The Way Back Support Service

Service Delivery Model

March 2020

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Introduction

Beyond Blue Limited (Beyond Blue) was founded in 2000 as a national depression initiative. Beyond Blue*'s* vision is that 'All people in Australia achieve their best possible mental health'. In 2011, in response to stakeholder feedback, Beyond Blue's remit was formally expanded from depression to include anxiety disorders and more recently suicide prevention in recognition of the strong interface and relationship between depression, anxiety and suicide. Beyond Blue aims to achieve its vision by promoting good mental health and creating change to protect everyone's mental health and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

Beyond Blue*'s* work and operating model is underpinned by six core values:

- **Collaboration** - we work willingly with others to collaborate and share knowledge.
- **Respect** - we treat others with respect and dignity, and believe diversity is important.
- **Enthusiasm** - we are passionate about enjoying life and work.
- **Excellence** - we continually strive for excellence.
- **Innovation** - we encourage innovative ideas and approaches.
- **Integrity** - we act with honesty, integrity and transparency.

The growing reach of Beyond Blue across the community and mental health sector over the years has seen its contribution extend beyond awareness-raising of mental health to increasingly shaping support services available to individuals, families, schools and businesses. Beyond Blue is driven to promote behaviour change across the continuum of mental health care, from the individual to the system level.

Today, Beyond Blue is seen as a national leader in the mental health sector working to:

- increase awareness of depression, anxiety and suicidality
- reduce stigma and discrimination
- improve help seeking
- reduce impact and disability
- facilitate learning, collaboration, innovation and research.

Policy context

In Australia, more than eight people die by suicide each day. Suicide is the leading cause of death for Australians between 15-44 years of age and the second leading cause of death among those aged 45-54 years.[1] Suicide accounts for one in three deaths among people aged 15 to 24 years and over one in four deaths among people aged 25 to 34 years[2]. There has been no meaningful decline in the suicide rate over the last decade — in 2018, 3,046 people died by suicide at an age-standardised rate of 12.1 per 100,000, compared with 10.6 deaths per 100,000 ten years earlier.

[1] Australian Bureau of Statistics. Causes of death, Australia, 2018. Cat no 3303.0. Canberra: ABS, 2019

[2] Australian Bureau of Statistics. Causes of death, Australia, 2018. Cat no 3303.0. Canberra: ABS, 2019.

The national average masks a much higher prevalence of suicide amongst men, rural communities, Aboriginal and Torres Straight Islanders, LGBTI communities and other high-risk groups. Approximately 75 per cent of people who die by suicide are male[3]. Among Aboriginal and Torres Strait Islander communities, suicide rates are twice as high as non-indigenous communities.

The impact of suicide across Australia was recognised in 2017 with the release of the Commonwealth Government's Fifth National Mental Health and Suicide Prevention Plan 2017-2022 ('The Fifth Plan'). The Fifth Plan was the first time suicide prevention had been incorporated into the national mental health plan. It recognised that there had been no significant reduction in the suicide rate over the last decade[4] and called on governments to reduce the incidence of suicide by providing 'more effective follow-up support for people who have attempted suicide'[5]. More specifically, the Fifth Plan committed all governments to a systems-based approach that focuses on the World Health Organisation's eleven elements for effective suicide prevention:

1. **Surveillance**—increase the quality and timeliness of data on suicide and suicide attempts.
2. **Means restriction**—reduce the availability, accessibility and attractiveness of the means to suicide.
3. **Media**—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. **Access to services**—promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
5. **Training and education**—maintain comprehensive training programs for identified gatekeepers.
6. **Treatment**—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. **Crisis intervention**—ensure that communities have the capacity to respond to crises with appropriate interventions.
8. **Postvention**—improve response to and caring for those affected by suicide and suicide attempts.
9. **Awareness**—establish public information campaigns to support the understanding that suicides are preventable.
10. **Stigma reduction**—promote the use of mental health services.
11. **Oversight and coordination**—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

[3] Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.
[4] Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.
[5] Fifth National Mental Health and Suicide Prevention Plan, 2017. p. 25.

Suicide Prevention Aftercare – The Way Back Support Service

A previous suicide attempt is a strong predictor of further suicidal behaviour, with the period immediately after discharge from hospital following a previous attempt being a time of increased risk[6,7,8]. The transition from tertiary to community-based care is a crucial but often neglected step for people experiencing suicidality. Providing access to high-quality follow-up and support following a suicide attempt or crisis (known as 'aftercare'), has been found to reduce the risk of further suicidal behaviours[9].

