# Culture Care Connect: A program evaluation.

Final report.

Prepared by Inside Policy for the

Australian Government Department of Health, Disability and Ageing and the National Aboriginal Community Controlled Health Organisation

28 May 2025

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# Acknowledgements

Inside Policy acknowledges the First Nations' lands on which we live and work. We pay our respects to the Elders past and present of these Nations. We thank them for their ongoing custodianship of land, waters, air, and all aspects of Country and remind ourselves that it always was, and always will be, Aboriginal and Torres Strait Islander land.

Inside Policy acknowledges and thanks the staff of Department of Health, Disability and Ageing (DHDA), the National Aboriginal Community Controlled Health Organisation (NACCHO), Culture Care Connects (CCCs) Aboriginal and Torres Strait Islander Advisory Group (ATSIAG), and all the participating CCC sites – Aboriginal Health Council of Western Australia, Moorditj Koort, Kimberley Aboriginal Medical Services, Pilbara Aboriginal Health Alliance, Wuchopperen, Cherbourg Regional Aboriginal and Islander Community Controlled Health Services, Apunipima, Aboriginal Medical Services Alliance Northern Territory, Danila Dilba, Awabakal, Waminda, Orange Aboriginal Medical Service, Ballarat and District Aboriginal Cooperative, Bendigo and District Aboriginal Cooperative, South Australian West Coast Aboriginal Community Controlled Health Organisation Network, and Nunkuwarrin Yunti. We are grateful for all the rich and diverse contributions that have helped shape and inform this report.

The research in sites was made possible by the support of NACCHO and sites themselves as well as the First Nations researchers who supported Inside Policy to undertake the evaluation – Dillon Bells, Linda Thomas, Jacob Peluso, Donna-Maree Stephens, Natasha Kickett, Dean Miller, and Tanika Perry.

This evaluation report addresses sensitive topics related to suicide prevention, mental health, and social and emotional well-being for Aboriginal and Torres Strait Islander peoples. Inside Policy acknowledges the disproportionate rate of suicide amongst First Nations communities, and the deep and lasting impact that suicide has on individuals, families, and communities. We also acknowledge the extraordinary efforts of all of those involved in the CCC program who are – through their efforts – supporting their communities in order to prevent more distress and suicide.

If you find any content distressing, we encourage you to seek support. Below are available helplines and services:

- Lifeline Australia – 13 11 14 or Crisis Support Chat
- Suicide Call Back Service – 1300 659 467 or online counselling
- Kids Helpline – 1800 551 800 or WebChat counselling
- Brother to Brother 24 Hour Crisis Line – 1800 435 799 or visit their website
- Mens Line Australia – 1300 789 978 or online counselling
- Open Arms Veterans & Families Counselling – 1800 011 046 or visit their website
- Qlife – LGBTI peer support and referral – 1800 184 527 or webchat (3pm to 12am daily)
- National Indigenous Postvention Service – 1800 805 801
- 13YARN: 13 92 76 (Crisis support for Aboriginal and Torres Strait Islander peoples)
- Beyond Blue: 1300 22 4636

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# Culture Care Connect-specific terminology

Indigenous, First Nations, Aboriginal and Aboriginal and Torres Strait Islander people(s) are used interchangeably within this report.

In addition to the above, below are the CCC-specific terms that are used throughout this report:

- **'Culture Care Connect' or 'CCC'** is used to connote the program and its activity streams.
- **'Activity streams'** is a term utilised in CCC to refer to the three primary streams of activity funded in the program, namely the establishment of Community Controlled Suicide Prevention Networks (CCSPNs), Aftercare Services and Aboriginal and Torres Strait Islander Mental Health First Aid.
- **'Affiliates'** refer to the Aboriginal Community Controlled health peak bodies from each state and territory that assist NACCHO in its leadership of the Sector. Affiliates coordinate activities within their jurisdictions and lead jurisdictional cooperation between Aboriginal Community Controlled Health Organisations (ACCHOs), government and the public health sector.
- **'Community Controlled Suicide Prevention Network (CCSPN)' or 'Networks'** are used interchangeably in this report. They refer to the community-controlled suicide prevention networks established through CCC, which are led by ACCHOs that coordinate and implement suicide prevention activities in their communities.
- **'Jurisdictions'** is a term utilised in CCC to refer to the domain overseen by affiliates within the program. The terms 'affiliates' and 'jurisdictions' are used interchangeably.
- **'Jurisdictional Coordinator' or 'JC'** refers to the CCC-funded position embedded within each affiliate. The JC oversees program implementation at the jurisdictional level.
- **'Network Coordinator'** or '**NC**' refers to the CCC funded position embedded within the lead Aboriginal Community Controlled Organisation (ACCHO) within a CCSPN. The NC oversees program implementation at the community level.
- **'Model of Care'** is a framework developed to support CCC to conceptualise the delivery of suicide prevention and aftercare activity in an ACCHO setting[1]. It reflects the holistic Aboriginal and Torres Strait Islander view of health and social and emotional wellbeing (SEWB). It also integrates aftercare services and suicide prevention coordination to provide a patient-centred approach.[2]
- **'Model of Implementation'** is a term developed for this evaluation and refers to the national, jurisdictional and community level structure established that enables the delivery of Aboriginal-led governance, guidance, resources. MoI enables community-led solutions, in genuine partnership with government across CCC.
- **'The National Agreement'** refers to the National Agreement on Closing the Gap.
- **'Tranches of Funding'** is a term used in CCC to refer to the four staged funding releases disbursed to newly established CCC sites.

[1] NACCHO, *Culture Care Connect: Operational Guidance Paper*, 4 June 2022, V.4 [Internal Document].
[2] NACCHO, *Culture Care Connect: Operational Guidance Paper*, 4 June 2022, V.4 [Internal Document].

# Definitions

| Term | Definition |
|---|---|
| Aboriginal and Torres Strait Islander leadership and community-controlled | Appropriate Aboriginal and Torres-Strait Islander-led governance structures established to ensure self-determination, community empowerment, and that all actions are co-designed with community, and address community priorities.[3] |
| Aboriginal Community-Controlled Health Organisation | Refers to a "primary health care service initiated and operated by the local Aboriginal and Torres Strait Islander community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management."[4] |
| Activity streams | Activity streams are an evaluation specific term and refer to the three primary streams of activity funded in CCC, namely the establishment of CCSPNs, Aftercare Services and Aboriginal and Torres Strait Islander Mental Health First Aid. |
| Aftercare Services | Within the CCC context, "CCC Aftercare are proactive services that are designed and delivered to support Aboriginal and Torres Strait Islander people following a suicide attempt or suicidal crisis. Aftercare provides a safe environment, culturally appropriate care coordination, and support and linkages with different aspects of treatment or response."[5] |
| Community | Community is defined in relation to Country, including family ties and shared experience. Community refers to Aboriginal and Torres Strait Islander people living in a geographical region. Community is about inter-relatedness and acknowledging that belonging is central to culture. There is diversity for those who form and live in communities, noting that Aboriginal and Torres Strait Islander people may belong to more than one community, including where they come from, where family is, where people live and what organisations they belong to.[6] |
| Cultural safety | In the Australian context, this refers to the ethical practice and principle of fostering an environment that is safe (in a broad holistic sense) for Aboriginal and Torres Strait Islander people. This means freedom from racism as well as any 'assault, challenge or denial of their identity and experience'.[5] It also means "ensuring self-determination for Aboriginal [and Torres Strait Islander] people".[6]<br>Within the Program's context, it refers to culturally safe services that are developed, delivered, and evaluated in a manner that recognises and respects the unique cultural identity of Aboriginal and Torres Strait Islander communities. These approaches can positively impact on SEWB, reduce suicidal behaviours and the risk of self-harm.[7] |

[3] AMSANT, Culture Care Connect: Jurisdictional Suicide Prevention Plan 2022-25, [Internal Document].
[4] NACCHO, *Aboriginal Community-Controlled Health Organisations (ACCHOs)*, NACCHO, accessed 19 June 2023.
[5] BDAC, Culture Care Connect: Aftercare Service Delivery Model 2022-25, [Internal Document].
[6] Australian Indigenous HealthInfoNet, The Australian Indigenous HealthInfoNet Guidelines for Aboriginal and Torres Strait Islander Terminology, 2022, accessed 23 August 2024.
[7] AMSANT, Culture Care Connect: Jurisdictional Suicide Prevention Plan 2022-25, [Internal Document].

| | |
|---|---|
| Elder | An Aboriginal and/or Torres Strait Islander person who has gained recognition as a custodian of knowledge, lore, and who has community permission to disclose knowledge and beliefs. It may also refer to an Aboriginal and/or Torres Strait Islander person above a certain age. |
| Model of Care | The CCC Model of Care (MoC) reflects the holistic Aboriginal and Torres Strait Islander view of health and SEWB. It integrates aftercare services and suicide prevention coordination to provide a patient-centred approach.[8] |
| Model of Implementation | A term developed for this evaluation referring to how the CCC is implemented. The Model of Implementation (MoI) includes the national, jurisdictional and community level structure established that enables the delivery of Aboriginal-led governance, guidance, resources. MoI enables community-led solutions, in genuine partnership with government across the Program. |
| National Agreement on Closing the Gap | The current National Agreement, which took effect on 27 July 2020, includes for the first time, Indigenous representatives as parties to the agreement through the leadership of Coalition of Peaks. The National Agreement centres the voices and aspirations of Aboriginal and Torres Strait Islander people in the design and delivery of services that affect them for more impactful outcomes to be achieved.[9] |
| Social and Emotional Wellbeing | "The term social and emotional wellbeing (SEWB) is used by many Aboriginal and Torres Strait Islander people to describe the social, emotional, spiritual and cultural wellbeing of a person. The term recognises the connection to land, sea, culture, spirituality, family and community which are important to Aboriginal and Torres Strait Islander people and impact on their wellbeing. It also recognises that a person's SEWB is influenced by policies and past events".[10] |
| Holistic and life-course approaches | Services that address the social and cultural determinants of health and promotes appropriate, sustainable investment in comprehensive Primary Health Care.[11] |
| Place-based | An approach acknowledging local control and adaptation to local contexts.[12] |
| Postvention | Postvention refers to services or interventions provided to bereaved or affected family, friends and community following a death by suicide. |

[8] NACCHO, *Culture Care Connect: Operational Guidance Paper*, 4 June 2022, V.4 [Internal Document].
[9] Australian Government, *National Agreement on Closing the Gap*, 2020, accessed on 5 June 2023.
[10] Australian Indigenous HealthInfoNet, Social and Emotional Wellbeing, accessed on 04 June 2024.
[11] AMSANT, Culture Care Connect: Jurisdictional Suicide Prevention Plan 2022-25, [Internal Document].
[12] NACCHO, *Culture Care Connect: Operational Guidance Paper*

# Acronyms

| | |
|---|---|
| ACCO | Aboriginal Community Controlled Organisation |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| AH&MRC | Aboriginal Health and Medical Research Council of NSW |
| AHCSA | Aboriginal Health Council of South Australia |
| AHCWA | Aboriginal Health Council of Western Australia |
| AMSANT | Aboriginal Medical Services Alliance Northern Territory |
| AOD | Alcohol and Other Drugs |
| ASDM | Aftercare Service Delivery Model |
| ATSIAG | Aboriginal and Torres Strait Islander Advisory Group |
| ATSIMHFAT | Aboriginal and Torres Strait Islander Mental Health First Aid Training |
| ATSISPEP | Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project |
| AIHW | Australian Institute of Health and Welfare |
| ABS | Australian Bureau of Statistics |
| BCR | Benefit-Cost Ratio |
| CBA | Cost-benefit analysis |
| CCC | Culture Care Connect |
| CoP | Communities of Practice |
| CtG | Closing the Gap |
| CtG PR | Closing the Gap Priority Reform |
| DHDA | Department of Health, Disability and Ageing |
| FTE | Full-time equivalent position |
| JSPP | Jurisdiction Suicide Prevention Plan |
| LGBTIQAP+ | Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual, Pansexual |
| MH | Mental Health |
| MoC | Model of Care |
| MoI | Model of Implementation |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NATSIHP | National Aboriginal and Torres Strait Islander Health Plan 2021–2031 |
| NATSIHWSFIP | National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 |
| NATSISPS | National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-35 |
| NC | Network Coordinator |
| NMHSPP | National Mental Health and Suicide Prevention Plan |
| NPV | Net Present Value |
| NSPP | Network Suicide Prevention Plan |
| PHN | Primary Health Network |
| QAIHC | Queensland Aboriginal and Islander Health Council |

| | |
|---|---|
| SEWB | Social and Emotional Wellbeing |
| SPP | Suicide Prevention Plan |
| TAC | Tasmanian Aboriginal Centre |
| UCM | Bayesian Unobserved Components Model (analytical model) |
| VACCHO | Victorian Aboriginal Community Controlled Health Organisation |

# Evaluation Report Summary

> When we came on, when we did the NACCHO onboarding, my eyes lit up. This is amazing. This is what every program should be like, every bucket of funding should be like this… an opportunity to and for community.

**What support and funding is being used to support community-led work?**

The CCC program is built and being delivered using a range of supports in a community-led and strengths-based way by providing:

**Funding** **$58 million** over four years

**93%** Program Delivery

**7%** NACCHO

**Staff** Employing people at NACCHO, State and Territory Aboriginal health peaks, and ACCHOs.

However, at their current CCC-funded staffing levels, ACCHOs/CCSPNs are not able to meet current demand for suicide prevention and aftercare services. This inability to meet demand is forecast to grow as annual demand is projected to grow by **4.22 per cent**. The CCC workforce must grow by **36 per cent** to meet the future demand, which will need additional funding.

**Expertise** Training in mental health, suicide prevention, aftercare, culture, and program delivery.

**Connections** Local relationships to support referrals, cultural guidance, & community engagement.

**Time** Time spent planning, setting up sites, and rolling out services.

# Survey Results

### Access to Services: Before vs After CCC

| | |
|---|---|
| prevention services easier to access | **82%** |
| aftercare services easier to access | **89%** |
| community-led design | **78%** |

Before CCC started, only a few staff said there were culturally safe services and referral pathways in place. Since CCC began, most people feel these services have improved. The majority said that culturally safe suicide prevention **(82%)** and aftercare services **(89%)** are now easier to access. Most **(78%)** also said these services have been designed together with the community.

### Geographic Differences in Impact

The survey showed that CCC staff working in more remote or smaller rural areas were more likely to report improvements in how services were delivered—things like referrals, coordination, co-design, and access to aftercare and suicide prevention. Staff from both remote and more urban areas said that service delivery had improved since CCC began.

### Experience Level & Training Impact

People with less experience said the training helped them better understand how to recognise and support people in distress. People with more experience were more likely to feel confident using what they learned in real situations.

### Need for Ongoing Professional Development

Staff who took part in the survey, interviews, and site visits said that one-off training like Aboriginal Torres Strait Islander First Aid Training isn't enough to help them in their jobs. Most survey respondents **(79%)** said they will need more support and learning in the future to keep helping their communities with social and emotional wellbeing. CCC staff need regular and more targeted training to do their aftercare work well.

# Executive summary

Culture Care Connect (CCC) is a suicide prevention and after care program for Aboriginal and Torres Strait Islander communities created by the National Aboriginal Community Controlled Health Organisation (NACCHO) in first of its kind partnership with the Department of Health, Disability and Ageing (DHDA) (formerly the Department of Health and Aged Care). It aims to fulfill commitments under the National Agreement on Closing the Gap[13]. In 2022, DHDA allocated $58,195,500 (GST inclusive) in funding to NACCHO to design and deliver CCC from May 2022 to June 2026. CCC operates across three levels with NACCHO overseeing program design and advocacy nationally; jurisdictional affiliates coordinating regional activities; and community-level sites delivering services. This interconnected structure supports ongoing learning, service delivery, and advocacy for systems change from local communities to the national level.[14]

## Focus of this evaluation

Inside Policy was engaged in 2024 conduct an independent evaluation of CCC which was overseen by DHDA and NACCHO. This formative evaluation is intended to produce key insights into the Australian Government's investment, inform future program planning, policy decisions and longer-term systems reform in support of Aboriginal-led suicide prevention and aftercare. To understand CCC's implementation the evaluation aims to answer four questions:

1. To what extent are CCC's supports and activity streams accessible to stakeholders (accessibility)?
2. To what extent is CCC and its activity streams enabling Aboriginal community-led coordinated suicide prevention services and supports (effectiveness)?
3. To what extent is the design and delivery of CCC appropriate (appropriateness)?
4. What are the resources used to enable community-led solutions (efficiency)?

## Methodology

A mix of qualitative and quantitative methods were used to collect data, assess outcomes and identify themes relating to the evaluation questions, including:

- a review of 516 policy and program documents across all levels of implementation
- 16 site visits and semi-structured interviews and focus groups with a total of 150 stakeholders at a national, jurisdictional and network-level including ACCHO and external staff
- two online surveys of Jurisdictional and Network Coordinators (JCs/NCs) and Aboriginal and Torres Strait Islander Mental Health First Aid Training (ATSIMHFAT) participants
- a cost-benefit analysis (CBA)
- a demand analysis examining the extent to which CCC is meeting current demand and can meet future demand.

### Limitations

There were a range of limitations to note that can assist reading and interpreting the findings contained in this report. Survey limitations include being unable to perform statistical analysis due to the small size of sub-groups. Other limitations include the stage of CCC implementation, inherent uncertainty in the cost-benefit analysis and the use of proxies and estimates for the demand modelling.

## Key findings

### To what extent are the CCC's supports and activity streams accessible to stakeholders?

Overall, the supports available through CCC are accessible by their target cohort, which includes:

- Affiliates including JCs and ATSIMHFAT Trainers
- Networks which include ACCHOs, NCs, Aftercare Workers (ACWs) and other related staff.

The data from the evaluation evidence the provision of, and access to, a wide range of program supports by

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[13] National Agreement on Closing the Gap to address Target 14: Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero

[14] NACCHO, *Culture Care Connect: Performance Report,* February 2024, [Internal Document].

CCC stakeholders. These program supports are:

- **CCC approach-specific** – including about the CCC principles, Model of Implementation (MoI) and Model of Care (MoC).
- **Financial** – including the funding for training as well flexibility about the timing and use of funds.
- **Technical** – including templates, examples, expertise, guides and tools to strengthen service delivery.
- **Wellbeing-focused** – including supervision, employee assistance programs, and flexible work.
- **Peer-to-peer** – including Communities of Practice (CoPs), peer-to-peer learning and conferences.
- **Practice-related** – including guidance and tools on clinical, cultural and CCC service provision.
- **Workforce-related** – including position descriptions, recruitment and development assistance.

The above supports relate to the establishment of sites, the design of services, the ongoing implementation / delivery of services, and CCC workforce learning and development. Supports are provided by NACCHO, Affiliates, JCs, NCs and ACCHOs, with NACCHO leading the development and delivery of all the CCC supports and their implementation. The availability of supports vary in their frequency, intensity and target audience.

### To what extent is CCC and its activity streams enabling Aboriginal community-led coordinated suicide prevention services and supports?

Overall the program and its activity streams are enabling Aboriginal community-led suicide prevention and aftercare. This finding is evidenced by the:

- funding of ACCHOs to establish of CCSPNs and aftercare-only sites (28 and seven respectively)
- creation of the CCC workforce (102.9 full-time equivalent (FTE))
- delivery of ATSIMHFAT to nearly 400 people across Australia including ACCHO and external staff and community members. Some sites offer more than ATSIMFAT training to CCC staff and other stakeholders, including Talk about Suicide and Safe Yarn training
- development of 27 Network Suicide Prevention Plans (NSPPs) and six Jurisdiction Suicide Prevention Plans (JSPPs)
- creation of new referral pathways and strengthening of existing referral pathways to access services
- development of a shared language for Aboriginal-led suicide prevention and aftercare
- perception of First Nations communities having access to culturally-safe suicide prevention and aftercare services
- perception of reduced stigma and increased awareness and understanding of suicidality across First Nations communities
- anecdotal reports by CCC staff of the prevention of suicide attempts.

The above findings demonstrate the effectiveness of an approach that is Aboriginal community-led, place-based and strengths-focused. This combination of guiding principles coalesce to ensure services are informed by local need and cultural perspectives resulting in community members having the trust to seek help. The agency provided to ACCHOs and Affiliates also enables them to innovate service delivery approaches.

The evaluation has also found that CCC stakeholders are largely implementing the MoI and care with fidelity. The operationalisation of these models at the program and sites levels has enabled the outputs and outcomes outlined above.

Areas of CCC and its activity streams that are less progressed include:

- place-based evidence building and sharing
- mature aftercare service provision
- collaboration with mainstream services, particularly hospitals.

### To what extent is the design and delivery of CCC appropriate?

Overall, the design and delivery of CCC is appropriate when examined from the perspective of national stakeholders (NACCHO and DHDA), CCC stakeholders (Affiliates and ACCHOs), other service providers, and when compared against the current evidence-base.

CCC stakeholders report that CCC is appropriate, in that it is:

- meeting community needs and addressing gaps including providing aftercare services and establishing culturally appropriate clinical roles to provide immediate SEWB care where no referral pathways existed
- empowering community leadership by enabling ACCHOs to respond to the needs of communities by resourcing activities that address service gaps in each CCC community
- supporting place-based service design by allowing ACCHOs and CCSPNs to customise it to their specific priorities and needs at the local level
- enabling culturally-safe and trauma-informed service provision through NSPPs, JSPPs and the development of cultural and clinical governance frameworks with community leaders to safeguard cultural integrity.

### What are the resources used to enable community-led solutions?

The document review, site observations, survey data and interviews all evidence a garnering of a range of resources to design and implement the CCC program in a community-led, place-based and strengths-focused way. As identified in the document and data review, the resources specifically allocated to the design and implementation of CCC are:

- Financial - $58m over three-years (extended to four-years) with $4.2m for NACCHO's administration of CCC and $53.8m for the establishment and implementation of each activity stream.
- Program staffing – FTE within NACCHO to administer CCC and support Affiliates and sites (three FTE roles).
- Activity stream staffing – FTE within Affiliates and sites to design and deliver the three activity streams (28 NCs, and eight JCs FTE, 58.9 ACWs, 13 ATSIMHFA trainers).
- Clinical and cultural expertise, knowledge and understanding – the expertise in SEWB, suicide prevention, aftercare, clinical practice, cultural practice, program design and delivery, project management, consultation and engagement, and operations.
- Relationships and networks – the connections required within place to establish referrals, gain cultural knowledge and oversight, to recruit ATSIMHFAT participants etc.
- Time – time was invested to select sites, design CCC, roll out the tranches and establish sites and deliver services.

## Key insights

The CCC approach demonstrates the potency of giving equal priority to how a program is implemented in addition to what is implemented. The MoI and MoC working together and operationalised with fidelity are producing powerful, future changing outcomes for communities and life-changing outcomes for First Nations individuals.

Models such as CCC that are Aboriginal community-led, and which build the ongoing capacity of the Aboriginal community and the program's workforce, provide a significant return on investment. These co-design processes should be prioritised. It takes time to establish a program the size and complexity of CCC, which includes robust community consultation and co-design of program documentation like Suicide Prevention Plans (SPPs) and Aftercare Service Delivery Models (ASDMs).[15] The evaluation shows that community engagement is necessary for program effectiveness. Thus, to roll-out CCC funding in a responsible manner; community engagement should be factored into the timeframes for future funding tranches.

A clearly designed program that not only includes intent but also a model of implementation and practice in addition to clear roles and responsibilities is critical for delivery success of the CCC program.

DHDA's relationship with NACCHO and their shared commitment to the aims of CCC and NACCHO's role as funder provide a vital authorising environment, agency and flexibility within the program. The role that NACCHO plays in stewarding the MoI and MoC across CCC and sites, while administering the funding agreements with flexibility and care, is enabling community-led, place-based, strengths-focused delivery in communities.

[15] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.

The implementation readiness of sites is an important driver of efficiency. The implementation readiness of sites is an important driver of efficiency. For each CCC location, conversations and consultation occurred between NACCHO and the relevant Affiliate/state, through emails and meetings, to identify site need and readiness.[16] Assessments to determine suitability and readiness documented Aboriginal and Torres Strait Islander population size; prevalence of suicide, self-harm and clusters (in some instances); need; and capacity to deliver services.

Assessment of the capacity and readiness to deliver CCC included whether ACCHOs had a strong community presence and demonstrated experience delivering a range of services to support SEWB, including clinic-based services such as counselling, mental health and Alcohol and Other Drugs (AOD). Capacity assessments also considered existing organisations and programs in the broader wellbeing space (i.e., cultural engagement and mainstream mental wellbeing/heath programs and services) as either an opportunity for partnership and leveraging existing activities or as something that is lacking and in need of a community-controlled network approach.

Other capacity and readiness considerations included: sites' willingness to work collaboratively; demonstrated capacity to deliver services in a certain timeframe; community engagement and desire for a network approach to improve service delivery; strength of workforce and ability to deal with high case numbers across the area/region; capability to develop and upskill workforce; and/or recent state-based government funding announcements or shortfalls into mental health/SEWB/SP. Sites that demonstrated need and a combination of the capacity/readiness indictors were assessed by NACCHO and the consulted Affiliates as suitable to be onboarded.

This implementation readiness assessment effectively enables more mature ACCHOs to draw on existing infrastructure and workforce to design and deliver at a faster pace. However, the reverse is true for less mature ACCHOs. Future assessments of site readiness and selection should include consultation with ACCHOs themselves (alongside Affiliates), to inform delivery of appropriate site supports.

The skills, knowledge and capability that staff at sites are critical for upholding the intent of CCC. Having a sufficient number of appropriately skilled workforce is the single biggest factor that enables or impedes the achievement of outcomes. This includes appropriate skills and staff capacity to deliver Aftercare and suicide prevention (male and female ACWs, culturally-aware, and trained), perform Network coordinator roles and also undertake community engagement. Where these skills or staff don't exist full adherence to community-led service delivery can't be achieved. Training, further funding and organisational and programmatic processes are all required to enable this capacity.

Peer-to-peer and self-directed learning, in addition to readily available structured onboarding, relevant training and operational and practice supports provided by NACCHO, are all required to enable the CCC workforce and CCC sites to fulfil their responsibilities.

An approach like CCC requires adequate resources to enable appropriate implementation. CCC's current level of resourcing is not appropriate for the demand and this requires urgent attention.

Measures to speed up recruitment, develop existing or less experienced staff and reduce turnover and maintain staff wellbeing should be actively risk managed in future tranches.

The complex constellation of support, coordination, planning, and relationships formed through CCSPNs and other processes coalesce to ensure individuals in need have the quickest and safest route to help through both referral pathways and / or capable community members. These factors combine to increase the help touchpoints available in communities as a result of CCC activities.

Certain cohorts within the community are not accessing CCC due to service delivery limitations and/or target cohort constraints. Opportunities exist to examine how specific cohorts in the community can be targeted and

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[16] Information on implementation readiness drawn from NACCHO, *Regional and Local Suicide Prevention and Aftercare Networks: Potential Tranche 1 Locations* document; *Culture Care Connect Program: Potential Tranche 1 Locations* document; *Culture Care Connect Program: Potential Tranche 2 Locations document; and Culture Care Connect: Tranches 3 and 4 Feedback* (NACCHO internal documents shared with Inside Policy).

supported by CCC and how different service models can support the community.

Using systems helps streamline processes and save time, this is evident in the faster implementation of Tranches 3 and 4 following the adoption of a contract management system. Program management systems and processes within NACCHO and knowledge systems accessible to CCC stakeholders will enable CCC to scale responsibly and with consistency.

## Implications for government

The evaluation findings consistently highlight the important role of the brokerage funding model and the authorising environment created by DHDA and NACCHO in CCC's success. These enablers of CCC speak to how programs are commissioned by governments, as well as how governments' commitments under the National Agreement on Closing the Gap can be implemented.

# Introduction

In 2024, the Australian Government Department of Health, Disability and Ageing (DHDA) engaged Inside Policy to design, undertake and report on an independent evaluation of the Culture Care Connect Program (CCC). DHDA and the National Aboriginal Community Controlled Health Organisation (NACCHO) have overseen this evaluation in partnership.

## About Culture Care Connect

Created by NACCHO in partnership with DHDA, CCC was born out of national commitments and a compelling evidence-base to address the disproportionate prevalence of suicide and self-harm amongst First Nations peoples.[17] CCC is a new approach to shared decision-making and partnership between government and the Aboriginal Community-Controlled Health sector to enable community-led, culturally safe, and trauma-informed solutions for suicide prevention and aftercare in First Nations communities.

## About the evaluation

CCC is 24 months into implementation, and this is the first evaluation of the program. Due to these factors, this evaluation takes a formative approach to understanding CCC's accessibility, effectiveness, appropriateness, and efficiency. The evaluation is intended to produce key insights into the Australian Government's investment, and to inform future planning and improvement of CCC. The evaluation examines how a community-led program such as CCC works to improve outcomes for First Nations peoples in the communities where it operates.

## Purpose of this report

This report presents the findings of the evaluation of CCC and outlines key implications for the program and government, along with corresponding recommendations for its future implementation.

## Structure of this report

The remainder of this report is structured as follows:

- **About Culture Care Connect** – describes CCC in further detail.
- **Methodology** – describes the data collected and methods of analysis used to inform this report, including limitations to frame how the report findings can be interpreted.
- **Key insights** – captures the high-level insights that are emerging from the evaluation.
- **Findings** – details the findings with respect to:
    - the perspectives and experiences of those who deliver CCC in community
    - current state of implementation
    - the four evaluation questions.
- **Implications** – outlines the implications of the evaluation findings for CCC and for government.
- **Recommendations** – outlines a series of recommendations for future implementation of CCC.
- **Appendices**:
    A. List of all sites funded to deliver CCC.
    B. Key features of all CCC-funded sites.
    C. CCC Theory of Change.
    D. List of documents reviewed.
    E. Stakeholders engaged in the evaluation.
    F. List of CCC sites selected to participate in the evaluation.
    G. Survey respondent profiles.

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[17] Including the National Agreement on Closing the Gap, National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (NATSIHP), National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (NATSIHWSFIP), The Aboriginal and Torres Strait Islander Suicide Evaluation Project Report 2016 (ATSISPEP), and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 (NATSISPS).

# About Culture Care Connect

In 2022, DHDA allocated $58,195,500 in funding to NACCHO to design and deliver CCC from May 2022 to June 2025. CCC was initially structured as three separate streams of funding for community suicide prevention network formation, ATSIMHFAT and aftercare service establishment. CCC was then consolidated by NACCHO and DHDA to focus on enabling safe systems, a strong Aboriginal mental health workforce and culturally safe services at the community, state/territory and national levels.[18] The funding supports:

- establishing up to 31 CCSPNS
- establishing community-controlled aftercare services in each network region
- jurisdictional suicide prevention planning and coordination within Affiliates
- community-controlled suicide prevention ATSIMHFAT
- evaluating the phased implementation of aftercare services and contributing to the evidence base for community-controlled suicide prevention and aftercare services.[19]

The list of sites funded to deliver CCC is at Appendix A. The key features of CCC-funded sites can be found at Appendix B.

## Aims and objectives

**Culture** is at the heart of CCC; Aboriginal and Torres Strait Islander people have a diversity of rich and vibrant cultures that must continue to be strong. **Care** is what this program provides to people and communities receiving these services and support, as well as the staff involved in delivering the program. This program **Connects** people, family and communities to the holistic trauma-aware, and healing-informed care they need.[20]

According to NACCHO, CCC's objectives are to improve Aboriginal and Torres Strait Islander mental health and suicide prevention outcomes and support a culturally-appropriate mental health system and workforce by:[21]

1. **Ensuring safety systems are in place that support SEWB**. This will require Aboriginal Community-Controlled Health Organisations (ACCHOs) and Affiliates to undertake a mapping of existing SEWB, mental health and suicide prevention services, identify and strengthen referral pathways within their networks. This information will help to form the SPPs.
2. **Engaging and preparing a strong program workforce with the skills and supports they need.** There are many important roles in this program, all requiring strong training and ongoing support mechanisms. Communities of Practice (CoPs) assist the workforce with shared learning and support.
3. **Developing and delivering trauma-aware, healing-informed aftercare services**. This takes into consideration the intersections between AOD services, SEWB and other complementary programs, and is informed by the network mapping exercise. In developing these services, CCC will acknowledge the existing strengths and skills of ACCHOs and build on their capacity.
4. **Continuously monitoring program activity to ensure quality improvement**. Being the first program of its kind means this is not a 'set and forget' or 'one size fits all' approach. CCC uses continuous quality improvement principles to ensure it is delivering for communities and adapting as needed.

The CCC Theory of Change is at Appendix C. Core to NACCHO's design of CCC and its Theory of Change is its MoC and MoI. These are described below.

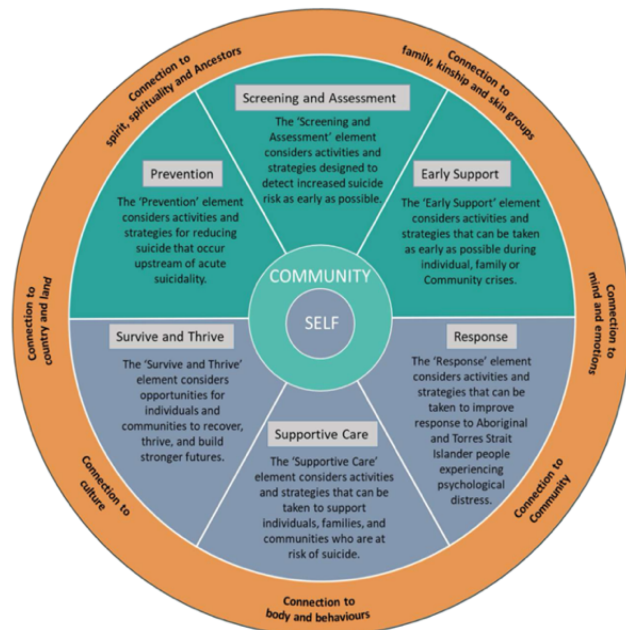
[18] NACCHO interview Health Interview.
[19] NACCHO, *Culture Care Connect: Performance Report,* February 2024, [Internal Document].
[20] NACCHO, Culture Care Connect Community-Controlled Suicide Prevention Networks Program Summary, N.D [(internal document].)
[21] NACCHO, Culture Care Connect Community-Controlled Suicide Prevention Networks Program Summary, N.D [(internal document].)

