KPIs (as outlined in the interim report) and therefore did not comment explicitly on these in the below recommendations.

Further information on how interim report recommendations have been incorporated into the final report are outlined in Appendix D.

Figure 30 | Summary of recommendations for future aftercare services in Australia

SERVICE INTAKE

1 Broaden inbound referral pathways.
Interim report recommendation 13

2 Reduce the average length of time between initial contact with the service and service delivery.
Interim report recommendation 4

3 Funding is made available for a liaison officer role with sufficient FTE in all referring hospitals.
Interim report recommendation 1

SERVICE DELIVERY

4 Increase the proportion of participants who have a completed safety and support plan.
Interim report recommendation 2

5 Investigate variations in aftercare models, including co-design, that would lead to more significant improvements to service access and outcomes for specific cohorts.

6 Continue to gather evidence to determine whether peer support should be included in the core service model for aftercare services.

7 Consider including the provision of support to participant support persons in the core service model for aftercare services.

GOVERNANCE AND FUNDING

8 Provide greater certainty through longer duration of funding and earlier advice on commissioning intentions/ service continuation.

9 Simplify and clarify funding arrangements.
Interim report recommendation 15

10 Simplify and strengthen future aftercare services' governance to ensure roles, responsibilities and accountabilities are clear and understood.
Interim report recommendation 3

WORKFORCE

11 Develop a capability framework for support coordinators.

12 Establish a community of practice to share best practice, problem solve and upskills providers.
Interim report Recommendation 8

13 Improve support for staff to better manage vicarious trauma and burnout.
Interim report recommendation 10

MONITORING & CONTINUOUS IMPROVEMENT

14 In the short term, ensure mental health outcome measures are used appropriately, consistently and comprehensively with participants who agree to completing an assessment.

15 In the medium to longer term, review the appropriateness of mental health outcome measures for participants.

16 Reconcile and simplify data collection sharing, monitoring and reporting requirements to ensure better data consistency and quality.

Figure 31 | Detailed recommendations for future aftercare services in Australia

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
SERVICE INTAKE		
1. Broaden inbound referral pathways so that individuals can be referred from community-based referral pathways such as GPs, ambulance, crisis hotlines, ACCHOs, AMSs, and other mental health service providers. (Interim report recommendation 13). States and territories should work with the providers to identify and resource opportunities to broaden inbound referral pathways appropriate for their local context. Commissioners should ensure that referral pathways have clear governance arrangements on who holds responsibility for the participant during handover.	Evidence and insights from consultations highlighted that people would greatly benefit from access to The Way Back from alternate referral pathways such as GPs, ambulance, crisis hotlines and other psychosocial services. This may increase access to the service for some cohorts such as Aboriginal and Torres Strait Islander people who are less likely to present to Eds when experiencing suicidal crisis given the history of institutional racism experienced by this cohort.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES SERVICE COMMISSIONERS
2. Reduce the average length of time between the initial contact with the participant and service delivery. *(Interim report recommendation 4).* Commissioners to: • Work with providers and referring health services to ensure the service is available to people who choose to access it within that immediate period of heightened distress/risk, as per the original model of service. • Work with providers to support reductions in the average amount of time between initial contact and first service engagement (noting some participants may choose to have a greater length of time before engaging). • Work with providers to ensure data collection for this period (between initial contact and actual service engagement) is captured more consistently and accurately. • Support providers and referring health services to develop interim supports/tools (for example, psychoeducation or referral to alternative services) to participants where service delivery cannot be delivered immediately after contact (if not already in place).	It is important to align the original service principles (timely support is critical managing risk) and evidence[156] around the criticality of immediate support for people who have attempted suicide or had a suicidal crisis.	SERVICE COMMISSIONERS