Aftercare has been identified as a promising suicide prevention strategy by keeping high-risk individuals connected with support services and networks to promote safe living. A recent Australian study found that coordinated assertive aftercare has the potential to decrease suicide attempts by up to 19.8%[10].

In 2014, Beyond Blue developed The Way Back Support Service ('The Way Back') as a psychosocial service response to support people following a suicide attempt or experiencing suicidal crisis.

This document outlines The Way Back Service Delivery Model for Primary Health Networks (PHNs) and service providers. The Service Delivery Model includes:

- service objectives
- core service elements
- intended recipients
- key performance indicators.

Adherence to the Service Delivery Model for The Way Back as described in this document is critical to model fidelity and essential to the licencing and sub-licensing arrangements agreed by PHNs and service providers with Beyond Blue. The Way Back Service Delivery Model should be read in conjunction with the following reference documents:

- Service Delivery Tools and Templates
- Minimum Data Set Dictionary
- Quarterly Reporting Templates
- Beyond Blue Clinical Governance Framework
- The Way Back Clinical Governance Strategy.

The Way Back Service Delivery Model excludes reference to any operational processes in the implementation of The Way Back. Frontline operationalisation of this service by PHNs and service providers is at the discretion of individual health networks and service providers in order to capture local needs and networks.

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[6] Christiansen E, Jensen BF. Risk of repetition of suicide attempt, suicide or all deaths after an episode of attempted suicide: a register-based survival analysis. *Australian and New Zealand Journal of Psychiatry.* 2007; 41:257-265.

[7] Commonwealth of Australia (2007) *Living is for everyone: Research and evidence in suicide prevention.* Department of Health and Aged Care: Canberra

[8] J. Michael Bostwick, Chaitanya Pabbati, Jennifer R. Geske, Alastair J. McKean. *Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew*. American Journal of Psychiatry, 2016; appi.ajp.2016.1 DOI: 10.1176/appi.ajp.2016.15070854

[9] Mann JJ, Apter A, Bertolote J; et al. Suicide prevention strategies. A systematic Review. The Journal of the American Medical Association, 2005;294(16):2064-2074.

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

The Way Back Service Model

The Way Back is a non-clinical support service focused on providing practical psychosocial support to people experiencing a suicidal crisis or who have attempted suicide.

The objectives of the Way Back Support Service are to:

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

Ultimately, the above objectives are intended to contribute to reducing the risk of suicide (re)attempts for individuals experiencing a suicidal crisis or who have made a suicide attempt.

Guiding Principles

The Way Back is underpinned by four guiding principles.

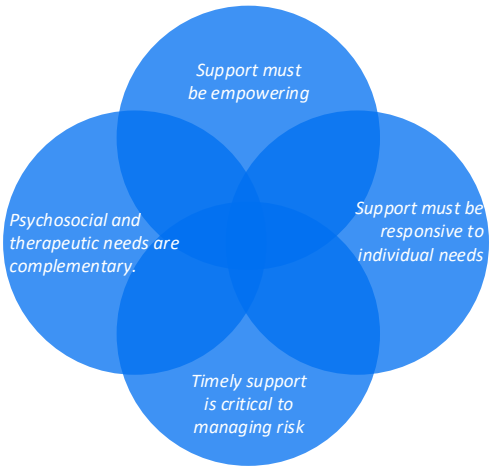

Figure 1. The Way Back Guiding Principles

Principle 1 - Promotes strengths and resilience – That The Way Back offer strengths-based support that empowers its clients to seek, connect, engage and maintain prosocial and positive community, social and family networks and supports that build resilience and create a sustained reduction in risk of suicide.

*Principle 2 - Psychosocial and clinical needs are complementary –*The Way Back psychosocial support is complementary to, and integrated with clinical supports by providing practical, everyday support that helps the client maintain safe and connected living. In doing so both clinical and non-clinical workforces must work collaboratively and consultatively to achieve positive client outcomes.

Principle 3 - Support must be responsive to individual needs – The Way Back recognises that each individual who has attempted suicide or is experiencing a suicidal crisis has a unique set of circumstances involving family, work, physical, psychological or financial circumstances among others. As such, supporting individuals following a distressing experience must be tailored to their individual needs, triggers, motivations, abilities and most importantly, their strengths.

Principle 4 - Timely support is critical to managing risk – The Way Back recognises that risk of suicide or escalation of suicidal crisis can be unpredictable. Providing individuals with timely support when they are most vulnerable is critical to achieving safety. Presenting at a hospital emergency department or community mental health service following a suicide attempt or suicidal crisis is a time of heightened risk. Tailored and timely support through The

Way Back provides the opportunity to support the client to manage their risk, safety and vulnerability immediately following their most acute phase.

