# The Way Back Support Services Evaluation | Interim Evaluation Appendices

## Beyond Blue

24 November 2021

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

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

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



**Acknowledgement of people with lived experience of mental illness:**

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

***Disclaimer:***

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

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

# Contents


Appendix A Glossary ..... 3
Appendix B List of sites ..... 6
Appendix C Data collection plan ..... 8
Appendix D Theory of change and Theory of Action (Program Logic) ..... 16
Appendix E What is being delivered under The Way Back, where, how and why? ..... 19
Appendix F Cohorts accessing The Way Back across Australia ..... 30
Appendix G Deep dive site profiles ..... 34
Appendix H Sources for Cohen's d analysis ..... 59
Appendix I Recommendations to improve data quality ..... 60
Appendix J Items for follow up ..... 62
Appendix K Key Performance Indicators ..... 64

# Appendix A Glossary

| | |
|---|---|
| **Assertive aftercare** | Assertive aftercare is assertive and rapid follow-up, case management and motivational support to remain engaged in a service. 'Assertive' means the care provider is responsible for maintaining contact with the client. |
| **Community mental health service** | Services that treat mental illness in community-based settings or hospital-based outpatient care. |
| **Context-mechanisms-outcomes (CMOs)** | In realist evaluation, the evaluator hypothesises in advance the likely mechanisms that cause change to occur and desired outcomes to be achieved. This also includes consideration of the context in which those changes occur. This is known as Context-Mechanism-Outcome (CMO) hypothesis.1 |
| **Core service model** | The core service model is the key elements of The Way Back that make it work. They are described in Figure 2, which draws from Beyond Blue's The Way Back service model documentation. |
| **Episode of care (referred to throughout this report as *service episode*)** | For the purposes of the PMHC MDS, an Episode of Care is defined as a more or less continuous period of contact between a client and a PHN-commissioned provider organisation/clinician that starts at the point of first contact and concludes at discharge. Further information available online at: https://docs.pmhc-mds.com/projects/data-specification-wayback/en/v3/data-specification/key-concepts.html#episode. |
| **Follow-up support** | Follow-up immediately after discharge to continue the provision of care and support to the individual, family and caregivers. |
| **Friends, families and other support people** | Friends, families, kinship groups and all other support people who play a vital role in supporting people living with severe mental illness by providing practical and emotional support to the person and assisting them with building capacity and the tasks of daily living.<br>For simplicity of language, on occasion we refer to all as 'families' or 'family members', in line with the idea of 'chosen families' as people with who strong supportive ties are formed. |
| **Key Evaluation Questions or KEQs** | High-level research questions that guide the evaluation. The KEQs for this evaluation were determined from the scope of enquiry, theory of change and program logic. |
| **Local Health Network (LHN) or Local Health District (LHD) or Hospital and Health Service (HHS) (referred to in this report as 'LHNs or equivalents')** | These entities manage the delivery of public hospital services and other community-based health services as determined by their state or territory government. |
| **Primary eligibility criteria** | The primary eligibility criteria applies to clients who have been hospitalised for a suicide attempt. |



[1] Gill Westhorp (2014), "Realist Impact evaluation: an introduction", accessed on 24 August 2021, cdn.odi.org/media/documents/9138.pdf

| | |
|---|---|
| **Primary Mental Health Care Minimum Data Set (PMHC MDS) or PMHC MDS and The Way Back extension** | Primary Mental Health Care Minimum Data Set (PMHC MDS) is a data set that will provide the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government. It will also be used for this evaluation.<br>TWB extension is a supplementary dataset linked to the PMHC MDS that collects information specific to the aims and activities of The Way Back. It will also be used for this evaluation. |
| **Psychosocial support** | Psychosocial support refers to non-clinical services that assist people with severe mental illness to build skills to manage their mental illnesses, improve their relationships with family and others and increase social and economic participation. |
| **Recovery** | Recovery is used throughout this document to refer to a person's personal recovery following a suicide attempt. This recovery journey will be different for each person, but will often include emotional aspects, physical safety and other factors. |
| **Secondary eligibility criteria** | The secondary eligibility criteria applies to clients who have been hospitalised for a suicidal crisis, or indicated they have had a suicidal crisis during. |
| **Service contact** | For the purposes of the PMHC MDS, a service contact is defined the provision of a service by a PHN commissioned mental health service provider for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client. A service contact must involve at least two persons, one of whom must be a mental health service provider.<br>Service contacts can be either with the client or with a third party, such as a carer or family member and/or other professional or mental health worker, or other service provider.<br>Service contacts are not restricted to face-to-face communication but can include telephone, internet, video link or other forms of direct communication.<br>Service provision is only regarded as a service contact if it is relevant to the clinical condition of the client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment). https://strategic-data-pty-ltd-docspmhc-mdscom.readthedocs-hosted.com/projects/data-specification/en/v2/data-model-and-specifications.html#service-contact |
| **Service model variations** | These are the site and context specific variations to the core service model, as articulated in Appendix E.1.2. They build on the core model to deliver a service that is suited to the needs of the local population and service provider. |
| **Severe mental illness** | Severe mental illness refers to mental illness characterised by a severe level of clinical symptoms and degree of disablement to social, personal, family and occupational functioning. |
| **State health service staff** | The staff operating in state or territory operated health services (e.g. hospitals) that collaborate to deliver The Way Back. |
| **Suicidal crisis** | When a person is experiencing distress, suicidal thoughts and articulating an intent to die. A suicidal crisis may or may not result in an ED attendance or a hospital admission. |
| **Suicidal ideation** | Suicidal ideation is thinking out, considering or planning suicide. It can range from fleeting thoughts to well-thought-out plans for suicide. |
| **Suicidality** | Suicidality covers suicidal ideation, suicide plans and suicide attempts. |

| | |
|---|---|
| **Suicide attempt** | A non-fatal, self-directed, potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in physical injury and may or may not result in an ED attendance or a hospital admission. |
| **Support providers** | Support providers refers to those organisations involved in the planning and delivery of psychosocial supports. This may include government and non-government organisations. |

# Appendix B List of sites

This appendix provides a list of sites under the bilateral agreements as at August 2021.

| Site | Status | In-scope for interim evaluation report? | Data provided into PMHC MDS and TWB extension for this report |
|---|---|---|---|
| Adelaide | Currently operational | In-scope | Yes |
| Albury Wodonga | TBC | Not in scope of evaluation | No |
| Bairnsdale, Wonthaggi & Sale (Gippsland SE) | Currently operational | In-scope | Yes |
| Bendigo/Echuca | Currently operational | Not in scope of evaluation | No |
| Brisbane North | Currently operational | In-scope | Yes |
| Brisbane South | Currently operational | In-scope | Yes |
| Broken Hill | Currently operational | In-scope – no data included in Interim Evaluation Report | No |
| Cairns | Currently operational | In scope – awaiting ethics approval | No |
| Canberra | Currently operational | In-scope | Yes |
| Casey | Currently operational | Not in scope of evaluation | No |
| CESPHN: Sutherland/St George, St Vincent, Royal Prince Alfred, Prince of Wales (Northern and Southern sector) | Currently operational | In-scope | Yes |
| Dandenong | Currently operational | In scope – declined to be involved | No |
| Darwin | Currently operational | In-scope | Yes |
| Geelong | Currently operational | Not in scope of evaluation | No |
| Gold Coast | Currently operational | In-scope | Yes |
| Gosford/Wyong | Currently operational | In-scope | Yes |
| Hobart | Currently operational | In-scope – no data included in Interim Evaluation Report | No |
| Launceston | Currently operational | In-scope – no data included in Interim Evaluation Report | No |
| Mildura | Currently operational | In-scope | Yes |
| Mt Isa | Currently operational | In scope – awaiting ethics approval | No |

| Site | Status | In-scope for interim evaluation report? | Data provided into PMHC MDS and TWB extension for this report |
|---|---|---|---|
| Murrumbidgee | Currently operational | In-scope | Yes |
| Newcastle | Currently operational | In-scope | Yes |
| North Coast | Currently operational | In-scope | Yes |
| Northern Sydney | Currently operational | In-scope | Yes |
| Sunshine Coast, Central Queensland and Wide Bay | Currently operational | In-scope | Yes (all locations are treated as separate in the PMHC MDS and TWB extension analysis) |
| South West Sydney | Currently operational | In-scope | Yes |
| Toowoomba & Ipswich | Currently operational | In-scope | Yes |
| Traralgon and Warragul (Gippsland Central) | Currently operational | Not in scope of evaluation | No |
| Warrnambool (Great South Coast) | Currently operational | In-scope | Yes |
| Westmead/Mt Druitt (Went West Sydney) | Currently operational | In-scope | Yes |

# Appendix C Data collection plan

This appendix provides the detailed data collection plan, that outlines KEQs, research questions, sub-questions and data sources (as outlined in the Evaluation Framework).

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| **KEQ1. What is being delivered under The Way Back, where how and why?** | | | | | |
| a) What need does The Way Back aim to meet? | What is the aim of The Way Back? | ✓ | | ✓ | |
| | What is the overall nature and scale of the challenge related to suicide prevention and how is this changing, or not, over time? | ✓ | | ✓ | |
| | What is the demand for aftercare? (overall, by cohort, by location)? How is this changing over time? | ✓ | ✓ | | |
| | What proportion of the demand is (or is expected to be) met by The Way Back compared to other services? | ✓ | ✓ | | |
| | Who are the clients of the service, including priority cohorts and how have they been identified? | | ✓ | ✓ | |
| | What needs do clients have at hospital discharge/when they enter into aftercare and which of these needs are expected to be addressed by aftercare (as shown in current evidence and/or practice experience)? | | | | |
| b) What is important, for whom, about the policy, operating and community context(s) in which The Way Back is delivered? | What policies, strategies and reforms are relevant to The Way Back design, implementation and delivery? | ✓ | | ✓ | ✓ |
| | What operational factors are relevant to The Way Back design, implementation and delivery? (e.g. hospital/tertiary care arrangements, funding structures, metro/regional/rural considerations, other relevant services operating in the area)? | ✓ | | ✓ | ✓ |
| | What community context is relevant to The Way Back design, implementation and delivery (e.g. identified need for aftercare services, family support networks etc.)? | ✓ | | ✓ | ✓ |
| c) What is the service and implementation | What is The Way Back' service model, including inputs, activities, outputs, outcomes, goals and vision? | ✓ | | ✓ | |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| model, including the core model and design variations? (i.e. how does The Way Back work to support its clients?) | What are the standards or quality requirements for key features of the service model? | ✓ | | ✓ | |
| | What variations in service model have been agreed on and why? Including the peer support enhancement and other variations (by location). | ✓ | | | |
| | What are the key mechanisms by which change is expected to occur? | ✓ | | ✓ | |
| | What are the circumstances needed for these mechanisms to work? (Note: contexts in-scope to be determined, e.g. will we consider implementation factors, organisational conditions, client characteristics etc). | ✓ | | ✓ | |
| | What evidence exists that supports the success/validity of these mechanisms? | ✓ | | | |
| | What is The Way Back implementation model and how is it expected to work? | ✓ | | ✓ | |
| d) What are the enablers of service delivery and implementation? (in each site and across the network) | What governance arrangements support The Way Back delivery? | ✓ | | ✓ | |
| | What financial, human and other resources are invested into The Way Back? e.g. operating budget, Full Time Effective (FTE), staff qualifications and certifications, overall and by site. | ✓ | | | |
| | What monitoring and continuous improvement processes are in place, overall and in sites? | ✓ | | ✓ | ✓ |
| | What key partnerships are established at each site and what is the nature of these partnerships? | | | ✓ | ✓ |
| | What workforce capacity and capabilities support The Way Back? | ✓ | | ✓ | ✓ |
| e) What activities and outputs has The Way Back delivered, in each site? | What activities has The Way Back delivered (across all sites and in each site)? | | ✓ | ✓ | ✓ |
| | What outputs have been delivered to clients, across all sites? (e.g. support plans, number of support periods, unique clients etc.) | | ✓ | | |
| **KEQ2. How well is The Way Back being delivered?** | | | | | |
| a) To what extent is The Way Back providing the expected service reach and coverage for target populations in each site and why? | What is the geographic reach of The Way Back, across all sites and for each site? | ✓ | | | ✓ |
| | Who is referred to The Way Back and from where? (number of clients, by: demographics, personal characteristics, location and source of referral) | | ✓ | | |
| | Who is accessing The Way Back, how does this compare to what was intended and why? | ✓ | ✓ | ✓ | ✓ |
| | Does the supply of The Way Back meet the demand for aftercare intended in its design and why or why not? | ✓ | ✓ | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| b) To what extent do clients take up, participate and continue in the service as expected and in line with their assessed need and why, for which clients? | What is the uptake of The Way Back? (by cohort and location) | | ✓ | | |
| | How do The Way Back participation rates compare with the evidence for effective aftercare (i.e. compared to support plan, weeks of participation and intensity of engagement) and for whom? | | ✓ | | ✓ |
| | To what extent does The Way Back effectively sustain engagement with clients (based on therapeutic need), for which clients and under what circumstances? | | ✓ | ✓ | ✓ |
| | What are, the key exit points and for whom and under what circumstances? | | ✓ | ✓ | ✓ |
| | How do the characteristics of those who disengage from The Way Back at different points differ from those of sustained engagement? How does this intersect with service delivery mode/workforce characteristics? | | ✓ | ✓ | ✓ |
| | To what extent does The Way Back meet its KPIs in all sites? (e.g. number of clients contacted within required timeframe) | | ✓ | | |
| | To what extent do the current set of KPIs create any unintended or perverse incentives? | | | ✓ | ✓ |
| c) To what extent are clients satisfied with The Way Back and why, for which clients? | How satisfied are The Way Back clients with their service? | | ✓ | ✓ | ✓ |
| | What aspects of The Way Back delivery model (e.g. trusted person to talk to) do clients like and why? | | | ✓ | ✓ |
| d) In each site, how effectively is The Way Back delivered to clients relative to its intended design and why? (e.g. considering evidence-based service standards and the local context) | How effectively is service delivery trauma-informed, for which clients and why or why not? | | | ✓ | ✓ |
| | How culturally safe is The Way Back delivery, for which clients, why and to what effect? | | | ✓ | ✓ |
| | What services have clients been 'recommended out' to by The Way Back (e.g. by type, frequency, unique client, client cohort & overall) and to what extent have they been taken on The Way Back clients? | ✓ | ✓ | ✓ | ✓ |
| | To what extent do clients engage effectively in services recommended by their The Way Back Support Coordinator? For which clients, where and which types of services referred out to is this being achieved for and why? | ✓ | ✓ | ✓ | ✓ |
| e) To what extent are expected (and | What was the experience of organisations referring people to The Way Back? What factors contributed to an effective or ineffective referral pathway? | | | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| unexpected) service enablers and barriers supporting The Way Back implementation and delivery in each site, how and why? How have they been made use of or overcome by providers? | What was the experience of The Way Back staff in delivering the service and what factors shaped this? | | | ✓ | ✓ |
| | What are staff retention rates, where and for which roles and what influenced this? | | ✓ | ✓ | ✓ |
| | What were the optimal skills and capabilities for the support coordinator role to deliver The Way Back as intended and why? Do staff have these capabilities? | ✓ | | ✓ | ✓ |
| | How culturally appropriate was recruitment and training of The Way Back workforce for key populations, including that of and for Aboriginal and Torres Strait Islanders people? | | | ✓ | ✓ |
| | To what extent did the training provided to The Way Back staff build their capability to deliver The Way Back as intended, why or why not? | | | ✓ | ✓ |
| | How effectively do governance arrangements support The Way Back implementation and delivery? | | | ✓ | ✓ |
| | How effectively do funding and contracting mechanisms support The Way Back implementation and delivery? | | | ✓ | ✓ |
| | How effectively do key partnerships support The Way Back implementation and delivery? | | | ✓ | ✓ |
| | How effectively do data and information sharing mechanisms support The Way Back implementation and delivery? | | | ✓ | ✓ |
| | How effectively do monitoring and continuous improvement processes support The Way Back? (Including how effective are the current outcome measures in understanding the experience of clients and how effectively The Way Back is adapted based on past evaluations) | | | ✓ | ✓ |
| | To what extent did implementation differ from what was planned and why, with what effect? (Including how core elements were modified) | ✓ | ✓ | ✓ | ✓ |
| • **KEQ3. What is changing, for whom, in The Way Back?** | | | | | |
| a) To what extent do clients attain expected outcomes and goals (and any unexpected | To what extent and in what ways has The Way Back improved the emotional state of its clients (e.g. increased feelings of hope, purpose and belonging; reduced psychological distress)? (overall and by cohort) | | ✓ | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| outcomes) during The Way Back service period and for which clients and why? | To what extent and in what ways has The Way Back improved emotional wellbeing and resilience of its clients (e.g. improved emotional wellbeing; greater knowledge of triggers/risk factors and ability to manage them)? (overall and by cohort) | | ✓ | | |
| | To what extent and in what ways has The Way Back improved the protective factors of its clients (feeling empowered as a partner in recovery; greater capacity to manage psychological distress; increased social connectedness etc.)? (overall and by cohort) | | ✓ | ✓ | ✓ |
| | To what extent and in what ways has The Way Back reduced suicidal ideation (rate, severity and duration) and behaviour (i.e. avoidance of suicide (re) attempt)? | | ✓ | ✓ | ✓ |
| | To what extent and in what ways has The Way Back improved family and community knowledge about how to respond to someone living with suicidality and improved their linkages? | | | ✓ | ✓ |
| | To what extent and in what ways has The Way Back improved outcomes for families and communities (e.g. improved knowledge of how to respond to someone living with suicidality)? | | | ✓ | ✓ |
| | To what extent and in what ways has The Way Back improved system outcomes (e.g. improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis, in sites and across the network)? | | | ✓ | ✓ |
| | What unexpected outcomes were observed? | | | ✓ | ✓ |
| b) In which ways do client outcomes vary, including for client cohorts, by service criteria (i.e. after a suicide attempt or suicidal crisis) and by service site/variation? | Are there significant differences in outcomes (see outcomes above) by site and 'enhancement present'? | | ✓ | | |
| | What were the experiences/outcomes of potential clients who declined to engage with The Way Back or had an unplanned exit? | | ✓ | ✓ | ✓ |
| | What does the recovery look like for key client cohorts? | | ✓ | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| c) What insights do these variations offer for what recovery looks like for different clients? | What are the critical points and critical differences in the recovery journey, for different cohorts or in different circumstances and why do they differ? | | | ✓ | ✓ |
| d) What role is The Way Back playing, if any, in improving the integration and sustainability of clinical and community-based mental health services? | To what extent are clinical and community based mental health services more effectively integrated in sites, why or why not and with what effect? | | | ✓ | ✓ |
| | What role did The Way Back play in this level and sustainability of service integration? | | | ✓ | ✓ |
| • **KEQ4. Why and how does change occur in The Way Back, in which circumstances?** | | | | | |
| a) What are the significant mechanisms of change for clients and for which clients, in which sites and how and why? | What are the most important mechanisms of change for clients and for which clients and why? They might include, but not be limited to, a combination of:<br>• clients' own response to their situation and to the service<br>• clients' personal circumstances<br>• aspects of The Way Back service<br>• other services and supports<br>• contextual and structural factors. | ✓ | | ✓ | ✓ |
| b) Overall, what contribution has The Way Back made to which client outcomes and goals and for whom, in which sites and how and why? | To what extent did The Way Back contribute to client outcomes and goals, for whom, in which sites and how and why? | | ✓ | ✓ | ✓ |
| | What else contributed to client outcomes and goals, for whom, in which sites and how and why? (e.g. what contribution did parallel clinical and community-based supports make to client outcomes?) | | ✓ | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| c) To what extent did the peer support enhancement in Murrumbidgee LHD contribute to client outcomes and goals, for which clients, how and why? What aspects of its contribution was unique, how does it compare to non-peer-based support and what was a reinforcement of benefits from the core model? | To what extent did the peer support model contribute to client outcomes and goals, for which clients, how and why? | | ✓ | ✓ | ✓ |
| | What aspects of the peer enhancement contribution was unique? | | ✓ | ✓ | ✓ |
| | How does the peer enhancement model compare to non-peer-based support and what was a reinforcement of benefits from the core model? | | ✓ | ✓ | ✓ |
| d) To what extent did other variations or enhancements on The Way Back service model contribute to client outcomes and goals, for which clients, how and why? What aspects of their contribution were unique and what was a reinforcement of benefits from the core model? | To what extent did the model variation contribute to client outcomes and goals, for which clients, how and why? | | ✓ | ✓ | ✓ |
| | What aspects of the model variation contribution was unique? | | ✓ | ✓ | ✓ |
| | How does the model variation compare to the core The Way Back model and what was a reinforcement of benefits from the core model? | | ✓ | ✓ | ✓ |
| • **KEQ5. What can be done to improve the contribution of The Way Back and similar services to service outcomes and goals?** | | | | | |
| a) How could The Way Back service model and its | What improvements can be made to the design and delivery of The Way Back' core service model and to its variations, to improve outcomes for all clients or particular client cohorts and circumstances? | ✓ | ✓ | ✓ | ✓ |

