The Way Back Support Service Northern Territory

Final Evaluation Report for *beyondblue*

24 October 2016

The Way Back Support Service Northern Territory was funded by donations to The Movember Foundation and *beyondblue*

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Abbreviations

Abbreviations used in this document are listed in the table below.

Term	Definition
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATAPS	Access to Allied Psychological Services
DRISPN	Darwin Regional Indigenous Suicide Prevention Network
ED	Emergency Department
HREC	Human Research Ethics Committee
MOU	Memorandum of Understanding
NT	Northern Territory
NT CATT	Northern Territory Crisis Assessment and Triage Team
NUM	Nurse Unit Manager
RDH	Royal Darwin Hospital
SUPPORT SERVICE	The Way Back Support Service
WHO-5	World Health Organisation Wellbeing Index

1. Executive summary

Suicide is a significant public health issue. On average 2,800 people die by suicide each year, with the latest data from the Australian Bureau of Statistics reflecting an increase over the previous year to a total of 2,864 deaths in 2014[i]. Tens of thousands more people attempt suicide each year[ii], and for every suicide, and suicide attempt, there are tragic ripple effects for friends, families, colleagues and the broader community[iii]. The single most influential risk factor for suicide is a prior suicide attempt – 15 to 25% of those people who have attempted suicide re-attempt, and 5 to 10% will die by suicide[iv]. The highest period of risk to die by suicide is within three months following a suicide attempt. Despite this knowledge, there is a critical gap in existing services and supports for people who have attempted suicide.

The *beyondblue* Way Back Support Service was developed with funding from The Movember Foundation and *beyondblue*, to fill the gap in the continuity of care for people discharged from hospital after a suicide attempt. It is informed by the current evidence on promising low intensity follow up interventions after a suicide attempt. It was designed to prevent deaths by suicide; fill an unmet need in the community and health system; and be a cost-effective and sustainable model that could be rolled out nationally.

The Support Service is an outreach service that provides non-clinical, short-term support to people who have attempted suicide, and links them to their supporting networks, health and community services and government agencies. It provides a person-centred model of care, that includes practical assistance and support that responds to the individual needs of the client, in the first three months after a suicide attempt or suicidal crisis. It is delivered in a community-based setting, with Support Coordinators providing care face-to-face, over the phone and by text messaging and email.

The Support Service was initially trialled in Darwin in the Northern Territory (NT), from June 2014 to December 2015. The service model was developed by *beyondblue*, in partnership with the service provider, Anglicare NT, and with local stakeholders, including NT Health, the Royal Darwin Hospital (RDH) Crisis Assessment and Triage Team (CATT), and Cowdy Ward (mental health inpatient unit) and an advisory group. During the trial period, the Service received 122 referrals and provided care and support to 87 people.

1.1 Evaluation

The evaluation of the NT Support Service assessed three key questions:

1. Has The Way Back Support Service met client need in terms of appropriateness and satisfaction?
2. Have the processes to plan and implement The Way Back Support Service been effective, efficient and appropriate?
3. Based on available evidence, how feasible is it to implement The Way Back Support Service into more jurisdictions around Australia, giving consideration to replicability, scalability and risk?

The evaluation methodology included a mix of quantitative and qualitative data. It included; administrative program data; client self-reported wellness data; a questionnaire with NT CATT staff; and interviews with clients and key stakeholders. Descriptive statistical analyses of the administrative and client level quantitative data and a thematic analysis of the qualitative data was undertaken. The original intention of the evaluation was to also include de-identified readmission data for consenting clients from the RDH, to assess the impact of the service on reducing suicide attempts or suicidal crises. Despite extensive consultation with the Northern Territory Department of Health, this data could not be obtained during the trial. In order to obtain a more informed understanding of suicide attempt presentations to the RDH ED at the commencement and finalisation of the trial period, EY proposed that a case review of Emergency Department (ED) presentations to the RDH was undertaken. However, this was not within the original scope of the project. The evaluation therefore focuses on the appropriateness of the service model, its

development and implementation, and whether it is feasible to implement the service model in other jurisdictions.

1.2 Key findings

The available evidence obtained through this evaluation strongly supports that The Way Back Support Service was an appropriate and feasible service model that met the needs of people who have attempted suicide, or experienced a suicidal crisis, and has a role in filling a critical gap in the service system. The small sample size and limited range of outcome measures available makes extrapolation to other jurisdictions difficult, and therefore, generalisations on scalability tentative. The evaluators support further development, implementation and evaluation of The Way Back Support Service in other phased locations prior to endorsing a comprehensive rollout.

> *"The Support Coordinator was so good; she really helped me get through a really rough few months. It made a real difference and I'm now through the other side and much more positive about life. Definitely worthwhile having a service like this around – it helped me back to being myself again"* Support Service client

There is evidence to demonstrate that the Support Service was appropriate and met the needs and expectations of clients. Stakeholder interviews revealed that clients valued and appreciated the level and type of care that was provided.

The processes to plan and implement the Service were appropriate for an action research project. However their execution could have been improved to enhance the effectiveness and efficiency of the Service planning and implementation phases. It is essential that roles and responsibilities, and supporting processes and systems are in place prior to commencement of Service delivery.

From the available evidence, there is potential feasibility to replicate the service model in other jurisdictions across Australia. However, further testing is warranted prior to endorsing an extensive rollout of the service model. This evaluation has revealed useful qualitative feedback and invaluable insights on the Support Service model of care and service design, governance arrangements and engagement processes. While the model could therefore be expanded, it is essential that a comprehensive evaluation of the impact and outcomes of the Support Service is undertaken, to inform any further Support Service sites. Since the NT trial, *beyondblue* has expanded the Support Service to the Hunter region of NSW and the ACT. The findings of this evaluation will be taken forward in these areas.

1.3 Recommendations

It is recommended that future activities to test and expand the Support Service include:

- Recommendation 1: A proactive approach is required to establish strong working relationships between the health and mental health hospital emergency department staff and the Support Service staff.
- Recommendation 2: Commissioning agencies should note that the development phase should include tailoring the service model to local needs, developing associated processes and systems, defining key performance indicators and data collection methodologies, clarifying roles and responsibilities, and obtaining buy-in of relevant stakeholders and agencies prior to the commencement of the service.
- Recommendation 3: The person-centred and non-clinical model of care that is delivered through the Support Service provided in an empowering and flexible manner is a core component of the Service and should be retained in all future sites.
- Recommendation 4: Support Coordinators should receive appropriate training and supervision that includes information and skills to understand the needs and experiences of people in a suicidal crisis, and deliver appropriate non-clinical support in an empowering, inclusive, non-stigmatising and non-judgemental way.

- Recommendation 5: Governance arrangements should reflect best practice principles, the views of key stakeholders and meet the need for both high-level strategic oversight and day-to-day operations.
- Recommendation 6: Prior to, or in parallel with, service commencement, the availability and quality of emergency department data on suicide attempts or people who present amidst a suicidal crisis should be determined, and a baseline rate of suicide attempts or suicidal crises should be established.
- Recommendation 7: Research should be undertaken to identify the most feasible, acceptable and useful approach to the collection of client level data, including Service utilisation and outcome measures, that supports client care and enables service evaluation.

2. Background

2.1 Rationale for the NT Support Service trial

In a typical year, about 2,800 people in Australia die by suicide. This is nearly eight people every day[v]. Tens of thousands more people attempt suicide each year[vi]. For every suicide, and suicide attempt, there are tragic ripple effects for friends, families, colleagues and the broader community[vii].

No group is at greater risk of suicide than those who have attempted suicide – a prior suicide attempt is the single most influential risk factor for suicide in the general population[viii]. The 24-hours, one week and up to three months following a suicide attempt are critical. For people discharged from hospital following a suicide attempt[ix]:

- 50% fail to attend follow-up treatment
- 38% of those who attend follow-up treatment, terminate treatment within 3 months
- 15 to 25% of those who have attempted suicide re-attempt, and 5 to 10% will die by suicide. The highest period of risk is within three months following a suicide attempt

People who have attempted suicide commonly describe feelings of great shame, isolation and hopelessness. Both individuals who have attempted and those close to them also describe feeling overwhelmed and totally ill-equipped to navigate through the initial crisis, let alone know if and how things could get better in the longer term[x].

The Way Back Support Service (Support Service) was established to address an identified gap in the continuity of care for people discharged from hospital after a suicide attempt. Darwin was chosen as the first trial site as the NT has the highest rate of suicide across all Australian States and Territories with the standardised death rate 18.1 per 100,000 population between 2008 and 2012, compared to 10.8 per 100,000 for the same period nationally[xi].

The Support Service was designed as an assertive outreach service providing non-clinical, short-term support to people who have attempted suicide and linking them to their supporting networks (family, friends, carers, and community), health services and private clinical providers, government agencies and other non-government agency supports.

The Support Service was intended to build on the protective factors of connectedness and belonging that can help to prevent suicide[xii]. It was informed by a review of promising low intensity follow-up services after a suicide attempt. The model incorporated components and learnings from earlier trials on sending postcards to people who had attempted suicide;[xiii] outreach follow-up phone contact[xiv]; safety planning[xv]; and an assertive follow up service with primary and community care services[xvi].

2.2 Overview of the Support Service

2.2.1 Objectives

The objectives of the Support Service are:

1. To prevent deaths by suicide by reducing the likelihood of a further attempt or suicide by people who have made a previous suicide attempt;
2. To provide a service for a currently unmet need in the community;
3. To successfully engage (and be supported by) clients, health care professionals and other relevant stakeholders;
4. To support individuals to connect with essential services during the period of high risk and vulnerability following a suicide attempt;
5. To reduce the burden on an individual's supporting network(s) (such as family and carers) following a suicide attempt;

6. To reduce the burden on existing community healthcare and support services;
7. To implement a cost-effective service which will provide economic benefits by preventing further suicide attempts; and
8. To provide a suitable model for national roll-out.

2.2.2 Setting

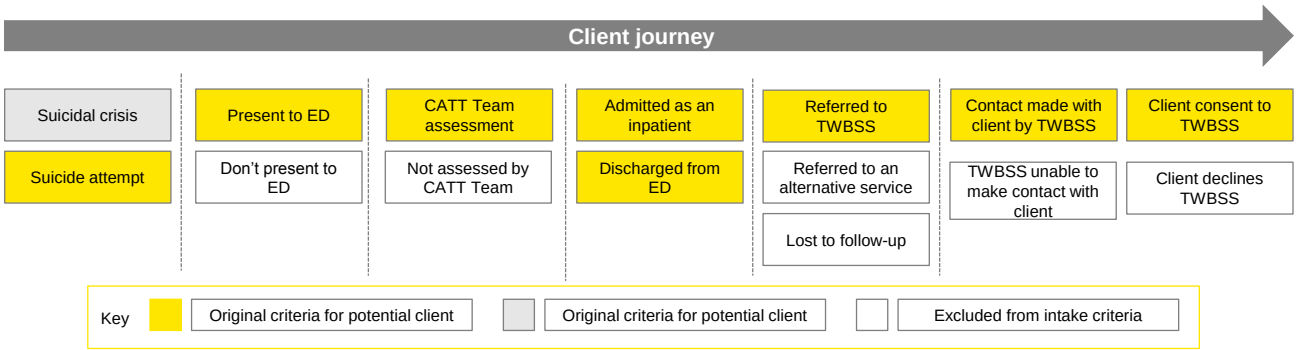
beyondblue contracted the delivery of the Support Service to Anglicare NT. Anglicare NT is a mainstream multidisciplinary service provider that has a strong focus on providing culturally appropriate services. Anglicare NT provided the service in a community-based setting, generally within business hours (with flexibility to provide services outside these times as required). The service was delivered in public places, where clients felt comfortable (for example, coffee shops and parks). The Anglicare NT was in the centrally located suburb of Ludmilla, which was easily accessible by public transport. Services delivered at this site included headspace, youth and family support services, financial counselling, literacy and microfinance services, and a support service for newly arrived migrants and refugees.

The original criterion for intake (June 2014 to May 2015) into the Support Service was: *"when self-inflicted harm has occurred but has not resulted in death, however the intention of the person was to cause a fatal outcome."* Following stakeholder feedback, this was subsequently expanded to align with the World Health Organization's definition of a suicide attempt, which does not require a physical injury to be present following the attempt. The intake criterion was again expanded to include those people at serious risk of suicide (a suicidal crisis). The final criterion for intake was: *"Distress accompanied by suicidal thoughts and articulating an intent to die in someone whom, in the absence of assertive follow-up to engage with other community-based services/agencies, would be vulnerable to increased risk of suicide."*

2.2.3 Referrals

The Support Service had two main referral pathways – people who had presented to Royal Darwin Hospital (RDH) and assessed by the NT Crisis Assessment and Triage Team (NT CATT) or admitted to the mental health inpatient unit (Cowdy Ward) following a suicide attempt or during a suicidal crisis. The Support Service also received a small number of referrals from the RDH based sexual assault service. The client referral and intake process is outlined in Figure 1.