Service Approach

The Way Back Support Service is a trauma informed, **psychosocial support service** delivered by **assertive outreach.**

As a non-clinical service, The Way Back views clinical and psychosocial care as complementary rather than alternate approaches.

Hospital and Health Service (HHS)/Local Health District (LHD) Mental Health Teams are crucial partners in the delivery of The Way Back. These mental health teams are typically the primary referrer and a crucial contact point for advice and escalation of care when needed. The service funding model includes funds earmarked for HHSs/LHDs to support the development of systems and processes to support referral, consultation and escalation.

Trauma informed care prioritises cultural, emotional and physical safety; respects personal dignity; and recognises that recovery is most likely in an engaged and collaborative approach to providing care.

Psychosocial support is by definition a process in which clients are supported to recover from a crisis and empowered to respond to future crises by building resilience within themselves and across families and communities. Psychosocial support is distinct from clinical support, which refers to interventions "carried out to improve, maintain or assess the health of a person, in a clinical situation[11]." Psychosocial wellbeing is achieved when a person's internal and external needs are met and he or she is physically, mentally, and socially healthy[12].

Another way of distinguishing clinical and psychosocial interventions is to consider that clinical services are typically diagnostically driven with medical and psychological treatments tailored to the diagnosis; while psychosocial interventions are typically driven by holistic needs assessments and assisting individuals to address identified needs through strong engagement, trauma informed practical support and encouraging clients to maintain clinical and other services.

Psychosocial support may be facilitated across a range of domains including community and social services like housing, finance, employment, education, family support, community controlled Aboriginal and Torres Strait Islander services, CALD specific services, LGBTIQ services, spiritual support as well as advocacy for any or all of the above domains. The Way Back service providers are expected to build strong relationships with local clinical and non-clinical services their clients may be referred to for the purpose of supporting their engagement.

The provision of this support through an assertive outreach approach aims to ensure that support is accessible and responsive to the day to day needs of the individual client by ensuring that the support provided is

[11] Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.
For the purposes of this paper, cognitive interventions are most relevant and refer to an intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling). http://meteor.aihw.gov.au/content/index.phtml/itemId/327220.
[12] Psychosocial Framework of 2005 – 2007 of the International Federation of the Red Cross

characterised by trauma informed, proactive, sustained and persistent efforts to reach and maintain contact with clients of The Way Back in appropriate settings and at times that are mutually suitable. Assertive outreach offers a partnership approach with the client, empowering them to improve their safety and quality of life. Psychosocial support through The Way Back is available for **up to three months.**

Eligibility

The Way Back targets individuals following a suicide attempt or those identified as experiencing a suicidal crisis. A person may be eligible for The Way Back based on primary or secondary criteria.
It is strongly recommended that client intake commence using the primary eligibility criteria only to ensure this particular high risk group is prioritised, and that referral pathways can be clearly established without the service being overwhelmed. It is important that capacity of the service be tested in the first three to six months of operation before considering expansion to the secondary criteria.

Primary Eligibility Criteria

The primary eligibility criteria are met when a person is referred to The Way Back after presenting to a hospital emergency department or community mental health service[13] following a suicide attempt. A suicide attempt is defined as a "non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour". A suicide attempt may or may not result in physical injury and may or may not result in a hospital admission.

Where service capacity permits, referrals for the 'Primary Eligibility Criteria' may also be made by General Practitioners.

Secondary Eligibility Criteria

The secondary eligibility criteria are met when a person is referred to The Way Back after presenting to a hospital emergency department or community mental health service in or following a suicidal crisis and whose risk of suicide is identified as imminent. A suicidal crisis is defined as a person experiencing distress, suicidal thoughts and articulating an intent to die. A suicidal crisis may or may not result in a hospital admission. Access to The Way Back via the 'Secondary Eligibility Criteria' is likely to be limited in most locations other than smaller rural locations due to the capacity of the service.

When applied, it is important to limit referrals for the 'Secondary Eligibility Criteria' to those made by hospital or community based mental health teams to ensure a consistent approach to prioritising limited service capacity.

Exclusion Criteria

Individuals are ineligible for The Way Back if they are already being supported by an intensive assertive outreach service that includes support for their mental health needs.

[13] Government-operated specialised mental health care provided by community mental health care services and hospital-based services, such as outpatient and day clinics. *Australian Institute of Health and Welfare 2018. Mental health services—in brief 2018. Cat. no. HSE 211. Canberra: AIHW.*

Discretion may be applied in considering the suitability of any such existing services to support the individual through their suicide crisis.