| Research question | Sub question | Secondary data documents | Secondary data Data sets (e.g. PMHC MDS) | Primary data Interviews or focus groups | Primary data Survey |
|---|---|---|---|---|---|
| variations be further developed to improve the reach, quality and outcomes of the service for clients? | What improvements can be made to The Way Back' implementation model and variations to improve the ease and effectiveness of delivering the service to clients? (i.e. to make the most of enablers and overcome barriers) | ✓ | ✓ | ✓ | ✓ |
| b) What insights and lessons does The Way Back offer for the sector's wider understanding of client recovery and for designing and delivering effective follow-up services, in complex operating environments? | What has been learned about how the suicide prevention sector can effectively support a client's recovery from a suicide attempt or crisis? | ✓ | ✓ | ✓ | ✓ |
| | What has been learnt from the design and delivery of The Way Back that is relevant to support the further development of effective follow-up support services and their coordination with clinical and community services? | ✓ | | ✓ | |
| | What has been learnt from the implementation of The Way Back that is relevant to support the further development of effective follow-up support services and their coordination with clinical and community services? | | | ✓ | |
| c) What data should be collected to support a future summative evaluation and value-for-money assessment of The Way Back? | What is the average cost of delivering The Way Back per client? | | ✓ | ✓ | |
| | What is the cost of someone presenting to an ED following a suicide (re) attempt? | | ✓ | ✓ | |
| | To what extent does The Way Back lead to its clients avoiding future suicide (re) attempts and how does this compare to known rates in the literature? | | ✓ | ✓ | |

# Appendix D Theory of change and Theory of Action (Program Logic)

This appendix outlines the program theory for The Way Back. A program theory is "an explicit statement or model of how change in a particular situation will occur and how an intervention will produce the causal processes that lead to that change".[2] The program theory has two elements, which are:

- The **theory of change**, which outlines: the need to prevent suicide; the desired changes for clients, families and communities who access The Way Back as well as the service system; and how those changes are expected to occur, given the contexts in which support is delivered.
- The **theory of action**, which sets out what The Way Back does (i.e. the inputs, activities and outputs) that aims to produce the desired changes (i.e. outcomes and goals), displayed as a program logic.

Below we outline the Theory of Change and Theory of Action for The Way Back that underpins this evaluation, as articulated in the Evaluation Framework.

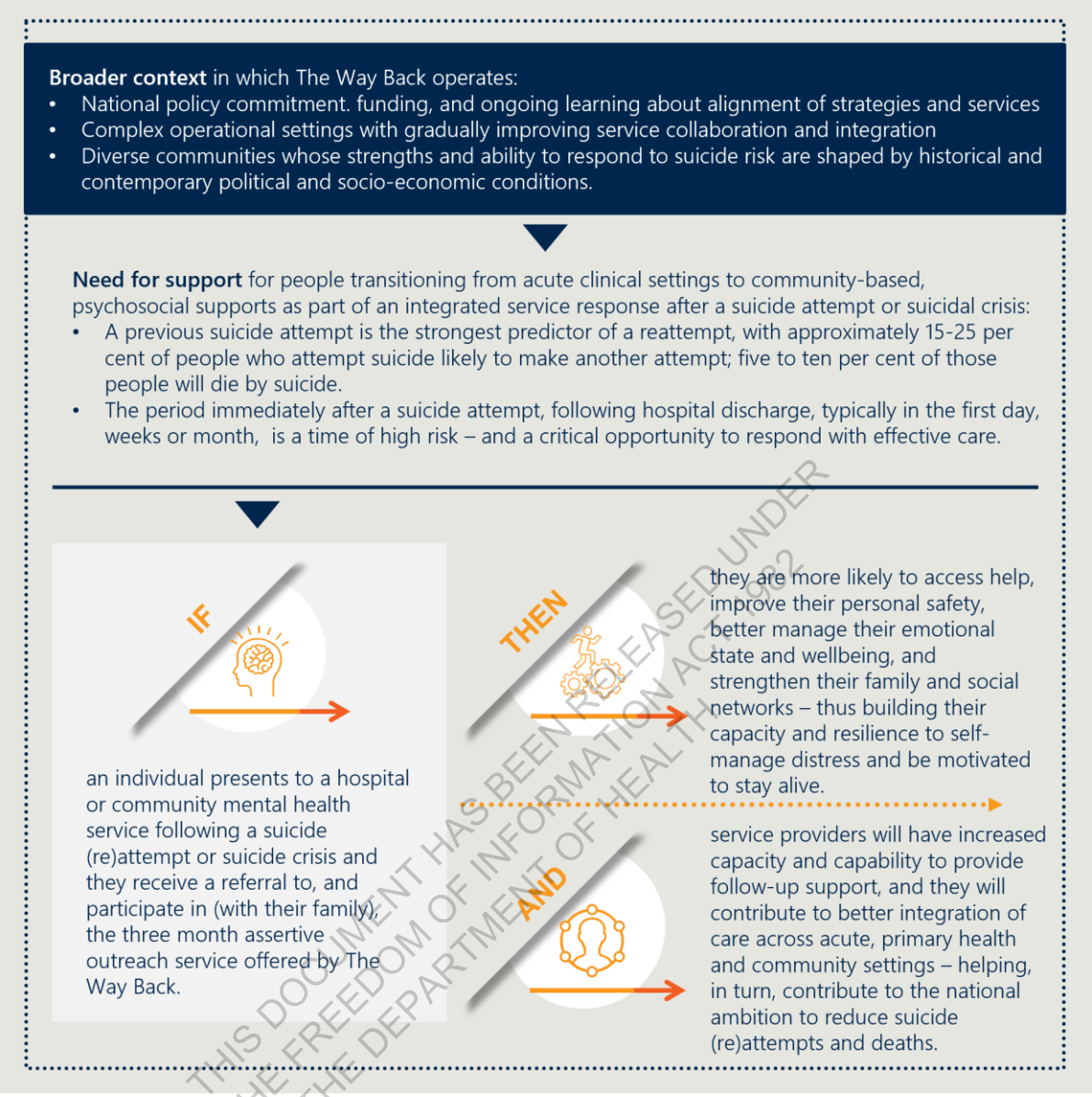
### Theory of change

The theory of change for The Way Back is summarised in Figure 1 overleaf.



[2] Funnell S and Rogers P 2011, Purposeful Program Theory – Effective use of theories of change and logic models, Jossey-Bass, pp. 13

**Figure 1 | The Way Back theory of change**






The theory of change informs the theory of action outlined below.

## Theory of action

***Program logic for the core The Way Back service model.***

The program logic presented overleaf sets out the way in which providers in The Way Back service network are expected to implement the service (the resources, capabilities and arrangements which allow them to set up the service as a whole, consistent with the nature of the service as assertive follow-up support and in line with its four guiding principles) and what service they are expected to deliver to clients (the service model, with this program logic expressing the core model).

# Appendix E What is being delivered under The Way Back, where, how and why?

## E.1 What is being delivered under The Way Back, where how and why?

***Reader note**:* It is important to understand the limitations of the PMHC MDS and TWB extension data that informs findings presented in this section. This includes limitations to its coverage (across sites) and the completeness of variables. Refer to the Full Report, Section 2.2 for detailed limitations.

### E.1.1 Policy, operating and community context

**The Way Back is delivered at the complex intersection of health and community services.**

The Way Back aligns to Australian policy priorities for suicide prevention. Key public policy includes the *Fifth National Mental Health and Suicide Prevention Plan*, the *Productivity Commission's Mental Health Final Report,* the *Royal Commission into Victoria's Mental Health System* and jurisdictional level suicide prevention frameworks.

In this policy and operational landscape, The Way Back has:

- Created opportunities for PHNs, providers and LHNs (and equivalents) to better integrate services.
- Increased opportunities for people with lived experience to participate in the mental health workforce.
- Improved funding for PHNs, providers and state health service staff to contribute to suicide prevention and aftercare (e.g. in response to recent events such as COVID-19, bushfires) (based on consultations).

Stakeholders also commonly noted challenges remain. These include:

- duplication and gaps in the mental health services.
- difficulty to achieve integration between clinical and non-clinical services.
- lack of longevity in service funding.

Stakeholders noted that these challenges can impact on awareness of The Way Back, integration between The Way Back and other services, sharing of patient information and workforce capacity and capability. Community needs and trends influence the design and delivery of The Way Back.

"You don't really know what's out there until you get referred" The Way Back client

Community needs and trends can influence demand and delivery approach. They include:

- **the varying needs of diverse cohorts within communities** e.g. for people with CALD backgrounds. The Way Back needs to be culturally appropriate and adapted to suit the needs of various cohorts.
- **socio-demographic characteristics** (e.g. socio-economic status) and the prevalence of domestic and family violence within a community, which can influence The Way Back design and outcomes.

- **changes to service design and delivery as the result of the COVID-19 pandemic** and associated public health orders have impacted (and will likely continue to affect) delivery of The Way Back. The service needs to be flexible to changing modes of delivery.
- **community stigma**, which can impact how psychosocial supports and services are accessed. Service delivery must be done cognisant of how the stigma around suicide may influence how specific groups (e.g. Aboriginal and Torres Strait Islander people) engage.

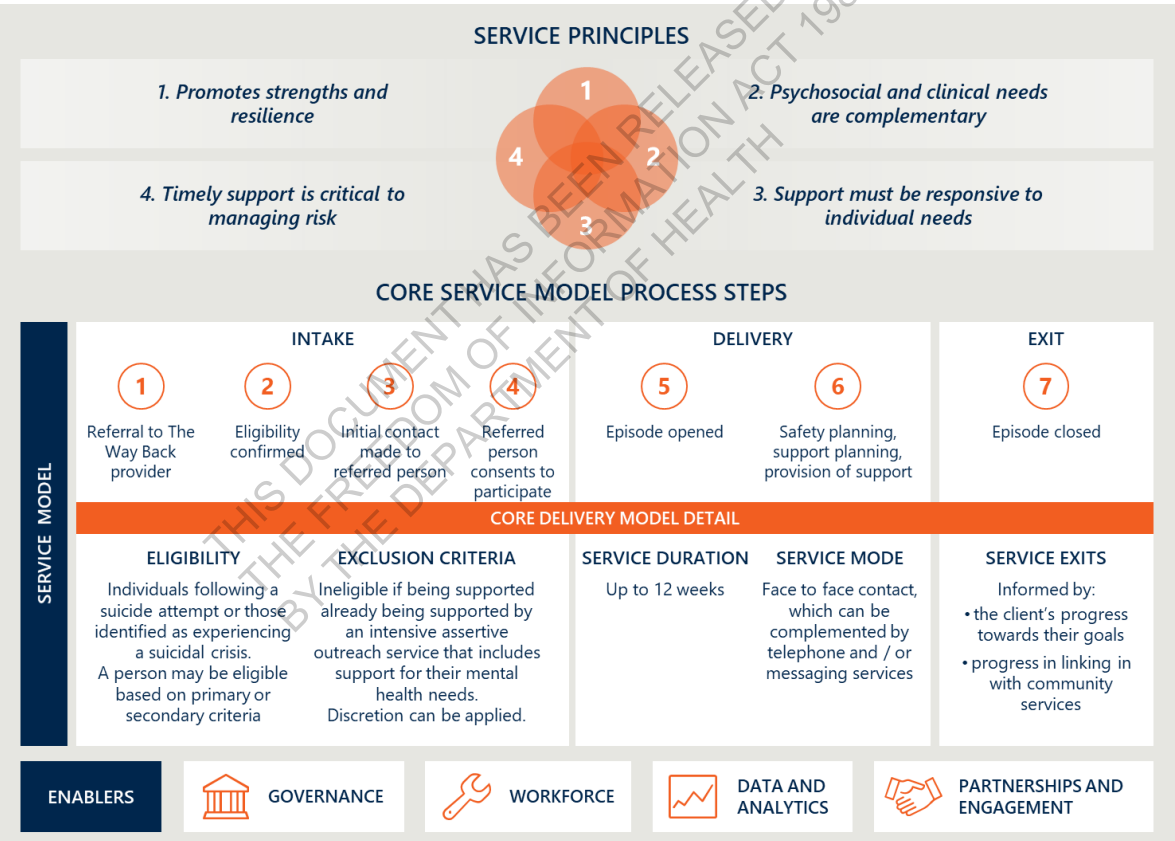
Additional local context for the eight deep dive sites is at Appendix G.

## E.1.2 Service model and variations

**The Way Back' service model was designed to reduce rates of suicide attempt in Australia.**

As of September 2021, the 25 sites in scope for this evaluation are operational. These sites deliver the 'core' service delivery model, detailed in *The Way Back Support Service – Service Delivery Model (March 2020)*. Figure 2 shows The Way Back core service model. Some sites also have planned and unplanned variations, detailed in Figure 3 below.

**Figure 2 | The Way Back service model**[3]






Many organisations and individuals are involved in direct The Way Back service. This includes:

- **EDs/Mental Health Teams (MHTs)/Community Mental Health Services (CMHSs):** They conduct mental health assessments and refer into The Way Back based on eligibility.
- **Providers:** This includes not-for-profit mental health, community health and/or disability organisations. providers contact the client within one business day and deliver support to them over

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

12 weeks, and house The Way Back Team Leaders and support coordinators (see workforce model in section E.1.2).

- **Community providers:** They receive referrals from The Way Back, for example for psychosocial supports and intensive community supports.

Detail on The Way Back workforce is in Section 3.1. Detail on governance is in section E.1.2.

**Service model variations allow for flexibility to respond to local needs and contexts.**

A key feature of The Way Back is the scope for variations that respond to local needs and contexts[4]. Some variations are planned, whilst others are designed to respond to needs identified during implementation. Variations across the eight deep dive sites are shown in Figure 3. In summary:

- Many planned variations were implemented, the most common being peer and family support. The least were variations to referral pathways. Stakeholders reported that this was due to infancy of partnerships with referral organisations (e.g. ACCHOs).
- Two unplanned variations for data enhancement emerged at the Gold Coast and Brisbane North sites to better integrate QLD mental health and The Way Back datasets.
- Several providers indicated there are other variations suitable for them, particularly an Aboriginal and Torres Strait Islander referral pathway. Some providers noted the rigidity of contracts limited their ability to develop variations upon delivery.

Site context information (provided by Beyond Blue in July 2020) identifies other variations that providers intended to deliver. Examples of variations include a GP and a toxicology unit referral pathway.

Appendix G provides further detail on the variations at the eight deep dive sites.

***For exploration in future data collection rounds: Nous will further explore the extent to which sites within scope of the evaluation (including non-deep dive sites) have delivered on planned service model variations.***



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

## Figure 3 | Variations to The Way Back delivery model for the eight deep dive sites[5]

| VARIATIONS | DESCRIPTION OF VARIATION | RATIONALE | SITES PLANNED | SITES DELIVERED |
|---|---|---|---|---|
| Referral pathway | Sites may establish a specific referral pathway tailored to a specific group. Current examples include an Aboriginal and Torres Strait Islander pathway, veterans, toxicology-only pathways or a GP pathway. | Certain cohorts or locations have specific needs or ways they interact with health services that mean they would benefit from a tailored pathway outside of referrals from emergency departments and community mental health services. In addition, certain cohorts are more at-risk of suicide (re)attempts or experience specific risk factors. | • Brisbane North as part of South East Queensland (Veterans)<br>• Darwin (Aboriginal and Torres Strait Islander pathway) | • Brisbane North as part of South East Queensland (Veterans – pathway closed June 2020) |
| Peer support | Sites may establish a peer support enhancement, in which clients interact with a peer with lived experiences to provide support (e.g. peer care companion, informal coffee catch ups with previous clients). | There is some evidence that peer support improves clients experiences and progress towards recovery. | • Murrumbidgee<br>• Canberra<br>• North Coast<br>• Mildura<br>• Adelaide | • Murrumbidgee<br>• Canberra<br>• North Coast<br>• Mildura |
| Family support | Sites may establish a family support role (e.g. family peer care companion), in which a family member is involved in supporting recovery. | Families of people who (re)attempt suicide can be an important support through recovery (e.g. strong relationships can be a protective factor). | • Murrumbidgee | • Murrumbidgee<br>• Mildura |
| After hours support | Sites may respond to referrals outside of standard business hours (e.g. one business day response, weekend coverage). | Capitalise on the moment and ensure clients are not waiting to hear from The Way Back | • Brisbane North | • Brisbane North |
| Integrated approaches | A site may integrate TWBSS with an existing program. E.g. in one location, Hospital Outreach Post-Suicidal Engagement (HOPE) program. | Sites may have existing services that TWBSS should align to, to prevent duplication and improve client experience of integrated care. | • Mildura<br>• Dandenong | • Mildura<br>• Dandenong |
| Additional funding for clinical care | Some sites have secured additional funding for a clinical psychologist to service the clinical needs of TWBSS clients. | Participants are unable to access local psychological support services in a timely manner. Additional clinical support acts as an in-between whilst a client is waiting for connection with a psychologist outside of TWBSS. | • Brisbane North<br>• Darwin (discontinued until further notice) | • Brisbane North<br>• Darwin (discontinued until further notice) |
| TWBSS hospital liaison officer | Sites/PHNs may fund a role that assist in implementing TWBSS, including establishing and embedding referral pathways within a tertiary setting (e.g. HHS or LHN funded role). | Referral of appropriate clients to TWBSS who may be more likely to take up referral. | • Gold Coast<br>• Adelaide<br>• Canberra<br>• Central Eastern Sydney<br>• Darwin<br>• Mildura<br>• Brisbane North | • Gold Coast<br>• Adelaide<br>• Canberra<br>• Central Eastern Sydney<br>• Darwin<br>• Mildura<br>• Brisbane North |



[5] Based upon analysis of site context information (received in July 2020), interview with providers and Q4 2021 quarterly reports.