## Model of Care

NACCHO and the Aboriginal and Torres Strait Islander Advisory Group (ATSIAG) developed an operational guide including a suicide prevention and aftercare MoC for participating ACCHOs. This guide was based on the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework (ATSISEWBF)[22] and the work undertaken by Professor Pat Dudgeon and others in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). The guide also aims to support the design and delivery of programs that centre culture, care and connection in suicide prevention interventions.

The ACCHO MoC takes a holistic view of the individual across their lifespan, which reflects the First Nations view of health and SEWB. Integrating aftercare services and suicide prevention coordination reflects this holistic and patient-centred approach.

CCC's MoC captures six elements of the possible patient journey from prevention to recovery. It provides an adaptable framework for key points of planning and action at the various stages in suicide prevention. Cultural safety is critical to making this model appropriate for Aboriginal and Torres Strait Islander people. As a result, the model emphasises that all suicide prevention activity should be informed by concepts of Aboriginal and Torres Strait Islander SEWB, with the individual at the centre and consideration of the community they belong to.[23] The six critical elements along the individual's journey which address specific stages of suicide prevention and response are:




1. **Prevention**: activities and strategies aimed at reducing the risk of suicide before acute crises occur. This involves upstream interventions to build resilience and prevent the onset of suicidal ideation.
2. **Screening and assessment**: early detection strategies to identify individuals at increased risk of suicide. This includes routine screenings and assessments to ensure timely intervention.
3. **Early support:** immediate actions taken during individual, family, or community crises to provide support and prevent escalation. Early support helps to stabilise situations and connect individuals with necessary resources.
4. **Response**: interventions for individuals experiencing psychological distress. This includes pharmacotherapy, psychological and counselling services, and other health and social supports. It is a crucial part of aftercare.
5. **Supportive care**: ongoing support for individuals, families, and communities at risk of suicide. This includes aftercare activities and other supportive measures to promote recovery and resilience.
   - **Survive and thrive**: opportunities for individuals and communities to recover and build stronger futures. This element emphasises the importance of thriving post-crisis and leveraging community strengths to overcome adversity.[24]

Implementation of the MoC at the community level is enabled by:

- **Data and indicators**: the use of jurisdictional, regional and local data to plan, monitor, and evaluate activities to ensure that interventions are evidence-based and tailored to community needs.
- **Workforce training and career pathways**: building a strong, skilled, confident, resilient, and culturally competent workforce is essential. Continuous training and clear career pathways support the development and retention of capable healthcare providers.

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[22] Gee, Dudgeon, Schultz, Hart, and Kelly, *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing*, 2013.
[23] NACCHO, Culture Care Connect (CCC) Operational Guidance Paper, NACCHO, 4 June 2022, V.4 [internal document].
[24] NACCHO Mental Health and Policy Team, *Culture Care Connect: Program Overview*, [Internal Document].

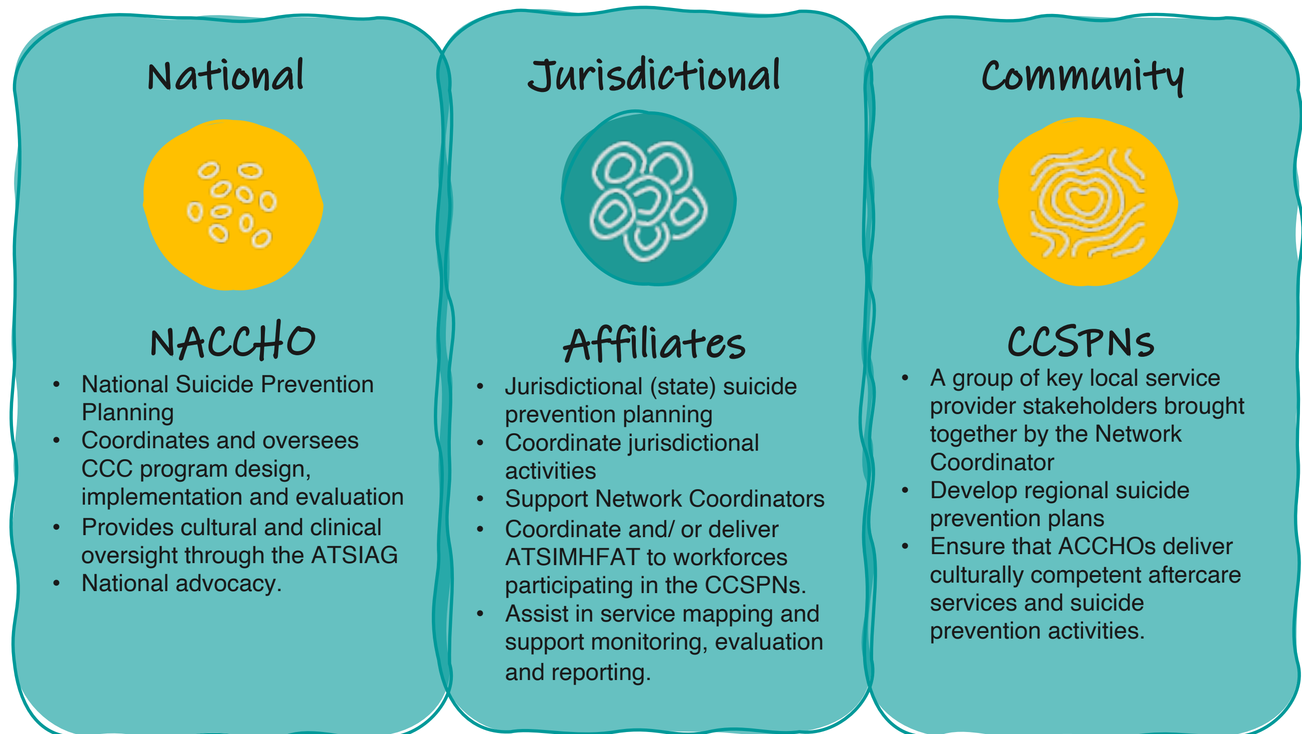
- **Community engagement**: the model emphasises the importance of genuine co-design with Aboriginal and Torres Strait Islander communities, ensuring that services are culturally appropriate and effectively meet community needs.

The MoC is a key framework utilised within CCC to support the assessment, planning and design of community-led, place-based interventions and strategies that can support integrating networks and aftercare services. The MoC also leverages existing SEWB and clinical services in the ACCHO and Aboriginal Community Controlled Organisation (ACCO) sector. ACCHOs and ACCOs are trusted access points for clients, families and communities to have culturally safe conversations about suicide prevention. They work together to identify appropriate, holistic responses through SEWB, clinical, and mental health teams.

## Model of Implementation

Critical to understanding CCC is how it has been implemented. Implementation has occurred through First Nations leadership and control, which forms the foundation for primary health care service design, integrated client and family-centred care, and community empowerment. This Aboriginal-led approach supports better health and wellbeing for Aboriginal communities by enabling a coordinated response to suicide prevention and aftercare aimed at reducing self-harm, suicidal ideation and suicide.[25]

The structure of CCC implementation (referred to in this evaluation report as the 'MoI') enables the community-controlled sector to lead the development and coordination of place-based solutions in partnership with government. CCC relies on three levels of delivery shown in the diagram below:




The three levels of program activity form an intricate, highly networked structure. This structure enables the delivery of place-based services and the ability to continually learn and share through COP. The three levels of program activity also support advocacy efforts to inform systems change from the community to the national level.

CCC is jointly governed by DHDA and NACCHO to make decisions about program implementation. To support this, NACCHO has established and chairs the ATSIAG. ATSIAG plays a critical role in directing and overseeing the implementation and evaluation of CCC in line with its intent. ATSIAG provides:

- Aboriginal governance
- clinical and cultural leadership across CCC activities

[25] NACCHO, *Culture Care Connect (CCC) Operational Guidance Paper*, NACCHO, 4 June 2022, V.4 [internal document].

- oversight of program implementation, including the development of a MoC, referral pathways and service integration
- monitoring of service gaps, workforce and training needs
- program evaluation and monitoring.

# Evaluation methodology

Inside Policy worked collaboratively with DHDA and NACCHO to design the evaluation to examine CCC's:

1. Accessibility of CCC and its activity streams (**Accessibility**).
2. Effectiveness of CCC and its activity streams at achieving their outcomes (**Effectiveness**).
3. Appropriateness of the design and delivery of CCC overall (**Appropriateness**).
4. Efficiency of the delivery of CCC (**Efficiency**).

In assessing CCC's accessibility, effectiveness, appropriateness and efficiency, the evaluation answers the following four questions:

1. To what extent are the Program's supports and activity streams accessible to stakeholders?
2. To what extent is the Program and its activity streams enabling Aboriginal community-led coordinated suicide prevention services and supports?
3. To what extent is the design and delivery of the Program appropriate?
4. What are the resources used to enable community-led solutions?

It is important to note that the focus of the evaluation was CCC including its activity streams, not the funded sites. 'Activity streams' are an evaluation specific term and refer to the three primary streams of activity funded in CCC, namely the establishment of CCSPNs, Aftercare Services and ATSIMHFAT. The data collection methods, methods of analysis and limitations of this evaluation are outlined below.

## Data collection methods

A mix of qualitative and quantitative methods were used to collect data, harvest outcomes and identify themes and patterns across different locations. These included:

### Document review

A total of 516 documents were reviewed, including policy and program guidance, workplans, grant agreements, activity reports and financial reports related to:

- the national level program
- 35 CCSPN sites
- one aftercare-only site
- eight jurisdictions.

The purpose of the document review was to assess readily available program data across all levels of CCC (national, jurisdictional, and regional). For sites selected for a visit, the document review also served to provide contextual information and to minimise duplication of questions during data collection. In addition, the document review contributed to the triangulation of evidence by complementing and validating information gathered through other data sources such as interviews, focus groups and workshops.

The documents reviewed are listed at Appendix D.

### Semi-structured interviews and focus groups with national CCC stakeholders

A total of seven national-level stakeholders participated in two virtual workshops, including:

- four NACCHO staff
- three DHDA staff.

The purpose of the engagements with national-level stakeholders, including government representatives and NACCHO, was to answer the evaluation questions specific to the national level. These activities were designed to deepen the understanding of CCC's design, implementation, and outcomes from the perspective of key national stakeholders. The stakeholders are listed at Appendix E.

### Semi-structured virtual interviews and focus groups with jurisdictional and regional level stakeholders

A total of 15 stakeholders participated in one-hour semi-structured virtual interviews or focus groups, including:

- 10 NCs

- five Jurisdictional Coordinators (JCs).

Semi-structured virtual interviews were conducted to gather insights from key stakeholders involved in CCC at the network and jurisdictional levels. Conducting the interviews virtually enabled participation from stakeholders across all jurisdictions and regions. All network and jurisdictional coordinators were invited to participate. The stakeholders engaged are listed at Appendix E.

### Site visits

A total of 16 site visits were conducted, engaging a total of 128 internal and external stakeholders connected to CCC. The site visits included 14 CCSPN sites and two jurisdictional affiliate sites. A virtual workshop was conducted with one site originally scheduled for a site visit as an in-person visit was not feasible. Those engaged through the site visits (both in-person and virtual) were:

- 13 NCs
- 24 Aftercare Workers (ACWs)
- two JCs (one currently employed, and one formerly employed)
- 51 other CSSPN staff
- two ATSIMHFAT Trainers
- 37 representatives of service providers external to the ACCHO/CCSPN.

Site visits were conducted to deepen understanding of how CCC is being implemented in different regional and jurisdictional place-based contexts. The purpose of the site visits was to engage directly with stakeholders, and explore how jurisdictional, regional, or community-specific factors influence program delivery. Site visits provided an opportunity to connect with stakeholders on the ground and gather meaningful insights that may not surface through virtual engagements.

Site visits created space for informal conversations, relationship-building, and contextual learning. These visits helped to comprehensively answer the evaluation questions through identifying innovative approaches, local adaptations, as well as operational challenges or barriers faced by sites. Face-to-face engagement also supported a more grounded and holistic understanding of the CCC's impact and variability across sites.

The list of CCC sites selected for participation in the evaluation can be found at Appendix E.

### Survey of Jurisdictional and Network Coordinators

An 18-question online survey was administered to all JCs and NCs to understand their perceptions of CCC. An anonymous link to the survey was distributed by email to all JCs and NCs.  A total of 28 respondents completed the survey[26], including:

- four JCs
- 16 NCs
- one person who held a combined Network Coordinator Jurisdictional Coordinator role
- seven respondents who nominated 'other' which included client and non-client facing roles such as Cultural Liaison.

The survey aimed to gather input from network and jurisdictional coordinators and other stakeholders involved in the program, including those not involved in interviews or site visits. The survey was designed to capture a range of perspectives and experiences in a consistent and accessible way, allowing for the collection of both quantitative and qualitative data. It provided an opportunity to explore key themes related to program implementation, strengths, challenges, and perceived impacts across diverse jurisdictions and roles. The survey respondent profile can be found at Appendix F.

### Survey of ATSIMHFAT participants

[26] Thirty-five respondents started the survey, seven of whom did not proceed to the end. The survey had a response rate of 57 per cent for JC and NCs (21 JCs or NCs responded out of a total possible 37).

An 11-question online survey was administered to all the participants who had taken part in ATSIMHFAT and other suicide prevention/mental health training as part of CCC. An anonymous link to the survey was distributed to ATSIMHFAT participants by email from JCs, NCs and NACCHO. A total of 24 respondents completed the survey[27], including:

- 16 staff from ACCHOs
- five staff from ACCOs
- three staff from non-ACCOs or ACCHOs.

The purpose of the survey was to understand the experience of people who have completed ATSIMHFAT or other mental health and suicide training delivered under CCC. This included assessing the relevance, quality, and perceived impact of the training on participants' knowledge, skills, and practice. The survey provided an opportunity to gather feedback from stakeholders who undertook the training in an accessible way. The survey respondent profile can be found at Appendix F.

## Methods of Analysis

A range of methods were used to analyse the qualitative and quantitative data collected through the evaluation.

### Thematic analysis

Qualitative data collected through the document review, survey and interviews was analysed thematically against the evaluation questions and domains. Thematic analysis was used to identify patterns and derive themes out of the qualitative data regarding each domain, evaluation question and sub-question. Codes for each of the evaluation questions, measures and indicators were entered into the software application NVivo®. NVivo coded all qualitative data collected through the document review, interviews and open-ended survey question responses to help the evaluation team identify the first parse of emerging patterns and themes. This first parse was refined and reviewed for inaccuracy and bias before data from separate data sources were triangulated.

### Descriptive analysis

Quantitative data from the survey, activity data were analysed in Excel using simple descriptive techniques. Where data allowed, simple comparative analysis was undertaken to compare change overtime or differences between cohorts, communities and tranches.

### Cost-benefit analysis

A preliminary cost-benefit analysis (CBA) was conducted to derive a benefit-cost ratio (BCR) for CCC that illustrates the return for every dollar invested in CCC. Financial data at the program and activity stream levels were utilised to inform the cost inputs of the model. Outputs accepted by peer-reviewed and published suicide prevention literature informed the definition of benefit inputs. The benefit outputs modelled for CCC were:

1. Improved service capability, including:
   - screening for mental health
   - health promotion, community outreach and presence in community.
2. Improved workforce capability, including:
   - extent to which trainees feel comfortable providing services post training
   - service providers empowered with prevention skills.
3. Changes in referral and service access behaviours.
4. Efficiency created through coordination, including:
   - cross referral between services
   - resources saved as a result of better coordination/collaboration across services
   - reducing barriers to care.

[27] Thirty-two respondents started the survey, six of whom did not proceed to any questions and two further respondents who had not completed any training and thus did not proceed to questions after the demographics.

5. Efficiency to address current and future demand, including:
    - relevance of the model in relation to unmet demand
    - addressing newly generated demand (as a result of improved access and visibility of service).

The framework for the CBA adheres to the guidelines as set out by the Office of Impact Analysis within the Department of the Prime Minister and Cabinet[28] as outlined below:

1. Statement of the objectives of the program.
2. Clear definition of the base case and alternative scenarios.
3. Identification of and forecasts of costs and benefits.
4. Valuation of the costs and benefits.
5. Identification of any qualitative factors and distributional impacts.
6. Assessment of any risks.
7. Assessment of the net benefit(s).

To achieve Step 7, costs and benefits were aggregated into an overall measure of net social benefit. To allow for costs and benefits occurring at different times, the CBA used the concept of present value – where future costs and benefits are discounted. The CBA calculated the net present value (NPV) i.e. the difference between the present value of benefits and the present value of costs; and BCR i.e. the ratio of the present value of total benefits to the present value of total costs. A core component of the above method is undertaking a literature review to identify, isolate and quantify the benefits of programs with objectives similar to CCC.

## Demand analysis

Analysis examined the extent to which CCC is meeting current demand and can meet future demand. This demand analysis evaluated:

- the literature on mental health disparities, workforce shortages, and the demand for culturally safe services
- data from the JC/NC and ATSIMHFAT participant surveys (referred to above) that detailed operational challenges, service utilisation trends, and training outcomes
- forecasting results from a Bayesian Unobserved Components Model (UCM) with a local linear trend to forecast demand for services provided through CCC.

The datasets relied upon to inform mental health service usage and suicide prevention needs of First Nations communities were:

- Intentional Self-Harm Hospitalisations Among Indigenous Australians, AIHW Suicide and Self-Harm Monitoring, Age Groups 0-14 and 15-19 years.
- Age-Standardisation Proportion of People Receiving Clinical Mental Health Services by Service Type and Indigenous Status, AIHW Mental Health Services Data.
- Census on Mental Health Service Utilisation and Socioeconomic Determinants, ABS Mental Health Statistics.

The Bayesian UCM is a statistical approach that helps achieve this by breaking down service demand into different components, namely:

- **Long-term trend:** This represents the overall increase or decrease in demand over time, helping to identify persistent patterns.
- **Short-term fluctuations:** These account for temporary changes due to external factors such as policy shifts, funding cycles, or economic conditions.
- **Uncertainty handling:** The Bayesian approach allows for flexibility in forecasting, incorporating new data and updating predictions in real time.

Since mental health service usage and hospitalisation rates do not always follow simple patterns, the Bayesian UCM helps extract meaningful insights from complex data. By continuously refining predictions with incoming information, it ensures that projections remain accurate and relevant, even in changing environments. This approach is particularly useful when working with limited data, as it allows for

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[28] Office of Impact Analysis (2023, August). *Cost Benefit Analysis: Guidance Note.* Department of the Prime Minister and Cabinet, Australian Government. Retrieved from https://oia.pmc.gov.au/sites/default/files/2023-08/cost-benefit-analysis.pdf

informed decision-making by leveraging prior knowledge and adjusting forecasts dynamically.

## Ethical review

Inside Policy did not engage with service users or individuals who were not employed in a professional capacity for CCC. This was due to the sensitive nature of service engagement, and the understanding that this was the first evaluation of CCC with many sites still in early implementation. Ethical approval was sought to engage with CCC staff due to the sensitive nature of their work and recognising that many staff were likely to have their own experiences related to mental health and suicide. Therefore, ethical approval for undertaking the site visits and surveys was sought and obtained from:

- Menzies School of Health Research
- Western Australian Aboriginal Health Ethics Committee
- Aboriginal Health and Medical Research Council NSW
- Australian Institute of Aboriginal and Torres Strait Islander Studies.

In consideration of CCC's core aim to address the prevalence of suicide, Inside Policy partnered with the Australian Indigenous Psychologists Association (AIPA) to provide culturally safe and timely support before, during and after consultations. AIPA provided oversight to ensure Inside Policy's practices fostered a safe engagement environment. A psychologist from AIPA was available to provide support to researchers and consultation stakeholders during the engagement period from November 2024 to March 2025.

## Limitations

The following limitations aim to assist reading and interpreting the findings contained in this report:

### Survey result limitations

Both the JC/ NC survey and the ATSIMFHAT survey were distributed using a direct email approach to JC/NCs and thus distribution of the ATSIMFHAT survey to respondents relied on onward distribution to trainees. As a result, the ATSIMHFAT response rate was very low at approximately 10 per cent or less of the total number of trainees[29], which makes it impossible to generalise the findings. The ATSIMFAT survey was also focused on professional impacts of the training and thus the views of community members were not captured in the survey.

The low response rate of the ATSIMHFAT survey and the large number of potential variable groups of interest in the JC/NC survey made statistical comparisons between sub-groups not feasible because numbers of respondents in sub-groups was too small.  There was a very low skip rate for the ATSIMHFAT survey, with all 24 respondents completing all primary questions (up to question eight) and 23 responding to all quantitative questions.  Likewise, while three out of 31 people started and dropped out of the survey, none of the quantitative questions were skipped by the cohort of 28 respondents. The other limitation of the JC/NC survey to note is that interviews suggest that some sites changed the names of their JC/NC roles or had staff members completing a dual role that included JC/NC responsibilities. It was not possible to ascertain this from the survey respondents who indicated 'other' by their job title alone.

### Discontinuity of CCC knowledge at the site level

Staff turnover is a common challenge for CCC. For some sites where there was staff turnover data was incomplete. At some sites, older or outdated contact information was listed, making it difficult to reach the appropriate personnel for interviews or data collection. This inconsistency in staffing and communication posed challenges in obtaining comprehensive and reliable data from all sites, particularly those under new or transitional staffing arrangements.

### Stage of CCC implementation

CCC is still in its early stages of implementation in many sites. As a result, a formative rather than summative approach to the evaluation was taken, noting the fullness of data in some sites may be limited depending on where they were in their CCC journey.  Certain sites experienced delays in program implementation, primarily due to challenges in staff retention. High turnover rates among key staff, combined with difficulties in recruiting

[29] The total number of trainees estimated for this calculation is based on the Affiliate data provided in the document review, which suggested at least 239 people had received training. The is an estimate only as evidence of numbers of training sessions was seen in four affiliates documentation, three did not indicate numbers of participants and one did not have any documents.

and retaining qualified personnel, slowed down the CCC's implementation and its ability to deliver services as planned.

### Inherent uncertainty in the cost-benefit analysis

This report aims to quantify all benefits and costs in monetary terms. This includes social as well as economic impacts. However, it is sometimes not possible to quantify all impacts. As such, we have tried to be clear about what can and cannot be reliably quantified and valued. Notwithstanding we have tried to describe the remaining impacts as fully as possible, along with an assessment of risks and sensitivity tests. CBA of CCC does not address equity concerns and distributional impacts. Finally, this CBA is based on a comparison of alternative scenarios containing forecasts of what is likely to happen in the future. As a result, there is inherent uncertainty within the analysis and results.

### Use of proxies and estimates for the demand modelling

Due to the limited availability of site-specific performance data, the use of Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW) datasets is necessary to construct demand forecasts for CCC services. This approach is consistent with best practice methodologies in program evaluation, ensuring that projections remain data-driven despite local data constraints. By leveraging national datasets, we account for broader trends in mental health service access while incorporating relevant Indigenous-specific indicators.

The inclusion of self-harm hospitalisation data provides a direct proxy for mental health distress levels, particularly among youth populations. Similarly, the age-standardised proportion of Indigenous Australians receiving mental health services serves as a robust indicator of service accessibility and utilisation trends. These datasets, combined with statistical modelling, enable a comprehensive analysis of CCC's role in addressing mental health and suicide prevention needs.

# Headline findings

The following are the evaluation's headline findings that are distilled from the detailed findings that follow,:

**Increased access to suicide prevention and aftercare services.**

Communities – especially remote and very remote communities – have greater access to culturally-safe suicide prevention and aftercare supports as a result of CCC. For some communities, the supports enabled by CCC are the first they have had access to, particularly for remote and very remote communities.

**Early evidence of positive outcomes.**

CCC is building, increasing and strengthening support touchpoints (referral pathways), increasing workforce and community capability, building culturally responsive (and safe) supports, and increasing community awareness of suicidality.

**Building the capability of the First Nations-led workforce.**

The CCC workforce is enabled by the supports and training they receive through CCC. The community is enabled by the ATSIMHFAT training. ATSIMHFAT participants who have the least experience benefit the most from the training, however further, more specialist training and development is also required.

**Outcomes are being achieved through a culturally-safe, Aboriginal-led model.**

Most ACCHOs and Affiliates are implementing CCC in line with its principles, the Model of Implementation and Model of Care. This CCC framework – including the brokerage funding model – is enabling the design and delivery of community-led, culturally-safe suicide prevention and aftercare supports.

**Strong evidence of significant economic benefits.**

Early signs of benefits from CCC are being experienced in communities including the early identification of suicidality and prevention of suicide. Additionally, over ten years, CCC returns $4.50 for every dollar invested in it. These benefits are enabled by the brokerage funding model, culturally-safe service provision, and workforce capability.

**Current and future demand goes unmet.**

At their current CCC-funded staffing levels, ACCHOs / CCSPNs are not able to meet current demand for suicide prevention and aftercare services. This inability to meet demand is forecast to grow as annual demand is projected to grow by 4.22 per cent. The CCC workforce must grow by 36 per cent in order to meet the future demand.

**Some learnings that will enhance implementation.**

Improvements can be made in the areas of workforce (attraction, retention and development), implementation fidelity, cultural responsiveness, comprehensiveness of services and supports, accountability, and access to information/knowledge.

# In the words of those who deliver CCC

The findings in this section draws on the experiences and perspectives of 107 ACCHO staff who have supported CCC implementation (two JCs,13 NCs, 24 ACWs, 51 other ACCHO staff, and two ATSIMHFAT trainers, across 15 site visits; and 10 NCs and five JCs across virtual interviews).

Experiences and perspectives were also collected from interviews or focus groups with 37 people employed by an external service provider connected to CCC, and 46 survey responses from Jurisdictional and Network Coordinators and ATSIMHFAT participants.

## The impact of CCC on clients

Staff who have worked in or alongside CCC spoke of how there are more available and accessible culturally-safe suicide prevention and aftercare services in their communities since CCC was introduced:

> "Something I see working well is providing culturally appropriate care coordination and creating a safe environment allows us to better support our clients (Our Mob). Having our local Indigenous staff on the front line ensures we can help our people in a way that truly meets their needs."

> "By aligning prevention and aftercare together, you're going to get a lot more outcomes than just setting up in aftercare service, or just setting up prevention funding, because you can intertwine the two, yeah, and you can be teaching community, you know, to break down that stigma, to break down the barriers, and that it is okay to reach out for help, but also where to reach out for help, how to ask for help in your own way, and that there is someone that understands and can support you in an aftercare worker."

Service providers communicated how identification of suicidality by community members has increased since CCC was implemented:

> "We are having more conversations in our service around suicide ideation and removing some of the language that is stigmatising. Community members have discussed their need for training around the right questions to ask around suicide/suicidality. There is more awareness around the gaps in suicide prevention and aftercare services."

Many staff supporting the implementation of CCC noted how they have seen CCC contribute to the prevention of suicide and/ or self-harm through their service and in their communities:

> "… you can't dismiss the biggest change being community members being still alive."

> "I think it's brilliant. I can't knock it, like without this program, I don't think we would have four or five community members here right now."

> "[Client] said it was life changing... I mean, so the work we do, is every day to us, but when you hear them stories, that feedback is that you are making an impact on people's lives. Now, if it's one person's life, that's what matters at that time. So we're starting to get a lot of that feedback, but it's just how we work."

## The impact of CCC on communities

Flexibility in the design of CCC allows program delivery to be person-centred and tailored to the needs of community. CCC staff spoke of how the flexible, person-centred approach was appropriate for their communities.

> "It’s very client led, individual based on their strengths. We meet them where they want to go. It’s yeah, very much how they want us to work for them. We don’t make them work how we want it’s whatever they feel comfortable. If you want to go sit at the beach, we’ll go sit at the beach. If you want to go to your house, we’ll go there. So taking away from like a clinical setting and stuff like that, that was very much identified that maybe in that moment, clinical settings not that great".

> “The flexibility that we have as well within our roles and within the delivery of the program. Like when you're working with clients, you can be quite flexible with how you deliver and how you work alongside them... So, it's not often that we're ever saying no to a client…if they want to do something on Country, go kick the footy. I don't ever feel like we're going to be restricted by our process or within what we're allowed to do... It's like we can really meet clients where they're at. I think that's really helpful.”

Staff working in and alongside CCC have seen an increase in coordination and collaboration between services in the suicide prevention space since CCC was implemented:

> They’re [ACCHOs] all there, talking together, talking with us as the primary care network representatives, and trying to come towards a collaborative positioning … [The NC] has brought in different people to try and knit together these other wider stakeholders that usually don't talk to each other either. So it's, it's on the right track. They have achieved a lot in a very short space of time.”

More open and honest conversations are being had in community, and staff working with CCC have seen change in the ways their communities address suicide.

> “[The biggest change seen since CCC began is] more open and honest communications with the community and services about suicide prevention. A stronger awareness and wanting to learn tools to assist family and community. Increased collaboration between community and services.”

> “I think probably the main barriers are, like stigma. That's what I think is the main barrier is, and the success stories, to me, are the community events and community engagement... just knowing that people have had those conversations, you know, with somebody”

## The impact of CCC on ACCHOs and their staff

Network Coordinators (NCs) were viewed by staff as having significant influence on the success or delay of assembling and implementing CCSPNs. While recruitment challenges for this role notably impact CCC’s rollout, a special skillset and personality is reported to be required. Perceived key traits for success in the NC role include prior experience, existing relationships with external services, motivation, and personal lived experience:

> “The constant for us was having local mob [employed] that have got those relationships, because that's the most important, because services come and go, but those people remain the same, and they can go out and advocate for us as much as you know we do for our patients.”

## The changes to CCC that would improve service delivery and support

Staff working with CCC spoke of the need for more comprehensive training, particularly for ACWs. Senior staff believed easily accessible information and resources relating to CCC could improve the implementation of CCC at their service:

> “More funding towards training of staff, because we do have an expectation for our staff to have minimum training qualifications or working towards it, and that can be really tricky, like we know that people have the actual skills to do it, But then to you know as to justify the salaries and everything, like, we don’t want people to just walk in at an entry level and then, you know, then they’re burdened with the impact of working with those people. So, you know, being able to provide the right supports for our staff to then deliver the best service to our clients that requires the investment".

Staff emphasised the need for time away from caseloads for self-care and to access cultural and clinical supervision. These were viewed as important ways to improve service delivery and retain staff:

> “I think it's around being able to provide the right support to your staff, particularly those ones who are in those roles. What does that look like in terms of supervision, professional supervision? How do we ensure that we are keeping our staff safe? Because we know that when we've got community in those roles, they don't just get to take their hat off that workers had on when they go home. So I think workforce development in that space and being able to support, yes, self-care is a highlight, I suppose”

Staff working in and alongside CCC noted the demand for CCC and needing longer-term and additional funding to continue servicing their community needs, retaining staff and building external networks:

> “I think two-year contract was unrealistic to co-design a program, implement a program, and see outcomes of that implemented program. I was involved in the development and co-design of the [another mental health service] model from start to now, and originally that was funded for two years, and we advocated and said, you are not going to see tangible outcomes for a minimum of five years. Government listened and gave us five years. So I think even five years is too short to see real quality outcomes. I think it takes time to change cycles in community.”

Staff referenced how their ACCHOs capacity prior to receiving CCC funding impacted their ability to effectively implement CCC. CCC staff noted the ways their ACCHOs were required to support CCC implementation, and the ways they were delayed or restricted due to preexisting resourcing or capacity constraints:

> “Think very carefully when you’re coming up with your policy concepts about the reality of the capacity of ACCHOs.”

> “We were a little bit lucky in the [the region] because we'd already had co-designed forums and things run. We had historical data that could guide the conversations that we were having, that could guide the, you know, prevention, plan, development. Not every region has that. Not every region has a starting point or historical context. I guess, we were lucky that we did, yeah, because it made our co-design process a little bit easier, but I can tell you that if we didn't have people come to those forums, didn't have people do the surveys, we wouldn't have a model. So, it's, it is the community's model. Yeah, it's their program. It's not ours. We just have to deliver it.”

The flexibility of CCC as a health program and being led by NACCHO was referenced by staff as integral to tailoring CCC to their sites’ unique capacities and requirements. NACCHO’s flexibility assisted CCSPNs to adapt program requirements to suit the needs and abilities of their ACCHO to effectively adopt CCC:

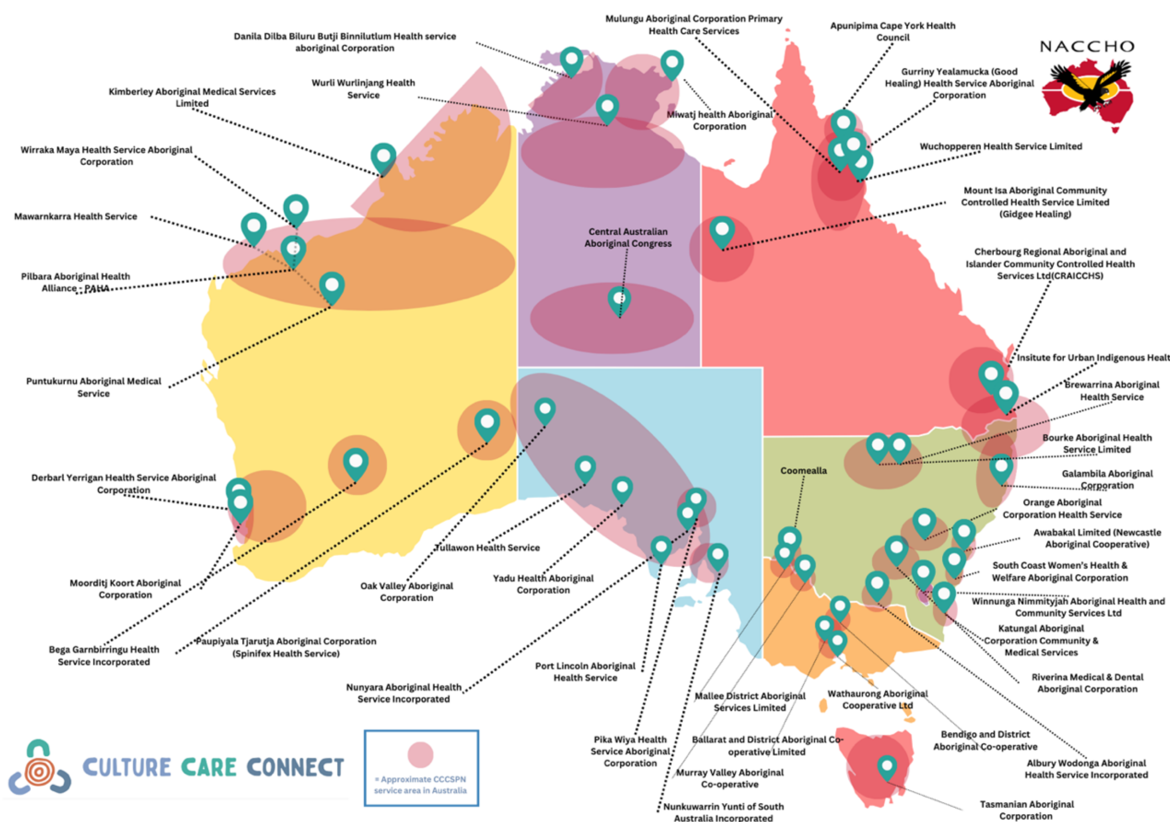
> “The experience for us in having NACCHO as the commissioning body, has been so incredibly significantly different to previous stuff we had ... they understand our staff... Just in the development of the contract, in the negotiation around why, and the context of our region, not having to explain the process, and a willingness to be flexible and work through probity and all that sort of stuff, but working through what was going to be right for our region. I just found them phenomenal in comparison to any non-Aboriginal organisation doing it.”