Subject to the above, individuals identified as eligible for The Way Back whether on primary or secondary criteria should not be excluded for reasons of age, gender, language, disability, cultural background or geographical location. Every effort should be made to provide the Service to consenting clients that is respectful and responsive to their particular needs.

Service Duration

Psychosocial assertive outreach support is made available to eligible clients for a period of **up to three months**. The frequency of contact is not prescribed and should be determined based on the interaction with the client and their identified needs. Clients of The Way Back may choose to exit the Service prior to the end of the three-month period.

Clients who exit **within three months** may re-engage with the Service within this period should they request to do so. Where clients exit the Service within or at the three-month period, and request to engage with The Way Back again at a later date, approval and the duration of support made available is at the discretion of the Clinical Advisor. In responding to this request the Service should consider:

- reasons for the request to reengage
- the risk of suicide for the client
- alternative service options available to the client.

Service Mode

Assertive outreach is most effective where clients are actively engaged in the support service and barriers to engagement are minimised. For this reason, The Way Back requires that clients be primarily supported through **face-to-face contact**. Support via telephone and / or messaging services (such as Skype, Messenger, WhatsApp etc) can occur alongside face-to-face contact but should not be the primary means of contact unless the following circumstances apply:

- where the client has indicated that this is their preferred mode of contact
- where geographic location presents as a barrier to regular face to face contact
- where the service is impacted by severely disruptive unforeseen circumstances e.g. natural disaster, epidemic or pandemic

Service Exits

Exiting from The Way Back should be a collaborative activity informed by:

- the client's progress towards their goals
- progress in linking in with community services.

When a client is exiting from The Way Back within or at the three-month period, the following **must** be undertaken as a minimum:

- the client's Safety Plan is reviewed and updated
- the client's Support Plan is reviewed and updated based on any outstanding needs and goals
- the client's Primary Nominated Professional is notified in writing of the exit of the client (where identified)
- Administration of Outcome Measures
- completion of the Client Experience Survey questions

In some cases, a client may choose to withdraw from The Way Back spontaneously and/or contact with a client may be lost over the course of the support period. For these clients, a minimum of three contact attempts (by phone, in person or by messaging) must be made over a **two-week period** before closing the client episode. Attempts at contact must also be made through the client's support person if one has been nominated.

If a client has been uncontactable for three weeks, their client episode must be closed. Should these clients make contact requesting to engage within the three months from Initial Consent to participate, they may do so without a referral and at the discretion of the Clinical Advisor/Team Leader.

Enhancing the Service Locally

A level of flexibility may be applied to the service model locally. Opportunities to enhance The Way Back should be considered locally according to the needs, priorities and complementary funding opportunities available at the local Primary Health Network level. To ensure model fidelity is maintained, local enhancements should be developed in consultation with Beyond Blue and other local stakeholders and endorsed according to the requirements of the Licence Agreement.

Some considerations for enhancements where feasible are:

- establishment of a priority referral pathway for Aboriginal and Torres Strait Islander people
- enhancement of lived experience, peer support or family/carer components of the service
- establishment of informal follow up supports such as coffee clubs
- brief follow up interventions such as postcard or other message systems
- establishing integrated approaches with other local suicide prevention strategies
- To ensure fidelity of the model is maintained, any enhancements must be discussed and approved by all relevant parties stated in the licence and services agreement.

Considerations for Operating through the COVID-19 Pandemic

The 2020 COVID-19 Pandemic has impacted severely on the delivery of The Way Back and has required changes to the way the service is delivered to reduce risks to both service providers and service users. The following points offer guidance in adjusting service delivery during this time:

- Confirm and adapt referral pathways with Hospital Mental Health teams where necessary
- Increasing phone and video-based online support
- Obtaining consent verbally by reading out the consent form over the phone

- Administering outcome measures via phone or other non-face-to-face technologies
- Working with community-based services to confirm and adapt outbound referral pathways and methods of communication
- Confirming escalation protocols, particularly between *The Way Back* and clinical providers, ensuring protocols account for the fact that face-to-face contact may be limited
- Communicating with service users about why support is being limited to non-face-to-face contact and how it will work
- Ensuring clinical/practice supervision and staff wellbeing support is maintained during periods where more independent working arrangements may be required
- Increasing contact by phone to enquire about general wellbeing, which may be beneficial for clients in times of increased distress such as this
- Considering particular needs of clients with visual and hearing impairments; those who need interpreters; and clients at risk of experiencing family/domestic violence

Workforce Model

The workforce for the delivery of The Way Back Service Delivery Model is summarised in Table 1 including roles and responsibilities.