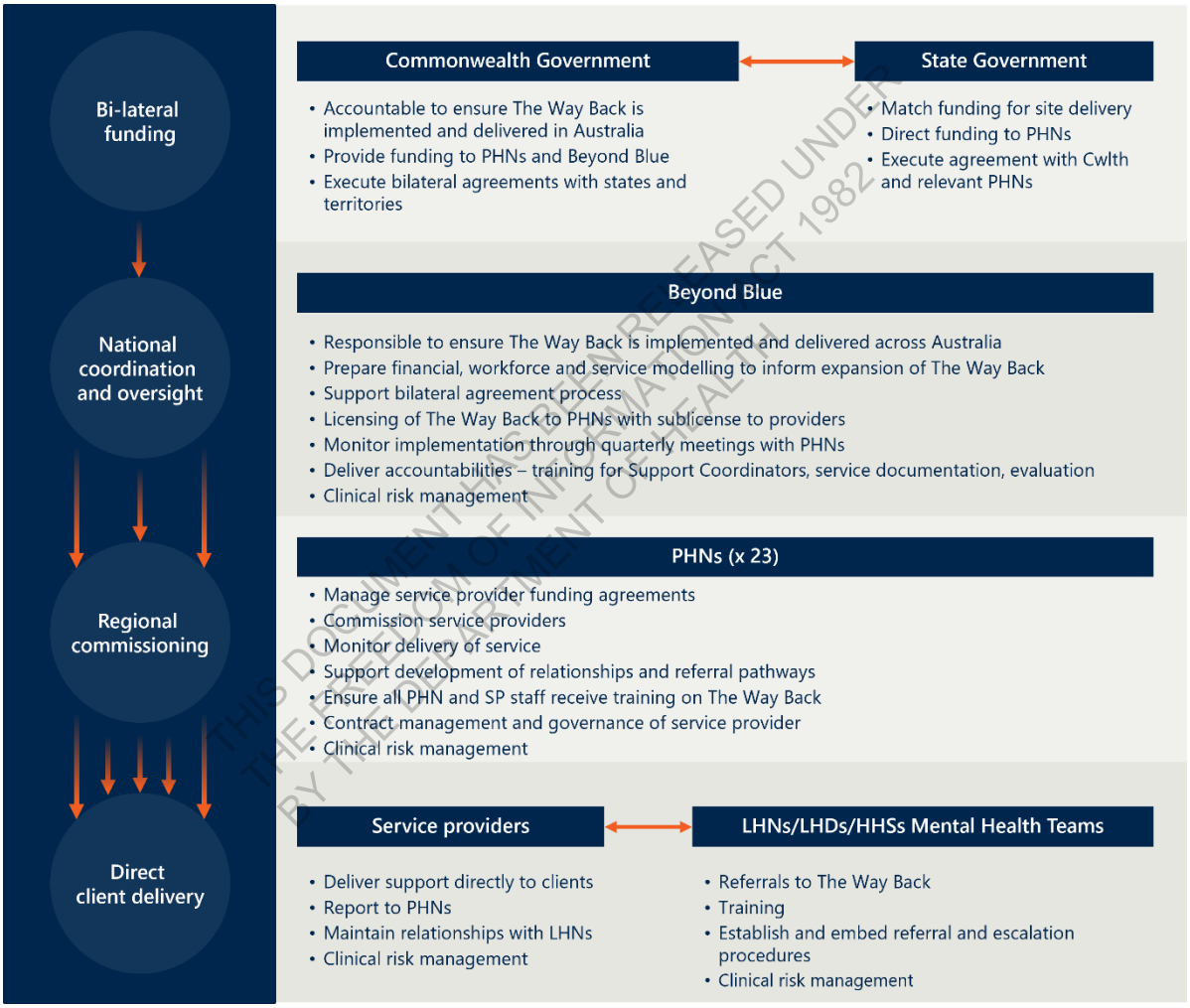
## E.1.3 Governance and partnerships

This sub-section describes enablers that support delivery of The Way Back. Appendix G provides site-specific insights as part of the deep dive site profiles. Strengths and challenges for each enabler is in Section 3.1.5. of the full report.

**Many organisations and governments are involved in governing The Way Back.**

The governance for The Way Back reflects the highly complex funding arrangements and complex policy and operational landscape for suicide aftercare services (see section 3.1.2). The roles of stakeholders in the commissioning and delivery of The Way Back are summarised in Figure 4.

**Figure 4 | The Way Back governance arrangements** [6]






**Clinical risk management will be reviewed in greater detail in the next phase of the evaluation**

Delivery of The Way Back must comply with The Way Back Clinical Governance Strategy. Services must have in place systems, mechanisms and processes that ensure compliance is recorded measured and monitored. The initial phase of the evaluation has not focussed specifically on clinical risk management as part of The Way Back's implementation or governance.

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

***Opportunities for improvement of The Way Back's clinical risk arrangements will be examined further in the next stage of the evaluation.***

**Strong networks with clinical and community services helps to deliver The Way Back.**

Providers are expected to develop partnerships with referring health services and psychosocial/community services. In consultations, providers reported that:

- Services that refer into The Way Back include hospitals and community based mental health staff, in line with the documented service model.
- The Way Back provides coordination for clients to a range of external supports to meet their needs, including to psychosocial supports. This can include psychologists, psychiatrists and a range of community services such as financial counselling, domestic and family violence and housing support.
- Providers engage with their local communities to better understand need. This can include attending local events and local service network meetings. Many providers noted they have limited partnerships with Aboriginal and Torres Strait Islander organisations, such as local ACCHOs.

"We have very good relationships with our LHD to support the stakeholder partnership. We had a foundational relationship to support this." The Way Back Service Provider, 2021



## E.1.4 Data collection

**Providers are required to capture a significant amount of demographic, activity and outcomes data.**

The Way Back data and analysis requirements are outlined in The Way Back Service Delivery Model and The Way Back Minimum Data Set and Dictionary.[7] providers primarily report data through the quarterly reports, which collect activity data, client profile data, service contact data and workforce capacity data, and through reporting into PMHC MDS.

The Way Back had an objective of a minimum of 20 sites with data uploaded into the PMHC MDS starting from at least 1 July 2021.[8] Twenty-one sites upload data into the PMHC MDS as at September 2021, with nine of these commencing uploads in 2021.[9, 10] In summary, the key types of data collected include:

- **Client demographic information,** including age, gender, sexuality, Aboriginal and Torres Strait Islander status, labour force status and more – noting some sites had more comprehensive data collection than others.
- **Completion status** for each episode (noting some exceptions), including whether treatment was concluded or if the episode was administratively closed.[11]
- **Outcome's data,** noting this is limited currently.

[7] Beyond Blue, ' The Way Back Support Service – Service Delivery Model', March 2020. And Australian Government, 'The Way Back Support Service Minimum Data Set and Dictionary', May 2020.
[8] September 2021 DMESC Meeting Minutes.
[9] September 2021 DMESC Meeting Minutes.
[10] PMHC MDS and TWB Extension extract contains data from 21 sites between January 2019 and August 2021. There are nine sites which commenced data collection in 2021: Sydney North, Sunshine Coast, Wide Bay, Central Queensland, Darwin, South West Sydney, Sydney North, Went West Sydney and Gosford/Wyong.
[11] It should be noted that neither the PMHC MDS and TWB extension provides an opportunity to determine the nature of a clients' exit from the service. That is, 'treatment concluded' does not necessarily mean a positive experience and clients who elect to leave the service before concluding their treatment does not necessarily mean a negative experience.

- **Eligibility criteria at referral.** A few sites had a high proportion of episodes with no eligibility criteria recorded or inadequately described, rather than the primary or secondary eligibility criteria.
- **Safety and support plans.** Many sites reported higher proportions of completed safety and support plans in the quarterly reports than in the PMHC MDS data extract for the same period.
- **Recommendations out.** Nine of 21 sites and 61 per cent of all episodes have no data recorded on which services The Way Back clients were referred to in the PMHC MDS.

## E.1.5 Funding

**Beyond Blue, 23 PHNs and governance agencies and health service staff deliver The Way Back.**

The program logic in Appendix D outlines the expected activities and outputs for The Way Back. This included the design, commissioning and delivery of the program at 31 sites. Progress against key outputs and activities is outlined below:

*Collaboration between Beyond Blue and governments*

As of September 2021, Beyond Blue has partnered with 23 PHNs and seven states and territory governments, together with the Australian Government Department of Health. Delays between the signing of bilateral agreements and led to delays in the commissioning and operationalisation of sites, discussed further in Section 3.1.5 of the full report.

*Funding*

The Way Back is jointly funded by the Australian government, state and territory governments, and Beyond Blue. As of September 2021, approximately $82.3 million of funding had been budgeted for the delivery of The Way Back. The funding arrangements are captured in Figure 11. Stakeholders including PHNs and providers consulted as part of the evaluation have reported that funding arrangements, particularly for PHNs, could be simplified.



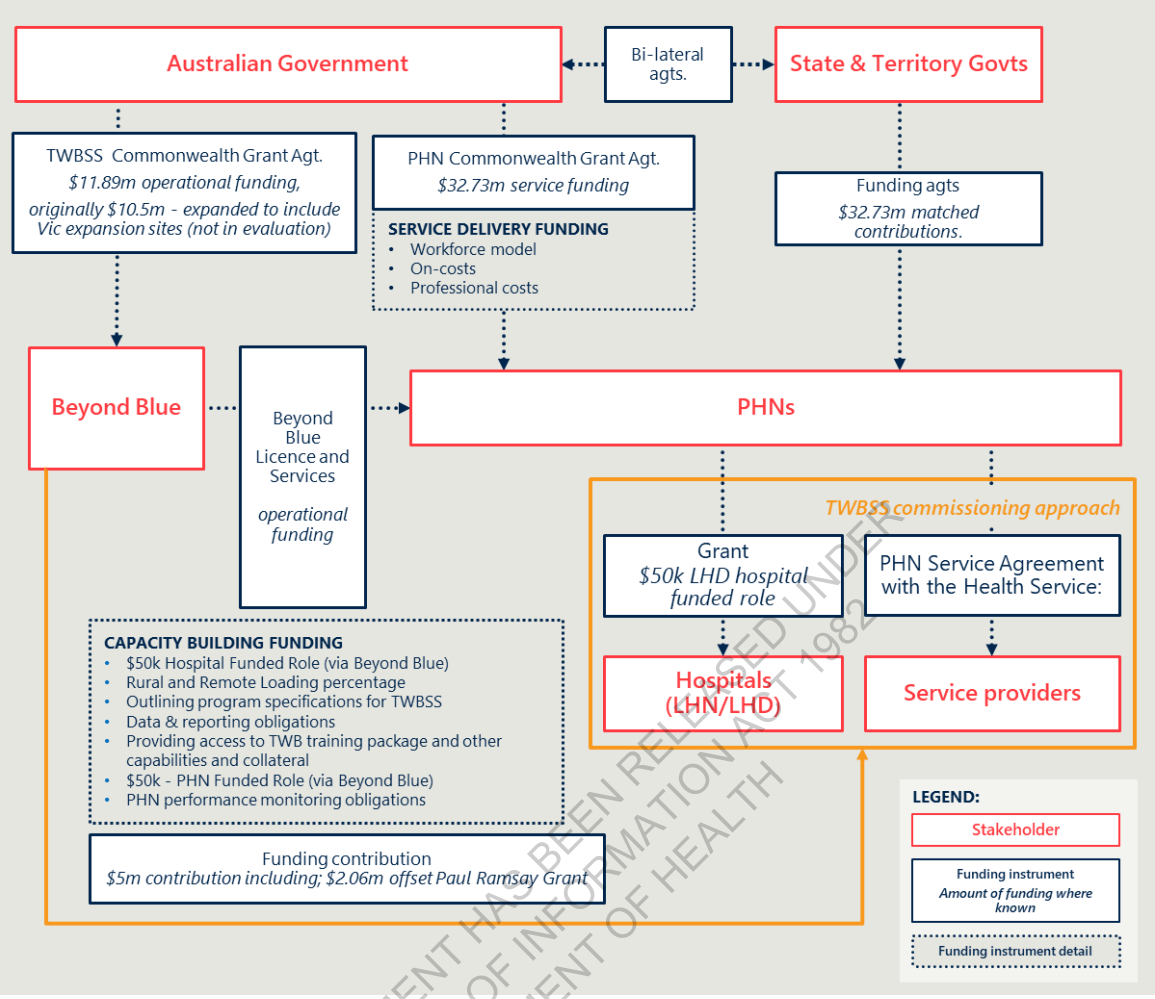
Funding includes:

- $32.73 million service funding and $11.89 million operational funding from 2018 to 2022 from the Australian Government. As at 30 September, Beyond Blue has spent $8 million of the $11.89 million on payments to PHNs including Modified Monash Model (MMM), staff costs, marketing and project management expenses including the evaluation. Nous does not yet have access to information on how much has been expended of the $32.73 million to date. We will continue to work with Beyond Blue and the Australian Health Department to include this in the final report.
- $32.73 million matched contributions from State and Territory Governments over the same period. Of this Nous does not yet have access to information on how much has been expended to date. We will continue to work with Beyond Blue and the Australian Health Department to include this in the final report.
- $5 million from Beyond Blue. Of this, $4 million has been spent by Beyond Blue on data enhancements (including a bespoke dataset add-on to the PMHC-MDS) and infrastructure to support service delivery, including The Way Back training package and online learning management portal. Beyond Blue are forecast to spend a further $1.7 million by the conclusion of 2021-22 (based on information provided by Beyond Blue in September 2021).

The funding arrangements that facilitate this include:

- The Australian Government and state / territory governments have entered into bi-lateral agreements which secures their matched funding contributions for The Way Back.
- Beyond Blue receives funding from the Commonwealth under The Way Back Grant Agreement to provide a range of national coordination and oversight functions (outlined above in Figure 4).
- Beyond Blue as the licenser of The Way Back enters into License and Service Agreements with PHNs who commission the service.
- Each PHN receives three separate funding streams for The Way Back:
    - **Australian government to PHN:** The PHN Commonwealth Grant agreement provides the Commonwealth's contribution of matched funding for suicide prevention directly to PHNs, representing $32.73 million of the Commonwealth's funding contribution to The Way Back. The funding is intended for service delivery.
    - **Australian government to PHN via Beyond Blue:** The Way Back Commonwealth Grant agreement provides funding from the Commonwealth to PHNs via Beyond Blue as the licenser (i.e. the funding from the grant agreement passes through the Beyond Blue License and Services Agreement with PHNs). This funding stream represents part of the Commonwealth's commitment of $11.89 million to Beyond Blue. The funding is intended for rural and remote loading and capacity building activities, including referral pathway establishment.
    - **State / territory government to PHN:** This funding stream represents the matched funding contribution of the relevant state/territory where that PHN operates. The funding is intended for service delivery.
- PHNs are the commissioner of The Way Back in their regions and hold service agreements with health providers (and in few cases, hospitals) in their regions to deliver The Way Back.

**Figure 5 | The Way Back funding model**






## E.1.6 Workforce

Nationally across 31 sites, 184 support coordinators and team leaders have registered for The Way Back training and a further 165 have commenced the Beyond Blue training. An additional 20 LHD/HHS representatives have registered for training and nine have commenced training. The implementation status of training is considered by The Way Back Data Management and Evaluation Sub Committee (DMESC) to be on-track and well progressed. The feedback on training provided has been overwhelmingly positive with more than 80% of respondents or more agreeing that the course was valuable and increased their confidence. Courses included: suicide-specific knowledge, interpersonal skills, The Way Back delivery techniques, trauma-informed principles and self-care.

*Workforce model and staffing profile*

the staffing profile used to design and commission sites across Australia is described in Table 1 below. This model underpins the funding and the FTE at each site (as outlined in Appendix E.1.2).

**Table 1 | Staffing profile by annual case target**

| Site category | Annual case target | Position | FTE |
|---|---|---|---|
| 1 | 220 | Team leader | 1 |
| | | Admin/data entry | 0.5 |
| | | Support coordinators | 2.6 |
| 2 | 280 | Team leader | 1 |
| | | Admin/data entry | 0.5 |
| | | Support coordinators | 3.4 |
| 3 | 350 | Team leader | 1 |
| | | Admin/data entry | 0.6 |
| | | Support coordinators | 4.3 |

### Key responsibilities of Team Leaders and Support coordinators.

The key responsibilities, qualifications and reporting lines of team leaders and support coordinators at each of The Way Back sites are summarised in Table 2.

**Table 2 | The Way Back workforce involved in delivery**[12]

| Element | Team leader | Support coordinator |
|---|---|---|
| Responsibilities | • Screening referrals for eligibility and appropriateness for the service (e.g. acuity/risks)<br>• Managing and supervising support coordinators.<br>• Advice and consultancy to support coordinators in supporting clients.<br>• Clinical and incident risk management.<br>• Compliance with clinical governance requirements.<br>• Directly provide practice advice and supervision to Support Coordinators (if a credentialed mental health clinician) or ensure Support Coordinators have comparable access to clinical/practice advice. | • Actioning all referrals.<br>• Confirming eligibility.<br>• Implementing service delivery tools for each client.<br>• Providing the assertive outreach support for all consenting clients.<br>• Making and/or advocating for referrals to community-based services on behalf of a client. |
| Reporting to | • Service Provider Management. | • Team Leader. |
| Minimum qualifications/ experience | • A credentialed mental health clinician (preferable) | • A non-clinical worker with relevant qualifications and/or expertise in supporting vulnerable people or at-risk cohorts |

[12] Beyond Blue, ' The Way Back Support Service – Service Delivery Model', March 2020.

*Workforce training*

Nationally across 31 sites, 184 support coordinators and team leaders have registered for The Way Back training and a further 165 have commenced the Beyond Blue training. An additional 20 LHD/HHS representatives have registered for training and nine have commenced training.[13] The implementation status of training is considered by The Way Back Data Management and Evaluation Sub Committee (DMESC) to be on-track and well progressed.[14]



[13] Training status accurate as of September 2021. Figures provided by Beyond Blue directly to the evaluation.
[14] September 2021 Data Management and Evaluation Sub Committee agenda and meeting minutes.

# Appendix F Cohorts accessing The Way Back across Australia

This appendix provides key prevalence statistics for the cohorts of interest described in Section 3.1.5 of the full report, including the prevalence of suicide deaths and self-harm hospitalisations, the proportion of clients in each cohort in The Way Back overall and whether this aligns to what we would expect.