“When we came on, when we did the NACCHO onboarding, my eyes lit up. This is amazing. This is what every program should be like, every bucket of funding should be like this… an opportunity to and for community.”

# The current state of CCC implementation

At the program-level, the funding agreement between DHDA and NACCHO commenced in May 2022. Of the total $58 million committed for CCC, $53.8 million is contracted for use by Affiliates and ACCHOs.[30] The current state of CCC implementation at the program level is as follows:

- **Brokerage model delivered:** DHDA has funded NACCHO to administer the CCC funds including funding Affiliates and networks.
- **Local and regional infrastructure built**: 42 CCC locations including eight Affiliates, 28 CCSPNs (excluding Winnunga and TAC which are both Affiliates and CCSPNs), and six Aftercare-only sites have been established across four tranches of funding released between 2022 and 2024. The locations and reach of jurisdictions and CCSPNs established are mapped below and listed at Appendix A and their key features summarised at Appendix B.
- **Workforce built:** CCC has resulted in 102.9 FTE roles being created including JCs, NCs, ACWs and other relevant clinical and/ or cultural roles.
- **ATSIMHFAT participants:** at least 399 people across Australia have participated in CCC-provided ATSIMHFAT.
- **Network activities being delivered:**
    - suicide prevention planning, coordination and advocacy
    - development of internal and external referral pathways
    - development of aftercare service delivery models in consultation with communities and delivery of these models
    - established and delivering ATSIMHFAT
    - developing workforce capacity in other ways (i-ASIST, SafeYarn and locally-driven models)
    - health promotion, community engagement and education activities.
- **Supports provided across the CCC network**: NACCHO coordinates and delivers a range of support including three formal CoPs, peer supports, onboarding, templates, conferences, and ad-hoc support.




[30] NACCHO, '2023 1 July – 31 Dec 2023 – Performance Report,' February 2024.

# Findings in detail

The findings in this section of the report answers the following evaluation questions and sub-questions that relate to the evaluation objectives of accessibility, effectiveness, appropriateness and efficiency:

## Accessibility

**Key Evaluation Question 1:** To what extent are CCC's supports and activity streams accessible to stakeholders?

Sub-questions:

1.1 What supports do CCC stakeholders access?

1.2 How do CCC stakeholders access these supports?

1.3 How and what suicide prevention and aftercare services are accessible to communities in CCC locations?

## Effectiveness

**Key Evaluation Question 2:** To what extent is CCC and its activity streams enabling Aboriginal community-led coordinated suicide prevention services and supports?

Sub-questions:

2.1 To what extent are activity streams achieving planned program outputs?

2.2 How is the CCC enabling ACCHOs to lead the design and delivery of suicide prevention services and supports?

2.3 What early evidence exists of progress toward achieving CCC's outcomes?

## Appropriateness

**Key Evaluation Question 3:** To what extent is the design and delivery of CCC appropriate?

Sub-questions:

3.1 To what extent does CCC align to its original intent?

3.2 To what extent is CCC able to address current and future need?

## Efficiency

**Key Evaluation Question 4:** What are the resources used to enable community-led solutions?

Sub-questions:

4.1 How do the resources used to deliver CCC for its intended outcomes compare between Tranches 1 and 2 and Tranches 3 and 4?

4.2 What is the return created by the CCC approach?

# ACCESSIBILITY

## To what extent are the Program's supports and activity streams accessible to stakeholders?

The findings in this section examine the accessibility of the supports and services provided by CCC, including stakeholders and communities access to supports and services.

### Key findings

Overall, the supports designed to build the capability of CCC stakeholders through the CCC Program are accessible by their target cohort. These cohorts include:

- Affiliates including JCs and ATSIMHFAT Trainers
- Networks which include ACCHOs, NCs, ACWs and others such as Clinical Leads and Cultural Leads, psychologists, social workers, community engagement workers and cultural liaisons
- ATSIMHFAT participants.

The data from the document review, JC/NC survey and interviews evidence the provision of, and access to, a wide range of program supports by CCC stakeholders. These program supports are:

- **CCC approach-specific**: Information about the CCC principles, MoI and MoC delivered through onboarding sessions.
- **Financial**: Funding for training as well flexibility about the timing and use of funds.
- **Technical**: Templates, examples, expertise, guides and tools to strengthen service delivery.
- **Wellbeing-focused**: Supervision, employee assistance programs, and flexible work.
- **Peer-to-peer**: CoPs (CoPs), peer-to-peer learning and conferences/summit.
- **Practice-related**: Guidance and tools on clinical, cultural and CCC service provision.
- **Workforce-related**: Position descriptions, recruitment and development assistance.

The above supports relate to the establishment of sites, the design of services, the ongoing implementation / delivery of services, and CCC workforce learning and development. As such, the availability of supports vary in their frequency, intensity and target audience.

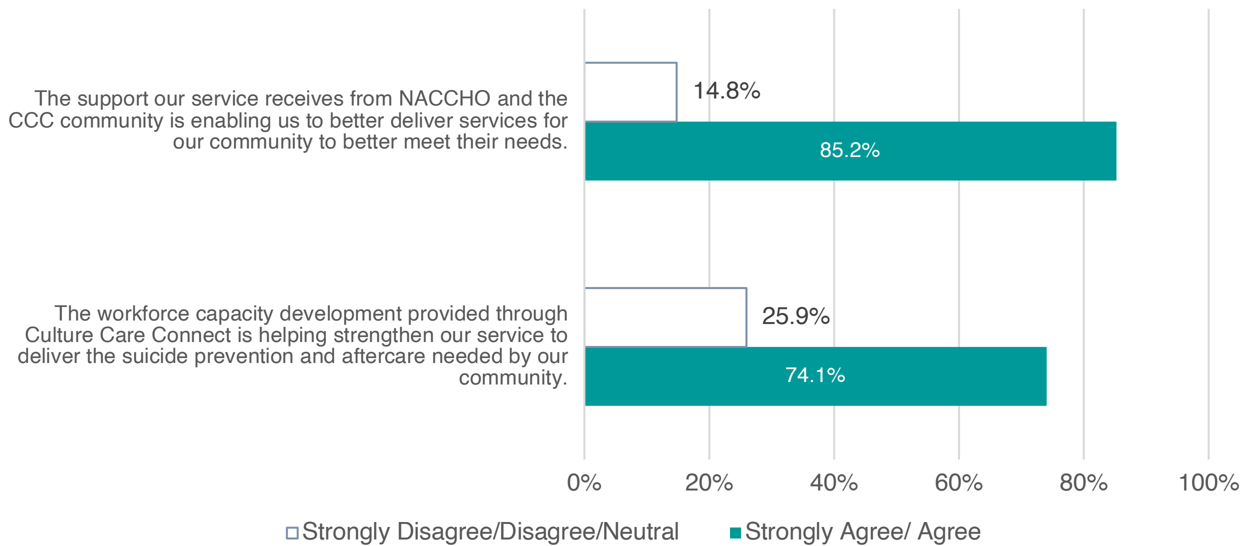
Supports are provided by NACCHO, Affiliates, JCs, NCs and ACCHOs, with NACCHO leading the development and delivery of all of the supports regarding CCC and its implementation. Affiliates tend to support ACCHOs in their State/Territory by disseminating information updates provided by NACCHO while ensuring JCs are accessing wellbeing supports. JCs support CCSPNs by coordinating ATSIMHFAT while also supporting NCs with design and implementation matters. ACCHOs provide wellbeing and practice supports to NCs and ACWs.

Peer-to-peer learning is a significant source of support for both JCs and NCs where both groups have established regular check-ins and information exchanges. This is in addition to participating in the formal NACCHO-led CoP relevant to their role.

JCs and NCs observed benefits of the supports provided by NACCHO, with:

- 74.1 per cent of JCs and NCs surveyed either agreeing or strongly agreeing that the workforce capacity development provided through CCC is helping strengthen our service to deliver the suicide prevention and aftercare needed by our community.
- 85.2 per cent of JCs and NCs surveyed either agreeing or strongly agreeing that the support their service receives from NACCHO and the CCC community is enabling them to better deliver services for their community.

Figure 1. Have CCC supports enabled service design and delivery: JC/NC survey (n=28)




The above supports are accessed through sharing of documentation and information, peer-to-peer learning including CoPs, formal training and onboarding, planned and ad hoc one-on-one contact, formal conferences.

The CCC activity streams are accessed as follows:

- CCSPNs are accessed by non-CCC program areas within ACCHOs and ACCOs and mainstream service providers outside of ACCHOs
- ATSIMHFAT is being accessed by CCC and non-CCC staff within ACCHOs, staff of ACCOs and mainstream organisations within the CCC community, and community members in the CCC community
- aftercare supports are being accessed by CCC and non-CCC staff within ACCHOs, staff of ACCOs and mainstream organisations within the CCC site, and community members in the CCC site
- education and awareness raising activities that target specific cohorts and/or are delivered in particular settings such as schools, and other services.

Communities engage with CCC through culturally safe services that reflect their voices and priorities. CCC's flexibility and local leadership have enabled communities to access support in new and affirming ways. Where barriers such as stigma or remoteness exist, communities and ACCHOs are actively working to build trust, increase awareness, and create accessible referral pathways. The presence of First Nations staff and the co-design of services are key enablers, ensuring services are meaningful and responsive.

In summary, CCC is rich with strengths, and while stakeholders access supports in different ways, all are actively engaged in building a responsive, culturally grounded system. Whether through formal structures or peer-driven innovations, stakeholders are enhancing their capacity and deepening the CCC's impact in ways that reflect their strengths, adaptability, and commitment to community wellbeing.

More information on what supports are accessed by CCC stakeholders, how these supports are accessed by CCC stakeholders, and how and what services are accessed by community can be found at pages 37, 40 and 42, respectively.

## Accessibility: what enables access to CCC?

The evaluation examined what enables CCC stakeholders to access program supports and communities' access to services. The trends in feedback from those interviewed reveal these common enablers of access:

- **NACCHO's role as funder and enabler**: NACCHO plays a pivotal role in fostering an environment where CCSPNs can access resources to develop community-led solutions while advocating for sites' needs. Their comprehensive approach during inception, including clear explanations and tools to implement CCC, was considered invaluable compared to other funders who typically work less closely with the sector. NACCHO's role in program support, governance, and sector collaboration has been vital to CCC's success. NACCHO established advisory structures, including ATSIAG for program guidance. By co-chairing with DHDA, NACCHO ensures alignment across the national service

landscape.

- **Flexible contract administration**: Direct funding through NACCHO was perceived more favorably than previous models, thereby bolstering community control. The brokerage model, which facilitates direct funding to ACCHOs through NACCHO, was viewed positively due to NACCHO's expertise. Direct contracts with NACCHO were a significant enabler, allowing Affiliates to assume supportive rather than oversight roles. This provided sites with greater flexibility and ownership over implementation. This flexibility has empowered sites to lead in a place-based, culturally responsive manner, enhancing service delivery and workforce development.
- **Onboarding supports**: The onboarding and support for NCs and ACWs is vital for the effective implementation of CCC; offering opportunities for connection and a deeper understanding of CCC as well as for learning from peers' experiences and different service delivery approaches. Induction training provided foundational knowledge about the program's structure, while ongoing support from NACCHO, Affiliates, and ACCHOs helped staff tailor the program to community needs. Overall, these meetings facilitate the sharing of ideas, understanding the work of other coordinators, and developing support networks for assistance.
- **Self-initiated peer learning**: Regular peer debriefing sessions provided emotional support and collaborative problem-solving. Many JCs and NCs initiated regular informal peer catch-ups, fostering mutual support and shared learning. They benefit from the mentorship of previous coordinators, which helped them identify gaps and advocate for site needs. Being embedded within SEWB teams and/or within a consortia of ACCHOs granted them access to expertise and professional networks.
- **Communities of Practice**: The COP meetings offer an excellent platform for idea exchange, collaboration, and role clarity allowing CCC sites to connect and foster learning among JCs, NCs, and ACWs. Participants share ideas and learn from peers in similar CCC groups, particularly in service design and delivery. NCs benefit from discussions about their roles.
- **Capabilities of NCs**: NCs were often cited as the conduit for the CCSPN workforce and others to access supports and training. NCs who are experienced, have local networks and understand suicide prevention and aftercare play a critical role in orchestrating the network which includes ensuring relevant staff have access to the information they require to fulfil their responsibilities. Where there is turn-over of NCs or where NC roles are filled with people without the requisite capabilities this is reported to negatively impact on access to supports by network staff.
- **Meeting communities where they are at**: The inherent flexibility of CCC has emerged as a crucial factor in its success across various sites. Its non-prescriptive design enables ACCHOs to tailor implementation to meet the specific needs, priorities, and structures of their communities. This adaptability extends beyond program design to encompass flexible funding, supportive leadership, and opportunities for CCC staff at different sites to develop place-based approaches. Collectively, these elements form a responsive framework that empowers communities to deliver care in culturally meaningful and community-led settings.

### Accessibility: what impedes access to CCC?

The evaluation examined what impedes access to CCC. The trends in feedback from those interviewed reveal common impediments to access:

- **Gaps between support offered and workforce needs**: For JCs, CoPs do not address the strategic and policy responsibilities of the coordinators, such as planning for suicide prevention, risk management, and stakeholder collaboration or practical aspects of ACWs roles. Onboarding and CoPs are infrequent. More detailed information about ASDMs and NSPPs is sought.
- **Lack of wellbeing supports**: In the view of ACWs, the current wellbeing measures often fall short in addressing the emotional challenges inherent in their roles. There is an urgent need to enhance and prioritise wellbeing strategies to ensure the long-term sustainability and effectiveness of ACWs. Many workers face difficulties such as a heavy emotional burden, limited access to structured support, and systemic obstacles affecting their clients, including stigma and inadequate housing, which necessitate

ongoing community involvement and advocacy. The SEWB policy partnership,[31] which brings together First Nations and government representatives with the aim to improve SEWB and mental health and reduce suicide rates, acknowledges the need to enhance and prioritise wellbeing, including addressing systemic obstacles, and aims for policy reforms in these areas.

- **Knowledge discontinuity**: Access to critical program knowledge and information by JCs, NCs and ACWs is being significantly disrupted by staff turnover, absence of specific contact points within NACCHO and lack of availability of education collateral. This also effects the frequency and consistency of information on CCC updates from NACCHO to Affiliates and ACCHOs.
- **Funding insecurity:** Many stakeholders have voiced concerns about the adequacy of aftercare funding, often seen as insufficient to meet demand. This funding gap has impeded efforts to recruit culturally appropriate staff, expand services, and offer ongoing support. The lack of long-term funding stability also affects staff retention and recruitment. Some locations have reported delays in contract negotiations and fund distribution, impacting the timely implementation of services.
- **ATSIMHFAT workforce shortages**: The implementation of ATSIMHFA training faced delays due to staff changes and the preparedness of the sites, underscoring the difficulties in resource availability at certain times. Even with various supports in place, JCs still encounter numerous obstacles. Factors including staff turnover and varying site readiness can postpone the delivery of ATSIMHFAT.
- **Complexity in coordinating a large, multi-faceted program at scale**: Both NACCHO and ACCHOs face resource constraints that limit their ability to provide adequate support, which can hinder access to technical assistance and guidance. This limitation affects the capacity of staff and service providers to implement the program effectively. Some stakeholders have noted a perceived lack of internal support and education for managers, impacting their leadership capabilities. Additionally, a lack of awareness among some staff about the support available from NACCHO exacerbates the situation, as they are not always informed about the resources at their disposal.
- **Lack of role clarity**: The JC role is often perceived as unclear or constantly evolving, underscoring the need for more precise duties and clear guidance. Further clarity is also sought on how the JC, NC and ACW roles are intended to collaborate. By explicitly defining the roles of JCs, NCs, and ACWs, stakeholders can more easily access the necessary support, thereby fostering more effective communication and collaboration. This clarity also benefits new staff during their onboarding process, ensuring they feel confident and supported from the start. By refining these role definitions, CCC can continue to leverage the strengths of its sites and improve overall accessibility and impact.
- **Stigma, mistrust and other challenges facing communities**: Suicide remains a deeply stigmatised and taboo subject, particularly in regional and remote First Nations communities. This stigma often prevents communities from seeking help, especially when services are perceived as culturally unsafe or unwelcoming. In some communities, suicide is normalised, which makes it even harder for individuals to acknowledge their struggles or reach out for support. Trust-building within these communities can also be a slow process, which require new programs to exert substantial efforts. The lack of infrastructure and limited access to mental health professionals in these areas further exacerbate the difficulty of reaching those in need, leaving communities unable to attend appointments or participate in available programs.
- **Insufficient coordination in aftercare services:** One significant obstacle to accessing effective suicide prevention and aftercare services in First Nations communities is the absence of coordinated culturally appropriate care. Prior to CCC, many communities lacked dedicated aftercare services and had to rely on mainstream systems, which were often viewed as unsafe, unwelcoming, or culturally insensitive, particularly when First Nations staff were not involved. For example, emergency departments typically focused only on immediate physical risks, leading to long waits in distressing settings without substantial support. This situation resulted in disengagement and frequent referrals back to ACCHOs. Services often operated independently, with minimal communication and weak referral pathways, making it challenging for individuals, especially young people, to navigate the

[31] **Gayaa Dhuwi (Proud Spirit) Australia, *Policy & Projects – Social and Emotional Wellbeing Policy Partnership*, accessed 23 May 2025.**

system or receive consistent care. Despite CCC's initiatives to create culturally safe, community-driven networks and enhance coordination, difficulties remain in dismantling these silos, forming trusted partnerships, and integrating mainstream and Indigenous-led services. These persistent issues continue to hinder timely and effective access to care for those most at risk.

- **Youth engagement:** Younger people, particularly men, are often less likely to engage with mental health services until they are in crisis. The general lack of youth-specific programs and outreach strategies, especially in rural and remote areas, exacerbates this issue. Stigma around mental health further deters youth from seeking support.

### Implications for increasing the accessibility of CCC's services and supports

- Peer-to-peer learning and self-directed learning, in addition to readily available structured onboarding and operational and practice supports provided by NACCHO, are required to enable the CCC workforce to fulfil their responsibilities. This enables the workforce to design and deliver suicide prevention and aftercare services in line with the CCC approach.
- Workforce shortages as well as different local needs effected the delivery of ATSIMHFAT. Affiliates and ACCHOs adapted to these constraints and needs by delivering ATSIMHFAT in ways that are different to what was originally intended. ACCHOs and Affiliates were able to do this because of the flexibility afforded by NACCHO and the agency to adapt to local needs.
- Opportunities exist to build on the strengths of the CCC approach. These include the brokerage funding model, peer-to-peer learning and building the constellation of supports to grow new sites. Further, building on the capability of the existing and new CCC workforce and supporting their wellbeing.
- NACHHO program management systems and processes and knowledge systems accessible to CCC stakeholders will enable CCC to scale responsibly and with consistency.
- Certain cohorts within the community are not accessing CCC due to service design limitations and/or stigma, lack of awareness and mistrust. Opportunities exist to examine how specific cohorts in the community can be targeted and supported by CCC and how different service models can support the community.

### What program supports do CCC stakeholders access?

Establishing CCC sites was a foundational step in delivering culturally safe suicide prevention and aftercare services. This process involved early engagement with ACCHOs and Affiliates to assess readiness, with site selection guided by NACCHO and the DHDA based on factors like remoteness, population size, and existing service capacity.

Once sites were identified, contracting and funding arrangements were managed through NACCHO, with a flexible approach that allowed services to adapt to local needs. Communities were closely involved in shaping services through co-design activities such as yarning circles and consultations, ensuring programs reflected local priorities and cultural contexts.

During site establishment, key program documents, such as ASDMs, JSPPs and NSPPs, were developed with guidance and their templates provided by NACCHO. Further, governance structures were established to support both clinical and cultural program delivery, often drawing on local leaders and Elders.

Recruiting and onboarding staff was a critical step of site establishment. Onboarding sessions, resources, and workshops were facilitated to support new staff, though the timing and experience of these varied. Integration of CCC activities with existing programs, like SEWB teams, helped embed services within the broader community health system.

Overall, the establishment phase required careful coordination, strong partnerships, and a place-based approach to build trust and lay the groundwork for effective service delivery.

In addition to the site establishment supports, specific supports have been designed for key roles within CCC. These supports are accessed predominantly by JCs, NCs, and ACWs. The responsibilities of each of these groups and the supports they accessible to assist them in fulfilling these responsibilities are discussed below.

#### *Jurisdictional Coordinators*

JCs operate at the jurisdictional level, where they play a pivotal role in supporting the development and ongoing work of CCSPNs, which involves:

- facilitating the delivery of the ATSIMHFAT
- liaising between various stakeholders to ensure the smooth coordination of suicide prevention and aftercare services
- contributing to broader program design and implementation through NACCHO-facilitated structures such as the ATSIAG and the Government and Sector Advisory Committee, ensuring that technical inputs remain grounded in lived experience, cultural integrity, and community leadership
- maintaining consistency and quality within the jurisdiction
- collaborating with peers to co-develop resources such as position descriptions and work plans, leveraging each other’s expertise to strengthen the overall technical capacity of the program.

To support JCs in fulfilling these responsibilities, the document review and interviews with JCs indicate that NACCHO provides:

- financial support, including flexibility, to assist with the establishment and ongoing support of their CCSPNs, delivery of ATSIMHFAT to these networks and participating in a trainer’s CoP
- technical supports to equip JCs to guide, mentor, and collaborate with CCSPNs including templates for Jurisdictional Suicide Prevention Plans (JSPPs), Activity Work Plans, Budgets, Risk Management Plans, and reporting tools - which JCs adapt to suit specific contexts
- guidance on the CCC approach including the MoC, operational guidance papers, and planning frameworks that provide clarity on expectations and program logic
- workforce development support through consultancy services to strengthen the delivery of ATSIMHFAT and respond to workforce needs identified by the sector as well as enhance the effectiveness of suicide prevention and aftercare services and reduce barriers to access
- updates to CCC are shared primarily through established communication and support structures
- a trainers’ CoP to provide ongoing support to ATSIMFAT jurisdictional trainers.

In addition to the support provided to JCs by NACCHO, JCs have developed their own peer support mechanisms such as monthly JC meetings and weekly debriefs. Further Affiliates support JCs with managing their wellbeing by providing access to an Employee Assistance Program as well as time to navigate program challenges.

JCs demonstrate strong leadership in accessing and creating supports. They benefit from NACCHO's responsiveness and have established peer catch-ups to enhance learning and connection. JCs find CoPs valuable for operational insights, however report limited access to strategic supports. While some aspects of their role are evolving, JCs continue to strengthen their impact through ongoing learning and adaptive leadership.

### *Network Coordinators*

NCs and their ACCHO are central to the CCSPN's operations and agenda. The NC influences CCC by shaping community consultations, prioritising target cohorts, and integrating the program within the ACCHO. The NC's experience, connections, and personality appear to influence the way CCC develops at each site. Overall, the NC is responsible for coordinating the establishment and implementation of CCC at their site.

To support NCs in fulfilling these responsibilities, the document review and interviews with NCs indicate that NCs receive support from ACCHOs, JCs and NACCHO. In supporting NCs, the evaluation found that NACCHO provides:

- technical supports to guide CCSPNs in designing and delivering effective, culturally responsive suicide prevention initiatives, including foundational frameworks, planning tools, coordination, and ongoing capacity building, all tailored to the unique needs of communities
- development of NSPPs, including templates, key reports, frameworks and evidence to inform the NSPP as well as a step-by-step guide for developing a locally tailored NSPP
- peer support including the NC COP which explores CCC objectives, the MoC, undertaking SWOT Analysis activities, and discussing Safety and Support Case Studies
- place-based planning, which involves service mapping and local needs analysis to shape relevant and impactful strategies
- comprehensive program documentation to assist with understanding and adopting the MoC
- on-boarding for all NCs to help them understand their role and CCC.

While ACCHOs tend to provide NCs with more support in the area of wellbeing and self-care as well as practice support in the form of cultural and clinical supervision (see **Case Study 1**). JCs and Affiliates support NCs through the provision and coordination of ATSIMHFAT.

Additional support mechanisms include informal check-ins with JCs, participation in broader SEWB or ACCHO-based teams, and access to external clinical supervision resourced by their ACCHOs. NACCHO remains easily accessible for queries via phone or email, providing timely responses that help NCs stay on track with program goals.

NCs are well-supported through NACCHO's flexible approach and user-friendly tools. They actively engage in CoPs, where they build relationships and deepen their understanding of the program. Their integration within SEWB teams and access to both internal and external support fosters a collaborative and empowering work environment. Many NCs have expressed enthusiasm for further opportunities to engage and grow through more frequent CoPs.

### *Aftercare Workers*

ACWs are key enablers of culturally safe, trauma-informed care. ACWs operate at the network/ACCHO level, where they play a pivotal role of being the "front door" to aftercare support for First Nations people in their community. While aftercare services vary across CCSPNs as they are intended to adapt to the changing needs of community, typical examples of aftercare responsibilities led by ACWs include:

- networking with external services and mainstream providers to co-design their Aftercare Service Delivery Model
- establishing referral pathways to receive aftercare clients
- developing flexible and responsive safety and needs assessment templates and processes
- establishing processes to triage SEWB caseloads and identify aftercare clients requiring short-term, intensive support
- establishing after-hours services
- providing postvention supports to those who are bereaved.

To fulfil these responsibilities, ACWs receive a comprehensive suite of supports designed to equip them for their complex roles, foster connection, and promote their wellbeing. These supports are primarily facilitated by CCC sites (their employing ACCHO) and/ or NACCHO. The range of support includes:

- dedicated workforce development and training opportunities aimed at building skills, knowledge, and resilience
- practical technical supports providing guidance, resources, and tools for service delivery and program adaptation
- the establishment and facilitation of CoPs and other networking forums to connect ACWs with their peers for mutual support, shared learning, and problem-solving
- crucial wellbeing supports to help them manage the emotional demands of the role and prevent burnout.

ACW's benefit greatly from strong managerial and peer support within their ACCHOs, and from the collaborative learning opportunities provided through onboarding sessions and summits. Their resilience and dedication are clear, and where there are gaps in onboarding or specific training, ACWs have voiced their needs with a view to further building their confidence and capability. Their feedback reflects a proactive commitment to growth and high-quality care.

**Case Study 1: Clinical and Cultural Supervision**

Case Study 1 is a regional service in Victoria and provides a range of health and wellbeing services across their surrounding region.

The CCC team collaborates with mainstream providers to ensure that their service delivery and programs are culturally informed and appropriate. CCC team members provide cultural mentoring and support, referred to as "informal cultural supervision" to external non-Indigenous stakeholders, to support their ways of working with shared clients. This cultural supervision is also seen as beneficial to non-Indigenous stakeholders working at the CCC site.

Informal cultural supervision provided by the CCC site involves: ensuring the language being used by services is safe, appropriate, and informed by the community; organising focus groups to make sure that services are reaching into community and discussing community needs; and, for one service, supporting the mentoring of a First Nations youth worker.

*"Having somebody that does that in that First Nations realm has been fantastic because it means we can double check our work and make sure we're on the right path. Language we're using is safe and appropriate, it's being informed by the community as well. I don't think our project would be successful without the support we've had from the Culture Care Connect team here."*

External providers report this cultural supervision as crucial to the success of their postvention program. Cultural supervision provided by the CCC site for non-Indigenous staff supports and improves local knowledge and understanding of client contexts, increasing culturally-safe service delivery at the CCC site and collaborating mainstream services.

## How do CCC stakeholders access supports?

Interviews with NACCHO and review of CCC documentation describe CCC as underpinned by culturally safe, community-led, and strengths-based approaches to suicide prevention and aftercare. In line with this commitment, NACCHO describes the supports for CCC stakeholders as being structured and flexibly delivered to empower ACCHOs, JCs, NCs, ACWs, and communities. Ultimately, supports should be accessible to enable all CCC stakeholders to fulfil the requirements of their funding agreement and their aspiration for suicide prevention and aftercare support service provision in their communities.

Data from the document review and interviews with JCs and NCs confirms the multi-faceted, flexible and responsive ways in which they and their teams access the supports described in the previous section. The ways in which these supports are accessed vary in their delivery, frequency, intensity and target audience. Given CCC is a national program and CCC stakeholders are located across the country, much of the support is accessed virtually, with in-person engagement at a national level being limited.

The supports described in the previous section are accessed through the following mechanisms:

### *Training and learning activities*

Training and learning are structured group activities that aim to help CCC stakeholders understand the CCC approach (including its principles, MoI and MoC) as well as to build their suicide prevention and aftercare capabilities through ATSIMHFAT and other training. NACCHO develops and delivers virtual and in-person group on-boarding workshops for new CCC staff and liaises with JCs and NCs to recruit participants for onboarding workshops.

ATSIMHFAT is delivered either in-person or virtually in group sessions by an accredited training provider or practitioner who has completed the train-the-trainer course. In some locations, JCs coordinate CCC staff and others' access to ATSIMHFAT while in other locations NCs and ACCHOs coordinate the delivery of ATSIMHFAT.

ACCHOs and Affiliates also identify other training needs for CCC staff and provide training as required, including i-ASIST, SafeYarn and other locally-driven training solutions.

### *Structured and guided peer-to-peer learning*

Structured and guided peer-to-peer learning support the exchange of ideas, problem-solving, and relationship-building, shared learning and peer support. Some learning activities are NACCHO-led while others are self-directed. JCs, NCs and ACWs access the NACCHO-led peer learning through virtual and in-person CoPs and an in-person annual CCC summit.

JCs and NCs have developed monthly virtual meetings for their role groups. The purpose of these meetings is to check in, problem solve and share experiences.

CoPs are particularly valued by stakeholders for helping participants grow in confidence and clarify their responsibilities.

### *Sharing of tools, templates and documents*

JC and NC access to tools, templates, guides and documents is when establishing and monitoring their sites as well as designing and delivering suicide prevention and aftercare supports. NACCHO develops and distributes (by email) to JCs and NCs:

- program guidance and information
- suicide prevention plan templates and examples
- guidance on culturally-safe community consultation and co-design processes
- position description templates and examples
- reporting templates and examples.

These tools, templates and guides are developed to be user-friendly and adaptable to each sites' local context and needs.

### *Ad hoc, responsive engagement with NACCHO*

The CCC team within NACCHO develops and coordinates the structured, pre-planned supports for CCC stakeholders while also being available to respond to ad hoc enquiries and requests for assistance. CCC

**Case Study 2: Role of the Network Coordinator as a key enabler**

Case Study 2 is an ACCHO with primary care facilities in two locations in Northern Queensland, providing a diverse range of culturally appropriate medical and social and emotional wellbeing services.

The CCC Network Coordinator at the CCC site has a regional role that also extends between two other ACCHOs in the region which are approximately 50 kilometres apart. Together, these ACCHOs service an extensive area of Northern Queensland.

The Network Coordinator has been successful in building strong relationships and collaborating with communities across the region. The Network Coordinator has applied an approach utilising their wisdom and experience, and maximising their ongoing and emerging community connections.

The Jurisdictional Coordinator has convened a regional Community Controlled Suicide Prevention Network made up of ACCHOs, government and non-government external providers who are working collaboratively towards a sustainable suicide prevention approach across the region.

*"I would never have seen that many ACCHOs in the same room, in unison, talking about the same things and complaining cooperatively together, which [the Network Coordinator] convened."*

stakeholders generally access this support by emailing or calling NACCHO's CCC team. NACCHO proactively communicates with CCC stakeholders by emails, phone calls, and video calls ensuring that key program developments are communicated and that support is readily available when needed.

*Relationships, networks and partnerships*

Relationships, partnerships, and networks are a cornerstone of CCC's success. Through proactive collaboration with peers, community partners, and mainstream services, stakeholders are able to enhance service delivery, share resources, and strengthen referral pathways. The consortium model in some areas amplifies these efforts through shared learning and support across sites.

*Coordination and orchestration*

JCs play a key role in supporting the delivery of a place-based and community-led CCC suicide prevention and aftercare activities.

Jurisdictional and network coordination is a strong enabler. JCs and NCs provide guidance, coaching, and facilitation of peer networks. Their work helps maintain alignment with the program's goals while allowing space for innovation and local adaptation. Their access to support from NACCHO and peers ensures they are well-positioned to lead and support others effectively.

The evaluation heard that NCs play an important role in orchestrating the work of the CCSPN, including ensuring the workforce have access to the information and support they need to enable them to fulfil their responsibilities. This orchestration involves regular communication with NACCHO, the Affiliate including JCs, while also building and strengthening relationships inside and outside of the CCSPN (see **Case Study 2**). This orchestration occurs when NCs have local networks, are proactive and are deeply knowledgeable in suicide prevention practice. The result of this orchestration is the team and community having access to supports and services respectively.