Table 1. The Way Back Support Service Workforce

The Way Back Workforce Model	Team Leader	Support Coordinator
Minimum qualifications/ Experience	A credentialed mental health clinician[14]	A non-clinical worker with relevant qualifications and/or expertise in supporting vulnerable people or at-risk cohorts
Reporting To	• Service Provider Management.	• Team Leader.
Responsibilities	• Managing and supervising Support Coordinators. • Advice and consultancy to Support Coordinators in supporting clients. • Clinical and incident risk management. • Compliance with clinical governance requirements.	• Actioning all referrals. • Confirming eligibility. • Implementing service delivery tools for each client. • Providing the assertive outreach support for all consenting clients. • Making and/or advocating for referrals to community-based services on behalf of a client.

[14] The Team Leader must be a Credentialed Mental Health Clinician and must provide clinical advice and supervision to Support Coordinators. In the event the Team Leader is not a Credentialed Mental Health Clinician, the Service Provider must ensure the Support Coordinators have comparable access to clinical advice and supervision.

Service Processes

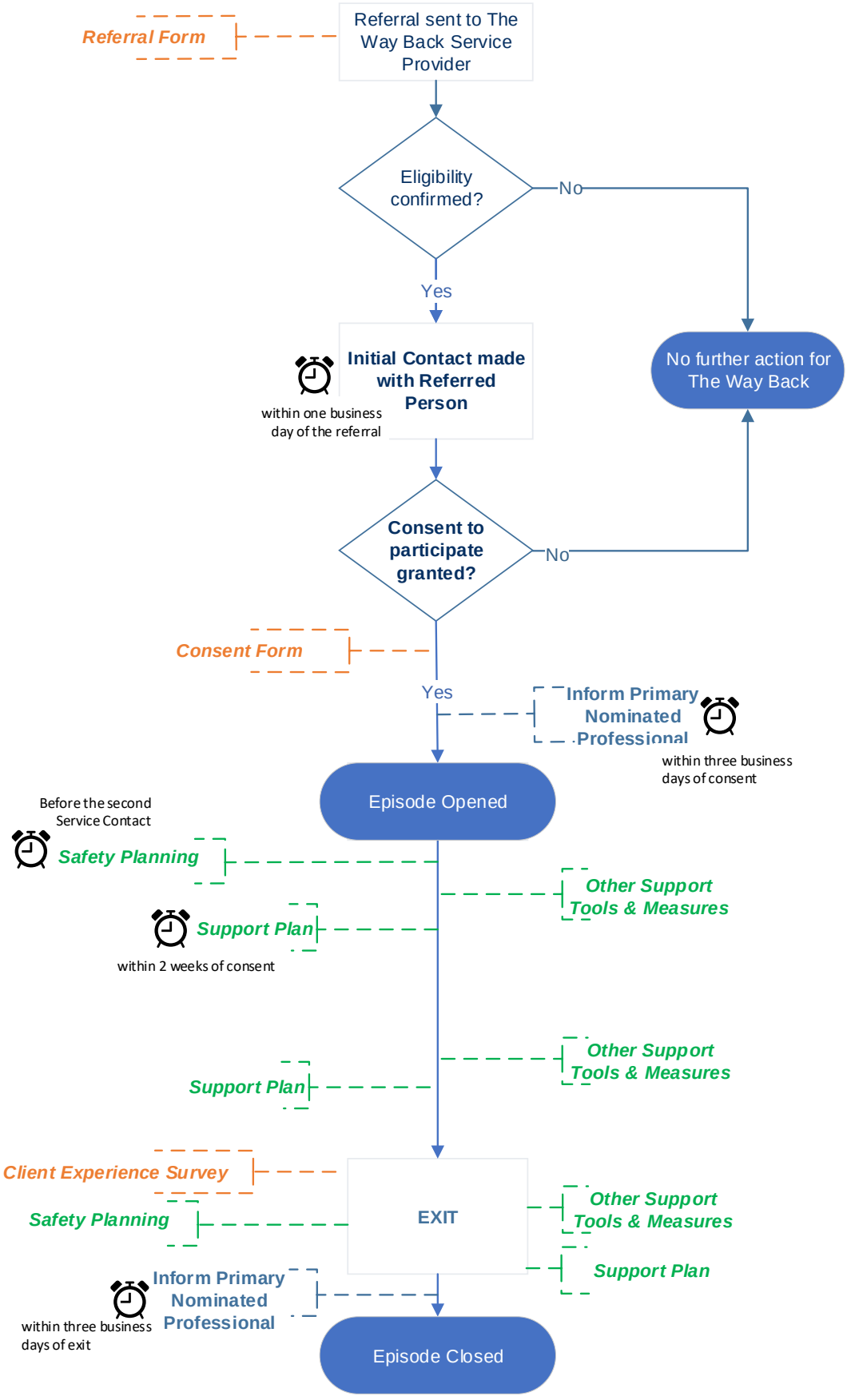

Figure 3. Flow of Service Delivery Model

Making Referrals to The Way Back

Referrals to The Way Back are typically made by hospital or community based mental health staff based on their determination of an individual's eligibility for the Service. This determination must be informed by:

- the eligibility criteria of The Way Back (refer above)
- the outcome of the Mental State Examination conducted by hospital or community based mental health staff (where available)
- any other information about the client considered to be relevant to the Service
- individual consent to be referred to The Way Back.

Referrals made by hospital or Community Mental Health Staff must be made within one business day of an individual consenting to be referred to The Way Back. A sample *Referral Template* is provided in the *Service Delivery Tools and Templates* document**.**

Receiving Referrals for The Way Back

The Way Back staff are required to confirm the referred person's eligibility for the Service based on information contained in the Referral Form. In some instances, further information may be required from the referrer to confirm eligibility.

For clients who are confirmed as eligible for The Way Back, initial contact[15] must be attempted within one business day of the referral. Where a client is deemed to be ineligible for referral to The Way Back or is unable to be contacted, the referrer should also be notified within one business day in writing.

Obtaining Consent

On successfully making initial contact with a person referred to The Way Back, consent to participate in the Service must be obtained in **writing**.

Once clients have consented to participate in The Way Back correspondence must be sent by the Support Coordinator to the client's Primary Nominated Professional (where identified) advising them of the client's participation in The Way Back within three business days of consent being obtained. A sample Consent Form is contained in the *Service Delivery Tools and Templates* document.

In some cases, referred persons may decline to consent to participate in The Way Back even after initially agreeing to be referred. In these cases, Support Coordinators should provide The Way Back Information Pack and encourage clients to continue to consider their participation, offering the following options:

- that they be contacted by The Way Back within an agreed timeframe in the future to discuss the possibility of consenting to participate
- that they contact The Way Back in the event that they reconsider their consent

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

Support Tools and Measures

The Way Back aims to create positive change in clients by:

- enhancing their motivation to engage in services for safe living
- establishing and strengthening their links to community services based on their needs and circumstances
- establishing and strengthening positive social supports and networks
- reducing distress and improving social and emotional wellbeing.

In line with these objectives, a sound understanding of the needs of each client is required to ensure that the Service can be appropriately targeted. To achieve this, a suite of tools is required to be administered at various points within the Service by Support Coordinators. These tools are listed in Table 2 below.

Alternate tools designed specifically for Aboriginal and Torres Strait Islander Clients may be utilised in addition to the below tools, with the exception of the K5 which may be utilised in place of the K10.

Table 2. Service Delivery Support Tools and Measures

Service Delivery Support Tools and Measures	Descriptor
Safety Plan	A safety plan is a collaborative process in which the provider and client identify strategies for their use when suicide risk is elevated'[16].
Support Plan	A Support Plan clearly identifies the needs and goals of each Client and is used to track progress against these goals.
WHO-5 Wellbeing Index[17]	A short 5-item self-reported measure of current mental wellbeing. The WHO-5 is available in 30 languages.
The Kessler Psychological Distress Scale (K10) PLUS[18]	Measure of psychological distress. The K10 PLUS scale involves 14 questions about emotional states each with a five-level response scale. The measure can be used as a brief screen to identify levels of distress. *Please note the K5 may be utilised for Aboriginal and Torres Strait Islander clients.*
Suicidal Ideation Attributes Scale[19]	Measure of the severity of suicidal thoughts. It consists of five items, each targeting an attribute of suicidal thoughts: frequency, controllability, closeness to attempt, level of distress associated with the thoughts and impact on daily functioning.

These Support Tools and Measures must be administered at the following points of service participation:

- **at commencement with The Way Back,**
- **at the six-week or mid-point of the expected support period, and**
- **at exit from the Service.**

They may be administered on additional occasions at the discretion of Support Coordinators and Team Leaders/Clinical Advisors based on the progress and needs of the client.

Details of, and a template for each tool is contained in the *Service Delivery Tools and Templates* document. There is also an Excel spreadsheet set up to make scoring and collating easier titled *Automated Scoring for Measures.*

[16] http://www.sprc.org/news/safety-planning

[17] WHO (1998). Wellbeing Measures in Primary Health Care/The Depcare Project. WHO Regional Office for Europe: Copenhagen.

[18] Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry. 2003 Feb;60(2):184-9.