**Table 3 | Cohorts accessing The Way Back across Australia**[15]

| Cohorts | Population proportion of suicide deaths for persons (2019-2020) [16] | Rate of intentional self-harm hospitalisations[17] | Proportion of clients in The Way Back (overall cohort)[18] | Trend/s observed in relation to impacts of suicide on cohort |
|---|---|---|---|---|
| **People who identify as female** | **6.3 per 100,000 population** | **141 per 100,000 population** | 58% | Overall, the proportion of The Way Back clients who are female is expected.<br>Based on analysis of the PMHC MDS and The Way Back extension, some sites have a higher proportion of female clients. These include:<br>• Newcastle (67%), Sydney North (64%), Adelaide (63%), Central Queensland (63%) |
| **People who identify as male** | **19.8 per 100,000 population** | **84 per 100,000 population** | 41% | Overall, proportion of The Way Back clients who are male is expected.<br>Based on analysis of the PMHC MDS and The Way Back extension, some sites have a higher proportion of male clients. These include:<br>• Gippsland (55%), Murrumbidgee (46%), Mildura (46%) |
| **People who live in regional or remote areas** | 10.9 per 100,000 population (Major cities)<br>**16.8 per 100,000 population (Inner Regional)**<br>**19.8 per 100,000 population (Outer Regional)**<br>**20.3 per 100,000 population (Remote)** | 101.6 per 100,000 population (Major cities)<br>**119.2 per 100,000 population (Inner Regional)**<br>**145.7 per 100,000 population (Outer Regional**<br>**188.7 per 100,000 population (Remote)** | 60% in major cities<br>**36% in regional or remote areas**<br>4% in unknown | The proportion of clients in regional or remote areas is lower than in major cities, which is inverse to the population proportion of suicide deaths and intentional self-harm hospitalisation. However, this is likely more reflective of service capacity in each area. |



[15] Results for sites where n<5 have been excluded to ensure confidentiality.
[16] AIHW, Deaths by suicide over time, 2021. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time (unless otherwise referenced)
[17] AIHW, Intentional self-harm hospitalisations, 2021. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations/intentional-self-harm-hospitalisations-by-age-sex (unless otherwise referenced)
[18] Based on data analysis from PMHC-MDS and The Way Back extension covering a period of January 2019 to August 2021 for 21 sites.

| Cohorts | Population proportion of suicide deaths for persons (2019-2020) [16] | Rate of intentional self-harm hospitalisations[17] | Proportion of clients in The Way Back (overall cohort)[18] | Trend/s observed in relation to impacts of suicide on cohort |
|---|---|---|---|---|
| | **29.4 per 100,000 population (very remote areas)** | **197.7 per 100,000 population (very remote areas)** | | |
| **People who have made a previous suicide attempt** | **Data unavailable** | **Data unavailable** | 37%[19] | Given the literature on suicide attempt as a significant predictor for future suicide attempts, a high proportion of previous attempts among The Way Back clients is expected. |
| **People aged under 25** | 16.1 per 100,000 population aged 18-24[20]<br>**8.9 per 100,000 population aged 15-17** | 354 per 100,000 population aged 15-19[21]<br>**252 per 100,000 population aged 20-24** | 30% | Some sites are accepting referrals for children aged from 13 years old. |
| **People aged over 65** | 10.7 per 100,000 population (65-69)[22]<br>11.0 per 100,000 population (70-74)<br>12.9 per 100,000 population (75-79)<br>13.1 per 100,000 population (80-84)<br>**17.9 per 100,000 population (85+)** | 40.7 per 100,000 population (65-69)[23]<br>32.4 per 100,000 population (70-74)<br>34.3 per 100,000 population (75-79)<br>43.5 per 100,000 population (80-84)<br>**44.6 per 100,000 population (85+)** | 4% | The overall proportion of clients aged over 65 is lower than expected. |
| **People who have a lower socio-economic background** | **18.3 per 100,000 population (most disadvantaged)[24]** | **135.4 per 100,000 population (most disadvantaged)[25]** | 24% clients unemployed<br>22% not in the labour force | Labour force status and homelessness can be used as a proxy for socio-economic background or disadvantage, noting this is not directly comparable. |



[19] Note: For 43 per cent of clients this information is unknown.
[20] AIHW, Deaths by suicide among young people, 2021. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-among-young-people
[21] AIHW, Intentional self-harm hospitalisations among young people, 2021. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/intentional-self-harm-hospitalisations-among-young
[22] AIHW 2019 National Mortality Database – Suicide.
[23] AIHW 2019 National Mortality Database – Intentional self-harm hospitalisations.
[24] AIHW, International self-harm hospitalisations by socioeconomic areas, 2021.
[25] AIHW identifies this population group as a priority population for suicide prevention in Australia.

| Cohorts | Population proportion of suicide deaths for persons (2019-2020) [16] | Rate of intentional self-harm hospitalisations[17] | Proportion of clients in The Way Back (overall cohort)[18] | Trend/s observed in relation to impacts of suicide on cohort |
|---|---|---|---|---|
| | | | 5% clients experiencing homelessness | |
| People who identify as Aboriginal and/or Torres Strait Islander | 27.1 per 100,000 population[26] | 348 per 100,000 population[27]<br>348 per 100,000 population | 9% | Overall, the number of Aboriginal and/or Torres Strait Islander people accessing the service is less than expected given the high rates of suicide deaths and intentional self-harm hospitalisation rates.<br>There are a number of sites with lower than population-level proportions of Aboriginal and/or Torres Strait Islander clients. These sites include:<br>• CESPHN (4%), Gold Coast (4%), Canberra (5%), Brisbane North (5%), Great South Coast (6%), Adelaide (7%), Brisbane South (7%), Sydney North (8%), South West Sydney (8%), Darling Downs (8%) and Newcastle (8%).[28]<br>However, some client populations roughly align to what is expected:<br>• Darwin (39%), Murrumbidgee (20%) and Central Queensland (18%). |
| LGBTIQ+ people[29] | Data unavailable | Data unavailable | 5%[30] | The evaluation interviewed a high proportion of LGBTIQ+ people.<br>Most deep dive site providers noted they often worked a higher proportion of LGBTIQ+ people. |
| Veterans | 28 per 100,000 population for ex-serving males[31]<br>16 per 100,000 population for ex-servicing females | Data unavailable | <1% | Population is underrepresented across The Way Back given suicide rate for ex-serving males and females is higher than the Australian population. |
| People who experience alcohol and/or other drug issues | Data unavailable | Data unavailable | 9% | The proportion of clients who experience alcohol and/or other drug issues is expected.<br>People who report higher levels of psychological distress were more likely to report recent illicit drug use, higher than average alcohol consumption and daily smoking |



[26] AIHW, Suicide & Indigenous Australians. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians
[27] AIHW, Suicide & Indigenous Australians. Available from: www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians
[28] It should be noted that while the proportion of total clients may align to the national average, there is a low number of Aboriginal and/or Torres Strait Islander clients (n = 12 on average) across most sites. Five sites have been excluded due to n<5.
[29] AIHW identifies this population group as a priority population for suicide prevention in Australia.
[30] Note: 41 per cent of clients did not state a sexual orientation.
[31] AIHW, National suicide monitoring of serving and ex-serving Australian Defence Force personnel: 2020 update, 2020.

| Cohorts | Population proportion of suicide deaths for persons (2019-2020) [16] | Rate of intentional self-harm hospitalisations[17] | Proportion of clients in The Way Back (overall cohort)[18] | Trend/s observed in relation to impacts of suicide on cohort |
|---|---|---|---|---|
| | | | | than those who reported low psychological distress.[32] There is also evidence that alcohol and other drug use increases risk of suicidal ideation and behaviours.[33] |
| **People who experience personality disorders** | **Data unavailable** | **Data unavailable** | 9% | The evaluation interviewed a high proportion of people with BPD. BPD is estimated to affect between 2-6% of Australians and be more common in women.<br>Most deep dive site providers reflected that they have begun to work with a higher proportion of people diagnosed with BPD.[34] |



[32] AIHW 2020 National Drug Strategy Household Survey 2019.
[33] Fisher, A., Morel, C., Morley, K., Teesson, M. and Mills, K., (2020). "The role of alcohol and other drugs in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours". Evidence check prepared for the National Suicide Prevention Task Force and commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia.
[34] National Education Alliance for Borderline Personality Disorder, About BPD, 2021. Available from: https://www.bpdaustralia.org/about-bpd/.

# Appendix G Deep dive site profiles

This appendix provides an overview of the deep dive sites. The intention of these is to articulate how The Way Back is delivered in each location and within what context it operates. Each deep dive site profile contains:

- a summary of the policy, operating and community context
- the quantitative journey of clients at the service (referrals, entries, supports, exits and recommendations)
- performance against KPIs
- service delivery insights
- implementation insights
- client demographics for the site
- site specific program logics.

To develop the profiles, Nous drew on several data sources, including:

- PMHC MDS and TWB extension data
- Q4 20/21 quarterly reports
- interview notes from deep dive sites (clients, staff, PHNs and LHDs)
- PHN funding proposals for The Way Back

It is important to note that there are some discrepancies between the numbers reported in the Q4 20/21 quarterly reports and those in the PMHC MDS extract (e.g. support and safety plans in Brisbane North). The drivers of these discrepancies are unknown but likely due to issues with data collection.

The remaining pages of this appendix work through the site profiles of the eight deep dive sites.

# Brisbane North

The Richmond Fellowship Queensland

**Opened: June 2018**

**Brisbane North's service networks and hospital integration supported effective implementation, but availability of local services remains a challenge**

## Policy Context

The Primary Health Network and Metro North Hospital and Health Service (MNHHS) have sponsored development of a 5-year Regional Plan in partnership with other healthcare providers and practitioners, and people with lived experience. A key focus area is suicide prevention, whose approach is integrated with that of both Queensland Health and the Queensland Mental Health Commission.

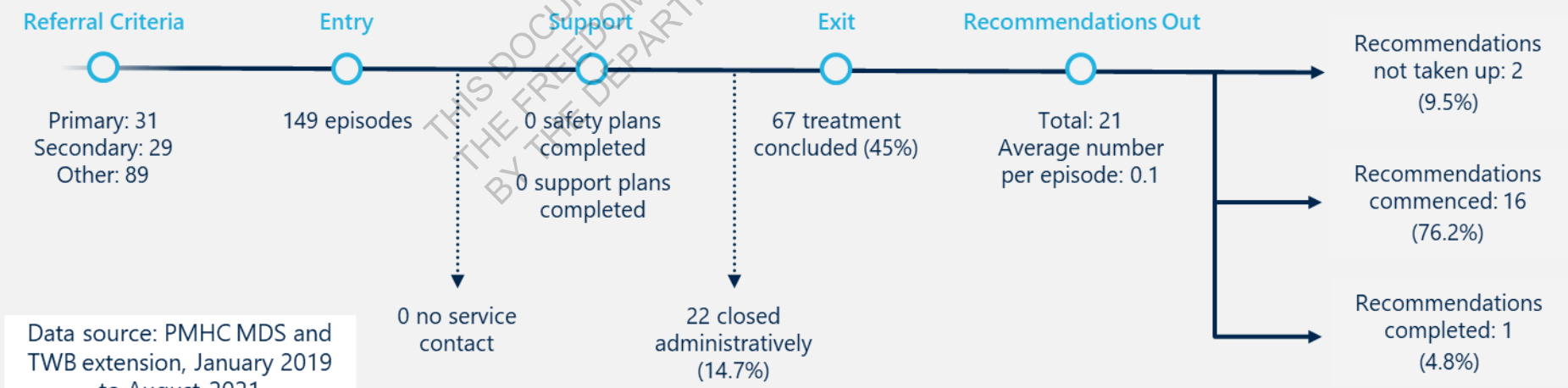
## Operating Context

The close but informal relationship with the health and hospital service has allowed The Way Back to access secondary consultations and advice to help streamline referrals to clinical psychiatric services within the hospital. The length of time The Way Back has been operating in Brisbane North has likely contributed to a perceived smooth referral processes both in and out of the program.

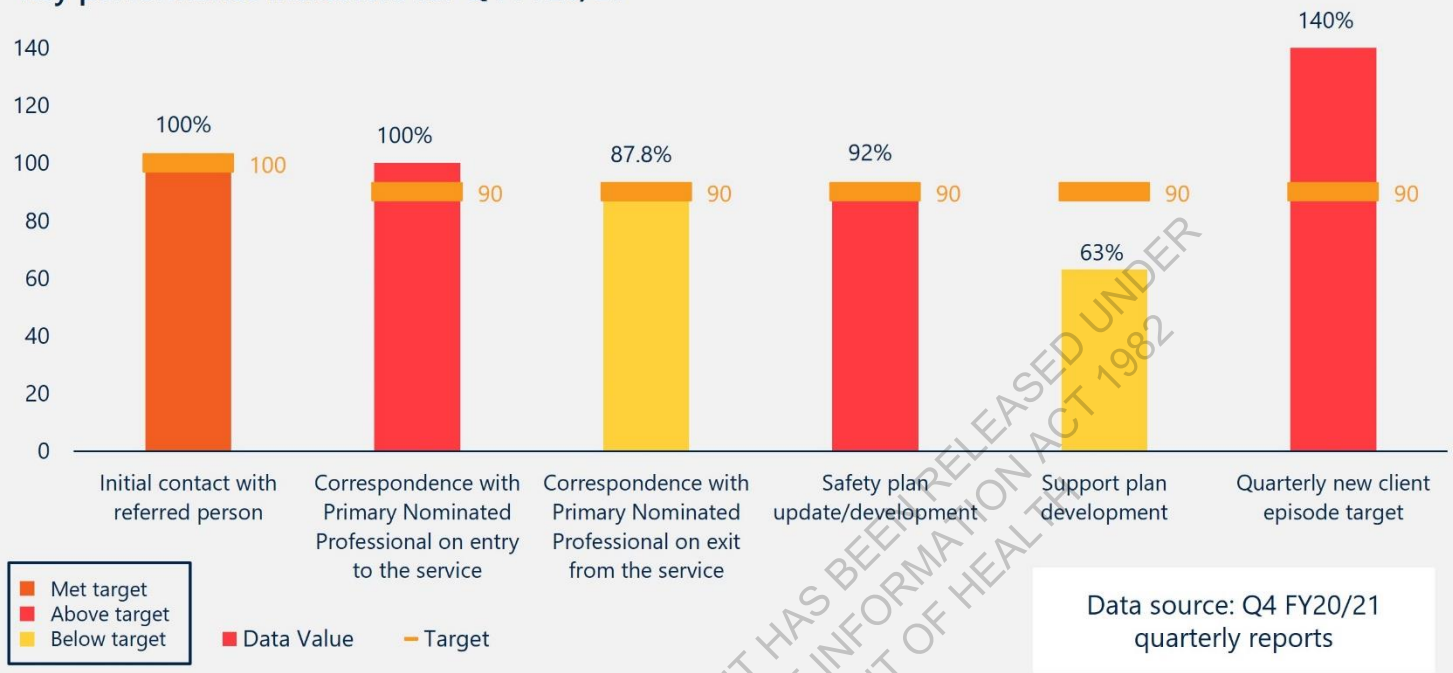
## Community Context

Brisbane North includes the geographically restricted area of the Redcliffe Peninsula, which has a lack of access to Medicare-supported psychology services. Young people are the most common client cohort in the service and there are increasing numbers of clients who identify as Aboriginal and/or Torres Strait Islander or as LGBTI+.





## Key performance indicators for Q4 FY20/21




Data source: Q4 FY20/21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- Meeting or exceeding most KPIs, but with relatively low levels of support plans for clients have been recorded in the Q4 2020-21 quarterly report.
- Brisbane North appear to have a high number of new clients, exceeding their KPI in Q4 2020-21.
- Clients valued workers who listened, were authentic and didn't just give advice but also invited self-reflection. It was important that the service was delivered in a non-clinical and informal nature.
- Having a central point of contact within the health and hospital service for questions helps to engage clinicians and engage appropriate referrals to The Way Back.

### Implementation

- Staff have reported that many clients, particularly repeat clients, have a diagnosis or visible traits of BPD or other personality disorders.
- Staff report the need for more training on how to work with clients who have BPD or other personality disorders.
- It is difficult to match workers to a client based on how they present on paper as their personalities may not fit. For example, vulnerable females may not want a male support worker, or a client with a history of violence may make it difficult for some workers to support them.

## Clients of the service/site since January 2019

**Gender**
33% Male
47% Female

**Country of Birth**
69% Australia
31% Unknown

**Sexuality**
38% Straight or heterosexual
3% Lesbian, gay or homosexual
1% Bisexual or pansexual
62% Not stated

**Aboriginal and Torres Strait Islander Status**
50% Neither
5% Aboriginal but not Torres Strait Islander
45% Not stated/ inadequately described

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE PROGRAM LOGIC – BRISBANE NORTH

## INPUTS

**Funding**

$805,687 service funding and $276,735 operational funding received via PHN during the period from 1 July 2020 to 30 June 2021.

$154,983 allocated funding for the brief intervention counselling role.