*Mentoring, coaching and supervision*

ACCHOs are pivotal in the successful delivery of CCC. Their direct relationships with NACCHO and ability to tailor services to community needs reflect their deep community knowledge and leadership. They provide essential supports to their teams, from supervision and wellbeing to strategic workforce development.

Access to a skilled and qualified workforce is recognised as essential, and supported through comprehensive approaches that include mentoring, supervision, professional development, and recruitment of Aboriginal staff. ACCHOs take a leadership role in supporting their workforce, helping build both individual and community capacity. Staff are encouraged and supported to pursue ongoing professional development, enhancing their skills in trauma-informed, culturally competent care.

## How and what suicide prevention and aftercare services are accessible to communities in CCC locations?

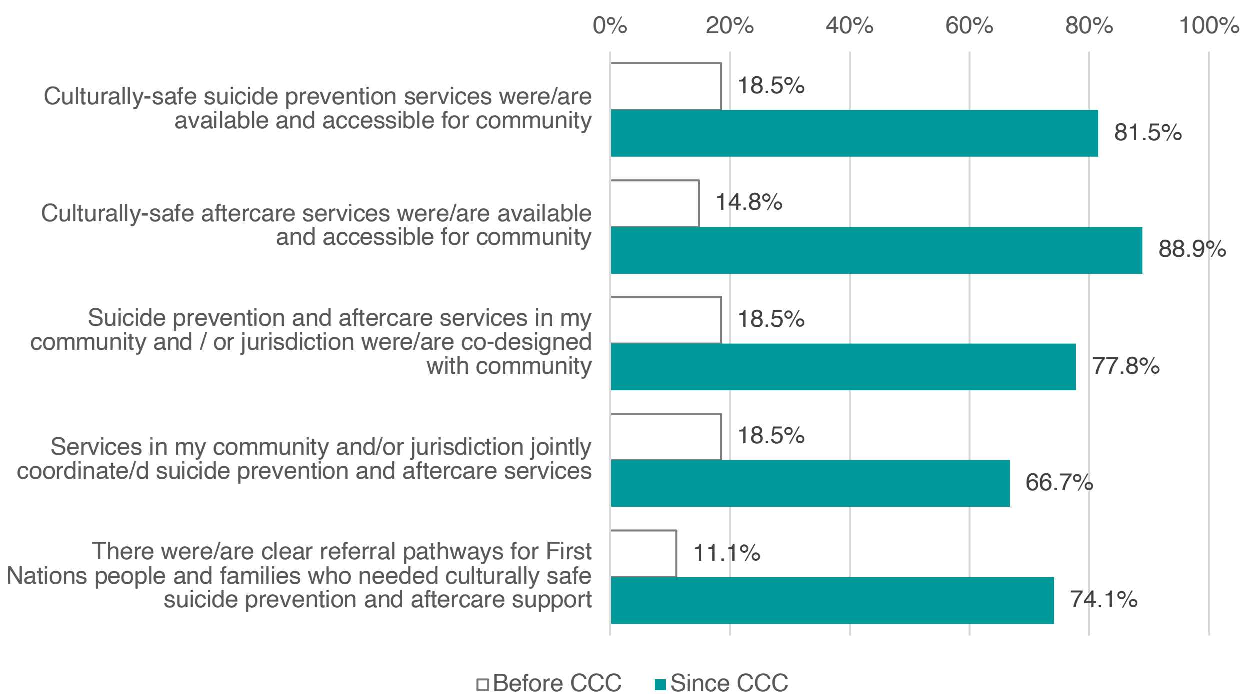
Across the 17 CCC sites that participated in this evaluation, patterns exist in terms of what services communities access, how they access these services and who has access. These patterns are examined in more detail below.

### *What services communities access*

CCC aims to meet the mental health and suicide prevention needs of First Nations communities by addressing gaps in support for suicide prevention, while tackling barriers such as stigma and a lack of culturally appropriate services. Having access to suicide prevention and aftercare services in community is an important part of this.

The JC and NC survey shows that communities where CCC operates have more access to suicide prevention and aftercare support since CCC's establishment. The data in Figure 1 indicates a positive perception among respondents on the impact of CCC on the availability and accessibility of culturally safe suicide prevention and aftercare services within their communities. Notably, most respondents agreed or strongly agreed that both culturally-safe suicide prevention (n=22, 82 per cent) and aftercare services (n=24, 89 per cent) are now more available and accessible since CCC.

Figure 2: Perceptions of change in communities' access to services before and since CCC




The above survey results are supported by interviews with CCC staff and community stakeholders at the sites visited. These groups perceived those in community who are seeking help and/or those who are grieving have first access or improved access to:

- culturally-safe suicide prevention and aftercare services that are delivered by First Nations staff in community and on Country
- spaces for communities to heal and manage the array of complex emotions after burials and funerals
- holistic and person-centred support, which recognises the interconnected nature of mental health and SEWB
- information on how to seek help and how to help others including access to ATSIMHFAT
- factual, evidence-based and culture-informed information about mental health, grief and loss (including intergenerational grief), and trauma.

NCs and ACWs across the 17 sites visited shared many examples of increased help-seeking, referrals and caseloads since CCC's establishment.

**Case Study 3: How referral pathways have been strengthened internally (within ACCHOs) and externally (outside of ACCHOs)**

Case Study 3 is based in the Northern Territory, provides comprehensive primary health care programs, community services and advocacy to the region.

The CCC site provides a suicide prevention service to the community where there previously was no such service. Prior to CCC, community members accessed social and emotional wellbeing services through the CCC site or postvention services through other external providers. The CCC site took an initial staged approach for receiving referrals to ensure staff capacity to support clients. Once this approach was embedded, the program moved to a holistic open-door policy, assessing all individuals and connecting clients with appropriate services, whether internal or external. The CCC site uses workshops and internal processes to encourage internal collaboration and ensure all programs at the ACCHO are aware of referral processes and the services offered within CCC.

*"all of our other services will be split that way, so that we can move towards a No Wrong Door service so that we'll get a referral in from GPs internally, or community members can self -refer, or other organisations can refer in, and then we assess through our clinical intake and allocate to appropriate workers. "*

The CCC site has developed relationships with the local Hospital Emergency Department and other external service providers through regular education sessions with staff. It has also formed a service delivery partnership with a national not-for-profit organisation to deliver aftercare services to all community members (First Nations and non-Indigenous) in the local area. This has been possible with additional funding from the Northern Territory Government (NTG) and the Northern Territory Primary Health Network (NTPHN).

Connections with external service providers initially increased referral numbers, however external service staff turnover is high. This external staff turnover has implications for progression of CCC and delivery of services to the community.

An important element of the CCC approach is ensuring communities in CCC sites can access suicide prevention and aftercare services in ways that meet their needs. How communities access these supports and services therefore is an important area of focus for this evaluation.

CCC staff within ACCHOs described building trust as the most important first step in enabling communities to access suicide prevention and aftercare services. Building of trust between CCC teams within ACCHOs, and other teams within the ACCHO, services providers in their community and community members themselves is a core practice that was observed at site visits. Building of trust is reflected in the CCC documentation.

NCs and ACWs in particular described building and maintaining trust as taking time, requiring them to listen to communities and demonstrate they have listened by providing supports in the way that communities have requested.

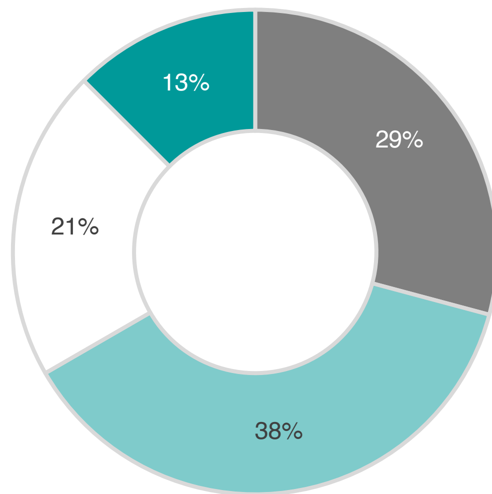
Once trust is established, the common ways in which services and supports are accessed by community, include through services that are:

- strongly informed by and/or delivered in settings that are strongly connected to culture and Country e.g. being delivered on Country, working with Elders to inform practice, and using traditional healing practices
- flexible and person-centred where activities are tailored to client's interests and goals
- better coordinated and integrated by breaking down silos within ACCHOs and between ACCHOs and other providers and developing referral pathways including taking the approach of "No wrong door"
- delivered through an outreach case management approach where ACWs offer regular wellness checks and case management to identify at-risk individuals and connect them with appropriate services
- holistic where multidisciplinary teams – including ACWs, psychologists, and casework managers – address co-morbidities like homelessness, substance abuse, and domestic violence
- engaging with communities in different and multiple ways including through community days, outreach activities, social media campaigns, and training and educating community members to become gatekeepers who recognise mental health issues within their families and communities.

*Who in community access services*

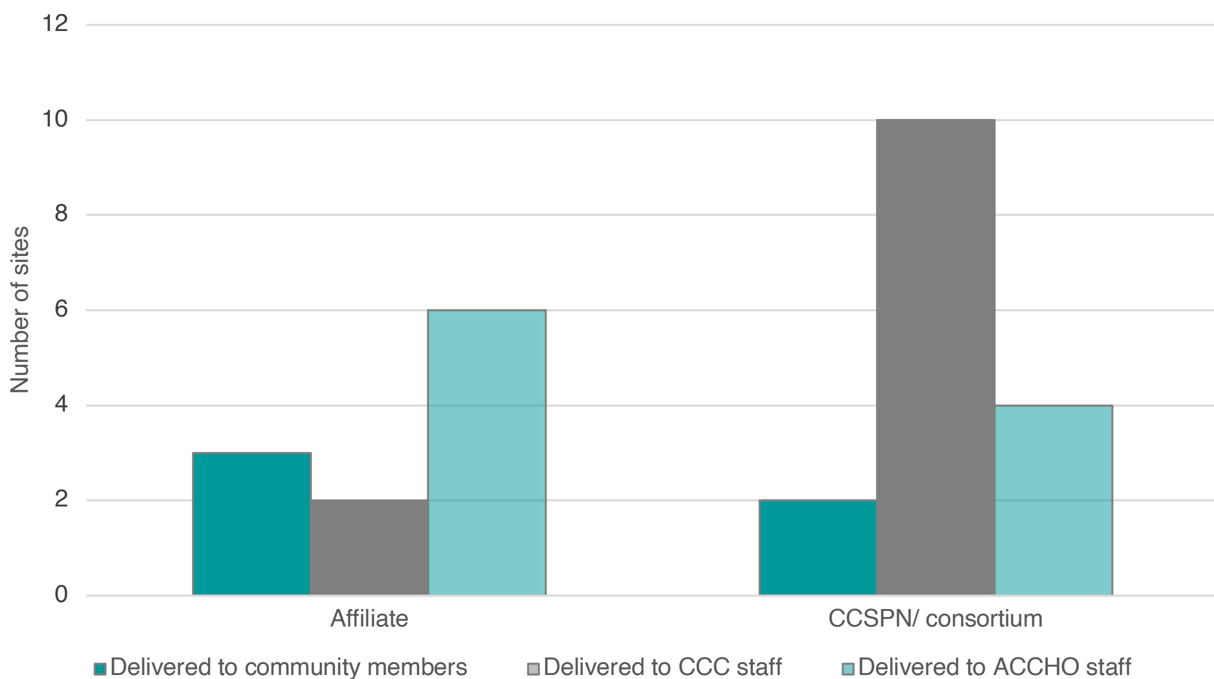
Access to capability development of the broader community through CCC comes via ATSIMHFAT. The ATSIMHFAT survey results show that the majority of people that access the training are ACCHO staff other than CCC staff or staff from mainstream providers operating in the community (72 per cent).

Figure 3. Proportion of ATSIMHFAT survey respondents from different cohorts (n=24)




Information gathered from the document review reflected in Figure 4 below, shows that five sites deliver ATSIMHFAT to members of their community in addition to CCC and ACCHO staff.

Figure 4. Number of sites that have trained community members, CCC staff and ACCHO staff (from document review)




First Nations community members – those in need as well as those who may have future need – having access to suicide prevention and aftercare supports is fundamental to the success of CCC.

Sites are targeting cohorts that reflect the specific needs and priorities of their local communities, as evidenced in site documentation. In doing this there is not a common set of target cohorts for CCC services that exists across sites. Across the sites that participated in the evaluation, the people with suicidal ideation and practices including self-harm who are accessing supports are:

- older men (one site)
- younger women in their 20's (one site)

- youth (one site)
- men and women (five sites).

In addition to the above, CCC is also accessed by Individuals who are stable (one site), individuals in crisis (14 sites), grieving families/families affected by suicide (most sites), non-Indigenous clients (two sites), people with mental ill-health (most sites), people experiencing homelessness (one site), and suicidal people with complex mental needs such as schizophrenia and psychosis) (one site).

The document review shows that the following community members are accessing aftercare services across the sites that participated in the evaluation:

- people with suicidal ideation and practices (16 sites)
- individuals in crisis (16 sites)
- people with mental health issues (most sites)
- grieving families/ families affected by suicide (most sites)
- individuals in Men's, Women's, Elder's and Justice, and other community and peer support groups (five sites).

The document review shows the cohorts who are targeted and reached by education and awareness raising are:

- First Nations young people (four sites)
- individuals with mental ill-health (most sites)
- mainstream health/mental health services (most sites)
- Men's, Women's, Elder's and Justice, and other community and peer support groups (five sites)
- older community members (three sites)
- school and university students (three sites)
- people who might benefit (one site).

# EFFECTIVENESS

## To what extent is CCC and its activity streams enabling Aboriginal community-led suicide prevention and aftercare?

The findings in this section examine the effectiveness of CCC and its activity streams. Effectiveness for a program like CCC that is an approach rather than a direct intervention, is assessed by understanding if and how community-led suicide prevention and aftercare is being enabled. Effectiveness therefore is not measured in terms of a reduction in suicide and self-harm.

### Key findings

Overall, CCC and its activity streams are enabling Aboriginal community-led suicide prevention and aftercare. This finding is evidenced by the:

- funding of ACCHOs to establish of CCSPNs and aftercare-only sites (28 and six respectively)
- creation of the CCC workforce (102.9 FTE)
- delivery of ATSIMHFAT to nearly 400 people across Australia
- development of 27 NSPPs and six JPPs
- creation of new referral pathways and strengthening of existing referral pathways to access services
- development of a shared language for Aboriginal-led suicide prevention and aftercare
- access of First Nations communities to culturally-safe suicide prevention and aftercare services
- perception of reduced stigma and increased awareness and understanding of suicidality across First Nations communities
- anecdotal reports by CCC staff of prevention of suicide attempts.

The abovementioned findings above demonstrate the effectiveness of an approach that is Aboriginal community-led, place-based and strengths-focused. This combination of guiding principles coalesce to ensure services are informed by local need and cultural perspectives resulting in community members having the trust to seek help. The agency provided to ACCHOs and Affiliates also enables them to innovate service delivery approaches. For example, ATSIMHFAT is being delivered to mixed groups of stakeholders including, NCs and ACWs, external service providers, broader ACCHO staff and partnerships between ACCHOs and mainstream external service providers. Some sites, while delivering ATSIMHFAT to their own staff, collaborated with other ACCHOs to provide sessions to remote communities and external service providers to build capacity in the region, and particularly in culturally appropriate responses to mental health first aid. Many sites rolled-out ATSIMHFAT to the broader community to improve the capacity of community members to provide wrap-around support to those considered at-risk.

Some sites offer more than ATSIMFAT to CCC staff and other stakeholders. For example, one site has partnered with an external service provider to run Talk About Suicide training and also Safe Yarn training for any relevant staff throughout the suicide prevention network. The external provider reflected on this ACCHO training collaboration as - *"helps make sure that [the training] had that First Nations lens is really, really important."*

The evaluation also found that CCC stakeholders are largely implementing the MoI and MoC with fidelity. The operationalization of the MoI and care at the program and sites levels has enabled the outputs and outcomes outlined above.

Areas of the program and activity streams that are less progressed include:

- place-based evidence building and sharing
- mature aftercare service provision
- collaboration with mainstream services, particularly hospitals.

More information on the effectiveness of the program with respect to the outputs that are being achieved and early evidence of outcomes can be found at pages 50, 55 and 59 respectively.

### Effectiveness: the factors that enable community-led suicide prevention and aftercare?

The evaluation has identified the following factors that enable community-led suicide prevention and aftercare and early outcomes:

- **Authorising environment, agency and flexibility**: Through DHDA's relationship with NACCHO and their shared commitment to the aims of CCC, early evidence suggests that DHDA has helped to create a responsive environment by operating flexibly to respond to the needs of NACCHO and sites. Combined, this is enabling CCC to realise innovative, place-based approaches.
- **Culturally-safe, holistic and person-centred approaches to aftercare**: Empowering Aboriginal communities to lead suicide prevention through culturally grounded approaches. Being a community-led program also enables place-based suicide prevention coordination and care. For most sites, they are not building a program, they are leading a movement, towards changing services and systems. This includes a focus on building collaboration and referrals with existing mainstream and other services, however this will take time to develop.
- **Community trust**: The adaptation and implementation of the MoC relies on community consultation to identify place-based needs, and thus community buy-in is vital for the successful implementation of the MoC.
- **First Nations recruitment and upskilling**: ACCHOs prioritise the recruitment of First Nations staff and their upskilling. The availability of appropriately experienced staff, especially for the JC and NC roles, who are vital for the coordination of planning and network activities. Recruitment and retention were noted throughout the evaluation as challenging and, especially in remote areas and areas of extreme climate. For ACW roles, availability of staff and in particular, most sites noted the importance of being able to offer a male and female ACW to maintain cultural safety within CCC.

### Effectiveness: the factors that inhibit community-led suicide prevention and aftercare?

The evaluation has identified the following factors that inhibits community-led suicide prevention and aftercare and early outcomes:

- **Siloed service delivery**: CCC stakeholders identify factors that block progress toward outcomes as traditionally siloed service delivery, which has hampered the development of relationships with mainstream services.
- **Lack of role clarity**: Outcomes are achieved when the roles and responsibilities of stakeholders were clear and staff were available for coordinator roles. In the particular case of JCs and Affiliates, confusion around their role meant that CCSPNs perceived the support of JCs to be limited. This role confusion was also seen in some CCSPNs, with internal and external providers uncertain about the role of CCC. In all cases, staff turnover or skills gaps within Jurisdictional Network coordinator roles hampered implementation and was a common occurrence.
- **Workforce constraints**: This includes staff availability and turnover due to vicarious trauma as well as inadequate funding to support the appropriate levels of staffing required for community need. This is more pronounced in remote and rural locations and locations with extreme weather.
- **Funding insecurity**: Is not unique to CCC, but funding insecurity has emerged towards the end of CCC's short-term funding cycles. This has led to uncertainty, a lack of progress and staff turnover at many sites.

### Implications for ensuring the effectiveness of the CCC program

- The CCC approach demonstrates the potency of giving equal priority to how a program is implemented in addition to what is implemented. The MoI and MoC working together and operationalised with fidelity are producing powerful, future changing outcomes for communities and life-changing outcomes for individuals. Despite this, adherence to the MoI is variable across sites, including cultural governance. Giving sites further clarity on CCC fidelity could improve this.
- The complex constellation of support, coordination, planning, and relationships coalesce to ensure individuals in need have the quickest and safest route to help through both referral pathways and / or capable community members. These factors combine to increase the help touchpoints available in communities as a result of the CCC activities.

- While green shoots of early outcomes are emerging in some sites, achievement of outcomes and positive change is dependent on the capacity within each ACCHO. Having sufficient appropriately skilled workforce – male and female ACWs, culturally-aware, and trained – is the single biggest factor that enables or impedes the achievement of outcomes.
- Importantly, CCC is filling gaps in service systems and responses and is benefitting remote and very remote communities in particular with examples provided by ACWs of preventing suicide as a result of their outreach and communities' increased help seeking.
- Trust and culturally-safe service provision are fundamental to the effectiveness of CCC. Culturally safe practice is what allows communities and those in need to trust ACWs and access support.

## To what extent are activity streams achieving planned program outputs?

CCC funds three activity streams – CCSPNs, ATSIMHFAT and Aftercare services. The outputs that these activity streams collectively aim to achieve are:

- establishment of CCSPNs
- development of SPPs
- coordination of SPPs
- delivery of suicide prevention activities
- delivery of ATSIMHFAT
- design and delivery of Aftercare.

The extent to which each of these outputs has been achieved is examine below.

### *Establishment of CCSPNs*

Suicide prevention networks are responsible for implementing place-based, community-led suicide prevention and aftercare. They coordinate regional suicide prevention efforts, identify gaps, and utilise funding to address these gaps.

Many stakeholders have confidence in Jurisdictional and Community Controlled Suicide Prevention Networks to create Aboriginal-led community-owned solutions if given adequate time and resources.

At the community level, the Network Coordinator and their ACCHO are central to the CCSPN's operations and agenda. The network coordinator influences CCC by shaping community consultations, prioritising target populations, and integrating CCC within the ACCHO. The coordinator's experience, connections, and personality appear to influence the way CCC develops at each site.

Each site has a different composition and degree of establishment, depending on the location, tranche, presence, skills and relationships of the Network or Jurisdictional Coordinator, and related services in the area. There are four types of community-level sites:

1. **Single ACCHO CCSPN:** A site comprising a single ACCHO within which the network coordinator is based, and the aftercare service is established.
2. **Multi-ACCHO CCSPN:** A site comprising multiple ACCHOs. One lead ACCHO will host the network coordinator, while aftercare services are established at multiple ACCHOs.
3. **Consortium CCSPN**: A site comprising multiple ACCHOs operating within an existing consortium, where the lead ACCHO will host the network coordinator, and aftercare services are established at all participating ACCHOs.
4. **Aftercare only site:** A site without a network coordinator, in which only aftercare services are being established. Aftercare sites are generally paired with a single-ACCHO CCSPN at another site for support.

There is representation of CCSPNs across most of Australia with ten in New South Wales, four in the Northern Territory, six in Western Australia, seven in Queensland, five in Victoria, and three in South Australia[32].

### *Development of suicide prevention plans*

For sites reviewed, most Network and Jurisdictional SPPs have been established at the Jurisdictional and Network levels. 27 out of the 29 networks[33] have developed NSPPs and six out of eight Jurisdictions have developed JSPPs.

Each of the jurisdictions have taken different approaches to the development of the JSPP. The intention for the Plans was that they be informed by the NSPP and consultation with sites to form a state-specific suicide prevention plan. In practice, a variety of approaches needed to be taken based on the timing of NSPP completion, and the availability and accessibility of sites to participate in consultation. These include desktop research and NC input; use of alternative sources of data; and mapping and engaging key stakeholders.

Networks have also taken a variety approaches to the development of their NSPP. Of the 27 CCSPN sites

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[32] Sites who provided documents and were included in the document review. No documents were received from sites in Tasmania or the ACT.

[33] From network and jurisdictional level administrative documents that were available to NACCHO at the time of the evaluation.

with an NSPP, three quarters involved community in the design in some way. Some sites NSPPs were developed after intensive community consultation (n=3) and many used a combination of consultations, codesign and prior research (n=14). The remaining sites indicated that they planned to conduct consultations at a later date due to either resourcing or skill deficits around stakeholder engagement or organisational planning (n=5).

Planned activities vary across sites dependent on community aspirations and priorities. However, some commonly cited activities under the SPPs included the development of community engagement plans, promotional activities, establishment of community support programs and mental health awareness promotion.

*Coordination of suicide prevention plans*

Suicide coordination activities are underway at most sites, particularly for earlier tranches. Activities undertaken as part of the network's suicide prevention coordination activities include:

- community programs promoting social and emotional wellbeing and de-stigmatising mental health
- community-focused ATSIMHFAT and gatekeeper training
- screening and assessment
- adjacent factor crisis-supports such as support to access or maintain access to housing, food security, financial support or employment
- peer support services and postvention support (not funded by CCC).

*Delivery of suicide prevention activities*

Suicide prevention activities are being delivered across most CCSPNs in a variety of ways, depending on the needs of the local communities and the geographic reach of the services. As part of their suicide prevention activities, some sites have formed or begun working with existing suicide prevention committees or working groups to coordinate responses to suicide in their communities. In this way CCC sites foster connections with external services and look to ensure that CCC is consistent with community perspectives, needs and resources.

In line with CCC's central premise, sites are also integrating holistic, culture-centred supports into services for suicide prevention. Where sites had existing cultural support programs and services as part of SEWB programs, these are being expanded to support suicide prevention and aftercare. As an example, one site had an existing 'Safety Plan Template' prior to engaging in CCC, which developed a safety plan for clients and connected them with community and cultural groups to build their safety networks.

Site visit data shows that in some instances, aftercare only sites are also delivering primarily education or health promotion-type activities to community, rather than in person aftercare services. This is to make the most of the small amount of funding that was received for aftercare staff. Sites that have large geographical footprints have also tended to take a greater health promotion approach, rather than aftercare service delivery. In some instances this is to enable a greater reach of support to local communities with finite resources.

A range of service and health promotion activities are taking place at CCSPNs to improve the awareness and understanding of SEWB, CCC and the services that are aligned with it. This service promotion is taking place in the community and also with external service providers who may need to refer into CCC. Appendix B summarises key service promotion and health promotion activities at each CCSPN that provided documentation for the evaluation. A summary of key methods are outlined below:

- **Advertising, awareness raising and campaigns:** The use of advertising or marketing, awareness raising and campaigns for CCC, mental health and/or suicide are mentioned by most sites during both the site visits and the document review (noted in 21 sites' documents).
- **Community education/information sessions**: There was evidence of education activities on SEWB and CCC services in 17 sites in the document review. Examples noted in the interviews included radio interviews (effective for the older community) and podcasts (effective for young audiences). Some sites also mentioned running community information and education sessions, either as special days designed specifically to promote mental health for the community (e.g. Aboriginal Youth Day) or targeting specific environments such as schools. Mental health promotion education sessions are being delivered to schools in some locations to help children recognise the signs of poor mental health. This is challenging schools to take initiative and work more effectively with First Nations

children to develop their knowledge and skills.

- **Cross sectional coordination activities**: These activities are occurring at many sites and are evidenced in the document review. Cross-service coordination meetings are most commonly noted (18 sites). Cross-service referral pathways also appear to be established at many sites (16 sites) and cross-service outreach activities are occurring at few sites (three sites).

*Delivery of ATSIMHFAT*

Through CCC, a key role of jurisdictions is to deliver ATSIMHFAT and provide oversight to the CCSPNs within their region. Jurisdictions have established training capacity and ATSIMHFAT training has been rolled out in many network sites by jurisdictions with the support of Coolamon Advisors. Despite initial delays, training delivered by Coolamon Advisors was successfully delivered to early tranches, and the training of staff across all Affiliates and most CCSPNs has now been completed. Documentation provided indicates Affiliates have provided approximately 24 sessions[34] to a range of stakeholders including CCC staff, internal ACCHO staff, and community members. Approximately 239 people have attended the training provided[35].

Affiliates have tailored ATSIMHFAT to meet site-specific needs, considering resource availability, contract deadlines, and geographic and developmental factors. Jurisdictions developed either in-sourced or out-sourced model of ATSIMHFAT delivery, while also exploring long-term solutions for the suicide prevention workforce. All Affiliates are assessing what sustainable training capacity should look like moving forward.

The outsourced mode involved transitioning to a contractor model for delivering ATSIMHFAT, that was utilised because contractors were already working in the field and CCC could leverage their expertise. In WA, this model was adopted due to the geographical spread of sites and the tight timeframes for delivery. This model was used to facilitate 13 sessions with around 160 participants[36].

The in-sourced model was adopted by several jurisdictions. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) developed a tailored NT roll-out strategy to prevent duplication by leveraging existing SEWB, mental health, and suicide prevention resources. This involved training AMSANT Coordinators and scheduling for ACCHO/ACCO. Aboriginal Health Council of South Australia (AHCSA) focused on building in-house capacity, certifying three staff to deliver ATSIMHFAT and using CCC funding to maintain Aboriginal Mental Welfare State trainers and recruit additional staff. AHCSA plans to use its Registered Training Organisation status to offer future accredited and non-accredited training.

Jurisdictions and Networks are also delivering other workforce capacity training including I-ASIST, SafeYarn and other locally-driven training solutions.

Feedback on the utility and delivery of ATSIMHFAT for different stakeholders have been mixed, with many sites emphasising the importance of ongoing workforce capability development, and a desire for more flexible options to meet the needs of their SEWB workforce. Further detail on the outputs and outcomes of training is described in the next section.

As part of their responsibility to develop training capability for delivery of ATSIMHFAT to sites, jurisdictions received resourcing to support the recruitment of dedicated ATSIMHFA trainers. Funding was also allocated to "train the trainers" to deliver a set number of modules each financial year. ATSIMHFAT was intended for delivery to mixed groups of stakeholders including:

- NCs and ACWs
- community stakeholders such as Elders, educators and police
- broader ACCHO staff.

In practice, how these roles have been operationalised has differed between jurisdictions, with some Affiliates choosing to outsource the role of the ATSIMHFA trainer to established third parties, and others choosing to build in-house capacity for training in the long-term.

*Design and delivery of Aftercare*

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[34] The is an estimate only as evidence of numbers of training sessions was seen in four affiliates documentation, three did not indicate number of sessions provided and one did not have any documents.
[35] The is an estimate only as evidence of numbers of training sessions was seen in four affiliates documentation, three did not indicate numbers of participants and one did not have any documents.
[36] WA-AF-01 Document Review

Aftercare supports are offered to people who have attempted suicide or are in suicidal crisis. Aftercare services provide safe, culturally-appropriate care coordination and support, and can link with other treatment services. Aftercare services work with their clients to guide them through recovery.

Under CCC, sites are required to develop an ASDM and deliver aftercare services. Aftercare service design and delivery has taken time to establish. The process of design and implementation requires specific staff skills, which some sites have expressed to be lacking.

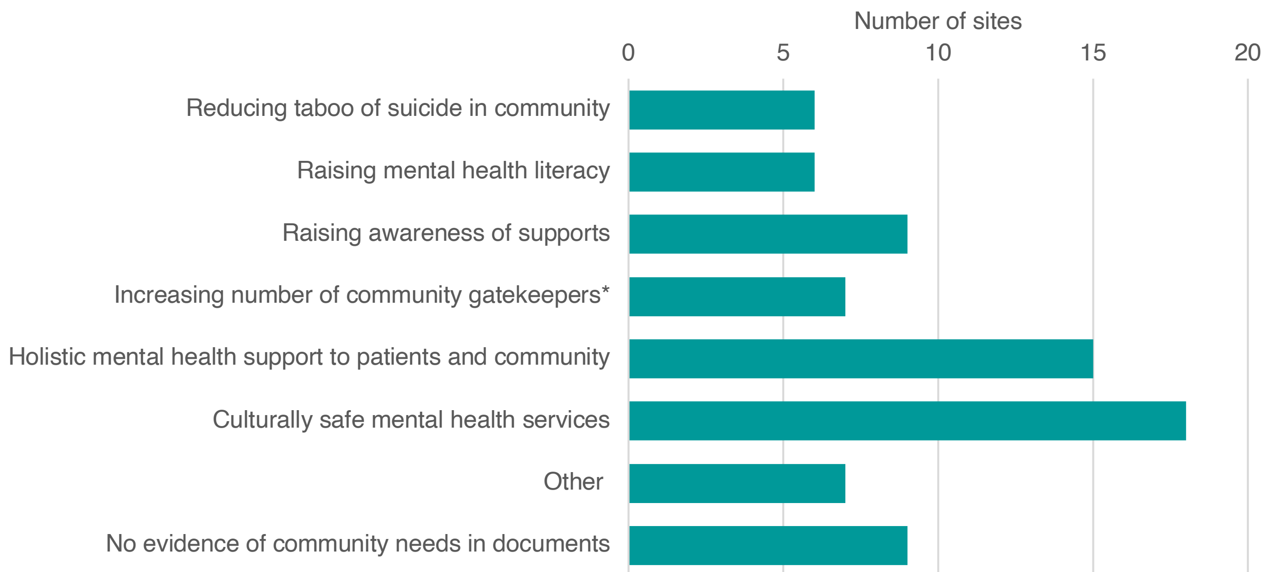
The evaluation shows that most sites are delivering aftercare services, but fewer have an ASDM. Aftercare services have been established in most of the sites, including the 29 CCSPNs and five Aftercare-only sites. Only five sites with documents available did not demonstrate any aftercare services.

Documents reviewed suggest that most sites (29) have an ASDM. Due to their shorter time to establish processes, sites without an ASDM are only present in tranche three and four sites. A range of methods has been used to develop ASDMs at sites including intensive community consultations (10 sites) or a combination of research and co-design with community (nine sites). There were also many sites however, who either did not document their design process at all (six sites) or who planned to conduct consultations at a later date (eight sites).

It was recognised across the site visits that specific skills are required to undertake these types of consultations, especially with the sensitivity of the topics for community. Some sites expressed a lack of inhouse capacity to undertake this work and have either not done it at all or have employed specialist consultants to conduct this work for them.