---

[156] SAX Institute. 2019. Suicide aftercare services. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
- The Australian Department of Health and Aged Care to refine aftercare service delivery model to ensure it is more explicit around the service intent for both immediate contact and immediate or rapid engagement.		
3. Funding is made available in future aftercare services for a liaison officer role with sufficient FTE in all referring hospitals to make initial contact with participants while they are in the emergency department or in-patient unit. *(Interim report recommendation 1).*	Sites that had a funded hospital liaison officer in referring services were more likely to report effective referral pathways (see section 9.2). This will also help to build confidence and hope for participants and their carers so that they have support arrangements in place prior to their discharge. It may also help to increase low uptake rates. Existing evidence (such as the Sax Institute 2019 Evidence Check) and participant interviews indicated the importance of hope in recovery.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES
SERVICE DELIVERY		
4. Providers to increase the proportion of participants who have a completed safety and support plan, where they have agreed to undertake them, or that they have opportunity to share and update existing plans. (*Interim report recommendation 2).* Providers should seek to improve to the coverage of safety and support planning (for participants who agree to develop them) through: • Co-designing safety and support plans with participants to ensure it provides participants with the flexibility in how information is gathered and presented (for example, a less clinical focus, use of Beyond Now app, and use of more culturally appropriate models that are more visual and simple). • Ensuring support coordinators provide the opportunity for participants to share, update and refine plans throughout their episode of service. • Establishing information sharing processes with referring providers to access existing safety plans developed with participants prior to accessing the service. It should be noted that while PMHC MDS data on the completion of safety and support plans has limitations in coverage and completeness, it is still important to explore the extent to which adherence to safety and support planning can be improved at sites (for participants who choose to complete them).	Completion of safety and support plans are a mandatory component of the service design (unless a participant declines). As outlined in section 10.1, there was a lower than expected proportion of safety and support plans completed, As such, there is an opportunity to improve the number of safety and support plans that were offered to participants and completed.	PROVIDERS

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
5. Investigate variations in aftercare service models, within the scope of the universal aftercare standards, including through co-design, that would lead to more significant improvements to service access and outcomes for specific cohorts. Providers, service commissioners and states and territories to: • Engage and co-design with people who have experienced suicidality to better understand what makes them consent (or not consent) to aftercare services and identify opportunities to develop more accessible aftercare services. Co-design should engage people to use their lived experience to identify their needs and design appropriate service models. Co-design should also be led by those that identify with these cohorts (i.e. Aboriginal and Torres Strait Islander) and should be culturally appropriate. • Seek to understand the learnings from and impact of specific model variations that have been developed to support different cohorts to engage with and optimise outcomes from the service. Update a participant's record for any additional demographic information that is disclosed during their time with an aftercare service before an episode is closed.	The Way Back service model was not explicitly codesigned with priority cohorts identified (Aboriginal and Torres Strait Islander people, and LGBTIQA+) and other cohorts of interest (for example, people from CALD backgrounds and veterans). The evaluation also found that The Way Back was less effective for participants for some specific cohorts compared to the average participant across some outcome measures These included those with a reported diagnosed with a personality disorder, aged under 25, identified as male, and unemployed. It should be noted that The Way Back was also more effective for participants who identified as Aboriginal and Torres Strait Islander and lived in regional/remote locations compared to the average participant across some outcome measures. Given the apparent low engagement from or identification of specific cohorts in the service and subsequently low involvement in the evaluation, the evaluation was limited in its ability to understand whether alternative service models would be appropriate to meet the needs of specific cohorts.	**AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE** **STATES AND TERRITORIES** **SERVICE COMMISSIONERS** **PROVIDERS**
6. Continue to gather evidence to determine whether peer support should be included in the core service model for aftercare services. Evidence on peer support should also consider Aboriginal and Torres Strait Islander definition of lived experience.[157]	The evaluation was unable to find strong evidence for the impact of peer support to improve participant outcomes during their time in The Way Back. There is also limited evidence available in the literature relating to the effectiveness of peer support models in aftercare services.[158] Nous conducted a separate evaluation of the Peer Support Trial in 2021, which indicated that peer	**AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE** **STATES AND TERRITORIES** **SERVICE COMMISSIONERS** **PROVIDERS**

---

[157] Black Dog Institute. 2020. Definition of Aboriginal and Torres Strait Islander Lived Experience. Retrieved from: https://www.blackdoginstitute.org.au/education-services/aboriginal-and-torres-strait-islander-network/