**Organisations**

Referring hospitals **Redcliffe Hospital, Caboolture Hospital**

**Brisbane North PHN**

**Metro North Mental Health Service**

**Richmond Fellowship Queensland**

**Human resources**

1 FTE Team leader

4 FTE Support coordinators

1 FTE Brief intervention counsellor

0.5 FTE Bilateral hospital care officer

**Governance**

Beyond Blue project staff

**Brisbane North PHN**

**Richmond Fellowship Queensland's** own governance processes

Governance committees

**Implementation resources**

Core service model, procurement and implementation guide

License Agreement with PHNs, which specifies agreed requirements

Guidance documents e.g. training package and communication strategy

Monitoring and evaluation support from Beyond Blue

PMHC data set, MHC extension and supplementary data

## SERVICE IMPLEMENTATION (ACTIVITIES)

**Beyond Blue**

Design The Way Back service and implementation model

Broker partnerships between PHNs, state governments and the Australian Department of Health

Administer funding for The Way Back implementation and operations

Support implementation and delivery activities with practice knowledge, communities of practice, administration and advisory support, monitoring, evaluation, reporting assistance and governance, **use of Beyond Blue portal**

Monitor and report on progress of **The Way Back at Redcliffe/Caboolture**

**Brisbane North PHN**

Commission **Richmond Fellowship Queensland** and monitor service performance

Assist with the integration of clinical and community mental health services through the development of referral and escalation pathways in the local area

Support implementation and delivery activities **through identification of relevant community providers and funded PHN support services**

Support relationship development to enable The Way Back service operation

**Referring hospitals**

Train **HHS** staff in working with The Way Back

Establish and use referral pathways

Establish and use data and reporting process

**Richmond Fellowship Queensland**

Recruit and train The Way Back staff with required knowledge, skills and confidence to support clients

Establish and use formal partnerships with **referring hospitals** and providers to enable service delivery

Provide education/promotion sessions for **referring hospitals** and providers to build understanding and willingness to refer

Establish and use processes for referrals, consultation and escalation

Establish and use data protocols to monitor service referrals and use, and client outcomes

**Community providers**

Establish referral pathways with The Way Back

## SERVICE DELIVERY (OUTPUTS)

**Referring hospitals**

Conduct mental health assessment

Assess eligibility for The Way Back

Obtain client consent and refer to The Way Back

**Richmond Fellowship Queensland**

Confirm client eligibility

Contact client **within 24 hours (including weekends)**; obtain client consent

Develop Safety and Support Plan

Administer client assessment and outcome measurement tools

Ensure immediate medical and psychosocial needs met; **including referral to brief intervention counselling**

Identify goals for recovery

Provide assertive **and flexible** outreach and psychosocial support that is trauma-informed, culturally safe and appropriate to clients' individual needs

Refer clients to external providers

Complete service exits/closure

Follow up with any un-planned exits

**Community providers**

Receive referrals from Richmond Fellowship Queensland

Support clients

## SERVICE OUTCOMES

### CLIENT

**RECOVERY**

Emotional state

Increased feelings of hope, purpose and belonging

Decreased feelings of psychological distress

Emotional wellbeing and resilience

Improved emotional wellbeing

Greater knowledge of triggers/risk factors and ability to manage them

Greater capacity to manage psychological distress (distress tolerance)

Increased sense of personal agency (or control)

Protective factors

Feeling empowered as a partner in recovery

Greater understanding of mental health (mental health literacy)

Increased confidence to reach out for help as needed

Increased engagement with interests/hobbies

Greater knowledge of where and how to access support (e.g. activate their Safety Plan)

Engagement with The Way Back (frequency, continuity)

Engagement with clinical mental health services (frequency, continuity)

Engagement with peer services

Engagement with other services as needed

Increased levels of (perceived) social and familial connectedness

**REDUCED SUICIDALITY**

Emotional state

Reduced levels of suicidal ideation and intent (rate, severity, duration)

Reduced self-stigma around suicidality

Emotional wellbeing and resilience

Ability to comprehend (e.g. make sense of) the drivers of suicidality

Protective factors

Increased willingness and capacity to communicate when experiencing suicidality

Behaviour

Total amount of suicidal communication (rate, duration)

Avoidance of suicide (re)attempt

### FAMILIES AND COMMUNITIES

Improved knowledge of how to respond to someone living with suicidality

Improved linkages between those with lived experiences

### SYSTEM

Improved evidence base about what works in suicide prevention and how to implement it

Improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis

Improved integration and sustainability of mental health services across tertiary and community care settings

## SERVICE GOALS

## VISION

REDUCED RATES OF SUICIDE ATTEMPT AND DEATH IN AUSTRALIA

# Canberra

Woden Community Service

**Opened: October 2016**

**Canberra is advanced in implementation, but is stretching to meet high and complex demand for The Way Back.**

## Policy Context

Affordable clinical care was perceived by the service provider to be a gap in ACT policy. Service providers noted that addressing this at a policy level will be a major enabler or barrier to client recovery.

## Operating Context

Referrals to clinical care often have long wait times, with the waiting lists for public sessions with a clinician around 8 weeks. This can impact The Way Back's ability to meet the immediate mental health needs of their clients, and therefore their potential for a successful recovery.

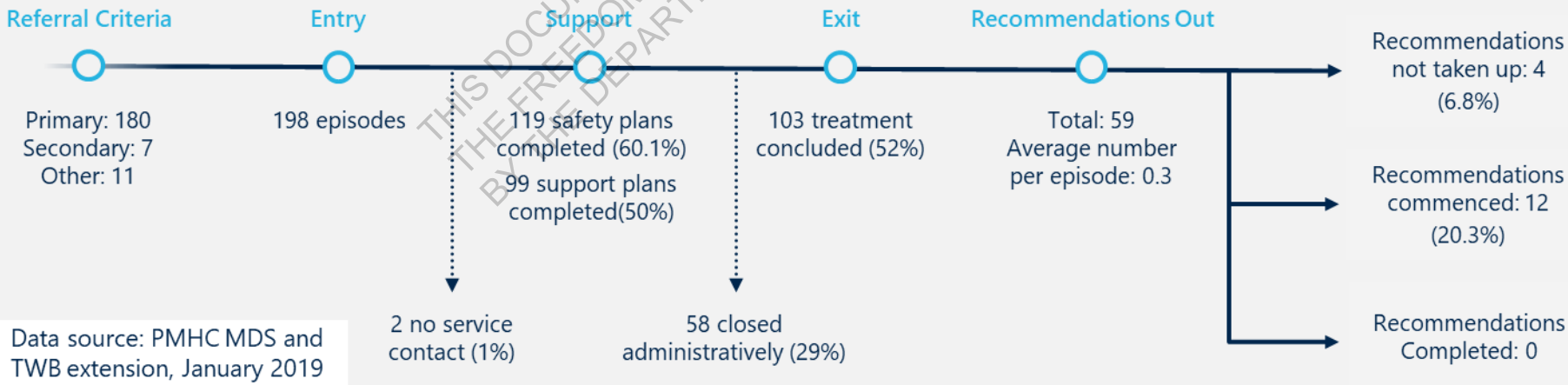
Clients are often already linked to some mental health services, so The Way Back is usually just one of the supports they receive.

## Community Context

Clients often have mental health needs that intersect with other immediate needs such as housing or breakdowns in familiar relationships.

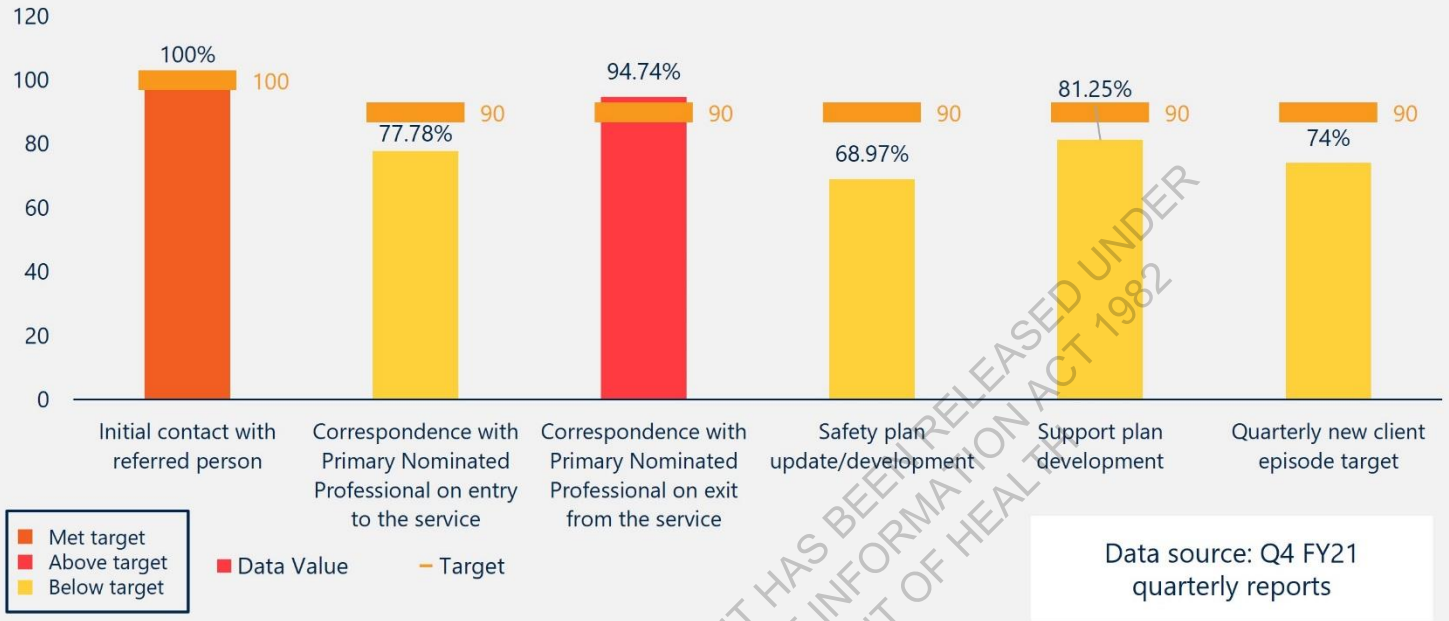
Often clients are unable to afford or choose not to have a private psychologist or psychiatrist.






Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## Key performance indicators for Q4 FY20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- Currently, the service is only open for those meeting the primary criteria of suicide attempts, despite wanting to open it up to secondary criteria, meaning they are limited in their ability to support such people.
- The areas for greatest improvements against KPIs for Canberra are the development of safety plans and quarterly new client episode targets.
- The Way Back provider notes that proactive engagement is needed by them to engage clients who are still under clinical care in the hospital as it helps them build confidence upon exit.

### Implementation

- Client and worker compatibility is important and while it may not always work, it often leads to clients dropping out of the service.
- Clients found it helpful to be engaged in parallel clinical care which can be mutually reinforcing.
- There was a perception that there may be value in allowing some clients to stay beyond the 12-week period to help those who need more support and tailor it to individual needs.

## Clients of the service/site since January 2019

**Gender**
40% Male
60% Female

**Country of Birth**
49% Australia
51% Unknown/not reported

**Sexuality**
33% Straight or heterosexual
4% Lesbian, gay or homosexual
63% Not stated

**Aboriginal and Torres Strait Islander Status**
31% Neither
5% Aboriginal but not Torres Strait Islander
64% Not stated/ inadequately described

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE (TWBSS) PROGRAM LOGIC – CANBERRA

# Gold Coast

Wesley Mission Queensland

**Opened: July 2020**

**Gold Coast is a new site The Way Back site, but built on experience of similar service prior to The Way Back and experiencing high demand for their services.**

## Policy Context

The Gold Coast Primary Health Network (GCPHN) aims to lead planning, commissioning and integration of services at a regional level to improve the outcomes of those at risk of mental illness and/or suicide.

## Operating Context

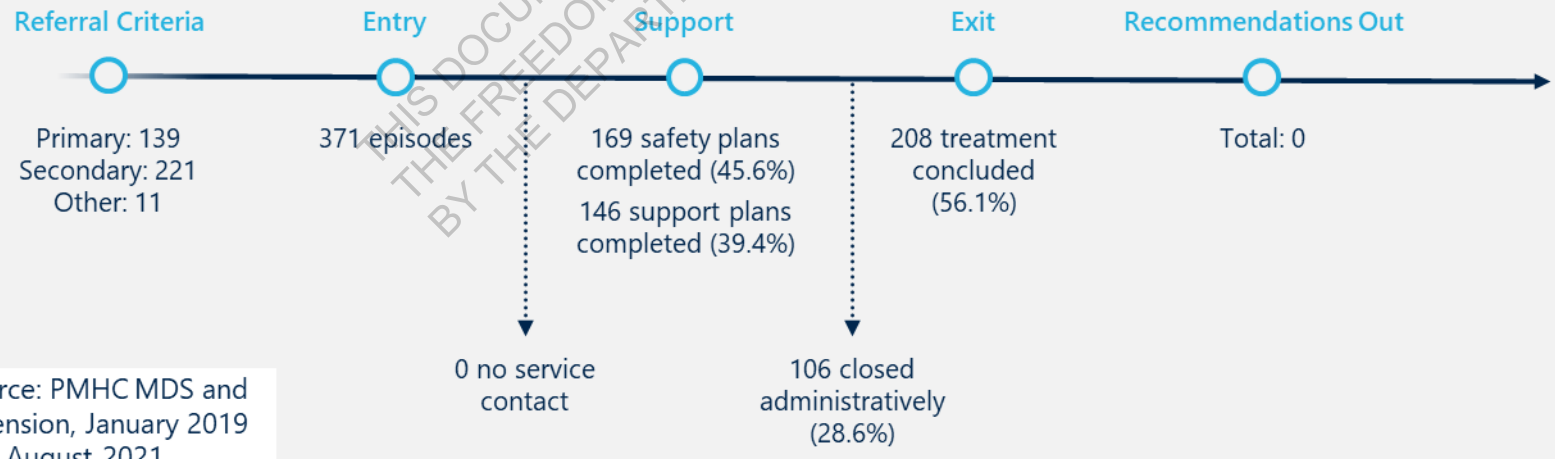
The Way Back is run concurrently with the Lotus Suicide Prevention (4-week psychosocial program). This is now run within the northern corridor of the Gold Coast region through GPs and The Way Back is run out of the ED/CMH.

GCPHN and Gold Coast Hospital and Health Service (GCHHS) have a robust relationship built through their hope for a single integrated care system. Their joint boards form the Integrated Care Alliance.

## Community Context

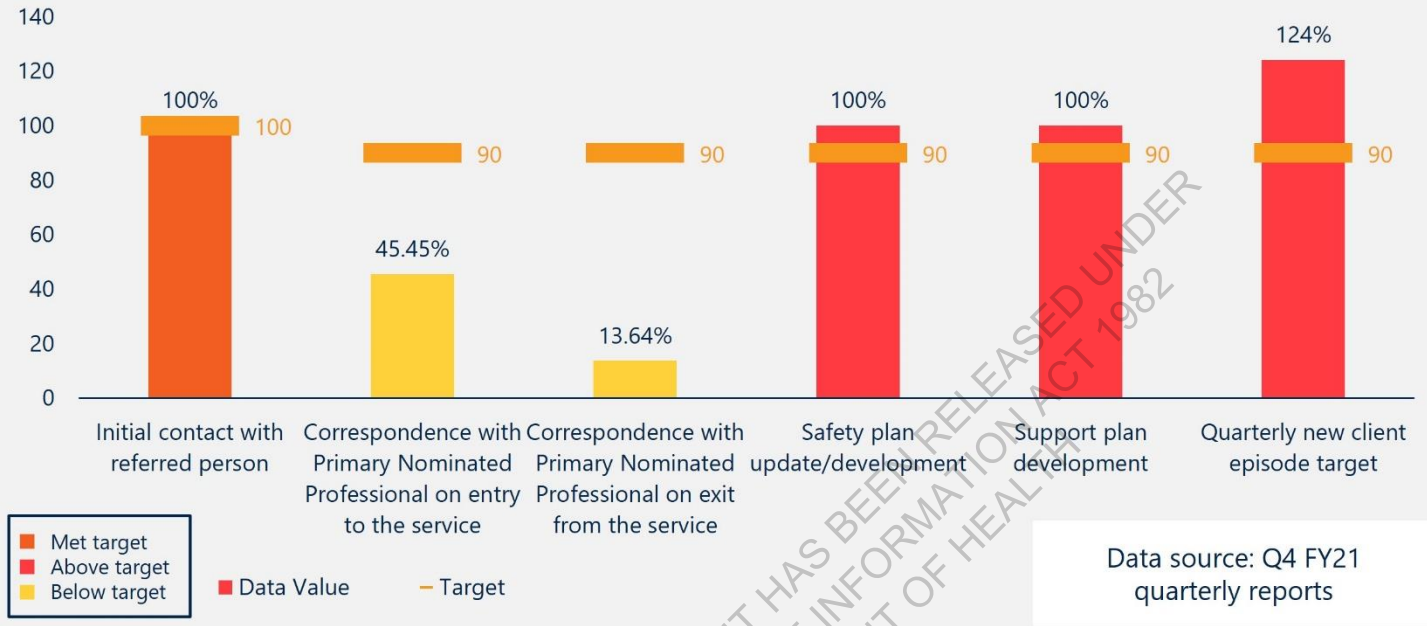
Homelessness, housing and alcohol and other drug issues are a significant issues on the Gold Coast.

The availability of services for people impacted by domestic and family violence and sexual violence is limited. Affordable psychology services within the community are also limited.




Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## Key performance indicators for Q4 FY20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- While meeting or exceeding most KPIs, the Gold Coast appears to be well below their KPIs for correspondence with Primary Nominated Professional on entry and exit to the service. This warrants further investigation to understand if it is a data anomaly.
- The service provider stated they feel it is important to have minimal note taking during sessions or with permission from the client to support a more informal setting and enable greater connection between people.
- The service is designed for 12 weeks but it maintains a flexible open-door policy for clients who reach out.
- Sites operating at capacity with clients sitting on waitlists.

### Implementation

- There may be a need to further clarify the boundaries set between clients and support coordinators at program completion as some clients felt uncertain as to whether it would be appropriate to reach out again if needed.
- The demographic data entered into the PMHC MDS and TWB extension appears to be incomplete for Gold Coast.
- The Gold Coast has strong partnerships with the local health districts, including data sharing arrangements so The Way Back workers can view case notes.
- Advanced implementation appears to correlate with high levels of safety plans, support pans and new client episodes. (well above KPI targets)

### Clients of the service/site since January 2019

**Gender**
40% Male
39% Female

**Country of Birth**
91% Australia
7% New Zealand

**Sexuality**
64% Straight or heterosexual
6% Lesbian, gay or homosexual
31% Not stated

**Aboriginal and Torres Strait Islander Status**
78% Neither
4% Aboriginal but not Torres Strait Islander
19% Not stated/ inadequately described

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE PROGRAM LOGIC – GOLD COAST

## INPUTS

**Funding**

$x service funding and $x operational funding from 2018 from the Australian Government

$x matched contributions from State and Territory Governments

$150,000 from Beyond Blue from 1 May 2020 to 2021 for PHN and HHS funded roles

**$ from QLD Health for Program Liaison Officer**

**Organisations**

**Gold Coast Hospital**

**Gold Coast (GC) PHN**

Hospital Health Service (HHS)

**Wesley Mission Queensland**

**Human resources**

1 FTE The Way Back Team leaders

5 FTE The Way Back Support coordinators (SC)

0.8 FTE Administration Officer

**Governance**

Beyond Blue project staff

**Gold Coast PHN**

**Wesley Mission Queensland**'s own governance processes

Governance committees

**Implementation resources**

Core service model, procurement and implementation guide

License Agreement with PHNs, which specifies agreed requirements

Guidance documents e.g. training package and communication strategy

Monitoring and evaluation support from Beyond Blue

PMHC data set, MHC extension and supplementary data

**Access to Consumer Integrated Mental Health Application (CIMHA) database**

## SERVICE IMPLEMENTATION (ACTIVITIES)

**Beyond Blue**

Design The Way Back service and implementation model

Broker partnerships between PHNs, state governments and the Australian Department of Health

Administer funding for The Way Back implementation and operations

Support implementation and delivery activities with practice knowledge, communities of practice, administration and advisory support, monitoring, evaluation, reporting assistance and governance, **use of Beyond Blue portal**

Monitor and report on progress of **The Way Back at Gold Coast**

**GC PHN**

Commission service providers and monitor service performance

Assist with the integration of clinical and community mental health services through the development of referral and escalation pathways in the local area

Support implementation and delivery activities **through identification of relevant community providers and funded PHN support services**

Support relationship development to enable The Way Back service operation

**ED/MHT/CMHS**

Train HHS staff in working with The Way Back

Establish and use referral pathway to The Way Back

Establish and use data and reporting process

**Wesley Mission Queensland**

Recruit and train The Way Back staff with required knowledge, skills and confidence to support clients

Provide clinical supervision of staff, **including team self-reflection**

Establish and use formal/informal partnerships with ED/CMHS and providers to enable service delivery

Provide education/promotion sessions, **in partnership with hospital liaison officer** for ED/CHMS and providers to build understanding and willingness to refer to The Way Back

Establish and use processes for referrals, consultation and escalation, **including use of CIMHA database for information sharing, allocation matching SC characteristics**

Establish and use data protocols to monitor service referrals and use, and client outcomes

**Community providers**

Establish referral pathways with The Way Back

## SERVICE DELIVERY (OUTPUTS)

**ED/MHT/CMHS**

Conduct mental state assessment

Assess eligibility for The Way Back

Obtain client consent and refer to The Way Back

**Wesley Mission Queensland**

Confirm client eligibility

Contact client within **1 business day**, obtain client consent

Develop Safety and Support Plan

Administer client assessment and outcome measurement tools

Ensure immediate medical and psychosocial needs met

Identify goals for recovery

Provide assertive **and flexible** outreach and psychosocial support that is trauma-informed, culturally safe and appropriate to clients' individual needs

Refer clients **and carers** to external providers

Complete service exits/closure

Follow up with any un-planned exits

**Community providers**

Receive referrals from The Way Back

Support clients

## SERVICE OUTCOMES

### CLIENT

**RECOVERY**

Emotional state

Increased feelings of hope, purpose and belonging

Decreased feelings of psychological distress

Emotional wellbeing and resilience

Improved emotional wellbeing

Greater knowledge of triggers/risk factors and ability to manage them

Greater capacity to manage psychological distress (distress tolerance)

Increased sense of personal agency (or control)

Protective factors

Feeling empowered as a partner in recovery

Greater understanding of mental health (mental health literacy)

Increased confidence to reach out for help as needed

Increased engagement with interests/hobbies

Greater knowledge of where and how to access support (e.g. activate their Safety Plan)

Engagement with The Way Back (frequency, continuity)

Engagement with clinical mental health services (frequency, continuity)

Engagement with peer services

Engagement with other services as needed

Increased levels of (perceived) social and familial connectedness

**REDUCED SUICIDALITY**

Emotional state

Reduced levels of suicidal ideation and intent (rate, severity, duration)

Reduced self-stigma around suicidality

Emotional wellbeing and resilience

Ability to comprehend (e.g. make sense of) the drivers of suicidality

Protective factors

Increased willingness and capacity to communicate when experiencing suicidality

Behaviour

Total amount of suicidal communication (rate, duration)

Avoidance of suicide (re)attempt

### FAMILIES AND COMMUNITIES

Improved knowledge of how to respond to someone living with suicidality

Improved linkages between those with lived experiences

### SYSTEM

Improved evidence base about what works in suicide prevention and how to implement it

Improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis

Improved integration and sustainability of mental health services across tertiary and community care settings

## SERVICE GOALS

## VISION

REDUCED RATES OF SUICIDE ATTEMPT AND DEATH IN AUSTRALIA

# Darwin

Team Health

**Opened: 2014-15**

**While an old site, Darwin has a new provider and is challenged by a nascent relationship with the referring hospital and a transient client and professional population**

## Policy Context

The lack of affordable clinical care in parallel to The Way Back is a major barrier to client recovery and should be considered in broader policy context to address.