A range of community needs were identified by CCSPNs in their networks and ASDMs based on community consultations. Needs identified by individual sites are summarised below:

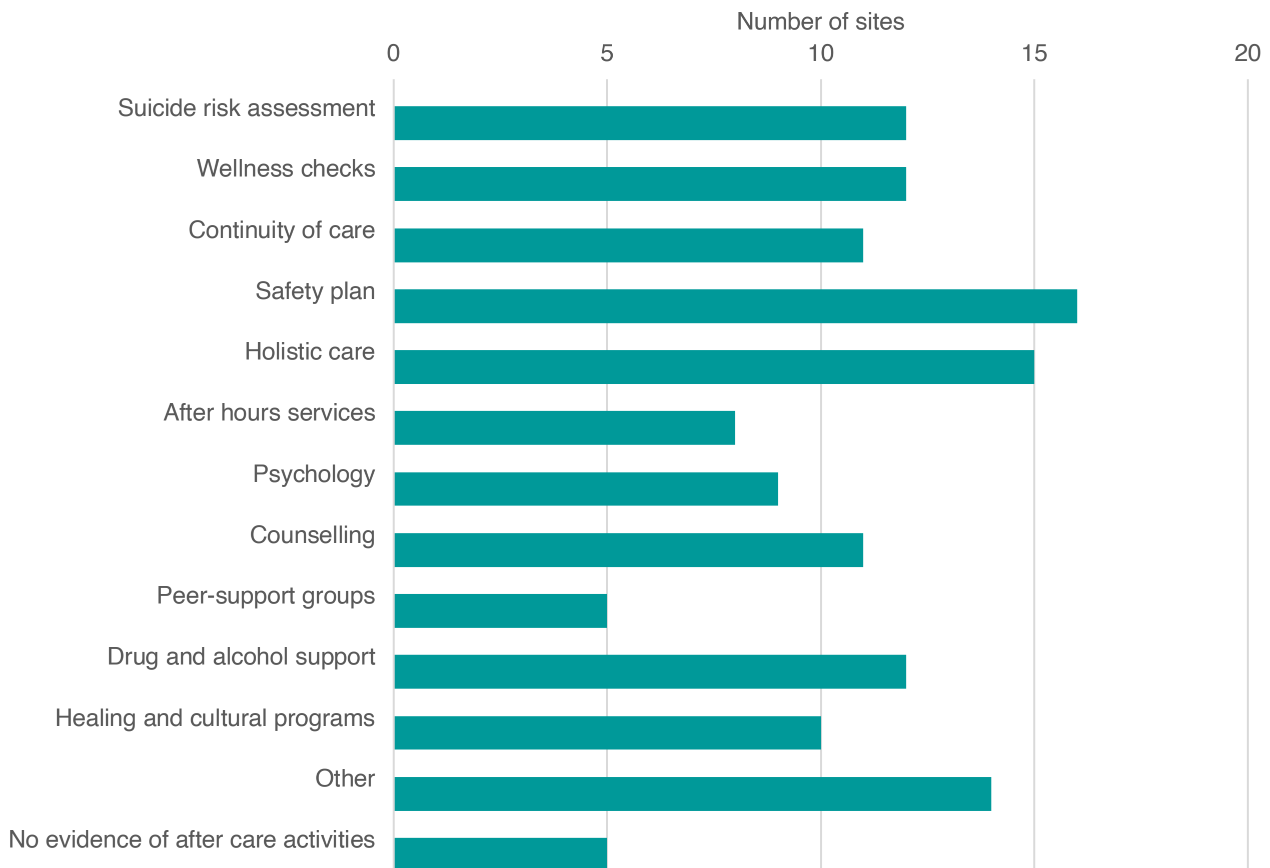
Figure 5. Community needs relating to suicide prevention and aftercare identified by CCSPN and aftercare sites in documentation (n=35)




* *Community gatekeepers are community members equipped to deal with people in suicidal crisis*

The document review notes a range of aftercare services being delivered at sites. Examples of aftercare services mentioned in documents are listed below:

Figure 6. Examples of aftercare services




Only two sites interviewed mentioned offering after hours support. The document review showed that four other sites described processes to connect clients to afterhours services by providing information to clients about local 24-hour crisis support or having formal partnerships with services that offer after hours services. One remote service described that they planned to build processes to facilitate closer to home after hours support to move away from an existing medical model that is not culturally appropriate and is not local. However, other sites mentioned that after hours support was a current gap in service delivery for suicide prevention and aftercare that is needed in their community.

Some sites offer counselling or psychology as part of CCC, and others refer on to psychology in their network or internally. One site highlighted that their aftercare funds were utilised by employing a registered psychologist when they identified a service gap in their community.

Site visit and interview data suggests that the most common feature of aftercare services in CCC is that they are holistic and providing a service that makes clients feel that they are not alone. They are an initial point of contact to find out what clients need, meet them where they are at in a culturally safe way, and then refer to other services to get help as required. Aftercare is described as helping clients navigate traditionally complex health care settings and reduce red tape through speeding up internal referral processes. A holistic approach can encompass a broad philosophy for services, including considering “whole of family” and also “whole of person”. This includes assistance with aspects of life beyond mental health and recognises other factors such as AOD, developing cooking skills, housing and other supports, social groups such as fishing, men’s groups and referrals to other internal and external services where needed (such as housing support).

## How is CCC enabling ACCHOs to lead the design and delivery of suicide prevention services and supports?

CCC exists to empower communities to self-determine the delivery of place-based, culture centred, holistic suicide prevention to support the social and emotional well-being of First Nations peoples. To enable successful implementation of CCC, two key models have been designed by NACCHO with the assumption that if both are implemented with fidelity (i.e. in the way that they were intended), this should enable successful implementation of CCC across all sites in Australia. The first is the MoI and the second is the MoC. Further detail how the MoI and MoC are enabling ACCHOs to undertake their work is outlined below.

### *Model of Implementation: enabling ACCHOs to design and deliver suicide prevention services*

The structure of CCC implementation (to be referred to in this evaluation as the **MoI**) is an approach that aims to enable the community-controlled sector to lead the development and coordination of place-based, community led solutions in partnership with government. The integration of suicide prevention coordination and delivery of aftercare services, underpinned by Aboriginal and Torres Strait Islander leadership and control, is proposed to enable an Aboriginal-led and coordinated approach to reduce the prevalence of self-harm, suicidal ideation, and suicide, in a way that meets the needs and priorities of First Nations communities.[37]

The model represents First Nations leadership, shared decision-making and genuine partnership with government to Close the Gap. The MoI is founded on, shaped and reinforced by Aboriginal and Torres Strait Islander culture. It functions through trust, agency, and the sharing of information and support. It recognises and embeds First Nations ways of being, knowing and doing, acknowledging the wisdom and knowledge of Aboriginal communities to support positive health trajectories individually and collectively.

The program is jointly governed by DHDA and NACCHO with additional Aboriginal governance being provided by ATSIAG, which is established and chaired by NACCHO. ATSIAG provides Aboriginal governance, clinical and cultural leadership across CCC activities and oversees program implementation, including the development of a MoC, referral pathways, service integration, addressing service gaps, workforce and training needs, and program evaluation and monitoring.

Further, the three-tiered structure of CCC coordination and implementation incorporates existing First Nations leadership at each level. Each level plays a role in empowering communities and creating structural changes for lasting impact. At the national level, NACCHO oversees program design and advocacy; existing Aboriginal peak bodies for ACCHOs in each state are designated as jurisdictional affiliates to coordinate regional CCC activities; and at the community-level, coordinators at existing ACCHOs establish networks and ensure culturally competent care.

The evaluation has found that the MoI is resulting in four benefits:

- networks and jurisdictions have support, resources and agency
- development of a shared language for Aboriginal-led suicide prevention
- system reform advocacy
- two-way capability building.

Networks and jurisdictions are enabled with support, resources and agency to deliver services that are place-based, Aboriginal-led and culturally-safe.

NACCHO appears to play a central role in creating an environment in which networks and jurisdictions can access the resources and support they need to build place-based, community-led and culturally appropriate solutions. NACCHO also provides operational and contract-related support. Sites reach out to NACCHO for guidance and examples of best practice learning and implementation from across the program.

The flexibility of the MoI and the support of NACCHO allows for creativity in the way that the program is implemented at a local level. However, both national, jurisdictional and network level interview data suggest there is a diversity of organisational capacity or readiness to implement CCC across different Affiliates and ACCHOs. This includes less mature ACCHOs finding the flexibility of CCC and funding levels inadequate to support implementation, despite appropriate Aboriginal leadership from NACCHO.

Conversely, examples of sites and Affiliates that felt adequately supported had the following traits: strong

[37] NACCHO, *Culture Care Connect (CCC) Operational Guidance Paper*, NACCHO, 4 June 2022, V.4 [internal document].

foundation of cultural and holistic ways of working and experience delivering SEWB services, existing resources and processes that can be drawn on, staff with experience developing services and access to existing cultural and clinical governance structures and leaders with organisational knowledge.

Jurisdictions interviewed reflect that they enable CCSPNs to develop networks in the site in a place-based manner by allowing autonomy and flexibility in their implementation approach and providing support when required. However, at a network level, many NCs expressed a sense of confusion around the role of Jurisdictions and that at times getting support from Jurisdictions was challenging, even when required.

Staff turnover seen at many sites and Jurisdictions may have been a contributing factor to uneven support. All types of stakeholders agreed that the JC and NC roles are both highly relational. For these roles to be maximised, staff are required who have the appropriate skills and relationships with other services in the system. The two JC sites visited experienced negative impacts on their ability to continue to set up and coordinate network efforts when their JCs left the role and as a consequence, the relationships left with them. As a result, additional work was required to re-build relationships with sites. Similar experiences are noted at the network level. Many sites describe the importance of the NC having negotiation, facilitation and relationship building skills to develop networks in the local service system and encourage traditionally siloed services to work in collaboration with CCC (e.g. the police in OAMs).

Finally, the evaluation found that while Aboriginal leadership is vital to effective co-design, CCC networks also benefit from additional specialised skills to support the development of place-based suicide prevention and aftercare services. CCSPNs with NCs possessing strong skills in co-design, facilitation and resources to build community engagement were in a better position to achieve their goals.

A shared language in Aboriginal-led suicide prevention promotes SEWB through the MoC within ACCHOs. There is evidence from all levels of interviews that the MoI which uses existing Aboriginal leadership structures is facilitating the development of a shared language for Aboriginal-led suicide prevention and aftercare that promotes SEWB at First Nations-led organisations. The primary facilitator for this is existing relationships between the Aboriginal-led organisations at different levels, which facilitates the development of trust and collaboration. For example, NACCHO's deep relationships with ACCHOs help build trust and facilitate communication, making it easier to implement and adapt CCC and ensure that it remains culturally appropriate and effective at the grassroots level.

At many sites at the network level, positive relationships have developed with external service providers in CCSPNs. There is evidence from site visits that these relationships have facilitated the sharing of a language for Aboriginal-led suicide prevention and aftercare networks to some mainstream services already. There is evidence across the evaluation data that this is facilitated by existing relationships between the network stakeholders and especially with the NC. Even in the absence of existing relationships, a NC with strong cultural knowledge, an understanding of the workings of the local service system and strong facilitation skills is vital to enable these relationships. In some instances NCs did not have these skills or the NC role did not exist. As a result, this hampered relationship development and the promotion of a shared language.

Many external service providers interviewed noted the benefit to their service in relying on CCC to support First Nations clients. There is early evidence that in some sites, CCC collaborations are encouraging a shared language of Aboriginal-led suicide prevention and aftercare between ACCHOs and mainstream services, including improving mainstream service provider cultural sensitivity. For example, one external provider delivering mainstream mental health services reflected on how CCC ACWs and the NC have provided them data or support to make sure that they are including a First Nations viewpoint on the work they are doing.

**Advocacy for system reform** is driven by NACCHO and Affiliates. NACCHO, as the national peak for ACCHOs has longstanding relationships with their member organisations and are invested in supporting their members. NACCHO is in a unique position to understand and effectively advocate for member's diverse needs at a national level.

The Affiliates' position within the MoI allows them to maintain close connections between NACCHO and community-level sites, enabling them to provide tailored support, advocate for collective needs, and work towards systemic changes with state and territory governments.

Insights from Affiliates have been key to developing the National Aboriginal Suicide Prevention strategy and sharing best practice. Continuous communication between Affiliates, ACCHOs, and NACCHO promotes quality improvement for Aboriginal and Torres Strait Islander communities by facilitating the sharing of learning across sites, leveraging shared wins for advocacy and cultivating opportunities for partnerships beyond the program.

Each Affiliate is engaging differently with their sites and state/territory governments depending on their capacity, context and relationships. These efforts focus on advocating for CCC and systemic reforms; universal aftercare support, culturally-safe aftercare and recovery services; SEWB workforce expansion; enhancing support programs; effective supportive care; and mapping and addressing service gaps.

NACCHO has facilitated a range of opportunities for **two-way capacity building and sharing of information** across the CCC system. The COPs implemented by NACCHO are perceived to be highly effective for shared learning and many NCs and ACWs are attending. Most NCs and ACWs in site visits and interviews reflected that the CoPs are a good opportunity for the people and organisations involved in CCC to get to know other staff, learn from each other's practice and problem-solve together.

The NACCHO Summit was also seen to be very useful for knowledge sharing and to develop a deeper understanding of how CCC was emerging across the nation. The Summit also facilitated learning on challenges and opportunities experienced across the country and exposure to the different tranches of implementation and capacity building across CCC sites.

Jurisdictions have facilitated training and capacity building by recruiting dedicated ATSIMHFA trainers or outsourcing the role to established third parties and "training the trainers" to deliver a set number of modules each financial year. In practice, funding, geography and staffing have all influenced the successful delivery of these capacity building activities.

CCSPN network meetings are also described as being useful for sharing learning between CCC sites, ACCHO internal stakeholders and external service providers. However, they are noted to rely on the presence and skills and relationships of the NC and do not take place in all areas. Some sites expressed the need for more opportunities for knowledge sharing between CCC sites and CCSPN stakeholders but low resourcing and lack of skilled staff to deliver these sessions was often a barrier.

**What is not being enabled?**

Place-based learning being to inform and strengthen Aboriginal-led suicide prevention and aftercare services is still emerging, reflecting the early stages of implementation across many sites. Limited information was available to demonstrate data capture and there were indications that ACCHOs had minimal resources or skills to undertake such work. Further, given the complexity and diversity of needs of the ACCHOs delivering CCC, there is a recognition by NACCHO that their capacity for extensive program analysis and data management is stretched and will require additional resourcing moving forward.

The document review noted the use of a range of monitoring and evaluation processes to capture data at sites.

Some sites described the use of monitoring and evaluation activities in their documentation. Some report using NACCHO report templates for monitoring and evaluation of outcomes (six sites) or reliance on internal ACCHO management to complete monitoring, evaluation and reporting activities (seven sites). Two sites explained that internal data collection uses health record systems such as Communicare or similar. Three sites indicated that they conduct surveys or feedback from community members, engage cultural governance structures, Elders and clients to assess satisfaction.

Some sites noted in documentation that there were gaps in their monitoring and evaluation data because of known gaps relating to suicide related harm in Aboriginal and Torres Strait Isander people and comprehensive SEWB data (two sites). Other sites also noted that the early stage of their implementation (some had only been running six months) and changes to internal staffing contributed to a lack of data capture on recent outcomes or impact (three sites).

*Model of Care: enabling ACCHOs to design and deliver suicide prevention services*

Key to CCC implementation is the **MoC.** NACCHO and the ATSIAG developed an operational guide including a suicide prevention and aftercare MoC for participating ACCHOs, based on the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework (ATSISEWBF)[38] and the work undertaken by Professor Pat Dudgeon and others in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). This guide aims to support the design and delivery of programs that centre culture, care and connection in suicide prevention interventions.

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[38] Gee, Dudgeon, Schultz, Hart, and Kelly, *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing*, 2013.

The ACCHO MoC takes a holistic view of the individual across their lifespan, which reflects the First Nations view of health and SEWB. Integrating aftercare services and suicide prevention coordination reflects this holistic and patient-centred approach. The model was designed to be flexible to allow for place-based adaptation to service delivery.

Most NCs and ACWs noted that CCC is a culturally appropriate service and that the services specifically align with principles Aboriginal leadership and control. CCC puts Aboriginal health in Aboriginal hands and is place-based, holistic and community-led in many sites.

Most of the respondents to the JC and NC survey agreed or strongly agreed (89 per cent of 28) that the flexible approach to funding and service design enabled by CCC is helping their service respond better to the specific needs of their community. The freedom and flexibility of the MoC is perceived to be beneficial for some ACCHOs interviewed but also challenging for others (e.g. sites with fewer existing resources to draw on). As mentioned at the beginning of this section, the flexible and adaptive nature of the MoC has enabled a range of place-based approaches to suicide prevention and aftercare services to be designed and implemented by ACCHOs and networks to meet the specific needs of their communities. However, less resourced and or established sites indicated the MoC is too broad to support program design which made it challenging for them to establish CCC without additional design and implementation support.

As indicated throughout this evaluation, further structured support is required to enable less established or "implementation ready" ACCHOs to implement CCC effectively, which may look like scaffolded support and funding based on organisational capacity.

Interviews suggest that consortiums can be a way to bring together ACCHOs with varying specialties and skills as they work together on cases but manage individual clients requiring each aspect of their service delivery. The challenge with consortiums that is noted however is the time taken to establish processes, due to having many leaders to agree before work can commence.

### What early evidence exists of progress towards achieving CCC outcomes?

The evaluation has found early evidence of outcomes in:

- improved aftercare capacity and capability which is filling gaps in local service systems
- strengthening of local mental health workforces
- increased health promotion
- improvements in coordination, pathways and touchpoints
- reduced stigma and increased community awareness
- increased demand for SEWB services
- positive externalities.

Each of these is explored below.

#### *Improved aftercare capacity and capability which is filling gaps in local service systems*

Aftercare capacity and capability has been improved by filling gaps in many service delivery systems that did not previously offer culturally appropriate aftercare services.

Of the sites that describe the service system prior to CCC in their documentation (19 sites), most indicate that suicide prevention and aftercare activities were only delivered by mainstream services (13 sites). Most commonly, sites mention that these activities were delivered by hospitals or Primary Health Networks (PHNs) (12 sites), the Police (nine sites) and Headspace (seven sites). A few sites also mention mainstream aftercare services such as Relationships Australia (three sites). Few sites mention the availability of activities delivered by cultural or community groups (five sites).

Similar findings were noted in the site visits and interviews. Many NCs and ACWs and some external service providers report that there were no culturally-safe aftercare services prior to CCC. In addition, mainstream activities operating through PHNs, hospitals, Headspace or NEAMI had low engagement by First Nations people due to mental health stigma and mistrust in mainstream services. Some sites noted their ACCHO already provided similar support before CCC and had staff who were experienced in delivering social and emotional well-being programs and services. One NC also reflected that the ACCHO did deliver some activities prior to CCC but that the holistic feature was not present. CCC staff from a remote community described examples of supporting friends, family and peers of individuals who had died by suicide and in doing so had prevented further deaths or self-harm.

One Affiliate also noted that before CCC, significant, dedicated, and multi-year funding for culturally safe suicide prevention and aftercare, healing, grief and loss support did not exist in the Northern Territory and another Affiliate noted that regional service delivery for aftercare was a significant gap in Western Australia prior to CCC.

There is evidence that since CCC's commencement, the service delivery landscape is changing for First Nations People, with the presence of culturally appropriate, holistic aftercare delivered through the ACCHOs as part of CCC. An Affiliate and many NCs and ACWs note the gap in aftercare services that CCC fills, particularly regionally. Some NCs and ACWs in the site visits and interviews report that aftercare through CCC allows the service to 'walk alongside' clients in their SEWB journey and another noted that through CCC, clinicians are more positively engaged with clients. Some external providers such as hospitals who have historically had poor relationships with the community note that having ACW workers present to advocate for First Nations clients helps bridge the relational gap and stop the cycle of readmissions for some of their patients.

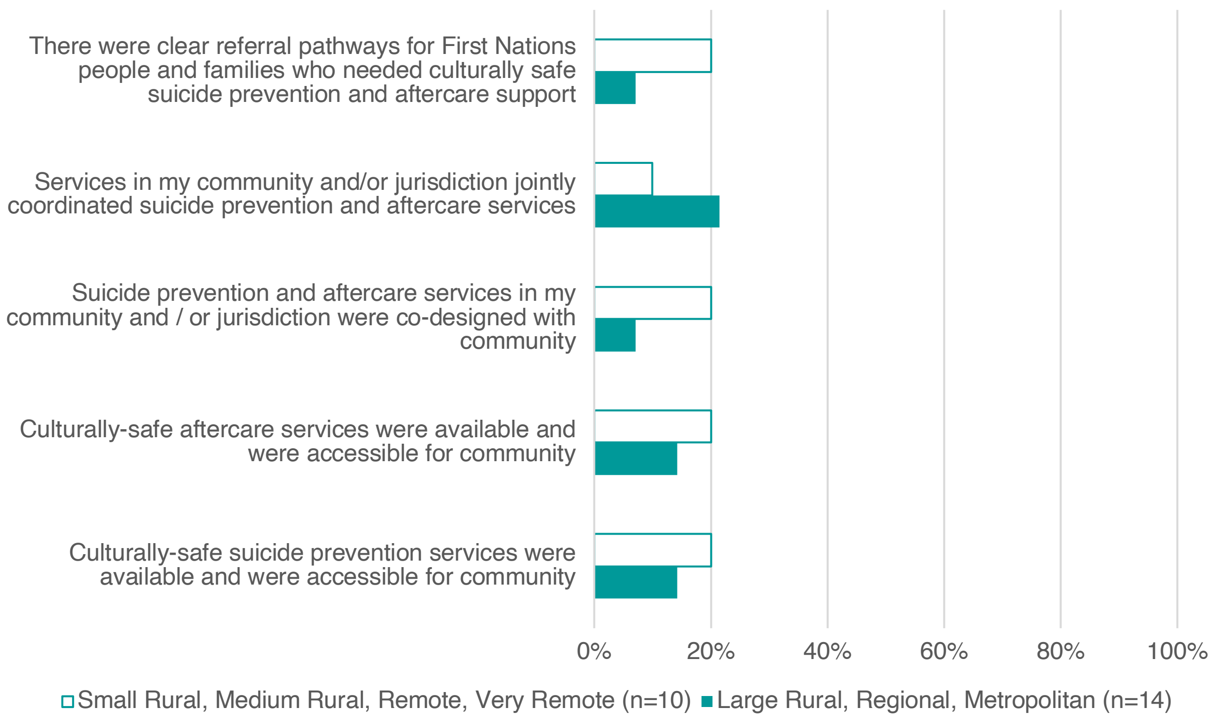
NACCHO reflects that the dedicated funding through CCC has enabled community-controlled services, whom were already culturally safe spaces, to expand and improve the quality of their service provision. The focus on mental health training and capacity-building has increased the ability of services to provide culturally appropriate support. However, quantifying increased access is difficult at this stage.

Gaps in this capacity and capability to deliver culturally appropriate and holistic aftercare still remain. The evaluation noted a gap in understanding of the ASDMs by ACWs, and also variation across the workers in their understanding of CCC and what is within their roles. The other major gap (which was described by all sites and will be detailed in KEQ3) is the lack of resources to fund enough ACWs to meet the demand for these services in the communities they serve. In many locations, recruitment of ACWs is the greatest challenge, especially in rural and remote sites.

This filling of service gaps is particularly pronounced for remote and very remote communities. Communities that are more remote, have a lower degree of access to services and larger distances to travel to reach them. Site visit data suggests that communities surrounding more remote CCC sites have typically had low to no access to SEWB services or relied on services that were offered on a fly in fly out or drive in drive out basis. Services in these locations note greater challenges in establishing adequate aftercare services with the funding provided, due to the geographical spread. These communities also experience greater challenges with recruitment, transient populations and the diversity of language groups in the communities they serve.

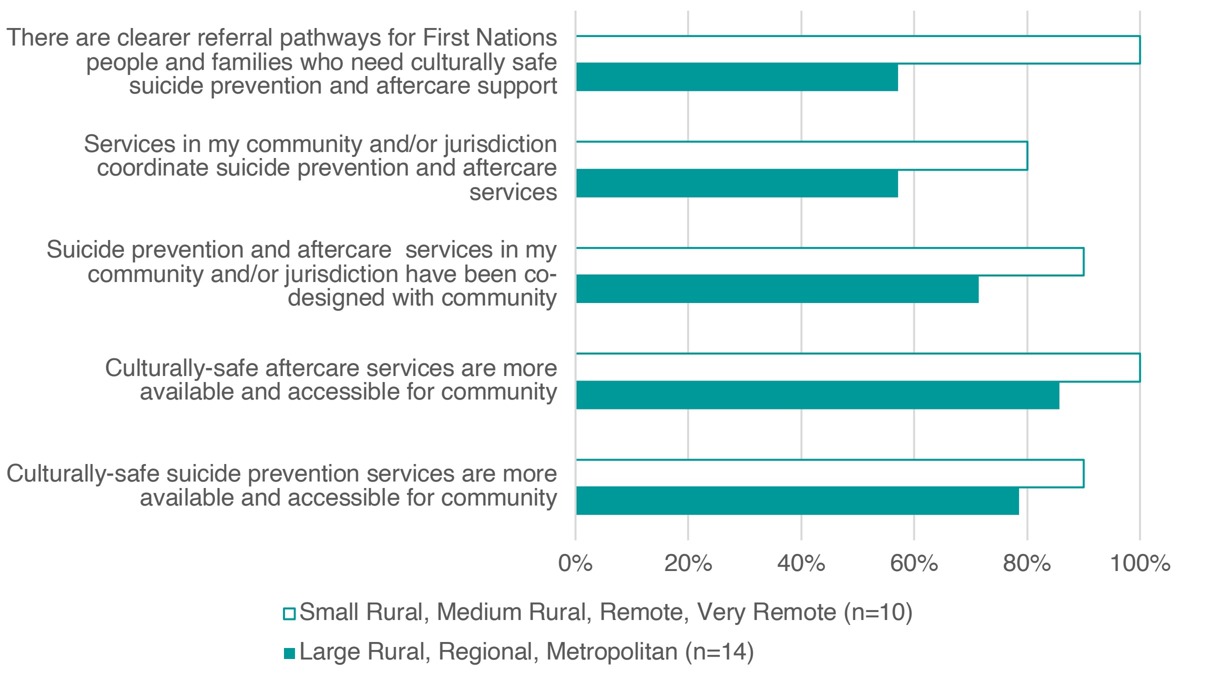
A subgroup analysis of the survey of JCs and NCs exploring the difference between experience of CCC staff in sites with different remoteness suggested that "Small Rural, Medium Rural, Remote or Very Remote" sites were more likely than the respondents from "Large Rural, Regional, Metropolitan" sites to indicate improvements in the service delivery experience across all five domains of: referral pathways, suicide and aftercare coordination, co-design, improved availability and accessibility of both aftercare services and suicide prevention (see Figure 8). Nevertheless, respondents from both types of site location were much more likely to respond positively about questions relating to service delivery since CCC than before CCC (see Figure 7 and 8).

Figure 7. Proportions of respondents strongly agreeing or agreeing with survey Question 10: Changes to service delivery "before Culture Care Connect….." Remote and rural sites compared to larger regional and metropolitan sites.




*Proportions denote the Proportion of respondents from the group that indicated 'Strongly Agree or Agree' to each item. Total n for location was 24 as 4 people did not provide the MMM rating of their service.*

Figure 8. Proportions of respondents strongly agreeing or agreeing with Survey Question 11: Service delivery since CCC. Remote and rural sites compared to larger regional and metropolitan sites.




*Proportions denote the Proportion of respondents from the group that indicated 'Strongly Agree or Agree' to each item. Total n for location was 24 as 4 people did not provide the MMM rating of their service.*

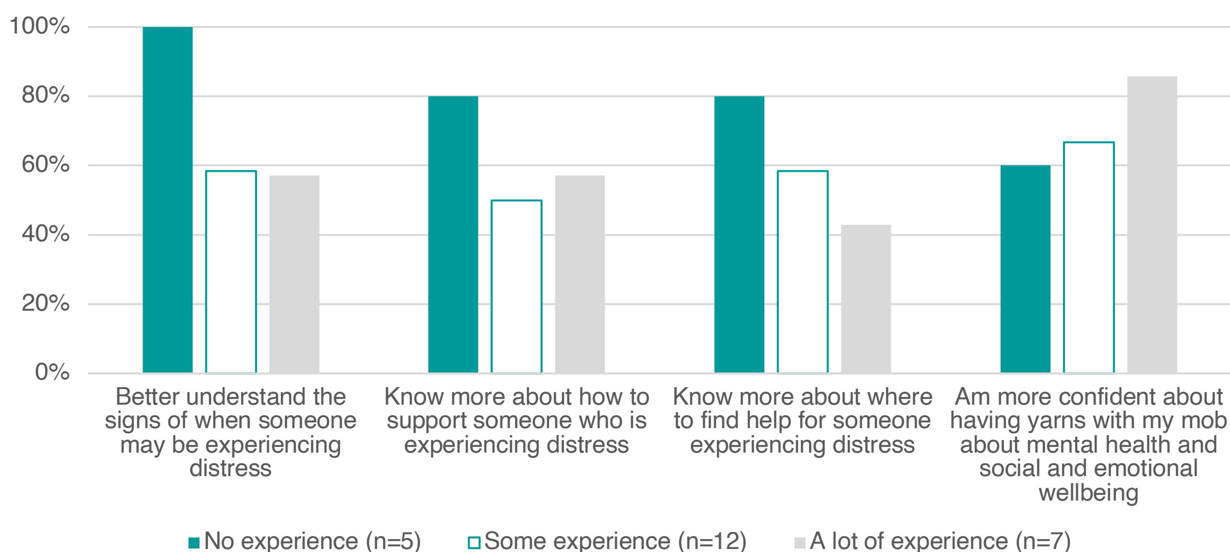
*Strengthening of local mental health workforces*

There is early evidence that a strong Aboriginal workforce is being engaged and enabled with skills and knowledge as a result of the ATSIMHFAT and other training delivered through CCC. However, more training is needed to further develop skills in mental health and suicide prevention.

Networks have mixed views on the utility and delivery of ATSIMHFAT for CCC staff at the network level, but it appears to be useful at a community level. Largely, CCC staff were of the view that the ATSIMHFAT in its current form is most useful for staff and community members who are new to or have a low level of experience in mental health service provision.

This finding was supported by the results of ATSIMHFAT survey.[39] Respondents with the least experience more commonly reported the training improved their levels of understanding and knowledge about the signs of and how to support people in distress than respondents with a lot of experience. However, those with more experience appear to be more likely to feel confident putting the knowledge gained in training into practice[40] (see Figure 9 below).

Figure 9. Proportion of responses per sub-group to survey question 7: "Because of the Aboriginal and Torres Strait Islander Mental Health First Aid training or other suicide prevention and mental health training I have received, I" Sub group analysis for level of experience working with people with distress prior to training (n=24)




Network stakeholders in site visits and interviews and survey respondents also identified the need for training beyond the once-off ATSIMHFAT. Most survey respondents agree or strongly agreed that they will need additional support or learning in the future to be equipped to support their community's social and emotional wellbeing needs (n=19, 79 per cent). CCC staff require more specific and ongoing training to equip them in their aftercare roles.

Many sites noted that it is vital that aftercare staff receive appropriate training during their induction period to ensure they can safely work with clients. One ACCHO noted that they require their aftercare staff to have a Cert IV in Mental Health or be working towards one to be employed to reduce the risk for staff burnout and risk to clients. Although ACWs without Cert IV are required to have more clinical supervision to ensure that a client is kept safe, there remains a need for more appropriate training to be provided during induction.

Some improvements to the training suggested by Affiliates included more gender balance with delivery. Currently trainers are predominantly female, and additional male trainers were seen as needed to help with stigma reduction in men and building the male workforce. In addition, suggested improvements to training

[39] People who had received Aboriginal and Torres Strait Islander Mental Health First Aid training or other suicide prevention and mental health training under the CCC program (n=24)

[40] It should also be noted that the sample size from the survey was small so care should be taken when interpreting the survey responses in isolation.

included embedding supports and distress protocols for trainers and trainees in the training and adopting flexible learning practices with a strong preference for training that is delivered in community.

Additional training suggested by survey respondents and interviewees are:

- refresher courses across all types of learning
- cultural competence training or cultural awareness workshops
- Gatekeeper Training
- Cert IV in Indigenous Mental Health
- Gallang Place
- grief and Loss
- Cert and Diploma of Mental Health (although this was noted to lack a cultural lens)
- Narrative Therapy accreditation
- Intergenerational trauma training
- suicide prevention and awareness training
- any training to update support workers Mental Health and SEWB knowledge
- AOD workshops
- self-care workshops.

I-ASSIST and Safe YARN were both mentioned as training of interest and some sites already enable their CCC staff to attend these courses. ACWs at one site where greater integration with mainstream services was already occurring noted the need for greater medical knowledge as there was a growing number of clients presenting with clinical and complex needs.

Finally, opportunities to extend learning to focus on specific issues as well as enable staff to obtain professional accreditations or educational qualifications are important for future CCC training opportunities.

*Increased health promotion*

As mentioned in section 2.1, health promotion and suicide prevention activities are now being delivered at most CCC sites, and in many cases these activities are being delivered for the first time in community. The data from the JC and NC survey also supports the findings of the interviews. Few respondents indicated the presence of culturally safe services and referral pathways prior to CCC (Figure 10). Conversely, most respondents indicated a positive perception of the presence of these services and pathways since CCC. Notably, most respondents agreed or strongly agreed that both culturally-safe suicide prevention (n=22, 82 per cent) and aftercare services (n=24, 89 per cent) are now more available and accessible since CCC. Most respondents (n=21, 78 per cent) also agreed or strongly agreed that suicide prevention and aftercare services in their community have been co-designed with the community.