[19] Van Spijker, B.A.J., Batterham, P.J., Calear, A.L., Farrer, L., Christensen, H., Reynolds, J. & Kerkhof, A.J.F.M. (2014). The Suicidal Ideation Attributes Scale (SIDAS): Community-based validation study of a new scale for the measurement of suicidal ideation. Suicide and Life-Threatening Behavior, 44 (4), 408-419.

Safety Planning

A safety plan is defined as the 'collaborative process in which the provider and client identify strategies for their use when suicide risk is elevated'[20]. Clients referred to The Way Back may have commenced the process of safety planning as part of their discussions with Hospital or community mental health staff. Any existing safety plans completed by hospital or community mental health staff should be shared with, or requested by, The Way Back service provider and updated as part of preliminary discussions with the client. Where clients referred to The Way Back have not completed any safety planning prior to their referral this should be completed as a priority once the client has consented to participate in The Way Back.

Safety Plans should be updated/developed at the initial contact with the client and no later than the second contact. Safety Plans are also required to be reviewed on a regular basis throughout the support period to ensure that strategies are current in the event of escalating risk.

A Safety Planning Guide, a recommended Safety Plan Template are contained in the *Service Delivery Tools* document. The 'Beyond Now' safety planning app is also an option for safety planning and support process. (https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning)

Client Support Planning and Goal Setting

All Support Coordinators of The Way Back must work with their clients to collaboratively develop a support plan and empower them to meet their articulated goals. As an assertive outreach service, client support may include but is not limited to:

- supporting clients to stay safe during a period of elevated risk and vulnerability
- encouragement to attend critical follow up appointments
- providing a resource pack, including resources for the client's family, friends and support people
- generate referrals to community-based services
- facilitate access to community-based services as appropriate
- advocacy for community-based services and support as appropriate
- supporting clients to attend key appointments
- reducing barriers to the client accessing follow-up care
- providing emotional and or cultural support

The support plan must detail a client's:

- **Needs** as assessed using the Support Tools and Measures.
- **Goals** of participating in The Way Back. Goals should be articulated as S.M.A.R.T. goals - Specific, Measurable, Achievable, Realistic, and Timely.
- Proposed **actions and interventions** planned to address identified needs and goals including referrals to be made.

[20] http://www.sprc.org/news/safety-planning

In developing Support Plans, discussion with clients should consider warning signs, strengths, support mechanisms and strategies that have enabled them to take the next steps. The Support Plan builds on Safety Planning by extending to key goals and actions to improve quality of life and safe living.

The Support Plan must be developed within the first two weeks of commencement. A suggested Support Plan template is contained in the *Service Delivery Tools and Templates* document**.**

The Way Back Governance

The Way Back Service Governance Model is presented in Figure 4 and Table 3 summarises the roles and responsibilities associated with this governance model.

Figure 4. The Way Back Service Delivery Governance Model

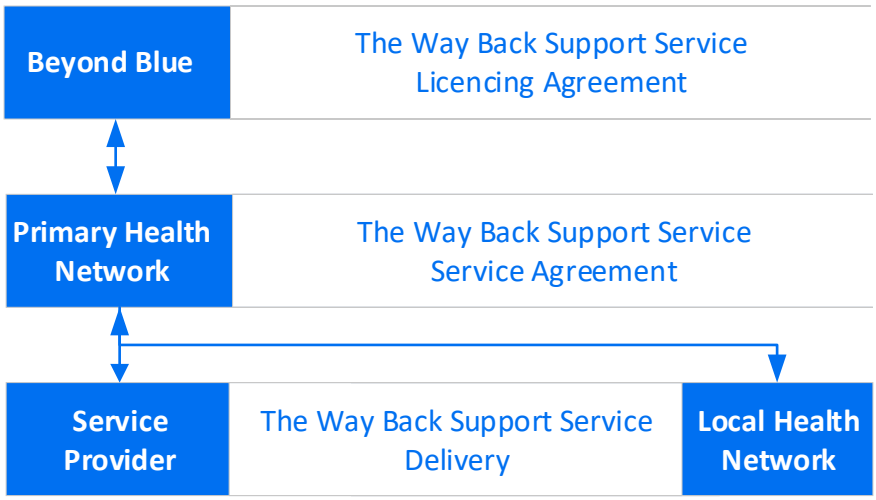

Table 3. Roles and Responsibilities

	Roles and Responsibilities
Commonwealth Government	• Execute bilateral agreements with States and Territories. • Provide funding to PHNs in order to commission a service provider for the delivery of the Service.
State Governments	• Match funding (50%) for site service delivery. • Execute agreement with the Commonwealth and relevant PHNs.