There is the NT Recovery Assistance Fund which is available for moderate to severe mental illness with support for up to a year or longer. There are also a variety of NDIS supports, but nothing specifically for suicide like The Way Back.

## Operating Context

Darwin has had two iterations of The Way Back since 2014. The current iteration is part of the national rollout and for the first time being implemented through the PHN with commonwealth and state funding.

They have an integrated model with Team Health where they deliver multiple service offerings, of which The Way Back is one.

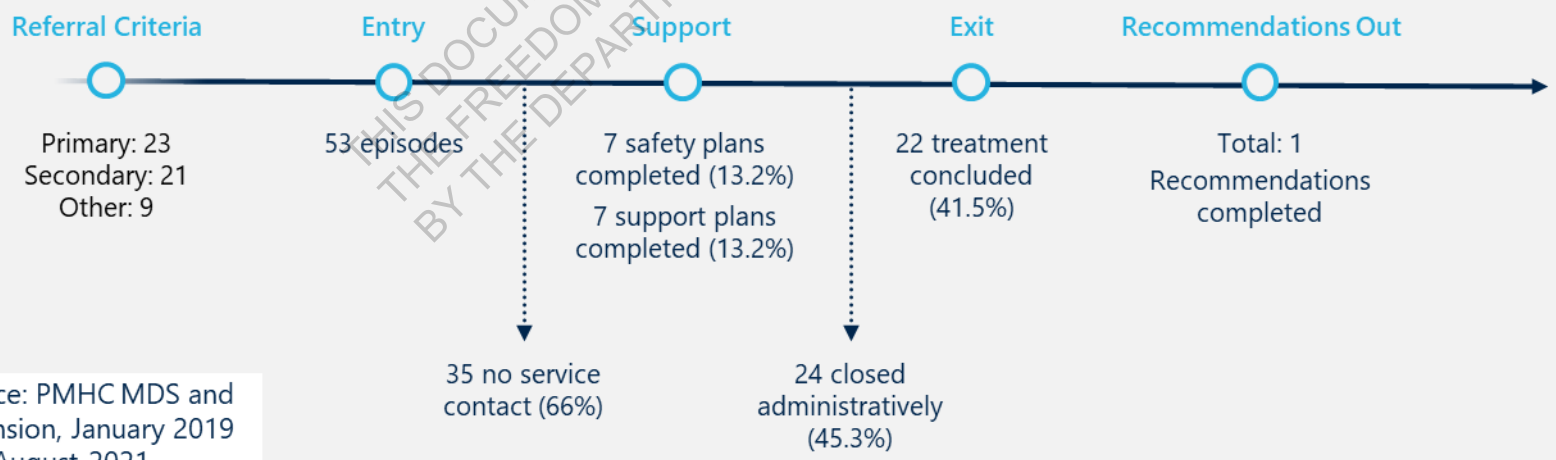
Retaining qualified professional staff is difficult in Darwin. This means turnover in The Way Back is high and it is difficult to find consistent and qualified professionals to refer clients to.

## Community Context

Due to the location and demographics, there is a strong focus on Aboriginal and Torres Strait Islander population groups. However, some stakeholders perceive that many Aboriginal and Torres Strait Islander groups don't use The Way Back as they don't see it as an Aboriginal service and there are alternatives that are better suited to Aboriginal people.

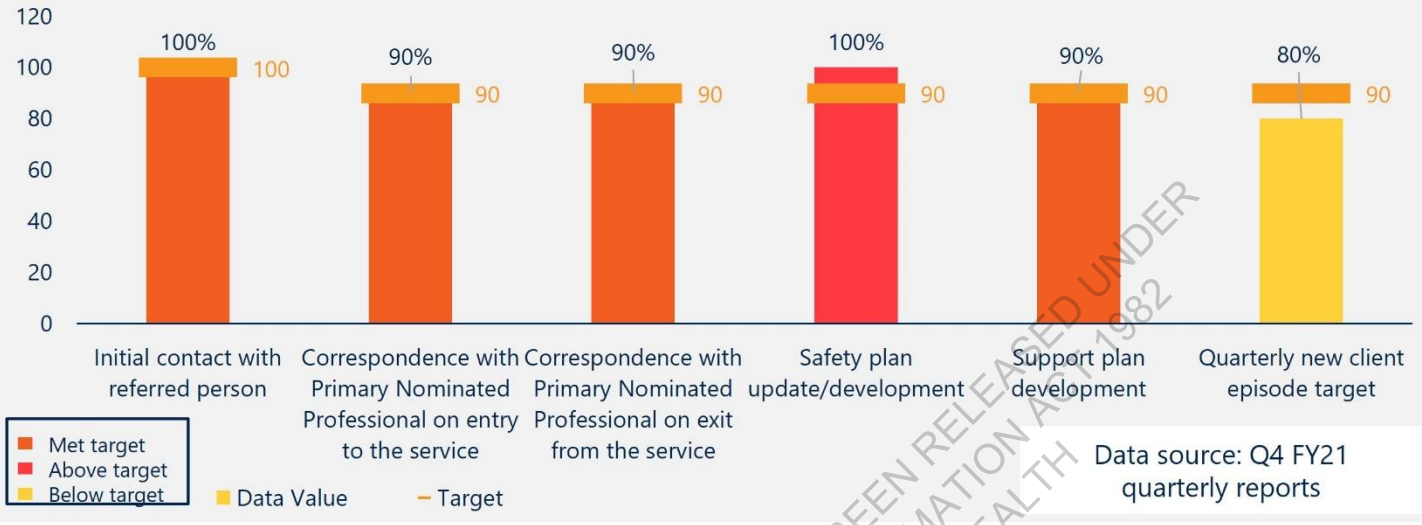
Homelessness and housing is a large issue in Darwin with a large transient population. This makes it difficult to provide continuity of care for individuals.






Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## Key performance indicators for Q4 FY20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- Due to the focus on the Aboriginal and Torres Strait Islander population, the service provider is eager to adapt outcome measurement tools with a stronger cultural lens.
- High staff turnover has been a challenge, which has had flow on effects on the quality of the relationship with The Way Back and referring health services.
- The lack of availability of key services such as affordable housing and clinical mental health support negatively impacts the outcomes for clients who can't work effectively on their recovery without it.
- Often clients responded to initial attempts of engagement where a meeting was booked, but don't attend on the day. This is quite common with clients who feel anxious about meeting someone face to face.

### Implementation

- There have been relationship issues between key stakeholders, which has highlighted the key role of Beyond Blue in mediation and engagement.
- The integrated model means Team Health shares The Way Back workforce across its different programs. Given the breadth of workforce operating across multiple programs, this has allowed for better matching of support coordinators and supports their workers by sharing the workload.
- However, the service has struggled to recruit an Aboriginal Support Coordinator and there have been less Aboriginal and Torres Straight Islander clients than expected.

### Clients of the service/site since January 2019

**Gender**
39% Male
61% Female

**Country of Birth**
100% Australia

**Sexuality**
100% Straight or heterosexual

**Aboriginal and Torres Strait Islander Status**
61% Neither
39% Aboriginal but not Torres Strait Islander

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE (TWBSS) PROGRAM LOGIC – DARWIN

## INPUTS

**Funding**

$x service funding and $x operational funding from 2018 from the Australian Government

$x matched contributions from State and Territory Governments

$x from Beyond Blue

**Organisations**

Top End Health Service (TEHS)

Darwin Hospital

Mental Health Access Team (MHAT)

Northern Territory PHN

TeamHEALTH

[x] Community-based service providers

[x] Primary health providers

**Human resources**

[x] TWBSS Team leaders

[x] TWBSS Support coordinators

**Governance**

Beyond Blue project staff

Northern Territory PHN

TeamHEALTH's own governance processes

Governance committees

**Implementation resources**

Core service model, procurement and implementation guide

License Agreement with PHNs, which specifies agreed requirements

Guidance documents e.g. training package and communication strategy

Monitoring and evaluation support from Beyond Blue

PMHC data set, MHC extension and supplementary data

## SERVICE IMPLEMENTATION (ACTIVITIES)

**Beyond Blue**

Design TWBSS service and implementation model

Broker partnerships between PHNs, state governments and the Australian Department of Health

Administer funding for TWBSS implementation and operations

Support implementation and delivery activities with practice knowledge, communities of practice, administration and advisory support, monitoring, evaluation, reporting assistance and governance, **use of Beyond Blue portal**

Monitor and report on progress of **TWBSS at Darwin**

**Northern Territory PHN**

Commission **TeamHEALTH** and monitor service performance

Assist with the integration of clinical and community mental health services through the development of referral and escalation pathways in the local area

Support implementation and delivery activities **through identification of relevant community providers and funded PHN support services**

Support relationship development to enable TWBSS service operation

**TEHS/MHAT**

Train staff in working with TWBSS

Establish and use referral pathway to TWBSS

Establish and use data and reporting process

**TeamHEALTH**

Recruit and train TWBSS staff with required knowledge, skills and confidence to support clients **e.g. ask and assist training, Westerman training**

Provide clinical supervision of staff

Establish and use formal/informal partnerships with ED/CMHS and providers to enable service delivery

Provide education/promotion sessions for **Top End Health Service/MHAT** and providers to build understanding and willingness to refer to TWBSS

Establish and use processes for referrals, consultation and escalation

Establish and use data protocols to monitor service referrals and use, and client outcomes

**Community providers**

Establish referral pathways with TWBSS

## SERVICE DELIVERY (OUTPUTS)

**TEHS/MHAT**

Conduct mental state assessment

Assess eligibility for TWBSS

Obtain client consent and refer to TWBSS

**TeamHEALTH**

Confirm client eligibility **through intake assessment**

Contact client within **1 business day**; obtain client consent

Develop Safety and Support Plan

Administer client assessment and outcome measurement tools

Ensure immediate medical and psychosocial needs met

Identify goals for recovery

Provide assertive **and flexible** outreach and psychosocial support that is trauma-informed, culturally safe and appropriate to clients' individual needs

Refer clients to external providers

Complete service exits/closure

Follow up with any un-planned exits

**Community providers**

Receive referrals from TWBSS

Support clients

## SERVICE OUTCOMES

### CLIENT

**RECOVERY**

Emotional state

Increased feelings of hope, purpose and belonging

Decreased feelings of psychological distress

Emotional wellbeing and resilience

Improved emotional wellbeing

Greater knowledge of triggers/risk factors and ability to manage them

Greater capacity to manage psychological distress (distress tolerance)

Increased sense of personal agency (or control)

Protective factors

Feeling empowered as a partner in recovery

Greater understanding of mental health (mental health literacy)

Increased confidence to reach out for help as needed

Increased engagement with interests/hobbies

Greater knowledge of where and how to access support (e.g. activate their Safety Plan)

Engagement with TWBSS (frequency, continuity)

Engagement with clinical mental health services (frequency, continuity)

Engagement with peer services

Engagement with other services as needed

Increased levels of (perceived) social and familial connectedness

**REDUCED SUICIDALITY**

Emotional state

Reduced levels of suicidal ideation and intent (rate, severity, duration)

Reduced self-stigma around suicidality

Emotional wellbeing and resilience

Ability to comprehend (e.g. make sense of) the drivers of suicidality

Protective factors

Increased willingness and capacity to communicate when experiencing suicidality

Behaviour

Total amount of suicidal communication (rate, duration)

Avoidance of suicide (re)attempt

### FAMILIES AND COMMUNITIES

Improved knowledge of how to respond to someone living with suicidality

Improved linkages between those with lived experiences

### SYSTEM

Improved evidence base about what works in suicide prevention and how to implement it

Improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis

Improved integration and sustainability of mental health services across tertiary and community care settings

## SERVICE GOALS

## VISION

REDUCED RATES OF SUICIDE ATTEMPT AND DEATH IN AUSTRALIA

# Adelaide

Anglicare

**Opened: September 2020**

**Adelaide is a new site building on a similar program that is showing promising signs for effective implementation.**

## Policy Context

Adelaide has a complex mental health system for The Way Back support coordinators to understand. The Way Back provider acknowledged their workers need a good knowledge of this to be effective, which can be difficult to find.

Primary catchment area is the Central Adelaide area. The pathways into the service are through the Queen Elizabeth Hospital and Royal Adelaide hospital.

## Operating Context

The referring health service will determine if someone is appropriate for The Way Back before referring, and often don't refer clients with BPD who need more intensive and long-term treatment.

It has been difficult recruiting for the support coordinator role as it is often poorly understood.

Training for staff is perceived to be important to reduce staff burn out, especially working with BPD, mindfulness and mental health assessments.

## Community Context

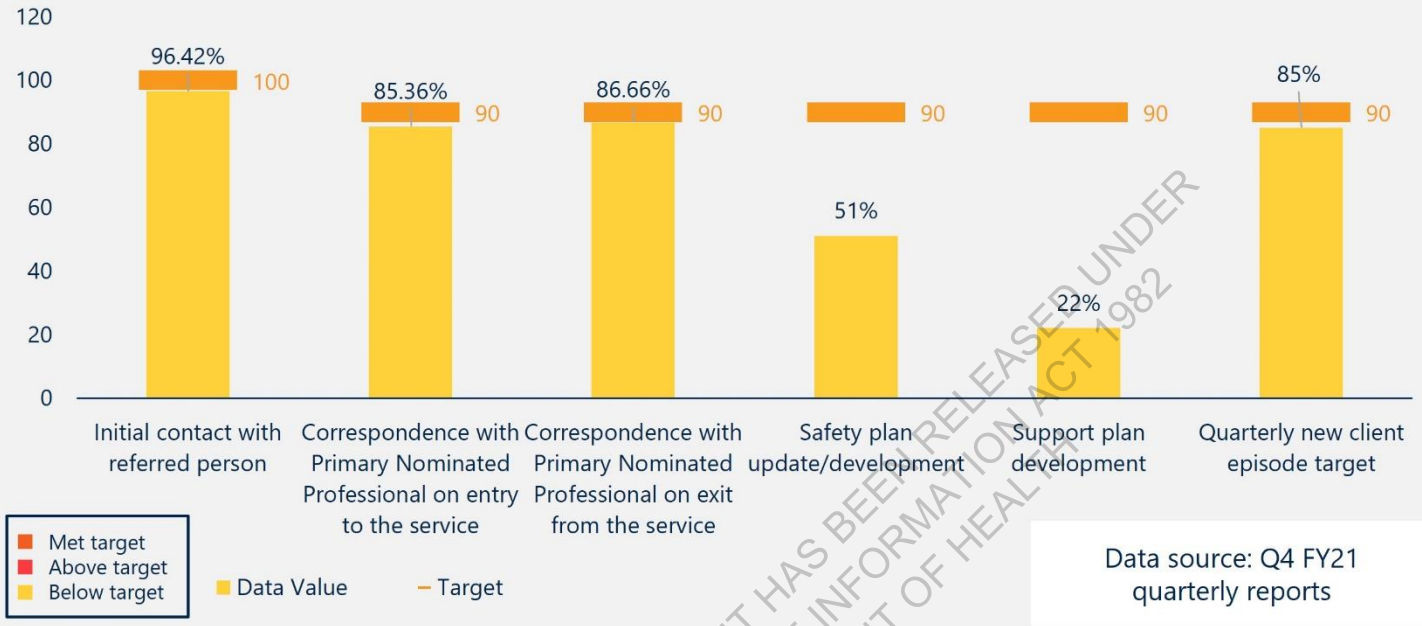
There are 17 LGAs in the Adelaide PHN region, with an estimated resident population of 1.22 million people.

The suicide rate in the Adelaide PHN was higher than the national average (12.0 compared to 11.2).




Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## Key performance indicators for Q4 FY20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- While The Way Back provider is has not met all KPIs, it is showing promising signs given its recency as a The Way Back site. For all KPIs except safety and support plans, which warrant further investigation, it is very close to meeting its targets.
- There was a perception that the ability to provide family or carer support would enable the support network of clients to better understand suicidality, and this is something that limits recovery in the current system.

### Implementation

- The addition of a funded position across Royal Adelaide and Queen Elizabeth Hospitals to support The Way Back, has enabled more consistent referrals.
- The LHD that manages referrals into The Way Back often don't refer clients with specific conditions (e.g. BPD) as they aren't seen as appropriate for The Way Back.
- The current staffing costs makes it difficult to recruit staff to the service (e.g. wages are not competitive).