Figure 1: Client referral and intake process



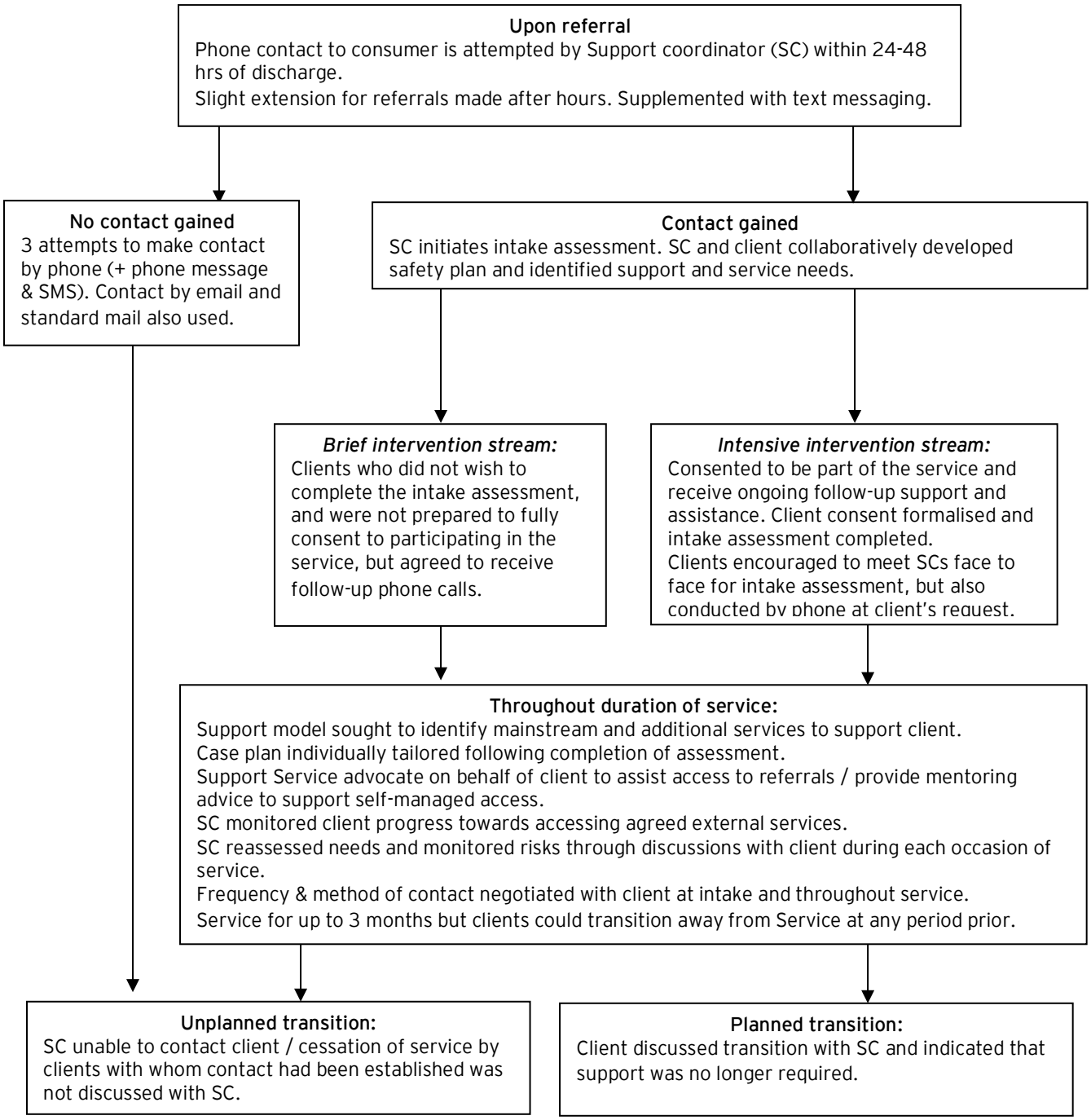
2.2.4 Model of care

The Service delivered person-centred, non-clinical care and practical support after a suicide attempt or a suicidal crisis. Core components of the model of care are:

- People who have attempted suicide are the target audience as this is one of the most significant risk factors for suicide
- Support will be offered free of charge to people of all ages (with tailored services and consent processes provided to those under 18 years), genders, and backgrounds and irrespective of a mental health condition.

- The intervention will be time limited with support provided within a three-month period immediately following a suicide attempt which is the period of highest risk.
- It is a non-clinical, assertive outreach service model focussed on empowering people to connect with informal and formal supports by providing guidance, encouragement, motivation and follow-up.
- Support provided to people will be collaborative and complementary to existing services to avoid duplication and confusion of service provision.
- It provides continuity of care by acting as a conduit between primary points of contact following a suicide attempt or a suicidal crisis, to community based supports/services able to address the issues contributing to a person's distress.
- Robust referral pathways from one or more hospitals with an emergency department must exist as the main access point to people after a suicide attempt or a suicidal crisis with secondary access points outside of the hospital possible where identified.

Figure 2: Flowchart of processes once referral is received from RDH.



2.2.5 Staff

The Support Service was delivered by 2.4 FTE – one Manager (0.5 FTE management; 0.5 FTE Support Coordinator); and two Support Coordinators (1.4 FTE).

The selection criteria for the Support Coordinators included:

- Tertiary qualifications in Human Services/Social Science related fields.
- Minimum 3 years prior experience in case management and/or providing professional and flexible assistance to individuals and/or families under stress.
- Demonstrated skills and ability working effectively with clients, family members, and service providers to identify solutions.
- Demonstrated experience working with Indigenous clients to effectively access clinical services, and social and emotional wellbeing support.
- Sound understanding of the personal, family, and social issues associated with suicide threats and attempts, and the issues surrounding Aboriginal suicide.
- Ability to liaise with mental health clinical specialists in acute, private, and community controlled healthcare settings.
- Commitment to reflective practices and experience in integrating client feedback and evaluation findings into program design.
- Demonstrated interest in and commitment to living in the Northern Territory and working with Indigenous and culturally and linguistically diverse communities, clients and work colleagues.
- Well-developed interpersonal skills and experience in networking, forming collaborative partnerships and working across sectors to achieve outcomes and service system improvement in response to client needs.
- Ability to work competently, be respectful to individuals, form part of a dynamic team, participate in supervision and appraisal processes and adhere to work plans.
- Ability to complete data and reporting commitments, self-organise and undertake a wide range of administrative and operational tasks on a daily basis.

The Support Coordinators received training which included:

- First Aid certificate (to be provided by Registered Training Organisation);
- Applied Suicide Intervention Skills Training (ASIST) (2-day suicide intervention training course provided by Anglicare NT registered Trainers using approved Living Works product);
- Safe Guarding Children program (online 3-hour training module provided through the Australian Childhood Foundation);
- WHS Induction includes Home Visiting Safety and Risk Assessment provisions (provided by Anglicare NT WHS officer);
- Home Visiting (in service training Home Visiting Safety and Risk Assessment provisions);
- Mandatory Reporting Orientation (in service on Child Abuse and Domestic Violence reporting requirements in the NT);
- Orientation to the NT CAT Team, Top End Mental Health Services and RDH; and
- Time allocation for professional reading / personal research on suicidality / case management / good practice client interventions / mental health system etc.

The Support Coordinators received day-to-day supervision and management from the Support Service Program Manager. Support Coordinators also received external clinical supervision as required.

The selection criteria for the Program Manager included:

- Tertiary qualification in Human Services/Social Science related fields.
- Experience (3-year minimum) in providing culturally relevant mental health case management / client support and / or family engagement services for 'at risk' / vulnerable individuals and/or families.
- Experience in project management or related areas.

- Experience in case work and project management (including contracts/budgets) with a strong focus on mental health and suicide prevention.
- Excellent oral, written communication skills and the ability to develop positive working relationships by liaising effectively with a wide range of internal and external clients, partners and stakeholders in an environment requiring cultural sensitivity.
- Experience in evaluation frameworks with strong data-gathering and analytical skills, being able to contribute to reporting and evaluation of health programs /initiatives.
- Strong Team Leadership, clinical supervision skills and management of day-to-day operations with the ability to monitor services to clients and deliver a service that is congruent with project guidelines.
- Personal qualities such as energy, initiative, commitment to teamwork and collaboration, focus on outcomes and respect for others.
- Cultural sensitivity.

2.2.6 Timeframes

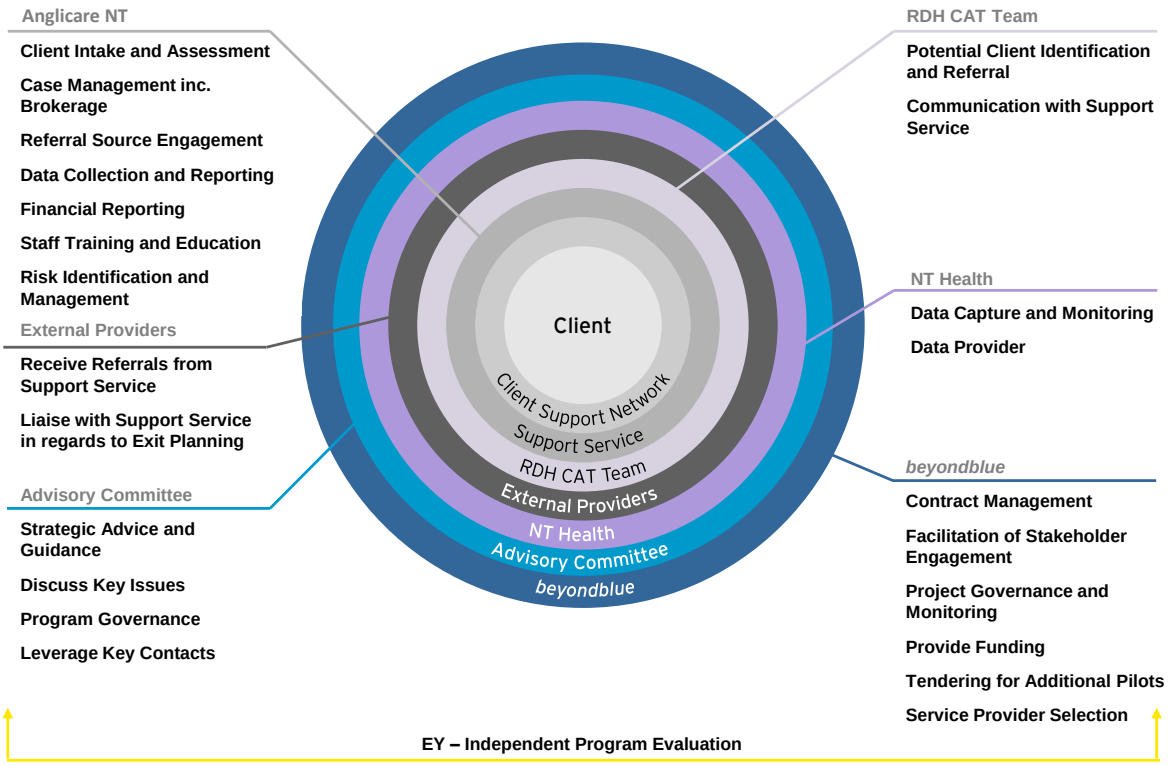
beyondblue commenced the scoping and development of The Way Back Support Service in January 2013. Anglicare NT undertook local planning processes (December 2013 to June 2014) and delivered the service (June 2014 – December 2015).

beyondblue contracted EY to develop and implement an evaluation of the Service (May 2014 to April 2016).

2.2.7 Stakeholders and governance

beyondblue project managed the development, delivery and evaluation of the Service. Key stakeholders and their functions are outlined in Figure 3. A steering committee was established to inform the development of the Service. This committee transitioned to an advisory group function once the operations of the Support Service were underway and well established.

Figure 3: Key stakeholders and functions



2.2.8 Funding

beyondblue funded the development, delivery and evaluation of the Support Service, with donations from The Movember Foundation ($930,000) over the period 2013 to 2015. This included research, service design and set up costs as well as service delivery costs.

3. The evaluation methodology

3.1 Key evaluation questions

The key evaluation questions to assess the feasibility of the Support Service model were:

1. Has The Way Back Support Service met client need in terms of appropriateness and satisfaction?
2. Have the processes to plan and implement The Way Back Support Service been effective, efficient and appropriate?
3. Based on available evidence, how feasible is it to implement The Way Back Support Service into more jurisdictions around Australia giving consideration to replicability, scalability and risk?

3.2 Evaluation process and design

An evaluation framework was developed to guide the evaluation. This included an outline of the project and evaluation approach, a program logic (see Attachment A), participant information sheets, survey templates and other supporting documents. EY consulted with the Aboriginal Medical Services Northern Territory (AMSANT) to design an evaluation was culturally appropriate for Aboriginal and Torres Strait Islander clients.

The evaluation process aimed to enable data capture, analysis and reporting to inform an understanding of each element of the Support Service and whether or not it met its intended outcomes. Data collection methods were selected based on appropriateness to the type of evaluation, available data and availability of stakeholders. This included qualitative and quantitative data collection. Through the analysis process, data was examined against the program logic and the objectives of the Service.

For the purpose of timely ethics approval, the evaluation consisted of two studies with mixed methods approach. The intended evaluation methods consisted of:

Study 1:

- Conducting interviews and surveys with key stakeholders regarding the formation and implementation of the Service, including *beyondblue*, Anglicare NT, the Advisory Group, and NT CATT.
- Obtaining de-identified data from Mental Health, Department of Health regarding the number of unconfirmed deaths by suicide in the Northern Territory.
- Obtaining de-identified data from Anglicare NT from their Penelope Client Information Management System.

Study 2:

- Interviews and surveys with clients and their support networks (e.g. family, friends, community), subject to consent, regarding their uptake and satisfaction with the Support Service.
- RDH de-identified readmission data for clients of the Support Service, subject to consent.

Three evaluation reports were provided to *beyondblue*:

- A formative evaluation report completed in March 2015.
- An interim evaluation report of process and early outcomes completed September 2015.
- A final report completed in August 2016.

3.3 Participants and data sources

The evaluation data sources included:

Administrative data collected through the client database (Penelope) and Anglicare NT monthly and brokerage reports. This included:

- Client demographics and geographical locations
- Referral sources
- Interventions provided

Client self-reported wellness data collected through the WHO-5 measure (n = 13). The WHO-5 is a wellbeing index questionnaire. It was to be completed at intake assessment, during the monthly or mid-way review, and during the discharge planning process. There were challenges undertaking the WHO-5 assessment, as described in Section 3.6.

Questionnaire with NT CATT staff (n = 6). Half of the CATT staff participated in a brief online questionnaire that assessed their use of the Support Service, a method consented to by the NT CATT Manager.