[158] SAX Institute. 2019. Suicide aftercare services. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
	support improves participant experiences of the service. This evaluation found that participants valued the lived experience of support coordinators as it makes them 'real' and 'relatable'. Participants were also significantly more likely to complete their service episode and have a duration of service episode greater than 12 weeks The evaluation also found that improvements to outcomes for participants who received peer support during their engagement with The Way Back did not significantly differ from the average participant. However, the evaluation was limited in its ability to comment on the extent to which peer support models impacted participant outcomes given the limited sample size available to conduct this analysis (see section 7.3).	
7. Consider including the option of provision of support to participant support persons (i.e. families, friends, and carers), subject to participant consent, in the core service model for aftercare services. Australian Department of Health and Aged Care should seek to: • establish a standard framework to deliver support to support persons of people experiencing suicidality. • further investigate how the provision of support-to-support persons contributes to outcomes for them, and for the participant they support, including support persons' capacity to respond to situations of distress and suicidality.	Interviews with support persons of people experiencing suicidality, although very limited, highlighted that receiving support through The Way Back enabled them to provide better support for the participant. However, research has found that where support persons were included in the provision of care of an aftercare service, the model was effective.[159] There is limited data to understand the extent to which this support contributes to the outcomes of participants. There is an opportunity to improve the understanding of the impact of support to the support persons of participants. The Way Back's approach to supporting support persons is not currently structured or consistent, and	**AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE** **STATES AND TERRITORIES**

---

[159] SAX Institute. 2019. Suicide aftercare services. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
	there is opportunity to clarify and enhance the assistance to support persons in the model of service.	
GOVERNANCE & FUNDING		
8. Provide greater certainty through longer duration of funding and earlier advice of commissioning intentions/service continuation at the end of existing contracts.	Funding arrangements have been short in duration which has had adverse implications for certainty of service continuity and workforce retention.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES SERVICE COMMISSIONERS
9.Simplify and clarify funding arrangements. (Interim report recommendation 15). It is recommended that funding arrangements are revised to flow from the Australian Department of Health and Aged Care and state and territory governments, through joint commissioning, directly to PHNs, and PHNs to commissioned providers.	Multiple funding flows have led to enmeshed lines of accountability for management and performance of service provision. See section 9.3 for further detail on these challenges.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES
10. Simplify and strengthen future aftercare services governance to ensure roles, responsibilities and accountabilities are clear and consistently understood. *(Interim report recommendation 6).* • this should include redefining and clarifying the role of PHNs to hold accountability and authority for service performance including monitoring of KPIs and performance management.	Existing governance and accountability arrangements are complex and unclear, leading to confusion in who has responsibility for performance management, risk monitoring and reporting (as outlined in section 9.3).	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES
WORKFORCE		
11. Develop a capability framework for support coordinators. A capability framework is used as a tool to record workforce capabilities deemed desirable or valuable within a particular role. The development of a capability framework for future aftercare services should involve testing with a small group of existing support coordinators and other external experts in aftercare. The framework should:	Providers (particularly in regional and remote sites) highlighted that there were challenges with attracting and retaining staff across sites. Providers noted that attracting and retaining staff required the need to better highlight professional development and	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
• be informed by current support coordinator job descriptions and a brief evidence review on core capabilities in aftercare services. • reflect the desirable capabilities of support coordinators identified in this evaluation. This includes trauma-informed care practices, cultural capability, active listening, building trust, rapport and ability to draw on own lived experience to share strategies for self-care, safety and wellbeing. • be defined across levels of increasing experience and expertise (for example, junior and senior support coordinators). • align with care and clinical governance requirements • align with training and development initiatives in place for future aftercare services. • outline core capabilities, responsibilities and cultural supervision for peer workers (see recommendation 2). The capability framework should be incorporated into existing performance review processes. This should enable support coordinators and team leaders to discuss performance against expected standards as well as growth and progression opportunities. The Australian Department of Health and Aged Care should also consider the development of a capability framework for peer workers (if it is deemed appropriate to include them in core aftercare service models), and administrative staff that support delivery of aftercare services.	accreditation opportunities (which was currently limited). There is an opportunity to standardise expectations about core capability to help ensure more consistent service delivery and participant experiences. There is a need to define levels of capability for different roles in order to provide clear pathways for professional development and progression opportunities for staff.	
Establish a community of practice for future aftercare services to better share best practice, problem solve and identify ways to upskill providers, including involvement of the broader network of aftercare services (for example, PHNs, referring health services). *(Interim Report Recommendation 8)* Improvements to the community of practice should include: • increasing the frequency with which they meet and therefore the opportunity to share good practice, including identifying ways providers can be appropriately upskilled or adapt the service model based on their local context. • continuing to include broader representation and greater engagement from other stakeholders across states and territories (for example, Australian Department of Health and Aged Care, state and territory health departments, PHNs, LHN/LHD/HHSs, and other service providers).	Providers in consultations indicated the importance of being able to learn from more mature sites or other good practice to further improve service access, quality and safety.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES SERVICE COMMISSIONERS PROVIDERS