Figure 10. Responses to survey Question 10: Changes to service delivery "before Culture Care Connect….." (n=28)

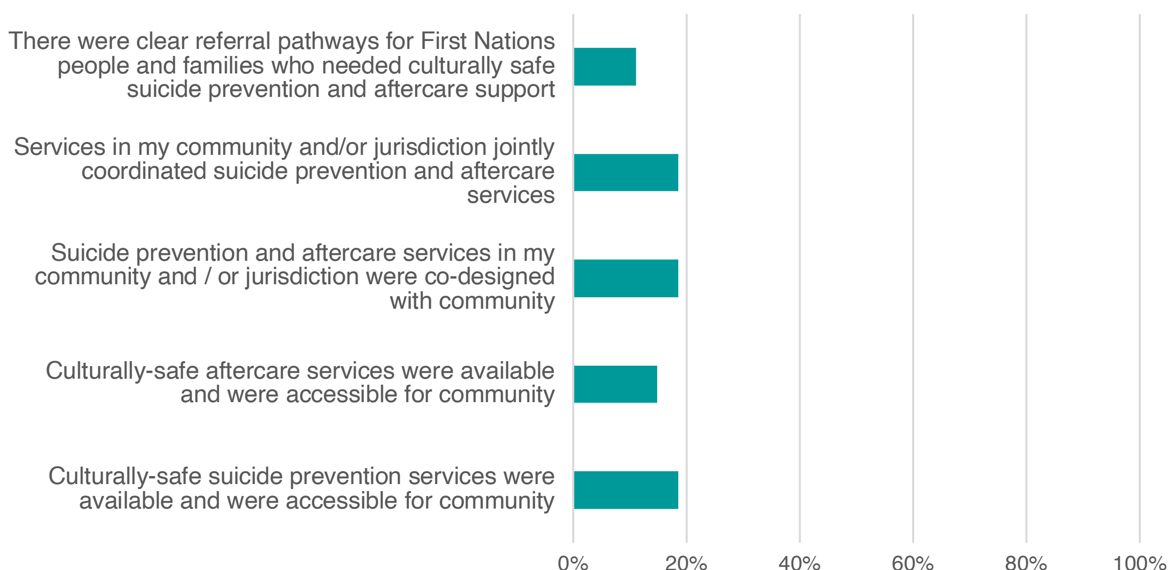
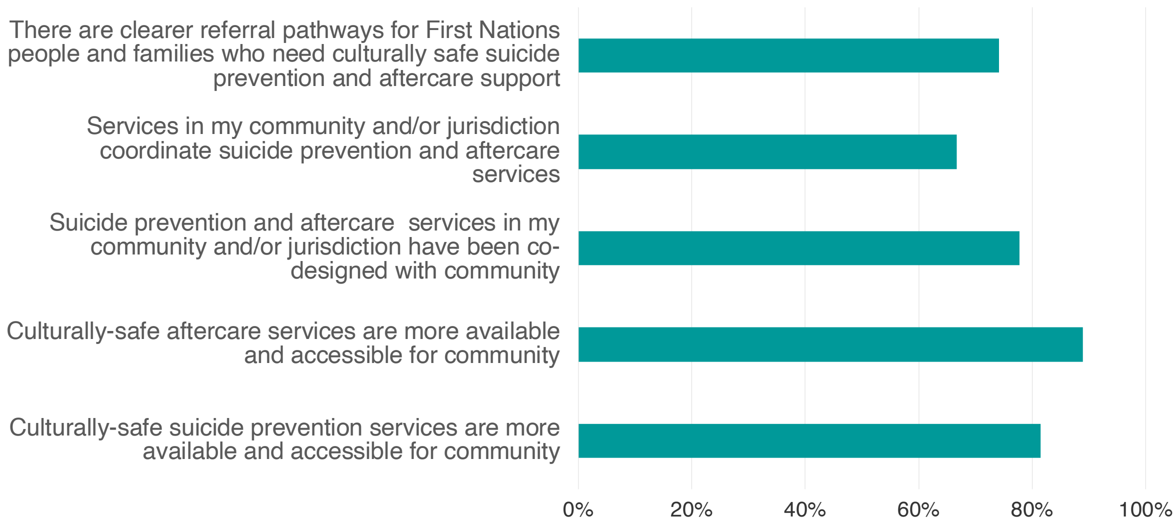


Figure 11. Responses from survey Question 11: Changes to service delivery “since Culture Care Connect…..” (n=28)[41]




### *Improvements in coordination, pathways and touchpoints*

There is early evidence of improved coordination, pathways and touchpoints between many ACCHOs and mainstream services; including early evidence of safe systems being established to support SEWB for First Nations peoples (see **Case Study 4**). Internal teams within ACCHOs where CCC is based describe referring clients internally to and from various services and some have internal information systems in place to improve joined up service delivery for clients. Internal ACCHO staff spoke of the wraparound support provided by the ACCHO, where CCC provides more support for the client as part of that holistic care. Many internal ACCHO staff spoke of an increase in culturally safe community support groups through CCC, that clients and community increasingly engage with. However, in some instances, there was also confusion about the scope of the CCC team and how it differed to the SEWB teams that already existed within ACCHOs before CCC.

Many sites note that engaging with mainstream services has been one of the most challenging aspects of network coordination. Despite this, there are examples in both documentation and site visits of successful multi-service CCSPNs and NCs in particular, are enabling conversations between CCC sites and external service providers. Where NCs are not in roles or they do not have relationships in the system, setting up the network and referrals can be more challenging and staff turnover hampers networking and coordination efforts. Interagency meetings are described by many as being pivotal by most for relationship development prior to referral systems improvement but some sites are struggling to engage stakeholders for these to occur.

When successful, CCSPNs appear to be facilitating shared learning and collaboration and increased engagement and awareness with external providers. One site describes how their CCSPN is truly breaking down barriers and has created a service collaborative. The primary goal of the collaborative is service integration to avoid duplication and improve collaboration through shared language and understanding of roles.

Referral pathways are proving slower to develop and challenging to set up due to traditionally siloed mainstream service delivery that relies on NC skill, relationships and availability. Ther is however evidence that it is happening across many sites. The document review suggests that cross-service referral pathways are established at many sites (16 sites), but the quality and effectiveness of these is not mentioned. Some

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[41]While participants were specifically asked about their experiences with CCC, it is important to note that their responses may also have been influenced by other programs or external factors that have existed since CCC was implemented

service providers in the site visits and interviews also noted that referral pathways, connection and collaboration between services has improved as a result of CCC. CCC aftercare sites are receiving referrals from GPs, ACCHO medical services, self-referral and external agencies such as, mental health services and even community corrections.

Likewise, many sites and external providers describe how ACWs are facilitating service coordination, building rapport and trust with clients in a culturally appropriate way and enable clients to connect to culture and then can refer onwards if required. ACWs mention referring to other appropriate services such as First Nations Women's or Men's Shelters and other homelessness programs, counselling, psychology, cultural support, domestic violence support or AOD support if they feel comfortable doing so or using other services such as 13 YARN. Other sites also note the flexible nature of CCC allows clients who do not meet strict eligibility criteria for other programs (such as NDIS or community mental health) to be supported thereby reducing the number of people who may otherwise not receive any support.

**Case Study 4: Service Coordination and Collaboration**

Case Study 4 is based in regional NSW, and provides an array of holistic health services to surrounding region. The CCC site has chosen to take a new name meaning "to strengthen, take care and recover" in the local language (instead of CCC).

The Jurisdictional Coordinator at the service was proactive in forming relationships with external service providers through existing relationships, attendance at events, and initiating meetings and presentations to external service providers. Relationship building by the CCC site raised awareness amongst mainstream services and staff on best practice engagement with First Nations clients, such as cultural differences that influence how First Nations people experience mental health.

The CCC site conducted consultations with community to ensure the provision of services was consistent with community need. In response to the consultation findings, the CCC site created a local Suicide Response Group with the Primary Health Network (PHN) and Local Health District (LHD) to coordinate a centralised response to suicide in community that is grounded in community voice. Coordination between services aims to reduce the number of stakeholders involved in a client's mental health journey; provides resources for first responders to best support clients; ensures culturally appropriate service provision; and provides accountability between services to coordinate supports for bereaved families. This approach forms part of a strong suicide prevention network, and external services rely on advice and support from the CCC site.

The service coordination and collaboration delivered by the CCC site has strengthened and streamlined suicide prevention and aftercare referral pathways in the region. Continued engagement and commitment by external stakeholders is necessary to ensure the effectiveness of broader suicide prevention.

Some external services are also now more cognisant of what services are available for suicide prevention for First Nations clients as a result of CCC and are able to offer clients options for where to go for assistance. This is however creating further demand on CCC services.

Some external agencies also note that role clarity of CCC staff can sometimes be lacking. CCC service providers also mention that external services lack clarity around the role of the CCC as a program.

*Reduced stigma and increased community awareness*

New shoots of medium-term outcomes- there is early evidence of reduced stigma and increased awareness of suicide and mental health in communities (see **Case Study 5**).

At a network level, there are also many examples of increased collaboration and sharing of approaches between different stakeholders to discuss and address suicide in community and reducing siloed working practices. This was seen in JC/NC survey, where many (67 per cent) respondents agreed or strongly agreed that services in their community or jurisdiction jointly coordinated suicide and aftercare services after CCC, but few (19 per cent) felt this was the case before CCC. There were also examples of this in the site visits, including OAMS CCSPN, who are working closely with their local PHN and have developed mutual respect for each other's services. This was seen by the PHN stakeholders and CCC staff as major success. Both stakeholders noted that the more they work together and promote each other's services, the more trust is built

within the community and credibility is built nationally.

Most internal ACCHO staff spoke of how consistency in CCC, through service delivery and awareness raising has helped change attitudes to mental health and suicide in their communities. Many NCs, ACWs and internal ACCHO staff report that clients and community have reacted positively to CCC, with some already noting increased in buy-in from the community, with more people feeling confident to make contact, talk and engage with the service.

**Case Study 5: Responding to community needs**

Case Study 5 is a CCC site that has developed an after-hours phone support service that serves clients who live in the surrounding regions through phone assistance until 7.00pm on weekends and 9.00pm on weekdays.

The program was established in 2012 to provide support to clients that require assistance outside of normal working hours. The after-hours phone support comprises of a "check-in" by the staff to monitor those deemed at risk. The support may also be assisting those in an immediate crisis.

The service has effectively responded to their community's needs for an after-hours support service. It works in partnership with other services at the ACCHO and provides holistic, continuity of care for women who use the ACCHO.

The model developed by Case Study 5 highlights that suicide prevention coverage may not fit a standard business day model. Future developments for CCC should recognise the importance of offering less confrontational approaches (such as phone help) and consider how afterhours services can be incorporated into future CCC design.

ATSIMHFAT is also helping general staff in ACCHOs (non-SEWB teams) look after each other better and know where to look for help if they have mental health concerns with friends or family.

There is early evidence that communities have improved access to culturally safe, trauma aware, healing informed suicide prevention and aftercare that meet their needs. This was seen in the JC/NC survey, where most respondents agreed or strongly agreed that culturally-safe suicide prevention services and after care services are more available and accessible for community since CCC (82 per cent for suicide prevention and 89 per cent for after care services). Many respondents to the survey (74 per cent) also noted that there were now clearer referral pathways for First Nations people and families who need culturally safe suicide prevention and aftercare support. Further, in some sites visited during the evaluation, staff noted that clients who had previously been unable to access the level of support they required to address suicidal ideation, were able to receive rapid in-person support through CCC. Examples of aftercare that encouraged self-help were also noted in the evaluation, such as a family member of client who was linked with 13 YARN by an aftercare worker who then learnt how to cope on their own.

Health promotion activities delivered by CCC services appear to be raising awareness of SEWB in the community. Many sites report that they have observed that health promotion efforts have improved community awareness of the services delivered through CCC and the availability of other supports. Sites describe reduced stigma about having conversations with mob about mental health and suicide. It was also highlighted that this topic has been stigmatised for such a long time that reducing stigma around mental health is a long process. Further, increasing mental health literacy in communities is noted in staff, clients and their families at many sites. This finding was also supported in the JC/NC survey where many respondents agreed or strongly agreed (74 per cent) that since CCC's commencement they have observed positive changes in my community's knowledge, attitudes and behaviours toward suicide, mental health, and their social and emotional health needs.

*Increased demand for SEWB services*

Some staff have identified positive impacts on the SEWB of their clients as a result of CCC. For example, for young people who have experienced suicide in the family and been involved in CCC programs.

CCC staff also noted that there has been a rise in demand for the service since CCC was implemented. Many survey respondents agreed or strongly agreed (78 per cent) that more people in their community were being identified and coming into the service for support with their social and emotional health needs.

*Positive externalities*

There are multiple examples of positive externalities seen at the SAWCAN consortium site. For example, the CCC funding has facilitated the establishment and strengthening of partnerships with StandBy and Three Rivers to provide more comprehensive support. Staff are passionate about the program continuing because the community sees it as the ACCHO and the government taking the issue seriously. Further the consortium notes building stronger relationships with the South Australian Department of Corrections through CCC. Finally, staff also mention the establishment and high engagement of men's and women's groups with CCC indicates increased community support.

Some positive externalities also noted at other sites include enabling the ACCHO to keep external services providers accountable for their work with First Nations people. Another site notes that CCC has supported the thinking of the ACCHO they now plan to build across life-span services for youth, middle age and Elder services.

**What evidence is still to be seen?**

There is limited early evidence of information and data being gathered to support suicide prevention and service planning and enable future investment in suicide prevention services.

CCC sites recognise that data capture and the use of either qualitative or quantitative data is valuable for ongoing review and development of CCC but very few services mentioned actively collecting data about their service or using it to inform service development. Some sites reflected that ongoing monitoring and learning built into CCC to support ongoing improvement is still required with specific guidance provided by NACCHO on data to be collected and clearly linkage to CCC reporting requirements. One site noted that they use annual client surveys that are a regular part of ACCHO reporting to inform CCC planning.

There is evidence of improved structures to support data sharing practices between ACCHOs and external service providers in some sites. For example, one site described the development of a Memorandum of Understanding and data sharing protocols between CCC service and external providers in the local service system to enable practitioners to share information about clients and refer between more effectively.

Aftercare staff in some sites note that it has taken time to develop their skills in data capture (such as writing notes) as this is a new skill for many. They also note that at times they do not have the time to undertake administrative tasks like reporting.

An Affiliate notes that there is a lack of feedback from NACCHO to the CoPs, this includes summarising what was discussed at the meetings to better inform service improvements for the members. Two Affiliates also note a lack of consistent monitoring evaluation and learning integrated into CCC. One describes that there has been a lack of clarity around the data that needs to be collected as part of CCC. It was also noted that the contractual reporting requirements were onerous, repetitive across different outputs and the intent was unclear. NACCHO also recognise that data collected potentially needs to be reassessed, so it is informative and constructive.

There is limited early evidence that advocacy and relationship building are influencing changes in the policy and funding environment to support suicide prevention services due to the early stage of implementation.

Examples of change at a policy or funding level were limited at the time of the evaluation and can be attributed to the early phase of CCC's implementation.

One Affiliate notes that the four members in the region they were funded to support were autonomous and capable of advocating independently and directly to NACCHO and state Government regarding their financial, programmatic, and operational needs. This JC supports the ACCHOs by providing broader CCC strategic/policy context but felt their substantive role could be scaled down for those higher functioning sites.

One of the ACCHOs successfully advocated to receive universal aftercare funding from the state Government to combine with their CCC funding. The same JC has undertaken regular advocacy in a broader state context – including, participating in consultations to develop the state Suicide Prevention Strategic Framework and advocating for the inclusion of culturally safe Aboriginal worldviews and priorities in the drafts of the Framework.

One NC described the importance of advocacy for Indigenous mental health in remote Western Australia, illustrated by their advocacy at a local, state and Federal-level. Mental Health suicide prevention programs had been made available for the first time in remote WA two to three years before CCC's commencement. This NC described their role to include highlighting to NACCHO and other CCC stakeholders how other issues affect their community, including access to food, homelessness, and a lack AOD and domestic and family

violence services.

# APPROPRIATENESS

## To what extent is the design and the delivery of CCC appropriate?

The findings in this section examine the appropriateness of the design and delivery of CCC. Understanding CCC's appropriateness involved examining:

- alignment to its original intent
- ability to meet current and future demand.

### Key findings

Overall, the design and delivery of CCC is appropriate when examined from the perspective of national stakeholders (NACCHO and DHDA), CCC stakeholders (Affiliates and ACCHOs), other service providers, and when compared against the current evidence-base.

CCC stakeholders report that CCC is appropriate in that it is:

- meeting community needs and addressing gaps including providing aftercare services and establishing culturally appropriate clinical roles to provide immediate SEWB care where no referral pathways existed
- empowering community leadership by enabling ACCHOs to respond to the needs of communities by resourcing activities that address service gaps in each CCC community
- supporting place-based service design by allowing ACCHOs and CCSPNs to customise it to their specific priorities and needs at the local level
- enabling culturally-safe and trauma-informed service provision through NSPPs, JSPPs and the development of cultural and clinical governance frameworks with community leaders to safeguard cultural integrity.

Other service providers (inside and outside of ACCHOs) report that some CCC sites are focusing on internal collaboration to integrate CCC aftercare into their existing holistic healthcare framework, while others have transitioned an existing program and realigned their tele-health service to CCC. Several sites have leveraged existing governance structures and committees to integrate program implementation and monitoring with broader health strategies. Across most CCC sites, collaboration with external services like police and hospitals is increasing, and warm handovers from inpatient units are occurring. The relationship and referral system built within CCC is seen as different from previous state government collaborations.

From an evidence-base and policy perspective, CCC is strongly aligned to key national policy frameworks aimed at improving health and wellbeing outcomes for First Nations peoples including:

- National Agreement on Closing the Gap[42], embodying its transformative approach to partnership, shared decision-making, and community control. Rather than addressing specific targets in isolation, CCC integrates the Agreement's Priority Reforms through its ACCHO-led structure, culturally safe service delivery, and commitment to data sharing and community-led planning.

- The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035 (NATSISPS)[65], CCC closely supports the vision, principles and priorities of NATSISPS[66]. The Strategy sets out a national framework to significantly reduce suicide and self-harm among First Nations peoples through community-led responses, in alignment with Target 14 of the National Agreement on Closing the Gap. CCC implements core elements of the Strategy by being delivered through the community-controlled sector, recognised for its ability to deliver culturally safe, holistic, and locally responsive care. Through the delivery of culturally safe suicide prevention and aftercare services, CCC strengthens community capacity and fosters sustainable, culturally grounded approaches to healing. The program is co-designed with First Nations communities, including Elders and cultural leaders, to ensure that services reflect local cultural knowledge, values, and priorities. Its place-based design allows each ACCHO and network to develop tailored NSPPs and ASDMs, responsive to the unique needs of their communities.

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[42] Closing the Gap, National Agreement on Closing the Gap, Australian Government, 2020.

In line with NATSISPS, CCC contributes to a culturally capable and responsive workforce by providing ATSIMHFAT and promoting peer support structures. Further, it supports building the evidence base for community-led suicide prevention through ongoing monitoring and independent evaluation. By strengthening the community-controlled sector and promoting self-determination, CCC delivers holistic, SEWB-centred care that advances the goals of the NATSISPS.

- National Aboriginal and Torres Strait Islander Health Plan 2021–2031[43], which provides a 10-year framework for ensuring First Nations peoples enjoy long, healthy lives, free of racism and supported by culturally safe, responsive care. CCC supports several Health Plan priorities, including shared decision-making, the expansion and sustainability of community-controlled primary health care, and a focus on social and emotional wellbeing (SEWB). Its place-based, trauma-informed approach reflects a deep commitment to embedding cultural determinants of health into service delivery.
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-31[44]. CCC's MoI strengthens this agenda by resourcing ACCHOs to recruit, train, and support a culturally capable SEWB workforce. It aligns with strategic directions focused on building leadership, creating culturally safe workplaces, supporting career development pathways, and improving workforce data systems. The Implementation Plan, which operationalises the Health Workforce Strategic Framework. Through flexible funding, non-prescriptive contracts, and support for local workforce initiatives, CCC enables communities to lead their own strategies for workforce growth and cultural capability. The program's use of data for planning and evaluation also aligns with national efforts to strengthen accountability and continuous improvement.

Taken together, CCC not only complements these national strategies - it operationalises them at the community level. By embedding principles of self-determination, cultural safety, and local leadership, CCC exemplifies how government and community can work in genuine partnership to deliver sustainable, strengths-based health solutions that are both effective and empowering.

In summary, CCC is fundamentally aligned with its original intent, particularly in its design principles of being community-led, culturally safe, trauma-informed, and place-based. The model of implementation and funding structure is specifically set up to enable this approach and align with key policy priorities. Many examples demonstrate how sites are utilising the program's flexibility and collaborative support to adapt services to local needs and cultural contexts. However, implementation challenges related to workforce capacity, resource limitations, and the need for clearer role definitions and consistent support highlight areas for ongoing refinement. Early indications suggest the model is creating new ways of thinking and doing for the community-controlled sector and First Nations communities as a whole.

More information on how the program aligns with its original intent and if it is meeting current and future demand can be found at pages 68 and 70 respectively.

## Appropriateness: what enables CCC to be appropriate?

CCC's appropriateness is enabled by:

- **The three-tiered MoI**: The community-controlled sector is empowered to lead the development of place-based solutions in partnership with government. Its three-level structure (national, jurisdictional, community) is designed to support ongoing learning, service delivery, and advocacy from local to national levels. Critical to the Model is First Nations leadership and control. The funding and commissioning model, established between DHDA and NACCHO with sub-grants to ACCHOs, is highlighted as unique and gives effect to Priority Reform 1 of the National Agreement on Closing the Gap (formal partnerships and shared decision-making). The flexible, outcomes-focused nature of the funding, administered by NACCHO, enables community-led and place-based approaches. Groundwork is being laid, supported by the maturation of the MoI, enabling community-driven solutions in partnership with government.
- **A dedication to Aboriginal-led evidence-based design and delivery**: The expertise, intellect,

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[43] Department of Health, National Aboriginal and Torres Strait Islander Health Plan 2021–2031, Australian Government.

[44] Department of Health, National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-31, Australian Government.

wisdom and knowledge that has informed the CCC approach is drawn from a deep evidence and policy base.

## Appropriateness: what inhibits the CCC from being appropriate?

The following factors inhibit the appropriateness of CCC:

- **A lack of community engagement skills**: While the intent and design strongly support community empowerment and tailored services, challenges exist in consistent engagement and adapting models to fit the unique contexts of each community, particularly due to varying capacities and resources across ACCHOs. Limited resources can reduce community engagement and engaging mainstream services can also be challenging.
- **A lack of FTE to meet current and future demand**: CCC sites lack the funding to recruit the level of workforce required to meet current and future demands in their communities for suicide prevention and aftercare services.

### Implications for ensuring the appropriateness of CCC

- A clearly designed program that not only includes intent, but also a MoI and practice, in addition to clear roles and responsibilities. All components are critical for delivery success.
- The skills, knowledge and capability that sites have are critical for upholding the intent of CCC. Where community engagement skills don't exist full adherence to community-led service delivery can't be achieved.
- The role that NACCHO plays in stewarding the MoI and MoC across the program and sites while administering the funding agreements with flexibility and care is enabling community-led, place-based, strengths-focused delivery in communities.
- Trust and culturally-safe service provision go hand-in-hand. The CCC program's focus on culturally-safe services and sites focus on building trust with communities ensure CCC is appropriate. This in turn increases community engagement and help-seeking.
- An approach like CCC requires adequate resources to enable appropriate implementation. Its current level of resourcing is not appropriate for the demand and this requires urgent attention.

## To what extent does CCC align to its original intent?

CCC's intent is to enable community-led, culturally safe, and trauma-informed suicide prevention and aftercare in First Nations communities. The document review and interviews confirm CCC was designed and delivered with five core features that aim to align to the program's intent.

The **first feature** includes the program's **nine principles**[45], **MoI, and MoC**. The principles guide the development and implementation of the program. The MoI provides the framework for "how" the program and activity streams should be implemented. The MoC provides the framework for "what" the program and activity streams should implement. Working together at the program and site-levels, the MoI and MoC are intended to enable community-led, culturally safe, and trauma-informed suicide prevention and aftercare in First Nations communities.

The principles, MoI and MoC were developed through consultation with First Nations communities, experts, and leaders, as well as clinical experts. They are designed to be highly adaptive and flexible to be customised to specific local priorities and needs through community consultations (see **Case Study 6**). Activities like "healing on country" are highlighted as important cultural supports. Some sites have incorporated traditional healing practices based on community feedback, seeking to move away from a purely western clinical approach. The program explicitly aims to connect people to trauma-aware care, and consultancy services may be engaged to translate models like the Narrative Recovery Model. The MoC, in particular, serves as a key enabler for culturally safe and comprehensive care. ACCHOs are seen as trusted access points for culturally safe conversations about suicide prevention.

**Case Study 6: Holistic Care**

Case Study 6 is situated in an ACCHO that supports the health and wellbeing of Aboriginal and Torres Strait Islander people living in Western Australia.

The CCC site has a strong focus on providing the community a 'one stop shop' service. Having all services available in the one Aboriginal community led organisation stops the need for clients to navigate multiple systems or service providers. This approach aims to minimise the barriers, delays, and stress that often comes with accessing support from different locations, making it easier for clients to get the help they need in one place.

Embedding a suicide prevention program within the broader health service, and equally, integrating health services within a suicide prevention program, supports a holistic model of care for clients. It recognises that people experiencing challenges with suicide often have other, interconnected health and social needs. When these services operate together, it enables warm referrals, coordinated support, and more seamless pathways for clients, reducing the risk of people falling through the cracks or an individual having to retell their story multiple times.

Engaging a psychologist from an external provider co-located within the service on a regular basis, and working onsite alongside the team is an example of the CCC site's integrated, holistic approach. A psychologist on site created a direct pathway to mental health support for clients, without the usual barriers of waitlists, referrals or needing to attend another service in a different location. It also supported the psychologist to develop their skills working with Aboriginal clients, including learning from the CCC team on how to work in a culturally safe manner.

The MoI empowers the community-controlled sector to lead the development of place-based solutions in partnership with government. Its three-level structure (national, jurisdictional, community) is designed to support ongoing learning, service delivery, and advocacy from local to national levels. Critical to the MoI is First Nations leadership and control. The funding and commissioning model, established between DHDA and NACCHO with sub-grants to ACCHOs, is highlighted as unique and gives effect to Priority Reform 1 of the National Agreement on Closing the Gap (formal partnerships and shared decision-making). The flexible, outcomes-focused nature of the funding, administered by NACCHO, enables community-led and place-based approaches. Groundwork is being laid, supported by the maturation of the MoI, enabling community-driven solutions in partnership with government.

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[45] NACCHO, Operational Guidance Paper, Culture Care Connect, V.4, June 2022.

The **second feature** is providing for a **range of CCC stakeholders** with different, yet complimentary roles and responsibilities. The intention was to ensure aftercare could be provided to communities (by ACWs), those ACWs had support, and the services and activities were coordinated (by NCs) while a bigger constellation of help touchpoints was built throughout community by Affiliates and JCs. These in-community services are supported by Affiliates and NACCHO. Fundamental to this resourcing structure is the principle of being Aboriginal community-led.

In practice the site observations, document review and interviews revealed that this mix of roles ensures the MoI is adhered to by providing for:

- informal help and support provision (T participants)
- direct service provision (Aftercare)
- education and awareness raising (ACWs, NCs and JCs)
- suicide prevention planning and service coordination (NCs and JCs)
- advocacy (Affiliates and NACCHO)
- training and support (NACCHO)
- funding (NACCHO)
- expert, Aboriginal-centred clinical and cultural governance (ATSIAG).

The **third feature**, the **supports and learning for CCC stakeholders** (discussed in the Accessibility Findings) aim to ensure the CCC workforce is competent and capable and has the information and knowledge it needs to implement the program in line with its intent.

The **fourth feature**, **community engagement and consultation**, comes in a range of forms including cultural governance, input into the NSPP development, participation in case coordination meetings and referral pathways, and participation in community education and awareness raising events.

Sites have highlighted that CCC being community-controlled allows them to lead the process in their regions and localities. CCC enables ACCHOs to respond to the needs of communities by resourcing activities that address service gaps in each CCC community. The flexible nature of contracts allows ACCHOs to tailor tasks and actions to suit their community's unique needs and existing structures, enabling ACWs to incorporate local contexts into their work. Community consultation and engagement are central to creating culturally appropriate and community-led plans and services. While many sites have shown strong capacity in engaging their communities, using methods like yarning circles and direct outreach to co-design key guiding documents, some sites have struggled to engage meaningfully with their community due to a lack of consultation skills. This co-design process ensures plans are culturally safe, respectful, and responsive to specific community needs.

The **final feature**, the **brokerage funding model**, where DHDA has commissioned NACCHO to administer the CCC program including funding ACCHOs and Affiliates is another embodiment of the program's intent.

Unique to CCC is its model of funding and commissioning. Established as part of DHDA's commitment to give effect to the National Agreement on Closing the Gap Priority Reforms, the head agreement for CCC has been established between DHDA and NACCHO to oversee the national rollout of community-led regional and local suicide prevention and aftercare networks. Responsibility for administering the full grant sits with NACCHO, who is required to provide consolidated reporting to DHDA on a six-monthly basis.

Sub-grant agreements have been established between NACCHO and all jurisdictional and network ACCHOs for their respective terms. Structured as a milestone-based payment model, funding to sites is paid on acceptance of reports and key deliverables such as the NSPP and ASDM.

One of the key enabling factors reported by stakeholders is the flexible, outcomes focused nature of the funding. Closely reflecting the principles and enablers for effective sector funding arrangements articulated in the 'Review of sector funding arrangements and service provider capability for Aboriginal and Torres Strait Islander mental health and suicide prevention services and the Integrated Team Care (ITC) program'[46] some of the key features of the funding management approach enabling Aboriginal and Torres Strait Islander community-led and place-based approaches include:

- **Needs-based funding and distribution:** Resources for sites are allocated on a funding model that

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[46] Ninti One Ltd, First Nations Co., '*Review of First Nations mental health and suicide prevention services and the Integrated Team Care Program – Final Report*', Department of Health and Aged Care, May 2024, Accessed July 2024

considers a site's population, remoteness, size/capability and planned activity.

- **Streamlined, consolidated outcomes-based reporting:** Stakeholders report that the systems for reporting have been flexible and accessible, and that they have been able to gain support from NACCHO where needed.
- **Flexibility to meet local and unique needs:** Both NACCHO and sites reported on regular interactions where they have to amend, adjust or redeploy funding to meet local needs, in a way that still aligns with contract requirements and guidelines.
- **Ongoing and accessible feedback mechanisms**: Regular and timely access to support from NACCHO at all phases of the grant management process.

## To what extent is CCC able to address current and future need?

This section examines the results of the demand modelling to assess CCCs ability to meet current and future demand based on its actual resourcing model.

### *Ability to meet current demand*

The CCC program, which currently supports 102.9 FTE across 42 CCSPNs and 6 Aftercare-only sites across Australia, is a critical conduit for delivering culturally safe, community-led mental health interventions. However, survey respondents have consistently reported significant shortfalls in staffing levels, particularly among frontline roles such as NCs and aftercare workers. These gaps are most pronounced in remote communities, where Modified Monash Model (MMM) ratings of 6–7 are common, and recruitment and retention challenges are acute. The self-reported operational challenges from the surveys indicate that many CCC sites are functioning below optimal capacity, a finding that is corroborated by national performance data.

The FTE required to meet current demand for the services provided by CCC across its current sites is 453.6 FTE. On this basis, the level of actual CCC FTE of 102.9 falls significantly short of the estimated workforce currently required to meet current demand by 350.7 FTE. Table 1 below estimates the current workforce per service scaled nationally.

**Table 1:** Estimated current workforce per service and scaled nationally

| Service level | Average FTE per service | Scaled total FTE (42 sites) |
|---|---|---|
| Suicide Prevention Coordinators (NCs) | 3.6 | 151.2 |
| Aftercare Workers (ACWs) | 5.9 | 247.8 |
| ATSIMHFAT Trainers | 1.3 | 54.6 |
| **Total current workforce** | **10.8** | **453.6** |

### *Forecast future demand*

The age-standardised proportion of Indigenous Australians receiving clinical mental health services between 2023 and 2029 is forecasted to increase annually on average by 4.22 per cent.

The projected growth rate of 4.22 per cent per annum builds upon a historical trend observed in data collected by the AIHW and the Productivity Commission. Between 2015 and 2022, there was an annual increase of approximately 3–4 per cent in the utilisation of mental health services by Indigenous populations. This historical growth has been underpinned by increased policy attention, funding for culturally appropriate services, and the expansion of community-based care.

Forecast data from 2023 to 2029 generated for the CCC demand modelling provides further insight into this upward trajectory. The forecasted values are as follows:

**Table 2:** Forecasted Age-Standardised Proportion of Indigenous Australians Receiving Mental Health Services

| Year | Proportion Receiving Services | Year-on-Year Percentage Change |
|---|---|---|
| 2023 | 55,756 | — |
| 2024 | 58,892 | 5.63% |
| 2025 | 60,641 | 2.97% |
| 2026 | 63,300 | 4.39% |
| 2027 | 65,841 | 4.02% |
| 2028 | 68,052 | 3.36% |
| 2029 | 71,441 | 4.99% |

The data shows consistent growth, with an average annual increase of 4.22 per cent. Notably, there is variability in the percentage change year-on-year, reflective of potential fluctuations in policy implementation, funding allocation, and other external factors.

This growth rate is both significant and aligned with findings from several key national and international studies. This projected growth reflects multiple converging factors, including demographic trends, increasing recognition of mental health needs, targeted policy interventions, and expanding culturally safe service availability.

Moreover, the forecasted rise in intentional self-harm hospitalisation rates among Indigenous Australians, particularly among children (0–14 years) and adolescents (15–19 years), underscores the escalating demand for suicide prevention and aftercare services. The data suggest an alarming increase in self-harm hospitalisations for younger cohorts, with annual increases exceeding 5 percent for children and remaining persistently high for adolescents. This reinforces the need for enhanced, community-led early intervention strategies.

Taken together, these forecasts provide critical insight into the evolving mental health service landscape, highlighting both the growing demand for culturally appropriate care and the necessity for sustained investment in Indigenous-led mental health programs.

The projected 4.22 per cent annual increase in Indigenous mental health service utilisation is strongly validated by CCC site performance data and national service utilisation trends. The CCC program has already demonstrated significant service engagement growth, with multiple sites reporting capacity constraints due to demand exceeding available resources. The correlation between the forecasted service growth and CCC site performance underscores the urgent need for sustained investment in workforce expansion, service integration, and community-led program development to meet the escalating mental health needs of Indigenous Australians.

*Required growth in CCC workforce to meet future demand*

Based on the Bayesian modelling, the projected workforce growth for CCC is approximately 36 per cent by 2029, reflecting an average annual growth rate of about 5.3 per cent. Importantly, the qualitative data gathered from the CCC and ATSIMHF/Training Surveys corroborate this projection. Respondents consistently reported that current staffing levels are insufficient to meet the increasing demand for culturally safe suicide prevention and aftercare services, particularly in remote communities where the gap is most pronounced. In qualitative terms, many service providers indicated that the existing workforce would need to expand by roughly 35–40 per cent to effectively manage the anticipated rise in service presentations. This range, derived from self-reported operational challenges and staffing shortfalls, is in close agreement with the 36 per cent increase forecast by the Bayesian model. Thus, both the model and the survey outcomes converge on an approximate 36 per cent growth in workforce capacity by 2029, underscoring the pressing need for substantial

recruitment and retention initiatives.