Interviews conducted with consenting clients (n = 6). Clients were interviewed following their participation in the program (see Section 3.6 for challenges in interviewing a higher number of clients). The interview was planned to be semi-structured but as three of the six clients indicated only limited time to complete the interview and the sensitive nature of the topic, a less structured approach to the interview was taken. Feedback was sought on:

- Perceived usefulness of the Support Service
- Experience of the interventions/meetings with the Support Coordinator
- Appropriateness of the support and linkages
- Level of knowledge and experience of the Support Coordinator
- Reason for conclusion of support with the service
- General outcomes since the Support Service

Interviews conducted with stakeholders. 46 interviews were conducted with key stakeholders across the commencement, formative, interim and final evaluations stages of the evaluation (see list at ***Attachment B for stakeholder list – repeat interviews conducted with selected stakeholders)***, including:

- Anglicare NT/Support Service staff – semi-structured face to face interviews (project commencement and formative evaluation) and semi-structured telephone interviews (interim and final evaluations)(n = 14 interviews with additional information on processes gleaned during data development assistance/combined project team meetings)
- NT Advisory Group (n = 19 interviews)
- *beyondblue* stakeholders (n = 8 interviews)
- RDH staff (n =5 interviews) + 6 online surveys

A semi-structured interview was used to seek feedback on:

- Perceived usefulness of the Support Service
- Effectiveness of the referral pathway
- Experience of interaction with the Support Service
- Level of knowledge and experience of the Support Coordinator
- Strengths and areas for improvement

The semi-structured interviews conducted included:

- Commencement/formative evaluation – 25 interviews
- Interim evaluation – 15 interviews
- Final evaluation – 6 interviews

3.4 Analysis

Descriptive statistical analyses of the administrative and client level quantitative data and a thematic analysis of the qualitative data were undertaken.

3.5 Ethics approval

The evaluator submitted the ethics application for Study 1 (HREC Reference Number 2014-2253) to Menzies Research Institute Human Research and Ethics Committee in August 2014 and received approval for commencement of Study 1 in October 2014. Study 2 ethics submission occurred in September 2014 with final approval received in March 2015. Approval for Study 2 was delayed by extensive consultation with the Northern Territory Department of Health to obtain consent and clarify methodology for obtaining de-identified readmission data for clients of the Support Service.

3.6 Limitations

There were a number of challenges in data collection during the evaluation. These include:

- Baseline data on presentation to the RDH for suicide attempt or suicidal crisis could not be obtained. No mechanism to clearly identify suicide attempt or suicidal crisis presentations at the emergency department was identified during the project. The existing process of coding self-harm presentations may or may not be related to a suicide attempt or suicidal crisis. Flagging and notification mechanisms were considered, but were not deemed practical given the high workload for NT CATT staff. The rate of referrals into the program is therefore unable to be reported. Anecdotally, however, CATT staff believed most appropriate clients were offered referral to the Support Service but this is unable to be confirmed. The rate of repeat suicide attempt or suicidal crisis also cannot be confirmed; however anecdotal feedback from CATT and ED staff suggests that the number of repeat presentations for suicide attempts or suicidal crises decreased during the trial period.

- Gaps in data collection by Support Coordinators (either not collected or missing data fields). These include the Indigenous status of clients (missing data for 21% of clients); and use of the WHO-5 (high rates of missing data, due to a perception among Support Coordinators that it may interfere with the client relationship).

- Limited data collection on a client's referral pathways on exiting the program. Some referral information was obtained through case notes, however there was no systematic collection of this data. There is also no clear data available to determine the contributing factors that may lead to an unplanned exit from the program.

- A limited number of clients being eligible to participate in the evaluation. Separate ethics applications were submitted for Study 1 and Study 2 of the evaluation. In Study 1 clients consented to providing de-identified data from the client information management system (including demographic information, marital/employment/financial status and occasions of service [frequency, mode, length of engagement]). In Study 2 clients consented to being contacted by the evaluators to participate in an interview following their participation in the program. There were delays in submitting and receiving ethics approval for Study 2. Of the 41 clients that consented to participate in the evaluation, 29 consented prior to the Study 2 ethics application being approved, and were therefore ineligible to participate in the follow up interviews. A subsequent ethics application sought to retrospectively contact clients who agreed to participate in the evaluation, under the ethics approval received for Study 1. However, this submission was rejected, as it was considered essential that clients were only contacted in the manner in which they originally consented to during the intake process.

- A limited number of clients participating in the follow up interviews. Of the 12 clients (14%) that consented to be contacted by the evaluators, following receipt of the Study 2 ethics approval, only 6 clients were able to be contacted. Multiple phone and text messages were used to follow up clients requesting the short 10 –15 minute interviews. Furthermore, although

appropriate risk mitigation strategies were in place and approved through the ethics submission, the evaluators recognise that the sensitive nature of the reason for referral to the Support Service, and the potential that revising the period of support reminds clients of a difficult period in their life may impact clients' willingness to participate in a follow-up interview.

- There is scope to improve the approach used to establish Key Performance Indicators (KPIs) and the data collection methodology prior to commencing service delivery. KPIs were not well defined at the RFP stage, and were not refined as the Support Service model became more defined in the planning phases. Furthermore, the Support Coordinators did not have prior experience with their chosen client information system, which was chosen and implemented without defining the required data necessary for an evaluation of outcomes. This led to retrospective process and data collection changes to capture the required data throughout the service delivery period. Early system planning is critical to the development of meaningful KPIs and reporting requirements to assess whether the Service is meeting its objectives.

Given the complexities in obtaining coronial data on suicides reflective of the period of the evaluation, the number of deaths by suicide was not included as one of the outcome measures. Anecdotally however, the Support Service are not aware of any suicide deaths of clients accepted into the service during the service delivery period (see Section 4.1.4 'Adverse outcomes' for more details).

While the limitations of this evaluation impact on the ability to draw conclusions about the role of the service in reducing suicide attempts, suicidal crises and deaths by suicide, it provides important process evaluation findings. The evaluation has assessed the feasibility of this new service model, and has documented key findings to inform the testing of the service model in larger trial sites.

4. Results

4.1 Quantitative results

4.1.1 Referrals

4.1.1.1 Demographic characteristics

During the trial period (June 2014 – December 2015) 122 clients were referred to the Support Service. Of these referrals:

- 40% (n = 48) were male and 60% (n = 74) were female
- 78% (n = 95) were under 45 years of age
- 14% (n = 17) identified as Aboriginal and/or Torres Strait Islander

Figures 4 and 5 outline the age, gender and Indigenous status of people referred to the program.

Figure 4: Age and gender of people referred to the program

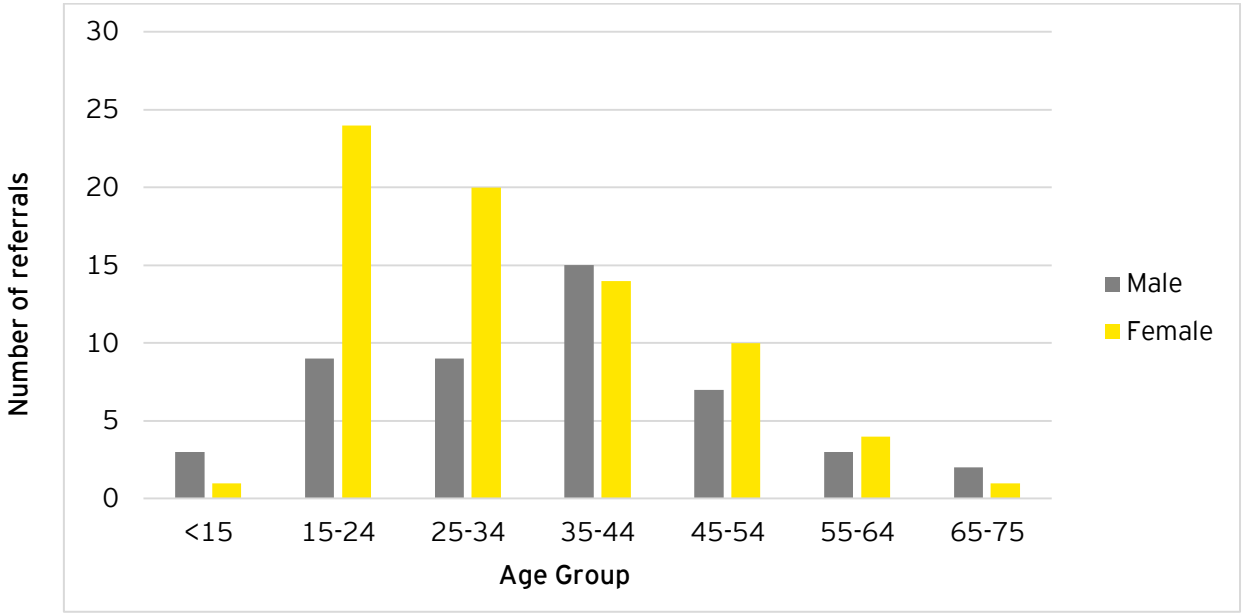
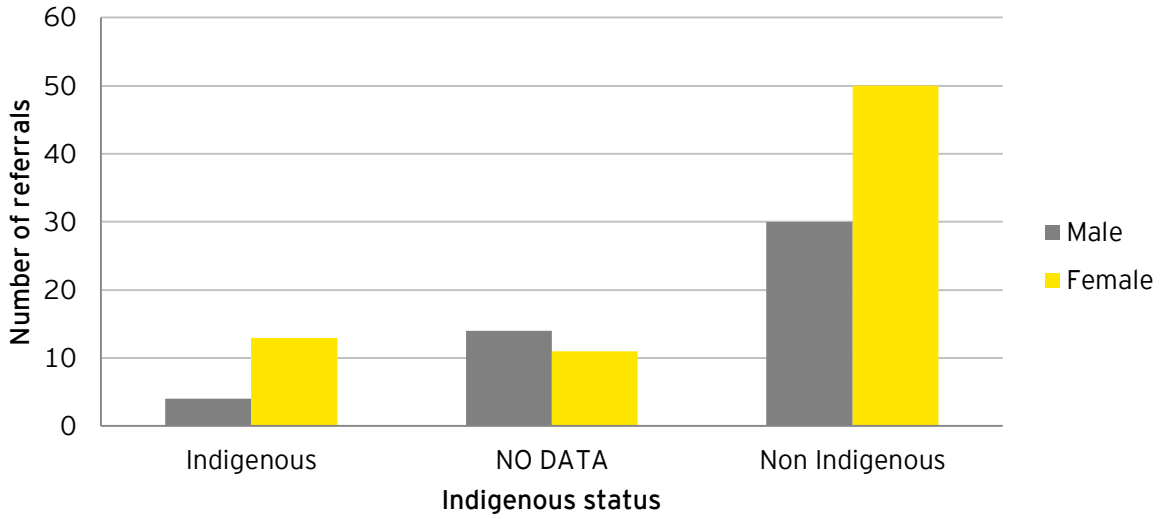


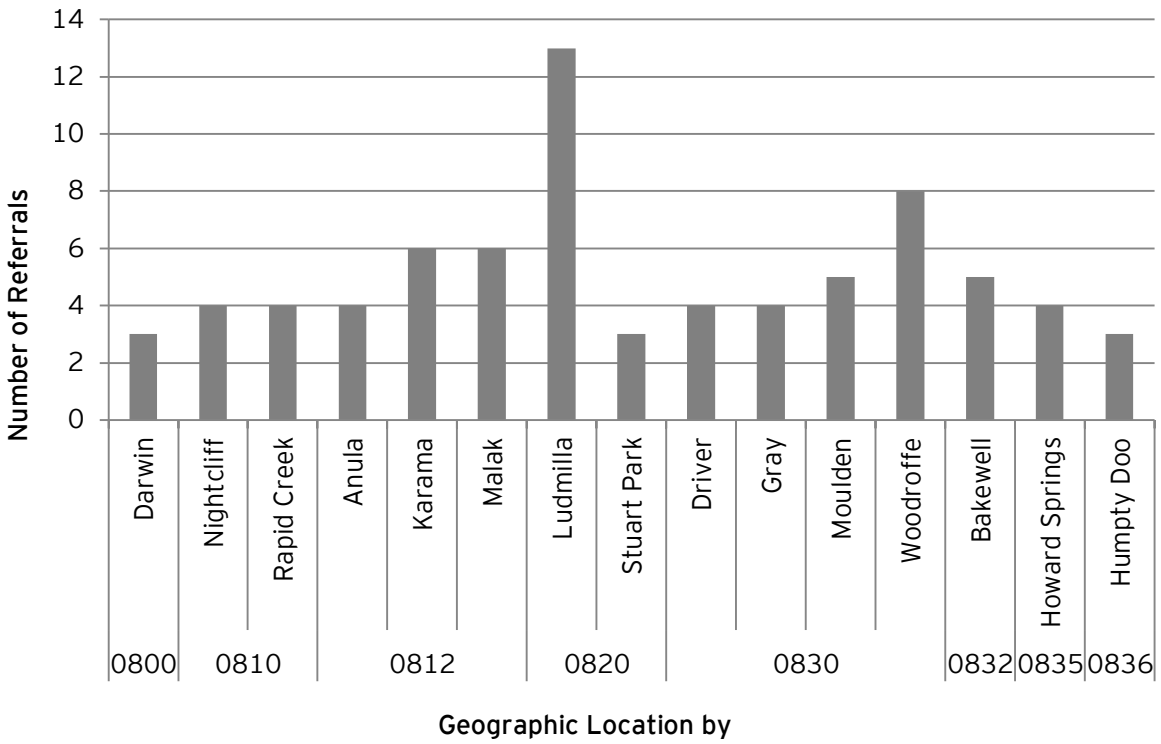
Figure 5: Gender and Indigenous status of referrals



4.1.1.2 Geographical location

The geographical location of people referred to the program is outlined in Figure 6. Most clients were from Darwin and the surrounding region.

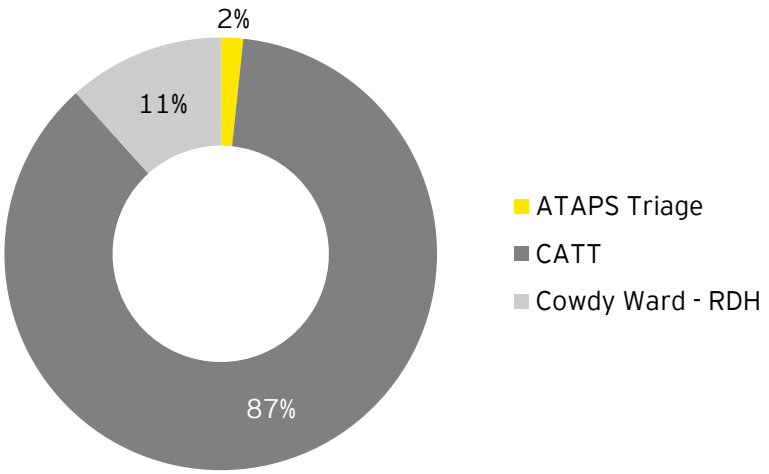
Figure 6: Referrals by geographic distribution



4.1.1.3 Referral sources

Of the 122 referrals to the Support Service during the trial 87% (n = 106) were referred by CATT; 11% (n = 13) from Cowdy Ward; and 2% (n = 2) were referred through the Sexual Assault Referral Service (via ATAPS triage) – as outlined in Figure 7. 96% (n = 117) of referrals were for a suicide attempt, and 4% (n = 5) were for suicidal thoughts.