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
• ensuring there is appropriately resourced Secretariat to coordinate agendas on key topics (for example, service integration mechanisms, outbound referrals, and data collection, reporting and analysis). • attendees that have lived experience of suicidality and were previously involved in accessing aftercare services (for example, using an expression of interest for recruitment of these attendees). • provide flexibility in how information and learnings are shared across aftercare services (for example, written documentation, presentations, working sessions etc.).		
13. Improve support for aftercare services staff to better manage vicarious trauma and burnout *(Interim Report Recommendation 10).* Support mechanisms could include: • additional leave allowances, • access to employee assistance programs, and • formal debriefing requirements for support coordinators / teams / individuals at regular intervals. • Cultural supervision and leave allowances. These mechanisms should be underpinned by care and clinical governance arrangements.	Providers indicated this is a risk, given the nature of the work and demand on services (see section 9.3). The Aboriginal Advisory Group also highlighted the risks to Aboriginal and Torres Strait Islander staff burnout and vicarious trauma given the expectation to be available 24/7 (due to community responsibilities and work) couple alongside the significant Aboriginal and Torres Strait Islander workforce shortages.	AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE STATES AND TERRITORIES PROVIDERS
MONITORING AND CONTINUOUS IMPROVEMENT		
14. In the short-term, ensure mental health outcome measures are used appropriately, consistently and comprehensively with participants who agree to completing an assessment. Providers should: • seek to understand the barriers and challenges in place that are contributing to issues with collecting data. • improve the consistency with which they either complete assessments and/or record the scores to enable a better understanding of participants' progress and outcomes. • ensure that participants who identify as Aboriginal and Torres Strait Islander are provided with the choice to use the K5 outcome measurement tool.	Only a small proportion of participants have matched pair assessments available in the PMHC MDS for the K10 (22%), WHO-5 (17%) and SIDAS (19%) due to: • Incomplete records, and • Inconsistent recording of scores (see section 7.3). An important component of care governance is to understand whether outcomes are improving for the participant.	PROVIDERS

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
15. In the medium to longer term, review the appropriateness of mental health outcome measures for participants of future aftercare services. The Australian Department of Health and Aged Care should Identify outcome measures that are more appropriate to deliver in a psychosocial setting. This should involve: • identifying outcome measures that represent a person's recovery (for example, the Recovery Star model) that does not result in a burdensome process of collecting information for support coordinators or participants of future aftercare services. • collecting information about participants' experience with aftercare services. • conducting a full review of culturally appropriate outcome measures for specific population cohorts (for example, Aboriginal and Torres Strait Islander peoples)	Recovery from suicidality is more than the absence of symptoms of suicidality or distress – which clinical measures tend to assess. Providers and the Aboriginal Advisory Group for this evaluation reported that K10, WHO-5 and SIDAS outcome measures may not be appropriate for participants of The Way Back given that • The Way Back is a psychosocial service, and these measures are 'clinical' in nature. • Assessments such as the K10 may not be culturally appropriate for Aboriginal and Torres Strait Islander people. Note that the K5 (an alternative to the K10) is provided as an option to participants who identify as Aboriginal and Torres Strait Islander.	**AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE**
16. Post transition, reconcile and simplify data collection sharing, monitoring, and reporting requirements to ensure better data consistency and quality across sites. This should involve: • reviewing all reporting requirements and associated data collection requirements, including PMHC MDS data requirements, to improve consistency and quality of data collection. • providing sites access to timely data reports and analysis to demonstrate activity, outputs, performance against KPIs, participant experience/satisfaction and outcomes to support service management and continuous improvement. • refining the minimum requirements for reporting on KPIs or for potential future evaluations (for activity, experience, and outcome data). • supporting providers to understand the most efficient processes and system/s for data collection, reporting and analysis, and identify opportunities for shared system/s across new and existing sites. • optimising the benefit of the existing community of practice (see recommendation 11) to provide providers with the opportunity to clarify data collection practices and the interpretation of reporting requirements.	Data collection on activity outputs, experiences and outcomes varies across states and territories as well as across providers due to the use of different CMSs and processes at the site level. Further, the existing data reporting requirements are extensive and burdensome on providers for which there is little to no perceived benefit.	**AUSTRALIAN DEPARTMENT OF HEALTH AND AGED CARE** **STATES AND TERRITORRIES** **SERVICE COMMISSIONERS**