### Clients of the service/site since January 2019

**Gender**
37% Male
63% Female

**Country of Birth**
100% Australia

**Sexuality**
12% Straight or heterosexual
88% Not stated

**Aboriginal and Torres Strait Islander Status**
75% Neither
25% Not stated/inadequately described

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE (TWBSS) PROGRAM LOGIC – ADELAIDE

# Murrumbidgee

Wellways

Opened: February 2018

**Murrumbidgee has built on strong integration with its referring health service for quality referrals; the peer support model appears to be working, but unclear whether the peer care companion and family support worker are used effectively.**

## Policy Context

The Way Back fills a current service gap for non-clinical support services for people who experience suicidality.

Murrumbidgee LHD is contracted to provide My Step in the western sector which means they provide a suite of services to people in those communities.

The local LHD is in the process of putting in Suicide Prevention Outreach teams and Safe Haven to cover Th/Fri/Sat/Sun which is when most ED presentations happen.

## Operating Context

Clinical mental health services in Murrumbidgee collaborate with The Way Back provider to use their non-clinical support.

Murrumbidgee operates in a rural location with the team working in a dispersed model to clients up to 3 hrs away by car. This can affect the number of clients they see face to face everyday.

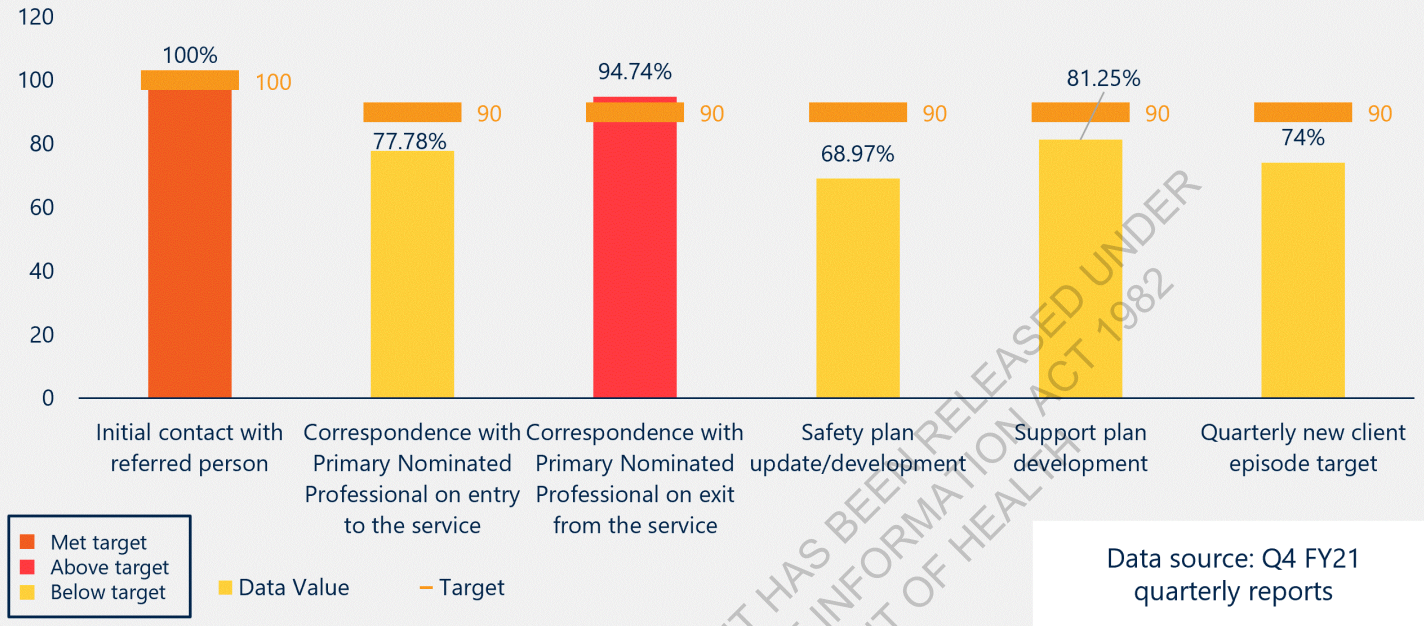
Referred by the Community Teams or the MH Emergency Consultation Service; some from the inpatient unit.

## Community Context

The Way Back is supporting the needs of key groups in Murrumbidgee, including people with BPD, alcohol and other drug use, domestic and family violence victims, child protection families and people with insecure housing locations.



## Key performance indicators for Q4 FY20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- Murrumbidgee did not meet most KPIs.
- A peer support trial is being delivered which offers peer care companions and family support workers. Their role is to support clients and share their own experiences of living with suicidality and recovery with the aim to normalise what the client may be experiencing.
- The process for internal referrals between support coordinators and peer care companions/family support workers does not always work smoothly. It relies upon the support coordinator championing the role, and there appears to be sporadic uptake.

### Implementation

Key enablers of good implementation at Murrumbidgee:

- building a good relationship with clinical staff at local health service
- high levels of community engagement to build awareness of the service
- mandatory assist model training and ongoing monthly meetings with Murrumbidgee LHD.

Some challenges included:

- recruitment of peer support workers
- ability to do further specialised training such as on how to work with participants who have BPD.

### Clients of the service/site since January 2019

**Gender**
47% Male
53% Female

**Country of Birth**
100% Australia

**Sexuality**
74% Straight or heterosexual
3% Lesbian, gay or homosexual
23% Not stated

**Aboriginal and Torres Strait Islander Status**
80% Neither
20% Aboriginal but not Torres Strait Islander

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## THE WAY BACK SUPPORT SERVICE (TWBSS) PROGRAM LOGIC – MURRUMBIDGEE

## TWBSS PEER ENHANCEMENT PROGRAM LOGIC

| NEED | INPUTS | IMPLEMENTATION ACTIVITIES | SERVICE ACTIVITIES & OUTPUTS | SERVICE OUTCOMES | SERVICE GOALS |
|---|---|---|---|---|---|
| **Broader context**<br>Lack of peer support services in community<br>**Individual need**<br>People who attempt suicide or have a suicidal crisis need:<br>• Someone to safely and appropriately tell and relate to their story<br>**Family need**<br>Families of individuals who attempt suicide or have a suicidal crisis need:<br>• Support from an appropriately qualified workforce | **Funding**<br>$600,000 from the Australian Government<br>**Human resources**<br>1.6 FTE TWBSS Peer Care Companions<br>0.8 FTE TWBSS Peer Family Support workers<br>**Implementation resources**<br>Agreed peer support service delivery guide | **TWBSS providers**<br>Recruit and train peer care companion and peer family support staff with the required knowledge, skills and confidence to support clients | **TWBSS providers**<br>Peer care companion contacts client to agree type of engagement and informal catch ups<br>Peer care companion implements client Safety and Support plan<br>Peer family support worker contacts family to agree type of engagement and informal catch ups<br>Peer care companions and peer family support workers provide assertive outreach that is informed by lived experience, culturally safe and appropriate to clients and families (e.g. mentoring, psychoeducation, connections to resources) | **CLIENT**<br>*Service outcomes already identified in the core model that are likely to be strengthened. These include:*<br>Increased feelings of hope, purpose and belonging<br>Feeling empowered as a partner in recovery<br>Greater knowledge of triggers/risk factors and ability to manage them<br>Increased confidence to reach out for help as needed<br>Engagement with TWBSS (frequency, continuity)<br>Engagement with peer services<br>Increased levels of (perceived) social and familial connectedness | *Service goals already identified in the core model that are likely to be strengthened. These include:*<br>Reduced self-stigma around suicidality<br>Increased willingness and capacity to communicate when experiencing suicidality<br>Total amount of suicidal communication (rate, duration)<br>Avoidance of suicide (re)attempt |
| | | | | **FAMILIES**<br>Improved psychological wellbeing<br>Increased confidence to reach out for help as needed<br>*Service outcomes already identified in the core model that are likely to be strengthened. These include:*<br>Improved knowledge of how to respond to someone living with suicidality<br>Improved linkages between those with lived experiences | **SYSTEM**<br>*Service goals already identified in the core model that are likely to be strengthened. These include:*<br>Improved evidence base about what works in suicide prevention and how to implement it<br>Improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis |

# Mildura

Wellways

**Opened: September 2020**

**Mildura is a less mature site whose referral rates and policy context are complicated by a similar Victorian Government initiative, known as the HOPE program.**

## Policy Context

The HOPE program is an initiative of the Victorian Government's suicide prevention framework 2016-2025, focusing on halving Victoria's suicide rate by 2025. The HOPE program delivers a hybrid model (i.e. both clinical and psychosocial support) however has a greater clinical focus.

The service provider works with Mallee Family Care (accommodation, mediation, mental health support, financial counselling), Orange Door, Headspace and Safe Haven.

## Operating Context

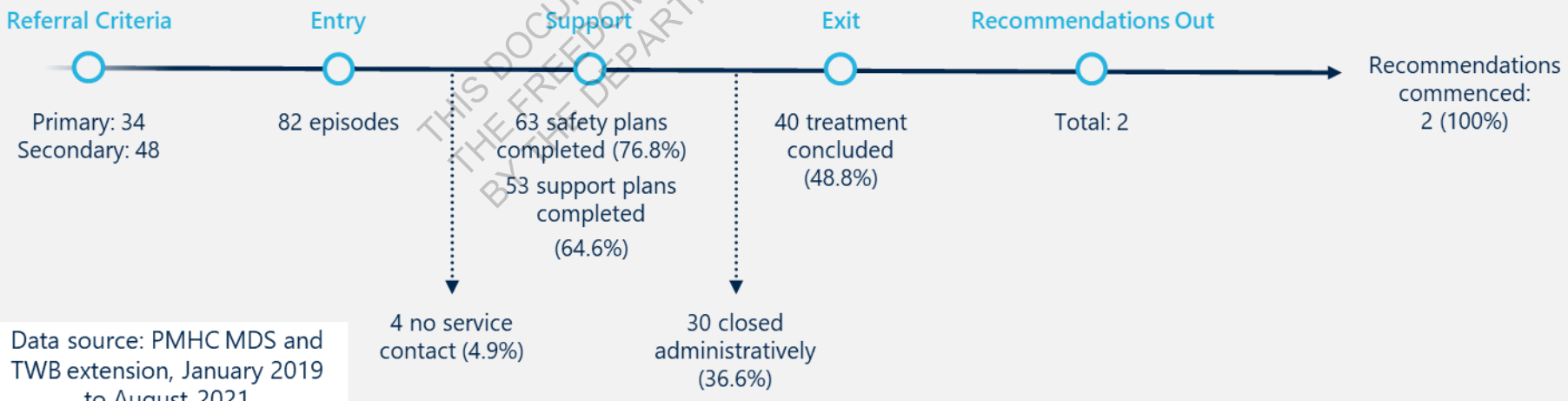
There is limited service capacity to support the mental health needs of the Mildura and surrounding community e.g. long psychologist waitlists and transient health workforce.

Mildura Base Public Hospital (MBPH) is highly engaged and involved in the governance of the program and the individual client. They are responsible for the risk of the client three months post discharge. To ensure clear and established parameters of responsibility and care MBPH hold a Service Level Agreement with the service provider.

## Community Context

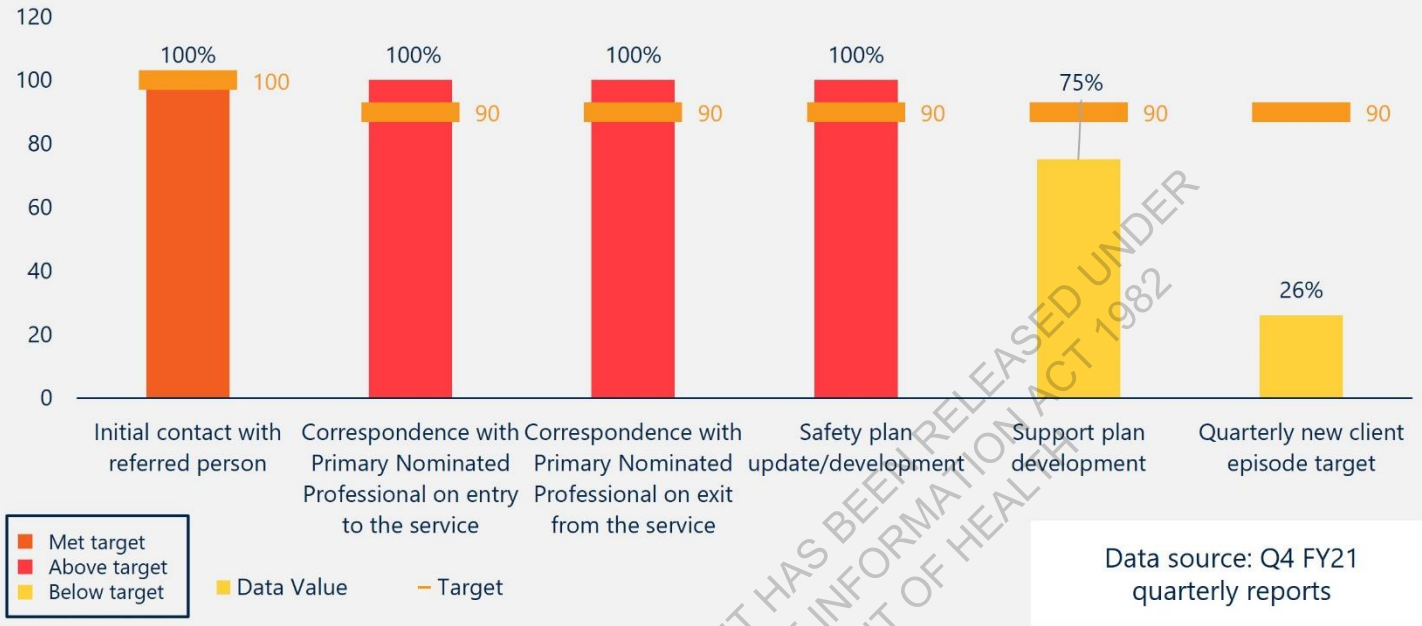
Suicidality in Mildura is often driven by social or rural isolation as well as alcohol and other drug use, chronic pain and relationship breakdowns.

There are lower numbers of Aboriginal participants than was expected for the Mildura region.




Data source: PMHC MDS and TWB extension, January 2019 to August 2021

## Key performance indicators for Q4 20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- Mildura is meeting most of its KPIs, with the exception of support plans and the new client episode target.
- Differentiating between clinical and psycho-social needs for the programs is challenging and relies on team leader and support coordinator roles.
- COVID-19 has complicated service delivery and client engagement with the service: lockdowns have greatly impacted how the service is delivered to clients, and issues such as relationship breakdowns, family and domestic violence, child caring responsibilities and social isolation have been amplified thus limiting client engagement with the service.

### Implementation

- Referrals into the service are filtered through HOPE in opposition to the documented service model. This limits the number of referrals coming through to The Way Back.
- The service provider viewed the current referral pathway as a barrier to potential Aboriginal and Torres Strait Islander clients due to past negative experiences with clinical health and mental health services.
- The Way Back staff indicated they could have better reach into local migrant and refugee populations.
- There has been quite a lot of turnover in The Way Back staff which reportedly has impacted implementation timeframes.

### Clients of the service/site since January 2019

**Gender**
46% Male
54% Female

**Country of Birth**
100% Australia

**Sexuality**
66% Straight or heterosexual
34% Not stated

**Aboriginal and Torres Strait Islander Status**
90% Neither
10% Aboriginal but not Torres Strait Islander

Based on Q4 FY21 quarterly report data

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# Central & Eastern Sydney PHN

Neami National

Opened: October 2020

CESPHN is a recent metropolitan service that leverages a large network of providers, hospitals and organisations to deliver a service to its clients.

## Policy Context

Towards Zero Suicides is an $87 million investment over three years in new suicide prevention initiatives that address priorities in the Strategic Framework for Suicide Prevention in NSW 2018-23 and contribute to the Premier's Priority to reduce the suicide rate by 20% by 2023.

Operates as the second largest of the 31 PHNs across Australia by population. The boundaries align with South Eastern Sydney Local Health District and Sydney LHD.

## Operating Context

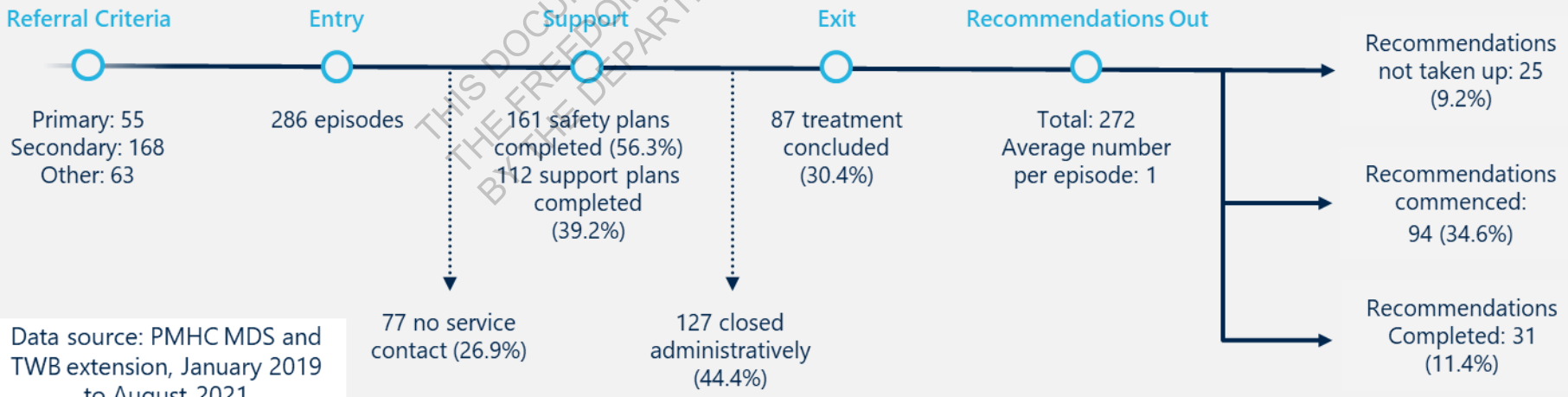
Governance structure includes consumer and carer representatives and those from LHD.
CESPHN has commissioned the SPConnect service, which provides comprehensive care coordination support for people following a suicide attempt. They work in partnership with St Vincent's Hospital, Prince of Wales Hospital and Royal Prince Alfred.
The service provider engaged the Black Dog Institute to tailor their Advanced Suicide Prevention training specifically to local general practice.