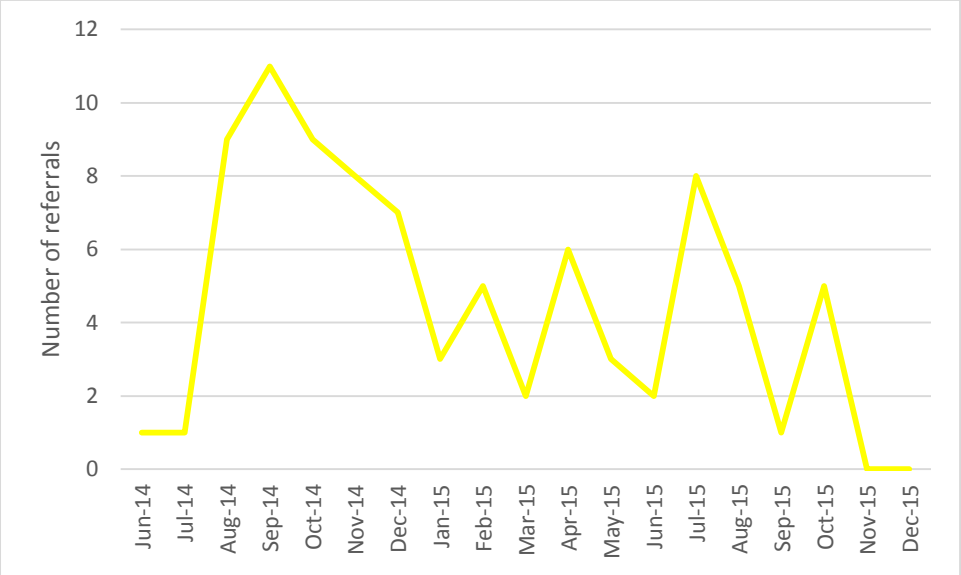
Figure 7: Referral source



4.1.1.4 Time trends

Referral rates fluctuated greatly month to month – as outlined in Figure 8.

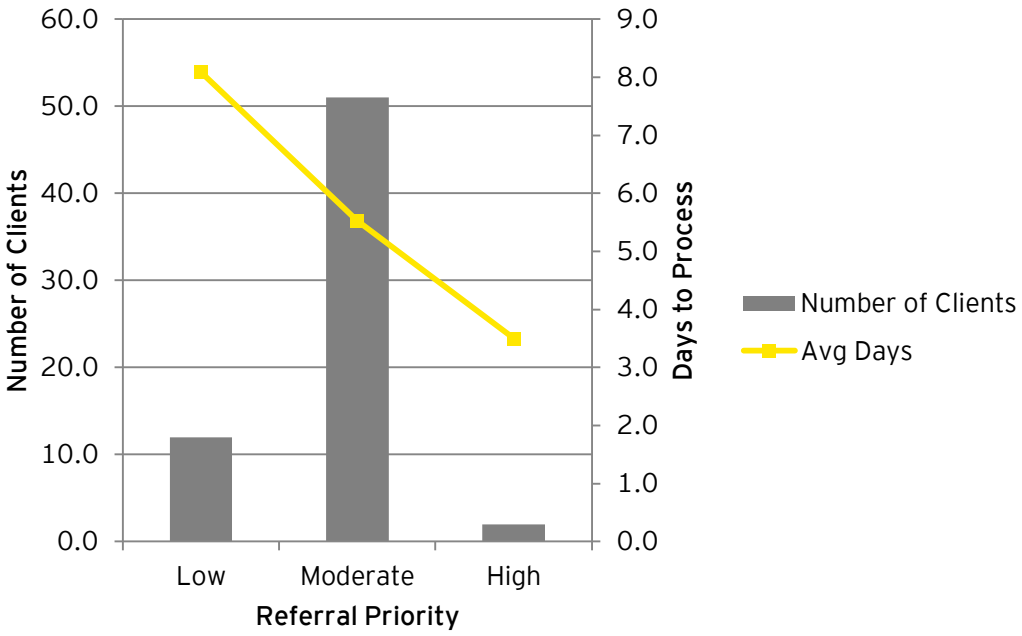
Figure 8: Referrals over time



4.1.1.5 Referral priority

Referrals were prioritised by staff, based on a self-assessment of the likely discharge time of the client and their level of family/community support. The referral priorities, number of clients, and days to process the referral, are outlined in Figure 9. No formal criteria were provided from the Support Service for the level assigned to the evaluator. In discussion with the service provider during the final evaluation it seemed this allocation was more arbitrary and a requirement of the data systems rather than a formal assessment of risk.

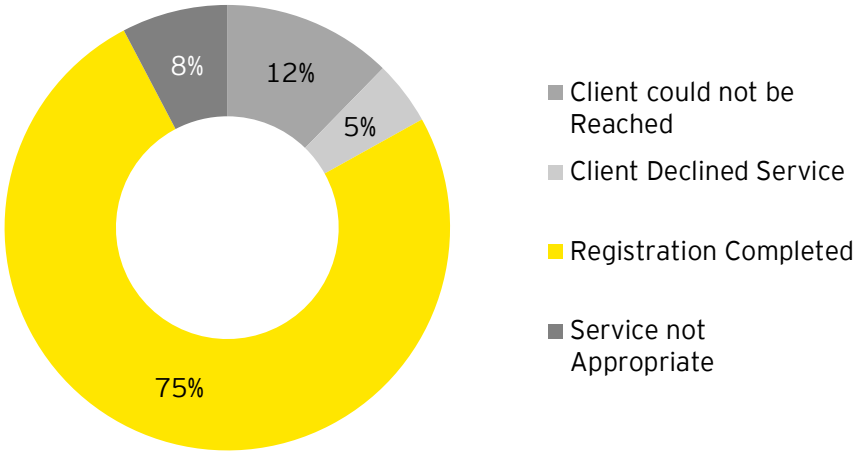
Figure 9: Referral prioritisation level comparison to intake time



4.1.2 Clients

Of the 122 referrals received by the Support Service, 71% (n = 87) participated in the program. The referral outcomes are described in Figure 10.

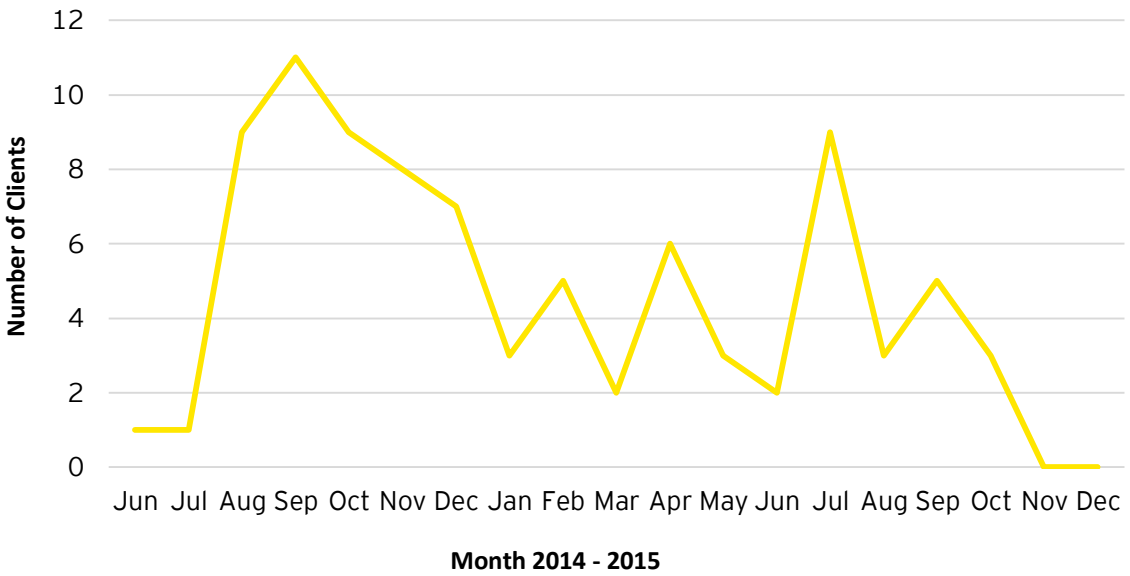
Figure 10: Referral outcomes



The Support Service notified NT CATT if there was no successful contact after seven days, and considered requesting a Police Welfare check. This occurred at least twice during the period of operations of the Support Service.

There was an average of six new clients each month, discounting the soft go-live period in June/July 2014 and the close out period from October to December 2015 (as outlined in Figure 11.

Figure 11: New clients per month (June 2014 – December 2016)



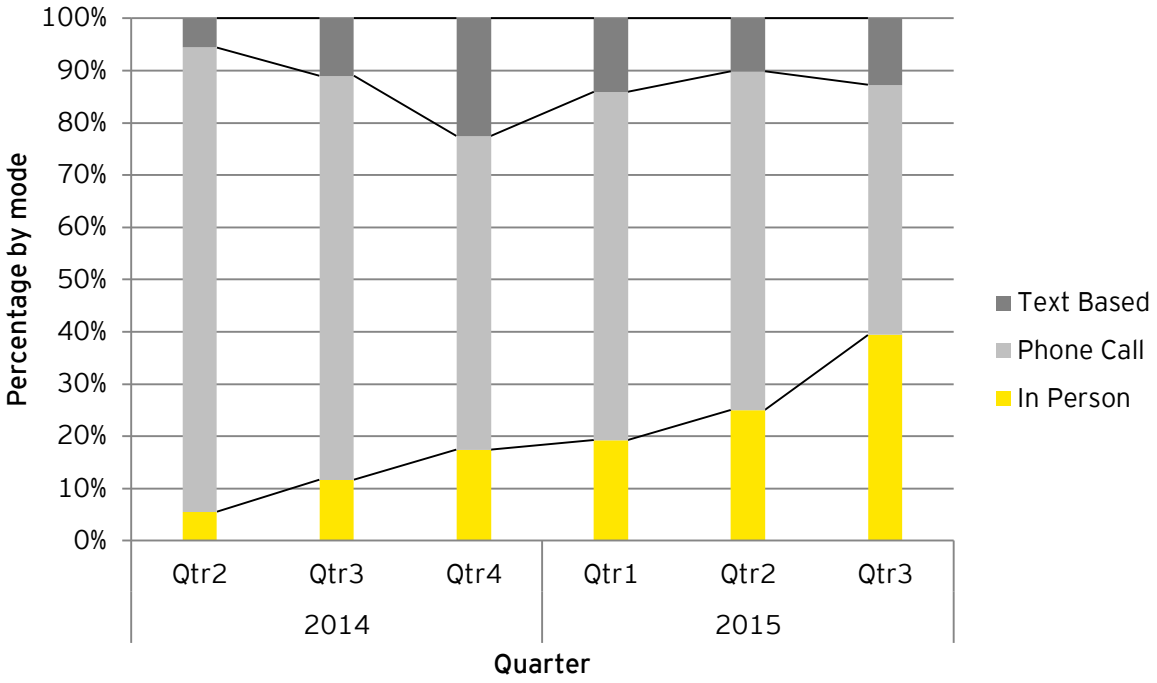
4.1.3 Services provided by Support Coordinators

4.1.3.1 Modality

Support Coordinators used a variety of methods to contact and support clients, including phone calls (64%, n= 497), in person (22%, n = 170), text messages (14%, n = 109). 776 direct contacts

with clients were made. Over time, Support Coordinators increased the proportion of contact made in person – as outlined in Figure 12. However, the reasons behind these increases were not able to be determined. Contact time would vary between 15 minutes for follow-up phone calls, to 1 to 2 hours when face-to-face assistance with managing/advocating with other service providers.

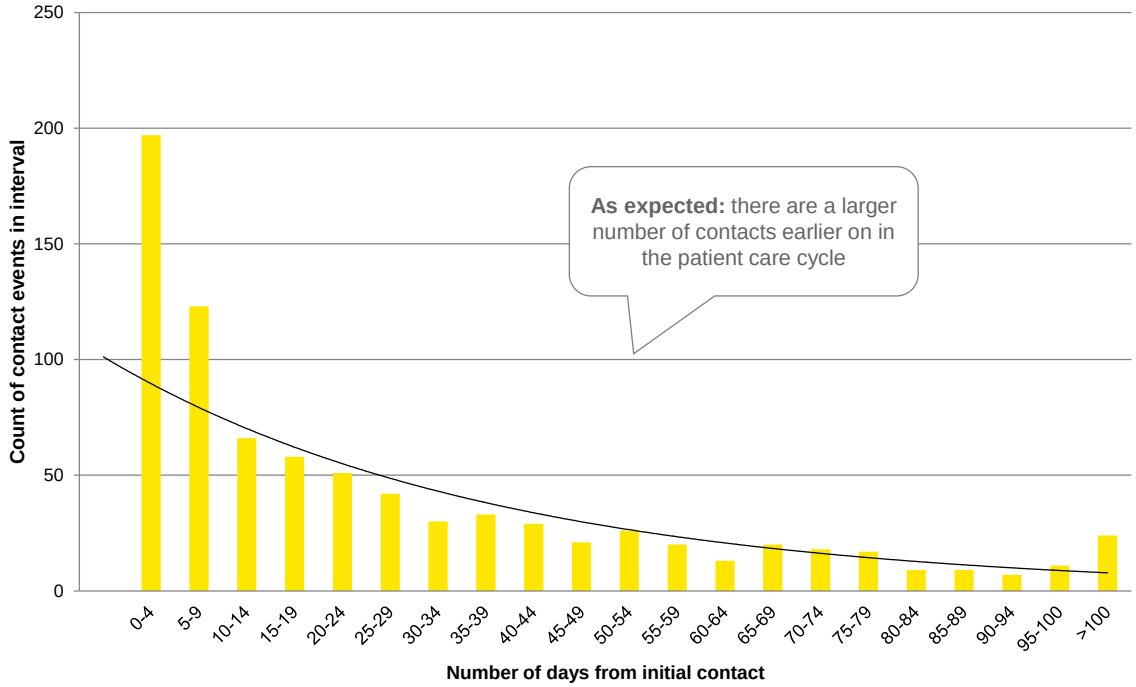
Figure 12: Contact modes over the trial



4.1.3.2 Frequency

Most contacts occurred in the first weeks after entry into the program. The frequency of contact then reduced over time – as described in Figure 13. This reflects the more intensive nature of client need in the period closest to the suicide attempt or suicidal crisis, and suggests that less support is required as the client begins to build resilience and self-sufficiency, although this varies from person to person and some people benefit from or require intermittent or more extensive contact over an extended period as discussed below. The Support Service aimed to provide up to 90 days support.