Beyond Blue	• Preparation of financial, workforce and other service modelling to inform expansion of The Way Back.
	• Support negotiation of agreements with States and Territories to fund 50% of The Way Back and advise the Commonwealth on the detail of bilateral agreements.
	• Licensing of The Way Back to PHNs.
	• Monitor implementation and delivery of the service in accordance with licencing agreements through quarterly meetings with the PHN to discuss and update on:
	  ○ Service activity
	  ○ Progress against service targets
	  ○ Fidelity of the service model
	• Deliver accountabilities in accordance with Commonwealth Services Agreement including but not limited to:
	  ○ National standardised training for The Way Back Service Support Co-ordinators
	  ○ Implementation Guide and other service support documentation
	  ○ Commission evaluation of the Support Service program

Primary Health Networks (PHNs)	• Manage Commonwealth and State funding agreements for delivery of the Service. • Commissioning an appropriate service provider for the delivery of The Way Back. • Monitoring the delivery of the service in accordance with the licensing agreement. • Providing monthly and quarterly reports to Beyond Blue regarding the delivery of the service as part of quarterly Licensing and Governance Meetings. • Support the development of relationships between the service provider and the LHD, particularly in relation to referral and escalation pathways. • Ensure all relevant PHN staff and personnel receive training in The Way Back Training Materials. • Ensure the staff of the Service Provider, delivering The Way Back Support Service, are trained in the Training Materials. • Provide contract management and governance of the Service Provider.
Service Provider	• Delivery of The Way Back in accordance with the licensing agreement and service delivery model. • Providing reports to PHN as articulated within service delivery agreements. • Develop and maintain relationships with the LHD and in particularly establish referral and escalation pathways
Local Health Network (LHN) Mental Health Teams	• Ensures 100% of referrals for consenting patients are made to The Way Back service provider in accordance with KPIs. • Ensures all relevant staff and personnel receive training in The Way Back Support Service policies and procedures. • Establishes and embeds referral and escalation procedures to and from The Way Back. • Establishes relationships with the PHN and any Service Provider for the purpose of promoting and referral to The Way Back Support Service.

Information Management

All 'The Way Back' Services Providers must have data management systems in place that allow the collection of The Way Back Minimum Data Set. All systems should also be compliant with State and Commonwealth privacy and data collection standards, regulation and legislative requirements. Details of The Way Back Minimum Data set are contained in the *Minimum Data Set and Data Dictionary.*

Key Performance Indicators and Reporting Requirements

The delivery of The Way Back is subject to six Key Performance Indicators. These are defined below in Table 4.

Table 4. Key Performance Indicators

KPI	Description	Target Metric
Initial contact with Referred Person	For Referred Persons who are confirmed as eligible for The Way Back Support Service, contact[21] must be attempted with the Referred Person within one Business Day of receipt of the referral by the Service Provider.	100% of eligible Referred Persons attempted to be contacted within one Business Day of receipt of referral.
Correspondence with Primary Nominated Professional on entry to the service	For all Clients who have provided consent for their Primary Nominated Professional to be notified, correspondence must be sent advising them of their Client's participation in The Way Back Support Service within three Business Days of consent being obtained.	Where consent has been obtained, 90% of Primary Nominated Professional are to be notified of the Clients' participation within three Business Days.
Correspondence with Primary Nominated Professional on exit from the service	For all Clients exited from the service (unplanned or planned) and who have nominated a Primary Nominated Professional, correspondence must be sent by the Service Provider to their identified Primary Nominated Professional within three Business Days of the exit date.	Where consent has been obtained, 90% of Primary Nominated Professional are to be notified of the Client's exit within three Business Days of the exit date.
Safety Plan Update/development	Safety Plans must be updated or developed preferably at the initial Contact with the Client and no later than the second Contact.	90% of safety plans must be updated/developed by the second Client Contact.
Support Plan Development	Support Plan is to be developed within two weeks of consent to participate in the service.	90% of Support Plans must be completed within two weeks of consent to participate in the service.
Quarterly New Client Episode Target	Achieve 100% of the relevant Quarter New Client Episode Target per Quarter.[22]	The Service Provider must achieve 90% of the Target.

PHNs will be required to provide Quarterly Performance Reporting on The Way Back. This includes both quantitative information derived from The Way Back Minimum Data set as well as qualitative information.

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

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

Clinical Governance and Quality Assurance

Delivery of The Way Back must comply with *The Way Back Clinical Governance Strategy*. Services must have in place systems, mechanisms and processes that ensure compliance is recorded measured and monitored.

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