The juxtaposition of survey outcomes and the demand model projections yields several critical insights:

1. **Aftercare Workers:** The largest expansion is required in this category. Survey respondents emphasise the importance of aftercare in preventing repeat crises and sustaining continuity of care, which is reflected in the need for an additional 89.2 FTE. This group is crucial for addressing the increasing mental health burden, particularly in high-risk populations.
2. **Suicide Prevention Coordinators:** An increase of 54.4 FTE is necessary to bolster crisis intervention and ensure timely, community-based support. The survey data indicate that many high-risk and remote communities are currently under-resourced in this area, which may lead to delays in intervention and increased rates of crisis presentations.
3. **ATSIMHFAT Trainers:** A moderate expansion of 19.7 FTE is projected for trainers. The survey findings highlight an ongoing need for culturally appropriate training programs to maintain mental health literacy and suicide prevention capacity, which supports the necessity for this increase.
4. **Alignment with Demand Model:** The overall forecast of a 36 per cent workforce increase (an additional 420.4 FTE) is consistent with the self-reported challenges identified in the surveys. Respondents have consistently noted that current staffing levels are insufficient to meet rising demand, particularly in remote areas. The explicit annual growth rate of approximately 4.22 per cent derived from the demand model reinforces the credibility of these projections.

These detailed estimates, combining survey outcomes with rigorous quantitative modelling, underscore the urgent need for strategic workforce expansion within CCC. The evidence indicates that to accommodate increasing service demand and to maintain the quality and cultural safety of service delivery, CCC must secure an additional 420.4 FTE nationally by 2029. This comprehensive analysis provides a nuanced understanding of current operational challenges and future workforce requirements, thereby informing strategic planning and resource allocation in a manner that is supported by both qualitative and quantitative data.

# EFFICIENCY

## What resources are used to enable community-led solutions?

The findings in this section examine the efficiency of the delivery of CCC, in particular the resources used to enable community-led solutions. Understanding the CCC's efficiency involved examining its:

- roll-out and the difference in resources used and activities undertaken overtime
- benefits compared to its costs involving a cost-benefit analysis.

### Key findings

The document review, site observations, survey data and interviews all evidence a garnering of a range of resources to design and implement CCC in a community-led, place-based and strengths-focused way. Identified in the document and data review, the CCC resources allocated specifically to the design and implementation of CCC are:

- **Financial:** $58m over three-years (extended to four-years) with $4.2m for NACCHO's administration of the program and $53.8m for the establishment and implementation of each activity stream.
- **Program staffing:** three FTE within NACCHO to administer CCC and support Affiliates and sites.
- **Activity stream staffing**: 107.9 FTE within Affiliates and sites to design and deliver the three activity streams.
- **Clinical and cultural expertise, knowledge and understanding**: The expertise in SEWB, suicide prevention, aftercare, clinical practice, cultural practice, program design and delivery, project management, consultation and engagement, and operations.
- **Relationships and networks:** The connections required within place to establish referrals, gain cultural knowledge and oversight, to recruit ATSIMHFAT participants etc.
- **Time:** Time invested to select sites, design the program, roll out the tranches and establish sites and deliver services.

In addition to the resources allocated specifically for CCC, the program and its activity streams also leverage existing resources, including:

- ACCHO infrastructure including governance, referral pathways, partnerships, operations and physical programming space.
- Non-CCC workforce within ACCHOs particularly cultural liaisons and SEWB teams.
- Cultural , organisational and clinical governance mechanisms.
- Training outside of ATSIMHFAT and including other clinical training.
- Affiliate (State/Territory ACCHO peak) infrastructure, relationships and networks.

While the financial and staffing resources are critical for CCC's design and implementation, as critical are the expertise, knowledge and understanding, existing infrastructure of ACCHOs, and relationships and networks. The sharing of, and access to, cultural and clinical expertise is fundamental to shaping the CCC MoI and MoC as well as the daily practice of CCC teams within ACCHOs.

The document and data review show that the financial and human resources used to implement CCC largely remain the same across tranches, however the time required to implement community-led solutions has taken longer than expected. More time was required at the program-level to enable a collaborative site selection process with ACCHOs. More time was also required (particularly in earlier tranches) to enable community-led solutions such as community engagement to design the NSPPs and ASDMs.

This combination of resourcing across sites has led to community-enabled service delivery including strengthened referral pathways and supports for sites in tranches 1 and 2 and community-enabled NSPPs for sites in tranches 3 and 4.

When considering the efficiency from a return on investment perspective, CCC's benefits are demonstrated to outweigh its costs in all scenarios analysed in the cost-benefit analysis (CBA). The most favourable scenario extends CCC to 10 years and increases its workforce by 25 per cent, resulting in a return of $5.08 for every dollar invested.

The drivers of the benefits of CCC include the support provided by NACCHO, the investment in workforce development, improvements in coordination, and an increase in touchpoints for support. Strategic

enhancement and continuity of CCC leads to significantly greater long-term benefits.

More information on the resources used by tranche and the overall return created by the program can be found at pages 76 and 79 respectively.

### Efficiency: what makes CCC more efficient?

The pace of design and delivery as well as the types of resources used and the manner in which they are used is optimised when the following factors are in place:

- **Existing resources and infrastructure of the ACCHO**: Sites were more quickly established and services more quickly and comprehensively delivered when led by more mature ACCHOs or consortia with existing resources (i.e. knowledge, workforce, partnerships, MoC and clinical practice) and infrastructure (i.e. systems, processes, transport, office space).
- **Training and development of the CCC workforce and broader community through ATSIMHFAT**: This training, particularly providing it to the non-CCC workforce and community members effectively extends the reach of the capability to provide help and support that is maintained in community over a longer period pf time. This approach effectively builds significantly more touchpoints for help than what any one ACCHO on its own could provide.
- **Implementation of contract management system:** NACCHO's implementation of a new contract management system prior to the roll out of Tranche 3 significantly streamlined the later tranches.
- **Aboriginal-controlled service design and delivery**: Sites design and deliver services and supports that address the needs of the community as they have designed the services with community. Where access to services is not occurring, or where a particular service is not the right fit, sites are quick to adjust.

These factors combined with the brokerage funding model increase the efficiency of CCC.

### Efficiency: what makes CCC less efficient?

The pace of design and delivery slows, and the types of resources used and the manner in which they are used becomes less sustainable and coordinated when the following factors are in place:

- **Existing resources and infrastructure of the ACCHO**: Sites took longer to establish, and services less comprehensively delivered when led by smaller, less mature ACCHOs that don't have existing resources (i.e. knowledge, workforce, partnerships and clinical practice) and infrastructure (i.e. systems, processes, transport, office space).
- **Workforce challenges**: Delays in recruiting CCC workforce, particularly ACWs, as well as a high rates of staff turnover have significantly delayed the establishment and delivery of some sites and therefore the overall delivery of the program. This also resulted in the use of consultants and/or less qualified staff to undertake the work resulting in higher cost (for consultants) or more training required (for junior staff). The inability to recruit workforce is exacerbated in remote locations due to the location and lack of affordable (or any) housing for staff.

These factors on their own and in combination reduce the efficiency of CCC.

**Implications for ensuring and improving the efficiency of the CCC program**

- It takes time to establish a program the size and complexity of CCC and to roll-out its funding in a responsible manner; this should be factored into the timeframes for future tranches.
- Using systems helps streamline processes and save time, this is evident in the faster implementation of Tranches 3 and 4 following the adoption of a contract management system.
- The implementation readiness of sites is an important driver of efficiency. More mature ACCHOs can draw on existing infrastructure and workforce to design and deliver at a faster pace; reverse is true for less mature ACCHOs. Level of site readiness should be assessed as part of future site selection to inform delivery of appropriate site supports.

- Workforce is another important driver of efficiency. Measures to speed up recruitment, develop existing or less experienced staff and reduce turnover should be actively risk managed in future tranches.
- Robust community consultation and co-design takes considerable time to build trust and develop program documentation like SPPs and ASDMs.[47] While necessary for program effectiveness, this inherently adds time to the site establishment phase.
- Models that are Aboriginal community-led that also build the ongoing capacity of the Aboriginal community in addition to the program's workforce provide a significant return on investment. These elements of the program design should be seen as essential for CCC.

[47] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.

### How do the resources used to deliver CCC for its intended outcomes compare between Tranches 1 and 2 and Tranches 3 and 4?

To answer this question, the evaluation examined the resources used to the deliver CCC at the program-level and at the site-level.

#### *Program-level*

The program-level refers to the resources used by NACCHO and DHDA to implement CCC. The implementation of CCC by DHDA involves:

- funding NACCHO to implement CCC
- managing the funding agreement between DHDA and NACCHO

The human resources required to undertake the above activities has remained constant over the life of CCC. The financial resources have remained constant over the life of CCC, however the original grant agreement was extended for an additional 12 months to 30 June 2026, with further funds of $20.7 million announced in December 2024. This extension of time was granted in recognition of the longer than expected identification and establishment of sites.

The implementation of CCC by NACCHO involves:

- identifying CCC sites for funding
- funding Affiliates and ACCHOs to implement CCC
- managing the funding agreements between NACCHO and 46 grant recipients
- developing and coordinating access to the suite of CCC supports for sites including CoPs, the annual Summit, onboarding, and responding to ad hoc support requests
- supporting the initial site establishment
- reporting to DHDA
- coordinating ATSIAG

The human resources required to undertake the above activities has remained constant over the life of CCC, notwithstanding staff turnover. The financial resources have remained constant over the life of CCC, however as noted above the original grant agreement was extended for an additional 12 months to 30 June 2026, with further funds of $20.7 million announced in December 2024. This extension of time was granted in recognition of the longer than expected identification and establishment of sites.

Site selection for Tranches 1 and 2 was agreed by August 2022 and Tranche 1 and 2 contracts began in November 2022, with 14 sites signed and executed by March 2023. Minor delays occurred during this process due to the time needed to reach consensus on the final sites, highlighting that collaboration across levels is critical but takes time.[48] The process of drafting, offering, and executing contracts for Affiliates and Tranche 1 and 2 ACCHOs took longer than expected.[49] Reasons included the program being the first of its kind requiring careful processes, detailed contract development and revision, time taken to tailor 24 contracts through consultation, time needed for ACCHOs' internal governance and contract approval processes, and negotiation of requested contract changes.[50]

Recruitment challenges and the competitive job market nationally also impacted the time it took for organisations to begin activity after contract execution, as positions needed to be advertised and filled.[51] Delays in contract offer and execution also pushed back timeframes for filling positions like JCs.[52]

Tranche 3 was to be engaged once sites were selected.[53] Between July and November 2023, remaining Tranche 3 and 4 contracts were executed.[54] This brought the total number of established CCSPNs and Aftercare sites to 43 by November 2023, across all four tranches.[55] At the time of the evaluation, one site had dropped out of CCC, leaving 42 in total.

[48] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[49] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[50] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.
[51] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.
[52] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[53] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[54] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.
[55] NACCHO, CCC Activity Workplan May 22-Jun23, Feb 2023.

Significantly, NACCHO's Mental Health Team developed new contracting management systems and processes specifically to streamline the process for Tranches 3 and 4.[56] This indicates a direct effort to make the site establishment phase faster based on learnings from the earlier tranches.

NACCHO shared that the learnings from implementation of sites in earlier tranches are applied to later tranches to enable new networks to establish faster. The document and data review shows the number of sites funded/established in Tranches 3 and 4 totaled 30 compared to a total of 16 sites being established in Tranches 1 and 2, representing nearly a 100 per cent increase in sites being established between those tranches.

CCC adopted an iterative and adaptive approach, with implementation evolving through ongoing stakeholder consultation. Learning from earlier tranches informed the support provided to later ones. NACCHO gained more knowledge and was better equipped to provide advice and assist with problem-solving for Tranches 3 and 4.[57]

Onboarding processes for staff have "morphed over time"[58] becoming more flexible and focused on peer support and sharing of experiences between sites, particularly leveraging the knowledge of earlier tranches.[59] Face-to-face onboarding for Tranches 3 and 4 staff was planned for April/May 2024, adapting to recruitment timelines.[60]

Despite delays in site establishment, later tranches have benefited from earlier experiences, with at least one Tranche 4 site delivering aftercare services just months after initiation. This suggests that while the overall establishment might take time due to external factors, the speed of service delivery initiation might be quicker for some sites in later tranches due to shared learnings and maturing program structures.

*Site-level*

The site-level refers to the resources used, and activities undertaken, by Affiliates, JCs, NCs, and ACCHOs to implement CCC. The purpose of understanding efficiency at the site-level was to capture resource use trends and patterns, rather than assessing the performance of any particular site or set of sites.

As noted in the earlier sections of this report, the implementation of CCC by Affiliates and ACCHOs involves:

- accessing the suite of CCC supports for sites including CoPs, the annual Summit, onboarding, and ad hoc support
- communicating updates to CCC to members/staff
- recruiting and training staff and / or consultants to full workforce gaps
- delivering suicide prevention and aftercare services
- coordinating and delivering ATSIMHFAT
- supporting the initial site establishment
- engaging with community to design their ASDM and J/NSPP
- coordinating the implementation of the ASDM and J/NSPP
- reporting to NACCHO.

For CCSPNs, the average FTE to provide its services and supports is 2.0 FTE. Aftercare only sites have less staff resourcing requirements and on average operate at a 1.0 FTE level. Overall, as identified in the previous section, when measured against its ability to meet demand, CCC staffing levels within CCSPNs and Aftercare sites are significantly under resourced in the order of 350.7 FTE. As noted in the demand modelling, this resourcing gap is expected to grow as demand for suicide prevention and aftercare services grown and staffing does not.

The document review shows that sites funded in Tranches 1 and 2 are further progressed in service delivery, strengthening referral pathways and deepening supports offered to community while sites funded in the later tranches are at the point of developing the NSPP and are yet to deliver supports. Sites across all tranches that were being led by more mature ACCHOs or  a consortia of ACCHOs tended to design and deliver services more quickly as they drew on existing resources and infrastructure (see **Case Study 7**).

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[56] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[57] NACCHO, National-level Interview, Phase 1.
[58] NACCHO, National-level Interview, Phase 1.
[59] NACCHO, National-level Interview, Phase 1.
[60] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.

Interviews with JCs, NCs and ACWs highlighted the positive role that the existing resources and infrastructure with an ACCHO, particularly more mature ACCHOs, have in increasing a sites rate of implementation and delivery. This stated different level of readiness and pace of delivery between more and less mature ACCHOs was observed during site visits.

Also impacting on the resources used and activities undertaken by sites, particularly impacting the extent and pace of delivery, are high rates of staff turn-over as well as the inability to fill CCC positions.

Funding uncertainty beyond June 2025 was a significant concern that impacted recruitment and retention across tranches. Stakeholders noted that the shorter remaining timeframe for later tranches (Tranche 4 workers having only about 8 months compared to 3 years for Tranche 1) made it harder to attract and retain skilled staff, particularly in remote areas with housing issues.[61] This suggests that external factors might have presented greater challenges for later tranches in some aspects of workforce establishment, even if internal contracting processes were faster.

While NACCHO actively worked to streamline internal processes like contracting for Tranches 3 and 4 based on learnings from Tranches 1 and 2[62], the timing of the rollout and resource utilisation for achieving outcomes across all tranches was significantly influenced by external challenges such as workforce recruitment and retention difficulties. The uncertainty of future funding may have particularly impacted the ability to recruit for roles in later tranches with shorter remaining program duration.[63] However, the iterative nature of the program and shared learnings meant that support and onboarding processes evolved, potentially enabling some later tranche sites to move towards service delivery more efficiently once staff were in.

**Case Study 7: Existing Infrastructure vs Reduced resources**

Case Study 7 is a consortium consisting of five ACCHOs across a region. The consortium have developed a community-led, place-based suicide prevention network, that leverages the strengths of each of their participating ACCHOs to ensure the success of the CCSPN through collaborative and coordinated efforts. The Network Coordinator for the consortium adapted NACCHO's Model of Care with each ACCHO, to tailor the framework to each service's capacity, expertise and community needs.

ACCHO number one in the consortium have a location and resourcing that enables the provision of clinical and cultural suicide prevention and aftercare services to clients, as well as the development of culturally safe spaces for men and women to discuss their social and emotional wellbeing in group settings. The team at ACCHO number 2 utilises effective service coordination and strong referral pathways to reduce duplication in their area, while ACCHO number 3 focuses on health promotion activities to raise awareness of CCC and reduce existing stigma in their community.

The organisational capacity of ACCHOs prior to CCC funding impacted service design and delivery. As a consortium, they have been able to share resources and adapt their approach to the unique needs of their respective communities. The flexibility within the consortium allows each of the member ACCHOs to deliver CCC in a way that aligns with local priorities while maintaining the broader network's goals.

Further, the proximity of ACCHOs within the consortium facilitates knowledge-sharing and collaborative learning between these ACCHOs, strengthening the network's overall impact. The capacity of each ACCHO (including staffing levels, capabilities and existing community relationships), had a clear impact on the timeliness and effectiveness of program rollout.

Overall, the delivery of CCC via the consortium has proved that working in this way can promote efficiency by enabling each ACCHO (consortium member) to leverage their strengths while also sharing resources, knowledge, and expertise.

## What is the return created by the CCC approach?

A Cost-Benefit Analysis (CBA) of CCC was undertaken to answer this question and focused on CCCs projected economic impact under various scenarios, critically assessing its alignment with existing literature.

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[61] DHDA, National-level Interview, Phase 1.
[62] NACCHO, CCC Activity Workplan Jul 23-Jun24, Feb 2024.
[63] DHDA, National-level Interview, Phase 1.

To understand CCC's effectiveness and economic viability across a range of scenarios, the analysis below evaluates its Net Present Value (NPV), benefit/cost ratios (BCRs) and other metrics.

The assumed measurable benefits generated by CCC include:

- **Improved service capability**: Achieved through enhanced mental health screening processes for early detection and intervention; strengthened health promotion initiatives and community outreach programs.
- **Improved workforce capability**: Resulting from increased confidence among trainees post-training; and empowerment of service providers with preventive skills.
- **Change in help touchpoints and service access behaviours**: Resulting from increased utilisation of CCC referral pathways and streamlined service access processes.
- **Efficiencies created through coordination**: Achieved through improved and increased support touch points; optimisation of resources through better coordination; and reduction of barriers to care.
- **Efficiencies to address current and future demand**: Defined as addressing unmet demand and ensuring service gaps are filled; responsiveness to newly generated demand; enhanced resource allocation; improved operational efficiencies; ability to forecast and plan for future demand; and improved quality of local data collection and reporting.

The above assumed benefits of CCC are well-supported by the literature, which emphasises the importance of culturally appropriate, community-led, and coordinated mental health services for Indigenous communities. These benefits align with findings from other studies, demonstrating the potential effectiveness and impact of CCC.

A reduction in suicide rates has not been included in the modelling due to the lack of robust and detailed available quantitative data necessary for reliable analysis. This approach aligns with international experience, ensuring the methodology remains credible.

The assumed measurable costs associated with administering CCC are categorised into direct financial expenditures and other related expenses. The financial costs include wages, administrative management fees, program-related expenditures, and suicide prevention activities. Additionally, other expenses such as travel and training are considered essential for the effective implementation of CCC. By examining these costs, the analysis aims to present a comprehensive view of the resources required to sustain CCC.

The table below summarises the key outcomes of the CBA conducted for CCC. It provides a comparison of the NPV of benefits and the benefit/cost ratios across the various scenarios, including the Base Case, Alternative Scenario 1, Alternative Scenario 2, and two sub-scenarios. These scenarios reflect different assumptions about the program's continuation, funding levels, and workforce expansion.

**Table 3:** CBA Scenarios Compared

| Scenario | NPV Benefits | NPV Costs | Benefit/ Cost Ratio |
|---|---|---|---|
| **Base Case: The current situation**<br>Funding for CCC ceases once the current agreement ends, and it is not renewed over the forecast horizon. Despite the cessation of funding, CCC's benefits are assumed to persist but gradually taper off over the 10-year forecast horizon. | $67,518,502 | $38,249,162 | 1.77 |
| **Alternative Scenario 1: CCC continues with renewed funding**<br>CCC continues beyond the initial funding period, with the funding agreement being renewed for the same quantum of funds over the entire 10- year forecast horizon. This allows CCC to maintain its operations and continue delivering benefits at a consistent level. | $491,170,034 | $109,216,850 | 4.50 |
| **Sub-Scenario 1: CCC continues with renewed funding over a constrained time horizon**<br>This is Alternative Scenario 1 but instead of a 10-year time horizon, the benefits are forecast over a four-year time horizon. | $304,801,245 | $109,216,850 | 3.58 |
| **Alternative Scenario 2: CCC continues with increased FTE and enhanced benefits**<br>Building on the scenario where CCC continues with renewed funding, this scenario explores the impact of increasing FTE employees by 25 per cent from Year 1 onwards. The increase in FTEs will be funded by productivity improvements generated by CCC itself, rather than by additional external funding. The increased staffing level is expected to enhance the program's service delivery and overall benefits. | $555,119,769 | $109,216,850 | 5.08 |
| **Sub-Scenario 2: CCC continues with increased FTE and enhanced benefits over a constrained time horizon**<br>This is Alternative Scenario 2 with the benefits forecast over a four-year time horizon. | $331,426,225 | $109,216,850 | 3.90 |

The results of the CBA clearly demonstrate that strategic enhancement and continuation of CCC would lead to significantly greater long-term benefits. The Base Case Scenario, where CCC discontinues after the current funding period, results in the lowest NPV of benefits ($67,518,502) and a modest benefit/cost ratio of 1.77. This scenario underscores the risks of discontinued funding. As highlighted by the Productivity Commission, short-term or intermittent programs fail to achieve meaningful and sustainable outcomes in Indigenous communities.

In contrast, **Alternative Scenario 1**- where the program continues with sustained funding - shows a dramatic increase in the NPV of benefits ($491,170,034) and a higher benefit/cost ratio of 4.50. This scenario aligns with the Productivity Commission's emphasis on the need for consistent and long-term funding to support Indigenous mental health initiatives. The results validate the importance of sustained financial support, which allows the program to expand its reach and enhance its effectiveness over time.

**Alternative Scenario 2**, which includes a 25 per cent increase in FTEs funded by productivity gains, presents the most favourable outcome, with an NPV of benefits reaching $555,119,769 and a benefit/cost ratio of 5.08. This scenario reflects the Productivity Commission's findings on the critical role of workforce capability and resource efficiency in maximising program impact. By strategically expanding the workforce through productivity improvements, CCC can achieve even greater benefits without the need for additional external funding.

**Case study 8: NACCHO 'how the brokerage model supports networks, provides flexibility and knowledge to enable implementation of CCC.'**

The brokerage model shared between NACCHO and DHDA has given practical effect to the recommendations from the 'Review of sector funding arrangements and service provider capability for Aboriginal and Torres Strait Islander mental health and suicide prevention services and the Integrated Team Care (ITC) program' (Capability Review). The partnership utilises the strengths of both organisations and promotes efficiency, flexibility and enables the self-determination of First Nations communities.

The brokerage model for CCC has improved pathways into culturally safe, community-controlled suicide prevention and Aftercare support. The model has positively contributed to Target 1 under the National Agreement on Closing the Gap and has realised all four Priority Reforms, especially Reform Area 2: Building the community-controlled sector.

The partnership between NACCHO and DHDA shows that working in genuine partnership with Indigenous-peak organisations is an efficient solution for improving health and wellbeing outcomes for Indigenous Australians. This brokerage model could be replicated in future-funding arrangements across the Commonwealth to fulfill its obligations under the National Agreement on Closing the Gap.

The sub-scenarios, which consider a shorter time horizon to 2030-31, also show substantial benefits but with lower benefit/cost ratios compared to the full-term scenarios. These results provide valuable insights into the program's potential short- to medium-term impact, reinforcing the value of sustained and strategic investments.

This analysis underscores the importance of continued funding and strategic enhancements, such as workforce expansion, to maximise CCC's long-term impact. The findings align closely with the literature on Indigenous suicide prevention and the Productivity Commission's recommendations, highlighting the need for sustained financial support, workforce capability, efficient resource allocation and funding and delivery models that are Aboriginal-led (see **Case Study 8**). By adhering to these evidence-based practices, CCC can achieve substantial long-term benefits, delivering significant value to Indigenous communities and contributing to the broader goals of suicide prevention and mental health improvement.

# Implications for government policy

The evaluation consistently highlights that the brokerage funding model – combined with the authorising environment created by DHDA and NACCHO – has been critical to the success of CCC. These enablers highlight the importance of how programs are commissioned by governments and demonstrate practical ways to deliver on commitments under the National Agreement.

The implications for government policy that arise from the findings on these two enablers are discussed below.

## Commissioning of programs

As noted in this report, outcomes under CCC are being commissioned in a unique way. DHDA does not directly fund ACCHOs or Affiliates to design and deliver CCC. Rather, DHDA has commissioned NACCHO to administer and oversee the roll-out of CCC. A head of agreement between DHDA and NACCHO authorises and guides this arrangement. Under this agreement, NACCHO is responsible for administering the grant and is required to provide consolidated reporting to DHDA on a six-monthly basis. Sub-grant agreements exist between NACCHO and all jurisdictional and network ACCHOs for their respective terms. Structured as a milestone-based payment model, funding to sites is paid on acceptance of reports and key deliverables such as the NSPP and ASDM.

Described as a brokerage funding model, this type of commissioning requires NACCHO and DHDA to play particular roles. NACCHO creates an environment in which networks can access the resources and support they need to build place-based, community-led solutions, while being in a position to hear, consolidate and advocate the needs of the CCC community as a whole. NACCHO also supports advocacy and research activity in addition to operational and contract-related support. This combination of support and responsibility is different to how ACCHOs and Affiliates have been funded previously, and they report this new approach as being more practical, supportive and beneficial.

DHDA has an important role in enabling CCC to operate on the principle of genuine partnership with the Aboriginal community-controlled sector. Through DHDA's relationship with NACCHO, and their shared commitment to the aims of the CCC, DHDA helps create a responsive environment by operating flexibly to the needs of NACCHO and sites and enabling the program to realise innovative, place-based approaches.

The specific examples of the different ways in which NACCHO and DHDA work together and the outcomes this achieves include:

- A willingness to establish principles to guide the funding of CCC that adheres to the Commonwealth grant guidelines and legislation while providing visibility to the Government of program outputs and outcomes. This can be done while still enabling NACCHO to drive and own the agenda for taking the program forward.
- An understanding of the importance of trust-building, community consultation, and the role that NACCHO plays within the sector. DHDA supported these foundations to be established by demonstrating an appreciation of the time it takes to establish enabling factors. At times, this required DHDA and NACCHO to work together to navigate alternative ways to work within the boundaries of government guidelines, but it was done in partnership.
- Connecting NACCHO and the program to state and federal opportunities for engaging in sector activities and policies that align with CCC's agenda.

Further, this brokerage funding model is consistently described by jurisdictional and network CCC stakeholders as being a critical ingredient for their achievements and the program's success. Specifically, this commissioning approach has led to:

- **Needs-based funding and distribution:** Resources for sites are allocated on a funding model that considers a site's population, remoteness, size/capability and planned activity.
- **Streamlined, consolidated outcomes-based reporting:** Stakeholders report that the systems for reporting have been flexible and accessible, and that they have been able to gain support from NACCHO where needed.
- **Flexibility to meet local and unique needs:** Both NACCHO and sites reported on regular interactions where they have to amend, adjust or redeploy funding to meet local needs, in a way that

still aligns with contract requirements and guidelines.

- **Ongoing and accessible feedback mechanisms**: Regular and timely access to support from NACCHO at all phases of the grant management process.

A final lesson learned from this approach is that investing in building a capable workforce, in addition to community-led approaches, has enormous benefits for individuals and communities. Trust is built within and across communities and this increases help-seeking and access to supports, while also building and strengthening referral pathways. The residual effects of building a capable workforce and community results in economic benefits and social capital over the longer-term.

Overall, the implications for government commissioning are that:

- similar brokerage funding models should be considered across the First Nations portfolio as it can achieve outcomes that government-led funding arrangements are less likely to achieve
- in the Aboriginal community context, it is important for the funder to be Aboriginal-led
- First Nations peak organisations – where appropriately sized, capable and resourced – can fill the role of funder when they understand the content and the circumstances of the grantees
- the relationship between government agency and Aboriginal-led funder is critical and must be trust-based and relational while maintaining appropriate accountability in a grants context
- SEWB programs require a multi-faceted, evidence-informed approaches that are built on trust, and a brokerage funding model can enable all of these.

## National Agreement on Closing the Gap

The way in which CCC is commissioned gives practical effect to the Australian Government's commitment to the National Agreement on Closing the Gap, specifically Target 14 and Priority Reforms 2 and 3:

### Contributions to Priority Reform One: Formal Partnerships and Shared Decision Making

Priority Reform 1's goal to empower Aboriginal and Torres Strait Islander people through formal partnerships and shared decision-making forms the basis of the commissioning model and the flexible operation of the program. Facilitated by a shared and strong belief in the importance of CCC's objectives, stakeholders reported that operational details such as contracts, schedules, and milestones have not been overshadowed by the broader vision and respect for Aboriginal self-determination. This partnership is enabled by the trust between DHDA, NACCHO and the ACCHOs.

### Contributions to Priority Reform Two: Building the Community Controlled Sector

The CCC's MoI strengthens the ACCHO sector, empowering ACCHOs to lead in addressing the needs of Aboriginal and Torres Strait Islander people. Through the commissioning model, NACCHO, as the lead funder, supports, enables, advises, and advocates for ACCHOs at both jurisdictional and community levels. The MoI allows communities to design services that meet local needs, with funding dedicated to workforce development. This is supported by flexible funding, strategic staffing, and meaningful consultation, fostering strong, community-controlled organisations.

The funding flexibility enabled by all the above is facilitating place-based design that aims to fill gaps and build on the strengths of existing infrastructure to achieve community-led outcomes. Data collected so far shows that the program's flexibility is allowing sites to determine their own approach to creating often the first Aboriginal-specific suicide response service in their communities. Early results suggest that this flexibility helps sites overcome common barriers associated with traditional funding agreements, which frequently impose strict guidelines on how funds are used, and programs are delivered. Instead, sites can assess available services, identify gaps and resources, and integrate or enhance these with CCC resources to achieve their goals effectively.

For example, at one site, a gap in SEWB support was identified, with no referral pathways for CCC staff to provide immediate clinical SEWB care. To address this and ensure clients received aftercare services and timely referrals, the site used CCC funding to establish culturally appropriate clinical roles, including a psychologist, mental health nurse, and social worker. Without the flexibility of CCC funding, developing this crucial support for individuals facing suicide-related challenges may not have been possible.

# Recommendations

These evaluation findings are overwhelmingly positive. They support the hypothesis that a program predominantly administered, designed and delivered in a First Nations community-led, place-based and strengths-based way is accessible, effective, appropriate and efficient. Specifically, programs delivered in such ways can ultimately improve outcomes for First Nations communities.

The CCC program is enabling First Nations communities to respond to the needs of individuals and communities who are in distress.

As reported in the findings, while CCC has been successful for the most part, it has experienced some implementation challenges. In the evaluator's view these challenges are surmountable through improved planning, increased resourcing and further embedding systems and processes.

Taking these factors into account, the evaluation makes following recommendations to DHDA and NACCHO.

## Recommendations to DHDA

### Resourcing

#### Recommendation 1: Continue CCC with increased total funding over a longer timeframe to enable current sites to meet current and future demand.

To meet current demand, this requires an increase of 350.7 FTE (on top of current FTE of 102.9) and to meet future demand, this requires an additional, 163.4 FTE (on top of the FTE to meet current demand). Increasing the workforce to meet current demand will enable:

- NCs to significantly reduce their caseloads allowing them to orchestrate the network including strengthening referral pathways
- male and female ACWs to be employed, ensuring services are culturally-safe
- management of burnout and workforce turnover
- greater access of the aftercare services by more cohorts across more flexible hours of service.

The evaluation shows more time is required for a complex program like CCC to identify and establish sites and to roll-out funding before changes can be expected to be seen on the ground.

At a minimum, it is recommended that DHDA increases CCC funding, extend the overall program timeframe while keeping the program's core components. This will enable sites to build trust in community and recruit the workforce needed to meet current suicide prevention and aftercare needs in a culturally-safe way.

#### Recommendation 2: The brokerage model continues and is further resourced to enable NACCHO to administer a large and complex program at scale.

NACCHO's role as an Aboriginal-led funder and enabler is a critical ingredient of CCC's success and this should continue. The resourcing attached to NACCHO's role has been underestimated.

It is recommended that DHDA provide additional resourcing to NACCHO for it to effectively administer CCC at a larger scale and level of complexity. This would involve a detailed analysis to accurately assess workforce needs, operating costs and technology requirements to develop and implement the systems and processes necessary to administer CCC consistently and efficiently at scale.

### Future policy

#### Recommendation 3: DHDA explores opportunities for joint funding.

Consistently throughout the evaluation the holistic nature of CCC, the social determinants of suicidality and the intergenerational nature of grief and loss were highlighted as fundamental to understanding and delivering effective suicide prevention and aftercare supports. Further, a brokerage model with appropriately sized and resourced First Nations peaks is an effective way to build community trust and deliver complex programs for First Nations People. These matters reach into adjacent policy areas and commitments under the National Agreement which open the opportunity for other government funders such as the National Indigenous Australians Agency and State/Territory governments – to invest in CCC through the existing brokerage model to enable its expansion to meet current and future demand.

It is recommended that DHDA explore opportunities and mechanisms for joint government investment in CCC through the existing brokerage model to enable its expansion to meet current and future demand.

## Recommendations to NACCHO

### Workforce

#### Recommendation 4: Onboarding to CCC and individual roles is frequent and mandatory.

CCC stakeholders praised the value of onboarding but noted that it was infrequent and new staff to CCC were reliant on existing staff to access knowledge. To address this, it recommended that NACCHO develops a forward schedule of onboarding for each role with frequent onboarding sessions and ensure that all new staff complete this within a specified timeframe.