Figure 13: Frequency of contact over time



4.1.3.3 Referral and brokerage services

Support Coordinators facilitated a range of referrals to external services. This included a mix of practical support and connections with health and social services. The most common referral and brokerage service included emergency accommodation, followed by support to obtain food, clothing and household items. Data was provided by the Support Service for external referrals between January and August 2015:

- Practical support (n = 31) – for example, emergency accommodation, support to obtain food, clothing, household items, legal aid, Centrelink, advocacy services
- Medical support (n = 12) – for example, general practitioners, alcohol and other drug rehabilitation
- Psychiatric support (n = 6)
- Counselling/psychologist (n = 6)

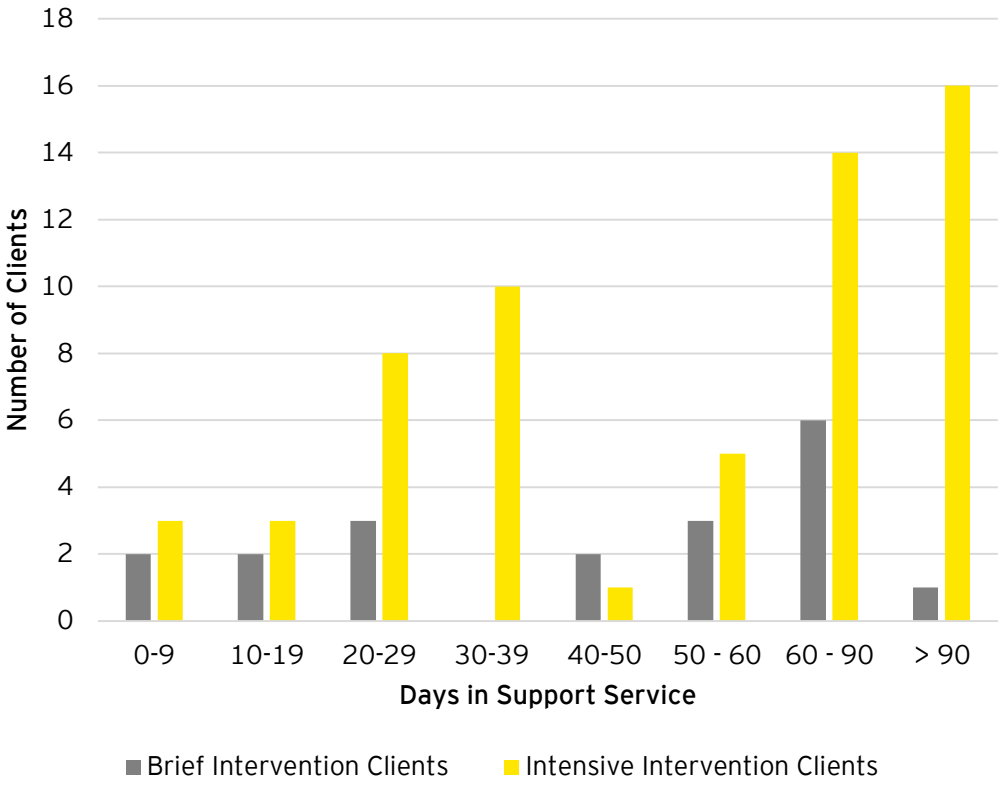
4.1.3.4 Brief and intensive interventions

Clients received a brief or intensive intervention. Brief interventions (22%, n = 19) occurred when a client was able to be contacted but did not agree to the Support Service consent / assessment processes. In these instances, Support Coordinators sought agreement from the client to provide follow-up via phone.

Intensive interventions (78%, n = 68) were defined as when the client consented and participated in the first intake assessment and agreed to ongoing support.

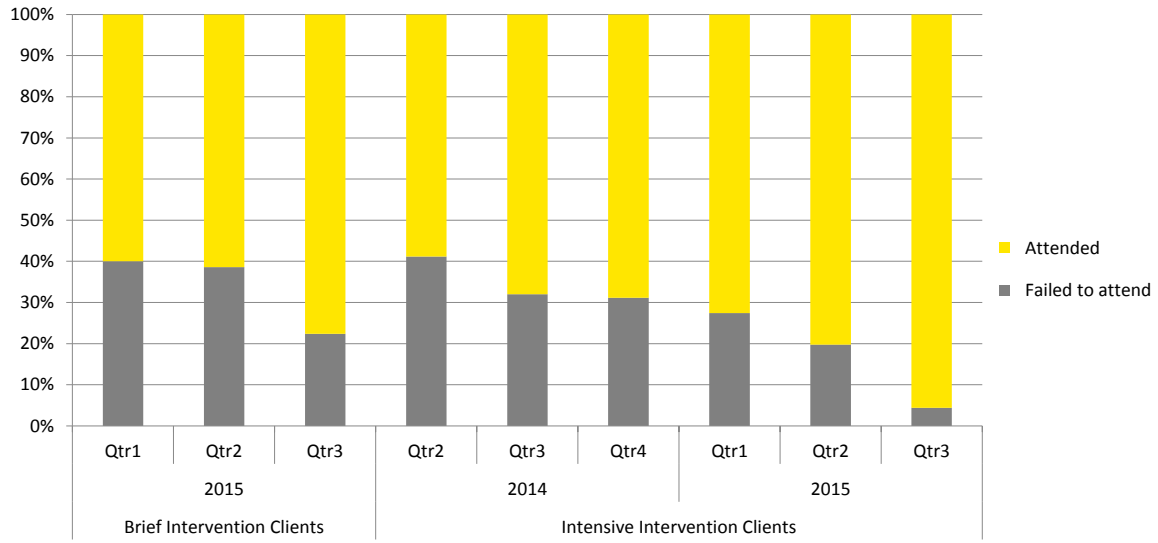
Clients that received a brief intervention received on average 31 to 34 days of support, while clients that received an intensive intervention received on average 86 to 88 days of support. The days in the Support Service, for people receiving both brief and intensive interventions is outlined in Figure 14. 28% (n = 24) of clients remained in support for less than one month; 53% (n = 46) of clients remained in support for between one and three months; and 20% (n = 17) of clients remained in support for greater than three months.

Figure 14: Number of days of support provided to brief and intensive intervention clients. (Note n = 79 due to unclassified data).



Most Support Service clients (73%, n = 64) attended their planned appointments with their Support Coordinator. The proportion of clients who failed to attend their appointments varied over time, with a slight downward trend in the closing quarters. The definitive reason for this was unable to be determined but staff suggested it may have related to individual characteristics of clients rather than a change in program approach. The attendance at appointments over time, for clients receiving both brief and intensive interventions, is outlined in Figure 15.

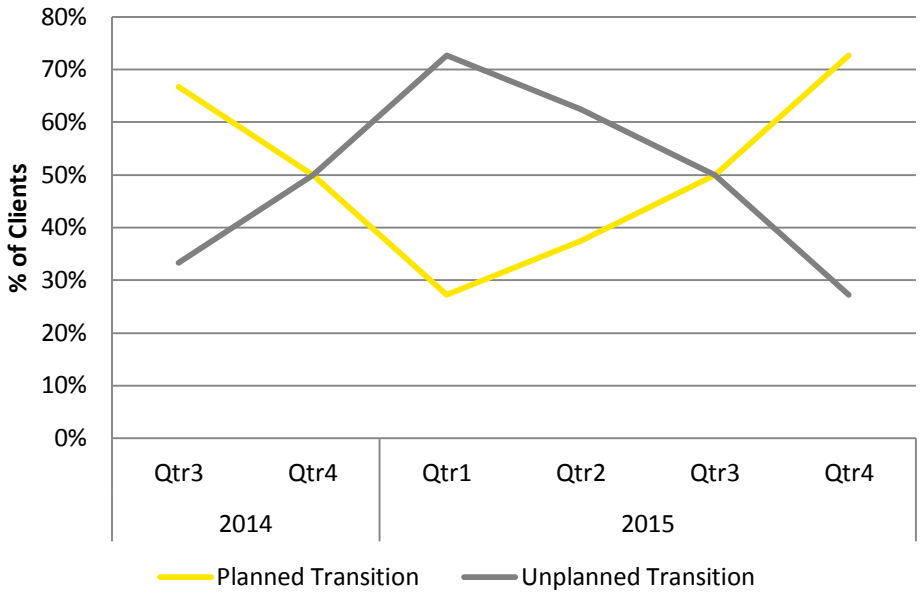
Figure 15: Contact attendance over time for brief and intensive intervention clients



4.1.3.5 Planned and unplanned exits

Clients exited the program in either a planned (47%, n = 41) or unplanned (53%, n = 46) way. An unplanned transition is when the Support Coordinator was unable to contact client or there was a cessation of service by clients with whom contact had been established was not discussed with Support Coordinator. The rate of planned and unplanned transitions varied across the trial – as outlined in Figure 16. There is no clear data available to determine the contributing factors that may lead to an unplanned exit from the program.

Figure 16: Percentage of planned versus unplanned transitions



4.1.3.6 Differences in client experiences

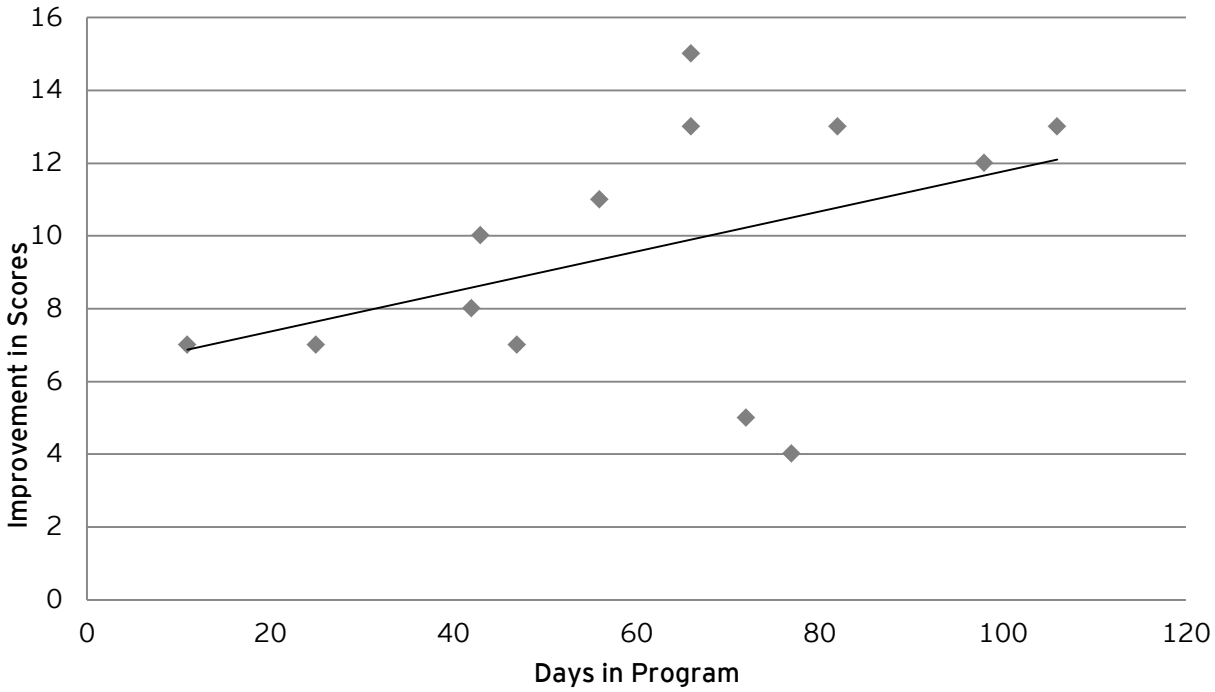
Client participation in the program varied based on the type of intervention (brief versus intensive) and whether the exit was planned or unplanned. Clients that received an intensive intervention had an average of 14 completed contacts for planned transitions and 9 completed contacts for unplanned transitions. Brief intervention clients had an average of 3 completed contacts in both planned and unplanned transition groups. Of those clients receiving greater than the planned three months support, two thirds had a planned transition and one third had an unplanned transition.

4.1.4 Client outcomes

4.1.4.1 Self-reported changes in wellness

15% (n = 13) of clients completed a WHO-5 prior to, and after, their participation in the Support Service. Of these clients, the average score on intake was 12.5 and the average score on exit was 22.5. This demonstrates a 10 point improvement in wellbeing following participation in the Service. The trends in WHO-5 improvements aligned with duration in the program, are outlined in Figure 17. It is important to note that improvements in wellbeing appear to be correlated with a longer duration in the program, however a causal relationship cannot be inferred.

Figure 17: Improvements in WHO-5 scores and days in program



4.1.4.2 Adverse outcomes

The Support Service reported an elderly client within the Service, who was receiving a significant amount of support and was progressing well, fell suddenly ill and passed away in RDH from non-external causes (i.e. non suicide death). Staff working with the client was well supported through this event, and were commended for the progress the client had made despite it being for only a short period.

One person died following referral and prior to the Support Service establishing contact. A full review of the critical incident highlighted the Support Coordinator had attempted to contact the potential client on receipt of referral in line with procedures but were unable to establish contact.

4.2 Qualitative results

4.2.1 Client views

Six clients were interviewed and provided feedback on their experience with the Support Service. One client received a brief intervention, and the other five clients received an intensive intervention.