RECOMMENDATION	RATIONALE	LEAD RESPONSIBILITY
• prioritising timely and well-resourced evaluation activities, including the establishment of an evaluation framework. • funding for systems (for example, PMHC MDS portal) and workforce that can support improvement of data collection.		

10.2 Recommendations for the handover of The Way Back

Two recommendations have been developed for the handover of The Way Back.

17. Beyond Blue to handover its existing role with The Way Back to the Australian Department of Health and Aged Care, and states and territories.

From June 2023, Beyond Blue will step back from their existing role in the delivery of The Way Back. Until then, Beyond Blue will continue to support the delivery of existing The Way Back services and support the transition of The Way Back to states and territories.

States and territories will be able to choose the aftercare model they embed in their jurisdiction. This means states and territories may:

- Choose to remain with The Way Back model
- Implement a new blended model of clinical and psychosocial support (for example, Victoria's HOPE)[160]
- Establish a different aftercare model.

Prior to December 2023, it is recommended that Beyond Blue to the extent possible with under transition funding provided:

- **Supports implementation of recommendations from the evaluation.** The implementation of the recommendations made in the national evaluation of The Way Back will contribute to improved service delivery and outcomes for participants. The recommendations should be implemented as a priority and shared with states and territories and PHNs to inform the development of models of aftercare.
- **Continues to refine KPIs.** Beyond Blue should continue its work to make refinements to the KPIs as proposed and share recommendations for KPIs going forward with the Australian Department of Health and Aged Care, states and territories, and PHNs.
- **Supports service continuity of existing The Way Back sites** from 1 July 2022 in line with bilateral arrangements committing to The Way Back until June 2023. Beyond Blue to re-issue The Way Back License to existing sites until June 2023 including access to Beyond Blue's resources including education and training.
- **Shares learnings on aftercare.** Beyond Blue should share all knowledge and learnings relating to service design, implementation and delivery since the rollout of The Way Back with the Australian Department of Health and Aged Care, states and territories and PHNs.
- **Determines what elements of The Way Back need to be handed over to the Australian Department of Health and Aged Care and states and territories.** This includes governance, licensing, workforce, training and education materials and performance reporting and data capabilities.

18. Beyond Blue should ensure it is involved in appropriate transitional governance mechanisms.

Throughout the Transition, it will be important to have appropriate governance and accountability in place to ensure that there is smooth handover of Beyond Blue's current role. It is recommended that Beyond Blue maintains its involvement in existing governance arrangements to support handover of The Way Back

---

[160] The HOPE program is a follow-up and aftercare service for people who attend a hospital ED in crisis or following a suicide attempt. HOPE provides both clinical and social support to individuals and their personal support networks.

and support smooth transition to new models of aftercare to be in place after 30 June 2023 (for example through membership and involvement in the National Mental Health and Suicide Prevention Agreement Aftercare Steering Group convened by the Australian Department of Health and Aged Care)

11 Conclusions

This section details the evaluation conclusions and implications for aftercare and mental health services in Australia.

11.1 The Way Back is an effective aftercare service that improves outcomes for people who have had a suicidal crisis or attempted suicide.