#### Recommendation 5: Training that builds on ATSIMHFAT is co-designed with the CCC workforce and delivered to sites.

CCC stakeholders value the ATSIMHFAT training but consider it a basic introduction, offering only the essential understanding appropriate for those without professional experience. CCC staff that are delivering suicide prevention and aftercare require more in-depth knowledge and training that helps deepens their practice. Informed by the challenges of the ATSIMHFAT rollout, it is recommended that NACCHO co-design enhanced training with the CCC workforce to ensure consistent and context-specific delivery across all sites.

#### Recommendation 6: Strengthen access to supports to manage CCC staff wellbeing, especially those on the front line.

Targeted wellbeing support for ACWs and staff managing caseloads was the identified as the most critical area of need. In addition to clinical and cultural supervision, EAP access and wellbeing days, it is recommended that NACCHO supports sites to provide targeted counselling and other measures to help staff manage vicarious trauma.

#### Recommendation 7: Co-design with sites innovative pilots for recruiting and retaining CCC staff.

Recruiting the qualified workforce to fill CCC roles has been an ongoing challenge for many sites. This will require dedicated resourcing to support design, implementation and evaluation at the site level. To address ongoing workforce recruitment challenges – driven by competition for talent, remote location constraints and remuneration limitations – it is recommended that NACCHO collaborates with sites to co-design and pilot innovative workforce models tailored to local community needs.

#### Recommendation 8: Develop a CCC Workforce Strategy to meet the current and future demand.

In addition to managing current workforce challenges, the demand modelling illustrates the need for a significant growth in CCC workforce over the next four years. This will require a large degree of planning to determine where this workforce will be recruited from, the skills and knowledge they need, the ongoing professional development they require, and the remuneration and other compensation that will make CCC a competitive employment proposition.

To address this, it is recommended that NACCHO develops a CCC Workforce Strategy from 2025-2030.

### Knowledge, information and supports

#### Recommendation 9: A knowledge management system is implemented to enable access to CCC information.

Access to current information about CCC often depends on the frequency of onboarding, informal networks, and relationships with NACCHO staff. This relational arrangement can be a barrier to new employees and limit efficiency when considering the scale of the program. A knowledge management system will ensure all CCC stakeholders can access up-to-date information, resources and guidance as needed. Sustaining the value of this system will require dedicated resourcing for its development, regular updates and ongoing maintenance to ensure its relevance and accessibility over time.

To address this, it is recommended that NACCHO develops a centralised, user-friendly knowledge management system.

### Recommendation 10: NACCHO co-designs with JCs, NCs and ACWs updates to the Communities of Practice program.

CoPs are one of the most valued peer-to-peer learning supports provided through CCC. As CCC and its delivery matures, CCC stakeholders will encounter more sophisticated challenges. To address this, it is recommended that NACCHO works with JCs, NCs and ACWs to co-design an updated agenda and schedule for CoPs to address more complex needs regarding service design, delivery, workforce, community engagement and implementing the MoI and MoC.

### Recommendation 11: NACCHO co-designs with Affiliates and ACCHOs mechanisms for capturing and sharing the data and evidence on what works in CCC service provision.

Embedding data informed and evidence-based practice are core principles of CCC. This will enable good practice to be scaled and adapted, while also identifying areas for further support and refinement. To support continuous learning and improvement, it is recommended that NACCHO co-designs with Affiliates and ACCHOs practical mechanisms for capturing, interpreting and sharing insights on what is working well across sites.

## Cultural safety

### Recommendation 12: NACCHO develops guidance for site-level community consultation and engagement.

Effective community consultation and engagement is a specialised skill set that can significantly enhance program design and delivery aligned with the MoI. To strengthen this capacity within ACCHOs, it is recommended, NACCHO develops practical guidance for ACCHOs and Affiliates outlining culturally responsive engagement methods, key stages for community input, tools for engagement and how to best use these.

### Recommendation 13: NACCHO captures and shares examples of cultural governance models operating within sites.

Many sites strongly incorporate cultural governance structures in areas separate to their organisational governance that guide the design and delivery of CCC in communities, while less mature ACCHOs rely on their organisational governance to provide this cultural governance. To assist less mature ACCHOs to develop CCC-specific cultural governance mechanisms, it is recommended that NACCHO shares across the CCC networks different examples of cultural governance, their benefits and risks, how these mechanisms interface with CCC all with a view to ensuring all sites have appropriate cultural governance mechanisms in place.

## Implementation and accountability

### Recommendation 14: NACCHO clarifies roles and responsibilities within the CCC approach including Affiliates.

As enablers with the CCC model, Affiliates have the potential to play a strategic role in engaging State and Territory governments and mainstream peaks to support the uptake of Aboriginal-led approaches to suicide prevention and aftercare. It is recommended that NACCHO works with Affiliates to clarify and articulate their role and actively communicate it to other CCC stakeholders. This would have the potential to strengthen coordination and shared understanding for those working in suicide prevention and in the health system more broadly.

### Recommendation 15: NACCHO develops a Implementation Framework to guide the identification and establishment of new sites.

Implementation timelines should account for varying levels of site readiness and capacity. Some sites faced workforce recruitment challenges, while others, despite having staff in place, required more time to design and deliver CCC effectively. To better understand the implementation readiness of sites, including existing infrastructure, resources and capabilities, it is recommended that NACCHO develops an Implementation Framework. This Framework can assist in making data-informed decisions about site selection, assesses site readiness, and identify additional supports required by sites. Flexible, staged implementation and tailored support can help ensure all sites are set up for success.

### Recommendation 16: NACCHO co-designs with sites an implementation fidelity tool.

While adherence to the CCC principles, and the MoC exists, implementation can be further aligned to the MoI. As the approach evolves, implementation will need to be adapted by NACCHO, Affiliates and sites. Sites are also very interested in understanding how the model is being implemented. To assist with this, it is recommended that NACCHO co-designs with Affiliates and sites a self-administered implementation fidelity tool. This would be a tool that JCs and NCs complete periodically to understand how implementation is progressing, how strongly it adheres to the approach and suggestions for strengthening adherence.

## Services and supports

### Recommendation 17: NACCHO supports sites to examine how services can be expanded.

How aftercare services are offered and who these services are available to were consistent areas of concern across sites. Sites were challenged by the inability to provide support afterhours and / or to reach particularly vulnerable cohorts such as young people, people experiencing homelessness or who are highly mobile, and people exiting prison. NACCHO should work with sites to examine options for expanding services including through design, resourcing and partnerships.

# Appendix A: Sites funded to deliver CCC

Listed below are the CCC locations including the network name and tranche of funding:

### Tranche 1

1. Awabakal Ltd (Newcastle Aboriginal Cooperative), Newcastle, NSW.
2. Institute for Urban Indigenous Health Ltd, Brisbane, QLD.
3. Bendigo and District Aboriginal Cooperative, Bendigo, VIC.
4. Ballarat and District Aboriginal Cooperative Ltd, Ballarat, VIC.
5. Nunkuwarrin Yunti of South Australia Inc., Adelaide, SA.
6. Tasmanian Aboriginal Centre, Hobart, TAS.
7. Winnunga Nimmityjah Aboriginal Health and Community Services Ltd, Canberra, ACT.
8. Central Australian Aboriginal Congress Aboriginal Corporation, Alice Springs, NT.
9. Pilbara Aboriginal Health Alliance, representing a partnership between three ACCHOs in the Pilbara region of WA, Port Hedland, WA.

### Tranche 2

10. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin, NT.
11. Albury Wodonga Aboriginal Health Service, Albury/Wodonga, VIC.
12. Derbarl Yerrigan Health Service Aboriginal Corporation, Perth, WA.
13. Orange Aboriginal Corporation Health Service, Orange, NSW.
14. NSW North Coast including four ACCHOs, North Coast, NSW.
15. Wathaurong Aboriginal Co-operative Limited, Geelong, VIC.
16. Kimberley Aboriginal Medical Service Ltd, Broome, WA.

### Tranches 3 and 4

17. Miwatj Health Aboriginal Corporation, North East Arnhem Land, NT.
18. Wurli Wurlinjang Aboriginal Corporation, Katherine, NT.
19. Aboriginal Health Council of South Australia Ltd, Adelaide, SA.
20. Pika Wiya Health Service Aboriginal Corporation, Port Augusta, SA.
21. The South Australian West Coast ACCHO Network (SAWCAN), SA.
22. Victorian Aboriginal Community Controlled Health Organisation Inc, Melbourne, VIC.
23. Mallee District Aboriginal Services Ltd, Mildura, VIC.
24. Murray Valley Aboriginal Cooperative, Robinvale, VIC.
25. Aboriginal Health and Medical Research Council of NSW, Sydney, NSW.
26. Bourke Aboriginal Health Service Limited, Bourke, NSW.
27. Brewarrina Aboriginal Health Service Ltd, Brewarrina, NSW.
28. Coomealla Health Aboriginal Corporation, Dareton, NSW.
29. Galambila Aboriginal Corporation, Coffs Harbour, NSW.
30. Katungul Aboriginal Corporation Community and Medical Services, NSW.
31. Riverina Medical and Dental Aboriginal Corporation, NSW.
32. South Coast Women's Health and Welfare Aboriginal Corporation (Waminda), Nowra, NSW.
33. Queensland Aboriginal and Islander Health Council, Brisbane, QLD.
34. Apunipima Cape York Health Council Ltd, Cairns, QLD.
35. Cherbourg Regional Aboriginal and Islander Community Controlled Health Services Ltd, Cherbourg, QLD.
36. Gurriny Yealamucka (Good Healing) Health Service Aboriginal Corporation, Yarrabah, QLD.
37. Mt Isa Aboriginal Community Controlled Health Services Ltd, Mt Isa, QLD.
38. Mulungu Aboriginal Corporation Primary Health Care Services, Mareeba, QLD.

39. Wuchopperen Health Service Ltd, Cairns, QLD.
40. Aboriginal Health Council of Western Australia, Perth, WA.
41. Bega Garnbirringu Health Service, Katherine,WA.
42. Mawarnkarra Health Service, Roebourne, WA.
43. Moorditj Koort Aboriginal Corporation, Midland, WA.
44. Paupiyala Tjarutja Aboriginal Corporation, Tiuntiuniara, WA.
45. Puntukurnu Aboriginal Medical Service, East Pilbara, WA.
46. Wirraka Maya Health Service Aboriginal Corporation, South Hedland, WA.

# Appendix B: Key features of CCC-funded sites

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **AMSANT** | Affiliate | NT | Alice Springs (LGA) | Affiliate | December 2022 | Yes | Holistic mental health support to patients and community | N/A[1] |
| **QAIHC** | Affiliate | QLD | Brisbane | Affiliate | January 2023 | Yes | Reducing taboo of suicide in community, Raising mental health literacy, Raising awareness of supports, Holistic mental health support to patients and community, Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **AHCWA** | Affiliate | WA | Perth | Affiliate | January 2023 | Yes | Culturally safe mental health services | N/A[1] |
| **ACHSA** | Affiliate | SA | Adelaide | Affiliate | September 2023 | Yes | Culturally safe mental health services | N/A[1] |
| **TAC** | Affiliate | | Tasmania | Affiliate | December 2022 | | Other | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **VACCHO** | Affiliate | VIC | Melbourne | Affiliate | November 2022 | Yes | | |
| **AHMRC** | Affiliate | NSW | Sydney | Affiliate | February 2023 | Yes | Other | Other |
| **Congress** | Single ACCHO | NT | Alice Springs (LGA) | T 1 | December 2022 | Yes | Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), Raising mental health literacy, Raising awareness of supports, Holistic mental health support to patients and community, Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **PAHA** | ACCHO consortium | WA | Pilbara (South Headland) | T 1 | December 2022 | Yes | Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **Nunkuwarrin Yunti of SA** | Single ACCHO | SA | Adelaide | T 1 | February 2023 | No | N/A[1] | N/A[1] |
| **Urban Indigenous Health Ltd** | Single ACCHO | QLD | Brisbane | T 1 | January 2023 | Yes | Culturally safe mental health services, Other | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Awabakal Ltd** | Single ACCHO | NSW | Newcastle | T 1 | March 2023 | No | | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **BDAC** | Single ACCHO | VIC | Bendigo | T 1 | November 2022 | Yes | Other | Community education/information sessions |
| **BADAC** | Single ACCHO | VIC | Ballarat | T 1 | November 2022 | Yes | Reducing taboo of suicide in community, Raising awareness of supports, Holistic mental health support to patients and community, Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Wirrika Maya** | Multi ACCHO | WA | South Headland | T 1 | | | | |
| **Galambila** | Single ACCHO | NSW | Coffs Harbour | T 2 | December 2022 | Yes | Reducing taboo of suicide in community, Holistic mental health support to patients and community, Other | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Wathaurong** | Single ACCHO | VIC | Geelong | T 2 | December 2022 | Yes | Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), Holistic mental health support to patients and community, Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **Derbarl Yerrigan** | Single ACCHO | WA | Perth | T 2 | February 2023 | Yes | Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), raising awareness of supports, Holistic mental health support to patients and community | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Danila Dilba** | Single ACCHO | NT | Darwin | T 2 | February 2023 | Yes | Reducing taboo of suicide in community, Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), Raising mental health literacy, Raising awareness of supports, Holistic mental health support to patients and community, culturally safe mental health services | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **KAMS** | ACCHO consortium | WA | Broome | T 2 | March 2023 | No | N/A[1] | N/A[1] |
| **Coomealla** | Single ACCHO | NSW | Dareton | T 2 | May 2023 | No | N/A[1] | Community education/information sessions |
| **Albury Wodonga** | Multi-ACCHO | NSW | Albury/Wodonga | T 2 | November 2022 | Yes | Reducing taboo of suicide in community, Holistic mental health support to patients and community, Culturally safe mental health services | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide, Other |
| **OAMS** | Single ACCHO | NSW | Orange | T 2 | | Yes | N/A[1] | Community education/information sessions |
| **Gurriny Yealamucka** | Single ACCHO | QLD | Yarrabah | T 3 | August 2023 | | | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **SAWCAN** | ACCHO consortium | SA | South Australia (West Coast) | T 3 | August 2023 | Yes | Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide, Other |
| **Miwatj** | Single ACCHO | NT | Nhulunbuy | T 3 | December 2023 | Yes | Culturally safe mental health services, Other | Community education/information sessions |
| **Paupiayala Tjarutja** | Single ACCHO | WA | Tjuntjunjara | T 3 | July 2023 | No | Reducing taboo of suicide in community, Raising mental health literacy, Raising awareness of supports, Holistic mental health support to patients and community, Culturally safe mental health services | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Mallee District** | Single ACCHO | VIC | Mildura | T 3 | July 2023 | Yes | Raising awareness of supports, Holistic mental health support to patients and community, Culturally safe mental health services | Community education/information sessions |
| **Wuchopperen** | Single ACCHO | QLD | Cairns | T 3 | July 2023 | Yes | Raising awareness of supports, Culturally safe mental health services | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Katungul** | Single ACCHO | NSW | | T 3 | May 2023 | No | N/A[1] | N/A[1] |
| **Murray Valley** | Single ACCHO | VIC | Robinvale | T 3 | May 2023 | | | |
| **Moorditj Koort** | Single ACCHO | WA | Midland | T 3 | May 2023 | Yes | Culturally safe mental health services | Community education/information sessions, advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Waminda** | Single ACCHO | NSW | Nowra | T 3 | May 2023 | Yes | Holistic mental health support to patients and community | N/A[1] |
| **Apunipima Cape York** | Single ACCHO | QLD | Bungalow | T 3 | May 2023 | No | N/A[1] | N/A[1] |

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **Bega Garnbirringu** | Single ACCHO | WA | Katherine | T 3 | September 2023 | Yes | Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), Raising mental health literacy, Holistic mental health support to patients and community, Culturally safe mental health services | Community education/information sessions |
| **Wurli Wurlinjang** | Single ACCHO | NT | Katherine | T 3 | September 2023 | Yes | Reducing taboo of suicide in community, increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), raising mental health literacy, raising awareness of supports, Holistic mental health support to patients and community, culturally safe mental health services, Other | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide, Other |
| **Brewarrina** | Multi-ACCHO | NSW | Far West NSW | T 4 | December 2023 | No | N/A[1] | Community education/information sessions, advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Bourke** | Single ACCHO | NSW | Far West NSW | T 4 | November 2023 | | N/A[1] | N/A[1] |
| **Cherbourg Regional** | Single ACCHO | QLD | Cherbourg | T 4 | November 2023 | Yes | Culturally safe mental health services | Community education/information sessions |
| **RivMed** | Multi-ACCHO | NSW | Murrumbidgee | T 4 | October 2023 | No | Holistic mental health support to patients and community | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Pika Wiya** | Single ACCHO | SA | Port Augusta | T 4 | September 2023 | No | N/A[1] | N/A[1] |

| Site Name | Site Type | State/ Territory | Region | Tranche | Site establishment date | NSPP provided | Community Needs outlined in the NSPP and ASDM | Health Promotion Activities delivered |
|---|---|---|---|---|---|---|---|---|
| **Mulungu** | Single ACCHO | QLD | Mareeba | T 4 | September 2023 | Yes | Increasing number of community gatekeepers (community members equipped to deal with people in suicidal crisis), holistic mental health support to patients and community, culturally safe mental health services | Community education/information sessions, Advertisements, awareness raising and campaigns for CCC/mental health/suicide |
| **Gidgee Healing (Mount Isa)** | Single ACCHO | QLD | Mount Isa | T 4 | September 2023 | No | Raising mental health literacy, raising awareness of supports, Holistic mental health support to patients and community, culturally safe mental health services, other | Advertisements, awareness raising and campaigns for CCC/mental health/suicide |

[1] *Not evident in documents.*

# Appendix C: CCC Theory of Change

The design, priorities and ethos of CCC are based on two underlying premises:

1. That addressing suicide prevention through culture, care and connection results in better outcomes for Aboriginal and Torres Strait Islander People**.**
2. That putting Aboriginal health in Aboriginal hands by empowering communities results in better outcomes for Aboriginal and Torres Strait Islander people**.**

The change that CCC seeks to create and the approach for doing so are defined by these two statements, embodying the principles of:

- Aboriginal leadership and community control
- evidence-based
- place-based
- rights-based
- culturally-safe and appropriate
- equity-focused
- holistic, life-course approaches
- strengths based approaches
- accountability.

## Culture Care Connect's purpose

At the centre of the theory of change are communities. CCC exists to empower communities to **self-determine** the delivery of place-based, **culture centred, holistic suicide prevention** to support the social and emotional well-being of Aboriginal and Torres Strait Islander people. CCC seeks to enable this through the priorities outlined in the National Agreement and the NATSIHP:

- **Working in partnership between government and communities.** Enabling shared decision-making and self-determination across communities aligned with the National policy to contribute to closing the gap at the local level.
- **Establishing the enablers for change** that establish Aboriginal leadership, strengthen the Aboriginal controlled health sector and the Aboriginal workforce and focus on shared decision making.
- **Focusing on prevention:** enabling preventative services to contribute to a significant and sustained reduction in suicide.
- **Improving the health system**: by addressing mental health and suicide prevention through person-centered and family centered care.
- **Establishing a culturally informed evidence base:** enabling shared access to information and data across systems and regions that can support planning and solutions to Close the Gap.

## How change happens

The change created by CCC is:

- **Non-linear**: It is created with communities, by communities and for communities.
- **Holistic and interconnected**: all principles, actions and changes are connected and indivisible.

## How change will be achieved

Surrounding and enabling the community is the MoI. The model represents Aboriginal and Torres Strait Islander leadership, shared decision-making and genuine partnership with government to Close the Gap.

The MoI is founded on, shaped and reinforced by Aboriginal and Torres Strait Islander cultures. It functions through trust, agency, and the sharing of information and support. It recognises and embeds Aboriginal and Torres Strait Islander ways of being, knowing and doing, acknowledging the wisdom and knowledge of Aboriginal communities to support positive health trajectories individually and collectively. Each level plays a role in empowering communities and creating structural changes for lasting impact.

**If we**… establish an Aboriginal-led model of implementation. **Then…**

- Networks and jurisdictions are enabled with support, resources and agency to deliver placed based, Aboriginal-led suicide prevention and aftercare services that meet their needs.
- A shared language for Aboriginal-led suicide prevention and aftercare that promotes SEWB through the MoC is established.
- Place based learning is being captured to improve the quality of Aboriginal-led suicide prevention and aftercare services.
- Networks, jurisdiction and NACCHO can advocate for system reform.
- Two-way and lateral capacity building will occur across agencies including government, non-government and to and from communities.

**So that…**

- Communities are empowered to self-determine solutions for improved health outcomes.
- A strong Aboriginal workforce is engaged and enabled with the skills and supports for suicide prevention and aftercare.
- Effective decision making for suicide prevention and aftercare is conducted in genuine partnership between government and Aboriginal and Torres Strait Islander people.
- Aboriginal-led suicide prevention and aftercare that promote SEWB is adopted and embedded in the broader health system.
- Government and Aboriginal and Torres Strait Islander communities can work in genuine partnership to contribute to better outcomes for communities and the targets under Closing the Gap.

## Suicide prevention coordination, ATSIMHFAT and aftercare based on the Model of Care

The MoC supports shared language and a framework for the design and delivery of place-based, culturally safe suicide prevention and aftercare that support SEWB. CCC enables the mechanisms, resources and structures to enable networks to:

- Coordinate across the health system to improve the opportunities for community to access the care they need.
- Resource improved capacity and capability for the delivery of aftercare services.
- Deliver and receive training on Aboriginal and Torres Strait Islander Mental Health First Aid to provide support to community, and to each other within the workplace.
- Establish systems and practice that enable the capture of data to support suicide prevention planning and investment.

**If we**… establish and resource suicide prevention coordination, ATSIMHFAT and aftercare based on the Model of Care. **Then…**

- There will be increased health promotion and awareness of SEWB, suicide prevention and supports in CCC communities.
- There will be improved coordination, pathways and touchpoints between ACCHOs and mainstream services to support community.
- There will be increased ATSIMHFA capacity and capability in communities and jurisdictions.
- There will be improved capacity for aftercare capacity and capability within ACCHOs.
- Data is available to support suicide prevention service planning.

**So that…**

- There is reduced stigma and increased awareness of suicide and mental health in communities.
- There are safe, accessible and sustainable systems in place to support SEWB and enable the MoC.
- Culturally safe aftercare services are available and accessible.
- Culturally safe suicide prevention services supports are available and accessible in community.
- An evidence base is available to inform future investment in suicide prevention.

# Appendix D: Documents reviewed

Table 1. Documents included in the document review

| Document type | Number |
|---|---|
| National level documents | 36 |
| Program guidance documents | 12 |
| Contracts/Deeds of Variation | 48 |
| Activity Work Plans | 78 |
| Progress Reports | 79 |
| Risk Management Plans | 63 |
| Budgets | 62 |
| Acquittals and Income Expenditure Reports | 60 |
| Aftercare Service Delivery Model | 33 |
| Network or Jurisdiction Suicide Prevention Plans | 33 |
| ATSIMHFAT training schedule | 12 |
| **Total** | **516** |

Documents were made available for the following sites/locations:

| | |
|---|---|
| **National** | • National Aboriginal Community Controlled Health Organisation (NACCHO) |
| **NSW** | • AH&MRC<br>• Awabakal Ltd<br>• Orange Aboriginal Medical Service (OAMS)<br>• Waminda<br>• Albury Wadonga Aboriginal Health Service Ltd<br>• Galambila Aboriginal Corporation<br>• Coomealla Health Aboriginal Corporation<br>• Katungul<br>• RivMed<br>• Bourke Aboriginal Health Service<br>• Brewarrina Aboriginal Corporation |
| **NT** | • Aboriginal Medical Services Alliance (AMSANT)<br>• Central Australian Aboriginal Congress Aboriginal Corporation<br>• Danila Dilba Biluru Binnilutlum Health Service Aboriginal Corporation (DDHS)<br>• Wurli Wurlinjang<br>• Miwatj |
| **QLD** | • QAIHC<br>• Wuchopperen Health Service Limited<br>• Apunipima Cape York Health Council Limited<br>• Cherbourg Regional Aboriginal and Islander Community Controlled Health Service (CRAICCHS)<br>• Institute for Urban Indigenous Health Ltd |

| | |
|---|---|
| | • Gurriny Yealamucka<br>• Mulungu Aboriginal Corporation Medical centre<br>• Gidgee Healing (Mount Isa) |
| **SA** | • Aboriginal Health Council of South Australia (AHCSA)<br>• Nunkuwarrin Yunti of SA Incorporated<br>• SAWCAN (Consortium)<br>• Pika Wiya Health Service Aboriginal Corporation |
| **WA** | • Aboriginal Health Council of Western Australia (AHCWA)<br>• Pilbara Aboriginal Health Alliance (PAHA)<br>• Kimberley Aboriginal Medical Services Limited (KAMS)<br>• Derbal Yerrigan Health Service<br>• Moorditj Koort<br>• Derbarl Yerrigan Health Service Aboriginal Corporation<br>• Paupiayala Tjarutja Aboriginal Corporation (spinifex health service)<br>• Bega Garnbirringu |
| **VIC** | • VACCHO<br>• Bendigo District Aboriginal Co-operative (BDAC)<br>• Ballarat & District Aboriginal Co-operative (BADAC)<br>• Wathaurong Aboriginal Co-operative Limited<br>• Mallee District Aboriginal Services limited (co-ordinating ACCHO)<br>• Murray Valley Aboriginal Cooperative Limited |
| **TAS** | • TAC |

# Appendix E: Stakeholders interviewed

Interviews and focus groups were conducted virtually or at site visits with representatives from:

| | |
|---|---|
| **National** | • Department of Health, Disability and Ageing (DHDA)<br>• National Aboriginal Community Controlled Health Organisation (NACCHO) |
| **NSW** | • Albury Wodonga Aboriginal Health Service (AWAHS)<br>• Orange Aboriginal Medical Service (OAMS)*<br>• Galambila Aboriginal Corporation<br>• Awabakal, NSW*<br>• Waminda, NSW* |
| **NT** | • Danila Dilba Biluru Binnilutlum Health Service Aboriginal Corporation (DDHS)* |
| **QLD** | • Queensland Aboriginal and Islander Health Council (QAIHC)<br>• Cherbourg Regional Aboriginal and Islander Community Controlled Health Service (CRAICCHS)*<br>• Wuchopperen, QLD*<br>• Cherbourg, QLD*<br>• Apunipima Bungalow, QLD* |
| **SA** | • Aboriginal Health Council of South Australia (AHCSA)<br>• South Australian West Coast ACCHO Network (SAWCAN)*<br>• Nunkuwarrin Yunti*<br>• Pika Wiya Health Service aboriginal Corporation |
| **WA** | • Aboriginal Health Council of Western Australia (AHCWA)*<br>• Moortditj Koort*<br>• Kimberley Aboriginal Medical Services (KAMS)*<br>• Pilbara Aboriginal Health Alliance (PAHA)*<br>• Bega Health<br>• Derbarl Yerrigan Health Service Aboriginal Corporation |
| **VIC** | • Wathaurong Aboriginal Cooperative Limited<br>• Mallee District Aboriginal Services limited (MDAS)<br>• Bendigo District Aboriginal Co-operative (BDAC)*<br>• Ballarat & District Aboriginal Co-operative (BADAC)* |

**Indicates site was selected for a site visit.*

# Appendix F: Survey respondent profiles

## ATSIMHFAT Survey

Most of the respondents were from ACCHOs (n= 16, 67 per cent) or ACCOs (n=5, 21 per cent). The remainder were from mainstream organisations (See Table 1). The highest number of respondents were either CCC Network or Jurisdictional Coordinators (n=4, 17 per cent) or CCC ACWs (n= 3, 12.5 per cent). There were a diverse range of other client facing and non-client facing respondents (see Table 2).

Most of the survey respondents were First Nations People (n=15, 63 per cent). (See Table 3).

The respondents were from a range of locations across Australia, with the highest response rate coming from Western Australia (n=11, 46 per cent), followed by Queensland (n=7, 29 per cent), Western Australia (n=5, 21 per cent) and New South Wales (n=1). A full breakdown of respondent locations can be seen in Table 4.

Prior to completing ATSIMHFAT or other suicide prevention and mental health training most of the survey respondents (n=19, 79 per cent) had either some or a lot of experience supporting people with distress (see Table 5).

Table 1. Where the respondent works

| Type of organisation | Number of responses | Proportion of responses (%) |
|---|---|---|
| ACCHO | 16 | 66.7 |
| ACCO | 5 | 20.8 |
| Mainstream Organisation | 3 | 12.5 |
| **Total** | **24** | **100** |

Table 2. Role of respondent

| Role | Number of responses | Proportion of responses (%) |
|---|---|---|
| CCC Network or Jurisdictional Coordinator | 4 | 17 |
| CCC Aftercare Worker | 3 | 12.5 |
| Mental Health/SEWB Worker | 2 | 8 |
| Outreach worker | 2 | 8 |
| Program manager | 2 | 8 |
| Other client facing roles[1] | 6 | 25 |
| Other non-client facing roles[2] | 5 | 21 |
| **Total** | **24** | **100** |

[1] One response each from other healthcare delivery, Cultural Liaison Officer, Family Support Worker, Aboriginal Health Practitioner, AOD worker, Social Worker

[2] One response each from Practice/ Care coordinator, Community Development Officer, Other community, public health and education, other community actor, and other Admin or support staff.

Table 3. First Nations or non-Indigenous heritage of respondent

| First Nations Background | Number of responses | Proportion of responses (%) |
|---|---|---|
| Aboriginal and/ or Torres Strait Islander | 15 | 63 |
| Non-Indigenous | 8 | 33 |
| Prefer not to say | 1 | 4 |
| **Total** | **24** | **100** |

Table 4. State or territory that respondent is located

| State | Number of responses | Proportion of responses (%) |
|---|---|---|
| WA | 11 | 45.8 |
| QLD | 7 | 29.2 |
| VIC | 5 | 20.8 |
| NSW | 1 | 4.2 |
| **Total** | **24** | **100** |

Table 5. Survey Question 6: level of experience supporting people with distress prior to completing Aboriginal and Torres Strait Islander Mental Health First Aid Training or other suicide prevention and mental health training.

| Level of experience | Number of responses | Proportion of responses (%) |
|---|---|---|
| No experience | 5 | 20.8 |
| Some experience | 12 | 50.0 |
| A lot of experience | 7 | 29.2 |
| **Total** | **24** | **100** |

## Jurisdictional and Network Coordinators Survey

The highest proportion of respondents held network coordinator positions (n=16, 57 per cent) followed by 'other' positions (n=6, 22 per cent), and jurisdictional coordinator (n=4, 14 per cent). See Table 1.

The respondents were from a range of locations across Australia, with the highest response rate coming from Queensland (n=8, 29 per cent), followed by New South Wales (n=6, 21 per cent), and Western Australia. A full breakdown of respondent locations can be seen in Table 2.

Many of the respondents worked for ACCHOs in major cities or regional centres (n=11, 42 per cent), followed by remote and very remote communities (n=7, 27 per cent). A full breakdown of respondent locations can be seen in Table 3.

The highest proportion of respondents were First Nations People (n=15, 53 per cent). See Table 4.

Table 1. Role of respondent

| Role | Number of responses | Proportion of responses (%) |
|---|---|---|
| Jurisdictional Coordinator | 4 | 14.3 |
| Network & Jurisdictional Coordinator | 1 | 3.6 |
| Network Coordinator | 16 | 57.1 |
| Other | 7 | 25 |
| **Total** | **28** | **100** |

Table 2. State or Territory of ACCHO that respondent works for

| State/Territory | Number of responses | Proportion of responses (%) |
|---|---|---|
| NSW | 6 | 21.4 |
| NT | 4 | 14.3 |
| QLD | 8 | 28.6 |
| SA | 1 | 3.6 |
| TAS | 1 | 3.6 |
| VIC | 3 | 10.7 |
| WA | 5 | 17.9 |
| **Total** | 28 | **100** |

Table 3. Remoteness of the ACCHO that respondent works for (see Table 4 for explanations of remoteness)[1]

| Remoteness | Number of responses | Proportion of responses (%) |
|---|---|---|
| 1-2 | 11 | 42.3 |
| 3 | 4 | 15.4 |
| 4-5 | 4 | 15.4 |
| 6-7 | 7 | 26.9 |
| **Total** | **26** | **100** |

[1]2 respondents indicated they did not have a MMM as they were from an Affiliate sites

Table 4. Modified Monash Model of Remoteness[64]

| Category | Title | Definition |
|---|---|---|
| MM1 | Metropolitan Areas | Major cities accounting for 70 per cent of Australia's population.<br>All areas categorised ASGS-RA1. |
| MM2 | Regional Centres | Areas categorised ASGS-RA2 and ASGS-RA3 that are in, or within 20km road distance, of a town with population greater than 50,000. |
| MM3 | Large Rural Towns | Areas categorised ASGS-RA2 and ASGS-RA3 that are not in MM2 and are in, or within 15km road distance, of a town with a population between 15,000 and 50,000. |
| MM4 | Medium Rural Towns | Areas categorised ASGS-RA2 and ASGS-RA3 that are not in MM2 or MM3 and are in, or within 10km road distance, of a town with a population between 5,000 and 15,000. |
| MM5 | Small Rural Towns | All other areas in ASGS-RA 2 and 3. |
| MM6 | Remote Communities | All areas categorised ASGS-RA4 and islands that are separated from the mainland in the ABS geography and are less than 5km offshore.<br>Islands that have an MM5 classification with a population of less than 1,000 without bridges to the mainland. |
| MM7 | Very Remote Communities | All other areas that are categorised ASGS-RA 5 and populated islands separated from the mainland in the ABS geography that are more than 5km offshore. |

Table 5. First Nations background or otherwise

| First Nations Background | Number of responses | Proportion of responses (%) |
|---|---|---|
| No | 8 | 28.6 |
| Prefer not to say | 1 | 3.6 |
| Yes, Aboriginal | 15 | 53.6 |
| Yes, both Aboriginal and Torres Strait Islander | 4 | 14.3 |
| **Total** | **28** | **100** |

[64] 2019 Modified Monash Model Classification., *Modified Monash Model*, Department of Health and Aged Care, https://www.health.gov.au/topics/rural-health-workforce/classifications