4.2.1.1 Perceived usefulness of the Support Service

- Every client interviewed stated the Support Service was extremely important, had helped them post their suicidal crisis or suicide attempt.
- All interviewees suggested the Support Service was needed in the NT and stated their belief the service or something similar should be available.
- Every client interviewed reported improvements in the social and emotional wellbeing following their engagement with the Support Service.
- The cultural flexibility, knowledge and respect were highly valued by clients with a non-English speaking background (two clients interviewed with English as a second language).
- Clients spoke of the service having assisted them to deal with or improve the circumstances which had led to hospitalisation.

- Every client spoke of some relationship issue or breakdown which was a co-contributor to their circumstances. Three clients spoke of significant financial/business hardship as a co-contributor. Immigration issues were a compounding factor for two of the clients interviewed.

4.2.1.2 Experience of the interventions/meetings with the Support Coordinator

- The non-clinical nature of the program was deemed highly beneficial and a supplement to clinical services.
- They reported the main contact was follow-up phone call, with three of the six clients providing feedback on the positive nature of the discussions which occurred when face to face meetings with the Support Coordinator occurred.
- Most reported that they felt there was benefit in the Support Coordinator not being a registered health professional. They stated they felt that the stigma around their circumstances was reduced by the highly competent, but non-health professional. Two people interviewed felt the Support Coordinators were less judgemental than hospital/health staff.

4.2.1.3 Appropriateness of the support and linkages

- Five clients had received a face to face intake assessment; one had completed the intake interview on the phone.
- Clients spoke of follow-up phone calls which ranged from every couple of days (initially) or weekly. When asked if this level of support was appropriate the majority of clients suggested the follow-up contact was of the right level.
- One client felt more follow-up and for longer than the three-month support period was required.
- Four clients talked about the advocacy / advisory approach taken by the Support Coordinators. They stated they highly valued this approach as it allowed them to remain independent and get back to doing things for themselves. At the same time, they stated they felt appropriately supported and that they would be able to return if needed.
- Clients spoke of a variety of support services to which they were linked. These included facilitation of psychological counselling for three of the six clients interviewed. Drug and Alcohol counselling was the linkage for one client, support accommodation for another and two clients were supported with obtaining financial counselling and support.

4.2.1.4 Level of knowledge and experience of the Support Coordinator

- All clients interviewed praised the experience, knowledge and engagement ability of the Support Coordinators.
- Every one of the clients interviewed spoke of a non-judgemental experience and felt the Support Coordinators listened and individualised support recommendations to their personal circumstances and needs.
- All clients spoke of the level of rapport they developed with Support Coordinator and they felt they could ask for support if required.
- One non-English speaking background client spoke of the Support Coordinator assisting them with completion of forms. Another spoke of the Support Coordinator taking them to the psychologist to so that the appointment occurred.

4.2.1.5 Reason for conclusion of support with the service

- Four of the six interviewed clients felt they had left the Support Service and concluded support at the right time. The reason for conclusion was stated by the majority of these as their personal decision – that the issues leading to the suicide attempt or suicidal crisis had resolved to a level that they could now manage on their own.
- There was a mix of feedback in relation to the duration of support. About half stated the flexibility of the support and timeframe was about right. However, the other half described challenges with the need to transition out from the Support Service after 3 months. This cohort felt strong rapport had been built with the Support Coordinator and did not want to lose this until they felt ready.

- Two clients interviewed were in the last three months of the study and stated that they left the service, as they were told it was closing.

4.2.1.6 General outcomes since the Support Service

- No client interviewed reported attempting suicide again, although two people interviewed stated they were still under significant stress and did not feel all of their problems had resolved. Both these clients had been with the Support Service for around 3 months but had ceased in December at the closure of the trial. Follow up with Anglicare has been facilitated for these clients.

One client summarised the general feeling of the people who agreed to be interviewed for the evaluation:

> *"The Support Coordinator was so good, she really helped me get through a really rough few months. It made a real difference and I'm now through the other side and much more positive about life. Definitely worthwhile having a service like this around – it helped me back to being myself again"*

Others stated:

> *"It is a very valuable service. Definitely the personal connection is what makes a difference. No point in holding back – be honest. I'm really in a good place now. Still have all these legal issues but I'm dealing with it. But timeline can't be just 3 months –you need time to be able to reconnect. The timeframe needs to be able to be flexible."*
>
> *"I'm back working now. It was a pretty hard hit to lose your business and have nowhere to go to. They really helped me pull myself up and get back on track. I travel now for work which I never thought I'd be able to do again"*
>
> *"Losing my relationship sent me into a spin. Doing FIFO work was so hard and I just lost all energy for life. …Following the contact with [Support Coordinator] I went and got some help and counselling. Now I'm moving back home down south. The job and relationship have gone but I've been able to move on"*

The following Case Studies are provided to further highlight the interventions provided during the Support Service trial:

Case Study – person who received a brief intervention (8 hours' support provided)

Female, non-English speaking background, 41 years old, Single with 3 young children

- Entered the Support Service following referral from NT CATT after presenting at RDH Emergency following suicide attempt.
- Her business had gone into liquidation and states she was under immense financial pressure and personal relationship stress, the latter related to a breakdown in relationship with her boyfriend.
- Received brief intervention support between July and August 2016. A total of 8 hours' support was recorded over the period
- Met with male Support Coordinator – she believes that was three times in person. Reported the Support Coordinator to be highly skilled, calm and practical in advice
- In addition to intake and exit assessments and procedures, the client received four support contacts with all but one of these support contacts being in person with the Support

Coordinator

- She also received an informal mentoring phone call follow up and practical facilitated support to assist with accessing financial counselling

Case Study – Person who received an intensive intervention – 91 days' support (20 hours)

Female, 51 years old, full-time employment in own business until liquidation of business

- Referred by Cowdy Ward following admission for depression post suicide attempt
- Received intensive intervention support between June and September 2016. This equated to approximately 20 hours' direct client support being recorded in Penelope over the period
- In addition to intake, progress and exit assessments and procedures, the client received nine support contacts in person with the Support Coordinator and seven facilitated support occasions of service with the Support Coordinator.
- Facilitated support was assistance with financial counselling, Centrelink and accommodation. Facilitated warm connection to a psychologist and psychiatrist through ATAPS/Medicare
- At interview the client spoke of her large family and work responsibilities. Due to her suicide attempt she had left work.
- Contacts were between 1 and 3 days apart. The space between contacts extended during the support period as the client felt more in control and able to manage with less regular support. Even with this the maximum period between contacts never exceed 2 weeks and was a tapering of support during the transition planning phase.
- Following facilitated support, the client reports she has recommenced work and travels to remote communities in the area of community development. She states life is much more balanced and she is able to cope better with the psychosocial stressors she faces.

Case Study – Person who received an intensive intervention with predominately phone based support

Female, 31 years old

- Received intensive intervention support for four weeks in September 2015
- Main support was telephone counselling during the period where the Support Service facilitated engagement with an ATAPS psychologist
- Support occurred on 8 occasions with a total direct client support time of approximately 4 hours
- She stated she was very happy with the service she received and the tailored support provided. The client stated she appreciated the non-judgmental, 'down to earth' nature of the staff and the way they engaged her at the time she was ready

Person interviewed by EY for the interim evaluation - Male, 30' s, FIFO worker, suicide attempt

- Mr W was referred to TWBSS via NT CATT after a presentation on a Friday to the Royal Darwin Hospital Accident and Emergency. His partner had been extremely worried about him when he expressed suicidal thoughts after a heavy bout of drinking and had called an ambulance.

- TWBSS case manager contacted Mr W two days later and discussed the program's approach with him over the phone. Mr W agreed to meet up with the TWBSS case manager and talk through what was happening for him. He was receiving daily calls from NT CATT in the interim.

- In their first meeting they went through the intake assessment and Mr W agreed to be part of the TWBSS evaluation. Mr W described a number of pressures on him including the breaking down of his relationship with his partner and the impact of working on 14 days on night shift with his Fly In Fly Out work with an Energy company. Mr W described the positive experience of meeting with an "everyday bloke" who listened and didn't judge him.

- While he felt OK at work it was reintegrating with his partner and family when he came back to town that was difficult. He used to play footy but now with the rosters he wasn't able to and felt very isolated. At work many of his work colleagues were quite down, with a number of people getting divorced. These issues impacted Mr W and eventually led to his attempt on his life.

- Mr W stated, "I didn't feel there was anyone I could go to and just having someone I could go up the street with for a talk was really helpful. I didn't want to see a shrink. Having a normal typical bloke you could go up the street with really helped.

- Mr W and his case manager discussed a number of support options. The case manager arranged follow-up with a GP and coached Mr W on how to access a parenting payment through Centrelink. Mr W followed through on both appointments.

- Mr W and TWBSS case manager continued to make contact both by phone and face to face over the next couple of months. Mr W reported TWBSS helped him "learn how to turn a negative into a positive". He felt he benefited from the regular follow-up phone calls, contact from the support service that was flexible to his roster and fitting into his routine. He would have liked to have had more face-to-face contact with the service but his rosters often didn't allow this – the phone calls provided continued support between these meetings. "They were always persistent in ringing up and following up. CATT line was also there and they kept reinforcing that".

- Mr W has now moved back to Melbourne taking away one of the stressors and being closer to his parents. He organised a local GP by himself and states he feels well supported. His partner recently had their second child and while they have not reconciled their relationship he remains an active part of his children's lives.

- Mr W was asked about his advice to other people in a similar situation to himself. He said, "Make sure you speak to someone. The FIFO life is hard and just telling someone to Fit In or F Off doesn't help. But that they should still be able to talk to someone like TWBSS. It really helps".

Case Study provided by Anglicare NT

Male, Indigenous, 33 years old, single with no children

- Relocated to Darwin from Remote region because of mental health / suicidal thoughts, strong connection to traditional lands, culture.
- Received intensive intervention support for four weeks in September 2015
- Main support was telephone counselling during the period where the Support Service facilitated engagement with an ATAPS psychologist
- Contact was both by phone and face to face
- After three months in the service, reported feeling more in control, mental health medications were reduced
- Moved back to community, then lost to follow-up support
- Sister reported that the Support Service had been very helpful for client

Case Study provided by Anglicare NT

Female, 31 years, full-time employment. Extensive case history of mental health issues, well known to services

- Referred by NT CATT following suicide attempt and presentation to Accident and Emergency
- Contact was both by phone and face to face
- Supported to access AOD services, re-engage with sexual assault Support Coordinator, re-referral to NT CATT following reports of suicidal thoughts, obtain furniture
- Re-admitted to Cowdy ward due to persistent suicidal thoughts. Contact with the Support Service ceased, but client had ongoing support with mental health services.

4.2.2 Stakeholder views

Interviews were conducted with key stakeholders from the service provider and *beyondblue* occurred during the formative analysis phase of the evaluation. Follow-up interviews were conducted with Anglicare NT staff during the interim and final evaluations. A survey of the NT CATT staff occurred during the operational phase of the project. Further interviews occurred with selected members of the Advisory Group, referrers and the staff employed in the Support Service to inform the transition planning process and to obtain their overall impressions on the impact of the Support Service in the Darwin area.

4.2.2.1 Support Service trial planning, governance and operational commencement

beyondblue undertook early stakeholder engagement through convening a local forum to discuss possible solutions to the high rate of suicides in the NT. The forum was used to inform the need of further suicide prevention activities, but not to directly develop the Support Service model.

Allowing for delays related to early unsuccessful negotiations, *beyondblue* made an early decision to work with a local service provider to develop and deliver the service. Interviewees noted that

Anglicare NT and the individuals delivering the Support Service were held in high regard in the local service system.

From idea conception to engagement of the Service Provider, the role taken by *beyondblue* shifted from the originally intended role of contract manager, to a more 'hands on' role. Changes were made in response to changes in the context of the project and learnings from earlier negotiations with a potential contractor. The original intention was that this contractor could develop the service delivery model and oversee it on behalf of *beyondblue*, but this was deemed unviable by *beyondblue* as the project definition and operational development phases of the project occurred. Interviews with the Service Provider highlighted their view that these expectations had been unclear. Interviews with *beyondblue* stakeholders found that *beyondblue* – as commissioner and funder (using donations to The Movember Foundation and *beyondblue)* and therefore ultimately accountable for the project results – felt it necessary to take a more active role in the development and approval of key operational documents than had been planned for. Both sets of stakeholders noted these issues led to tensions throughout the trial/project.

Figure 18 below summarises the timeframe for development and implementation of the service. It highlights the extensive period of development and engagement in a trial of a service model of this kind.

Figure 18: Summary of project and trial development and operation phases

Project Milestones	2012	2013				2014				2015				2016
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1. Qualify														
Establish need for the program, project objectives & outcomes		Establish												
Secure funding	AHA + Mov-ember													
2. Plan														
Define Project Management Plan, governance, resourcing, risk management, procurement and communications (beyondblue)		Establish						Revise		Expand				
Define Service parameters: Criteria, referral pathways, delivery model, resourcing, and risks		Establish		Refine				Revise						
Engage Key Stakeholders														
• Mental Health, NT		Mental Health, NT												
• Service provider			NTML		Tender	AnglicareNT								
• Steering/Advisory Committee						Steering Com.		Revise		Advisory Committee				
• Referrers						CAT Team		Revise		CATT + Cowdy Ward (RDH)				
• Consumers		Forum												
• ATSI representation						Advisory Group members + Case manager								
• Evaluator						Tender	EY							
3. Service Delivery														
Client intake						Prepare		Intake						
Project management						beyondblue								
Reporting						beyondblue, AnglicareNT, EY								
4. Project Close														
Service wind-down													Finalise	
Project evaluation							Mobilise	Ethics		Evaluate				Report

There was some initial ambiguity about the role of the Advisory Group. Initially the committee was formed as a steering committee, but appeared to be designed to function more as an Advisory Group. This led to some confusion at the initial meetings, with members appearing to take different approaches to the meeting discussions, based on their individual understanding of their role. This was recognised as a problem by *beyondblue*, who then redefined the committee and explained the role of the committee as being advisory, rather than directive. However, the main referring agency noted that they had early involvement in developing the service model and that their views were accepted and incorporated.