Participants' suicidal ideation, psychological distress and mental wellbeing significantly improved during their engagement. In summary participants experienced a:

- 63 per cent reduction in suicidal ideation
- 28 per cent reduction in psychological distress
- 86 per cent improvement in wellbeing.

Participants in interviews also reported the value of The Way Back in contributing to their recovery through helping them gain hope and motivation, gain access to supports, and strengthening their capacity to cope and manage their own recovery.

> *"She contributed to my wellbeing. I think I'm alive because of her."*
>
> *- The Way Back Participant*

11.2 What makes The Way Back effective is relevant to other aftercare and mental health services across Australia.

Key learnings include:

- **Aftercare has a significant impact on people's recovery following a suicide attempt or suicidal crisis.** The evaluation found that during participants' engagement with The Way Back, they experienced significant improvements to wellbeing and significant reductions to suicidality and psychological distress.
- **There is a clear need to address social, economic, and cultural determinants (for example, housing and employment).** The evaluation highlighted how people's situational crises that led to their experiences of suicidality (such as homelessness) is crucial to address before they can engage in recovery that responds to their mental health needs. It is important for mental health services and social supports to be connected so that people's needs are addressed holistically.
- **The therapeutic alliance is an essential foundation for successful service engagement and outcomes.** The evaluation demonstrated the criticality of the therapeutic alliance between the participant and support coordinator, a finding supported in existing literature.[161]
- **Effective mental health models of care are participant led, and flexibly respond to individual needs.** Participants of The Way Back emphasised the importance of being provided with choices on what best responded to their needs.
- **Participants reported that peer support was an important contributor to their experience of The Way Back service.** This evaluation highlighted that participant with peer support were more likely to complete their service episode, and stayed in the service for longer than participants without peer

---

[161] SAX Institute. (2019). Suicide aftercare services. pp. 28-30. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf

support – though there is no evidence that leads to better outcomes in suicidality, distress or wellbeing. Participants expressed that building a therapeutic rapport was a positive experience, however quantitatively unable to identify statistically significant differences in outcomes.

- **Strong partnerships supported by formal arrangements with referring partners.** Providers highlighted the importance of having stronger referral partnerships with LHDs/LHS/HSSs. This ensures there are timely and seamless processes for participants.
- **There are some good examples of aftercare models that respond to (local) Aboriginal and Torres Strait Islander needs and preferences**. It should not be assumed that a universal aftercare model should attempt to replace or duplicate these. There is scope to partner with Aboriginal and Torres Strait Islander organisations already delivering effective services to understand the need to expand, and at minimum ensure existing aftercare services that are not targeted to Aboriginal and Torres Strait Islander people are nonetheless culturally safe.
- **The success of aftercare services as a time-limited service that holds people between acute and ongoing supports is limited by the effectiveness of the surrounding systems (acute, mental health and community systems).** Acute health services that refer into aftercare services must be culturally safe and accessible and have the ability to identify and refer eligible participants in a timely manner. Psychosocial and clinical supports must be available, of quality and have capacity to accept referrals in order for aftercare supports to fulfill its role in connecting participants to services to enable their recovery. This was reported as more of a challenge in rural and remote areas than metropolitan areas.
- **There is still a gap for people who want access to more intensive psychosocial suicide prevention support prior to the point of crisis.** The evaluation found that The Way Back is responding to critical gap within the mental health system. Participants highlighted that they would have benefited from accessing a service such as The Way Back before their point of crisis. However, this would represent a deviation from the purpose of an 'aftercare' model to a more general mental health/psychosocial support service. The Way Back cannot respond to all gaps evident in the suicide prevention space and so consideration is needed to determine what other models of treatment, care and support are needed to fully support people before the point of crisis.

nous

A bigger idea of success

Nous Group is an international management consultancy operating across Australia, New Zealand, the United Kingdom, Ireland and Canada. We are inspired and determined to improve people's lives in significant ways. When our strengths complement yours and we think big together, we can transform businesses, governments, and communities. We realise a bigger idea of success.

700	70	5
PEOPLE	PRINCIPALS	COUNTRIES

+80.7 **2020–22 NET PROMOTER SCORE** – global consulting average: **+76.6**