## Community Context

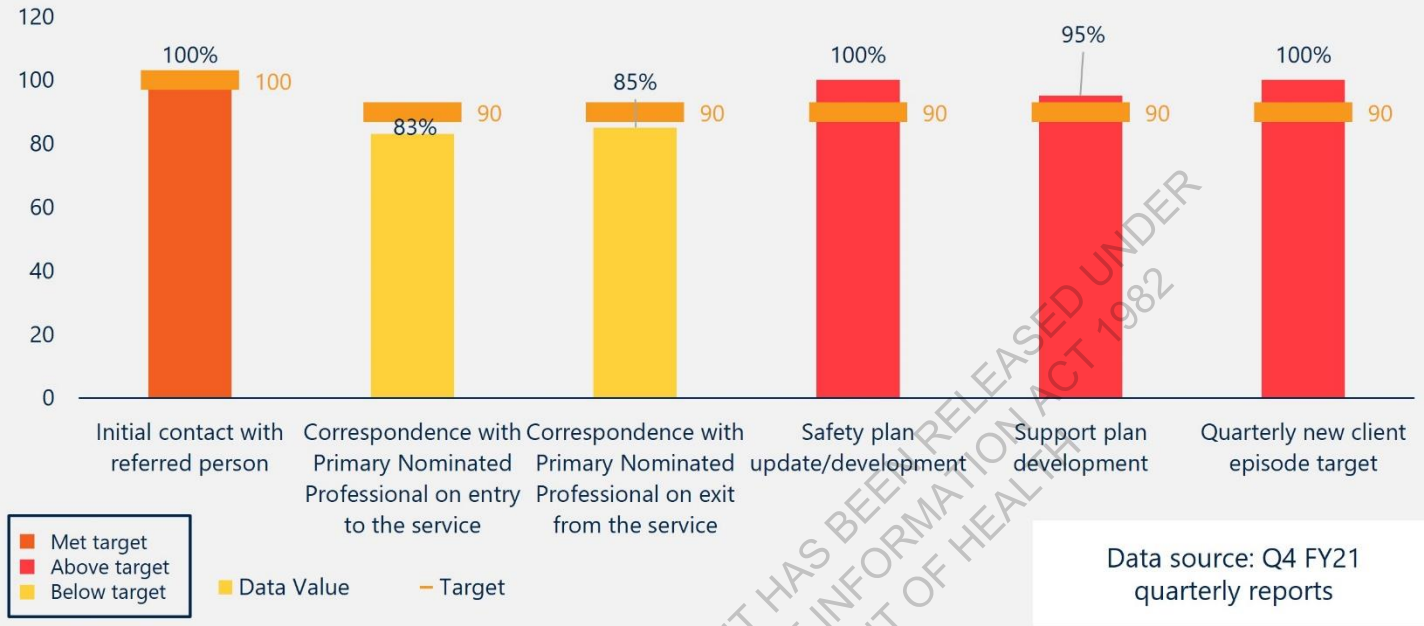
The CESPHN provides funding to implement and deliver the psychological support service which helps to connect people with psychologists without having to attend a GP.

The catchment population is characterised by high cultural diversity and high population growth. 35% of the community were born outside Australia.

During COVID and past lockdowns, a lot of elderly people were referred because they were isolated, as well as young people who felt economic stress.



## Key performance indicators for Q4 20/21




Data source: Q4 FY21 quarterly reports

## Key insights to learn and improve on

### Service delivery

- The CES region benefit from a lots of services and programs. There are many NGOs and government funded services to cater for a range of mental health and suicide presentations.
- Partnerships with hospitals and referring partners, transparent information sharing across the team and with partners have made a big difference.
- There appeared to be a greater emphasis on the role of the community care coordinators as service navigators and accountability mechanisms, than on the importance of their companionship compared with rural/regional sites.

### Implementation

- Partnerships with hospitals and other organisations have been successful, with everyone supportive of the general aim of the program.
- Funded role within the local health district has been helpful in bridging the gap between community and clinical.
- During service establishment, there were not many referrals and a delay in offering the service to hospitals.

### Clients of the service/site since January 2019

**Gender**
39% Male
61% Female

**Country of Birth**
100% Australia

**Sexuality**
16% Straight or heterosexual
3% Lesbian, gay or homosexual
80% Not stated

**Aboriginal and Torres Strait Islander Status**
81% Neither
3% Aboriginal but not Torres Strait Islander
16% Not stated/inadequately described

Data source: PMHC MDS and TWB extension, January 2019 to August 2021

# THE WAY BACK SUPPORT SERVICE (TWBSS) PROGRAM LOGIC – CESPHN

## INPUTS

**Funding**

$x service funding and $x operational funding from 2018 from the Australian Government

$x matched contributions from State and Territory Governments

$x300,000 from Beyond Blue

**$x allocated funding for clinical supervision**

**Organisations**

**Seven referring hospitals**

[x] Mental Health Teams (MHT)

**Central Eastern Sydney PHN**

**South Eastern Sydney Local Health District (LHD)**

**Neami National**

1 Community-based service providers

**Human resources**

1 FTE TWBSS Team leaders

7.7 FTE TWBSS Support coordinators

0.6 FTE Admin/data support

**TWBSS clinical supervision role**

**Hospital project officer**

**Governance**

Beyond Blue project staff

**Central Eastern Sydney PHN**

**Neami National's** own governance processes

Governance committees

**Implementation resources**

Core service model, procurement and implementation guide

License Agreement with PHNs, which specifies agreed requirements

Guidance documents e.g. training package and communication strategy

Monitoring and evaluation support from Beyond Blue

PMHC data set, MHC extension and supplementary data

## SERVICE IMPLEMENTATION (ACTIVITIES)

**Beyond Blue**

Design TWBSS service and implementation model

Broker partnerships between PHN, state governments and the Australian Department of Health

Administer funding for TWBSS implementation and operations

Support implementation and delivery activities with practice knowledge, communities of practice, administration and advisory support, monitoring, evaluation, reporting assistance and governance, **use of Beyond Blue portal**

Monitor and report on progress of **TWBSS Sutherland/St George**

**Central Eastern Sydney PHN**

Commission **Neami National** and monitor service performance

Assist with the integration of clinical and community mental health services through the development of referral and escalation pathways in the local area

Support implementation and delivery activities **through identification of relevant community providers and funded PHN support services**

Support relationship development to enable TWBSS service operation

**South Eastern Sydney LHD**

Train **LHD** staff in working with TWBSS

Establish and use referral pathway to TWBSS

Establish and use data and reporting process

**Neami National**

Recruit and train TWBSS staff with required knowledge, **lived experience**, skills and confidence to support clients

**Provide clinical supervision of staff**

Establish and use **formal partnerships with seven hospitals in the LHD** and providers to enable service delivery

Provide education sessions **in partnership with hospital project officer for hospitals in LHD** to build understanding and willingness to refer to TWBSS

Establish and use processes for referrals, consultation and escalation

Establish and use data protocols to monitor service referrals and use, and client outcomes

**Community providers**

Establish referral pathways with TWBSS

## SERVICE DELIVERY (OUTPUTS)

**South Eastern Sydney LHD**

Conduct mental health assessment

Assess eligibility for TWBSS

Obtain client consent and refer to TWBSS

**Neami National**

Confirm client eligibility

Contact client within **1 business day**; obtain client consent

Develop Safety and Support Plan

Administer client assessment and outcome measurement tools

Ensure immediate medical and psychosocial needs met

Identify goals for recovery

Provide assertive **and flexible** outreach and psychosocial support that is trauma-informed, culturally safe and appropriate to clients' individual needs

Refer clients to external community providers

Complete service exits/closure

Follow up with any un-planned exits **or hospital readmissions**

**Community providers**

Receive referrals from Neami National.

Support clients

## SERVICE OUTCOMES

### CLIENT

**RECOVERY**

Emotional state

Increased feelings of hope, purpose and belonging

Decreased feelings of psychological distress

Emotional wellbeing and resilience

Improved emotional wellbeing

Greater knowledge of triggers/risk factors and ability to manage them

Greater capacity to manage psychological distress (distress tolerance)

Increased sense of personal agency (or control)

Protective factors

Feeling empowered as a partner in recovery

Greater understanding of mental health (mental health literacy)

Increased confidence to reach out for help as needed

Increased engagement with interests/hobbies

Greater knowledge of where and how to access support (e.g. activate their Safety Plan)

Engagement with TWBSS (frequency, continuity)

Engagement with clinical mental health services (frequency, continuity)

Engagement with peer services

Engagement with other services as needed

Increased levels of (perceived) social and familial connectedness

### FAMILIES AND COMMUNITIES

Improved knowledge of how to respond to someone living with suicidality

Improved linkages between those with lived experiences

## SERVICE GOALS

**REDUCED SUICIDALITY**

Emotional state

Reduced levels of suicidal ideation and intent (rate, severity, duration)

Reduced self-stigma around suicidality

Emotional wellbeing and resilience

Ability to comprehend (e.g. make sense of) the drivers of suicidality

Protective factors

Increased willingness and capacity to communicate when experiencing suicidality

Behaviour

Total amount of suicidal communication (rate, duration)

Avoidance of suicide (re)attempt

### SYSTEM

Improved evidence base about what works in suicide prevention and how to implement it

Improved provision of high-quality aftercare services for people who have attempted suicide or who are in suicidal crisis

Improved integration and sustainability of mental health services across tertiary and community care settings

## VISION

REDUCED RATES OF SUICIDE ATTEMPT AND DEATH IN AUSTRALIA

# Appendix H Sources for Cohen's d analysis

This appendix outlines the sources used for the Cohen's d analysis of the K10+ scores used in Section 3.

**Table 4 | Sources used in Cohen's d analysis of K10+ scores**

| Program or study | Description | Relevance to The Way Back | Findings | Effect size |
|---|---|---|---|---|
| The National Institute for Mental Health Research, 2015, Evaluation of Transition to Recovery (TRec) Program. Available at: www.wcs.org.au. | The TRec program provides support for people with mental illness to support recovery following discharge from hospital. | High | The K10 pre-TRec scores were higher than the K10 post-TRec scores. Pre-TRec participants were approximately 11 times more likely to be categorized in the 'high to very high' distress category compared to post-TRec participants | Large effect size ($\eta^2$ = .31) |
| UNSW Social Policy Research Centre, Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program. 2015. Available at: www.headspace.org.au. | headspace is focused on mental health and social and emotional wellbeing more broadly. This evaluation focuses in part on suicidal ideation and self-harm. | Medium | Overall, almost half (47 per cent, n=12,233) of young people who attended headspace's K10 scores decreased: 13.3 per cent experienced a clinically significant improvement, 9.4 per cent a reliable improvement and 24.3 per cent a insignificant improvement. | -0.11 for the difference-in-differences between 'headspace' and 'no treatment' group |
| CSAPHN, National Suicide Prevention Trial Evaluation: Final Report, 2021. Available at: countrysaphn.com.au | An evaluation of a range of community-based suicide prevention events in regional areas of South Australia including aftercare services. | Medium-Low | Total (N=322) mean scores on the Kessler K10+ depressive symptoms scale was 33.91 (SD=9.18). However, mean symptom scores reduced over time from episode start, review and end showing the success of aftercare service treatment. | No effect size provided. |
| Blackdog Institute, Ibobbly mobile health intervention for suicide prevention in Australian Indigenous youth: a pilot randomised controlled trial. 2016, BMJ Open. | Ibobbly is an app that targets suicidal ideation, depression, psychological distress among Indigenous youth in remote Australia | Low | Participants in the ibobbly group showed substantial and statistically significant reductions in K10 scores compared with the waitlist control group (t=2.44; df=57.5; p=0.0177). reflecting a substantial effect. | Large effect size Cohen's d = 0.65 (95% CI 0.12 to 1.17). |

# Appendix I Recommendations to improve data quality

This appendix is supplementary to Recommendation 7 in Section 4 and provides early detailed suggestions for immediate improvements to data collection and use for The Way Back.

This report is informed by analysis of four main quantitative data sources: the PMHC MDS and TWB extension data, quarterly reports and supplementary data. Exploration of these data sources has demonstrated a range of challenges including:

- availability of relevant data to inform ongoing monitoring and evaluation of The Way Back
- inconsistent data collection practices across sites and data fields
- discrepancies across data sources for the same variables and time periods (i.e. the quarterly reports and the PMHC MDS).

Further exploration is needed to better understand the drivers of these challenges and the extent to which Beyond Blue can address some of these limitations compared to those under the jurisdiction of the Commonwealth.

Noting this, the evaluation has identified some early suggestions to address these limitations to be further explored with Beyond Blue and the Australian Government Department of Health:

- Assess the appropriateness of current data governance arrangements to enable access raw and Commonwealth data for reporting
- Engage with providers to review and refine data collection processes to ensure that they:
  - are practical and reflect the day-to-day service delivery of The Way Back
  - are fit for purpose to enable ongoing monitoring and improvement.
- Automate quarterly reports to draw from PMHC MDS data extracts and remove the option to populate quarterly reports manually.
- Collaborate with the Commonwealth to provide additional training and guidance to providers to improve understanding and use of key data fields in the PMHC MDS and TWB extension (see Table 5 for key fields identified through the analysis for this report).

Table 5 below outlines some key data fields used in the interim report that could be improved.

**Table 5 | Key data fields to improve**

| Data field | Issue | Potential change |
|---|---|---|
| **Eligibility criteria** | 15 per cent of clients have neither the primary nor the secondary criteria recorded and are listed as 'not adequately described'. | Establish binary input options for eligibility criteria (primary or secondary criteria). |
| **Service contact type** | There is no clear way to define whether a client's first contact is the initial phone call within 24 hours or whether the client has fully engaged in their first episode with their support coordinator. | Clarify with providers how this variable is commonly used and provide guidance on the most appropriate option. |

| Data field | Issue | Potential change |
|---|---|---|
| **Episode completion status** | While the PMHC MDS provides a 'completion status' variable that provides some indication of whether a client successfully completes their episode with The Way Back, it is unclear how 'treatment concluded' is defined and whether this indicates a positive outcome for the client. | Clarify with providers how this variable is commonly used and provide guidance on the most appropriate option.<br>Consider adding a 'reason for episode closure' field in TWB extension. |

# Appendix J Items for follow up

This Interim Evaluation Report has identified several items for further investigation in the next phase of the evaluation. Table 6 below provides a summary of these items.

**Table 6 | Items for follow up**

| Domain | Item for follow up |
|---|---|
| **Engagement and data collection** | • Nous, Beyond Blue and the deep dive sites will seek to increase engagement and increase the sample size of consulted clients in the next round of data collection.[35]<br>• The support persons' survey responses were excluded as there were only two responses. Nous is working with Beyond Blue to identify mechanisms to increase response rates in the next round.<br>• The next round of data collection will co-design strategies to address some of these limitations (e.g. refinements to the recruitment process for interviews, positive bias, limited sample size, incomplete outcomes data).<br>• There was insufficient data available to reliably run regression analysis assessing the impact of different variables on changes in WHO-5 scores in this initial drawdown from the PMHC MDS and TWB extension. Future drawdowns are expected to increase the amount of data and likely allow regression analysis to occur in the next round of analysis. |
| **Understanding the data** | • Initial analysis of PMHC and TWB data suggests that some client cohorts were more likely to complete their service episode than others.[36] Early analysis illustrates a correlation and requires further investigation in the next round of data collection as to why this has occurred.<br>• PMHC MDS data suggests that only 39 per cent of The Way Back clients engaged in the support services that they were referred out to during their support period. Reasons why over 60 per cent of referrals are not taken up will be explored. |
| **Understanding reasons for performance** | • The next stage of the evaluation should further explore barriers to meeting the KPI for initial contact and confirm provider understanding of the importance of the critical days following hospital discharge. Following this confirmation there may be an opportunity to further strengthen provider understanding the critical importance of timing in The Way Back's design and improve performance on the initial contact KPI.<br>• For exploration in future data collection rounds Nous will seek to explore the reasons why some sites are meeting KPIs and many sites are not. Nous will work with Beyond Blue and providers to further investigate why this is happening in our next round of data collection. |
| **Understanding variations in service model design** | • The Way Back and HOPE aims to improve access to both clinical and non-clinical supports in parallel. In some locations this is done through an integrated approach (for example, in Mildura, via a hybrid model between). The extent to which this works in practice will be further explored in the next round of data collection. |

[35] The Way Back does not collect the details of support people currently, nor do they collect the appropriate permissions to contact support people directly as part of the evaluation. The evaluation is exploring ways to overcome this challenge in the future rounds of data collection.
[36] Based on analysis of the PMHC MDS and TWB extension from January 2019 to August 2021 which covers 21 sites.

| Domain | Item for follow up |
| --- | --- |
| **Other** | • The impact of The Way Back differs between different cohorts. In particular, the next phase will seek to gather additional information on those with AOD issues or those who are from lower socioeconomic backgrounds.<br>• The initial phase of the evaluation has not focussed specifically on clinical risk management as part of The Way Back's implementation or governance. Opportunities for improvement of The Way Back's clinical risk arrangements will be examined further in the next stage of the evaluation.<br>• The CMO hypotheses developed in this interim report will be further tested in subsequent rounds of data collection to understand their validity and any additional framing that is required. These will be presented in the final evaluation report.<br>• Further examination of the experiences of support persons of The Way Back clients, including families and carers. |

# Appendix K Key Performance Indicators

The delivery of The Way Back is subject to six KPIs. KPIs are shown in Table 7 (as outlined in The Way Back Service Delivery Model March 2020). Sites are required to track KPIs quarterly. As part of the licensing agreements, where a service provider fails to comply with a KPI for two quarters or three KPIs in any one quarter, a remediation plan is required to be developed. PHNs are expected to undertake reasonable efforts to rectify the breach or non-compliance.

**Table 7 | The Way Back KPIs**

| KPI | Description | Target metric |
|---|---|---|
| **Initial contact with referred person** | For referred persons who are confirmed as eligible for The Way Back, contact[37] must be attempted with the referred Person within one business day of receipt of the referral by the service provider. | 100 per cent of eligible Referred Persons attempted to be contacted within one business day of receipt of referral. |
| **Correspondence with primary nominated professional on entry to the service** | For all clients who have provided consent for their primary nominated professional to be notified, correspondence must be sent advising them of their client's participation in The Way Back within three business days of consent being obtained. | Where consent has been obtained, 90 per cent of primary nominated professional are to be notified of the clients' participation within three business days. |
| **Correspondence with primary nominated professional on exit from the service** | For all clients exited from the service (unplanned or planned) and who have nominated a primary nominated professional, correspondence must be sent by the service provider to their identified primary nominated professional within three business days of the exit date. | Where consent has been obtained, 90 per cent of primary nominated professional are to be notified of the client's exit within three business days of the exit date. |
| **Safety plan update / development** | Safety plans must be updated or developed preferably at the initial contact with the client and no later than the second contact. | 90 per cent of safety plans must be updated / developed by the second client contact. |
| **Support plan development** | Support plan is to be developed within two weeks of consent to participate in the service. | 90 per cent of support plans must be completed within two weeks of consent to participate in the service. |
| **Quarterly new client episode target** | Achieve 100 per cent of the relevant quarter new client episode target per quarter.[38] | The service provider must achieve 90 per cent of the target. |



[37] In some cases, more than one attempt at contact may be required before The Way Back Support Service is able to reach the Client. The requirement of contact to be made within one business day relates to the first attempt at contact and not necessarily when contact is made.
[38] A grace period of 120 days shall be provided on achievement of the Total Annual Cases KPI. This is recognising that there will be a period of time before the Service Provider builds to full capacity and the referral pathways are efficiently established.

nous

## ABOUT NOUS

**Nous Group** is an international management consultancy operating in 10 locations across Australia, the UK and Canada. For over 20 years we have been partnering with leaders to shape world-class businesses, effective governments and empowered communities.




400 PEOPLE

11 LOCATIONS

3 COUNTRIES

**Financial Review Client Choice Awards 2017**
**Best Management Consulting Firm**
Best Provider to Government & Community
Most Cost Conscious Firm