Some committee members noted that there were significant shifts in activity or other service-related matters during the project establishment. This is accepted as normal and, in fact, desirable

in a new project, however there was a view that members could offer more value in their advisory role if they were kept up to date on major changes between Advisory Group meetings.

When asked about the Anglicare NT staff involved and recruited to the project, all relevant stakeholders interviewed were highly supportive of the recruitment, skill set and levels of training provided to Support Coordinators. The Support Coordinators and managers were seen to be highly skilled. The inclusion of a Support Coordinator who identified as Aboriginal or Torres Strait Islander was seen to be beneficial given the demographics of the region. Stakeholders reported Support Coordination staff employed as having extensive local experience with highly regarded client engagement skills. This was seen to be a benefit for a new program in its trial phase, an essential element of the rapport and engagement model which underpins the Support Service and a risk mitigation strategy.

4.2.2.2 Referral processes and referral agent engagement was key

Stakeholders interviewed during the formative evaluation phase suggested the referral criteria and referral processes were appropriate and working. Informants noted the effort being made by the Support Service staff to maintain engagement and inform local stakeholders about the service. This was seen as essential for a new service.

The referral process relied heavily on the trust, relationship, confidence and ongoing engagement between NT CATT / Cowdy Ward and Anglicare NT. While a Memorandum of Understanding (MOU) and referral procedures were developed collaboratively, operationalising the process and NT CATT / Cowdy Ward staff referrals required ongoing engagement. Face-to-face meetings and regular phone contact between the services increased referrals throughout the project but staff and leadership changes within referring units meant regular engagement was required to maintain the regularity of the referrals.

While referrals into the program were slow to begin with, this was not viewed by the Advisory Group and referring agencies as a criticism of the service or the service provider, but more an issue of marketing and embedding the new service into local systems and processes. Some informants commented that it was important that the service and being offered by a locally established organisation as this enhanced the Support Service its credibility with local providers. When key leaders in the referring units were on leave or secondment, stakeholders interviewed suggested referral rates would decline. While the inclusion and referral criteria were well understood by the teams, the sporadic nature of referrals and clinical commitments meant referral to the Support Service was not always front of mind, according to some stakeholders. The need for constant and ongoing investment in engagement with referrers is a key finding of the trial.

CATT NT was a key stakeholder in the service and the largest source of referrals. An interview was undertaken with the Acting Team Manager. This stakeholder expressed strong support for the Support Service, as it provided another referral option for clients and it filled a current gap in services for people who had attempted suicide. The stakeholder reported good relationships between the CATT NT team and Anglicare NT, and considered the team to have a good understanding of the Support Service.

A survey was also conducted with the CATT NT team as part of the interim evaluation, with six of the 12 team members responding. This stakeholder requested that a very brief computer based survey be provided to staff, to minimise impact on staff time. The survey was conducted; however, the findings of the survey are limited. Nevertheless, the results indicated strong support for the Support Service, which is supported by interviews with CATT and Cowdy Ward staff. A summary of the results is shown below:

- All participants had referred to the service
- All participants found the referral process easy
- Four out of five staff found the referral criteria clear

The relationships with referrers required ongoing development. Staff changes from referring units may have impacted on the number of referrals despite ongoing engagement and communication of the inclusion criteria and referral pathway. While definitive referral targets were not set for the trial, the number of referrals was anecdotally lower than those expected at the conception of the trial.

4.2.2.3 Service level operations feedback

Support Service staff attempted to meet clients who are inpatients of Cowdy Ward face-to-face prior to discharge. As most clients are referred through NT CATT the ability to visit the client prior to discharge (often from ED) was often limited. The Support Service staff interviewed for the formative evaluation noted challenges with initially contacting some referred clients. The Support Service staff felt some clients may agree for referral at the time of discharge planning in order to facilitate discharge, but may later choose not to engage. While the client may have consented to referral by NT CATT, they often chose to either not answer their phone following discharge and/ or not return calls.

Referring agencies and selected Advisory Group members interviewed during and at the conclusion of the trial highlighted their view that the interventions and support provided by the Support Service was extremely valuable. The extensive experience and expert engagement skills of the staff employed in the Support Service was highly regarded. Stakeholders interviewed felt it was this engagement skill set, experience in the suicide and community service area and local network knowledge that influenced the success of Support Service at the individual and local level. Stakeholders also stated that the Support Service filled an important service delivery gap in Darwin. Both these groups of stakeholders spoke of the respect they had for the local expertise of the Service Provider and in particular the knowledge and competence of the Support Coordinators employed in the service.

There had been some initial concern expressed by a few external stakeholders as to the overlap of the Support Service with other service offerings (e.g. Partners in Recovery program). While acknowledging this may be a concern in other locations and jurisdictions, stakeholders on the Advisory Group, from Anglicare NT and NT Health countered this concern by highlighting the limited access to support services in the Darwin area. When the types of support, interventions and linkages were described to these stakeholders they reported these as appropriate for the local environment. That is, the Darwin area has limited service provision options and those utilised were deemed appropriate within local service availability.

A high number of clients are lost to follow up and efforts to contact required a substantial investment of time in order to determine safety and to confirm their wish to leave the service. Anglicare NT reported that they continued to follow the established protocols regarding follow up. Service providers reported that unplanned exits occur when clients feel they are ready to move on and do not feel a need to contact the service.

Staff reported challenges supporting those clients residing outside the metropolitan area but Support Coordinators spoke of the need and impact of utilising local health services and family networks when someone lives outside Darwin. The Service was able to provide significant encouragement and mentoring to the isolated clients, and transitioned them out of care once they were no longer at risk.

4.2.2.4 Transition planning

The Support Service trial was funded until the end of December 2015.

Planning for the closure of the Service began in July/August 2015, with the cessation of new referrals from the RDH CATT team and Cowdy ward taking effect on 30 October 2015. Other notifications were scheduled so that all stakeholders within the NT Health Department had ample notice that the Service was closing. Current clients during the ramp down period of the Support Service were all expected to have planned exits during December and all clients were exited during

late November/early December. Stakeholders, referring organisation and external community support service partners were notified of the service closure in September/October 2015. The program manager stated that in retrospect the ramp down period was too long given most clients had existed prior to December. He stated additional referrals could have been managed but the challenge would have been in ensuring referrers' and clients' expectations were met during the ramp down period.

Those consulted during the interviews provided positive feedback on the Support Service's role and function. These stakeholders expressed concerns regarding the impact the closure would have if plans to continue the Service did not eventuate or were delayed. While acknowledging the trial nature of the program these stakeholders felt the program had been effective, responsive and had filled an important gap in the Darwin region. Anecdotally they felt suicide rates had been lower during the period of the Support Service trial but acknowledged the challenge of timely access to validated data to confirm these impacts and the challenge of attributing any decrease in suicide rates to the Support Service.

5. Discussion

The Support Service was developed to address an identified gap in the continuity of care for people discharged from hospital after a suicide attempt. There is strong evidence which demonstrates that a prior suicide attempt is the single most important risk factor for suicide in the general population [xvii]. The Support Service model was designed to provide an assertive outreach service that included non-clinical, short-term support for this at-risk population group. This initial trial of the Service assessed three key questions:

- Has The Way Back Support Service met client need in terms of appropriateness and satisfaction?
- Have the processes to plan and implement The Way Back Support Service been effective, efficient and appropriate?
- Based on available evidence, how feasible is it to implement The Way Back Support Service into more jurisdictions around Australia giving consideration to replicability, scalability and risk?

Has The Way Back Support Service met client need in terms of appropriateness and satisfaction?

Despite the limitations in the evaluation and data access there is strong support from the evidence available that indicates that clients were satisfied with the level and type of services provided through the Support Service. Key results that support the Service being appropriate to client needs include:

- High rates of participation. Most people who were referred into the program decided to participate – 71% of all people referred became clients. This suggests that the scope and delivery of the service was appropriate to the needs of the client, and it was meeting a gap in existing services.

- High rates of referral. The service received 122 referrals, primarily from the NT CATT service. While baseline data on suicide attempts or suicidal crises is not available, these referral rates, and feedback from stakeholders, indicate that the service was accepted and endorsed by the NT CATT team, and it was a valuable addition to the existing supports provided to people following a suicide attempt or a suicidal crisis. This data also demonstrates that the service can be incorporated into existing service systems and referral pathways.

- High levels of client participation and engagement in the program. Most clients (78%) participated in the intensive intervention stream of the program, with these clients receiving support for between 86 and 88 days on average. Most clients (73%) also attended their planned appointments with their Support Coordinators. People who have attempted suicide are a vulnerable population group that are often difficult to engage in services. The high levels of client participation, and positive client feedback, suggests that the Support Service was providing a person-centred model of care, in which clients valued the support being offered. It also indicates that the Support Coordinators engaged with clients in a non-stigmatising and non-threatening manner, which encouraged and facilitated client participation.

- High levels of client satisfaction. Support Service clients praised and valued the experience, knowledge and skills of Support Coordinators. Clients appreciated the non-judgemental way in which Support Coordinators engaged with them, and the practical support they received, that responded to their needs. Clients demonstrated an average 10-point improvement in self-reported wellbeing (as measured through the WHO-5 measure) during their participation in the program. This suggests that the social and emotional wellbeing of clients improved throughout their participation in the Support Service.

- Strong linkages into other support services. The Support Coordinators provided non-clinical care and support that assisted clients to utilise other appropriate, existing services, as required. Clients were referred into a wide range of supporting services, which ranged from emergency accommodation and household assistance support, through to legal support and

psychological counselling services. The breadth of referrals demonstrate that the service was responding to the needs of the individual client; the immediate stressors that may have contributed to the suicidal crisis were being addressed; and the service was facilitating access to existing services. This is critical to preventing people who have attempted suicide or who are experiencing a suicidal crisis from not 'falling between the cracks' in the service system.

Key findings:

- The Support Service was an appropriate service that met the needs and expectations of clients.
- Clients valued and appreciated the person-centred model of care delivered through the service, and being treated in a respectful, non-stigmatising way by the Support Coordinators.

Have the processes to plan and implement The Way Back Support Service been effective, efficient and appropriate?

There were appropriate and relevant processes in place to plan and implement the Support Service, as an action research project. However, the execution of these processes could have been improved.

The development of the service model was done through an iterative process, which facilitated the service model responding to local needs and opportunities. This process was effective in developing an appropriate service model. It was, however, difficult in establishing clear boundaries and expectations of the service; determining the appropriate skill sets and experience required to effectively manage the service; and developing an efficient service that reached maximum service capacity. While changing the service model, and developing it through an iterative process, was appropriate, stakeholders indicated that it is critical to communicate any changes to all interested and involved organisations, in a timely manner. It also would have been more effective and efficient for the service model to be more clearly defined prior to the commencement of the service.

The roles and responsibilities of organisations involved were at times unclear. The development and implementation of the Support Service included a large number of organisations and stakeholders. There were different understandings and expectations of roles and responsibilities between the three primary organisations – *beyondblue,* as the project manager; Anglicare NT as the service provider; and EY as the evaluator. There were ongoing tensions in the need to demonstrate the feasibility of the Support Service model (for example, by regularly collecting and reporting data) and provide direct client care. The different expectations and roles could have been improved through greater communication throughout the project, clearer organisational accountabilities, and greater levels of co-design between the three organisations in the initial development phase.

An Advisory Group was established to provide advice and guidance on the service model and its implementation. The formation and membership of this Group was appropriate. However, there was not a clear and shared understanding of the role of the Group. This was addressed throughout the project, and it was then clarified that it was an advisory, rather than decision-making, group. The effectiveness and efficiency of the group would have been improved if there was clarity from the outset of the intended purpose, role and scope of the group.

The implementation of the Service, would have been enhanced by **developing stronger relationships between the organisations involved, and supporting these relationships with strong processes and systems.** Stakeholder feedback highlighted the importance of individual relationships to the effective implementation of the Service (for example, to receive referrals from the NT CATT service). To improve the sustainability of the Service, and to embed it into the service system, it is critical that strong processes and systems are in place to support these relationships. This would help to facilitate that the success of the Service is not dependent upon individuals, and a consistent approach is adopted across the service.

Key findings:

- The processes to plan and implement the Support Service were appropriate for an action research project.
- The effectiveness and efficiency of the planning and implementation processes could have been improved by developing a more defined service model prior to commencement of the service; developing clearer roles, responsibilities and accountabilities across organisations earlier in the development process; improving relationships between individuals and organisations involved; and embedding the service into organisational systems and processes.

Based on available evidence, how feasible is it to implement The Way Back Support Service into more jurisdictions around Australia giving consideration to replicability, scalability and risk?

The Support Service has been demonstrated to be a feasible service model that complements and supports other existing services. Key factors associated with the expansion of the service model are:

- **Replicability.** The Support Service includes an operations manual that could inform the implementation of the model in other jurisdictions. This operations manual includes detailed information on the service model; support coordination practices and processes; referrals protocols, intake and assessment procedures; staffing requirements and roles and responsibilities; and record keeping. It is important that the operations manual, and the approach adopted in the NT trial, informs the development and implementation of the model in other sites. However, it is also important that the delivery of the service is adapted to meet the needs of different communities and settings. The person-centred model of care that underpins the Support Service promotes the adoption of this approach.

- **Scalability.** The Support Service was delivered to 87 clients by 2.4 FTE. The Support Service did not reach capacity during the trial, and further information is needed to determine an appropriate and efficient caseload size and mix. However, early indications suggest that the model is scalable. A core strength of the service is its ability to draw on the skills and expertise of a range of different individuals to provide the support coordination service. This will assist service implementation in diverse regions, and it is particularly suitable for those areas that may face workforce shortages.

- **Risk.** The Support Service effectively managed clinical risk. The Support Service operations manual and materials included information on identifying and responding to risk, and a clinical governance plan. The Support Coordinators were highly experienced and skilled in managing risk, and supporting client to self-manage and recover in the least restrictive and most appropriate manner.

While it is feasible to implement the Support Service in other jurisdictions, it is important that the impacts and outcomes of the service model are comprehensively evaluated. This comprehensive evaluation data should inform the refinement and expansion of the service model.

Key findings:

- The Support Service has been demonstrated to be a feasible service model which could be implemented in other jurisdictions across Australia.
- The available evidence suggests that the service model has potential to be replicable, scalable and effective in managing risk.
- A comprehensive evaluation on the impacts and outcomes of the Support Service is needed to inform expansion of the service model.

5.1 Strengths and limitations of the service

The Support Service had been demonstrated to be an appropriate service model which responds to the needs of the client, in a non-stigmatising and non-threatening manner. The Service has been effective in reaching a highly vulnerable population group that is traditionally difficult to engage in services. The Support Service has filled a gap in the service system, and links people into other existing services and support options that they may not have otherwise accessed.

A limitation of the service is the relatively high proportion of clients (47%) that had an unplanned exit from the service. Planned exits are more likely to support better client outcomes, and be less resource intensive for the service provider. The rate and reasons for unplanned exits should be further considered in future evaluations of the service model. It is also important that the closures of any future trial sites are well planned, so that all clients receive appropriate follow-up and support at the end of the trial service. Client feedback suggested that there were concerns about the level and type of support available following the service's closure.

5.2 Limitations of the evaluation

There are a number of limitations of this evaluation with respect to data collection (as outlined in Section 3.6 – Limitations). These data limitations impact on the ability to determine:

- The impact of the Service on reducing suicide attempts, suicidal crises and deaths by suicide. Access to linked or de-identified data on suicide-related presentations to the RDH was not able to be obtained as part of the trial. This limits the ability to draw definitive conclusions on the impact of the service on reducing suicidal behaviour.

- The project did not establish a method for staff to identify the number of presentations to the RDH that were eligible for the Support Service, but were not referred as this was seen as an undue burden of reporting for staff within existing workloads by the CATT Manager. The referral rate, the appropriateness of the referral levels, and differences across population groups, can therefore not be determined. It was also not possible to identify opportunities to potentially increase the referral rates, if all possible clients were not being referred into the program.

- The impact of the service on improving wellbeing during and after the program. There were difficulties integrating the WHO-5 outcome measure into the everyday practice of Support Coordinators. This resulted in low completion rates of this measure. The delays in ethics approval, and the low number of clients consenting to participate in the evaluation, also resulted in limited follow-up interviews conducted with clients. There was also a relatively high number of unplanned exits from the program, and there is no data available to explore what factors may have contributed to an unplanned exit, and the differences in planned versus unplanned exits have on a client's suicidal behaviour. Conclusions about the role of the service in improving wellbeing, both during and after the program, are therefore limited.

The intended scope of the evaluation excluded assessing the cost effectiveness of the service model, and the efficiency and adequacy of the staffing model. Future evaluations of the service should incorporate these factors, as they are critical to informing the feasibility of the service model.

6. Recommendations

This evaluation has demonstrated that the Support Service is an appropriate service model that is feasible to implement in more jurisdictions around Australia. It also demonstrates the need for data at three levels, to inform the expansion and implementation of the model: service level (hospital emergency department and inpatient admissions data and Support Service program data); client level (e.g. changes in suicidality, need, and wellbeing and satisfaction with services), and stakeholder level (e.g. feedback on interaction with the Support Service). The following recommendations draw on the learnings of the evaluation of the NT trial.

Recommendation 1: A proactive approach is required to establish strong working relationships between the health and mental health hospital emergency department staff and the Support Service staff.

The experience from the NT trial suggests that a strong interface between the community-based Support Service personnel and the hospital-based emergency department and mental health service staff (consultation liaison and/or crisis assessment) is pivotal to the successful referral, follow-up, support, and step-up of at-risk clients. Information and referrals need to flow both ways. Time is therefore required to create a shared vision for the Service, clarify the roles and responsibilities of each team, codify these in intra- and inter-agency protocols, provide relevant training as required, and develop personal relationships and build trust.

Recommendation 2: Commissioning agencies should note that the development phase should include tailoring the service model to local needs, developing associated processes and systems, defining key performance indicators and data collection methodologies, clarifying roles and responsibilities, and obtaining buy-in of relevant stakeholders and agencies prior to the commencement of the service.

The development of the Support Service model of care was an iterative process that enabled the service model to be adapted to local needs and opportunities. While this process promoted the development of an appropriate service model, it also contributed to inefficiencies in processes and confusion about roles and responsibilities. The service model, and associated processes and systems, should be well defined prior to service commencement for any further Support Service sites. This should retain the core components of the service model that have been demonstrated to be effective, and adapt its implementation to meet local needs.

Recommendation 3: The person-centred and non-clinical model of care that is delivered through the Support Service, provided in an empowering and flexible manner, is a core component of the Support Service and should be retained in all future sites.

The Support Service clients valued and appreciated the person-centred model of care that responded to their individual needs. Clients also reported that being treated in a respectful, non-stigmatising way by the Support Coordinators was a strength of the service. The empowerment approach, building on the strengths of individuals and their support networks, is critical to the success of the model, and should be retained in any further sites. It is important that the person-centred model of care is underpinned by strong operational policies and procedures that provide a consistent framework to develop and implement the Service. This promotes the integrity of the service model being maintained and the incorporation of local needs.

Recommendation 4: Support Coordinators should receive appropriate training and supervision which includes information and skills to understand the needs and experiences of people in a suicidal crisis, and deliver appropriate non-clinical support in an empowering, inclusive, non-

stigmatising and non-judgemental way.

The Support Coordinators were recruited based on their existing skill sets and experience, and provided training to facilitate delivery of appropriate, evidence-based care and support to clients. Clients and stakeholders reported that a key strength of the service was the competency and skills of Support Coordinators to provide effective and supportive care, that met the needs of different population groups (including Aboriginal and Torres Strait Islander people and people from a culturally and linguistically diverse backgrounds), in a respectful, culturally appropriate and safe manner. It is important that this strength of the service is retained.

Recommendation 5: Governance arrangements should reflect best practice principles, the views of key stakeholders and meet the need for both high-level strategic oversight and day-to-day operations.

There were ongoing tensions in the delivery of the Support Service in demonstrating the feasibility of the Support Service model (for example, by regularly collecting and reporting data) and providing direct client care. It is important that the governance arrangements, and roles, responsibilities and expectations of key stakeholders are developed in a collaborative process and established early in the development of the service. This should be reflected through written agreements between key stakeholders (for example, Terms of Reference for advisory groups, contractual arrangements between parties).

Recommendation 6: Prior to, or in parallel with, service commencement, the availability and quality of emergency department data on suicide attempts or suicidal crises should be determined, and a baseline rate of suicide attempts or suicidal crises should be established.

Robust emergency department data on all suicide attempts or suicidal crises are essential for the operation and the evaluation of the Support Service. The accurate recognition of a suicide attempt or suicidal crisis enables appropriate referrals to be made to the Service. The accurate coding of a suicide attempt or suicidal crisis used in hospital administrative systems provides a solid foundation to establish the rate of single and recurrent suicide attempts or suicidal crises so as to determine whether the Support Service is having the desired impact. Ideally, the availability, completeness and accuracy of suicide attempt or suicidal crisis data and the 'baseline' suicide attempt or suicidal crisis rate in the referring hospital emergency department should be established before commencement of the service. Any gaps in data quality should be addressed through training, audits and other quality improvement initiatives and any lack in baseline data should be addressed through a period of preliminary data collection to establish a suitable baseline. In reality, it is likely that these data gathering and quality improvement initiatives may need to occur in parallel to service start up, which while less ideal, is still a reasonable approach.

Recommendation 7: Research should be undertaken to identify the most feasible, acceptable and useful approach to the collection of client level data that supports client care and enables service evaluation.

Client level data is required to track client's progress against their goals and to track that the Service is improving client outcomes in relation to their social and emotional wellbeing. The experience from the NT trial site highlights the need to introduce data collection mechanisms that are easy for the Support Coordinators to use, and are meaningful and relevant to the clients using the service, many of whom are in crisis and may be hard to engage in service provision let alone in completing questionnaires. While the WHO-5 Wellbeing Index was used in this trial as a measure of subjective quality of life, difficulties were encountered in getting Coordinators and clients to complete the scale. In addition, it seems that the tool lacked utility in assisting Support Coordinators to support clients, or in assisting clients to reflect on their current situation and needs. Given this, it is recommended that further research be undertaken to identify suitable

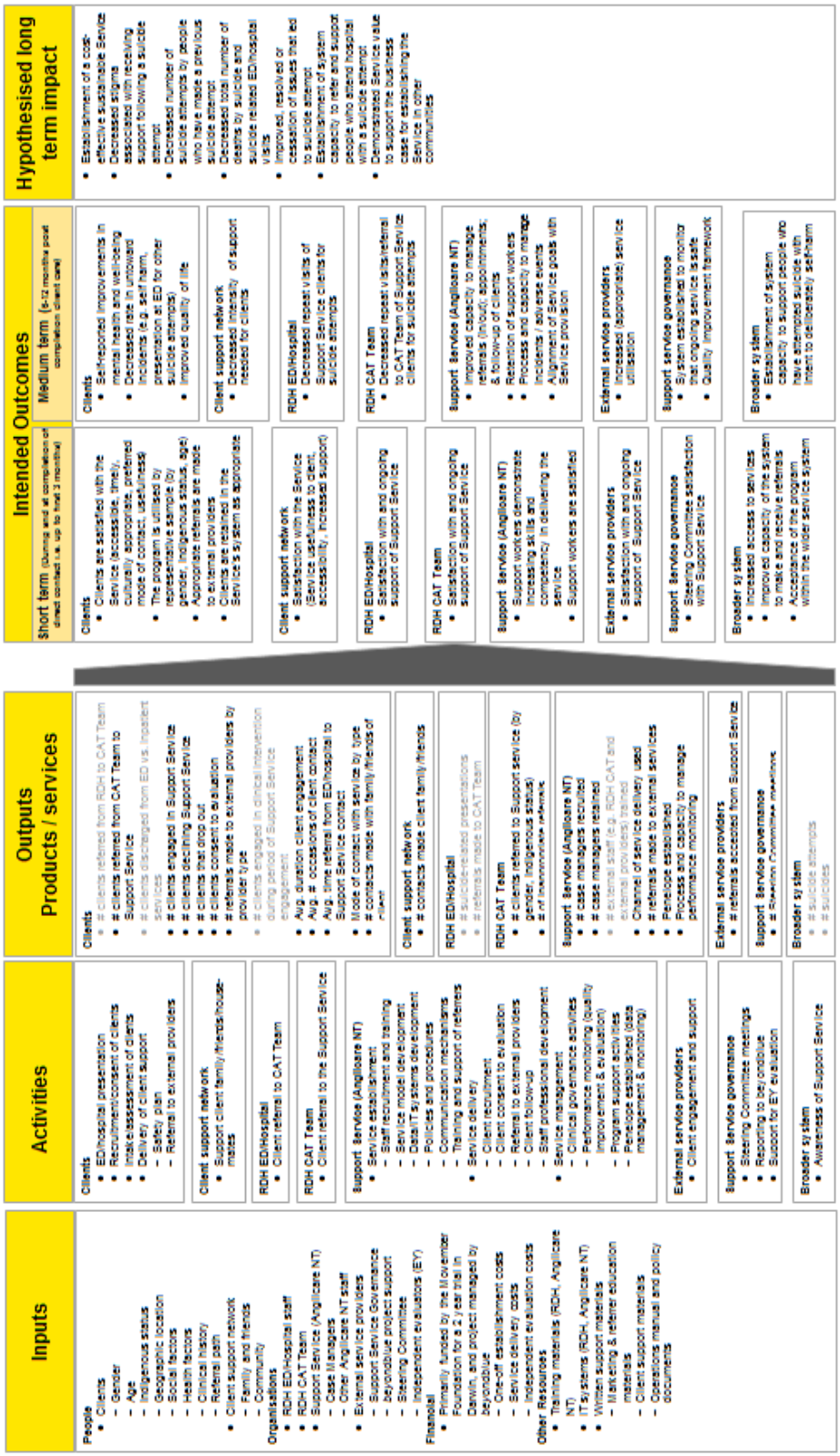
measures that can be incorporated as part of routine service provision that are meaningful and acceptable to clients and that help to guide ongoing care. Consideration should be given to adopting a participatory action research approach that involves people with personal experience of a suicide attempt or suicidal crisis, to guide the selection and/or development of a suitable questionnaire.

Recommendation 8: Strong monitoring processes are in place to track progress against service targets and identify areas for improvement.

The experience from the NT trial suggests that there are opportunities to improve the implementation of the Service by better setting and tracking progress against targets, and implementing routine continuous improvement activities. The referral rates and patterns of engagement in the service varied over time. A formal process to monitor changes, and identify and implement opportunities for improvement (for example, through a Plan, Do, Study, Act cycle) would enhance the delivery of the service.

7. Attachments

Attachment A – Program logic



Attachment B – Stakeholder interviewees

Formative and Interim Evaluation	
Name	**Position**
Matthew Davis	Program Manager, The Way Back Support Service NT
Gavin Coehn	Support Coordinator, The Way Back Support Service NT
Kirsten Robb	Support Coordinator, The Way Back Support Service NT
Margaret Farrell	A/Director Mental Health NT Health
Ngaree Ah Kit	Darwin Regional Indigenous Suicide Prevention Network (DRISPN)
Anthony Ah Kit	Top End Mental Health
Susan Beaton	Suicide Prevention Advisor - *beyondblue*
Sarah Haythornthwaite	AMSANT
Monique Gale	Director Mental Health
Andrea Hill	A/Manager NT Crisis Assessment and Triage Team
Yvonne Roberts	Cowdy Ward NUM
Danyelle Jarvis	Executive Manager, Anglicare NT
Bella Burns	Suicide Prevention & Support Services Leader, *beyondblue*
Kristopher Wood	Suicide Prevention & Support Services Project Manager, *beyondblue*
1 x former Support Service client	

Final Evaluation	
Name	**Position**
Matthew Davis	Program Manager, The Way Back Support Service NT
Andrea Hill	A/Manager NT Crisis Assessment and Triage Team
Danyelle Jarvis	Executive Manager, Anglicare NT
Gavin Coehn	Support Coordinator, The Way Back Support Service NT
Kirsten Robb	Support Coordinator, The Way Back Support Service NT
Margaret Farrell	A/Director Mental Health NT Health
Andrew Wieczynski	Clinical Nurse Consultant
5 x former Support Service clients	

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ED None

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